A Qualitative Study of Healthcare of the Elderly:

A case study of Indians in

Avoca, Durban

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DECLARATION

I, Sachin Sewpersad, declare that:

1. The research reported in this thesis, except where otherwise indicated, is my original research.
2. This thesis has not been submitted for any degree or examination at any other university.
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Abstract

Global populations are rapidly ageing, and as a result there is an elevated burden of disease and ill-health. This increase is generally associated with the process of ageing especially in contexts where there is a lack of resources and access to medical healthcare. The recent emergence of the COVID-19 pandemic and its high mortality risk for the elderly now sheds more light on the issues surrounding ageing and health, as the elderly are the most vulnerable to mortality from such diseases. This study investigates the healthcare needs, opportunities and challenges of elderly Indians in Avoca, Durban. The study employed a qualitative approach, relying on interviews with 20 elderly Indian men and women living in Avoca, Durban. The interviews revealed that the elderly mainly required healthcare for chronic non-communicable diseases such as hypertension, diabetes mellitus, and cardiac diseases, which they sought at formal healthcare facilities. Finance had a major influence on the choice of healthcare. Healthcare choices are dependent on affordability and accessibility. Some of the participants reported not being able to meet all their needs such as treatment for certain health conditions. There were also challenges in accessing reliable and affordable transport to health facilities. Participants who met their healthcare needs were able to do so with their social grants or family support. Participants that were able to afford medical aid preferred to visit private healthcare providers, whilst those that could not afford medical aid had to visit public healthcare facilities. There was great dissatisfaction with the public health facilities due to overcrowding, never-ending queues, long waiting periods, lack of medication, and poor attitude of staff. Studying the healthcare needs of the elderly provides an opportunity for policy and health system reformation in order to cater to the needs of the growing elderly population. In order to overcome the challenges posed by ageing, interventions must centre around structural reform of existing health systems, the possibility of a national health insurance to create equitable access to healthcare, proper training and gerontology education for health service providers, and policy formulation that will enable health systems to prepare for the rapidly increasing ageing population.

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List of acronyms

COVID-19:	Coronavirus Disease 2019
HIV:	Human Immunodeficiency Virus
NHI:	National Health Insurance
SARS CoV-2:	Severe Acute Respiratory Syndrome Coronavirus 2
TB:	Tuberculosis
UNDP:	United Nations Development Programme
WHO:	World Health Organization

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Chapter 1: Introduction

1.1 Background to study

Ageing can be defined as a biological change during which there is a gradual increase of molecular degeneration and cellular damage in the human body over time - which cannot repair itself as the physiological capacity to do so reaches its functioning peak (Clegg et al., 2013; WHO, 2015). Observational studies support a temporal relationship between cognitive impairment, memory loss or dementia, weakening immune system and frailty (Clegg et al., 2013). As people age they are more likely to experience several health problems and reduced physiological capabilities - ultimately resulting in death (Clegg et al., 2013; WHO, 2015). Although ageing is a biological process, the meaning is socially constructed (Ameh et al., 2014).

There is no global consensus on the definition of elderly or on an age margin that clearly defines elderly. Many countries often acknowledge a person as being elderly at age 65 and older, however, this may be challenged by improvements in life expectancies, quality of life, and level of function (Sabharwal et al., 2015). Defining 'elderly' is a multifaceted process that often adapts for factors such as chronology, social role dynamics, and changes in capabilities (United Nations, 2012, cited in Sabharwal et al., 2015). In South Africa, elderly refers to persons aged 60 years or older (Statistics South Africa, 2017).

Population ageing occurs when older people increasingly make up a larger proportion of the total population (Maharaj, 2020) and it is likely to become the next global health challenge (Suzman et al., 2015). Demographic extrapolations strongly imply that global populations are ageing. This might be the biggest demographic dynamic of the 21st century, bringing with it many socio-economic and health challenges for countries worldwide - the majority of which will be felt in low and middle-income countries (Chatterji et al., 2015; Tanjani et al., 2015). The elderly will soon outnumber children aged younger than 5 years globally for the first time in history (Suzman et al., 2015).

The increase in the ageing of populations is due to the global epidemiological shift from high fertility and mortality rates to the (deliberate) slowing down of fertility, whilst the increase in life expectancy around the world is an attribute to the success of modern medicine and socio-

economic development (Clegg et al., 2013; Dokpesi, 2017). Life expectancies are expected to rise to 83 years in high-income regions and 75 years in low and middle-income regions (Chatterji et al., 2015). However, greater life expectancy is accompanied by many health problems (Gresh and Maharaj, 2013) and multi-morbidities (co-occurring diseases). With ageing population comes a plethora of disabilities, mental health problems, and non-communicable degenerative diseases. These diseases account for the majority of deaths worldwide, especially in the developing world, posing a major challenge for public health and global healthcare systems (Aboyade et al., 2016; Chatterji et al., 2015; Tanjani et al, 2015). Not only are older people living longer, but some are living longer with poor health (Maharaj, 2020). Multi-morbidities do not only affect the elderly, yet the prevalence is much higher among them. More than 65% of the elderly are affected by several chronic diseases (Banerjee, 2015). The increase in chronic non-communicable diseases requires health systems to acclimatise and strategize methods to meet the needs of older patients with increasing multiple chronic conditions (Peltzer and Phaswana-Mafuya, 2012).

By the year 2050, the total number of people aged 60 years and older is predicted to be greater than 2 billion people and will constitute 21.1% of the global population, 80% of whom shall reside in low and middle income countries (Clegg et al., 2013). In Japan, declines in fertility and early mortality have resulted in rapid population ageing. Japan has the largest ageing population – 23% of Japan's total population – in the world, which has resulted in an increase in the need for long term care of older persons in the country (Furuta et al., 2013). China has the largest population in the world, and its ageing population is also on the rise. By 2015, China's ageing population was more than 137 million people, or just over 10% of the population at the time, and is expected to reach more than 23% (around 400 million people) of the population by 2050 (Liu et al., 2015). Over 100 million of the Chinese elderly will need daily life assistance (Zeng and Hesketh, 2016). Increased life expectancy, combined with the one-child policy has slowed down the rate of population replacement, and China will eventually have the largest elderly population in the world (Ren and Treiman, 2015). Europe is also a good example of a region that suffers from population ageing. The United Kingdom's elderly cohort is expected to consist of 23% of the total population by 2034 (Parker et al, 2014). The majority of the United Kingdom's health budget is already spent on non-communicable diseases due to their prevalence and large population (Frost et al., 2015). Germany is also one of the European countries most severely affected by ageing, with an

elderly population that is predicted to double by 2030, and increasing the pressure on healthcare services and the cost thereof (Heider et al., 2014).

Ageing is a major social and public health concern, not only in the developed world, but also in developing regions such as Africa (Callixte et al., 2015; Schatz et al., 2015) where the elderly population will increase substantially over the proceeding decades (Alli and Maharaj, 2013). By 2050, Africa's elderly population will reach around 212 million people, which will be approximately 11% of the total population on the continent (Frost et al., 2015). Most African governments have not adequately addressed the ageing conundrum (Maharaj, 2013) and very little light is shed on the problems of old age in the region (Aboderin and Beard, 2015). Death rates from age-related non-communicable diseases are much higher for countries in sub-Saharan Africa than in other regions, with elderly women at higher risk than elderly men (Aboyade et al., 2016). The hospital admission, and death, of patients is quite high for the elderly worldwide and continues to increase, but more so in Africa. This is mainly because the continent is experiencing a demographic transition of falling mortality rates and high fertility rates, in which life expectancies increase, resulting in an ageing population (Adebusoye et al., 2015).

In Nigeria the growing number of the elderly and their healthcare needs have been receiving more recognition (Odaman and Ibiezugbe, 2014). Nigeria has the largest population size of any country in Africa, and it is ageing amidst the country's poor health, society, and economy (Dokpesi, 2017). Nigeria has an absence of social security services for the elderly, whose households are solely responsible for their healthcare expenses, which may lead to great financial costs (Ameh et al., 2014) as most of Nigeria's healthcare expenditure comes from out-of-pocket spending (Dokpesi, 2017). Nigeria had an elderly population of over eight million people in 2012, which is expected to increase to over 11 million by the year 2025 (Dokpesi, 2017).

Mid-year demographic estimates by Statistics South Africa for 2017 show that the country's elderly population constitutes 8.1% of the total population, implying that South Africa's population is ageing (Schatz et al., 2015). Between 2002 and 2022, South Africa's elderly population is expected to increase from 3.3 million to 5.7 million (9.1% of South Africa's total population will be elderly), with a 69.7% increase in the elderly in this period (Solanki et al., 2019). South Africa's life expectancy has been increasing over the past few decades

(Aboyade et al., 2016) and has been aided by HIV antiretroviral treatment and other improvements in sanitation, housing, and nutrition. This treatment helps to suppress the viral load in the human body, thereby effectively allowing infected people to live longer healthier lives, and increasing life expectancy in the country (Ameh et al., 2014; Bor et al., 2015; Mayosi and Benatar, 2014). The HIV pandemic has had a significant impact on the structure of traditional families and caring for the elderly. Usually the younger generations care for the aged, however, since the younger cohort is largely affected by HIV this is no longer possible (Kautz et al., 2010). South Africa's growing number of elderly is suggestive of a country that is on a demographic and health transition, suggesting impending resource requirements (social-economic and health) that the country will have to meet. HIV/AIDS triggered a decline in the country's life expectancy at birth between 2002 and 2006, after which health programmes and anti-retroviral treatment were expanded to prevent vertical HIV transmission. This resulted in fundamental improvements in life expectancy in South Africa between 2007 and 2017. By 2020, life expectancy at birth was 62.5 years for males, and 68.5 years for females (Statistics South Africa, 2020b).

1.2 Motivation for study

Although Africa's population is largely youthful, the total number of elderly is expected to grow radically over the next few decades, and more so in this region than any other region in the world. Therefore there should be more focus on the population aged 60 years and over (Pillay and Maharaj, 2013). Sub-Saharan Africa's rapidly ageing population presents challenges to health-care systems (Frost et al., 2015), which needs specialised knowledge to cater for the approaching increment in age-related healthcare problems. Dokpesi (2015) states that a blend of existing care methods is required, which must also account for prevailing environmental conditions of the society, and prioritize each method according to the needs of the elderly. Ageing is a critical process in human society therefore, it is imperative to study and understand the need for care of the elderly. The recent emergence of the COVID-19 pandemic and its high mortality risk for the elderly now sheds more light on the issues surrounding ageing and health - especially since the risk factors for COVID-19-related mortality include pre-existing chronic conditions such as hypertension, heart diseases, and diabetes mellitus (Zhou et al., 2020) which are highly prevalent in older persons.

Even though there is a growing awareness surrounding the rapid ageing of the world's population, policy debates mainly surround ageing in developed regions, with less attention in developing regions such as sub-Saharan Africa, which remains the world's most destitute region (Aboderin and Beard, 2015). This is also attributed to the issues of ageing being overshadowed by the plethora of other problems faced by the African continent such as HIV and youth issues (Fonchingong, 2014). Africa's population of elderly is increasing, with older people becoming more vulnerable to social inequities caused by urbanisation, nucleation of families, and rising healthcare costs, with no social health protection in most African countries (Parmar et al., 2014) and have, until recently, been ignored due to the continent's youthful population receiving more attention (Gresh and Maharaj, 2013).

1.3 Problem statement

Maharaj (2013) argues that ageing has dire consequences for both the elderly and the broader society, especially since it occurs alongside health profile dynamics. Limited resources, fiscal constraints, spatial differences, and under-served areas result in the elderly practicing informal healthcare such as traditional healing, self-care, or home-based, community-based, and family-based care (Apt, 2013), or neglecting their care altogether. A lack of long-term healthcare policies for the elderly also effectively creates a deficit in health service packages for the elderly.

With age comes age-related medical conditions or degenerative diseases (such as physical disability). Rapidly ageing populations are testing health care systems, and providers are not equipped with the specialised knowledge and skills that are required to cater to the needs of the increasing age-related medical conditions and health statuses (Frost et al., 2015). Sub-Saharan Africa's swiftly ageing population is presenting challenges to health care systems due to the increase in the number of people requiring treatment from age-related chronic diseases, and doctors need specialised knowledge to prepared for the increase in age-related medical conditions (Frost et al., 2015). Some of the problems with South Africa's current health service provision include long waiting periods due to human resource shortages, poor hygiene, medical negligence and litigation, medicine and equipment shortages, and poor record-keeping (Maphumulo and Bhengu, 2019).

The Lancet (2012, cited in Parmar et al., 2014) recognised global ageing populations as a precarious issue that must be challenged in order to create sustainable health improvements. Health systems will experience major pressure as more elderly require healthcare services due to the increase in non-communicable diseases. Ageing threatens the sustainability of healthcare systems of all countries therefore it is imperative to redesign care processes to properly respond to the needs of the elderly (Ilinca and Calciolari, 2015).

The economic position of the elderly affects their health-seeking behaviour and decision-making, and they may be reluctant to seek healthcare due to high costs, which is problematic as many of them are unemployed and do not have a reliable source of income (Zihindula and Maharaj, 2013). Financial constraints to healthcare, spatial differences, and under-served (especially rural) areas, all result in the elderly practicing informal healthcare behaviours such as traditional healing, self-care, or home based care (Apt, 2013). These problems are often exacerbated by the elderly who need to care for their grandchildren, and they have minimal financial resources (Hölscher, Kasiram, and Sathiparsad, 2009). A lack of long-term healthcare policies for the elderly results in family-based care being the backbone for the elderly with poor health status (Teerawichitchainan and Knodel, 2018). In sub-Saharan Africa there is a lack of formal pensions and social welfare schemes due to limited resources, effectively creating a deficit in health service packages for the elderly, which is a conundrum since the elderly inherently have a heavy burden of, mostly chronic and degenerative, diseases (Alli and Maharaj, 2013). These diseases have a multitude of risk factors, which are exacerbated by prevailing socio-political conditions in the continent (Alli and Maharaj, 2013).

South Africa is currently reforming its health system by increasing primary healthcare implementation (Nxumalo, Goudge and Manderson, 2016). Studies such as Nxumalo et al. (2016) and Mashau, Netshandama, and Mudau (2016) explore the experiences, constraints and impacts of primary elder care to meet elderly healthcare needs in South Africa, especially in terms of voluntary community and home-based care. Mashau, Netshandama, and Mudau (2016) explain that home-based care programmes are found to be imperative in easing pressure on healthcare institutions globally, especially in caring for the elderly, however, their study in South Africa found that it may have negative impact the wellbeing of caregivers, which in turn influences the quality of the care provided. Knight, Mukumbang, and Schatz (2018) argue that South Africa's ageing is concurrent with the country's double

burden of diseases - high HIV prevalence and increasing emergence of non-communicable diseases - and elderly who live with HIV are more susceptible to other chronic diseases, yet have to visit separate healthcare facilities for treatment, creating a barrier to healthcare and exacerbating their ill-health. There are also gender disparities in ageing, as functional disabilities are unequally distributed, affecting women and the socio-economically disadvantaged more severely (Serrano-Alarcón and Perelman, 2017).

The situation of ageing in low and middle-income countries is much less studied than in higher-income countries, with very little available data (Chatterji et al., 2015). In Western contexts, there are several studies surrounding ageing and challenges for the elderly. However, in the African context, there is very little literature to draw from, due to the deficit of research that focuses on elderly care. There are very few studies that focus on the Indian population in South Africa. Additionally, existing literature is outdated. Indians (sometimes classified as Asian) form one of the major population groups of South Africa, consisting of around 2.6% of the country's total population (Statistics South Africa, 2020b), and therefore play a major role in society and the economy. Additionally, the Sustainable Development Goals highlights 'leave no one behind' as one of its major goals on the 2030 Agenda, which aims to promote the socio-economic and political growth and inclusion of all members of society, irrespective of their demographic background – such as race (United Nations, 2016).

Very few studies focus on the experiences of Indians. Statistics South Africa's (2019a) Vulnerable Groups Indicator Report repeatedly stated that results from the Indian population should not be taken at face value or generalized as there was a smaller sample of Indian participants in the South African Demographic and Health Survey. This leaves a major gap in vital research. This lack of inclusion of Indians may result in severe inequalities in policy and intervention formulation. This sort of challenge must be addressed to allow for their easier participation in society, politics, and the economy (United Nations, 2016) therefore, research must more sufficiently represent Indians.

