# Health Status and Social Health Protection of the Ageing Population in Pakistan

**A Thesis Submitted As a Requirement for the Degree of**

**Master of Philosophy in Health Economics**

**By**

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**Abstract**

The aim of this study is to examine the health status, health seeking behavior, and financial support for the ageing population in Pakistan. All these factors are with regard to the social health protection of the elderly, which is an ignored area in Pakistan. Methodology of this study encompasses two main components: a quantitative study based on the analysis of data from the Pakistan Social and Living Standards Measurement Survey (PSLM) 2012-13, and a qualitative part on the perspectives of healthcare providers in both public and private sector. The ageing population in this study is defined as population of age 60 and over, a standard set by WHO. The findings from both quantitate and qualitative study reveal the ageing population in Pakistan is very vulnerable with regard to health and physical care. There is no mechanism for their social health protection with very few government and non-governmental agencies providing health services to the elderly having limited coverage. This situation demands for a proper system of social health protection for the ageing population which will protect elderly from being vulnerable to poor health.

**Key Words**: Social Health Protection, Ageing, Pakistan

# Dedication

**I dedicate this Thesis to**

**My family**

**&**

**My supervisor and well-wisher Dr.Durr-e-Nayab**

**Acknowledgements**

I would like to give very special thanks to my supervisor Dr. Durr-e-Nayab for her time, patience, guidance trusting and supporting me throughout my university life; and making this thesis possible. I would also like to thank and give special recognition to my parents whose prayers and sacrifices helped me attaining higher education.

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# Chapter 1: Introduction

## 1.1 Background

Ageing population is a result of demographic transition which is a shift from high fertility and high mortality to low fertility and low mortality. As the fertility declines the proportion of population shifts towards older ages and at one time period the proportion of ageing population becomes higher which we are observing in the developed countries like Japan and Netherland. 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 challenges to each developing country. Although not as rapid in Pakistan, but is also facing this challenge with an ageing population of more than 11 million. According to Nayab (2006) the proportion of the elderly in Pakistan is projected to show a substantial increase only after 2025, which would take the dependency ratios higher as against the 20th century when it was mainly young dependency that contributed to the total dependency ratio.

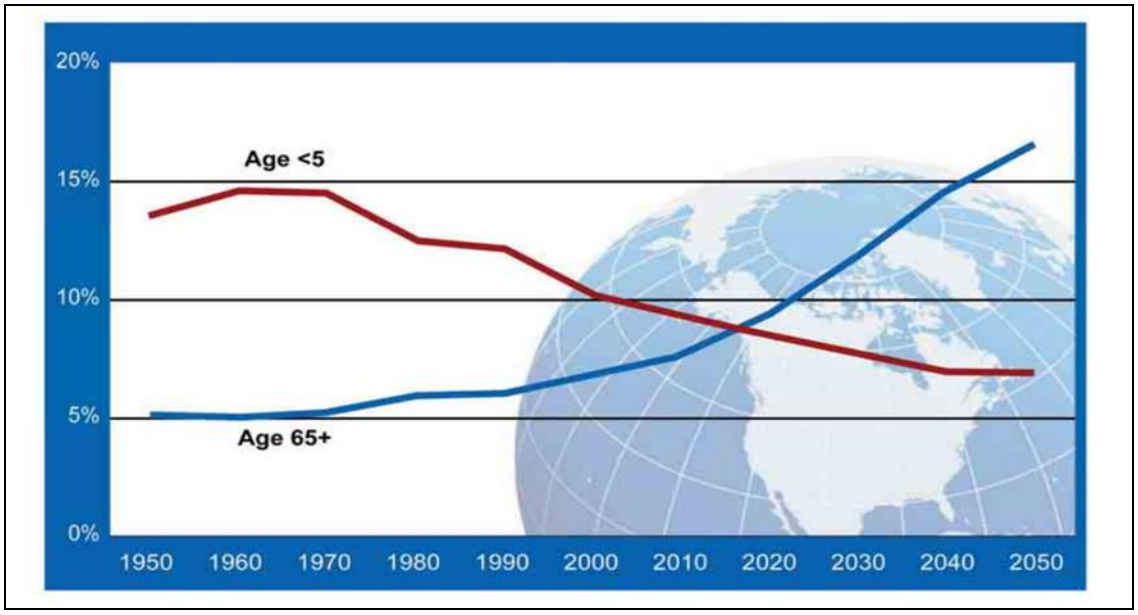
Social protection is a very important area of government that aims to ensure that vulnerable groups of population receive the effective and appropriate support to safeguard the financial security and health (Bloom Jimenez & Rosenberg 2012). Social protection explains all the private and public initiatives that provide income to the vulnerable groups and protect them against life risks. Social protection enhances the social status and rights of the vulnerable groups with the objective of reducing the social and economic vulnerability of poor (Devereux and Sabates 2004). National governments, non-governmental and international organizations play a

