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Socio-Economic and health Status and the social Protection of the Ageing Population in Pakistan

Sabahat Hussain[1]

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ABSTRACT

The aim of this study is to scrutinize the socio-economic status of the ageing population in Pakistan. All these factors are in the context of socio-economic protection of the ageing population, which is a neglected area in our country. The methodology of this study has two main components: (1) a quantitative analysis using the micro data of Pakistan Social and Living Standards Measurement (PSLM) Survey 2012-13, and (2) a qualitative analysis by conducting In-depth interviews (IDIs) with doctors in both the public and private sectors to investigate their perspectives. The ageing population in this study is defined as population age 60 and above, a standard set by the World Health Organization (WHO). The findings from both the quantitative and qualitative studies reveal that the ageing population in Pakistan is very vulnerable to poor health and physical care. There is no proper mechanism for their socio-economic protection with very few government and non-governmental agencies providing them health services with a very limited coverage. This situation demands for a proper system of socio-economic protection for the ageing population to protect them from socio-economic and health vulnerabilities.

Key Words: Ageing, Health Status, Socio-Economic Protection, Pakistan

1. Introduction

The Ageing population is a result of the demographic transition which is a shift from high fertility and high mortality to low fertility and low mortality. As fertility declines the proportion of population shifts towards older ages and at one time period the proportion of ageing population becomes higher, the shift we are observing in most of the developed countries. Developed countries experienced population ageing after long stretches of time but what developing countries are experiencing currently is a rapid rise towards the proportion of ageing population. This rapid change in age structure is accompanied by huge

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1. **Research Demographer** (Population Council - Islamabad)

challenges to developing countries. According to Nayab (2008) the proportion of the elderly in Pakistan is projected to show a substantial increase only after 2025, which would raise dependency ratios than in the 20th century when it was mainly young dependency that contributed to the total dependency ratio.

Pakistan being the sixth most populous country of the world also stands as one of the top 15 world countries where ageing population is over 10 million. According to the UN "World Population Prospects 2019" the current ageing population in Pakistan is about 14 million. Until Pakistan reaches replacement level fertility, the ageing population will rapidly be increasing and creating a dependency burden on family members as well as on the health sector. The proportion of ageing population is increasing every year followed by the ongoing fertility transition in Pakistan. According to Sathar and Casterline, (1998) "fertility has started to decline, and life expectancy has been increasing, resulting into increase in the ageing population in Pakistan.

Social protection is an important area of government policy that aims to ensure that vulnerable groups of a population such as elderly, receive an effective and appropriate support to safeguard their financial security and health (Bloom, Jimenez & Rosenberg 2012). Social protection enhances the social status and rights of vulnerable groups with the objective of reducing the social and economic vulnerability of the poor (Devereux & Sabates 2004). For the ageing population, according to the United Nations Population Fund (UNFPA 2012), a system of social protection must be implemented to insure or guarantee income security and access to essential social and health services and provide a safety nets that contribute to the prevention of impoverishment and disability in later ages.

The Government of Pakistan is almost unaware of the consequences of this demographic change. Pakistan lacks a national policy to safeguard the fundamental rights of the elderly. In 2014, a national policy was designed by the government for promoting better health among older people; unfortunately, the implementation of this policy is still awaited.

The elderly population in Pakistan is vulnerable to health insecurity and lack of physical care. There is no mechanism or policy for their socio-economic protection. The Global Age Watch value for Pakistan is 12.7 (out of the ideal values of 100) and the country ranks 92nd in this respect, in comparison, Switzerland, which ranks first, has a value of 90.1 (Help Age 2015).

The primary objective of this study is to scrutinize the socio-economic and health status and the social protection of the ageing population in Pakistan. Social protection in this study covers the living arrangements and health care financing for the elderly at government as well as household level. The study also aims to know the elderly's perception about the quality of care they receive and the importance of old age healthcare. Although the traditional family system in Pakistan has looked after the elderly, in the long run, these family norms may change with the worldwide trends in declining birth rates and increased migration for jobs, and eventually communities may replace joint family roles (Khan and Ghosh 2003).

2. Literature Review

In developing countries like Pakistan, the population ageing is on its way due to decline in fertility and mortality rates and increase in life expectancy (Mahmood and Nasir 2008). In both developed and developing countries, the elderly face a lot of vulnerabilities like health insecurity, lack of income, and need for physical care (Bloom Jimenez & Rosenberg 2012). The elderly in Pakistan are expected to face serious insecurities owing to their poor health status and inadequate public support services. All these areas will add to their vulnerabilities and constrain familial transfers. It may also create a conflict between the public objectives of downsizing the families and the socially desired family size or its composition (Alam and Karim 2005).