Research in the context of the health and care of persons must also cover all groups of people. Chronic illnesses such as diabetes mellitus, hypertension, and heart disease are some of the leading causes of mortality, and are highly prevalent among Indians, particularly in South Africa (Abate and Chandalia, 2001; Prabhakaran, Jeemon, and Roy, 2016; Prakaschandra et

al., 2016; Seedat et al., 1990). These are mainly attributed to poor lifestyle choices and dietary habits such as the consumption of saturated fats (Wolmarans et al., 1999).

A study by Prakaschandra et al. (2016) was the first to document the dangerously high prevalence of cardiovascular disease risk factors among Indians. The study explains that hypertension, coronary heart disease, and diabetes mellitus are highly prevalent diseases in this population group and their rates of change over the past few decades have been of epidemic proportions (Prakaschandra et al., 2016). This is a major cause for concern, especially in light of the ongoing COVID-19 (Coronavirus) pandemic, as these chronic illnesses (hypertension, heart diseases, and diabetes mellitus) significantly increase the risk of complications and mortality from infections, especially in older persons (Zhou et al., 2020). Therefore, this study investigates the healthcare needs of elderly Indians in Avoca, Durban.

1.4 Aim of the study

The overall objective of this study is to shed insights into the health of elderly Indians in Avoca, Durban.

The specific objectives of this study are:

1. To ascertain the healthcare needs of the elderly.
2. To identify the factors that influence decision-making about healthcare of the elderly
3. To explore the opportunities and constraints in meeting the healthcare needs of the elderly Indians

In order to understand the objectives of the study the study has a number of key questions.

- What are the healthcare needs of the elderly based on their current health status?
- What factors determine healthcare choices of the elderly?
- What challenges and opportunities do the elderly face in accessing healthcare?

1.5 Theoretical framework

The theoretical framework of this research centers on the hierarchy of needs, by American psychologist Abraham Maslow. In his 1943 paper titled “A Theory of Human Motivation”, Maslow proposed that healthy human beings have a certain number of needs which are arranged in a hierarchy, with some needs being more basic and essential than others (Maslow, 1943). These needs motivate human beings to survive. The hierarchy is often represented in a five-tiered pyramid, within which higher needs come into focus only after basic needs at the base of the pyramid have been met. They are organised from the bottom up as follows:

1. Physiological needs include biological requirements for human survival, such as air, water, food, rest, health. The body cannot function optimally without satisfying these needs. These are the most essential, as all other needs are secondary until these are met.
2. Security needs includes shelter from the elements, safety and law, stability, freedom and fear.
3. Social needs are the need for the feeling of being loved, the feeling of belonging, the need for interpersonal relationships, and social inclusion.
4. Egoistic needs include self-esteem, power, recognition, prestige.
5. Self-actualization involves the realization of personal potential and the need for personal development and creativity.

Figure 1.1 below illustrates each of the needs in their respective order.

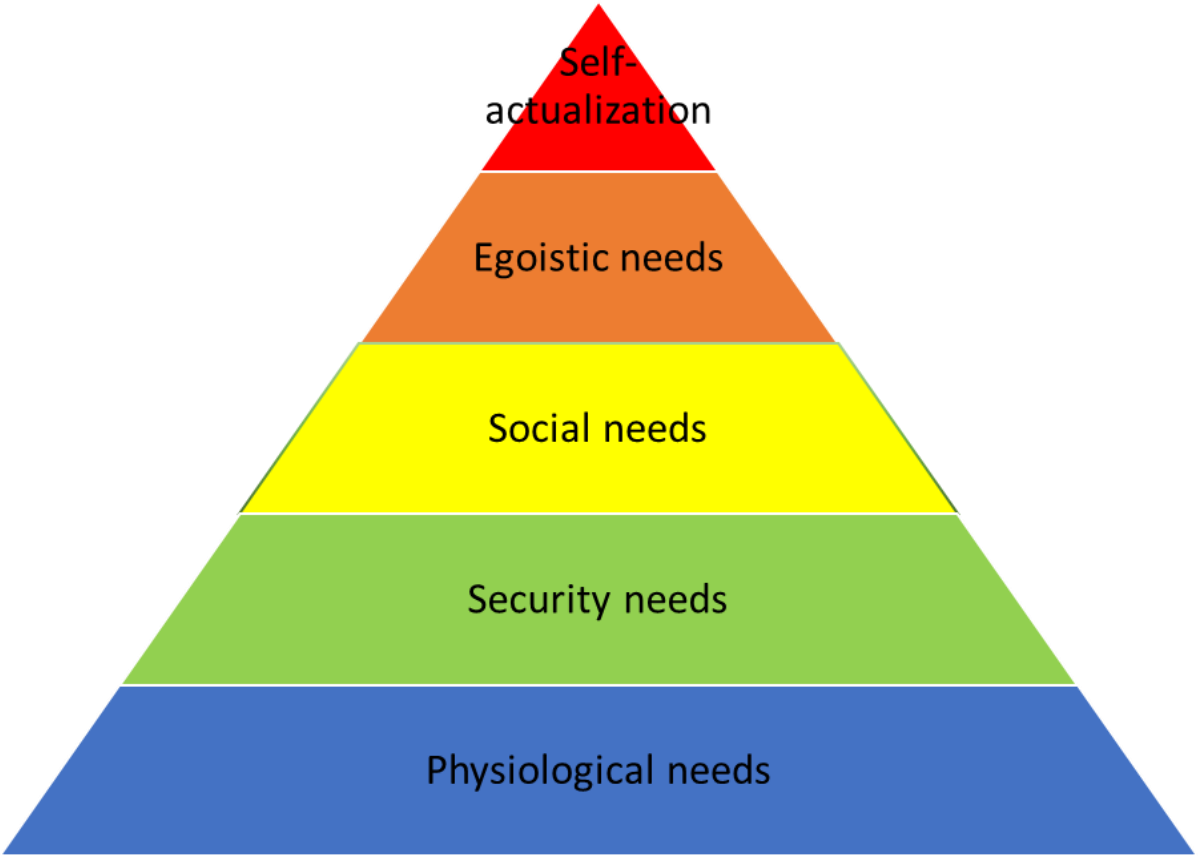

Figure 1.1 Maslow's Hierarchy of Needs.

Research has previously criticised this theory as being irrelevant in many parts of the world due to its Western origin (Jerome, 2013). However, Maslow's hierarchy of needs theory remains relevant in multiple social science disciplines, particularly geriatrics, as it best analyses lower order needs (physiological needs and security needs) such as healthcare, which is the main focus of this study. The elderly must meet their lower-order needs, which are imperative for survival. The third level of needs, social needs, may apply to this research in the sense that the elderly also have the need for being loved, having a feeling of belonging in society and within their families, as people seek to overcome feelings of loneliness and alienation. According to Maslow, one does not meet the needs of the next tier until the demands of the first have been satisfied, therefore the first three needs would result in self-esteem, such as self-respect, and self-actualization, which may be achieved through the elderly living fulfilled lives (Maslow, 1943).

Maslow's hierarchy of needs can be applied to this research in the sense that the elderly have healthcare needs that must be met in order for them to live healthy and functional lives. Vertejee and Karamali (2014) explain that according to Maslow's theory, there are various needs that individuals must attain throughout their lives, and if any of these are unmet, it may impact their quality of life. Healthcare needs fall under the foremost hierarchy, physiological needs, which are biological requirements for human survival. In this research, healthcare needs will be studied as the requirements for maintaining and restoring the physical and mental well-being of the elderly according to their current health status. According to Gold, Stevenson, and Fryback (2002 cited in Kindig, 2007) health status is defined as the health of an individual at any point in time.

1.6 Organisation of dissertation

This dissertation is subdivided into five chapters. Chapter one provides an introduction and background to the study, the motivation behind the study, problem statement, overall and specific objectives, research questions, and theoretical framework of the study. Chapter two reviews the literature on ageing, the elderly's health status, their healthcare needs, and challenges. Chapter three outlines the main methods used in the study. It outlines the research methods, design, and data collection instruments utilised in this study. Chapter four presents the results of the interviews that were conducted with the elderly in accordance with the objectives and research questions of this study. The fifth chapter concludes the research and presents a discussion of the main findings of the interviews, comparing the results to that of other studies, and provides recommendations for future research.

Chapter 2: Literature Review

2.1 Introduction

Ageing comes with a dramatic increase in the incidence of non-communicable chronic degenerative diseases, mental health disorders, and disabilities (Gresh and Maharaj, 2013; Tanjani et al., 2015) which all in-turn, affect overall quality of life. Multi-morbidities or having more than one disease at the same time are related to higher use of health care services (Bähler et al., 2015). This chapter reviews existing research on the healthcare of elderly from a global to a local perspective. The chapter first overviews ageing populations, then overall quality of life and health status conditions of the elderly, healthcare needs of the elderly, barriers and challenges to elderly, and finally existing healthcare policies, opportunities and future avenues in elderly healthcare.

2.2 Health status and diseases

Health status is multifaceted and incorporates a range of meaning including physiological, physical, social, and mental factors (Tanjani et al., 2015). The World Health Organisation defines health as a state of complete physical, mental, social, and spiritual well-being (WHO, 2006). The elderly are afflicted by various multi-morbidities, co-morbidities (additional health problems that often come along with a primary condition) and functional limitations (such as disabilities). These health conditions must be assessed differently from the younger population group (Tanjani et al., 2015). Studying the health status of the elderly may be challenging due to ageing being in multi-faceted process and not a disease in itself (Adhikari and Rijal, 2015).

2.2.1 Communicable diseases

Communicable diseases such as HIV are common among the elderly, particularly in South Africa, and may exacerbate non-communicable diseases (Aboderin and Beard, 2015; Mayosi and Benatar, 2014; Odaman and Ibiezugbe, 2014). The number of HIV positive cases in elderly South Africans is predicted to double by the year 2025 (Hontelez et al., 2011) which is alarming, as it increases the susceptibility to other infectious diseases due to having a compromised immune system. The elderly are more vulnerable to communicable or

infectious diseases, especially those of the respiratory tract - such as tuberculosis and severe acute respiratory syndrome (SARS CoV-2/COVID-19) and as a result, are at higher risk of infection and death (Byng-Maddick and Noursadeghi, 2016; Centers for Disease Control and Prevention; 2020).

The elderly are susceptible to pulmonary tuberculosis infections, which results in coughing up blood, fevers, sweats, and weight loss (Byng-Maddick and Noursadeghi, 2016). The outbreak of the COVID-19 pandemic has shed even more light on the vulnerability of older people to contracting infectious diseases. The Centers for Disease Control and Prevention (2020) of the United States reported that 80% of deaths from COVID-19 (SARS CoV-2) were of older adults aged 65 and over. This was the same as in China where the disease first broke out and had 80% of deaths among 60 year olds and over, highlighting the extreme vulnerability and risk of the elderly to infectious diseases. Other communicable diseases that affect the elderly include kidney infections, flus and colds, fever, and malaria (Ameh et al., 2014; Odaman and Ibiezugbe, 2014).

2.2.2 Non-communicable diseases

Non-communicable diseases account for about two-thirds of mortality globally, posing a major public health challenge, and affects more people at older ages. The elderly are more susceptible to developing non-communicable diseases with attendant co-morbidities, and are also more vulnerable to the long-term health consequences of non-communicable diseases (Aboderin and Beard, 2015). The process of ageing also comes with an increase in the rate of non-communicable diseases, each with their own physical and mental challenges (WHO, 2015). Some of the most frequent non-communicable diseases include hypertension, diabetes mellitus, arthritis, hearing problems, and oral health problems (Adhikari and Rijal, 2015). Chronic diseases and multi morbidities are some of the biggest burden on health services globally (Bähler et al., 2015).

Hypertension, or high blood pressure, occurs when the blood vessels have increased pressure inside caused by the force of blood pressing against their walls as it is pumped through the veins, and this forces the heart to pump harder, increasing the risk of cardiovascular diseases, stroke, and death (WHO, 2018. cited in Statistics South Africa, 2019b). South Africa has the highest prevalence of hypertension of all sub-Saharan African countries. For the elderly aged

65 and over, 84% of them suffer from hypertension (Statistics South Africa, 2019b). Almost every second elderly person has hypertension in South Africa which is disturbing as hypertension increases the risk of other diseases and strokes (Statistics South Africa, 2019b).

Diabetes mellitus is also common among the elderly and is one of the most prevalent lifelong chronic diseases globally. It is caused by the deficit or inefficiency of insulin produced in the pancreas resulting in high blood glucose levels, which in turn damages the body's nervous and vascular systems (Statistics South Africa, 2019b). According to the General Household Survey of 2016, 16.6% of elderly in South Africa suffer from diabetes mellitus (Statistics South Africa, 2019b).

Cardiovascular disease develops gradually with age, and ischaemic heart disease contributes to high mortality numbers (Prince et al., 2015). Periphery artery diseases have a higher prevalence among the elderly in Africa and globally (Desormais et al., 2015). Cancers of the breast, colon, rectum, ovaries, and prostate are also common in the elderly, and the rapid ageing of populations will result in a peak in the number of cancer cases (Poynter, 2013).

There are many cases of disability-adjusted life-years in sub-Saharan Africa (Aboderin and Beard, 2015). The elderly also suffers from nutritional deficiencies, visual impairment, functional limitations, and musculoskeletal diseases (Aboderin and Beard, 2015). Depression and anxiety are also prevalent, and these mental illnesses tend to be more prevalent in older-ages due to the risk of adverse life-events that have accumulated over time (WHO, 2015).

As people age they may face a decline in dental count and if the elderly are unable to access dentures they may encounter eating disorders, such as dysphagia, impairing the ability to consume the right amount of food for meeting their healthy nutritional needs. This may lead to malnutrition (Furuta et al., 2013). Poor food security and access to nutritious food highlights how healthcare schemes with limited integration are unable to respond to the socio-economic conditions of the communities they are meant to serve, and the lack of food may also result in poor adherence to treatment (Nxumalo, Gouge, and Manderson, 2016).

Oral health problems are also rife among the elderly, and may cause pain, embarrassment, and also facial musculoskeletal problems (Molete, Yengopal, and Moorman, 2014). Poor oral health status may negatively affect the general health and quality of life of the elderly,

hindering chewing and swallowing functions, and negatively impacting self-esteem due to poor dental health (Molete, Yengopal, and Moorman; 2014). Oral health status is also a growing concern for the elderly, with most suffering from periodontal conditions, however, only a small proportion of these people utilise oral health care due to perceived barriers (Molete, Yengopal, and Moorman; 2014). Oral health problems in the elderly, such as lower dental count are directly related to problems in swallowing food, which often results in cognitive impairment and malnutrition. Preventing dental loss (maintaining dental count from a young age) and encouraging the use of dentures may indirectly improve daily life of the elderly by recovering swallowing function, and improving nutritional status (Furuta et al., 2013). Malnutrition in turn contributes to the exacerbation of cognitive and functional decline in the elderly, resulting in a diminished quality of life and increasing loss of independence (Naidoo et al., 2015). There is also a high need for oral health care due to dental loss and other oral health problems that the elderly face. A study in Johannesburg, South Africa found that the utilisation of oral health care was very low due to perceived barriers to oral healthcare, even though such services were provided at the public level (Molete, Yengopal, and Moorman; 2014).

There is a high prevalence of malnourishment among the elderly in South Africa. A study conducted in KwaZulu-Natal by Naidoo et al. (2015) found that half of the study population were at risk of malnutrition. The elderly suffer from malnutrition due to other physical or physiological changes, such as health problems, age-related illness, poverty, oral health decline, and poor access to nutritious food (Statistics South Africa, 2019b). South Africa's elderly are highly affected by malnutrition due to poor dietary practices such as eating foods that are high in fat sodium sugar and low in fibre (Statistics South Africa, 2019b).