major role in protecting the vulnerable and the poor. Among these the older people figure prominently with regard to social protection (Bloom Jimenez & Rosenberg 2012).

### 1.2 World's Ageing Population

The world is on the edge of a demographic milestone. From the beginning of time the young children have outnumbered the number of elderly population, but now the latter will outnumber children (Figure 1.1). Due to falling in fertility rates and rapid increases in life expectancy, elderly population will continue to increase proportionally. The elderly population aged 65 or older is projected to grow to nearly 1.5 billion in 2050 from an estimated 524 million in 2010 with the main increase in developing countries (World Health Organization 2011).

**Figure: 1.1 Children and elderly people aged 65+ as a Percentage of world's Population 1950-2050**

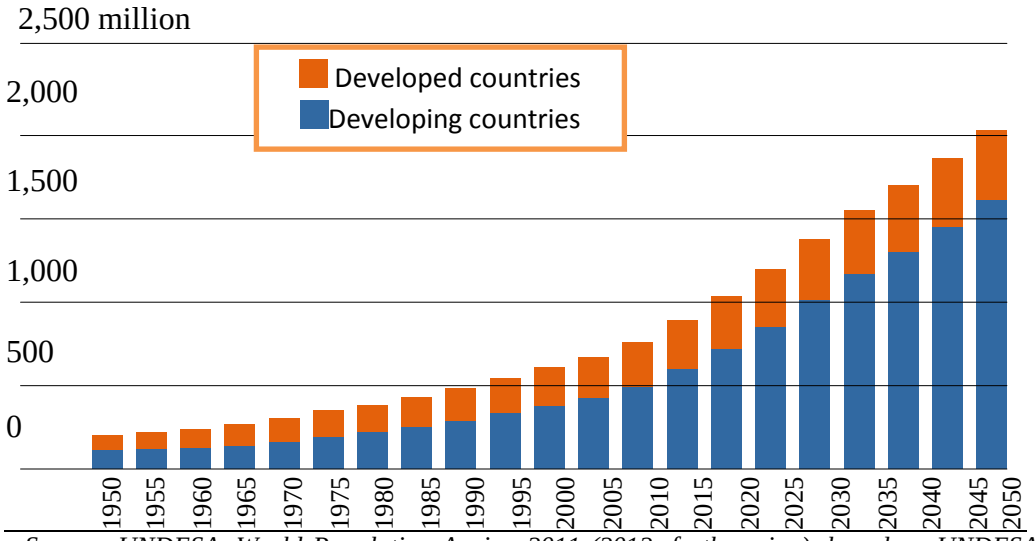



*Source: United Nations. World Population Prospects: The 2010 Revision. Available at: http://esa.un.org/unpd/wpp*

Worldwide ageing population is rapidly increasing and according to the population projections for the year 2050, the number of people over 60 will increase by 3 times from 650 million to two billion (11% to 22% of world's population). Over 80 percent of the world's older people will be living in developing countries as compare to 60% in 2014. Of the current fifteen countries with more than ten million elderly people, seven of them are developing countries and Pakistan is one of them (UNFPA, 2012).

The figure 1.2 shows the trends of ageing population in developing and developed countries. The world's ageing population in 1950 was around 200 million (8 percent of total world's population) and according to projection the ageing population will be more than 2 billion (22 percent of total world's population). In 1990's there is a slow increase in ageing population but in new millennium the rapid increase in ageing population is observed mainly in developing countries.

