The Health Status of the Ageing in Northern Thailand

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Abstract
The objectives of this study were to investigate the health status of the ageing by their resident conditions and sex. The purposive sampling was employed to select a group of the 702- ageing aged between 60 and 90 years old using statistical values which were Mean (70.29) and Standard Deviation (7.32). The subjects were 285 men and 417 women. Based on the conditions of residence, 470of them lived with families (Lf) while 232 lived alone (La). The health status was classified based on the aging-questionnaire,2015 by the Ministry of Public Health. Three health conditions indicators namely chronic conditions, health issues and health risk behavior, were investigated. The results of the study found that (1) regarding chronic conditions, hypertension was at the highest rate found, osteoarthritis and diabetes coming respectively in the second and third places (2) Vision loss, dementia, hearing loss and insomnia symptoms were the most common health issues found in aging (3) regarding to health-risk behaviors. The first type was nonparticipation in social activities, second was having no leisure activities and the third was not exercising. The result of this study helps to understand the health status of aging. In order for management planning for health prevention and promotion due the local context for the better health and quality of life of aging.
Keywords: Health Status, Quality of Life, Ageing, Northern Thailand

Introduction
The data from Institute for Population and Social Research, Mahidol University (2006) found that the population of aging in the north of Thailand had the highest number compared to other areas of the country. The increase of older adults with the decline share in working force will affect societies and cause economic problems. Into ageing phase of life, cells and physiological systems begin to deteriorate thus causing worsened physical movement and memory (Brent, 2009). In physical health, even though we do not fall ill with any illnesses, when our body deteriorate with age, physical fitness in various functions will decrease as the age increases, causing movement ability to decrease (Shinichi & et al., 2003) and possibly lead to other various types of health problems.

There are many factors both inside and outside related to the process of aging. The inside factors originate in the body and any behavior which affect to the body, physical fitness, movement or any activities for living. The outside factors affect from the dynamic of surrounding such as economic status, society and the change of the environment and society (Thumcharoen, 2012). All of these factors are directly affected by the physical and mental changes that occur in aging.

When aging up, more diseases and various problem syndromes were found. From the survey of Health Status of the Elderly found that 41.4% of the aging had been diagnosed with hypertension,18.2% with diabetes, 8.6% with osteoarthritis, 58% was limited physical ability, 24% was hearing impairment or communication, 19% was vision impairment and 4% was learning disability (National Committee for the Elderly, 2014). And the quality of life of the aging decreased with increasing age and various problem syndromes (Tongdee, Rongmuang& Nakchatree, 2013) and the cause of the aging's sickness, affect from the health behavior from the past.

The purposes of this study were to study the health status of the ageing based on gender and living conditions. This information may be useful to planning aging health education and promotion due the local context for the aging to have better health and quality of life

Research Methodology

The research is a quantitative survey research. The subjects were 720 ageing (285 men and 417 women, 470 living with families and 232 living alone) aged 60 years and over. The subjects were selected by the purposive sampling selected from Maeka Sub-district, Muang District, Phayao Province; Tantong Sub-district, Wang Nuea District, Lumpang Province and Ban Du Sub-district, Muang District, Chiang Rai Province. Sample size was calculated with Taro Yamane (1967) at a 95% confidence level.

Research Instrument

The research instrument used in this study was the aging questionnaire, 2015 by the Ministry of Public Health. Classified health problems into three categories namely 1) chronic status 2) health issues and 3) health risk behavior.

Data Analysis and Statistics

1) The data were collected focusing on three health condition indicators namely (1) chronic status (2) health issues and (3) health risk behaviors. Data analysis was conducted using three statistical values that are percentage, Mean, Standard Deviation.

2) Independent t-test was used to compare the mean scores obtained from health behavior between males and females and between two kinds of living conditions.

Research Results

The average ages of the subjects in this study were 70.81 (for men) and 70.02 years old (for women). In men, an average body weight was 59.45 kg and an average height was 163.94 cm. The average body weight of the women was 55.28 kg and the average height was 156.20 cm. Both groups consisted of a number of those with no occupation (57.9 % for men and 52 % for women). Regarding widowhood, women had a higher ratio than men while men showed a higher score of being unmarried. Considering the living conditions, comparing between the ageing living with their families (Lf group) and the ageing living alone (La group), the median age of the Lf group was 70.06 while La group was 70.92) For the average weights of the Lf group and La group, 57.19 kg. was of the former and 56.54 kg. was of the latter. The average height of the Lf group was 163.94 cm. and 159.11 cm. were that of La group. The La group had a higher portion of people with no occupation than the Lf group. In addition, the La group had a higher ratio of being single than the Lf group. The data is presented in table 1.