The ageing population in Pakistan is not completely healthy and is not getting its due share in health and social services (Baig, Hasan and Iliyas 2000). In the absence of any state planned old-age security system and the existing low saving patterns in Pakistan, the

demographic dividend can turn into a demographic nightmare for most of the elderly, if they do not increase their savings during their prime working age (Nayab 2008).

Elderly people in Pakistan face significant levels of social, physical, and psychological health issues that lead to increase in burden of disabilities, chronic diseases, and psychiatric illnesses. Respiratory and cardiovascular diseases, visual and hearing problems, osteoporosis, and cognitive problems are very common among elderly people. Depression among the elderly is a growing and major public health problem in both developed and developing countries (Cassum 2014). In Pakistan, most of the policies address the economic sector with minor attention given to the health sector (Westly 2000). The findings of Alam and Karim (2005), shown in Table 1, indicate that living arrangements for the elderly are totally dependent on family members. Elderly men as well as women are mostly dependent on married sons. Some elderly live alone, even without spouses. Male elderly are found to have spouses more commonly than elderly females. Most of the elderly report sons do not provide the support while those who provide support, are mostly partially supporting. Work status of the elderly indicates that most of them do not work. However elderly females are less likely to work as compared to elderly males. The major reasons for not working are reported as sickness and weakness.

Table 1: Status of Elderly in Pakistan

A Social and housing arrangements for elderly:		
	Female (%)	**Male (%)**
Living alone	11.6	9.1
Living with spouse	19.2	30.9
Living with spouse and children	6.3	14.0
Living with married son	51.6	37.0
Others including daughters and relatives	11.3	9.0
Total (N)	473	465
B Do/does adult son/s provide support?		
Provide support	18.2	13.1
Do/does not provide support	72.1	73.5
No response	9.7	13.3
Total (N)	473	465
C Proportion of support provided by son/s		
Full support	18.2	13.1

Partial support	33.8	34.8
No support	38.3	38.8
No response	9.7	13.3
Total (N)	473	465
D Work status of elderly		
Working for pay	14.1	36.5
Not working	71.2	58.5
No response	14.7	5.0
Total (N)	473	465

Source: Alam and Karim 2005."

In Pakistan, elderly care is primarily provided by the family, which results in an increase in the level of satisfaction. Some of the elderly are still not satisfied because of shortfalls in the fulfillment of their needs. This situation demands efforts to strengthen the family support system by increasing awareness on old age care and starting a support system by the government (Ashfaq and Mohammad 2014). Support from family members and care giving among generations mostly runs in both ways. Elderly mostly provide care for a variety of other family members (spouses, grandchildren children, and nonfamily members), while family members, especially young adults, are the major source of care and support for elderly relatives (World Health Organization 2011).

In Pakistan, the joint family system provides an opportunity to family members to play their role as care givers to older people in their families. This type of care leads to greater satisfaction of the elderly and might be the reason that the government is not taking any steps to make any policies for elderly care in Pakistan (Qidwai, and Tabinda 2011). This phenomenon is also captured by Crampton (2009), according to whom, "The reality is that the state often relies upon families and informal networks for most old age care. Long-range aging policy, then, requires consideration of the social contract between the state and family." "

The majority of the elderly can take care of most of their routine needs; however, for some of the daily activities, they need assistance. The difference between elderly people in urban and peri-urban settings in terms of assistance for daily activities reflects the differences in the lifestyle of these communities. Among the urban middle-income

residents, assistance is provided by hired domestic help, and in the peri-urban residents, the family members provide care. The majority remains happy and satisfied with life when they have a feeling of control on life and family decisions. This means that if the elders are frequently independent, they can stay happy and satisfied with life (Baig, Hasan and Iliyas 2000).

The elderly in Pakistan, particularly the females, face issues of rising morbidity and impaired wellbeing. Social participation is strongly associated with elderly's health and their life quality. The main associated factors with social participation of elderly in Pakistan are identified as their socio-economic status, presence of severe chronic diseases, widowhood, and gender. Chronological age is highly associated with reduced social participation (Ahmad and Hafeez 2011). In Pakistan a very small proportion of the ageing population receives any pension and benefits from social security programs. The majority of the elderly continue to work beyond age 60, especially in rural areas (Mahmood and Nasir 2008).

The health protection of the elderly population is directly associated with spending. Pakistan is spending only 0.42 percent of its GDP on healthcare services (Pakistan Economic Survey 2014-15), and this very low level of health spending deprives most of the elderly of proper health protection. The serious budgetary problems currently confronting health delivery systems in developing and developed countries relate to the availability of only moderately effective or expensive treatments which may prolong the life of elderly patients (Westerhout and Pellikan 2005). A detailed and coherent package of socio-economic protection measures can help a development trajectory that helps in reduction of both inequity and poverty, without affecting the government budgets (Devereux and Sabates 2004).