**Figure: 1.2 Number of people aged 60+: World, developed and developing countries, 1950-2050**




*Source: UNDESA, World Population Ageing 2011 (2012; forthcoming), based on UNDESA Population Division medium projection scenario, World Population Prospects: The 2010 Revision*

Aging accompanies by various changes that could weaken or threaten the existing mechanisms of support for elderly. First, the social norm of traditional family system is changing due to fertility transition and some other socio-demographic changes. Secondly, in many poor countries the role of the government sector in general is either non-existent or weakening. This feature, in addition with massive poverty and inequalities, create unfavorable conditions for safety nets for the elderly (Palloni, Pinto, & Wong, 2009).

According to a report of World Bank (1994), 92 percent of the ageing population in Philippines and the Thailand, 83 percent in China and 82 percent in Malaysia were living with family or children during the 1980s. In Japan with its high advanced economy, only 69 percent of the older people were living with family or children. This proportion was still much higher than in the United States at 13 percent (Westley et al. 2000).

### 1.3 Problem statement

The sheer size of the population, and the age structure changes due to declining fertility in particular, have clear implications for social and economic development (Bongaarts, Sathar & Mahmood 2013). A large uneducated and unskilled young population along with a significant elderly population in the future would place an extreme burden on Pakistan's economy (Wazir, Goujon & Lutz 2013). The government of Pakistan is almost unaware of the consequences of the demographic change like health and social vulnerabilities associated with ageing. In 1999 National Policy was designed by government for promoting better health of the older people. The policy incorporated availability of dental care, training of primary care doctors, domiciliary care, and a proper multi-tiered system of health care service providers for elderly including social workers and physical therapists. Unfortunately the implementation of policy is still

awaited. Family system is breaking down from social perspective and healthcare service delivery for elderly is not yet been separately recognized like in western world known as geriatrics.

### 1.4 Research Questions

- What is the current health status and frequency of health care utilization by ageing population?
- What are the socio-economic issues and corresponding arrangements for elderly ?
- What are the sources of financing for ageing population?
- How to strengthen the cycle of social health protection for ageing population?

### 1.5 Objectives of the study

The primary objective of this study is to

- To scrutinize the health status and social health protection mechanism for the ageing population in Pakistan.
- To know about the arrangements for elderly at government as well as household level.
- To analyze elderly's perception about the quality of care they receive and the importance of old age health care.
- Provide their suggestions to uplift the social health protection for elderly.

### 1.6 Hypotheses of the Study

The hypotheses of the study are as follows:

- Health Status of elderly population in Pakistan significantly varies among Socio-economic subgroups

- Income of elderly has more impact on their health as compared to other variables.
- Elderly in joint families have better health than nuclear families

This study will provide findings from the in-depth quantitative analysis of PSLM data set and qualitative part that exhibits health care provider's (doctors) perspective about the social health protection of ageing population in Pakistan. The doctors will provide the information about health status and issues and challenges of elderly.

### 1.7 Importance of studying Ageing

Ageing population presents various socio-economic and cultural challenges which are important to be addressed. Access to quality health care is one of the most important factors that are linked to ageing population. Therefore older persons must have an access to affordable and friendly health care services that meet all their needs. Income security is another most important concern of ageing population. This concern could be easily meet in shape of investments in pension systems because this system has found to be negatively associated with Poverty. When a country if succeeded to face the challenges of these two factors (Quality of health care and Income security) then that country is growing prosperous ageing. According to (UNFPA, 2012) the floors of social protection must be implemented to insure or guarantee income security and access to essential social and health services for all elderly people and provide a safety net that contributes to the prevention of impoverishment and postponement of disability in old ages.

### 1.8 Significance of the study

This study remains very important, that scrutinizes the health status, and social health protection mechanism for the ageing population in Pakistan; the study indicates the level of impact of socio-economic variables on health of elderly and recommends a way forward for the betterment

of elderly in Pakistan. Although the traditional family system in Pakistan has looked after elderly, however in a short run these family norms would continue but with the worldwide trends in declining birth rates, increased migration for jobs; communities may replace joint family roles Khan and Ghosh (2003). The Current ageing population in Pakistan is more than 11 million that means until Pakistan reaches replacement level fertility the ageing population will be rapidly increasing by creating burden on family members as well as on health sector; this situation demands for evidence based policies to work on social health protection of ageing population.

