ACHSM Asia-Pacific Journal of Health Management

CONFERENCE ARTICLE

HEALTH BASED QUALITY LIFE AND THE FINANCIAL BURDEN AMONG THE PEOPLE OF INDIA EXPERIENCING CHRONIC DISEASES

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ABSTRACT

Financial burden influences elderly individuals' health-related quality of life (HRQoL). Very little is understood concerning the association between financial strain and HRQoL in vulnerable groups. This study aimed to examine the relationships among financial load and HRQoL of Odisha State, India who suffer from chronic illness, along with cancer. In this cross-sectional investigation, 72 Citizens of Odisha (aged 60-89) with one or maybe more chronic diseases took part in a randomized preliminary trial. We investigated financial burden components using factor analysis. A 27-point FACT-G (Functional Assessment of Cancer Therapy-General) was applied to measure HRQoL.

The correlations among financial burden and HRQoL sub-dimensions were investigated using multiple linear regression. The factor analysis showed three financial burden constructs: health costs issues, financial burden medication compliance, and monetary stress.

Financial burden was related to lower HRQoL throughout various areas in this research of older adults of Odisha with chronic conditions.

"This paper was selected from the Global Conference on Emerging Technologies, Business, Sustainable Innovative Business Practices, and Social Well-being on 10th and 11th December 2022 in India organized by Confab 360 Degree."

KEYWORDS

health related quality of life, financial burden, chronic disease, medical cost, vulnerable community

INTRODUCTION

People suffering from chronic illnesses have continuing financial responsibilities, seek medical attention, and face a substantial financial burden [1, 2]. Financial obligations include food instability, a housing crisis, a need for more drug resources, an unwillingness to get medical attention, and an absence of healthcare. Financial burden could also manifest itself in the form of lower earnings or jobless following the discovery of a significant health problem, so this weight can remain across decades when people find it difficult to work again [3, 4]. Furthermore, when the illness worsens or patients are treated with other medical concerns, the financial burden might worsen [5-8]. According to the National Health Interview Survey (2015-2017), people aged 18-64 face a financial burden in the United States (U.S.). Some with lesser academic achievement and more medical issues had a more considerable financial burden from healthcare [9]. Furthermore, underprivileged groups are more prone to monetary difficulties and fears that have a detrimental influence on their lives.

Interestingly, Odisha makes up 3.4% of the Indian population. Having lesser economic status, a shortage of work, residential instability, and medical disparities are more exposed, including financial and health inequality [10]. Odisha faces a significant financial burden regarding medication due to the absence of comprehensive medical insurance. People in Odisha who rely on medical facilities have a higher prevalence of chronic illnesses, often dealing with one or multiple severe health conditions. Furthermore, Odisha people could face significant obstacles in health coverage if people do not have a regular supply of health insurance (such as no general practice provider); it could be mainly attributable to certain Odisha people having the lowest earnings or literacy levels, preventing them from losing their work because of health issues all of that restrict them financially [11].

The financial burden considerably influences health-related quality of life (HRQoL) in Odisha and is becoming more prominent when coping with chronic illness and health care. People's capacities to sustain interpersonal and physical functioning and emotions as a vital aspect of daily life and good life are referred to as HRQOL [12]. Patients suffering from a continuing, chronic condition may face an exponentially increasing economic burden due to their sickness and healthcare expenditures. Treating a chronic disease may be stressful, especially when the financial burden forces people and their families to confront painful choices about whether or not to seek medical treatment according to their earnings [13]. People who describe hardship, unemployment, and funds issues are also more prone to depression disorder than individuals who are not suffering such difficulties [14, 15].

There have been reports of relationships between financial burden and HRQoL results. The cancer-based financial burden is widespread across people with cancer. According to studies in patient care, it is linked to decreased HRQoL in the interpersonal, physical functioning, and emotional categories. There is limited information regarding these interactions between people with chronic conditions and much less for susceptible people of Odisha. Nevertheless, older adults with many chronic diseases are significantly more prone to have low HRQoL [16] and a pessimistic life perspective in general. [17, 18] Their unhappiness might grow more acute, with depressive symptoms occurring practically daily. Health disparities experienced by vulnerable communities can exacerbate mental distress [19].

