

Determinants of Healthcare Utilisation among the elderly in Malaysia

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Abstract

Purpose: Ageing is a truly important global phenomenon that is proceeding at very fast paced in many parts of the developing world. Consequently, this trend will demand larger proportion of financial resources to be allocated for healthcare services in the future. Therefore, this study will be conducted to investigate the determinants of utilisation of healthcare services for the elderly.

Design/methodology/approach: This paper is based on literature review, presents the theoretical and empirical literature on determinants of healthcare utilisation and the outcome of healthcare utilisation towards the elderly.

Findings: Drawing from the past literature review, the authors argue that individual characteristics, psychosocial characteristics and health literacy contribute to the utilisation of healthcare resources of the elderly. Furthermore, the researchers discussed the impact of healthcare utilisation towards the outcomes, namely perceived health status and patient satisfaction of the elderly.

Originality/value: This paper will build up upon the present knowledge by exploring the contributing factors of utilisation of healthcare services among the elderly. This paper is valuable for researchers interested in the field of healthcare utilisation.

Keywords: Healthcare utilisation; Population ageing; Individual characteristics; Psychosocial characteristics; Health literacy; Health status

Paper type: Literature review

INTRODUCTION

Population aging is one of the most important demographic events in the 21st century. This phenomenon occurs globally as the proportion of elderly relative to younger generation increases. In Malaysia, elderly persons are defined as those who are 60 years old and above (Jabatan Kebajikan Masyarakat n.d.). It is reported that the total number of elderly are 28.25 million (10.21%) and Malaysia is forecasted to be an aged nation by 2030 when 15 per cent of the population is classed as elderly. As the number and percentage of the elderly in Malaysia continues to increase, the need for extensive and current information on this population increases and thus, issues regarding the elderly are becoming increasingly important to be discussed (Wan-Ibrahim & Zainab 2014).

Over the years, Malaysia has developed a healthcare system that is envious to everyone where the population live within 3 km of a healthcare facility. The UN Development Program has called Malaysia as “model for other developing” as Malaysian receive high quality and equitable primary care delivered at rock-bottom prices. Healthcare strategies adopted by the country since independence has been successful in raising the health status of the population. As a result of a good

healthcare system in the country, the people are living longer. Malaysia life expectancy rate had increased by 20 years over the last six decades from 54.3 years in 1957 to 74.75 years in 2015 (MOH, 2015). With increasing life expectancy and low birth rates, Malaysia is facing the ageing population.

Population ageing is inevitable and this will be a major challenge to Malaysian healthcare system (Ambigga et al. 2011). The growing number of the elderly in Malaysia poses new challenges to the government, as this will impact on the national development both economically and socially. Thus, ageing is a matter of great concern for the health sector as population ageing will lead to an increase in demand for healthcare and social support, which may consume a large portion of funds to be allocated for healthcare (Rechel & Doyle 2009).

It is described that the rates of healthcare utilization by senior citizens are increasing. An average visit by the elderly is 6.1 visits per-year compared to 4.1 visits for those who are between 20-25 years old. The elderly have more hospital admissions and a longer length of stay. It is estimated that about 40 per cent of total healthcare expenditure is utilised by the elderly which amounted to 9.32 billion a year (MOH, 2013). These factors lead to an increase of the complexity of health services required and increase expenditure. The changes that happened in the age structures of the world make providing services for the elderly is a major challenge to the healthcare professionals (Christensen, Doblhammer, Rau & Vaupel, 2010).

Given the escalation of healthcare cost for the elderly, population ageing has become a serious concern for both policy makers and researchers. However, in Malaysia research on healthcare utilisation on the elderly is few and far between. In view of this phenomenon, the study is proposed to investigate the determinants of health care utilisation of the elderly people in Malaysia. The study aims to bridge the gap in health care utilisation literature in relation to the elderly people as a sample, by understanding the factors that lead to the utilisation of health care facilities align with healthcare focus and resources with the government's agenda in promoting positive ageing as espoused in the 11th Malaysia Plan.

HEALTH ISSUES OF THE ELDERLY IN MALAYSIA

As stated by National Health and Morbidity Survey IV (NHMS IV), chronic illnesses were reported to be most prevalent among the elderly. Numbers of chronic non-communicable diseases such as hypertension, type 2 diabetes, chronic heart diseases and stroke commonly affect Malaysian elderly. Moreover, visual impairment and blindness were described to be highest among the elderly. The increasing pattern of orthopedic diseases and functional impairment was also found to be common among the elderly which interferes their daily activities such as mobility, self-care, house chores and access to public places (Institute of Public Health 2011a).