2.3 Quality of life

Steptoe, Deaton, and Stone (2015) states that there are three aspects of subjective wellbeing - evaluative wellbeing (life satisfaction), hedonic wellbeing (feelings of happiness, sadness, anger, stress, and pain), and eudemonic wellbeing (sense of purpose and meaning in life – or self-actualization) and all three may be linked to Maslow's hierarchy of needs. Measures of economic performance, such as gross domestic product (GDP) are inadequate indicators of societal progress, and self-reported, subjective wellbeing should also be accounted for, and

are therefore becoming a key focus of intense debate in public policy and economics (Steptoe, Deaton, and Stone, 2015).

The elderly's quality of life is influenced by their health status along with non-health-related factors as measured by subjective wellbeing, such as material conditions, familial and societal relationships, social roles and activities – which are all also temporal factors associated with ageing (Steptoe, Deaton, and Stone, 2015). The elderly may lose their independence as they get older due to disabilities, cognitive decline, financial problems, and the loss of motor functions (frailty), and may thus require family-based support in terms of care, living arrangements, and financial assistance (Ren and Treiman, 2015; Schatz et al., 2015).

Health and subjective wellbeing are interrelated, and this relationship becomes more important as people grow older since the risk of chronic and degenerative illnesses increase with age. It may preserve health, minimizing the risks of chronic diseases and degenerative disorders, and promoting longevity. Subjective wellbeing should be implemented as a measurement of health evaluation and used in allocation of healthcare resources (Steptoe, Deaton, and Stone, 2015).

As life expectancy increases, and treatment for dangerous diseases become more effective, maintaining wellbeing at older ages becomes more important (Steptoe, Deaton, and Stone, 2015). Low socioeconomic status and poverty are highly associated with poorer health as the lack of financial resources are a barrier to health seeking behaviour (Ameh, 2014). Preserving a healthy lifestyle for the elderly is necessary for longevity as life expectancy alongside education and per capita income are used to measure human development index which is used as an indication of a country's overall socio-economic progress (UNDP, 2010).

European countries such as Italy, Spain, and Greece seem to have much larger proportions of disabled people across all ages, yet impediments with activities of daily living (such as bathing, walking and dressing) become more apparent in the elderly across all countries (Chatterji et al., 2015). Even though successive cohorts of elderly have steadily improved in health - with respect to overcoming the challenges in activities of daily living- these activities (walking, bathing, and dressing) did not improve (Chatterji et al., 2015). More elderly women than elderly men report poor health status and lower quality of life (Aboyade et al., 2016). In a study conducted in Iran (Tanjani et al., 2015), there were notable gender disparities in the

health status of elderly men and women. The majority of elderly were independent in their active daily lives, and required no assistance, however, there was higher dependency among women than among men. Less than a quarter of elderly did not participate in any physical activities or sport. Nearly half the elderly population were at risk of malnutrition.

As people age they may experience multi-morbidities, including multiple chronic illnesses that occur at once which may lead to negative interactions between each condition or their specific treatments. Multi-morbidities are associated with higher usage of healthcare services which also increases the pressure on the healthcare system as populations age (Bähler et al., 2015; WHO, 2015). Hospitalisation of the elderly for any medical condition is a risk factor for death as it is associated with increased exposure to infections, loss of independence and autonomy, isolation, and disability (Adebusoye et al., 2015). Frailty and cognitive decline are also major health concerns for people as they age because they cause a decline in the activities of daily living and affect the quality of life of the elderly (Buckinx et al., 2015; Clegg et al., 2013). One of the growing problems that the elderly face is abuse. More than 60% of elderly men and women experience some form of abuse in South Africa (Bigala and Ayiga, 2014).

Frailty is the most challenging expression of ageing, and is defined as the increased vulnerability of the human body to a weakened homeostasis (which is the stability of the cells of the body) and increases the risks of dangerous occurrences such as falling, delirium and disabilities (Buckinx et al., 2015; Clegg et al., 2013). Between 25% and 50% of the elderly aged 85 years and older are expected to be frail, and these people have greater risks of falling, disabilities, long-term care, and ultimately, death (Clegg et al., 2013). Mobility independence and the ability to perform activities of daily living autonomously become compromised as well (Buckinx et al., 2015; Clegg et al., 2013). Frailty, along with disabilities, physically prevent the elderly from accessing their healthcare (Vergunst et al., 2015; Serrano-Alarcon and Perelman, 2017). Cognitive decline is the loss of the mental ability to acquire and understand knowledge, concentrate, and make decisions – and is caused by a number of cognitive disorders such as dementia, delirium, and other mental depressive conditions that are exacerbated through underlying neuropathological causes (WHO, 2015; WHO, 2019). Frailty increases the utilisation of primary and secondary healthcare services, and the condition requires exercise and a healthy nutritional diet in order to combat the effects that come along with it (Clegg et al., 2013; Ilinca and Calciolari, 2015; Kehusmaa et al., 2013).

Isolation and feelings of loneliness are often detrimental to the mental health of the elderly and leads to risky health behaviour such as substance abuse, and causes other physical health problems (Mudege and Ezeh, 2009). Elder abuse - which may be physical, financial, emotional, or sexual - is getting more attention as a public health concern as it often results in suicide, depression, anxiety, post-traumatic stress, neglect, loneliness, and death. The prevalence of elder abuse is quite high in South Africa (Bigala and Ayiga, 2015). Factors associated with elder abuse include being single, living in rural areas, no working children, poor self-awareness of health, and being disabled. The high and common prevalence of elder abuse requires strategies to prevent the act (Bigala and Ayiga, 2014). The mental health of the elderly may also be affected by their wellbeing, for example, depression levels increase after being diagnosed with diabetes mellitus, coronary heart disease, stroke, cancers, and kidney disease.

2.4 Accessibility and availability of healthcare for the elderly

The elderly require a great deal of healthcare attention. However, they are more likely to suffer from inequitable access to required healthcare due to socio-economic and institutional barriers. The healthcare needs of the elderly should be incorporated into emergent frameworks in order to provide the adequate required health care services for the elderly (Aboderin and Beard, 2015). The high prevalence of chronic health problems and multi-morbidities (co-occurring diseases) in the elderly warrants the need to determine which chronic conditions have the greatest implications on their health status and quality of life, and ascertain where supplementary interventions may be required to improve these conditions (Parker et al., 2014). Multi-morbidities require special attention, and each disease requires special treatment, and precautions need to be taken so that the treatment for each of these diseases do not interact with each other (Marcum et al., 2014).

In sub-Saharan Africa the growth in ageing populations are exceeding socio-economic development and the ability of countries to provide health and social services (Gyasi, 2018). As the ageing population in sub-Saharan Africa grows rapidly, doctors in most medical fields will have to learn how to care for geriatric patients. This requires educating future doctors in the treatment of non-communicable diseases, which will require skills such as educating patients about their lifestyle choices, how they increase their risk factors for non-communicable diseases, and pharmacological knowledge to minimise the effects of taking

more than one treatment for non-communicable diseases (Frost et al., 2015). A study in Iran showed that diabetes mellitus self-management education is essential for improving the quality of life and health of those living with illness; however, these programmes need to be amended in order to meet the needs of the targeted age group (Dehkordi and Abdoli, 2017).

The elderly, in different parts of the world, mainly seek health care at public institutions or private healthcare institutions, whilst others prefer homoeopathic or traditional medicine (Aboyade et al., 2016; Odaman and Ibiezugbe, 2014). In some countries, the impoverished elderly are unable to access private healthcare so public healthcare is utilised, however, in the absence of government provided healthcare, they are forced to make out-of-pocket payments for their healthcare needs (Adisa, 2015). This becomes challenging as the elderly are often unemployed and have to rely on social grants to make ends meet.

South African citizens are provided with free public health care services, and it is stated in the country's constitution that everyone has the right to access healthcare. The country has two current healthcare systems: the publicly funded – that serves most South Africans – and a privately funded system that serves the minority of people who are able to afford it (Kon and Lackan, 2008). There is also rivalry between both sectors as medical professionals prefer to work in the more profitable private sector (Kon and Lackan, 2008). Even though South Africa's healthcare system has stark inadequacies, the public perceptions of how the government is conducting health care service provision are not entirely negative, as the majority of Blacks and Coloureds believed that the government was adequately improving health care services, whilst the opposite was found for Whites and Indians (Kon and Lackan, 2008). Local clinics and health centres are the primary entry point into the healthcare system where people are initially treated, whilst emergency cases are referred to the district hospital, which is the secondary level of care (Ameh et al., 2014). South Africa already has a lot of pressure on its health care system and the increasing population of elderly are expected to exacerbate the many challenges already experienced by the healthcare system. This is of great concern due to the number of non-communicable diseases that come along with ageing and require chronic treatment (Aboyade et al., 2016).

Elderly South African citizens aged 60 and over are entitled to a social grant of R1 860, or R1 880 for those 75 years and older (as of 2021) which is used to prevent absolute poverty amongst the elderly (Schatz et al., 2015). In South Africa a great deal of pressure is put on the

public sector due to the fact that most people cannot afford private sector health services, and only 16.2% of the population has a medical aid or hospital care plan, or make out-of-pocket payments, whilst the rest of the population use government facilities (Statistics South Africa, 2019b).

Chronic conditions require chronic medication which must be taken for the rest of the patients' lives (WHO, 2015), and these are provided at public health care facilities, however, they may also be purchased privately via a private medical practitioner (Statistics South Africa, 2019b). Diseases such as hypertension and diabetes mellitus require long-term treatment, thus landing a huge financial impact on the public sector that must therefore provide the medication for the disease (Statistics South Africa, 2019b). Communicable diseases also require their own type of treatment; HIV requires antiretroviral therapy; tuberculosis requires antibiotic treatment. However, new or emergent communicable diseases such as SARS CoV-2 (COVID-19) still do not have specific modes of treatment (Clerkin et al., 2020).

In traditional societies the elderly were primarily taken care of by their families, mainly their children, however, changing societal norms have altered these ways of life, and changed family structures (Panigrahi, 2013). This is especially so in countries such as India, China, and South Africa where the family is the main support structure for the elderly, especially in areas where there is a lack of nursing homes or other facilities that are required to treat older people as they become more frail (Panigrahi, 2013; Ren and Treiman, 2015; Schatz et al., 2015). South African Black communities still expect families to be the primary sources of care for the elderly (Schatz et al., 2015).

Despite their health status being worse than that of younger people, the elderly of sub-Saharan Africa use healthcare services at a lower rate than the youth (Aboderin and Beard, 2015). This disparity is due to barriers to health care faced by older Africans, such as the lack of an escort or high costs of transport to healthcare facilities, and private sector charges for treatment (Aboderin and Beard, 2015). These needs may be hard to meet since health services are not always equitable especially in developing countries (Thakur, Banerjee, and Nikumb, 2013). Therefore, the barriers and challenges to health care must also be explored.

2.5 Challenges and Barriers to healthcare

The healthcare needs of the elderly with multi-morbidity (having multiple co-occurring diseases), and the degree to which these needs are met, are indicative of the challenges faced by global health-care systems in the 21st century (Banerjee, 2015).

2.5.1 Cultural barriers

Access to health care may also have socio-cultural barriers. Women's access to healthcare is also limited by traditional beliefs and culture, especially since they have multi-tasking roles in society and in their households, which require them to prioritize the needs of men and children over themselves (Aboyade et al., 2016). Other cultural challenges include the belief that poor health is just another part of ageing and getting old, and this is a major deterrent to seeking health care (Adhikari and Rijal, 2015). Traditionally, elders were respected in society, however, changing times and modernism have eroded these cultural norms, resulting in mistreatment and anti-altruistic behaviour towards the elderly (Bigala and Ayiga, 2014).

Some elderly also put their faith in religion to heal them of diseases and ailments, and believe that medical care is not required, which may only seek to exacerbate their conditions (Adhikari and Rijal, 2015). There are sometimes negative perceptions of 'western' medications and treatments, and some people believe that they are detrimental if taken in excess, and therefore incorrectly self-adjust their medication dosage (Zeh et al., 2014). Women seem to be more restricted by cultural barriers due to the fear of physical harassment, gender norms, and sociocultural rules and expectations that oppress women and prevent them from visiting health services (Zeh et al., 2014).

2.5.2 Transportation and distance

Distance poses a major barrier to accessing healthcare. High transport costs, especially to healthcare facilities, may dissuade health-seeking behaviour for prompt treatment. Without transport it is very difficult for the elderly to travel to healthcare facilities, especially those with disabilities, frailties, and other elements that prevent them from walking long distances (Aboyade et al., 2016; Nxumalo, Gouge, and Manderson, 2016; Vergunst et al., 2015). Lack of transportation may also cause missed appointments with doctors or delayed treatment and

therefore consistency in the management of non-communicable diseases (Syed, Gerber, and Sharp, 2013). Aboyade et al. (2016) stated that non-communicable diseases are poorly managed in Africa due to infrequent access, caused by the lack of transport, to the required health facility to obtain medication. Long distances to points of healthcare services limit access to healthcare (Maharaj, 2013) and may also interrupt chronic treatment for ailments such as HIV.

Post-apartheid residential location is still generally racially defined, which may exacerbate transportation barriers if healthcare facilities are far from non-White areas (McLaren et al., 2014). Most elderly in sub-Saharan Africa live in or retire to rural areas, which are typically categorised by underdeveloped infrastructure, and poor service provision, and high dependency burden – meaning that there are fewer people available to take care of the elderly (Maharaj, 2013). This is problematic as travel times to health facilities are longer in non-urban areas (Harris et al., 2011). Maharaj (2013) stated that the ability of the elderly to access health providers and their services are hindered by poverty and longer distances to health facilities.

Travel costs in South Africa are relatively high in comparison to other developing countries, thus minor differences in distance translate into large disparities in terms of access to healthcare (McLaren et al., 2014). Malignant apartheid legacies, caused by the geographic separation of people by race group, indicate ethnic disparities in access to health care in current times. The Black and Coloured population groups are still underserved in comparison to the Indian and White population groups (Kon and Lackan, 2008). However, there have been no further studies on this disparity, therefore the current status of these disparities is unknown. These disparities have deeply divided the health system, as the wealthiest people enjoy private health insurances, whilst the others suffer the poorly managed and resourced public health sector (Marten et al., 2014).

2.5.3 Poverty

Poverty is another major challenge and barrier to accessing health care for the elderly. The costs of chronic diseases are continuously increasing, and in doing so are a major public health burden (Liu et al., 2015). Poverty deters health seeking behaviour as the elderly consider seeking treatment for their illnesses to be a waste of money (Adhikari and Rijal,

2015). Out-of-pocket spending on healthcare may further exacerbate the financial problems already faced by the elderly who must also depend on social grants for an income (Dokpesi, 2017). Poverty causes unequal access to healthcare resources, and also affects other basic needs of the elderly, such as access to clean water, sanitation, nutritious food, housing and shelter, education, and overall quality of life (Mayosi and Benatar, 2014; Naidoo et al., 2015; Nxumalo, Gouge, and Manderson, 2016; Wandera, Kwagala, and Ntozi, 2015; WHO; 2015).

Budgetary constraints prevent the formulation and implementation of policies to improve care for the elderly (Fonchingong, 2014; Gresh and Maharaj, 2013). In sub-Saharan Africa policymakers and researchers spare little attention to the issue of ageing (Parmar et al., 2014). The increase in the number and proportion of the elderly population causes major problems in terms of planning and catering for the healthcare needs of the elderly (Heider et al., 2014; WHO, 2015). Yilmaz et al. (2018) explained that during an economic crisis the elderly suffered the most as they are already unable to generate their own income and must rely on social grants for their support.

South Africa is plagued by extreme poverty, and health is largely affected by lack of access to basic requirements of life (Mayosi and Benatar, 2014). South Africa, when compared to other middle-income nations does poorly in terms of age-adjusted death rate, premature or early deaths, years of life lived with a disability, and life expectancy at birth. This is concurrent with non-communicable diseases continuously emerging in both rural and urban areas, mostly among the vulnerable and poor sectors of society (Mayosi and Benatar, 2014). The rising burden of these diseases, alongside an increase in the proportion of the elderly contributes to the pressure on both short and long-term healthcare services. This burden of non-communicable diseases will likely grow further as antiretroviral therapy curtails mortality from HIV/AIDS (Mayosi and Benatar, 2014). Oral health care is freely available in the South African public health care sector, however, perceived barriers prevent most elderly from accessing oral healthcare, such as the perception that dental treatment is not affordable (Molete et al., 2014). (Molete, Yengopal, and Moorman; 2014).