Even though numerous studies have been published regarding financial burden in connection to psychological and mental hardship (e.g., anxiety, depression) [20] within and between cancer patients, there is a lack of research to assist us in comprehending the remarkable impacts of such burden for suffering from chronic ill Odisha populations suffering from a variety of chronic sicknesses. Throughout this research, we looked at the relationship between financial responsibility and HRQoL in older people of Odisha with chronic conditions.

DESIGN OF A METHODOLOGY

This study employed baseline data of cross-sectional analysis from a pilot experimental control trial, and the research methodologies have been available elsewhere. The KIIT Deemed to be University's Ethics Committee approved this work (Ref. KIIT-DU/KSFH/2023/454). Before participation in the study, respondents were vetted and after all verification the respondents were allowed to give their responses and they were given Rs. 1,000 gift cards as a mark of gratitude for expressing their time and views.

SETTING FOR RESEARCH

Respondents in this research lived along the tribal belt of Odisha. This area ranks among the poorest in the state of Odisha; several elderly Odisha residing in this zone have significant differences in food, housing, income insecurity, staying near the Indian poverty line, and without sufficient medical coverage [21-23].

CRITERIA FOR SELECTION

72 Odiyas (respondents) with chronic conditions participated in this research (i.e., those diagnosed with chronic disease or undergoing some treatment). Respondents became qualified if individuals self-identified as being from Odiya, were older than 50 years, and had any chronic medical disorders (e.g., stroke, renal/liver failure, hypertension, diabetes, HIV, heart disease, chronic disease, and cancer).

SAMPLING

Selection of respondents from tribal areas of the state of Odisha, involved a purposive sampling method being employed in a group method. Engaging with social ties and giving a chance to gain knowledge about Advance Care Planning (ACP) were used to select respondents for this research [22]. Individuals were recruited via meetings with governmental bodies, social assistance programs, below-poverty-line housing complexes, and grocery shops. Participants were initially provided with details on the research through the selection process. Participants were then informed if they wanted to participate. Individuals who showed willingness were engaged at the time. Several people asked that we approach again afterward. Participants gave their contact data and then were after that contacted by phone. Participants have also been provided an informative brochure and encouraged to distribute it to anyone else who may be willing to participate, who afterward reached us by telephone. Eligible participants were checked by the research adviser to see if they satisfied the eligibility requirements. Two researchers fluent in Odia and Hindi considered who delivered interview guide questionnaires through the telephone or by a person. Table 1 shows the financial burden. (8 are supplied in Hindi, 59 in Odiya, and 5 in both languages).

MEASUREMENT TOOLS

Medical condition and socio-demographics are assessed, and personal data comprised marital status, primary language, health insurance, gender, education, birthplace, and age. Chronic illness was examined using self-declaration. Respondents responded if they suffered from chronic diseases, ranging from experiencing just one ailment to having several co-morbid disorders, up to four. Hospital treatment in the previous six months was measured by inquiring respondents, "In the past six months, had already spent 24 hrs in a clinic as a patient?" with answer choices of "Yes" and "No."

TABLE-1 DESCRIPTIVE STATISTICS OF RESPONDENTS ON FINANCIAL BURDEN

Variable		Categories	Frequency	Percentage
Job Position		Presently working	8	11.1
		Jobless	42	58.3
		Retired	22	30.6
Healthcare Bills		I am concerned regarding the expense of hospitalisation.	42	58.3
		Have you had fears regarding the expenses of treatments?	36	50.0
		Have you had issues concerning the expenses of hospitalisation?	32	44.4
		Could your finances restrict you from receiving the care you require?	22	30.6
		Could your financial state restrict you from processing your treatments?	22	30.6
		Have always been you willing to pay for all of the treatments recommended by your doctor?	8	11.1