### 1.9 Structure of the Thesis

This thesis is structured around seven chapters. First chapter is the introduction that covers the problem statement, Research questions, objectives, hypothesis and significance of the study. Second chapter presents the in-depth review of literature on thesis topic, third chapter tells us about the data sources and methodology used; fourth chapter presents socio-economic and demographic profile of the ageing population. Findings of the quantitative and qualitative analysis are presented in chapter five and chapter six, respectively, while chapter seven encompasses conclusions and policy recommendations.

# Chapter 2: Literature Review

## 2.1 Introduction

In developing countries including Pakistan the ageing process is on its way due to declining trends in fertility and mortality and an increase in life expectancy during recent decades (Mahmood and Nasir 2008). In both developed and developing countries, elderly face a lot of vulnerabilities like health insecurity, lack of income, and 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). Socio-economic groups are central to the provision of care while the nuclear family system may be a privilege of the affluent. In the state of poverty, the health inputs may be directed away from the elderly towards the young, who are mostly more economically productive, and in greater need (Qureshi 2014).

Older people form an important group in a society and any aspect of abuse or neglect will have long term negative effect at all levels. Therefore there is a big need for remedial and preventive measures (Gadit 2010). The ageing population in Pakistan is not completely healthy and is not getting their due share in health and social services (Baig, Hasan and Iliyas 2000). In most parts of Pakistan's elderly people have so many socio-economic issues including no involvement in all kinds of affairs related to family, no any entertainment opportunity or outing/excursion, no relations with neighbours and relatives to interact with them in culturally and geographically strange urban environment, and inability to play a strong economic role in families affairs and

accomplishment of their economic desires (Muhammad et al. 2009). Per capita food and non-food consumption, gender and type of residence appears to be a major determinant of the elderly's Quality of Life in Pakistan Ul Haq (2012b). 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 majority of the elderly, if they do not increase their savings during their prime working age (Nayab 2006).

### 2.2 Social health protection of elderly; a missing chapter in Pakistan

The concept of social health protection for elderly is a missing arena in Pakistan that is why elderly population is mostly neglected on different grounds. Saeed, Shoaib and Ilyas (2011) states discrimination against older people has a greater impact on their health status. According to the authors, most of the elderly people have no access to household goods and proper health care; they are treated as second citizen. They face discriminations at different levels like in, decision making, communication and household level activities.

The findings of Alam and Karim (2005) in table 2.1 support the poor ranking where we find living arrangements for elderly are totally dependent on family members, both elderly men and women are mostly dependent on married son. Some elderly live alone even without spouse, Male elderly are more found to have spouse 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 elderly indicates majority of elderly do not work, however elderly females are less likely to work as compare to elderly males. The major reason for not working was reported to Sickness and weakness.

**Table 2.1: Status of Elderly in Pakistan**

| **A Living 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 |
| **E Reasons for not working** | | |
| Sickness | 22.27 | 28.67 |
| eyesight issues | 7.56 | 10.19 |
| Functionally dependent | 2.52 | 0.0 |
| Weakness/ Frail | 22.69 | 34.39 |
| Too old | 22.69 | 22.29 |
| No need | 17.65 | 0.0 |
| No job opportunity | 1.26 | 0.0 |
| Others including overweight | 3.36 | 4.46 |
| Total (N) | 238 | 157 |

Source: (Alam and Karim 2005).

## 2.3 Determinants of Insecurity and Vulnerability of Elderly

The health insecurity and poor health of ageing population in Pakistan is associated with different multidimensional factors ranging from socio-economic to political, regional and environmental factors. In Pakistan 5.3 percent people over age 65 are receiving a pension after their retirement but there is no concept of social pension in a country. There are several factors including, poverty and lack of knowledge among elderly for protecting their rights in relation with poor state laws determines the poor quality of life for older people in Pakistan. (Vertejee and Karamali 2014).