3. Materials and Methods

The research methodology of this study includes two main components: (1) A quantitative analysis using the micro data of Pakistan Social and Living Standards

Measurement (PSLM) Survey 2012-13, to find out the health status and health seeking behavior of elderly by different socio-economic subgroups. (2) A qualitative analysis by conducting in-depth interviews (IDIs) with 12 doctors in both the public and private sectors to investigate their perspectives regarding socio-economic and health status and the social protection of the ageing population in Pakistan. The IDIs were conducted in Islamabad, Pakistan with 8 public doctors and 4 at private doctors. All the doctors provided rich, experienced-based information, perspectives and suggestions regarding the study topic of socio-economic protection of the elderly population in Pakistan. Regression Model

Binary logistic regression was run to test the multivariate analysis outputs of elderly health status. Health status is the dependent variable which is converted into dichotomous variable, i.e., Health Status = 0 (Did not get sick in past two weeks) and health status =1 (Got sick in past two weeks).

$$\text{Log } [Y/ (1-Y)] = \alpha + \beta 1X1 + \beta 2X2 + \beta 3X3 + \beta 3X3 + \ldots\ldots + \beta kXk$$

"Y" is the dependent variable "health status", βs are the coefficients; k represents number of independent variables and X represents all the independent variables, that includes: X1 = Gender of elderly, X2 = region (urban/rural), X3 = Marital status of elderly, X4 = Province, X5 = Pensions or benefits, X6 = Household income, X7 = Elderly Income, X8 = Source of drinking water, X9 = Educational level of elderly, and X10 = Occupation of elderly.

- **Findings of the Quantitative Study**

The quantitative study on the impact of socio-economic variables on health status and health seeking behavior among the elderly in Pakistan selected independent variables such as region, gender, marital status, source of drinking water, education, employment, income and occupation. Looking at the level of impact of the dependent variables on health status and health seeking behavior will help in finding out the area of high interest to be focused from policy perspective.

According to results of this study, 21 percent of elderly in Pakistan got sick or injured in the two weeks preceding the survey. Elderly people in urban areas are more vulnerable to becoming sick as compared to their peers in rural areas. Elderly women are more vulnerable to becoming sick as compared to elderly men in each province. Around 37 percent of elderly women in Baluchistan got sick--the highest level among all provinces—while Punjab had the lowest rate, i.e., 20 percent.

Social subgroups are closely associated with health outcomes. Comparison by marital status of ageing population indicates that widowed people in Pakistan are much more vulnerable to illness and poor health as compare to married elderly. Around 26 percent of widowed elderly had been ill in the couple of weeks preceding the survey, compared to 17.7 percent of married elderly.

Level of education is also found to affect health outcomes. There is negative relation between level of education and getting sick: elderly people with no education are most vulnerable, and in the same way, elderly people with primary education are more vulnerable to becoming sick (20 percent) than those in the highest educational groups (17 percent).

Safe drinking water is a prerequisite for a healthy life and access to it is therefore a key aspect of health protection of the elderly population. The impact of available sources of drinking water on the health of the elderly population is very strong. The safer the source of drinking water the better the health of elderly population is protected. Elderly people who drink safe water, e.g., water from filtration plants, are less vulnerable to becoming sick (10 percent) than those who drink piped water (24 percent).

The elderly population in Pakistan working for any income was found to be less at risk of getting sick than the elderly population that does not work. According to the findings of this study, 12 percent of working elderly had been sick in the last month compared to double the proportion—24 percent--of the non-working elderly. The income of elderly people also has a strong impact on their health: as the level of income increases,

the proportion of elderly getting sick decreases. Among elderly people whose income was just up to 3,000 rupees, 17 percent had fallen sick in the past two weeks compared to only 8 percent of those whose monthly income was 30,000 rupees or more.

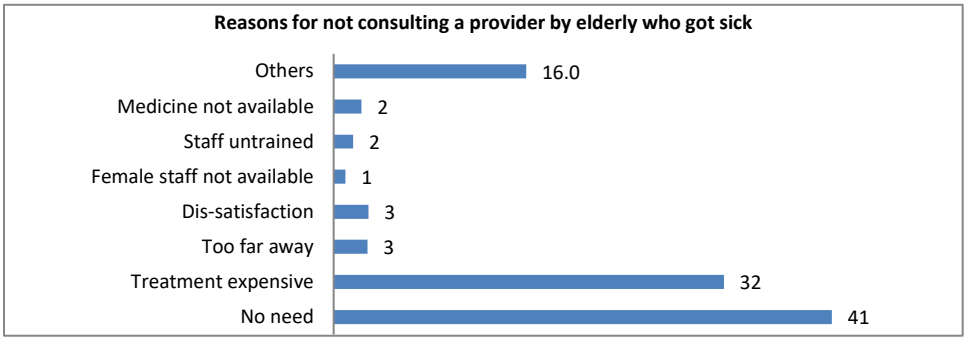
The elderly who receive pension or benefits are less likely to get sick (18 percent) as compared to those who do not receive any pension (21 percent). The impact of occupation on the health of ageing population shows variations. Among occupational groups the least vulnerable group is skilled workers. Among this group 11 percent elderly got sick in past two weeks. The group most vulnerable to diseases is that of service workers (19 percent).