Apart from physical health, psychological health problems are also prevalent among the elderly in Malaysia (Institute of Public Health, 2011b; Rashid, Azizah & Rohana, 2012). The most common mental disorders in this age group are dementia and depression (WHO 2013). However, to date there has been relatively little research in this area in Malaysia. MOH reported that 13% of the elderly in Malaysia suffers from depression and 4% with severe depression. A community survey conducted among 418 elderly in 22 villages in north Malaysia found that there was increasing prevalence of cognitive impairment among the elderly (Rashid, Azizah & Rohana, 2012). Another study (N=223) among the Malay elderly in Selangor, reported that 24% were cognitively impaired (Mohd Sidik et al. 2003). A large community study (n=2980) reported a 14.4% prevalence of organic mental disorder (dementia) among

the elderly in Malaysia (Ministry of Health 2009). Early recognition, diagnosis and treatment of mental disorders that are common in old age are important to prevent avoidable suffering and disabilities.

In correspond to this matter, research reported that the rates of health care utilisation by the senior citizen, is increasing. As of December 2014, almost about 75% of the elderly in Malaysia had registered with public primary healthcare facilities and had undergone health screening and intervention for physical health, cognitive function as well as other mental health conditions. An average outpatient visit to a physician by the elderly is 6.1 visits per-year. The elderly has more hospital admissions (157 admission per 1000 compared to 86 admissions per 1000 average population) and a longer length of stay (HCDA, 2012; Institute of Public Health, 2011; Krishnaswamy et al., 2009). Moreover, the elderly use the public sector much more than private healthcare services with 83% of admissions in public hospitals and 67% outpatient visits in public facilities (HCDA, 2012).

Review of literature highlighted that Malaysian elderly suffers from multiple and complex health needs, which require holistic and comprehensive care (Ambigga et al. 2011; Wan-Ibrahim & Zainab 2014; Selvaratnam et al. 2012). It is necessary to provide older persons with the same access for preventive and preventive care and rehabilitation as other groups for humanitarian and economic reasons . However, one of the concerns is, Malaysia was unequipped to cater for the needs of the ageing population (Teng 2015) where currently, there are limited number of doctors who specialise in geriatrics and rehabilitative medicine for the elderly (SUHAKAM 2011; Arokiasamy 1997).

As Malaysia heads into demographic changes, a larger percentage of general practice consultations and acute hospital admissions will be demanded by the older people. Geriatric medicine needs to be firmly embedded in undergraduate and postgraduate curricula in medical, nursing and other allied sciences programs (United Nations 2002; Ambigga et al. 2011; Poi et al. 2004) to ensure Malaysia's future healthcare professionals possess the skills to assess and manage our ageing population in the years to come. This is critical in the deployment of multidisciplinary team based care for the elderly (Ambigga et al. 2011).

HEALTHCARE UTILIZATION

It is very crucial for health services providers to understand the importance of healthcare utilisation in order to identify the issues that prevent the use of healthcare services. Moreover, it is important for health managers to determine the factors influencing healthcare utilisation. Recognising who will utilise which services and when these services will be used can help organisations target consumers for medical contact. Importantly, this information can benefit managers to identify new customers, spot concerns of clients who are rejecting health services and ultimately increase customer satisfaction

The concept of healthcare utilisation has been extensively studied around the world (Andersen & Newman, 2005; Fernández-Olano et al., 2006; Krishnaswamy et al., 2009; Lee, Tsai, Tsai & Kuo, 2010; Saeed, Oduro, Ebenezer & Zhao, 2012; Snih et al., 2006). Globally, healthcare utilization depends on many factors that pertain both to the health care system and to the characteristics of individual patients, with the slight difference among cultures. Analysis of the determinants of medical care utilisation is receiving increasing attention in almost all nations.

Previous section mentioned about the increasing number of the elderly around the world. As such, the shift in demographics should be an indicator that utilisation of

health services is likely to increase. WHO (2012), found out that it is estimated that the occurrence of disability rises with age and suggest that more than 46% of people aged 60 years and over have disabilities. Furthermore, increasing age also is related with higher morbidity, higher use of health services, and greater demand for specialized services (Crimmins, 2010). These lead to an increase in demand for healthcare and social support among the elderly.