## 2.4 Health Issues Confronting Elderly Population of Pakistan

Elderly people in Pakistan face significant level of social, physical, and psychological health issues that leads 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 elderly is a growing and a major public health problem in both the developed and developing countries (Cassum 2014). In Pakistan there is no any policy that addresses the sufferings of the older people. Most of the policies address the economic sector with minor attention given to health sector (Westlyet el. 2000).

## 2.5 Role of Family care

In Pakistan elderly care is primarily provided by the family that results in increase in level of satisfaction. Some of the elderly are still not satisfied because of unmet needs. This situation demands for making efforts to strengthen the family support system by increasing awareness on old age care and starting support system by the government (Ashfaq and Mohammad 2014).

Support from family members and care giving among generations mostly run 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 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 a greater satisfaction of elderly. This might be the reason that government is not taking any steps to make any policies for elderly care in Pakistan (Qidwai, and Tabinda A. 2011). This phenomenon is also captured by Crampton, (2009) who states "The reality is that the state often relies upon families and informal networks for most of old age care. Long-range aging policy, then, requires consideration of the social contract between the state and family".

Developed countries are giving priority for the care of older persons in fact due to high demand but in developing countries like Pakistan the priority is given to health care at young ages especially the care of children and infants. Health system in Pakistan is inadequate even to meet the demands of common diseases, the health care demand by old people to deal with their degenerative disease and health care remain almost unmet. According to (UNFPA, 2002) In most developing countries, public sector provides very limited health services, so the needs of elderly and the poor remain unmet for most of the time. Elderly sharing goods that might be available in a larger family and the risk of falling into poverty in older age may increase as family size falls. On the other hand, older people are also a resource for younger generations, and their absence may create an additional burden for younger family members (World Health Organization 2011.

In a traditional family system in Pakistan that is joint family system, is found to be very favorable in terms of old age health care. This is also one of the reasons that government is giving less importance to social health protection of ageing population. Mubashir and Kiani (2003) find that the elderly people living in extended families have better quality of lives than those living in single families. This relation persisted after taking account of the variation in quality of life associated with other crosscutting factors such as age, gender, urban-rural residence, and poverty.

### 2.6 Health Care Delivery for Elderly and Challenges for the State

This is evident from the fact that health care system in Pakistan mainly focus on primary health care that means most of the health budget is spent on primary health care not on secondary health care or degenerative diseases among elderly. These gaps are also analyzed by Tabor (2005) where he states, although all the countries have public health service provision but few governments provide all range of health services. Inefficient delivery systems, small healthcare budgets, poor quality of services, and the user fees make it difficult to meet the health care needs of poor and older people.

The challenges that an increasing population of the elderly is likely to pose to the existing health delivery systems in the country are going to be tremendous. Such challenges are multidimensional in nature and will include provision of emotional, social, financial and physical support to the older population, in addition to the provision of medical coverage. An exhaustive coverage in all these areas will require mobilization of resources on a large scale. An existing lack of resources will require development of cost-effective innovative models of health care delivery that can address the issues of elderly on a holistic basis (Qidwa 2009).

A study in peri-urban Karachi was conducted by Ladha et al. (2009) to present social and demographic characteristics and health-seeking behavior of ageing. According to the findings of this study elderly woman mostly economically deprived and with no education are most of the time dependent and thus vulnerable. The ageing population of peri urban area has financial obstacles for health care utilization. Hypertension was very common and more prevalent among women as compared to men, the ratio being 1:2. Small number of people knew they are diabetic. This might be due to ignorance and non-availability of screening and investigations.

Karachi being a metropolitan city of Pakistan, health services are available to the majority of residents but insufficient to deal with elderly population, additionally the elderly do not have a high image of these services. The quality of these services is considered as unsatisfactory by more than fifty percent of the elderly population. Although the elderly are generally happy with their lifestyle and status but they have hopes and aspirations for improving their lives. The majority want to be employed and independent (Baig, Hasan and Iliyas 2000).