- **Health Seeking Behavior**

The findings of this study show that 5 percent of the elderly in Pakistan did not consult anyone for treatment even once when they got sick. Overall, the proportion of those who did not consult anyone was slightly higher in rural areas (6 percent) than in urban areas (4 percent). In rural Khyber Pakhtunkhwa (KP) and Balochistan, the elderly are less likely to consult a healthcare provider than those in urban areas; in Punjab and Sindh, there is no urban-rural differences. Gender differences in health consultation show that elderly males are less likely to consult compared to elderly females. Unlike Punjab provinces have the same trends as well.

The elderly state different reasons for not consulting any health service provider for care (Figure 1). One of the main reasons is lack of awareness among elderly about the need to consult a healthcare provider when they get sick: 41 percent stated they did not seek a consultation because there was no need for it. The second main reported reason by elderly people was the high expense of the treatment (32 percent).

Figure 1: Reasons Given by Elderly People who Needed Health Services for Not Consulting a Provider



Source: Pakistan Social Living Measurement Survey (PSLM) 2012-13

The results show that the majority of elderly went to the private sector for health consultation when they got sick (68 percent); the rest consulted providers in the public sector (20 percent), at basic health units or rural health centers (BHU/RHC) (3 percent), hakeems (5 percent), and other sources (4 percent). From the perspective of gender and marital status, there are no differences in sources of healthcare consultation. Elderly males and females, whether married or widowed, have almost the same proportions consulting with the private and public sector (68 and 21 percent, respectively). Despite the difference in income levels, the majority of elderly go to the private sector for health consultation; however, the average proportion of consultation from private sector does increase with increase in level of income. At every level of education most of the elderly go to private sector for health consultation. Again, however, the average proportion of consultation from private sector increases with increase in level of education (see Table 2).

Table 2: Distribution for source of health consultation by elderly who got sick by subgroups (%)

	Private dispensary/ hospital	Govt. dispensary/ hospital	BHU/ RHC	Hakeem	Homeopath	Chemist	Others	Total
Gender								
Males	68	21	2	5	1	2	0	100
Females	68	20	3	4	1	3	0	100
Place of Residence								
Urban	70	20	0	5	3	1	0	100
Rural	67	21	4	4	0	3	0	100
Marital status								

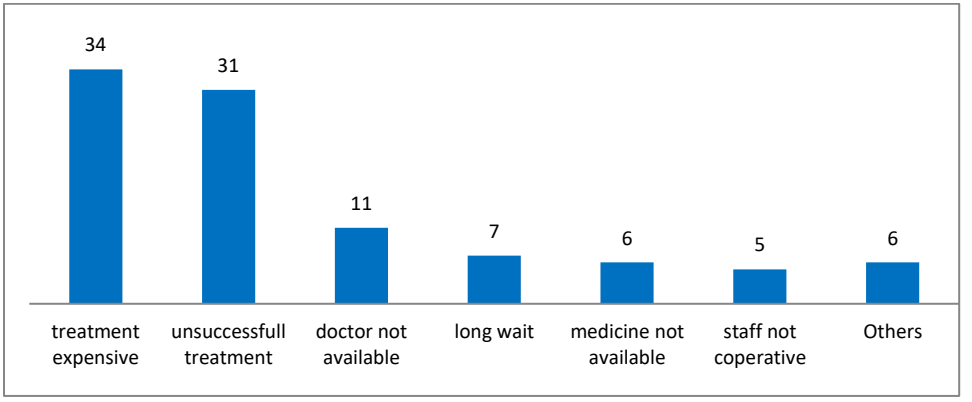
Married	68	21	2	5	1	2	0	100
Widow	68	20	3	4	1	3	0	100
Work Status								
Working	66	23	3	0	5	1	3	100
Not working	65	23	4	0	5	1	3	100
Income Groups								
up to 3000	70	26	0	2	2	0	0	100
6001-9000	68	22	3	4	0	1	3	100
15001-30000	81	12	0	2	2	0	4	100
Greater than 30000	78	15	0	4	4	0	0	100
Level of Education								
Under Primary	73	20	3	3	1	1	0	100
Primary	73	16	1	6	3	1	0	100
Middle	71	17	1	5	4	0	1	100
Secondary	79	16	1	1	1	1	0	100
Higher Secondary & Above	75	16	0	5	2	0	1	100
Total	**68**	**20**	**3**	**5**	**1**	**1**	**2**	**100**