There are considerable barriers to accessing healthcare services in South Africa, particularly for the poorest of the poor. There is a deficit of healthcare workers and an uneven distribution of services between sectors and geographical areas (Marten et al., 2014). South Africa's health system fails to provide equitable access to effective healthcare, and the poorest groups

who suffer the greatest burden of ill-health have the lowest rates of health service use and achieve fewer benefits from the use of health care (Marten et al., 2014).

2.5.4 Negative perceptions of the elderly

Negative attitudes towards the elderly with disabilities results in poor communication with care providers and inadequate treatment (Vergunst et al., 2015). Anti-altruistic behaviour and stigma may deter them from seeking health care due to the emotional impact it may have on them (Vergunst et al., 2015; Adhikari and Rijal, 2015). The negative perceptions that not much can be done to treat the problems of the elderly, and the association of hospital with death dissuades them from seeking health services. This may be curbed if healthcare workers are trained and equipped with the knowledge to properly care for the elderly (Adebusoye et al., 2015).

2.5.5 Structural barriers

The elderly sometimes prefer private health providers due to the unavailability, perceived poor quality, or age-inappropriate services in government facilities. Some health services are unavailable at government facilities and insensitivity towards the elderly. Patients often complain of crowding, long queues, long waiting periods, and long procedures in terms of administration in order to get healthcare services provided to them at public hospitals (Aboderin and Beard, 2015; Adhikari and Rijal, 2015 Vergunst et al., 2015). The healthcare providers typically emphasize services for infectious diseases, the youth, and reproductive-aged adults (Aboderin and Beard, 2015).

Another challenge is access to care and essential medication for non-communicable diseases (Aboyade et al., 2016). There is also a lack of geriatric education and staff expertise in the teaching of geriatric care (Frost et al., 2015). Doctors have to treat age-related health issues such as non-communicable diseases. Without the knowledge of geriatric treatment and care, they will be unable to provide and manage the proper treatment of these conditions in the elderly patients (Frost et al., 2015). Care homes sometimes lack information and resources that are required to take care of the elderly especially those with mental health conditions (Gordon et al., 2013).

2.6 Policies and interventions

There is growing awareness of the global ageing population (Aboderin and Beard, 2015). In the agenda of the sustainable development goals, ensuring healthy lives and promoting wellbeing for everyone at all ages is a goal that cannot be achieved without attending to the health of the elderly (Suzman et al., 2015). Strategic policy development in all health care systems should rely on information pertaining to promoting good health and health-seeking behaviours alongside the factors that influence these behaviours (physical, socio-economic, cultural and political) (Adhikari and Rijal, 2014). Health inequalities in the developing world are persistent, and act as strong drivers for reforms in healthcare systems and in the mechanisms of care provision, providing a breeding ground for strategies that attract various sectors, besides health, to address the social determinants of health (Nxumalo, Gouge, and Manderson, 2016).

The Madrid International Plan of Action on Ageing called for the eradication of socio-economic inequalities in access to health care and the expansion of healthcare and long-term care to meet the needs of the elderly (Prince et al., 2015). The Madrid Plan of Action was presented at the World Assembly on Ageing in Madrid, Spain, and was a key in highlighting the problems of ageing and encouraging African governments to place more focus on the matter (Gresh and Maharaj, 2013). The plan includes recommendations in areas that include development and the elderly, advancing wellbeing and health into old age; and providing supportive environments for all (Sidorenko and Mikhailova, 2014). It also highlights the importance of the role of governments - and the fact that policy implementation is the responsibility of national governments - in the promotion and provision of basic social services, especially for the elderly (Gresh and Maharaj, 2013). The plan is not mandatory, but is more of a strategy that has been created for advocating the development of public policies surrounding ageing (Padmadas et al., 2018; Sidorenko and Mikhailova, 2014). The implementation varies throughout Africa, however, budgetary constraints and the lack of resources have created barriers in the formulation and implementation of policies (Gresh and Maharaj, 2013).

Africa has a lack of formal pensions and social welfare schemes due to limited resources, effectively creating a deficit in health service packages for the elderly, which is problematic as the elderly inherently have a heavy burden of diseases (Alli and Maharaj, 2013). Poor

elderly are the most susceptible to poor health status and lack the resources to access treatment and care, which is especially true in Africa, therefore it is crucial for governments to intervene and develop policies that focus more on these groups of people whom have a greater need for healthcare (Gresh and Maharaj, 2013). Cameroon, for example, has a lack of social pensions, a situation that exacerbates the financial problems of the elderly, who are already destitute (Fonchingong, 2014). In Cameroon the elderly heavily rely on the public sector for their wellbeing, and any administrative delays in social services may be detrimental to their health and wellbeing (Fonchingong, 2014). Policies and programmes that aim to assist the elderly may also filter down to their households and communities – this is especially so with cash transfer programmes (Maharaj and Gresh, 2013).

Many elderly across Africa are unable to receive social grants of financial support as they are involved in the informal sector which is not catered for by these programmes (Gresh and Maharaj, 2013). Treating ailments and improving access to health care will in-turn assist with poverty-reduction by improving quality of life, thereby increasing productivity and preserving livelihoods (Gresh and Maharaj, 2013). The burden of poor health status and inequitable access to healthcare are evidence that there must be socio-economic action to meet the needs of the elderly in sub-Saharan Africa. A national health insurance scheme would ensure equal access to appropriate, efficient, and good quality health services (Naidoo, 2012). However, it would also require a complete overhauling of the current health system and its administration and management (Naidoo, 2012).

Health literacy (the ability to pursue, understand and implement health information) is a cornerstone in treating chronic health conditions as Liu et al. (2015) demonstrate that health literacy was considerably associated with positive health behaviours in elderly Chinese people. Educational interventions that aim to improve health literacy may reduce risky health-seeking behaviours and need to be conducted in health-promoting activities (Liu et al., 2015) as the elderly now want to be in control of their heath and rely less on healthcare practitioners as their sole source of health information.

From 2000, nursing services supporting the daily lives of the elderly in Japan requiring long-term care – mostly due to physical disabilities - have been delivered via the country's social insurance system (Furuta et al., 2013). This system was approved in the 'Long-term Care Insurance Act in Japan'. In this system, patrons of these services are categorised into five

grades that are stratified by the severity of their physical disability, which determines the amount of nursing care and resources provided to them (Furuta et al., 2013).

Parmar et al. (2014) explain that Senegal and Ghana have schemes to aid the elderly in accessing healthcare. Senegal has Plan Sesame, which is a user-fee-free plan for the elderly. Ghana has a National Health Insurance Scheme where the elderly do not have to pay premiums. The application of these schemes, for the elderly over 70, epitomises noteworthy efforts to overcome fiscal barriers to healthcare access for the elderly. Evidence to show the effectiveness of these schemes are very limited. Parmar et al. (2014) explain that there are perpetual inequities in enrolment for older people in these schemes, which are caused by a mix of economic, political and sociocultural factors. In terms of enrolling in the schemes, the richest elderly were most likely to enrol than those of a poor economic background, and there is considerable evidence of low enrolment for the poorest individuals in these schemes, which is shocking, considering that these schemes were specifically targeted towards the most destitute.

There needs to be an improvement of geriatric education especially in Africa and also to improve health education amongst the elderly in order for them to become more knowledgeable in taking care of themselves (Frost et al., 2015; Liu et al., 2015). The process of ageing should be better understood in order to effectively plan and prevent health problems in the elderly population (Odaman and Ibiezugbe, 2014).

In Nigeria, the lack of public health services has resulted in some health care advocates suggesting a national health fund for the elderly which would be funded by tax revenue from a luxury goods (Adisa, 2015). In South Africa there is the prospect of a National Health Insurance (NHI) fund to be subsidised by tax funding that could be implemented to allow for more equitable health care provision. The National Health Insurance is a health funding system designed to pool funds to provide equal access to quality affordable health services for all South Africans based on their individual healthcare needs, irrespective of socio-economic status (Naidoo, 2012). This system is meant to ensure that there are no financial backlash for citizens when utilizing health services, therefore all South Africans will be able to access healthcare services for free at accredited facilities closest to where they live or work. However, this is likely to create even more challenges within the country (Marten et al., 2014; Mayosi and Benatar, 2014). According to Blecher et al. (2019) the national annual

economic growth is not high enough to stimulate the NHI. The effects of the COVID-19 pandemic on the national economy will further impact this disparity. There are also a lot of uncertainties surrounding the rollout of the NHI as the South African government has not yet effectively and coherently communicated the meaning and designation of the NHI, its health services, financial contributions, evaluation of quality of care, and role of healthcare providers and workers within the public and private sectors (Blecher et al., 2019). Mayosi and Benatar (2014) states that expectations that equity levels in health service delivery would reach that of the current private sector appear to be unrealistic. It is clear from the existing disparities in funding of private and public sectors and large number of additional healthcare professionals required, that the NHI is unlikely or would take a very long time to be achieved. Parmar et al. (2014) also found that directly targeting the removal of economic barriers may not adequately meet the healthcare needs of the elderly in this case, and efforts should be made to reach those who live in remote areas, women, ethnic minorities and those whom are socially isolated. The NHI policy primarily focuses on creating an exceptional health-care system, yet it does not address the poor behavioural issues and the shortage of efficient, skilled and professional healthcare workers (Sekhejane, 2013). Most low-income citizens are dissatisfied by the quality of service they receive from facilities that suffer from the negligent attitude of staff. It is also unlikely that those who are on medical aid will abandon healthcare at private hospitals, and therefore it seems unrealistic for the NHI planners to assume that the private sector would suffer long-term effects from its implementation (Sekhejane, 2013).

By 2016, South Africa was reforming its health system by reinforcing primary health care implementation so as to move into a more holistic and proactive model, and a fundamental principle of this method is the emphasis of social determinants of health at the community level (Nxumalo, Gouge, and Manderson, 2016). The community-based framework is conceptualised with three streams: district health specialists providing central support; school-based public healthcare to providing school healthcare services; and ward-based public healthcare outreach teams, consisting mainly of community health workers led by a nurse. In this framework community health workers are recognised as being pivotal in the reform of primary healthcare by providing cohesive health and social care to households, creating a connection between government services and poor communities (Nxumalo, Gouge, and Manderson, 2016).

Nxumalo, Gouge, and Manderson (2016) state that community healthcare workers are recognised by the democratic South African government as partners of the healthcare system, and many are integrated as government workforces that are directly remunerated by the state and managed by state health facility managers or nurses. Others may be formally hired by local community-based organisations or non-governmental organisations, contracted to deliver particular healthcare services. The ability of community health workers to develop a link between the formal health system and vulnerable groups, and so establish personal relationships of care are poorly documented.

South Africa's district health system employs clinics as the lowest level in the hierarchy of healthcare services and is the point of care for a catchment population within close proximity, and implements district level programmes, such as HIV and TB treatment. However, healthcare barriers and varying quality of healthcare at different levels still deter the provision of equitable holistic healthcare services across South Africa, and the poor integration of primary healthcare services creates fragmentation and ineffective quality of care, disadvantaging the most vulnerable people such as the poor and the elderly (Nxumalo, Gouge, and Manderson, 2016). Community-based healthcare schemes and community health workers may work in this context.

Since South Africa's transition from apartheid to a democratic government, there has been considerable social progression in reversing the discriminatory legacies of apartheid. However, the health and wellbeing of most South Africans remains overwhelmed by persistent burdens of infectious and non-communicable diseases, social inequalities, and insufficient human resources to provide care for a growing population that is increasingly full of refugees and economic migrants (Mayosi and Benatar, 2014). Addressing the social determinants of health outside the healthcare system, strengthening the healthcare systems and providing universal coverage for healthcare would be the most suitable responses for these South African health challenges (Mayosi and Benatar, 2014). Odaman and Ibiezugbe (2014) advocate for the elderly to be provided with free, accessible and comprehensive health care services as they would utilise them when available, accessible and affordable, and would – in the long term – direct the population towards the attaining the right to age gracefully, and contribute to sustainable development. Appropriate economic, social, and health system policies, together with alterations in individual behaviour, may ensure good health and wellbeing of the elderly in the future (Chatterji et al., 2015).

2.7 Summary

This chapter reviewed literature from an international and local perspective. An overview of chronic and age-related illnesses that affect the elderly was provided. Quality of life and health status are closely related as different health conditions affect the quality of life of and their daily activities of the elderly. The most common health problems affecting the elderly are chronic non-communicable diseases such as hypertension and diabetes mellitus, and it is important to understand the different non-communicable diseases and their required treatment, as they place a lot of pressure and demand on public healthcare providers. There are several barriers to accessing healthcare, including financial barriers, transport, and structural barriers within the health system itself.

Chapter 3: Methodology

3.1 Introduction

Ageing brings with it several challenges, including non-communicable diseases and pressure on healthcare services and health systems. In order to properly address this conundrum, more research surrounding ageing and the elderly is required so that policy formulation, and preparations may take place in order to mitigate the socio-economic and health impacts that ageing will have in the future. This study seeks to study the healthcare needs of the elderly, particularly those of Indian origin in Avoca, Durban. This chapter first highlights the study context and geographic setting of the study. Thereafter, the research design is presented. This is followed by explanations of the study's sampling methods and data collection. Finally, the chapter outlines the ethical considerations and limitations of the study.

3.2 Study context

The study was conducted within the suburb of Avoca situated in northern Durban, KwaZulu-Natal. Figure 3.1 provides a map of Avoca. Durban is a city that is rich in history and cultural diversity. It is also the city with the most Indians outside of India, many of whom arrived during the colonial era, in 1860, as indentured labourers to work in the agricultural sector, and along with the rest of the country, had to endure the tyranny of apartheid (Mukherji, 2011). Durban still faces issues pertaining to reconciliation on a daily basis, as the city was formerly segregated according to race groups as part of the Group Areas Act during the apartheid era, a period in which society was explicitly and systemically segregated according to racial constructs (Seekings, 2008). Living areas were also racially separated, and this marginalized the poorer residents of the city, creating geographic barriers to accessing resources such as education and healthcare (Schoeman, 2018). Post-apartheid South Africa is also known as the 'rainbow nation', as the country now celebrates racial integration and a very diverse modern society (Seekings, 2008).

According to the South African census of 2011, approximately 7568 people live in the suburb of Avoca, 63.2% of whom belong to the Indian population group. This is followed by Black Africans (30%), Coloureds (4.7%), other (1.8%), and Whites (0.3%) (Statistics South Africa, 2013). The most spoken languages in Avoca are English (70%), isiZulu (16.6%), others

(6.5%), Xhosa (4.8%), and Afrikaans (1.2%) (Statistics South Africa, 2013). Avoca was a demarcated ‘Indian-area’ during apartheid. In terms of socio-economic background, residents of the suburb describe the area as being mainly a middle-income area, with a large ageing population.

The suburb has many landmarks owing to the history of the Indians, such as Hindu temples and memorials. Avoca is also home to the Avoca Shree Lutchmee Narain Temple, which is currently 109 years old. On its 100th year anniversary, the temple’s committee published a souvenir centenary brochure, in which some of Avoca’s Indian history is chronicled. The temple acted as a cornerstone for many Indians of the Hindu religion as a provider of religious, cultural, and social activities and services, such as prayer, Hindi-language classes, dance classes, cultural day events, and senior-citizen events, among others.

Geographically Avoca is north of the city centre and is situated in a hilly area with a network of rivers and streams intersecting parts of the area. The suburb has a lot of greenery and open spaces for recreational purposes and is mainly a residential area, however, they are also a few light industries, with parts of the Riverhorse Valley Industrial Park being in the suburb. Figure 3.2 provides a photograph of the northern area of Avoca, with the suburb’s aforementioned geography visible. Avoca is highly accessible by road and railway. It is a relatively well-developed area with brick housing, and proper sanitation and water supply. The area was also formerly home to a number of florist businesses, and the suburb was known informally as ‘Phoolwa Ples' (or ‘Place of Florists’, in Hindi). The suburb also had a number of small farms, surrounded by sugarcane plantations. Avoca also has its own Central Policing Forum (CPF) with an Outreach Programme that serves the community in several ways, one of them being a senior citizens’ community and awareness day, for which fundraisers are held throughout the year. Figure 3.3 is a photograph taken during the Avoca Outreach Programme’s senior citizens day.