### 2.7 Reasons for Poor Health Protection of Elderly

The low budgetary allocations in public health sector results in inadequate delivery of health care services, thereby affecting the ageing population and poor dependent families with more severity. Shortages or unavailability of health care staff and supplies affect many poor families that also includes elderly who cannot afford to get health care from private sector (Mahmood and Ali 2003), (Afzal 1997). Various factors have been identified in Pakistan as the main cause for poor health care utilization that also includes poor social and economic status, lack of access, cultural norms, low education and large family size (Shaikh and Hatcher 2005). Mahmood and Ali (2003) find that around 57 percent people go to a private sector for treatment when they get

sick and around 45 percent reported unavailability of money as one of the main reasons for not having health consultation for their treatment.

### 2.8 Financial Arrangements for Elderly Population

The government of Pakistan spends only 3.1 percent of its GDP on socio-economic and community services and around 43 per cent are on debt servicing. A very small proportion of 0.8 percent is being spent on health sector service delivery; this is even lower than Bangladesh who spends 1.2 percent of their GDP on their health sector, Sri Lanka spends even more which is 1.4 percent (Shaikh and Hatcher 2005). The health protection of elderly population is directly associated with spending while in Pakistan very low level of health spending's deprive majority of elderly from properly protecting their health. 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).

### 2.9 Gender and Elderly

Gender is one of the most important factors which differentiate the health status of the ageing population in Pakistan. Gender is also associated with the management and care for poor or ill health amongst the ageing population. Patriarchal gender relations impinge on women's health status throughout the life-course. Elderly women mostly have higher disability rates, communicable and non-communicable diseases, and they report a poor quality of life (Qureshi 2014).

A gender analysis relating health status of the elderly in Pakistan by (Qureshi 2014) explores how gender shapes the ageing structure of women and men and encroachment of disability and

ill health. The norm or system of family care may break-down due to separation, widowhood, polygamy, childlessness, divorce, family issues and where there are no de-facto family members available.

The traditional role of women as family caregivers may result in increasing the level of poverty and ill-health among elderly people. Women will have to stop working to fulfill their gender specific roles of caring their families. Most of the women have no access to employment opportunities to earn money because they are mainly busy in unpaid household activities like look-after the children, elderly parents or relatives, grandchildren and ill spouses. This means that the provision of family care is mostly attained at the expense of the women caregivers' economic security and good health in old ages (Zahidi 2011).

**2.10 Poverty Trap and Health Outcomes**

Poverty and economic issues force majority of elderly to continue working even beyond age of seventy five. It is mostly observed that the role of women in Pakistan is totally limited to unpaid house hold activates; they are financially dependent on other household members who are earning, this dependency becomes 100 percent during old ages. This situation demands for some specific interventions and programs that would provide the dependent women some social and economic assistance in relation to changes in social conditions (Mahmood and Nasir 2008). The health of elderly in developing countries like Pakistan must be viewed at broader perspective because there are millions of people who are falling under the vicious cycle of poverty, malnutrition, no education, and lack of power. (World Health Organization 2003).

From the perspective of poverty, economic disparities and lack of health facilities, the ageing population in Pakistan suffers from a number of setbacks like missing social relations,

deprivation, painful health conditions, lack of resources, and loss of a spouse or partner (Gadit 2010). The state of poor elderly's health in Pakistan demands for the quick attention of the policy makers for the allocation required funds for the social health protection of elderly (Mahmood and Ali 2003). A detailed and coherent package of social health 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).

### 2.11 Issues Confronting Caregivers

The elderly's' health typically deteriorates with the increase in age. This generates greater demand for long term care as the number of elderly people increases. Elderly women can moslty serve as caregivers themselves, as well as being among those who need to be cared for, in both developing and developed countries. The burden of care giving for the younger and the older groups often falls upon females (Zahidi 2011).

In most traditional societies of Asia, elderly people live in joint families and multi-generational households; therefore they rely primarily on their young children for monetary support and all types of care (Westley et al. 2000). In this way the caregiver in Pakistan are mostly adult children or working age population. According to Muhammad et al. (2009) women in households play a role of informal caregivers but in result they bear the burden of care giving in terms of emotional, physical and financial stresses. These informal caregivers need counseling services and formal support.