Salary Concerns	Are you going to have any cash left when the months end?	59	81.9
	Are you struggling to pay your expenses?	13	18.1
Money Considerations States	Are you concerned regarding the present economic situations?	44	61.1
	Did you believe the present monetary status will improve drastically?	21	29.2
	Can you describe the economic position is deteriorating?	7	9.7

Financial burden. We looked at financial burden utilizing questionnaires derived from research by Walker (2007) that looked at the impact of financial burden on life quality in economically poor cancer women. We examined financial responsibility in this research employing the underlying principles: details relating to work background, health care cost, pay issues, and monetary stress. The inquiries below were used to implement every notion. Respondents were questioned about their job situation: "Are they presently hired?" (Yes, working; no, jobless; and no, departed/retired). Details on healthcare bills considered: (Yes/No): "I am concerned regarding the expense of hospitalization."; "Have you had fears regarding the expenses of treatments?";"Have you had issues concerning the expenses of hospitalization?"; "Could your finances restrict you from receiving the care you require?"; "Could your financial state restrict you from processing your treatments?"; and "Have you always been willing to pay for all of the treatments recommended by your doctor?" Inquiries about salary concerns considered: (Yes/No): "Are you going to have any cash left when the month end?" "Are you struggling to pay your expenses?" Inquiries about money monetary stress: (Yes/No): "Do you concerned regarding the present economic situation?" "Did you believe the present monetary status will improve drastically?" and "Can you describe the economic position is deteriorating?" (See Table 1).

Quality of Life concerning Health. The Functional Assessment of Cancer Therapy-General (FACT-G) is a frequently employed evaluation of HRQoL in people with cancer, encompassing fundamental HRQOL dimensions in the social/family, physical, functional well-being, and emotional contexts [23]. For each of the 27 questions, the FACT- G employs a Likert scale of 5 points; responses vary between 0 (Not always) to 4. (Very much). Social/Family Well-Being (SFWB), Physical Well-Being (PWB), Functional Well-Being (FWB), and Emotional Well-Being (EWB) components were combined. The PWB (7-item scale, potential ranges 0 to 28) measures physical functioning, pain, nausea, and energy. The SFWB (7-item scale with a potential ranging of 0 to 28) measures sentiments of closeness to peers, emotional assistance from the family, and pleasure with family interactions. EWB (6 subscales, potential ranging from 0 to 24) concerns being unhappy, scared, giving up hope, having problems managing, being concerned regarding the condition worsening, and being concerned about death. The FWB (7-item scale with a potential ranging of 0 to 28) examines the willingness to function, find happiness, tolerate sickness, relax usually, enjoy pleasurable activities, and be satisfied with one's life quality. The FACT-G overall rating spans from 0 to 108, with larger numbers suggesting significantly better HRQoL. While significant study has supported the application of the FACT-G in investigating HRQoL in people with cancer, there has been little study on HRQOL and patient groups with chronic disease. According to a specific study, the FACT-G can be utilized appropriately with older adults with chronic diseases [24].

STATISTICAL EVALUATION

We began by looking at the ranges of HRQoL sub-dimensions and total well-being ratings. Adversely phrased questions were reversed encoded before totalling every construct and average well-being, with higher scores indicating greater HRQoL. The content validity of the elements in the subdimensions and the total score were assessed using Cronbach's Alpha. Furthermore, we identified components clustered closely concerning the financial burden queries using exploratory factor analysis (EFA), including an orthogonal rotation." The FA contained 11 measures estimating the age (in years) wise financial burden. We utilized a factor loading criterion of 0.5 and preserved factors with eigenvalues more significant than 1.0, as well as the regression scores for all three components that appeared for inclusion in the regression analysis. Cronbach's alphas were generated for every scale item to measure each component's internal reliability. The study then moved five multiple linear regression analyses to look

at the associations among the financial burden factors that have been recognized in the factor analysis and the total score of FACT-G, in addition to the four subscales of FACT-GSFWB, PWB, FWB, and EWB while controlling for unified and dominant variables such as demographics, comorbid health issues, and occupational condition.