Avoca was chosen as the study area due to the large number of Indians, especially those aged 60 and over. The researcher also lives in the study area, therefore, it was well-known and easily accessible to the researcher, whom was aware of the vast number of potential participants that fit the required sample characteristics of this study.

Figure 3.1: Map of Avoca, Durban.

Source: Google Maps, 2020.

Figure 3.2: Photograph of northern Avoca.

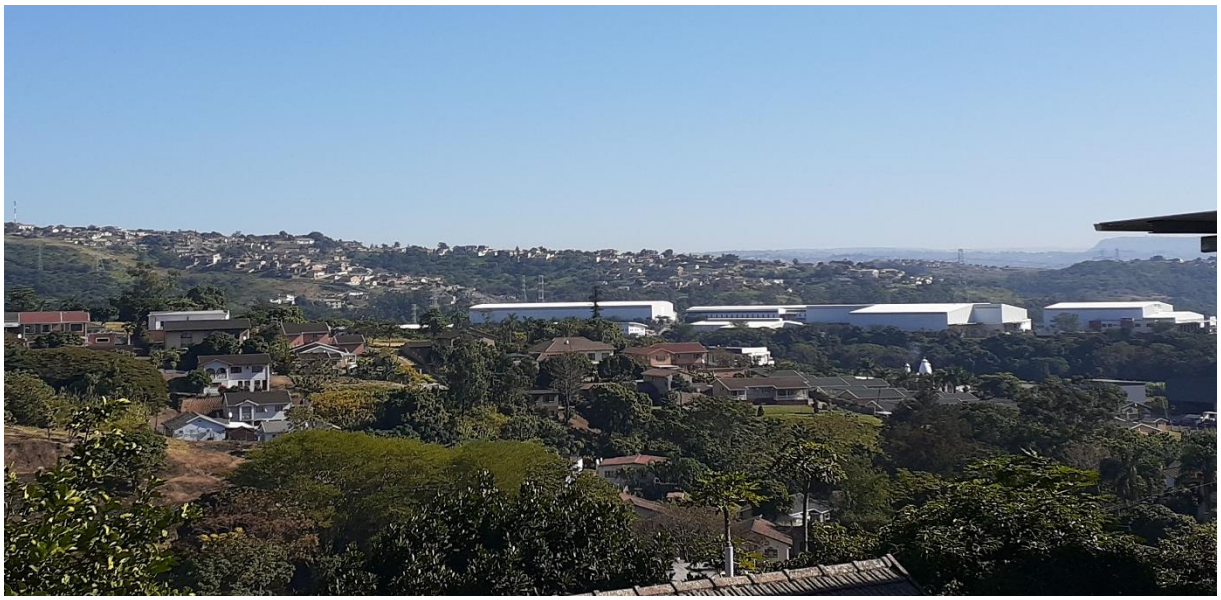

Figure 3.3: Photograph of the Avoca Outreach Programme.

3.3 Research design

According to Akhtar (2016) the research design of a study is the crucial adhesive that holds all the elements of a study together, and is the plan of the projected research work. In this study, the researcher employed a research design with step-by-step guidelines that were used to structure and coordinate the study from start to finish. This was done in order to logically assimilate the various components of the study in order to collect data and address the research questions. This research aimed to study the healthcare needs of the elderly, identify the factors that influence decision-making about their healthcare, and to explore the opportunities and constraints in meeting their healthcare needs, all from the perspective of the participants. Therefore, a qualitative research design was appropriate for this study.

Qualitative research is concerned with data that is not measureable in quantity - or by manipulating numerical data – such as underlying motives, decisions, and desires, and mainly utilises in-depth interviews to obtain research data (Kothari, 2004). Qualitative research allows us to study the phenomena that motivates certain behaviours in human beings (Kothari, 2004). It is suitable for building and expanding theory that may also be related to personal experiences, perceptions and opinions of participants in the study (Sloan and Quan-

Haase, 2017). Dokpesi (2015) states that a blend of existing care methods is required, which must also account for prevailing environmental conditions of the society, and prioritize each method according to the needs of the elderly. This may best be explored qualitatively.

There are several advantages and disadvantages to qualitative research methods. Qualitative research provides an in-depth account and description of the emotions, thoughts, and experiences of the participants, and are deployed to do such (Denzin, 1989). It completely comprehends the experiences of human-beings in particular settings, and its interdisciplinary standpoint provides a multifaceted viewpoint of human experiences (Rahman, 2017). Individual cases or events can be studied, along with participant behaviour and the influences on them (Klein and Myers, 1999). This research methodology also allows for researchers to ascertain the participants' inner experiences and understand what shapes these (Corbin and Strauss, 2008). Researchers are able to closely observe and interact with participants – unlike in quantitative studies – and data collected is subjective and comprehensive (Rahman, 2017). Qualitative research designs are flexible, and expandable, making them appropriate for analysing complex problems (Maxwell, 2012).

There are a few disadvantages of qualitative research. Qualitative approaches sometimes leave out important contextual issues, and focus more on meanings and experiences (Silverman, 2010). Policy-makers tend to discredit results from qualitative research and favour the results of quantitative studies (Rahman, 2017). Pure qualitative research may ignore socio-cultural influences of the variable studied (Rahman, 2017). The small sample size of qualitative studies means that the results cannot be generalised to entire populations (Flick, 2015). Collecting and analysing qualitative data takes a significant amount of time, which may be crippling if results are needed over shorter periods of time (Rahman, 2017).

3.4 Study sample

Sabharwal et al. (2015) concurs that there is no single global consensus on the definition of elderly or on an age margin that clearly defines being elderly. For the purpose of this study, which is in the South African context, 'elderly' was defined as a person whom is 60 years of age and older (Statistics South Africa, 2017).

Sample size refers to the number of participants in a study. Qualitative research requires a smaller sample size than quantitative research. The general purpose is to acquire information that may be used to understand the complexity or context surrounding phenomena and not to represent entire populations (Gentles et al., 2015) so long as saturation is reached. Saturation is the point at which no new data is obtained from the data collection process (Dworkin, 2012). The sample size of this study was 20.

This study focused on elderly Indians, both male and female aged 60 and over, residing in Avoca, Durban. Indians form one of the major population groups of South Africa, consisting of around 2.6% of the country's total population (Statistics South Africa, 2020b), however, there is little to no research done on ageing within the Indian population in the country. Therefore, this study investigated the healthcare needs, opportunities and challenges in accessing healthcare of the elderly Indians in Avoca, Durban. The study did not require specific numbers of participants from either male or female sexes, as the study was gender-neutral and did not seek to research gender disparities.

3.5 Sampling strategy

Sampling is defined as the selection of relevant data sources from which data is collected to answer the research questions and objectives (Gentles et al., 2015). Participants for this study were mainly selected using purposive sampling - which is a non-probability sampling method that selects participants based on characteristics of a population and the objective of the study (Etikan, Musa, and Alkassim, 2016). This was used as the study area was well-known and easily accessible to the researcher, who was aware of the vast number of potential participants that fit the sample criteria of this study. Snowball sampling - a non-probability sampling technique – was also deployed as a secondary sampling strategy. This technique allowed for the elderly to suggest potential participants from among their acquaintances (Etikan, Musa, and Alkassim, 2016).

3.6 Data collection methods

This study used semi-structured interviews with open-ended questions. These questions allowed participants to give as much information as possible, and allowed the researcher to probe or ask follow-up questions (Turner, 2010). The interview collected demographic

information of the participants, their perceived health status, as well as their healthcare needs and choices. They were also asked about the challenges they faced in obtaining healthcare services. The researcher first identified possible participants whom fit the sample criteria. The researcher thereafter approached the individuals, presenting the purpose and full nature of the study along with the informed consent forms. After the participants agreed to partake in the study, an appointment was set up for the interviews. The interviews took place at the homes of the participants, within the suburb of Avoca. In all the interviews maximum privacy was ensured and interviews lasted between 10 to 35 minutes.

3.7 Data analysis

Data analysis in qualitative research is used to classify and interpret research data to make meaning of it (Flick, 2013). The researcher self-immersed in the study and the collected data in order to recognise and comprehend the responses from the study participants. After the in-depth interviews were undertaken to collect the data, they were then transcribed and analysed thematically to identify and report recurring themes within the data collected. Thematic analysis allowed the responses to be arranged according to different patterns or trends within the research. This form of analysis systematically identifies, organises, and groups information into patterns or themes in a data set (Braun and Clarke, 2012; Turner, 2010).

Braun and Clarke (2012) state that there are six steps to thematic analysis. The first is immersion and familiarity with the data. The second is to generate codes, which are labels used to categorise data of similar themes or recurring meanings. The third step is to search for themes within the coded data, and identify where codes are similar and overlap each other. The fourth step requires reviewing of the themes, involving revisiting and removing some themes. The fifth step is to clearly define and name themes that were identified in step four. The final step is to produce the report. This allows researchers to identify and make sense of different meanings and experiences that may be mixed within a data set, and identifies common or recurring phenomena that may be related to the research objectives (Braun and Clarke, 2012). The researcher used the qualitative data analysis package NVIVO, version 12, to store and code the interview transcripts.

The data was first imported into NVIVO in the form of interview transcripts as Microsoft Word documents. The main approach to systematically categorizing data in qualitative

research is coding, which is basically applying a set of classifications and sub-classifications to the data according to obvious recurrences, and mutually-exclusive details, with the primary goal being to identify recurring information within a given code or theme (Maxwell, 2012). After immersing in the data, the researcher was able to formulate the different codes (known as nodes on NVIVO) according to which the data was separated and analysed.

3.8 Ethical considerations

Ethical considerations protect human participants via the implementation of appropriate ethical principles, especially in qualitative studies, due to the in-depth nature of the research (Arifin, 2018). Arifin (2018) states that participants should give their consent freely, and should be well informed of the purpose of the study and what is asked of them, along with the knowledge that they have freedom of choice to participate or decline to do so.

This research was approved by the Humanities and Social Sciences Research Ethics Committee at the University of KwaZulu-Natal. All participants were required to provide written informed consent via an informed consent form and were fully informed of the nature and purpose of this study. Participants were given an opportunity to ask questions about any of their concerns. It was fully explained that their participation was completely voluntary, anonymous and confidential, and that they were free to refuse to participate or withdraw from the interview at any given time. Participants were given pseudonyms throughout the study. The researcher also provided all contact details such as email addresses and telephone numbers should the participants require any feedback.

Some participants were reluctant to answer questions truthfully as some questions or answers may have been perceived as sensitive. However, participants were fully informed of the purpose of this study, the importance of providing truthful and relevant information, and the anonymity involved in the research, in which their participation was voluntary. The elderly may experience some form of secondary traumatization, for example: recalling unpleasant health care experiences, therefore the researcher was equipped with emergency medical contact numbers and referral details of the nearest health facilities. Participants were also informed of the nature of questions that they would be asked prior to the interviews, and they were informed that they are able to withdraw from the study at any time should they wish to do so. Introductory conversation was used to establish rapport and make participants feel

comfortable with the researcher. Validity was ensured by using a vernacular that the participants easily understood, such as simple words, and further explaining terms where the participants had difficulty understanding them. All interviews were conducted and transcribed in English.

3.9 Study limitations

A problem that arose was the reluctance of participants to answer interview questions honestly due to the sensitivity of questions pertaining to health status and need for financial assistance. There was also the possibility of social desirability bias in the interviews, where participants provided answers that they believed were more desirable. Time was also a limitation, as the researcher had to set up appointments with participants that was best suited to the availability of both participant and researcher. The study may also be biased in terms of gender, as the researcher did not restrict sampling to any one gender or seek to sample an equal number of males and females, and as a result there were more female than male participants. The 2020 mid-year population estimates by Statistics South Africa (2020) shows a disparity between the number of females and males for age groups 60 years and older. There is a larger female-to-male proportion of elderly, which may provide a possible explanation for the gender-biased results in the study.

3.10 Summary

This chapter provided information on the research methodology employed in this study. This study was qualitative in nature, and collected data via 20 in-depth interviews among elderly Indians aged 60 years and older, in Avoca, Durban. Data was analysed thematically, and participants were assigned pseudonyms throughout the study in order to maintain anonymity and confidentiality. The study was granted ethical approval by the University of KwaZulu-Natal. Participants were informed of the nature and intent of this study, and the importance of providing accurate information.

Chapter 4: Results

4.1 Introduction

As populations age, the risk of chronic health conditions increase along with the need for healthcare. The overall objective of this study was to investigate the healthcare needs of the elderly with particular focus on opportunities and challenges in accessing healthcare. In total, 20 semi-structured interviews were conducted with Indian men and women in the suburb of Avoca, Durban. This chapter explores the results of the study by first providing the demographic characteristics of the participants. Thereafter, health problems and diseases are presented. This is followed by the presentation of the results pertaining to the access to and need for healthcare. Satisfaction with healthcare services are also explored. Finally, the challenges faced by the elderly in accessing healthcare are presented. Pseudonyms are used in the results in order to maintain confidentiality of the participants.

4.2 Sample characteristics

Interviews were held with 20 men and women living in Avoca in KwaZulu-Natal. The age of participants ranged from 60 to 80 years old. Five of the 20 participants were male, and 15 of the 20 participants were female. As people age they are more likely to be married. Only one person reported that they had never married. Seven reported that they were currently married, while three were divorced. Of the 20, nine participants were widowed and they reported that they were living either alone or with their children. All the married participants were living with their spouses, and one of the divorced men was still living with his wife. All participants were permanent residents of Avoca and recipients of the old-age social grant. These details are displayed in Table 4.1.

Table 4.1: Sample characteristics of participants

Participant	Age	Gender	Marital status	Highest education level
1	67	Female	Widowed	Primary
2	68	Female	Married	Matric
3	66	Female	Married	Tertiary
4	72	Male	Widowed	Tertiary
5	62	Female	Never married	Secondary
6	80	Female	Widowed	Secondary
7	69	Female	Widowed	Tertiary
8	62	Female	Married	Secondary
9	78	Female	Widowed	Primary
10	72	Female	Widowed	Primary
11	60	Female	Widowed	Secondary
12	64	Male	Married	Secondary
13	64	Female	Divorced	Secondary
14	63	Female	Married	Secondary
15	63	Male	Divorced	Tertiary
16	68	Female	Widowed	Secondary
17	60	Male	Widowed	Secondary
18	63	Male	Married	Secondary
19	78	Female	Married	Secondary
20	64	Female	Divorced	Unknown

4.3 Types of diseases and illnesses

Table 4. 2: Chronic and Acute health status conditions of participants

Participant	Pseudonym	Age	Chronic Illness	Acute Illnesses
1	Anna	67	Hypertension and high cholesterol	Occasional Aches and Pains
2	Crystal	68	Hypertension	Headaches, backaches,
3	Bertha	66	Hypertension and heart disease	Body pains.
4	Anthony	72	Hypertension, arthritis, and irritable bowel syndrome	None
5	Diana	62	Diabetes mellitus, hypertension, and high cholesterol	Body pains, headaches
6	Elena	80	Diabetes mellitus and hypertension	None
7	Freya	69	Hypertension and cancer	None
8	Gretel	62	Hypertension and cholesterol	Acute arthritis
9	Hannah	78	Diabetes mellitus, angina, heart disease, hypertension, and thyroid disease	Short breath and body pains.
10	Isabelle	72	Diabetes mellitus and thyroid disease	Occasional Aches and Pains
11	Jessie	60	Hypertension and diabetes mellitus	Acute arthritis
12	Bob	64	Diabetes mellitus	None
13	Katherine	64	Chronic leg pains and hypotension	Severe headaches
14	Lana	63	Diabetes mellitus and hypertension	None
15	Cyril	63	Heart disease and diabetes mellitus	None
16	Moana	68	Cancer and osteoarthritis	Hot flushes
17	Derrick	60	Heart disease	None
18	Ernold	63	Diabetes mellitus	None
19	Nisha	78	Colon cancer, heart disease, spine pains, rheumatic arthritis, and leg weakness.	Spinal pain
20	Obara	64	Hypertension and thyroid disease	Occasional leg and back pains.