Source: Pakistan Social Living Measurement Survey (PSLM) 2012-13)

The findings of the study show that quite a high proportion of elderly people in Pakistan are not satisfied with the care they received during a recent health consultation. About 31 percent at the national level were not satisfied with the consultation with the healthcare provider. The urban elderly, as expected, are more satisfied with health consultations as compared to their rural counterparts (79 percent and 64 percent, respectively). Gender makes no difference in reported level of satisfaction. These high levels of dissatisfaction with health consultations indicate a need to improve the quality of health services being provided to the elderly population in Pakistan.

Among reasons cited by elderly people for dissatisfaction with their recent health consultation, the most frequently cited reason is expensive treatment (34 percent), and the second major reason is unsuccessful treatment (31 percent). Other reasons reported include unavailability of doctor, long wait, unavailability of medicines, and non-cooperative staff. These findings about the reasons for dissatisfaction with health consultation indicate poverty among elderly and poor quality of health services (see Figure 2).

Figure 2: Reasons for Dissatisfaction with Health Consultation (% Elderly)



Source: Pakistan Social Living Measurement Survey (PSLM) 2012-13

- **Reasons for Dissatisfaction by Subgroup and Source**

Looking at the reasons for dissatisfaction with health consultation among elderly people by subgroups reveals that expensive treatment mostly remains the major reason. By gender, expensive treatment and unsuccessful treatment remain the main reasons (32 percent each) followed by unavailability of doctor (11 percent). Among provinces, expensive treatment remains the major reason for dissatisfaction except in Punjab where the major reason is unsuccessful treatment. The elderly in Sindh reporting expensive treatment as major reason (50 percent). In urban areas, expensive treatment is the major reason (44 percent) but in rural areas unsuccessful treatment remains the major reason of dissatisfaction with health consultations (32 percent).

Viewing responses by source of health consultation shows that among elderly people consulting public sector sources, doctors' unavailability is reported as the major reason of dissatisfaction (22 percent). On the other hand, among the elderly who consulted a private healthcare provider, expensive treatment is the major reason for dissatisfaction (43 percent) (Table 3).

Table: 3 Reasons for Dissatisfaction from Consultation by Subgroups (%Elderly)

	Treatment expensive	Unsuccessful treatment	Doctor not available	Long wait	Staff not cooperative	Medicine not available	Others	Total
Gender								
Male	32	32	11	8	5	6	6	100
Female	35	31	11	6	5	6	6	100
Region								
Urban	44	30	8	6	5	4	3	100
Rural	30	32	12	7	5	7	7	100
Source of healthcare provider								
PrivateDisp/ Hosp	43	37	5	6	2	1	6	100
Govt. Disp/Hosp	17	20	22	11	11	15	4	100
Hakeem	30	40	5	2	0	4	19	100
Total	**34**	**31**	**11**	**7**	**5**	**6**	**6**	**100**

Source: Pakistan Social Living Measurement Survey (PSLM) 2012-13

- **Result of Binary Logistic Regression**

Binary logistic regression was run to test the multivariate analysis outputs of elderly health status. Health status is the dependent variable which is converted into dichotomous variable, i.e., Health Status = 0 (Did not get sick in past two weeks) and health status =1 (Got sick in past two weeks). The Binary logistic regression model is developed as below

$$\text{Log } [Y/ (1-Y)] = \alpha + \beta 1X1 + \beta 2X2 + \beta 3X3 + \beta 3X3 + \ldots\ldots + \beta kXk$$

The results of binary logistic regression with confidential interval 95% are presented in Table 4 using Level of Significance and Odd Ratios.