The definition of healthcare utilisation as suggested by Saeed et al., (2012), refer to an extent of an individual having contact with any recognized medical or health facility that is manned by qualified or trained medical practitioners. This is with an agreement with the definition from Gamme & Morin (2009), as they defined healthcare utilisation as the process of seeking professional healthcare and submitting oneself to the application of regular health services, with the purpose to prevent or treat health problems. It is well known that apart from need related factors, health care utilisation is also supply-induced and thus strongly dependent on the structures of the health care system (Babitsch, Gohl & Von Lengerke, 2012). Healthcare utilisation is an important dimension because the configuration of the other components of the framework vary significantly, depending on special characteristics of the respondents (Andersen & Newman, 1973).

DETERMINANTS OF HEALTHCARE UTILISATION OF THE ELDERLY

Research on the determinants of healthcare utilisation has a long history. One of the most frequently used frameworks for analysing utilisation of healthcare services is the behavioural model (BM) developed by Andersen and Newman. This framework assumes that utilisation of healthcare services is influenced by the predisposing factor, the enabling factors and need to use health services, which in this study refer to as individual characteristics. There is a large volume of published studies describing that individual characteristics as the determinants of healthcare utilisation (Sandberg et al. 2012; Vegda et al. 2009; Hoeck et al. 2011; Dhingra et al. 2010; Laporte et al. 2008).

However, little is known about individual characteristics as the determinants of healthcare utilisation with related to the elderly in Malaysia. Thus, this study is proposed to investigate the role of individual characteristics as guided by BM as the antecedent of healthcare utilisation among the elderly. Some individuals have a tendency to use services more than other individuals, where predisposition toward use can be predicted by individual characteristics that occur prior to the onset of specific episodes of illness. Andersen and Newman (1974) uses the term predisposing to refer to the socio-cultural characteristics of individuals that exist prior to their illness. This definition takes into account demographic, social structural and attitudinal variables (Andersen & Newman, 2005). Age, gender, ethnicity and education will be investigated as the variables under predisposing. These variables are explained in detailed below.

Among the demographic variables, age was found to have significant association with healthcare utilisation (Afilalo et al., 2004; Andersen et al., 1994; Blackwell et al., 2009; Chen et al., 2008; Dhingra et al., 2010; Hochhausen et al., 2011; Nabalamba & Millar, 2007; Nie, Wang, Tracy, Moineddin & Upshur, 2008; Surood & Lai, 2010; Thode et al., 2005). Malaysia NHMS IV, for example stated that among 28,411 respondents of the survey, the elderly aged between 65 years old and older had higher utilisation of out-patient and in-patient rate than the other age group (Institute of Public Health, 2011).

Few authors reported that the elderly has higher rate of consultation with general practitioners (Hammond et al. 2010; Nabalamba & Millar 2007; Blackwell et

al. 2009) and more hospital services, ambulatory services, nursing home and home care services (Evashwick, Rowe, Diehr & Branch, 1984, p. 365). However, few scholars argue that age was no longer a prominent factor as age was influential only for the probability of hospitalization (Liu 2014), different types and amounts of illness and different patterns of medical care (Andersen & Newman, 2005). Similar findings have been reported in The Netherlands where it was found that age may not be the major cause for healthcare expenditures, but instead may act as proxy for the health status of the elderly (Werblow, Felder & Zweifel, 2007).

Other than age, gender is also associated with the utilisation of healthcare utilisation. Women were found to live longer as compared to men but unexpectedly, report greater morbidity and disability and make greater use of health care services particularly at the end of life (Macintyre, Hunt & Sweeting, 1996; Nathanson, 1975; Rieker & Bird, 2005; Verbrugge, 1985). It was found that female are more proactive in medical help seeking in comparison with man (Bertakis & Azari, 2011; Dhingra et al., 2010; Dunlop, Manheim, Song & Chang, 2002; Institute of Public Health, 2011; Krishnaswamy et al., 2009; Liu, 2014; Redondo-Sendino, Guallar-Castillón, Banegas & Rodríguez-Artalejo, 2006). As in previous study of Redondo-Sendino et al. (2006) (p. 4), it is indicated that women use more health care services than men in terms of visit to general practitioners, home medical visits, number of medications and overall utilisation.