Participants were asked if they suffered from any chronic or long-term illnesses. All the participants reported that they suffered from at least one chronic illness. The most common chronic disease was hypertension (high blood pressure), followed by diabetes mellitus, then heart disease, high cholesterol, cancer, thyroid diseases, irritable bowel syndrome, hypotension (low blood pressure) and different types of arthritis.

Some participants displayed a positive attitude despite having several chronic health conditions, alongside cancer, which is a life-threatening disease. Moana suffers from a range of health conditions including cancer and osteoarthritis of the knees. She fully understands the effects of her illness and the implications of their progression as she ages, yet remains resilient and maintains a positive attitude towards her struggle with fighting cancer.

> "Well my health is not good because just two years ago now I had contacted cancer and I don't consider myself a victim because I'm going to fight this till the very end. And I've had cysts removed in hospital and all that. Because of my age I am going through the full menopausal stage while fighting cancer, so I have things like hot flushes. I will continuously have weaker bones, I have osteoarthritis of my knee at the moment, and I'm not as mobile as before, there was a time where I was actually on the crutches so that way I needed help from my kids" (Moana, 68 years).

It was interesting to note a number of women in the sample were affected by cancer. Nisha recovered from cancer, but suffers from heart disease and several muscular-skeletal pains as well as arthritis, which often affects her ability to walk and perform daily activities of living. Katherine also suffers with leg problems and severe headaches.

> "I had cancer of the colon. In 2016, I had heart triple bypass. I got spine problems, and diabetes. I suffer from spine pains, and rheumatic arthritis, my legs don't always function. I feel weak on my feet on my own, like I can't walk on my own. If I go anywhere I have somebody to hold me" (Nisha, 78 years).

> "I'm suffering with pain in my knees, my two legs and I get severe headaches so I'm taking my treatment in hospital" (Katherine, 64 years).

One participant, Anthony – whom is a Hindu priest, stated that he did not develop any chronic health conditions until after his wife recently passed away. He believes that his wife's death triggered his illnesses. He had recently been praying for patients at hospital and ended up contracting an infection which he believed may have triggered his chronic irritable bowel syndrome, but also expressed that he was trying to adapt to the condition.

> "I have chronic - ever since my wife passed on - but previous to that I did not have diabetes or pressure, but after my wife passed on I got diabetes, I got pressure, I got arthritis, and as of recently I've been going to hospital and praying for patients, and at a particular hospital I contracted an infection that led to chronic irritable bowel syndrome, and I'm trying to live with that" (Anthony, 72 years).

The participants were also asked if they suffered from any acute or short-term illnesses. These, unlike chronic conditions, often do not last more than six months. In the study sample, 12 participants reported suffering from acute health problems, of which the most common were muscular pains, hot flushes, arthritic pains, and short breath. As people age they are more likely to experience difficulties with mobility. A number of participants reported body pains and leg problems. Nisha explained her acute illnesses, which mainly includes body pains, and how this impacts her life, as she requires assistance when walking. Crystal and Isabelle also suffer from body pains, but expressed that they felt that this was normal and came naturally with ageing. Sometimes the elderly do not feel their illness is serious but is rather part of the ageing process. They are therefore less likely to pay much attention to their health conditions.

> "Yes, I do, I have spine pains, and rheumatic in my bones, arthritis, my legs doesn't function. I feel weak on my feet on my own, like I can't walk on my own. If I go anywhere I have somebody to hold me" (Nisha, 78 years).

> "Yeah now and then, headaches, backaches, that's normal" (Crystal, 68 years).

> "I suffer from aches and pains, but that comes with age" (Isabelle, 72 years).

4.4 Accessing healthcare

4.4.1 Reasons for accessing healthcare

Participants were asked if they were being treated by any specialist doctor for any of their illnesses, and the majority (13) agreed. The remaining were not seeking any specialist for treatment. Thirteen participants stated that they visited their healthcare providers at least once a month for their medication or check-ups - depending on when they were called in for their medical check-ups by their doctors. The participants also visited their healthcare providers whenever they were unwell and required treatment for non-chronic conditions. All the participants with heart disease, such as Isabelle and Ernold were seeing a cardiologist.

> "Like I do go to my heart specialist, that is once in two years" (Isabelle, 72 years).

> "I report to King Edward hospital and Albert Luthuli. Both are state-run hospitals" (Ernold, 63 years).

Participants also had to visit specialist doctors for various other conditions. Crystal was in hospital after an incorrect type of medication was administered to her and triggered jaundice. She has since recovered, however, she still has to visit a specialist to track her recovery. Anthony had to visit a specialist regarding his irritable bowel syndrome. Freya visits an oncologist regarding her cancer treatment.

> "I was in hospital, I had jaundice and I'm still getting treatment at the moment" (Crystal, 68 years).

> "I have gone for few tests regarding my IBS, and I went for few tests for the stomach, endoscopy, colonoscopy." (Anthony, 72 years).

> "I am seeing an oncologist for the cancer" (Freya, 69 years).

The participants were asked if they had to take any medication that a doctor had prescribed for any of their health conditions. Seven participants were taking prescribed medication for just one health condition. These conditions include diabetes mellitus, heart disease, hypotension, and cancer. Crystal was given a strong dose of medication for her hypertension,

which triggered her jaundice, and her medication had to be changed. Moana has to take different medication to repress her cancer, including one that she will have to take for the rest of her life.

> "Yes, my pressure medication, but that's what caused the jaundice, it was very strong medication. Now they've changed the medication" (Crystal, 68 years).

> "I am taking a cancer tablet called Femara for the next five years, in January it will only be two years, after that I will be reassessed whether I will need it for another 5 years, but the rest of the medication I will have to take for the rest of my life so that I don't let a recurrence of cancer" (Moana, 68 years).

It is common for the elderly to suffer from more than one chronic condition, and seven participants were taking prescribed medication for at least two chronic conditions, such as diabetes mellitus, thyroid disease, hypertension, heart disease, and high cholesterol.

> "I take chronic medication for pressure and thyroid." (Obara, 64 years)

> "I take two tablets a day, for sugar and pressure" (Elena, 80 years).

> "I suffer from high blood pressure and cholesterol is high so I'm taking treatment for those two" (Gretel, 62 years).

In this sample there were several participants that were suffering from more than two chronic health conditions. Six participants were on prescribed medication for more than two health conditions that include hypertension, diabetes mellitus, high cholesterol, irritable bowel syndrome, and heart disease.

> "I take medication for hypertension, and cholesterol. And actually I'm taking painkillers, it's just because of my pains, aches and pains and all that like, you know" (Anna, 67 years).

> "For my irritable bowel syndrome, there is some medication I'm taking every evening. I also take pressure medication and diabetes medication" (Anthony, 72 years).

> "For my heart disease, diabetes, angina, pressure, diabetes" (Hannah, 78 years).

The participants were asked if they used or needed to use any medical equipment or devices. The most used medical device among the participants were tested eyeglasses, followed by dentures, crutches, and wheelchairs. This highlights eyesight degeneration, and dental-count decline, as other major health hazards among the elderly. Moana explained that she has a pair of crutches should her osteoarthritis flare up again and she be unable to walk by herself. She also states that she uses prescribed eyeglasses due to her eyesight degeneration. Nisha stated that even though she has a wheelchair, she prefers to manage without it as she feels that it inhibits her freedom.

> "I have a pair of crutches that I have to use if my osteoarthritis works up again, then I balance myself with the crushes, I have one here. I have tested glasses because of my age and degeneration of the eye" (Moana, 68 years).

> "I have wheelchair, I managed to get it through medical aid, but I want to be free and carry on with my normal life without it" (Nisha, 78 years).

4.4.2 Types of health facilities

Participants were asked if they visited a private or public facility for their health conditions. Half (10 participants) stated that they received their healthcare at public facilities, and the rest stated that they visited private facilities for their health conditions. These facilities included clinics, hospitals, and general practitioner surgeries. The most common reason for receiving healthcare at government provided facilities is affordability. Many of the elderly cannot afford private healthcare, nor can they afford medical aid.

Isabelle and Derrick stated that they went to government provided healthcare facilities as they were more affordable than private healthcare facilities. In South Africa the majority of the population rely on public facilities that are provide health care for free.

> "At the moment what I am doing ever since my husband passed away money is a bit tight, so what I do is go to the public clinic here, Redhill clinic. I take all my medication there" (Isabelle, 72 years).

> "I don't have medical aid. I go to state run hospitals … the medication at the private hospital is so expensive and at the state hospital you get the same medication actually next to nothing" (Derrick, 60 years).

Cyril and Gretel explained that receiving healthcare at government facilities was not a choice and that they felt forced to go to government facilities as they could not afford alternative or private healthcare providers. There was a feeling that if they had an option they would prefer to go to a private health facility.

> "Government facility. There's no other option, and that's the most affordable option. Medical aid is unaffordable, I would it like to have one. It would make life much easier" (Cyril, 63 years).

> "I go to the government. I never actually chose to. I'm forced to because I'm financially not well off and just with the pension money, I have to do it … I don't have medical aid, can't afford it" (Gretel, 62 years).

Jessie stated that while she had no medical aid, she preferred to visit her private general practitioner for her healthcare as it was convenient for her to travel back and forth from the facility as it was not far from her residence and she is able to walk to and from the doctor. She managed her doctor's fees with the money from her pension, and when she goes for blood tests, her daughters help to finance some of the costs.

> "Just the private general practitioner doctor, because its closer to home and I can just take a walk it's not far from home. No medical aid, because we not working at the moment, it's just me and my husband, we living on pension. If I go for blood tests, my daughters pay for me. It would have been nice; it would have made things easier for me" (Jessie, 60 years).

Moana explained that even though she visits a private healthcare facility and has a medical aid, all of her treatment is not covered by the plan which only covers the cost of her chronic medication. Nisha expressed the same.

> "Because I pay the hospital plan, chronic medication is covered to a certain extent by the hospital plan, but all my medication for anything extra for my bone pain or hot flushes and all that, vitamin c, vitamin d, that's all absolutely necessary for my wellbeing I got to buy with my own money" (Moana, 68 years).

> "I go to private hospital … because of medical aid - it does cover expenses but certain things I have to pay for" (Nisha, 78 years).

Freya stated that while she is on medical aid, she had to see a private doctor that was recommended to her in order to treat her cancer which requires specialist treatment. Elena is able to receive healthcare at a private hospital as her daughter pays for a medical aid for her, highlighting the importance of family support for the elderly.

> "I'm on a medical aid. I actually see a private healthcare provider. I was recommended by family to see a particular person who is in a private practice" (Freya, 69 years).

> "I go to private hospital because I'm on a medical aid, and my daughter pays for me" (Elena, 80 years).

4.5 Satisfaction with type of healthcare

The participants were asked if they were satisfied with the type of healthcare they were receiving or if they would prefer another kind of healthcare. In addition, they were asked what they would prefer or whom they would prefer to take care of them. Most (13) of the participants stated that they were satisfied with the healthcare that they received.

Seven participants were not satisfied with the healthcare they received. Freya has a medical aid and visits a private healthcare provider, but stated that she was not satisfied with her healthcare. This was due to it being expensive, and she expressed that would rather prefer healthcare that is of the same quality but cheaper than what she is currently receiving in treating her cancer, as the cost often takes a toll on her financial savings. Bob expressed that healthcare in South Africa is not truly about satisfaction because one does not get to choose the quality of care received.

> "This healthcare that I, at the moment have to go to, is quite expensive and sometimes it can have an impact on my savings, so if there is something that will provide a similar healthcare which is cheaper, that will definitely benefit me" (Freya, 69 years).

> "Well that's the only thing we've got in this country at the moment so it is not a matter of 'happy' or 'unhappy' with what we've got" (Bob, 64 years).

Many of the participants whom were not satisfied with their healthcare visit government-provided facilities and stated that if it were affordable, they would prefer to access private healthcare facilities due to the hardships they faced at the facilities. Cyril stated that he would prefer another healthcare provider, preferably a private healthcare provider to government-provided facilities because he has to wait in long queues at the hospital, only to face unhelpful staff and be told that there is no stock of certain medications. Obara also stated that she would prefer private healthcare as she receives poor service from the government-provided facility where they are constantly losing her paperwork and are unhelpful in solving the issue. The staff then send her to look for her own paperwork, and this wastes her entire day, which is difficult at her age as she needs to get home and rest.

> "I definitely would prefer another healthcare. Private would be better … waiting in the long queues, wasting half the day there, then sometimes being told that they don't have stock of certain medications. Nobody bothers. They come to do their job just for the sake of it, and have a don't-care attitude … to them you are just a number not a human being" (Cyril, 63 years).

> "I would prefer to go private. In the (government-provided) hospital they are forever losing my chart. Then, same time I have to go do a lot of running around – upstairs, downstairs, and stuff like that, for them to find my chart. And they don't look for it, they send you to look for it. I finish off so late, and am not at the age where I am going to take my time the whole day to come home. We go there and we need to come home quickly and rest" (Obara, 64 years).

The participants were then asked about aspects of their healthcare they were most satisfied. Isabelle stated that she did not have any problems with the clinic she attended. Derrick and Ernold also stated that they were satisfied with care at the government-provided health

facilities.

> “So far I didn’t have any problem with the clinic hey” (Isabelle, 72 years).

> “I get very nice treatment over there” (Derrick, 60 years).

> “Well actually I don’t have any problems, I get a good service at the clinic” (Ernold, 63 years).

Moana stated that if it were not for her medical aid, she would have to go to government hospital, where she knows the treatment is not up to standard along with the other infamous challenges one must face at government-provided healthcare institutions. She was aware that only a very small proportion of the population are on medical aid in the country. She further explains that her health facility is well suited to her needs. Bertha also stated that her facility caters well to her needs as it has all the required equipment to treat her. Anna stated that she received good care at the government hospital that she attended and that she was happy with it because the doctors take good care of her, and she is satisfied with the medication that they prescribed for her.

> “Well because of the medical aid I cannot complain. Obviously, if I didn’t have medical aid I’d be in dire straits just like the rest of the country, because very few people, I think it’s just about 12 to 15 percent, have got medical aid and the rest of the country is accessing it at the government hospital and all are battling. Because of my medical aid I got to private places that have everything so its wheelchair friendly and they have crutches, and open the door for you and all that stuff” (Moana, 68 years).

> “The facility I visit is very well equipped with all with all the medical technology available there” (Bertha, 66 years).

> “I’ve been taken care of by doctors at the hospital and they prescribe the medication I have to take, and I’m happy with it” (Anna, 67 years).

4.6 Challenges in accessing healthcare

4.6.1 Distance and transportation

The participants were asked how they travelled to their healthcare facilities. Most participants stated that their family members, mostly their children, drive them to their healthcare facilities. This was the most relied-on transportation method amongst all the participants, once again highlighting the importance of family support for the elderly. Others also said that they relied on public transportation to get to the healthcare facilities. Some participants were fortunate to have their own vehicle and as a result, they were able to drive themselves to their healthcare facility. Few participants observed that the health provider was in close proximity to their place of residence and they were able to walk to and from their healthcare facilities.

The participants were also asked about the challenges and barriers they face in accessing healthcare facilities. The lack of reliable transport was identified as one of the barriers to accessing healthcare – the transport is either late, or does not arrive on time. Katherine stated that she sometimes gets let down by her public transport, and ends up going late to the hospital. Gretel stated that she has to walk a long distance to get a taxi to the public hospital as there is no public transport access near her residence. Besides this, she has to leave home early to beat the queues at the hospital or she will be seen by a doctor very late and may not even receive her medication. Similarly, Hannah stated that the lack of transport where she stays is a problem, and as the hospital queues are very long, she has to wait the whole day to receive medication.

> “Sometimes I have a problem because I’m let down by my transport, and go late to the hospital” (Katherine, 64 years).

> “I have to leave home very early, and transport is a problem - we don’t have buses near my house so we have to walk a long distance to take the taxi, and long distance to get back home. For hospital, I have to go early to follow the queues. If you don’t go early, you have to wait even longer and may not get your medication.” (Gretel, 62 years).