Table 1 General information, by Gender and Residential Conditions

General Information	Sex				Residential Conditions			
	Men (285)		Woman (417)		Living with family (470)		Living alone (232)	
	Number	%	Number	%	Number	%	Number	%
With occupation (employed)	120	42.1	200	48	283	50.6	82	35.3
Without occupation (unemployed)	165	57.9	217	52	234	49.4	150	64.7
Married	151	53	186	44.6	282	60	55	23.7
Widowed	61	21.4	158	37.9	117	24.9	102	44
Divorced	10	3.5	19	4.6	10	2.1	19	8.2
Single	63	22.1	54	12.9	61	13	56	24.1
Age	Mean 70.81 S.D. 7.10		Mean 70.02 S.D. 7.11		Mean 70.06 S.D. 7.32		Mean 70.91 S.D. 7.26	
Weight (cm.)	Mean 59.54 S.D. 8.59		Mean 55.28 S.D. 9.03		Mean 57.19 S.D. 9.08		Mean 56.54 S.D. 9.09	
Height (kg.)	Mean 163.94 S.D. 7.68		Mean 156.20 S.D. 7.25		Mean 159.11 S.D. 8.19		Mean 159.80 S.D. 8.63	

As shown in table 2, chronic diseases, calculated in percentage, found in this research were, of the ageing men, hypertension (44.9), osteoarthritis (23.9), diabetes (13.3), gastritis (8.4), cataracts (5.3); of the elderly women, hypertension (56.6), diabetes (24), osteoarthritis (18), gastritis (8.6), cataracts (8.4); regarding Lf group, hypertension (50.2), diabetes (18.7), osteoarthritis (17.4), gastritis (8.5), cataracts (6.8); of the La group, hypertension (55.2), diabetes (26.3), osteoarthritis (21.6), gastritis (8.6), cataracts (7.8).

Table 2 Chronic Disease, Classified by Gender and Residential Conditions

Chronic disease	Sex				Residential Conditions			
	Men (285)		Woman (417)		Living with family (470)		Living alone (232)	
	Number	%	Number	%	Number	%	Number	%
Hypertension	128	44.9	236	56.6	236	50.2	128	55.2
Osteoarthritis	68	23.9	75	18	82	17.4	61	26.3
Diabetes	38	13.3	100	24	88	18.7	50	21.6
Gastritis	24	8.4	36	8.6	40	8.5	20	8.6
Cataract	15	5.3	35	8.4	32	6.8	18	7.8

Table 3 Health Issues, Classified by Gender and Residential Status

Chronic disease	Sex				Residential Conditions			
	Men (285)		Woman (417)		Living with family (470)		Living alone (232)	
	Number	%	Number	%	Number	%	Number	%
Vision loss	91	31.9	145	34.8	150	31.9	86	37.1
Dementia	88	30.9	143	34.3	146	31.1	85	36.6
Hearing loss	62	21.8	88	21.1	89	18.9	61	26.3
Insomnia	55	19.3	107	25.7	112	23.8	50	21.6
Movement Disorder	56	19.6	59	14.1	66	14	49	21.1

The Data from table 3 shows health issues, classified by gender and residential status. Along with the percentage, the rank of each category was ranked from the highest to the lowest scores as follows: of the ageing men, it starts from vision loss (31.9), dementia (30.9), hearing loss (21.8), movement disorder (19.6), to insomnia (19.3).
Of the ageing women, it also starts from vision loss (34.8 percent), dementia (34.3), insomnia (25.7), hearing loss (21.1), movement disorder (14.1).
For the Lf group, vision loss has the highest score. The calculated percentage was 31.9) Dementia was next (31.1) followed by insomnia (23.8), hearing loss (18.9) and movement disorder (14.1).
Regarding to the La group, the percentage of vision loss is 37.1, followed by dementia (36.6), hearing loss (26.3), insomnia (21.6) and then movement disorder (21.1).

Table 4 Health Risk Behaviors, Classified by Gender and Residential Conditions

Chronic disease	**Sex**				**Residential Conditions**			
	Men (285)		**Woman (417)**		**Living with family (470)**		**Living alone (232)**	
	Number	**%**	**Number**	**%**	**Number**	**%**	**Number**	**%**
Without social activities	90	61.2	105	49.3	232	49.4	148	63.8
Without leisure activities	106	37.2	130	31.2	173	36.8	63	27.2
No-exercising	40	27.2	50	23.5	148	31.5	30	12.9
Non-health screening	64	22.5	54	12.9	90	19.1	28	12.1
Social drinking	23	15.6	8	3.8	33	7	26	11.2

Data from table 4 shows health risk behaviors classified by gender and residential conditions:
It can be explained that the percentage of the elderly men who do not participate in social activities is 61.2) Those without leisure activities in the same category is at 37.2, and the percentage of the elderly men who have no exercising is at 27.2 percent. The score for non-health screening is at 22.5 percent while the score of social drinking is at 15.6 percent.
Regarding the elderly women of nonparticipation in social activities, the percentage is 49.3 followed by 31.2 percent of those who have no leisure activities, 23.5 percent of the elderly women without exercising, 12.9 percent of non-health screening and 3.8 percent of social drinking.
The Lf group shows the score of nonparticipation in social activities at 49.4 percent, then followed by 36.8 percent of having no leisure activities. No-exercising is at 31.5 percent, and then Non-health screening is at 19.1 percent. Finally, social drinking comes at 7 percent.
The La group has 63.8 percent for nonparticipation in social activities, 27.2 percent for having no leisure activities, 12.9 percent for no exercising, 12.1 percent for non-health screening, and social drinking is at 11.2 percent.
From table 5, it is seen that the average score of health risk behaviors in women is significantly better than men with statistically significance at .00, and the average score of the Lf group is significantly better than that of the La group, with statistically significance at .00 as well.