Yet, the greater utilisation of health services by women is not a constant finding but depends on the type of services (Redondo-Sendino et al. 2006). For instance, women tend to use preventive and diagnostic services more frequently whereas men make greater use of emergency services (Redondo-Sendino et al. 2006). Furthermore, although women are more likely than men to contact a general practitioner (Bertakis, Azari, Helms, Callahan & Robbins, 2000; Green & Pope, 1999; Song & Bian, 2014) when it comes to hospital admissions there is no difference (Bertakis, Azari, Helms, Callahan & Robbins, 2000) or, alternatively, men are hospitalized more frequently than women (Song & Bian 2014; Fernández-Olano et al. 2006; Mutran & Ferraro 1988).

Past literature indicates that there are association between ethnicity and the utilisation of the healthcare services (Brown et al. 2004; Blackwell et al. 2009; Chen et al. 2008; Dhingra et al. 2010; Nabalamba & Millar 2007). Malaysia NHMS 1996, 2006 and 2011, reported that Indian had the highest utilisation of outpatient care, followed by other Bumiputeras, Malay and Chinese. Furthermore, Indians had the highest hospitalization followed by Malays and other Bumiputeras (Institute of Public Health, 2011).

Besides the factors mentioned above, education plays an important role in determining an individual utilisation of available services. Previous studies found that education was significantly associated with utilisation of healthcare services (Andersen et al., 1994; Blackwell et al., 2009; Chen et al., 2008; Dhingra et al., 2010; Hammond et al., 2010; Parslow, Jorm, Christensen & Jacomb, 2002). A study conducted among Mexican immigrants showed that those with higher level of education seek for professional medical care while those with lower levels of education utilized more traditional means (Vega, Kolody, Aguilar-Gaxiola & Catalano, 1999). Similar findings have been reported in a study conducted in Taiwan which found out that the elderly with higher education used more health services (Liu, Tian & Yao, 2012) and highly educated people tend to spend more on ambulatory care services and use fewer in-patient care (Liu 2014). Moreover, Malaysia NHMS 1996 reported that respondents with lower education level utilize more healthcare

compared to the other education level. Contrary to these findings, Malaysia NHMS 2011 indicated that there is no significant difference in prevalence of utilisation among different education level.

Enabling Factors

Even though individuals may be predisposed to use health services, some means must be available for them to do so. The term enabling refers to the logistical aspects of obtaining care (Aday & Andersen, 1974). Enabling factors make health services resources available to the individual. These factors can be measured by income, health insurance coverage, regular source of care and the accessibility of the source of the individual. Besides, the availability of health facilities and personnel contribute to the healthcare seeking behavior. If resources are reasonably plentiful and can be used without queuing up for so long, the population might use them more frequently (Andersen & Newman, 2005).

Review of literature found out that there were association between income and health services use (Andersen et al., 1994; Bazargan et al., 2008; Blackwell et al., 2009; Brown et al., 2004; Dhingra et al., 2010; Hammond et al., 2010; Parslow et al., 2002; Surood & Lai, 2010). NHMS 1996 reported that the utilisation of healthcare services increase when income increase. In contrast to these, NHMS 2006 and NHMS 2011 reported that there is no significance difference between income level and health services utilisation (Institute of Public Health, 2011).

Apart from income, accessibility play substantial part in choosing the healthcare provider. Accessibility to health care centers is a serious concern especially in developing countries (Buor 2002). Accessibility to healthcare is defined as the ability of a population to obtain a specified set of healthcare services (Halden 2002). In the context of this study, accessibility is referred to as physical accessibility. Physical accessibility addresses the complex relationship between the distribution of the population and the supply of healthcare facilities (Ebener, Black & Zine El, 2005). A number of studies have measured the impact of distance on healthcare utilisation. The result indicate that distance and access to health care facilities significantly impact health care utilization (Mattson 2012). Moreover, past research indicates that health care centers were attended mostly by people living nearby (Krishnaswamy et al. 2009) and there was a noticeable drop in rates of health care service use among the population residing far from the health facilities (Kinman 1999).

Much have been done by the government to expand access to healthcare. In Malaysia, the primary healthcare services are delivered through an extensive network of static public and private health clinics throughout the country, complemented by community clinics and mobile clinics (Ministry of Health 2011). However, there are some issues pertaining to inadequate physical access to clinics in rural and isolated villages. The implementation of outreach programs like mobile health teams and flying doctors services were initiated by the government to compensate the issues.

