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Relation of socio-economic status to the independent application of self-care in older persons of South Africa

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ABSTRACT

Background: Many older persons in South Africa (SA) are affected by a poor socio-economic status, leading to an increase in the use of the public healthcare sector. However, the public healthcare sector is burdened by high volumes of patients and long waiting periods. As a result, professional nurses in primary healthcare (PHC) facilities are not able to spend enough time on proper physical examinations and assessment of needs, including health education and support to older persons to help them apply independent self-care.

Aim: To determine if the socio-economic status of older persons affects their ability to apply self-care independently without support from professional nurses in the PHC facility.

Design: Quantitative, descriptive research design.

Methods: Older persons (N = 198; n = 192 respondents) were asked to complete the Appraisal of Self-care Agency (ASA-A) and Exercise of Self-care Agency (ESCA) questionnaires. Seven self-care deficits were identified through deductive logic after analysis of the two questionnaires. These seven self-care deficits were compared to the socio economic status of the same sample.

Results: Seven self-care deficits were identified after analysis of the ASA-A and ESCA questionnaires. One self-care deficit was found to have a relationship with the socio-economic status of the older persons.

Conclusions: Low literacy levels of older persons with a low socio-economic status affect their ability to apply self-care independently without the support from a professional nurse in the PHC facility. Data analysis of the ASA-A and ESCA revealed that these older persons suffer from a "lack of knowledge and ability to acquire knowledge with regard to self-care" which had a relationship with the socio-economic status of older persons with specific reference to low literacy levels and poverty.

Implications for practice: More attention should be given to older persons with a low socio-economic status as their ability to apply self-care independently without the support from a professional nurse is limited. This would lead to less frequent visits to PHC facilities by older persons for minor ailments, decrease healthcare costs, relieve overcrowding in PHC facilities and prevent possible unintentional self-neglect.

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1. Introduction

Currently, ageing of the global population represents one of the most distinctive changes in the demographic profile. In parts of the population where there are scarce resources, ageing has the potential to become a major issue, especially as it has been predicted that the population of old people is going to increase in the next two to three decades. Worldwide there are 600 million people over the age of 60 years (World Health Organization, 2013). The United Nation's estimated projection of older persons in 2000 was 21.3 million, with the figure expected to rise to 80.3 million in 2025. Sub-Saharan Africa has a lower number of older persons compared to other developing regions (Kimuna, 2005, p. 13). According to Nabalamba and Chikoko (2011, p. 2), the older population in Africa accounts for 3.6% of the entire population and this percentage is expected to rise to 4.5% in 2030 and to 10% in 2050. In South Africa in 2001 there were 3.3 million persons over 60 years of age (Turok, 2006, p. 1), which represented 7.5% of the total population; this number has since increased to 7.7% (Statistics SA, 2011). In the North West (NW) province the 2011 census revealed that the percentage of older persons (60 + years of age) increased to 7.7% (Statistics SA, 2011) from 7.34% in 2001 (Joubert & Bradshaw, 2004, p. 152). The reality of the increasing older population is putting increased pressure on the public healthcare sector serving 83% of the total South African population (Council of Medical Schemes, 2011). This means that professional nurses are not able to spend enough time on physical examinations and health education focusing on independent application of self-care in the PHC facilities.

Additionally, older persons have different socio-economic needs that should be considered; for example accessibility of healthcare, needs regarding nutrition, shelter, clothing, transportation, community amenities and various types of abuses (May, 2003). Previous health experiences, the nature of medical complaints, past experiences at healthcare services, requests for information and advisory visits to healthcare facilities are all issues that are faced by older persons (Laditka, 2004, p. 233;Vožehová, Zikmundová, Zavázalová, Zaremba, & Vlasák, 2003, p. 48) together with the reality of a low socio-economic status (Nabalamba & Chikoko, 2011, p. 12). The studied population is also affected by a low-socio-economic status, low literacy levels and poverty. Due to the latter, they have no other choice than to visit PHC facilities which is the first point of access to healthcare for patients in the public healthcare sector.