The level of financial barriers faced by family members is reflected in Table 2.2 taken from Ahmad (2010) where among male care givers sons mostly face financial problems (56 percent) and overall 88 percent of male care givers faced financial problems. Among female caregivers,

daughter-in-laws faced more financial problems (12 percent) followed by daughters ten percent and wives 6 percent, Over all sixty seven percent female care givers faced financial problems

**Table 2.2: Percentage distribution of care givers by monetary problems and by gender**

| Sex of Care-giver | Relationship to care recipient | Frequency of facing financial problems | | | |
|---|---|---|---|---|---|
| | | Not at all | Sometimes | Most often | Total |
| Male | Husband | 0 | 0 | 4 | 4 |
| | Son | 12 | 20 | 56 | 88 |
| | Son- in- law | 0 | 0 | 8 | 8 |
| | Total | 12 | 20 | 68 | 100 |
| | N | 3 | 5 | 17 | 25 |
| Female | Wife | 5.9 | 4.9 | 5.9 | 16.7 |
| | Daughter | 8.8 | 8.8 | 9.8 | 27.5 |
| | Daughter- in- law | 18.6 | 18.6 | 11.8 | 49 |
| | Grandchild | 1 | 2.9 | 2 | 5.9 |
| | Other relative | 0 | 1 | 0 | 1 |
| | Total | 34.3 | 36.3 | 29.4 | 100 |
| | N | 35 | 37 | 30 | 102 |

Source: (Ahmad 2010)

The frequency and associated factors of care giving among elderly were assessed by Qidwai et al. (2011) in a teaching hospital in Karachi. The table 2.3 indicates sixty seven percent elderly want care givers, and eighty five percent reported caregivers are available for them. Elderly care is mostly provided by the household members that increase the level of satisfaction among elderly people; however some of the elderly people are still not satisfied due to some other unmet needs due to different socio-economic issues faced by the household members. Lack of awareness among household members relating elderly care is another most important concern and issue.

**Table 2.3: Frequency of care giving and associated factors**

| Respondents | Frequency | percent |
|---|---|---|
| 1.Need care giver service (n 400) | | |
| Yes | 268 | 67 |
| No | 132 | 33 |
| 2.Care givers present for your needs (n 268) | | |
| Yes | 227 | 85 |
| No | 41 | 15 |
| 3.Relationship with the care giver* | | |
| Family members | 195 | - |
| Relative | 25 | - |
| Neighbor | 6 | - |
| House maid | 40 | - |
| Health care providers | 5 | - |
| 4.Impact on relationship with the care giver after receiving care (n 227) | | |
| Improved | 85 | 37 |
| Detoriated | 8 | 4 |
| No change | 134 | 59 |
| 5.Did you get any Improvement in general wellbeing (n 227) | | |
| Yes | 158 | 70 |
| No | 69 | 30 |
| 6.Improvement observed in the general wellbeing after care provided: ** | | |
| Financially | 33 | - |
| Medically | 116 | - |
| Physically | 74 | - |
| Emotional | 51 | - |
| Social | 39 | - |
| Spiritual | 5 | - |
| 7.Did Your care givers faced any barriers in providing care (n 227) | | |
| Yes | 98 | 43 |
| No | 129 | 57 |
| 8.Barriers which prevent care givers to provide care (n 98) | | |
| Financial | 29 | 30 |
| Lack of time | 29 | 30 |
| Health reasons | 6 | 6 |
| Job responsibilities | 22 | 22 |
| Home responsibilities | 12 | 12 |

Source: (Qidwai et al. 2011)

* (multiple responses so n cannot be 227 and there percentage cannot be computed).