Table: 4 Result of Binary Logistic Regression

Explanatory variables	B Coefficients	Level of Significance	Odd Ratios
Gender vs. "Female"			
Males	-2.937	.000	.053
Region vs. "Rural"			
Urban	.546	.000	1.726
Marital status vs. "Widow"			
Married	.416	.000	1.515
Pensions or benefits vs "Elderly not receiving"			
Elderly receiving	-.373	.000	.689
Household income groups (excluding elderly's) vs. "30,000 and above"		.000	
Up to 3000	1.110	.000	3.035
3001-6000	.787	.000	2.196
6001-9000	.955	.000	2.599
9001-15000	.534	.000	1.706
15001-30000	.651	.000	1.917
Elderly income groups vs. "30,000 and above"		0.000	
Up to 3000	-1.020	.000	.361
3001-6000	-.255	.000	.775
6001-9000	-.425	.000	.654
9001-15000	-.271	.000	.763
15001-30000	-1.126	.000	.324
Source of drinking water vs. "Filtration plant"		.000	
Piped water	-.536	.000	.585
Hand pump	-.541	.000	.582
Motorized pumping	-.908	.000	.403
Level of education vs. "Higher secondary and above"		0.000	
Under primary	.644	.000	1.904
Primary	.840	.000	2.316
Middle	.296	.000	1.345
Secondary	-.018	.539	.982
Occupational groups vs. "Elementary occupations"		.000	
Legislators, senior officials and managers"	.408	.000	1.504
Service workers and shop and market sales workers	.479	.000	1.615
Skilled agricultural and fishery workers	.306	.000	1.359
Craft and related trades workers	.432	.000	1.540
Constant	-.012	.921	.988

Source: Pakistan Social Living Measurement Survey (PSLM) 2012-13

The results in Table 4 are significant and most of the independent variables show a strong impact on dependent variable. According to the results elderly males are 0.9 times less likely to get sick than elderly females. By place of residence, elderly in urban areas are 0.7 times more likely to get sick than those in rural areas. By marital status, married elderly are 0.5 times more likely to get sick than widows. As compared to Baluchistan, elderly in both Punjab and KP are 0.1 times less likely to get sick, while the elderly in Sindh are 0.4 times more likely to get sick.

The household income, excluding elderly's, has a strong impact on health status of elderly, and while the elderly's their own income has less impact. As the household income level increases, elderly people are less likely to get sick. Those who receive pensions or benefits are 0.7 times less likely to get sick as compared to elderly who do not receive any pension or benefits. By source of drinking water, elderly who use water obtained from motorized pumping are less likely to get sick, while those who use piped water are more vulnerable.

Level of education has a strong impact on health status of the elderly: with increase in level of education, elderly are less likely to get sick. As compared to higher secondary and above level of education, elderly with under primary level are 0.9 times more likely to get sick, but with middle level they are 0.3 times less likely to get sick. As compared to elementary occupations, elderly people with all other occupations are more likely to get sick, especially the service worker (0.6 times). The results of binary logistic regression show that socio-economic background has a strong impact on the health status of the elderly.

The findings of quantitative study provide evidence of poor socio-economic protection of elderly in Pakistan. There is no any concept of geriatric health in Pakistan, which is a broad area in the health sector in western countries. Health insurance is another missing element that is unknown to the majority of the elderly. Only 8 percent of the country's elderly receive pensions or benefits (PSLM 2012-13) and the amount of these

pensions or benefits are insufficient to meet their basic needs. Socio-economic background matters a lot. We can see from the results that a higher level of education reduces the chances of getting ill and is associated with higher awareness about healthcare utilization. A high proportion of elderly people even do not consult service providers for treatment when they get ill. Those who consult health providers mostly go to the private sector. The satisfaction level after consultation is also high in the private sector. This indicates poor healthcare service delivery at government level. Family care is the main source for health protection of the elderly in Pakistan as stated in the previous chapter. The qualitative study in the next chapter, based on in-depth interviews with healthcare providers, provides rich findings to complete our picture of the status of socio-economic protection of the elderly in Pakistan.

4. Findings of the Qualitative Study

This section presents the findings of the qualitative study regarding healthcare providers' views on the health status, health seeking behavior, and social and state level arrangements for socio-economic protection of the elderly in Pakistan. The providers' recommendations for the socio-economic protection of elderly and the challenges providers face in serving the elderly are also captured in this study. While the qualitative study was conducted with the purpose of getting information that was missing from the quantitative picture, to a great extent, its findings also support the findings of the qualitative study.

When the interviewed healthcare providers were asked about the health status of elderly patients based on their examinations, most of the providers said the health status of these patients is mainly poor. Some providers from the private sector said elderly patients have better health status but public sector health providers considered elderly to have a very poor health status. The elderly who have worked in the government sector, such as the army, have access to good facilities for healthcare. Military hospitals, for example, can

be a source of free treatment for them. However, the people who have not worked in any government sector, especially those living in villages, are very vulnerable to poor health.

According to healthcare providers the state of both mental and physical health of elderly people is poor. The state of individuals' health is greatly determined by their socio-economic background. Distance from a health facility is another important indicator: according to healthcare providers, elderly people who come from far-flung areas are mostly in a more critical state as compared to elderly who live near a health facility. All the providers have a common consensus that improvement is possible even within the present setup of health service delivery. Increase in resources will further bring improvements.