RESULTS

AS set out in Table 2, most of such 72 Odiya respondents in the survey were female (n = 61), presently unmarried (n = 53), and graduated from higher education (n = 44). More than 50% of patients confirmed by themselves that they are experiencing two co-morbid health issues, with 41% experiencing three or even more.

The complete well-being aggregate value on the FACT-G (consistency reliability, Cronbach's alpha a) was used to represent HRQoL in Table 3, and well-being HRQoL was shown (ranging 68-110, M = 70.2., SD = 17.64, = 0.931). The FACT-G scores of a subscale for SFWB varied between 1 to 23 (= [0.817]), PWB varied between 4 to 23 (= [0.864]), FWB varied between 2 to 23 (= [0.897], and EWB went between 3 to 21 (= [0.832]).

FINANCIAL BURDEN

Factor Analysis with a cut-off of 0.50, the FA on the 11 elements indicating financial burden created three components composed of 9 parts; 2 elements failed to load on either of the components (Table 4).

TABLE-2 RESPONDENTS CHARACTERS (N=72)

Samples Character	Categories	Number, Mean	Percentage or Range
Age		67.72	60-89
Gender	Male	11	15.28
	Female	61	84.72
Marital Status	Married	19	26.39
	Unmarried	53	73.61
Education Background	Above high School	44	61.11
	Less or up to high school	28	38.89
Insurance Coverage (Health)	Yes	58	80.56
	No	14	19.44
Types of Coverage	Government Scheme	52	72.22
	Private Company	16	22.22
	None	4	5.56
Critical Health Condition (No. of Times)	1	24	33.33
	2	28	38.89
	3	8	11.11
	4	12	16.67
Stay in hospital for last 6 months	Yes	41	56.94
	No	31	43.06

TABLE-3 SUBSCALE AND TOTAL VALUE OF QUALITY OF LIFE

Subscale of Well being	Abbreviation	n	a	M	SD
Social/ Family	SFWB	72	0.817	15.33	4.92
Physical	PWB	72	0.864	21.06	5.61
Emotional	EWB	72	0.832	18.67	5.39
Functional	FWB	72	0.897	15.14	6.73
Sum Score	WBSS	72	0.931	70.2	17.64

TABLE-4 FINANCIAL BURDEN A FACTOR ANALYSIS

	Statement of Items	Item	1	2	3	Means	SD	a
Concerns for medical Bill	I am concerned regarding the expense of hospitalisation.	11	0.887			0.61	0.524	0.817
	Have you had issues concerning the expenses of hospitalisation?	3	0.837			0.52	0.511	
	Have you had fears regarding the expenses of treatments?	4	0.749			0.56	0.519	
Financial Burden for Adherence to Treatment	Could your finances restrict you from receiving the care you require?	1		0.766		0.31	0.501	0.701
	Have always been you willing to pay for all of the treatments recommended by your doctor?	5		0.739		0.22	0.422	
	Could your financial state restrict you from processing your treatments?	2		0.701		0.32	0.481	
Monetary Stress	Are you concerned regarding the present economic situations?	9			0.801	0.57	0.573	0.707
	Are you going to have any cash left when the months end?	7			0.768	0.81	0.497	
	Are you struggling to pay your expenses?	6			0.731	0.41	0.461	
	Eigenvalues		3.441	1.334	1.261			
	Percent variance		41.090	16.573	14.617			
	Number of Items		3	3	3			

The three components were kept with 1.0 as more significant as a cutoff eigenvalue, with 70.23% of shared variance. The three components were characterized as follows:

- Healthcare Cost Aspects, shown by three parts (= [0.817])
- Financial Burden Medical Compliance constructs, demonstrated by three parts (= [0.701])
- Monetary Stress, shown by three parts (= [0.707])

The items' mean of every component represents the minor common Financial Burden issues. Bartlett's sphericity test result was 179.354 (p =.001, df 36), suggesting the eligibility to maintain an FA. The Kaiser-Meyer-Olkin (KMO) was 0.746, which was sufficient for FA.