However, distance tends to matter less when patients have particular concerns about quality or reputation of the provider or when their health condition is deteriorated. Thus, some people choose to visit more distant healthcare professionals with high reputation and skills and if their health status is in bad shape in such that only a particular provider can treat their diseases (Kinman, 1999; Qian, Pong, Yin, Nagarajan & Meng, 2009).

Need for Care Factors

In order to utilize care, an individual must perceive illness or the probability of its

occurrence. Need for care can be defined as the most immediate cause of health service use, from functional and health problems that generate the need for health care services (Aday & Andersen, 1974). This definition takes into account specific disabilities or diseases that cause a person to seek health care. Need for care is considered as an important component in HBM and in fact is the major determinant of utilisation which included both perceived need and evaluated needs (Andersen & Newman, 2005).

Evaluated need is more closely related to the kind and amount of treatment that is given after a patient has presented to a medical provider (Andersen & Davidson, 2007). Evaluated need measures are attempts to get at the actual illness problem that the individual is experiencing and the clinically judged severity of that illness (Aday & Andersen, 1974). Under this situation, a physician will make a physical examination of the individual and make objective measurement about patient's physical status and need for medical care. This is closely related to the kind and amount of treatment that will be provided after a patient has presented to a medical care provider.

On the other hand, perceived need will help to understand care seeking and adherence to medical regime. According to a definition provided by Aday and Andersen (1974), perceived need for health services is how people view and experience their own general health, functional state and illness symptoms. This is further explained by how people experience and respond to symptoms of illness, pain and worry about their health condition. Perception about the importance and magnitude of health problem or symptom will lead to a decision to seek medical care. Perceived need is largely a social phenomenon that can be explained by social characteristics such as ethnicity or education and health beliefs such as health attitudes, health literacy and so on (Andersen & Davidson, 2007).

Finally, perceived need can be measured with number of disability days that an individual experiences. Such days are those during which the individual is unable to do what he usually does. Other measures include symptoms the individuals experiences in a given time period and a self reported of general state of health for instance excellent, good, fair and poor (Andersen & Newman, 2005). It is an important factor that contributes to health care utilisation (Fylkesnes 1993; Connelly et al. 1989; Fernández-Olano et al. 2006; Anderson 1973).

Psychosocial Characteristics

There are extensive research on healthcare utilisation, in relation to individual characteristics or socio economic aspects (Sandberg et al. 2012; Vegda et al. 2009; Hoeck et al. 2011; Dhingra et al. 2010; Laporte et al. 2008). Thus, little is known about how healthcare utilisation is related to psychosocial variables. Knowledge on the relationship between healthcare utilisation and psychosocial variables will help the provider to provide high quality care for the elderly (Jakobsson et al. 2011). However, studies focusing on psychosocial variables in relation to healthcare utilisation are intermittent. Thus, more research is needed about this issue.

United Nations High Commissioner for Refugees (UNCHR) (2013) defined psychosocial as close connection between psychological aspects of human experience and the wider social experience. UNHCR further explained that the term psychosocial is used based on the combination of factors that are responsible for the psychosocial wellbeing of people and that these biological, emotional, spiritual, cultural, social, mental and material aspects of experience cannot necessarily be separated from one another (p. 9). Moreover, Kimmel (2001) stated that patient-level psychosocial

variables include personality factors, affect and perception of distress, well-being or illness, patient/spouse indices include marital satisfaction, satisfaction with healthcare, compliance with dialysis regimen and level, number and quality of interactions with personnel and staff (p. 1601). As little is known about psychosocial characteristics towards healthcare utilisation, this current research seek to contribute to the academic discourse on psychosocial variables as one of the antecedents of healthcare utilisation guided by Theory of Care Seeking Behaviour developed by Lauver in 1992. Two psychosocial characteristics that influence healthcare utilisation namely affect and norms will be discussed in detail below.

Affect

The role of emotions in physical health has been a significant topic in health psychology (Cohen & Pressman, 2006). Generally, emotions and affect in health is referred as negative emotions such as anger, depression and anxiety. Negative affect is defined as a general dimension of subjective distress and unpleasurable engagement that considers a variety of aversive mood states (Hu & Gruber 2008). Findings from past research on older adults reported that there is a relationship between negative affect and poorer functional status and higher level of depression (Hong, Zarit & Malmberg, 2004). Affect refers to feelings associated with care seeking such as anxiety about receiving a serious diagnosis, fear or embarrassment about an medical examination (Lauver 1992).