> “But there are long queues, plus waiting the whole day for medication. Transport is

another difficulty" (Hannah, 78 years).

4.6.2 Physiological challenges

The physical conditions of the elderly also make it difficult for them to access their healthcare. Anna and Obara expressed that their body pains often prevent them from going to their healthcare facilities. Anna experiences back pain while waiting in queues, and Obara's leg problems prevent her from walking. Jessie stated that even though she sometimes gets tired when walking to the doctor, she does need the exercise.

"I have back pains when waiting" (Anna, 67 years).

"Sometimes I have problems with my legs, so I find it hard to go" (Obara, 64 years).

"I do get a bit tired at times, but we need the exercise hey" (Jessie, 60 years).

4.6.3 Financial challenges

The participants were asked if they felt as though they required financial assistance with any aspect of their healthcare. Some participants were reluctant to answer this question. Those who did not feel that they required financial assistance stated that they were able to manage with either their medical aid, pension or family support, or by visiting government-provided healthcare facilities which are free of charge, as stated by Obara below.

"Not really, no. I get my medication free in the hospital" (Obara, 64 years).

Cyril and Gretel stated that they needed financial assistance in getting their prescribed eyeglasses, as their eyesight is deteriorating. Gretel further expressed that she would like to be able to privately buy her medication so that she does not have to go to government hospital for it.

"Definitely, money for getting glasses would help me a lot" (Cyril, 63 years).

> "Yes, especially for my eyesight - which is getting bad - and I would like to get my medication for pressure and cholesterol at a cheaper cost so I don't have to go to government hospital" (Gretel, 62 years).

Bob and Nisha stated that they need financial assistance because their medical aid is very costly, with Nisha further explaining that the medical aid does not cover all her medical expenses resulting in her having to use her pension for the extra medication.

> "Yeah, with the medical aid because that's where the huge cost is" (Bob, 64 years).

> "My medical aid … only certain tablets they pay for. What they don't pay for - I use my pension for that" (Nisha, 78 years).

One of the recurring themes throughout the study was that of medical aid not covering the cost of all treatment and the elderly having to pay the excess themselves, which is problematic as the elderly are often unemployed, and rely on state pension – which is often not adequate to meet their needs– or rely on their families for financial support. Anthony experienced trouble with his medical aid, with the first one covering general practitioner expenses and not hospital cover, which caused him to switch medical aids, and ended up with the aid again covering only one expense over the other. Isabelle described how difficult it is to have to meet healthcare needs with just the state pension.

> "One of my medical aids had paid for the doctor (general practitioner) but refused to pay for the hospital, so I had to immediately change that to another medical aid, which then paid for hospital but not the doctor" (Anthony, 72 years).

> "Sometimes you know if you collect your grant and you really want to buy like tablets or something, you can't afford it and then you have to wait another month. I don't worry the kids" (Isabelle, 72 years).

There are often times where the hospital fails to provide all the required medication to the elderly, leaving them with no choice but to buy the medication. Obara explained that she often has to make-do without some medication as the hospital does not provide it, and she is unable to afford it by herself.

> "Sometimes I do need certain medications the hospital doesn't give, so I find it hard. I have to make do without it because I can't afford it" (Obara, 64 years).

In addition to his chronic ailments, Cyril suffers from sciatic nerve pains and requires traction to treat the problem. Jessie explained how the cost of food prevents her from following a healthy diet that is required for her diabetes mellitus, so she just eats what she can afford even if it may not be good for her health.

> "Yeah, maybe traction of something for my back because I've got sciatica in the leg nerve so sometimes to wake up from the bed and to even walk becomes a problem. And back traction costs a lot" (Cyril, 63 years).

> "Well, you have to stick to a certain diet because of diabetes, and diet food is a bit expensive, so if it was cheaper it would have been nice. I just have to make do with what is affordable and sometimes what is affordable may not be good for the health" (Jessie, 60 years).

Moana explained that she is very satisfied with her healthcare at private facilities, and relies on her children for medical aid, putting emphasis on medical aid as a salient factor in avoiding the poor standard of treatment at government-provided health facilities, and brings up the importance of her children's support in her healthcare.

> "If I didn't have my children I'd be destitute and joining all the endless queues (at the government health facilities). I am definitely happy because in my condition I definitely cannot wait in like a general hospital where the queues are endless. There is not even many oncology departments that are really working now, and although you are made all sorts of promises, it aint going to happen, so even if we have to cut down on any extras, we have to keep our medical aid" (Moana, 68 years).

4.7 Recommendations by participants

The participants were finally asked if they would like to discuss any other experience, be it a challenge or an opportunity, about their healthcare that had not been previously discussed in the interview or any other remarks. The participants responded with a plethora of

recommendations, much of which could be used in formulating interventions for the elderly.

Freya expressed that that there may come a time where she will not be able to cope on her own with her daily activities of living, and may need assistance from a nurse or helper. She further explained that it would be great to look into alternative treatments for cancer that do not have adverse side effects on the patients.

> "Right now I'm coping on my own but there may come a time when I need extra help with a nurse or someone to help me to do things. I find that the chemo treatment that we get (for cancer) is quite intensive and if there was another way to treat cancer without making the person feel sick and weak, I feel that is something that should be looked into" (Freya, 69 years).

Diana suffers from diabetes mellitus, cholesterol, and hypertension, and stated that as much as doctors and treatment may help her manage her chronic illnesses, it was up to her to have a positive mind-set, engage in physical activity, and maintain a healthy lifestyle. It is the responsibility of each person to keep fit and try to stay healthy.

> "The treatment helps, I won't say no. But it is also up to us to stay healthy. As much as the doctors can help with treatment and advice, if I do not make changes in my life, I am not going to see a difference. I have changed my diet as much as possible for my sickness. And I could easily just go to bed and sleep, but instead I choose to stay active … I go outside and walk, and exercise as much as possible. If I don't make these changes to make my life better, who else will?" (Diana, 62 years).

Moana once more displayed her vast knowledge and provides a strong opinion of the state of affairs in healthcare in South Africa. She argued that more emphasis should be put on the healthcare of the elderly as they were once tax-paying citizens, and should not be neglected or unfairly treated. She also mentioned the National Health Insurance (NHI) scheme, and placed emphasis on long-term care. She also expressed that the elderly need to be taken more seriously, as they are voiceless and millions are feeling the impact of this.

> "Our country needs to fulfil its promises and not waste money unnecessarily. The healthcare system is in dire straits, and if they could help the poor because the

pensioners are forgotten for a while, but that pensioner was a taxpaying person, and it's not like pension is a bonus or something falling into the lap. So the government should really look after the old because they were the people that were running the country before and now it's their children …"

"… if we are going to be neglected, not everybody is capable of looking after their parents, some people are not even employed so how are they going to look after the elderly? So that's the thing, they (government) promise you everything but unfortunately, there isn't everything. So we should be very worried about how the NHI (National Health Insurance) thing is even going to go, because it's something you've got to think about, what your future holds for you medically.

I am fortunate and have the healthcare, but it is also very depressing to see someone who cannot do what we are doing because they are not in position to do it financially, and the idea of going to hospital for the cancer or whatever it is, and if there is no help who do you complain to? because you're going to be ignored. You are voiceless you know; millions are voiceless because nobody is taking them seriously" – (Moana, 68 years).

4.8 Summary

This chapter provided the results of the study. Semi-structured interviews were conducted with 20 elderly Indian people in the suburb of Avoca, Durban. The results found that hypertension, diabetes mellitus, and heart disease were the most common chronic conditions found among the elderly. A number of women also suffered from cancer. Body pains and aches made mobility more difficult as the participants got older. The participants accessed healthcare at both government, due to affordability, and private institutions. Those who accessed healthcare privately were mainly dependent on their family for financial support and medical aid. It was also found that the medical aid did not cover all medical costs and often required out-of-pocket expenditure. Challenges to accessing healthcare included distance and transportation to healthcare facilities, the lack of finance, and physiological barriers.

Chapter 5: Discussion and Conclusion

5.1 Introduction

As populations continue to age, there is a growing need for more focus into the dynamics of ageing and its resulting impacts on different societies, and their health systems. The overall objective of this study was to investigate the healthcare needs, opportunities and challenges of elderly Indians in Avoca, Durban. There is a lack of research done on the healthcare of elderly Indians, and this study was conducted with the motivation to fill this gap. This chapter summarises and evaluates the research findings, and provides recommendations for interventions.

5.2 Discussion

The novelty of this study is central to the study sample, which focused solely on the Indian/Asian population group. South Africa has a plethora of people from various backgrounds which is a result of the nation's rich history. The Indian population group is one of the country's largest race groups, and they also have a rapidly ageing population. Traditional norms and culture among the Indian population have been passed down for generations, and these place high value on the elderly thus, they are respected because of their age (Sinha, 1984). Indians, being family-orientated and promoting familial collectivism and cohesion, are also heavily involved in caring for family members and are important support-structures for the elderly (Chadda and Deb, 2013). This traditional social institution has been endured through ages and influences the lives of the individuals within it. In traditional Indian societies, the elderly were primarily taken care of by their families, mainly their children. The experiences of the elderly Indian community of Avoca may be somewhat different to that of the larger South African elderly community; this study highlighted the reliance on familial networks in meeting the healthcare needs of the elderly.

The most commonly reported chronic non-communicable illnesses was hypertension, followed by diabetes mellitus, and heart disease. These are similar to results found in other studies (Aboderin and Beard, 2015; Aboyade et al., 2016; Adhikari and Rijal, 2015) which also suggested that hypertension and diabetes mellitus were the most prevalent chronic diseases among the elderly. According to Statistics South Africa (2019) the most prevalent

chronic diseases amongst elderly South African's are diabetes mellitus, cardiovascular diseases, and hypertensive diseases, and almost every second elderly South African has hypertension. Hypertension increases the risk of a stroke, and both diabetes mellitus and hypertension were among the leading causes of deaths among the elderly in 2016 (Statistics South Africa, 2019b). According to Statistics South Africa (2020a), in 2017 diabetes mellitus was the leading cause of death for those aged 65 and older (9,0%) and the second leading cause of death for those aged between 45–64 (7,2%) This was followed by cerebrovascular diseases (8,5%), hypertensive diseases (8,4%), and ischaemic heart diseases (4,8%). In South Africa, coronary heart disease is one of the greatest causes of death among Whites and Indians in terms of circulatory system diseases. This is attributed to poor dietary and lifestyle choices – such as the high consumption of polyunsaturated fatty acids, which is of major concern for Indian South Africans (Wolmarans et al., 1999). Prakaschandra et al. (2016) explain that there is a high prevalence of cardiovascular risk factors in Indian South Africans. Hypertension, coronary heart disease, and diabetes mellitus are highly prevalent diseases in Indian South Africans (Prakaschandra et al., 2016).

It was found that the elderly visited healthcare providers at least once a month for either their medication or check-ups or if they were called in by the doctors. Chronic medication was mostly taken for hypertension, diabetes mellitus, high blood cholesterol, and heart disease. Chronic diseases require long-term medication which must be taken for the rest of the patient's life (WHO, 2015). These are provided at public health care facilities, however, they may also be purchased privately via a private medical practitioner (Statistics South Africa, 2019b). Diseases such as hypertension and diabetes mellitus require long-term treatment, thus landing a huge financial impact on the public sector that must then provide the medication for the disease (Statistics South Africa; 2019).

Most participants were on medication for two or more chronic conditions, or multi-morbidities, and these were mainly for hypertension, diabetes mellitus, heart disease, and cholesterol. As people age they are more likely to experience multi-morbidities that may lead to negative interactions between each condition or their specific treatments. In addition, multi-morbidities are associated with higher usage of healthcare services which also increased the pressure on healthcare systems as populations age (Bähler et al., 2015; WHO, 2015).

Half of the participants received their healthcare at government-provided health care facilities, whilst the other half relied on the private sector. The reason for this is that government-provided health care services are free, and many of the elderly cannot afford private healthcare or medical aid. South Africa's a public health sector is under a lot of pressure due to the fact that most people cannot afford private sector health services, and only 16.2% of the population have a medical aid, hospital care plan or able to afford out-of-pocket payments, whilst the rest of the population use government facilities for healthcare (Statistics South Africa, 2019b).

Some participants felt as though they had no choice but to go to government facilities as they could not afford private healthcare and treatment and felt that government-provided health care was not up to standard due to long queues, and long waiting periods. Strong dissatisfaction was associated with visiting government provided healthcare facilities, and it was expressed that private healthcare was more desirable if it were affordable, and government provided healthcare is not truly about choice because one does not get to choose the quality of care received. Dissatisfaction with the government provided healthcare facilities were attributed to long queues, long waiting hours, anti-altruistic or poor attitude on behalf of the staff, and poor administration and record-keeping. Aboderin and Beard (2015) found that elderly patients use commercial healthcare providers because of the unavailability, poor quality, or age insensitivity at government provided facilities. Maphumulo and Bhengu (2019) explain that poor record-keeping is a major challenge within South Africa's health system, and lost documentation causes confusion and delay for patients. The elderly have to leave home early and spend the majority of the day following queues so that they may receive health services, and this deters good health-seeking behaviour (Maharaj, 2013). Other challenges faced at government health facilities include long waiting periods, human resource shortages, poor hygiene, medical negligence and litigation, and medicine and equipment shortages (Maphumulo and Bhengu, 2019).

Some of the reasons for accessing private healthcare included distance as the facilities were located closer to the homes of the elderly. Transport costs are a barrier to obtaining healthcare, and hinders health seeking behaviour for proper management of health conditions. Without transport it is very difficult for the elderly to travel to healthcare facilities, especially those with disabilities, frailty, and other ailments that prevent them from walking long distances (Aboyade et al., 2016; Nxumalo et al., 2016; Vergunst et al., 2015). Harris et al.

(2011) found that the majority of people visiting health facilities used public transport, followed by walking, and then private means of transport - which was only for those whom were able to afford it and for those not living in rural areas - and is problematic as travel distances to health facilities are longer in non-urban areas. Maharaj (2013) stated that the ability of the elderly to access health providers and their services are hindered by poverty and the long distance to these facilities. The majority of the elderly in this study relied on family members, to drive them to their healthcare facilities emphasizing, once again, the significance of family support for the elderly and the close-knit family structure of Indians.

The elderly depended on their children to help pay the medical aid. The medical aid did not cover all the costs, thus requiring out-of-pocket expenditure. This is problematic as the main source of income for the elderly (at the time of the study) was the old age grant of R1 750, which was reported to not be adequate to cater to all the needs of the elderly. Elderly South African citizens aged 60 and over are entitled to this means-tested social grant which is used to prevent absolute poverty amongst the elderly (Schatz et al., 2015). In South Africa a lot of pressure is put on the public sector due to the fact that most people cannot afford private sector health services (Statistics South Africa, 2019a).

Participants mainly were taken to the hospital or another health care facility by their family members, usually their children. This was the most reliable transportation method for all of the participants which again highlighted the importance of family support for the elderly. The elderly may lose their independence as they get older due to disabilities, cognitive decline, financial problems, and the loss of motor functions (frailty), and may thus require family-based support in terms of care, living arrangements, and financial assistance (Ren and Treiman, 2015; Schatz et al., 2015). In many traditional societies such as in India, China, and South Africa, the family is the main support structure for the elderly, especially in areas where there is a lack of nursing homes or other facilities that are required to treat older people as they become more frail (Maharaj, 2013; Panigrahi, 2013; Ren and Treiman, 2015; Schatz et al., 2015). Where there is a deficit of government-provided care, the elderly are taken care off within family systems due to norms of intergenerational support (Mayston et al., 2017). However, these traditions and norms are increasingly eroded by socio-economic and political changes, along with urbanization and development (Maharaj, 2013; Alli and Maharaj, 2013). Traditional extended family systems are eroding away, and changing norms and values have

also changed cultural practices (Rademeyer and Maharaj, 2020) including caring for the elderly.