FINANCIAL BURDEN REGRESSION ANALYSIS FOR HRQOL

Table 5 depicts the findings of five multiple regression studies wherein the study regressed the overall FACT-G rating and all of the FACT-G sub-dimensions on the components of healthcare expenditure related to financial burden adherence to treatment and monetary stress. The first regression analysis (F [9,62] = 2.65, p.001) described 33.7% of the variation within FACT-G overall points. Being elderly, experiencing financial burden adherence to treatment, and currently suffering monetary stress have all been adversely linked with overall FACT-G values after adjusting for hospitalizations, gender, age in the last six months, and health coverage position. These variables were related to poorer FACT-G ratings. Surprisingly, seeking health expense worries was unrelated to the FACT-G rating or sub-dimensions. Furthermore, neither factor was significantly associated with the EWB subscale.

TABLE-5 HRQOL AND FINANCIAL BURDEN REGRESSION ANALYSIS

	Social Well-being			Physical Well being			Functional Well-being			Emotional Well being			Factor Total Score		
Summary of model															
F		2.772			2.314			3.416			0.947			2.65	
R2		0.304			0.271			0.322			0.171			0.34	
P value		0.009			0.039			0.007			0.561			0.01	
df		9,62			9,62			9,62			9,62			9,62	
N		72			72			72			72			72	
Covariates															
	SE	P	β	SE	P	β	SE	P	β	SE	P	β	SE	P	β
Age	0.113	0.033	-0.247	0.113	0.339	0.121	0.112	0.312	-0.119	0.091	0.408	-0.08	0.31	0.49	-0.3
Gender	1.86	0.764	-0.764	1.86	0.809	0.462	1.84	0.067	3.21	1.63	0.452	1.58	5.29	0.27	4.97
Hospitalised in last 6 months	1.63	0.552	-1.26	1.63	0.564	1.25	1.61	0.527	-1.38	1.43	0.931	-0.24	4.69	0.64	-1.62
Medical coverage	3.41	0.551	-2.71	3.41	0.866	-1.15	3.37	0.627	-2.13	2.98	0.663	-1.81	9.87	0.6	-7.33
Financial Burden															
	SE	P	β	SE	P	β	SE	P	β	SE	P	β	SE	P	β
Employment position															
Jobless	2.34	0.402	-2.07	2.34	0.312	-2.45	2.34	0.08	-3.64	2.07	0.237	-2.94	6.89	0.22	-9.67
Retired	2.68	0.148	-3.98	2.68	0.039	-5.28	2.66	0.004	-7.31	2.49	0.337	-3.72	7.88	0.02	-18.4
healthcare bills	0.755	0.207	0.971	0.755	0.476	-2.59	0.821	0.834	0.317	0.572	0.719	-0.24	3.12	0.89	0.617
Financial Burden Adherence to treatment	0.791	0.088	-1.44	0.791	0.003	-2.12	0.837	0.031	-1.83	0.549	0.725	0.882	3.38	0.02	-6.34
Monetary stress	0.877	0.011	-2.06	0.877	0.241	-1.36	0.739	0.027	-2.74	0.637	0.088	-1.37	3.67	0	-5.91

The second regression model (F[9,62] = 2.314, p =.039) of the variation in PWB described 27.1%. Retiring and financial burden influence on healthcare were adversely linked with PWB ratings after adjusting for hospitalizations, gender, age in the preceding six months, and health coverage position. PWB decreased by 2.12 units (SE = 0.791) for every one-unit rise in the financial burden influence on medicine component value.