"The health status of the elderly could be better. I'm not saying it's all that bad, but improvement could definitely be made." Female nephrologist, age: government hospital

"In our country not only the ageing population but every one's health condition is less than satisfactory." Male orthopedic surgeon, age: 40, private hospital

"The elderly patients who come to the hospital from areas nearby are found to be at initial stage of disease but those who come from far-flung areas are in a worse condition." Female nephrologist, age: 50 years, government hospital

Some providers said that there is a lack of data about elderly people's health in Pakistan; therefore, it is difficult to comment on their health status. Some providers closely linked the health status of the elderly with their economic and social background. According to healthcare providers some of the elderly even do not seek healthcare in times of illness; the quantitative study also reported a significant proportion of elderly not getting a health consultation when they get sick (5 percent). One of the public sector healthcare providers was of the view that elderly people in Pakistan are in moderate health conditions due to the widespread joint family norms. Another healthcare provider from the private sector had the perspective that there has been improvement in general although there is

scope for plenty more. Compared to previous generations, for example from 50 years ago, life spans have increased, indicating this improvement.

"We don't have any data that would tell us about the health status of the elderly in Pakistan but the elderly patients who come to us mostly do not have a satisfactory health status. Not all the elderly come to hospital when they get ill; some stay at home." Female nephrologist, age: 50 years, government hospital.

"Now there is media to create awareness, and therefore patients come from the countryside to cities for medical treatment. If they do not have money, they borrow from someone." Male consultant surgeon, age: 81, private hospital

When asked about the awareness of elderly people for healthcare utilization, most of the providers were of the opinion that elderly people are generally less aware of their needs for proper healthcare. Unless there is a severe problem, they do not go to the doctor and ignore the illness. Only the educated and rich elderly have some awareness about what the precautions and preventive measures are to follow when they suffer from any illness. Poor and uneducated elderly people remain vulnerable to poor health all the time.

"The educated have awareness but not the poor class. The rich people who come to us know everything about their medicines and healthcare, so they have proper awareness." Male Causality Medical Officer (CMO), age: 28, private hospital

Some healthcare providers are of the view that elderly people consider themselves to be less important and a burden on their family. Therefore, they do not take good care of their health; they ignore the illness and do not go for health consultation. One provider was of the view that in old age or at any age as a nation, health is not our priority and we do not think about saving some money for any future medical emergency. One of the private sector health providers pointed out that, typically, in household budgets, people include house rent, utility bills, food expenses, and educational expenses. In that budget we do not

keep any share for health expenses. Our mindset as a nation is that this is the government's duty. Ageing is like useless part and it is considered as a burden.

"They are very careless about themselves because most of them are at an age where they consider themselves to be less important for their families. A few of them are very careful, but this is like one in a thousand." Male physician (medicine), age: 38, government hospital.

5. Socio-Economic Issues of Elderly

The socio-economic issues faced by the elderly population in Pakistan are enormous. Based on interviews with healthcare providers, this study finds that elderly people in the country comprise a neglected part of the age strata. There are no any arrangements for their socio-economic protection. Most of our elderly population lives in rural areas; the family is the only source of socio-economic protection and otherwise there is no concept of geriatrics at the government level. Most of the elderly are financially weak, less educated, and dependent on other family members. These findings of the qualitative study are supported by the quantitative study as well.

Most of the healthcare providers consider poverty as the first main reason for elderly people's poor health, which is directly associated with malnutrition. Elderly people's health depends on resources, access to healthcare, proper diagnosis, and proper treatment. Elderly people mostly lack resources because they are dependents. Capturing the social issues, one of the healthcare providers said that the concept of old age homes is emerging in Pakistan, which means that the norm of family support for the elderly is diminishing.

"When I used to work at a military hospital ("CMH"), the OC CMH used to tell us not to admit any elderly patient on weekends unless there was a genuine case. People have started a trend that if they have to go somewhere on the weekend, they admit their

elderly family members in the CMH." Male dermatologist/venereologist, age: 45, private hospital

"At state level, the elderly are a neglected part of age strata; they are only taken care of by household members in our family system." Female nephrologist, age: government hospital

The findings of the interviews present another important issue that most of the time there is no one who can take elderly people to the hospital and if there is someone who can bring them to the hospital, financial constraints emerge. If they are financially stable then they can go to the hospital but if they are not or if they belong to any far-flung area, it becomes very difficult for them to visit a hospital. Degenerative diseases are mostly costly and therefore poor elderly people are unable to meet the expenses.

Government hospitals are mostly free, and there is negligible spending by people, mainly for medicines that are not available and have to be bought from outside. The population that goes to public hospitals mostly belongs to the lower middle class. From this angle we can guess that economic issues are the biggest issues. Affordability is a prime issue and that is why patients go to a government hospital--they cannot afford private hospitals. Affordability is directly linked to distance as well.