The elderly also complained of the lack of reliable transport as a barrier to accessing health care as public transport is not always reliable. This results in late arrivals at healthcare facilities, missed appointments, and delayed treatment. Without transport it is very difficult for the elderly to travel to healthcare facilities especially those with disabilities frailty and other elements that prevent them from walking long distances (Aboyade et al., 2016; Nxumalo, Gouge, and Manderson, 2016; Vergunst et al., 2015). Lack of transportation may also cause missed appointments with doctors or delayed treatment and therefore consistency in the management of non-communicable diseases (Syed, Gerber, and Sharp, 2013). Aboyade et al. (2016) state that non-communicable diseases are poorly managed in Africa due to infrequent access to the required health care and medication.

The study found that a recurring problem of medical aids not covering certain medical expenses. Osman (2019) explains that medical aid savings are mainly used for acute expenditure such as general doctor visits, and chronic medication are not always paid as it would run the risk of depleting the medical savings. Osman (2019) further explains that self-payment gaps occur when the medical aid account becomes depleted over time, resulting in out-of-pocket expenditure for patients until the medical aid account reaches the annual threshold. This may provide an explanation as to why some participants complain of their medical aids not covering or paying for certain expenses. This situation may be further exacerbated if the medical aid holder has more than one chronic disease, as treatment costs would be higher and the medical aid would not cover all chronic conditions.

Some participants were reluctant to state whether they required financial assistance with their health care or not, and those who felt that they did not require financial assistance were able to manage their health care needs with either their medical aid, pension, family support, or by visiting government provided healthcare facilities. Financial assistance was mainly required in getting prescribed eyeglasses and buying medication privately so as to avoid government facilities, and to assist with medical aid as it is costly and does not cover all medical expenses. Policies and programmes that aim to assist the elderly such as social grants and cash transfer programmes – may assist with improving access to health care, and will in-turn assist with poverty-reduction by improving quality of life, thereby increasing productivity

and preserving livelihoods (Gresh and Maharaj, 2013). Not being able to follow a certain diet required for health conditions such as diabetes mellitus due to lack of affordability may result in poor dietary and nutritional practices which may ultimately lead to poor medication intake, affecting the way in which certain health conditions are managed.

There was some satisfaction with government provided facilities, this was especially in the case of the local clinics. Private facilities were well suited to the healthcare and physical needs of the elderly and treatment in government facilities was perceived as not being up to standard. It was also indicated by participants that government hospitals failed to provide all required medication at times leaving the elderly no choice but to buy the medication themselves. Often, the elderly had to do without some medication as they were unable to afford it themselves. This indicates poor health-seeking behaviour due to institutional barriers, and the lack of medication may worsen the health status of the elderly. Peltzer and Phaswana-Mafuya (2012) found that there were greater dissatisfaction levels over public sector healthcare services, and one of the many reasons being the non-availability of prescribed medication. It was also found that certain participants had good knowledge of the situation of ageing in the country, and stated that there was not enough emphasis of health care of the ageing population and that the elderly should not be neglected as they were once tax paying citizens, and that the elderly were not taken seriously as they are voiceless.

Maslow's hierarchy of needs can be applied to the study results by emphasizing the importance of lower needs which are the physiological and security needs, in order to reach self-actualization and live a fulfilled life. If any of these base needs are not met it affects the entire flow from the bottom of the pyramid to the top, meaning it affects the capabilities of the elderly to reach self-actualization and live a healthy and happy life. The elderly must first meet their lower-order needs, which are imperative for survival. In this study, it was found that some participants were unable to afford a healthy diet required for the management of diabetes mellitus – healthy diet and nutrition belong to the lowest order of need, which are physiological needs. The cost of food prevents the elderly from following a healthy diet, which is important especially since a healthy diet is required for diabetes mellitus – as it is a lifestyle influenced disease. Poverty causes unequal access to healthcare resources and also affects other basic needs of the elderly such as access to nutritious food (Naidoo et al., 2015; Nxumalo, Gouge, and Manderson, 2016). If these needs are not met, it causes a negative chain reaction up the pyramid and eventually effects the quality of life of the elderly. The

findings indicate some elderly are unable to meet all their healthcare needs. This affects their ability to meet security needs in Maslow's hierarchy. In the case of this study, social needs are reached in the sense that many of the study participants are able to receive support from their family members. A lack of family support and family presence would affect the ability of the elderly to meet their social needs. The fact that many of the elderly participants are not able to meet their need at some level in Maslow's hierarchy is indicative that they are unable to lead a fulfilled life.

5.3 Recommendations

There should be more emphasis on healthcare of the elderly and health systems must develop effective strategies to provide health care and to respond to the needs of the elderly. As the global impetus towards universal health coverage increases, the specific healthcare needs of the elderly will have to be addressed by health systems (Suzman et al., 2015). There is a possibility of a National Health Insurance for South Africans, which would provide improved access to good quality healthcare services for citizens. However, South Africa is unable to implement such a system as it is unsustainable, very costly, and destructive (Naidoo, 2012). Therefore, it is imperative to look for more sustainable methods of improving South Africa's health system to make treatment more equitable, especially for those with fewer fiscal resources.

Challenges faced at the healthcare facilities such as waiting in long queues, unhelpful or rude staff, and administrational incompetence must be addressed at the institutional level. Health care for the elderly must be safe, effective, efficient and responsive without imposing fiscal burdens on individuals, and will be a cornerstone to achievement of the goal of universal health care coverage (Suzman et al., 2015). Proper training of staff, better management of patient volumes, and an overall increase in speed and efficiency is required to protect the elderly from these challenges. The poor attitude of healthcare workers towards the elderly must be addressed therefore, healthcare workers must be properly trained and equipped with the knowledge to properly care for the elderly (Adebusoye et al., 2015) and the quality of care given should be thoroughly assessed and evaluated. The dispensing of chronic medication should also be decentralised and be provided closer to the residences of the elderly to prevent high volumes of patients at hospitals and prevent great travelling distances and costs for the elderly. Alternatively, free or financially reasonable age-specific

transportation should be provided for the elderly to and from healthcare institutions. Care must be taken to minimise the distance that vulnerable South Africans must travel to meet their health care needs by placing health facilities in under-served/remote areas. Mobile clinics staffed by qualified personnel could also be introduced as a method to minimize transportation costs. A reduction in travel costs may cause an increase in health care access and use, especially for preventative and chronic healthcare (McLaren et al., 2014).

Health literacy (the ability to pursue, understand and implement health information) is a cornerstone in treating chronic health conditions as Liu et al. (2015) demonstrate that health literacy was considerably associated with positive health behaviours in elderly Chinese people. Educating people about the lifestyle risks associated with non-communicable diseases and the prevention of such may help to curb future burden of disease, and lighten the load on the health system, and therefore should occur as early as possible, especially for people at risk of developing age-related illnesses. Health education of the elderly should be provided by physicians, or designated trained health-educators. When health education plans are drawn up, elderly individuals' socio-economic and cultural backgrounds should be considered to ensure that the material to be used in the education is chosen carefully (Kececi and Bulduk, 2012). The level of teaching or instruction should also be on par with the level of understanding of the elderly in order to ensure maximum assimilation of health education (Kececi and Bulduk, 2012). Appropriate socio-economic and health system policies together with alterations in individual behaviour may ensure good health and wellbeing of the future elderly (Chatterji et al., 2015). As life expectancy increases, it is important to maintain good health for as long as possible, thus keeping this expanding group of the population healthy (Chatterji et al., 2015). Special attention must be given to addressing inequalities in elderly access to healthcare; removing stereotypes and stigmas surrounding the elderly; empowering people to adapt to challenges and social dynamics surrounding ageing populations; and being more considerate to the perspectives of the elderly, their functioning, and health (WHO, 2015).

Health systems must develop effective strategies to provide health care and to respond to the needs of the elderly. The healthcare needs of the elderly should be incorporated into new frameworks to attain universal health coverage access in Africa and across a person's entire life span (Aboderin and Beard, 2015). Treatment action must also focus on providing chronic care for the most prominent chronic diseases that affect ageing population (Aboderin and

Beard, 2015). Health care for the elderly must be safe, effective, efficient and responsive without imposing fiscal burdens on individuals and will be a cornerstone to achievement of the goal of universal health care coverage (Suzman et al., 2015).

Policy formulation should target health promotion and health seeking behaviours whilst researching factors that determine these behaviours (Adhikari and Rijal, 2015). Considering the high prevalence of diabetes mellitus, preventive measures are recommended in order to decrease and control the incidence and prevalence of the disease and its complications (Tanjani et al., 2015). Physical activities and sports improve the overall quality of life and increases level of independence of elderly, and promotes happiness, good physical and mental health, healthy appetite, peace and proper sleeping habits (Tanjani et al., 2015).

Clegg et al. (2013) state that there is a need for more efficient frailty detection methods as this would properly targets health resources and improve quality of life for those who suffer from frailty and motor function loss. Along with other illness and disabilities, healthcare systems should also account for secondary methods to improve positive mental wellbeing (Steptoe, Deaton, and Stone, 2015). Future studies should investigate the risk factors for age-related non-communicable diseases, and gender and racial disparities in health status and access to healthcare. More emphasis should be placed on larger, mixed-method studies to allow for generalization of results to the whole population.

5.4 Conclusion

Global human populations are ageing, and this is a problematic demographic change as ageing brings with it a huge burden of age-related non-communicable diseases. These diseases put pressure on health systems as they require chronic treatment. This study found that the main health problems among the elderly were non-communicable diseases such as hypertension, diabetes mellitus, and cardiac diseases, and every participant suffered from at least one non-communicable disease. These diseases require chronic treatment, which are accessed at both government-provided (public) and private healthcare institutions. Elderly participants in this study visited their respective healthcare providers from as little as once a year, to as often as every month for either check-ups or to collect chronic medications. Finance had the biggest influence on healthcare choices as most of the reasons for healthcare choices boiled down to affordability and accessibility. Those who are able to afford medical

aid visited private healthcare providers, whilst those whom did not have medical aid could not afford it and had to visit government-provided/public healthcare facilities. There was great dissatisfaction with the government health facilities due to overcrowding, long queues, long waiting periods, lack of medication, and poor attitude of staff. Some of the participants were not able to meet all their healthcare needs. Studying the healthcare needs of the elderly provides an opportunity for policy and health system reformation in order to cater to the needs of the growing elderly population.

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Appendix A: Interview guide

General demographic questions

1. How old are you?
2. What is your marital status?
3. What is your highest level of education?
4. What religion or faith do you follow?

[Transition to research interview questions]

Research interview questions:

1. Do you have any long-term (chronic) medical health conditions/illnesses? If yes, what are they?
2. Do you have any short-term (acute) medical health condition/illnesses? If yes, what are they?
3. Are you seeing any specialists (doctors who specialise in a particular field of medicine, such as a cardiologist) for any of your medical health conditions/illnesses?
4. Are you taking medication that a doctor has prescribed? If yes, what are they are for?
5. Are you on a healthcare plan or medical aid?
6. Do you go to private or government-provided healthcare facilities (clinics or hospitals) for your medical healthcare, or do you receive it at home? Why do you choose this method of receiving your healthcare?
7. If healthcare is received at a facility, how do you get to the facility? How often do you have to go?
8. Do you experience any problems with physically accessing healthcare? If yes, what are they?
9. Are you happy with this type of healthcare or would you prefer another kind of healthcare? If yes, what would you prefer or who would you prefer to take care of you? Why?
10. Do you need to use any medical equipment? (for example, a wheelchair)
11. Do you need any financial assistance with any aspect of your healthcare? If yes, what do you need financial assistance with? If no, are you able to afford all your healthcare needs?

12. Based on what we have discussed; do you have any other requirements/needs for your healthcare that you cannot meet? If yes, what are they?
13. What aspects of your healthcare do you think are best facilitated, or not have any difficulty with?
14. Would you like to discuss any other experience, be it a challenge or an opportunity, about your healthcare that we have not previously discussed?

Closing

A. Maintain Rapport (express appreciation, ask interviewee if they have any questions for the researcher).

B. Action to be taken (researcher to explain that he should have all the required information, and ask if it would it be alright to call should the researcher have any more questions).

C. Closing pleasantries and greetings.

Appendix B: Informed consent form

UKZN HUMANITIES AND SOCIAL SCIENCES RESEARCH ETHICS COMMITTEE (HSSREC)

APPLICATION FOR ETHICS APPROVAL

For research with human participants

INFORMED CONSENT RESOURCE TEMPLATE

Note to researchers: Notwithstanding the need for scientific and legal accuracy, every effort should be made to produce a consent document that is as linguistically clear and simple as possible, without omitting important details as outlined below. Certified translated versions will be required once the original version is approved.

There are specific circumstances where witnessed verbal consent might be acceptable, and circumstances where individual informed consent may be waived by HSSREC.

Information Sheet and Consent to Participate in Research

Date: _____

Dear community member

My name is Sachin Sewpersad from the School of Built Environment and Development Studies at the University of KwaZulu-Natal. My contact number is 0737518633, and my email address is sachu1271@gmail.com. My supervisor is Professor Pranitha Maharaj, and she may be emailed at maharajp7@ukzn.ac.za or telephoned on 0312602243.

You are being invited to consider participating in a study that involves research on the healthcare of the elderly Indian population group in Avoca, Durban. The title of this research is *A Qualitative Study of Healthcare of the Elderly: A case study of Indians in Avoca, Durban*. The aim and purpose of this research is to better understand the healthcare needs, challenges, and opportunities of the elderly in the suburb. The study is expected to interview 20 participants aged 60+ of the Indian population group in the suburb of Avoca. It will involve face-to-face semi-structured interviews. The duration of your participation, if you choose to enroll and remain in the study, is expected to be between 30 to 40 minutes.

The study may involve the following risks and/or discomforts: questions surrounding the participant's health status and healthcare needs. We hope that the study will create the following benefits: a better understanding of the healthcare needs, and healthcare challenges and opportunities of our elderly citizens.

This study has been ethically reviewed and approved by the UKZN Humanities and Social Sciences Research Ethics Committee (approval number HSS/0167/019M).

In the event of any problems or concerns/questions you may contact the researcher at 0737518633, or the UKZN Humanities and Social Sciences Research Ethics Committee, contact details as follows:

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Email: HSSREC@ukzn.ac.za

Participation in this research is voluntary and participants may withdraw participation at any point, and in the event of refusal/withdrawal of participation the participants will not incur any penalty or loss of treatment or other benefit. There will be no potential consequences to the participant for withdrawal from the study. Under the circumstance that the participant wishes to withdraw from the study, the researcher will terminate the participant from the study.

No costs will be incurred by participants as a result of participation in the study. Confidentiality will be maintained throughout the duration of the study. The recordings of the interview will be strictly and solely accessible to the researcher, and transcripts will be labelled by pseudonyms to maintain anonymity. Once the research has been completed, the samples will be stored by the researcher for future reference.

CONSENT (Edit as required)

I (name)_____ have been informed about the study entitled "A Qualitative Assessment of Healthcare within the Elderly Indian Population of Avoca, Durban" by Sachin Sewpersad.

I understand the purpose and procedures of the study, which are interviews that surround the healthcare needs, opportunities and challenges of the elderly.

I have been given an opportunity to answer questions about the study and have had answers to my satisfaction.

I declare that my participation in this study is entirely voluntary and that I may withdraw at any time without affecting any of the benefits that I usually am entitled to.

I have been informed about any available compensation or medical treatment if injury occurs to me as a result of study-related procedures.

If I have any further questions/concerns or queries related to the study, I understand that I may contact the researcher at 0737518633.

If I have any questions or concerns about my rights as a study participant, or if I am concerned about an aspect of the study or the researchers then I may contact:

HUMANITIES and SOCIAL SCIENCES RESEARCH ETHICS ADMINISTRATION

Research Office, Westville Campus
Govan Mbeki Building
Private Bag X 54001
Durban
4000
KwaZulu-Natal, SOUTH AFRICA
Tel: 27 31 2604557 - Fax: 27 31 2604609
Email: HSSREC@ukzn.ac.za

Additional consent, where applicable

I hereby provide consent to:

Audio-record my interview / focus group discussion	YES / NO
Video-record my interview / focus group discussion	YES / NO
Use of my photographs for research purposes	YES / NO

_____ _____

Signature of Participant **Date**

_____ _____

Signature of Witness (Where applicable) **Date**

_____ _____

Signature of Translator (Where applicable) **Date**