The third regression model (F[9,62] = 2.772, p =.009) identified 30.4% of the variation in SFWB. Financial stress was related to lower SFWB ratings after adjusting for hospitalizations, gender, age in the preceding six months, and health coverage position. SFWB decreased by 2.06 units (SE = 0.877) for every one-point rise in monetary stress component value.

The fourth model of regression identified 17.1% of the EWB variation (F[9,62] = 0.947, p =.561). Although hospitalizations, gender, age in the preceding six months, and health coverage position have all been controlled for, neither of the financial burden characteristics was linked to EWB.

The fifth regression model identified 33.7% of the FWB variation (F [9,58] = 2.649, p =.001). When hospitalizations, gender, age in the preceding six months, and health coverage position have all been controlled for, getting older, financial burden adherence to treatment, and monetary stress have all been linked with FWB. One-point rises in the financial burden adherence of treatment component rating were connected with such a 1.83-unit (SE 0.837) drop in FWB. A one-point rise in the financial stress component level was significantly related to a 2.74-unit (SE = 0.739) reduction in FWB. Due to the worsening of FWB as the factors rose.

DISCUSSION

Throughout this research, we examined the association between HRQoL and financial burden in elderly Odiyas with chronic illnesses. In summary, Financial Burden, Adherence to Treatment, Monetary Stress, and getting retired were connected with HRQOL, although Healthcare Expense Issues did not. Significant statistical relationships exist between HRQoL and Financial Burden Adherence To treatment in Functional and Physical Well-Being sub-dimensions, but not for the Well-Being of Social/ Community and Mental. The Financial Burden Adherence to Treatment component shows that individuals had difficulties paying for medications, obtaining the required treatment, or acquiring drugs recommended by doctors. In this negative connection, there is a fall in the well-being of functional and physical with an increase in Financial Burden and Adherence to Treatment. Financial Burden Adherence to Treatment was found to be adversely connected to respondents' Physiological Well-Being, which meant they had problems with fatigue, experiencing discomfort, unwell, or sickness, experiencing difficulties fulfilling the demands of someone's household, were troubled by medication adverse reactions, and also being compelled to devote time spent lying down. Financial Burden Adherence to Treatment was found adversely connected to Functional Well-Being respondents, indicating that they had been unable to take a job, had difficulties experiencing life or doing the work they generally are doing for pleasure, had trouble reconciling the disease, had sleep problems, or have been dissatisfied with their existing HRQoL. Our earlier study looked into the association between HRQoL and financial burden between people with Odiya cancer and discovered a significant statistical link between monetary problems and lower well-being Emotional, affective, and functional. The results of this analysis align with the previous studies on this topic; for instance, the cancer-based financial burden between neck cancer and head victims was strongly associated with worse well-being emotional, functional, and physical. Our findings add to the increasing collection of information that financial burden is related to worse HRQoL in people with chronic conditions [25]-[27].

Nevertheless, the research with elderly Odiyas found that, despite a significant statistical link between Financial Burden Adherence To treatment and the well-being of functional and Physical, Monetary Stress remained the only factor connected to the well-being of functional and Social/Family. The sensation of anxiety regarding one's present economic status is known as monetary stress. Most survey participants (68%) reported having no cash available towards the month's end, reflecting the financial situation. These worries have a detrimental impact on individual connections and social well-being. People suffering monetary stress may experience fewer ties with the primary supporting people, like family members and friends, as well as poorer people's understanding of and openness regarding the condition.