"If we write something that has to be bought from outside, that is torture for patients: they insist that we prescribe the medicine that is available within the hospital." Female associate radiologist, age: 37, government hospital

According to the healthcare providers, the government sector is lacking in offering the necessary facilities and resources and therefore elderly patients prefer to go to private hospitals. The quantitative study also revealed that most of the elderly go to the private sector for health consultation (68 percent) and a small proportion go to the public sector (20 percent). Most of the elderly are poor and remain un-served; family care remains the only hope and source for them. Most of the providers are of the view that the joint

family system is breaking down in Pakistan. However, it continues to be considered the main source of care for the elderly and that is the reason the state is not considering any socio-economic protection arrangements for elderly. Until the government sector is able to offer better healthcare facilities, the elderly will remain vulnerable to poor health because most of them, being poor, cannot afford the private sector.

"Joint family was an asset for elderly people but now this family structure is getting weaker. Due to this family breakdown the elderly are becoming prey to loneliness and depression." Male consultant surgeon, age: 81, private hospital

"Even at very old age, elderly are earning members of their family. Their health status definitely becomes poor and they become a burden on the society, family, and themselves." Male physician (medicine), age: 38, government hospital

The interviewed doctors were asked about the types of disease elderly people typically suffer from Pakistan. All the doctors reported diseases related to their field of specialization and in this way a large number of diseases were mentioned but some diseases were commonly reported by all the sampled healthcare providers, including heart and bone related diseases, and diabetes.

According to the providers, elderly people suffer from both physical and mental diseases. Physical issues include heart diseases; Parkinson's disease; and diabetes. Among mental health issues, the number of dementia patients is higher. Elderly people with dementia are harder to take care of because they are entirely dependent on care for routine minor activities, e.g., going to the wash room, eating food, etc. One of the healthcare providers from a physiotherapy department said that elderly patients most commonly have joint pain and muscular diseases and face spinal abnormalities of degeneration.

"Elderly mostly suffer from osteoclasis and osteoarthritis (joints pain, back pain, bones pain). Other than that, our common elderly diseases are diabetes, hypertension, pneumonia, and so on." Female nephrologist, age: 38, government hospital

Gender also determines the types of degenerative diseases elderly patients suffer from. One of the private sector healthcare providers said that among males, diseases associated with the prostate gland are very common. Among female patients, symptoms associated with menopause and hormonal changes can lead to complaints like heavy sweating at night and many other problems.

"Most of the diseases or issues elderly patients present accrue from age-related changes in the body, like liver fatty, diabetes, and hypertension. Secondly, there is osteoporosis--very common among females--and other changes in bones. These are all degenerative diseases." Female (associate radiologist), age: 37, government hospital.

6. Conclusions

Findings from both the quantitative and the qualitative study reveal that aged people in Pakistan are neglected at government level and are dependent on their families. Unlike western countries, the concept of socio-economic protection for senior citizens is totally missing. The health status of the elderly varies across different socio-economic subgroups, but gender and urban-rural differences remain huge. Women, especially those living in rural areas, are more vulnerable to ill health. The quantitative results also show higher levels of education to be associated with lower chances of getting ill and with higher awareness for effective healthcare utilization.

In the absence of government institutions, some local social welfare organizations are trying to meet the needs of the elderly but unserved senior citizens are much higher in numbers. The elderly in rural areas remain totally unserved. All the providers noted that there is no separate government institution to cater to the needs of the elderly, but some non-governmental charities, either belonging to religious groups or social welfare groups, do focus on the elderly, usually as part of wider efforts to help poor and vulnerable groups. The government does not have sufficient funds available to provide adequate healthcare to the elderly, but this limitation is also associated with the fact that people do not pay taxes

in our country. If people would pay taxes, the government would have enough money to spend on social welfare of the general public.

- **Policy Implications**

Based on the findings of the quantitative and qualitative study, the following policy measures are recommended:

a. First of all, the state needs to consider senior citizens as its responsibility because they have spent their life serving the state. Arrangements should be made according to the needs of the elderly for their better socio-economic protection.
b. Government will have to do from the beginning because the current health setup that our government is running is nothing.
c. Every elderly person, regardless of whether or not he or she has served any government institution, should be eligible for and provided monthly old-age benefits in the shape of social pensions, as in western countries.
d. The NGO sector should be brought up and existing social safety nets, like the Edhi Foundation's network, should be financially supported by the government to provide socio-economic protection to the elderly.
e. All public and private hospitals should establish a geriatrics department so that the elderly are properly treated, with special attention to malnutrition, poor mental health, and weak memory.
f. If some hospitals are not able to set up a full-scale geriatric care unit, at the very least separate wards for the elderly should be introduced.
g. Medical care of the elderly should be free for elderly or subsidized by the government.

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