Table 5 Comparison of Health Risk Behaviors Average Scores between Men and Women and Two Types of Living Conditions Using Independent t - test

	N	Mead	S.D.	t	P
Sex					
Men	285	10.42	2.27	4.237*	.00
Women	417	11.12	2.00		
Residential Conditions					
Living with Family (Lf group)	470	11.13	2.263	2.784*	.00
Living alone (La group)	232	10.69	1.839		

* P< .05

Discussion and Conclusion

According to the result analysis, Hypertension is the most common disease in the ageing, both men and women and both ageing living with their family (Lf) and living alone (La). The finding from this research is consistent with the report from Thai National Health Examination showing that the ageing aged between 60 to 69 years old are hypertensive, 47.2 percent in men and 49.5 percent in women and it would increase to 58.7 percent in men and 68.9 in women when they are over 80 years of age (Aekplakorn, 2014). Osteoarthritis and Diabetes is found as the second and third most disease in men and in the group of the elderly living alone.

Hypertension, Osteoarthritis and Diabetes are the syndromes resulting from the abnormal function body systems and syndromes associated with NCDs. They are caused by behavior and daily lifestyle affects from the health behavior from the past like food consumption behavior, exercise, daily activities. These symptoms are not only caused by aging, but are caused by many reasons (Polasak, 2017). Osteoarthritis is the syndromes affected from various behaviors in daily life, such as squatting, sitting for a long time for meditation or being overweight (Newman, 2009; Stevenson & Roach, 2012). In addition to causing health problems, it may also affect to reduce self-esteem level of aging (Hawker, 2012). However, although it can prevent health problems, most older people still have a limited understanding (Hurley et al., 2010) and still continue practicing health risk behavior, especially the sitting postures that increase the severity of the symptoms.

Focusing on health issues, vision loss is the most common health problem found in the ageing, both the ageing men and women and in both Lf and La groups. Dementia is the second most common health problem in all groups followed by Insomnia in women and Hearing Loss in men. The health issues cause the quality of living performance. Aging is the major factor of health issues. The protein fibers in the eye lens will have less flexibility when aged it leads to vision loss (Salvi, Akhtar& Currie, 2006). The brain cells that are associated with occurrence of delta brainwave also decrease by aging and there is also a decrease in circadian rhythm that controls the rhythm of sleep causing the ageing to have a short deeper sleep period which leads to nocturnal awakenings or Insomnia (Ohayon, & et al., 2004). The most common hearing problem found in the ageing is presbycusis symptom or age-related hearing loss (AHL). This symptom is the hearing impairment that increases with age. The treatment is necessary to use hearing aids to helps patients to be able to communicate effectively (Opatwattana & Utoomprurkporn, 2018) Also, the elderly who have health issues problems will affect the ability to perform daily activities and have the risk of having depression (Watkinson, 2005; Eichenbaum, 2012; Dennison,2014; Wimo, Winblad & Jonsson, 2010) Therefore, people who involved in caring for the aging need to understanding that health issues are incurable

symptoms. And must have understanding and empathy for the aging with health issues symptoms.

The result found that most of ageing in all group do not participate in social activities and not engaged in leisure activities and some of ageing men and women never exercise at all. There are many factors that cause the ageing not to participate in the activities such as travel problems, personal health problems such as having diseases or pain, being impatient to wait, feeling weak or having no motivation (Crombie, Irvine, Williams, & et al. 2004). It is suggested that the aging should have the opportunity to participate in social activities. Participation in community social activities will make the ageing feel that they are still valuable and proud of themselves, help in maintaining their social roles and status, make their life happy. The ageing who have social activities, hobbies or activities that promote physical health will always have a good quality of life and be adaptable to various changes (Sumalrot & Suksawai, 2015). In addition, the ageing who spend free time on hobbies such as reading books, writing notes or stories, recreational activities, or entertainment activities will improve the quality of their life (Adams, Leibbrandt & Moon, 2011; Silverstein & Parker, 2002). The Social activities that appropriate for the ageing should be activities that promote group integration, enhance physical and mental health and should encourage the elderly to check their health, whether they are NCDs, cancer examination or even stress tests (Sazlina, 2015).

It could be concluded that mostly of aging had a chronic conditions and health issues with incurable symptoms. Therefore, people who involved in caring for the aging need to understanding, empathy and planning for reduce the risk factors stimulate the severity of the existing symptoms. Because many variables of health status associated with increasing age causes reduced mobility, increase of pain, loss of self-confidence, decrease of self-esteem, and can give negative effect to the quality of life. In addition, must also promote for more physical activities whether social activity, physical activity or leisure to help promoting the health and quality of life of the aging. Therefore, the management of learning or health care in the elderly need to be aware of the increasing age in accordance with the health conditions and ability to perform daily activities of the ageing, in order to achieve and continue the health care management with efficiency.

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