Past research had found that embarrassment has been rank among the most important deterrents to cancer screenings (Harewood et al. 2002; Thompson et al. 1997; Facione et al. 2000; Consedine et al. 2011). Past studies found that embarrassment with cancer screening is a particular concern for minorities (Robb et al. 2008), including Asian American women (Lor et al. 2013), African American (Holt et al. 2009) and Caribbean populations (Goldman & Risica 2004). In addition, Al-Meer, Aseel, Al-Khalaf, Al-Kuwari and Ismail (2011) indicated the reasons for not having a recent Pap smear, were belief that it might be painful, followed by embarrassment.

A qualitative study by Oon, Shuib, Ali, Hussain, Shaaban, Yusoff (2011) identified two reported groups of women in their study. First group were women who never done Pap smear test and these group mentioned that fear and embarrassment are the reasons of not having Pap smear. One of the respondents stated that she would not perform the screening procedure due to the shyness of exposing her private parts. The second group of women disclosed that they were fear of pain and perceived the procedure and the instrument used as scary. They further revealed that it was better for them to not know the results because they feared that the results would show something was wrong with them after performing the procedure. In agreement with this, research by Lor et al. (2011) discovered that unfamiliarity with screening procedures made the participants feel terrified including dealing with the results, having no experience with the healthcare environment and worrying about privacy.

Study of Oon et al. (2011) remark that the sex of the healthcare provider as one of the impediment of screening procedure as majority of the participants expressed their uneasiness and embarrassment with male doctor. The participants stressed that as Muslim women, they prefer female doctor to perform the procedure. This view is supported by number of studies where women preferred to have female health professionals during mammography and breast cancer screening procedures because of their embarrassment (Facione et al., 2000; Moy, Park, Feibelmann, Chiang & Weissman, 2006). The above literature highlighted that anxiety, fear, and

embarrassment are the facilitators and barriers of healthcare utilisation. These are largely characterised by culture and religious belief particularly in Malaysia. Understanding this scenario is critical and in need to a successful provision of care of the elderly in Malaysia.

Norm

Normative influences include social and personal norms as well as interpersonal agreements to engage in care seeking. Social norms are others belief about care seeking (Lauver, 1992, p. 284). It states that our behaviour is influenced by incorrect perceptions of how other members of our social groups think and act (Berkowitz 2005). A study conducted among continence patients by Burgio (1994) reported that as the number of close friends with whom subjects felt at ease and could discuss private matters increased, the more likely they were to tell a doctor about their condition.

This is supported by Kinchen and colleagues (2003), where they reported that women who talked with others about urinary incontinence were more likely to seek incontinence care compared with women who did not talk about others about urinary incontinence. Moreover, a qualitative study conducted among Asian American women revealed that friends and relatives significantly influence their perceptions about screening procedures (Lor et al., 2013, p. 425). However, a study by Earp et al. (2002) indicated that women can be strongly influenced to obtain mammograms by individuals outside the circle of family and friends such as lay helpers or breast cancer survivors.

Personal norms are one's own beliefs about morally correct behaviour regarding care seeking (Lauver et al. 1997). Sieverding, Matteredne and Ciccarello (2010) indicate that personal norms play an important role in men's CS intention and behaviour. Moreover, it is reported that among the reasons for not seeking continence care include not wanting to talk about it, not knowing whom to talk to and believed that other people could not help (Rekers, Drogendijk, Valkenburg & Riphagen, 1992). Based on the above literature, it can be seen that norm can be considered as one of the critical component in healthcare utilisation. Malaysia is a multi-cultural society and each ethnic group still hold on their religions, customs and way of life, particularly the elderly. Moreover the perception of health and illness is heavily influenced by cultural beliefs and practices.

CONCLUSION

In this paper, the researchers have presented a review of healthcare utilisation studies. The purpose of this paper is to contribute to the body of knowledge related to healthcare utilisation. Research on healthcare utilisation can help the healthcare providers to meet the impending growth of the ageing populations. Measure of utilisation plays a critical role for the planning of healthcare delivery capacity to meet the needs of the elderly. A better understanding of the context of utilisation will assist the government in identifying healthcare services, which could be provided to promote positive ageing align with the government's agenda as espoused in the 11th Malaysia Plan.

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