PHC was introduced in South Africa in 1994 to reform the health services. The focus of PHC is to make essential services freely available, cost-effective, affordable and equal to all members of the population, and includes the care and treatment of chronic and other diseases in older persons (Hattingh, Dreyer, & Roos, 2010, p. 65; Phaswana-Mfuya et al., 2008, pp. 611–612). According to Hattingh, Dreyer, and Roos (2012, p. 70), PHC stresses self-reliance and self-determination and therefore aims to redistribute power and build self-confidence in people. This also applies to older persons and should be able to assist them to increase their independence in caring for self. Self-care among older persons has the potential to reduce medical care needs as well as healthcare costs (Joubert & Bradshaw, 2004, p. 157; Lloyd-Sherlock, 2004, pp. 292–294; SA, 2004, p. 3).

However, according to The DG Murray Trust (2012:4), the healthcare provided to older persons in the public sector is not satisfactory. This could be due to a lack of expertise in the care of older people, leading to a systematic failure of the system. Other factors in the public healthcare sector which possibly also affect the older person to independently apply self-care include ineffective appointment arrangements, lack of medication, poor handling of physical examinations (Turok, 2009, p. 1), overcrowding, long waiting periods, staff shortages, inadequate provision of health education to specifically older persons, poor quality of care and disrespect (Kruger, Greeff, Watson, & Fourie, 2009, p. 42). This uncaring attitude is not intentionally inflicted on older persons in the PHC facilities, but is rather as a result of factors such as time constraints, staff shortages, high workloads and overcrowded public PHC facilities which lead to frustration among the staff (Bradshaw & Steyn, 2001, p. 9; Turok, 2006, p. 5). More attention should thus be given to the management of older persons' health problems and their independent self-care abilities in PHC facilities.

If older people do not have sufficient knowledge about their healthcare problems, including their chronic diseases, they will not know how to independently treat or take care of themselves, and the less they know, the less they will discuss any issues they have with the healthcare provider, thereby decreasing their self-care ability (Guinn, 2004, p. 270; Bastiaens, Van Royen, Rotar Pavlic, Raposo, & Baker, 2007, p. 38).

Gibbons (2006, p. 324) mentions that self-care means purposeful management of the self and could be considered intentional. Other authors such as Kendall and Rogers (2007, p. 130) and Lauder (2001, p. 96) describe self-care as activities a person engages in to promote health, prevent disease, assess symptoms and reinstate optimal healthy functioning. Self-care also includes those actions a person engages in to ensure optimal health for a long period of time or to preserve health and ensure healthy functioning by taking part in self-development activities in order to prevent self-neglect (Tomey, & Alligood, 2006, p. 269).

Self-care encompasses the following concepts: self-care agency, self-care agent and self-care deficit (Orem, 2001, pp. 53; 268 & 282). Self-care agency refers to the ability (capability and power) a person has to engage in self-care operations (Callaghan, 2006, p. 45; Evers, Isenberg, Philipsen, Senten, & Brouns, 1993, p. 332; Lauder, 2001, p. 96; Orem, 2001, p. 53; Tomey & Alligood, 2006, p. 271). Self-care agent refers to the individual who engages in self-care (Orem, 2001, p. 268; Tomey & Alligood, 2006, p. 271), and self-care deficit refers to the limitations in the self-care ability and power of the self-care agent to meet therapeutic self-care demands (Orem, 2001, p. 282). Lastly, self-neglect means that a person is not able to provide goods or services to self to meet basic needs (Deyer, Goodwin, Pickens-Pace, Burnett, & Kelly, 2007, p. 1671).

The initial healthcare profile obtained during the Prospective Urban and Rural Epidemiological study (PURE) (Kruger, 2005, p. 4) revealed that the studied older population had a low socio-economic status and was affected by low literacy levels and poverty (Watson, 2008, pp. 72–74) (see Table 1). The