This research never connected the financial burden to the FACT-G sub-dimension of Psychological Well-Being. Whereas prior studies have found a link between financial burden, psychological well-being, and emotional distress [20], especially among people with cancer, the research was not to examine such [28]. Psychological issues sometimes compound the pairing of financial pressure and low HRQOL, although such was hardly the case in our research. Individuals may have adapted cognitive skills that help people deal with financial stress and chronic disease. Although economic concerns tend to be relevant

while coping with chronic conditions, they are unlikely to be connected to Odiyas persons' psychological well-being as defined by the topics given in this research (For example, whether you experience depression or worried, give up hope, are concerned over expiring or that your illness will worsen, or are you comfortable the way you are adjusting? Odiya people with chronic diseases may previously confront different problems that render people susceptible (e.g., low pay and an absence of medical coverage) [10], implying why individuals have learned to cope with these concerns throughout their lives in the past. Furthermore, Odiya cultural practices must be considered because many are inclined to recognize their challenging situations and place them all in God's eyes in an attempt to adapt. Odisha people also likely choose a family-centered strategy for chronic illness support [29]; hence, maintaining parental involvement may mitigate the overall psychological state of a financial burden.

Whereas earlier studies have corroborated similar results, our research emphasizes the perspective of elderly Odiyas with chronic illness. Elderly Odiyas under medication for anyone or maybe more chronic disease might be increasingly prone to financial burden, compromising their HRQOL via well-being through emotional, functional, and physical. The inability to spend money on health care or medicines might harm daily HRQOL. Response from a financial burden to deal with a chronic health situation is frequently linked with numerous different problems, a form of spiraling out of control impact caused by various issues in well-being and illness affecting professional, social, and day-to-day life that are difficult to deal with. While dealing with the vulnerable communities included in this research, the consequences of financial burden seem to be particularly essential to address (for instance, elderly Odiyas that are surrounded by various co-morbid chronic situations). People towards the final stages of their lives who seem severely sick and have spent their monetary capacity may require greater intensive hospital attention, raising their financial burden by raising medical expenses and diminishing household economic capacity" [30]. Aged and disabled Odiya people with chronic diseases and their dependents describe many barriers to medical treatment and financial burdens. Moreover, individuals face challenges in various groups due to dealing with and treating a chronic condition. The above extra medical care constraints are causes of stress that might cause discomfort, increasing the challenges of staying with more than one chronic condition.

Addressing the issues while they emerge (for example, to enhance decision-making, manage compliance, and minimize emotional discomfort), medical services practitioners must be conscious of the effects of a financial burden on HRQoL with elderly Odiyas with chronic medical conditions. Medical, social work, and nursing practitioners must collaborate to detect financial obligations while diagnosing and treating a chronic ailment. Throughout health treatment and diagnosis, medical service clinicians can link families and case managers, financial navigators, patient navigators, and social workers across their health industry to connect individuals to monetary help for sickness.

LIMITATIONS

The above research, like other specific exploratory investigations, has constraints. The first one is the procedure of sampling that uses the sampling technique as purposive to acquire respondents for the research. Because of self-selection in the study, the research results might be biased. However, the Odiya people with various vulnerabilities communities should be studied more. Hence this sample strategy is highly suitable. Secondly, we used a cross-sectional approach to explore the association between HRQOL and financial burden. An observational design was adopted for the pilot project to develop hypotheses for a more extensive investigation. Research based on longitudinal might be better helpful in determining when the financial burden becomes significant in HRQoL. The FACT-G test, utilized to analyze research results, was designed for people with cancer. However, the research covered individuals with various chronic illnesses, both non-cancerous, and cancerous.

Furthermore, the Financial Burden assessment has never been validated for accuracy or reliability. Lastly, because the research had a limited sample size, the study advises against generalizing the results. The sample size influenced the Financial Burden component analysis outcomes, which produced two sub-dimensions with consistency as low. The results might not be reflective of the realities of certain other elderly Odiya people with financial burdens, as well as of the effects on HRQoL. Nonetheless, this research offers insight into the link between financial responsibility and HRQOL and may pave the way for additional studies in this area.

CONCLUSIONS

Throughout this study, researchers discovered that higher financial burden was related to decrease HRQoL in social, family, functional, and emotional well-being. The outcomes of this research add to the rising body of literature on the relevance of recognizing financial burdens in the presence of chronic illness. As the population of Odisha states ages, one should address in what ways several chronic medical issues to manage to decrease the financial burden that comes with spending life with a chronic disease.

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