** (multiple responses so n cannot be 158there percentage cannot be computed).

**Table 2.4: Characteristic of Family Caregivers**

| **Age** | **%** |
|---|---|
| Equal to or less than 30 | 40.2 |
| 31 - 35 | 14.2 |
| 36 - 40 | 24.4 |
| 41 - 45 | 3.9 |
| 46 - 50 | 4.7 |
| 51+ | 12.6 |
| Total | 100 |
| **Gender** | |
| M | 19.7 |
| F | 80.3 |
| Total | 100 |
| **Caregivers' Marital Status** | |
| Currently Married | 66.9 |
| Widow | 2.4 |
| Separated | 1.6 |
| Never married | 29.1 |
| Total | 100 |
| **Caregivers' level of Education** | |
| Illiterate | 16.5 |
| literate (no formal schooling) | 4.7 |
| up to $5^{th}$ | 19.7 |
| up to $10^{th}$ | 26 |
| Undergraduate | 22 |
| graduation and above | 11 |
| Total | 100 |
| **Relationship with Care Recipient** | |
| Spouse | 14.2 |
| Son or Daughter | 39.4 |
| Daughter- in- law | 40.9 |
| Grandchildren | 4.7 |
| Other relative | 0.8 |
| Total | 100 |
| **Caregivers' Work Status** | |
| Working | 33.8 |
| Non-working | 66.2 |
| Total | 100 |
| **N** | **127** |

Source: Ahmad (2010)

Ahmad (2010) finds the Characteristics of family caregivers where most of the care givers are age 30 or below. Eighty percent of care givers are females; marital status of care givers shows currently married women mostly provider elderly care followed by never married. This behavior reflects the joint family system of Pakistan. Majority of care givers are literate but non-working, the relationship to care receivers show majority care givers are either daughters in law or son/daughter (80 percent) (see Table 2.4)

**2.12 Socio-Economic Participation of Elderly Population in Pakistan**

In the socio-cultural structure of Pakistan although the ageing population is taken care of by their family members but the majority of elderly wants to continue their work to remain less or not dependent. Majority of the elderly could take care of themselves routinely however for some of the daily activities they needed assistance. The difference between urban and peri-urban in assistance for daily activities reflects the differences in the lifestyle of these communities. Among the urban middle income residents these are performed by servants and in the peri-urban residents the family members took care. The majority remains happy and satisfied with life with a feeling of control on life and family decision This means that if the elders are independent they can stay happy and satisfied with life (Baig, Hasan and Iliyas 2000).

Elderly in Pakistan particularly the elderly females face the issues of rising morbidity and impaired wellbeing. This critical situation demands for some strong policy intervention to enhance social participation of elderly in a society (Ahmad and Hafeez 2011) .Social participation is strongly associated with elderly's health and their life quality. The main associated factors with social participation of elderly in Pakistan were identified as their socio-

economic status, presence of severe chronic diseases, widow-hood and gender. Chronological age is highly associated to the reduced social participation (Ahmad and Hafeez 2011).

Labor force participation of the ageing population is very important to assess their economic conditions and monetary support in view of the inadequate social security system in Pakistan. A very small proportion of ageing population receives any pension and benefits from social security programs, majority of elderly continue to work beyond age 60 especially in rural areas (Mahmood and Nasir 2008).

### 2.13 Ageing Population as an Opportunity

A positive view of ageing population shows us an opportunity that may contribute to over development of society. The "Madrid International Plan of Action on Ageing.2002" also focuses on this positive view of ageing Population. A healthy ageing population also contributes in development of all sectors by their lifetime experience therefore the authority, wisdom and dignity of ageing population must be recognized instead of considering them as a burden on societies and health sector. According to Madrid Plan the spread of the media has resulted in spreading ageism to societies in which it was unknown. Elderly women are mainly affected by negative and wrong stereotypes. Instead of being portrayed in ways that reflect their strengths, contributions, humanity and, resourcefulness they are mostly seen as dependent and weak. This reinforces the exclusionary practice at the national and local levels.

Paragraph fifteen of the Madrid Plan (2002) states: "Mainstreaming ageing into global agendas is essential. A concerted effort is required to move towards a wide and equitable approach to policy integration. The task is to link ageing to other frameworks for social and economic development and human rights. It is clear that successful adjustment to an ageing world will depend on both

ageing-specific and ageing-mainstreaming approaches. Ageing mainstreaming is the integration of older people's issues into wider national policymaking. Mainstreaming should lead to the inclusion of the needs of people of all ages into the wider policymaking process".

HelpAge International points out some important contributions that elderly population can give and these points really demonstrate that elderly are really a great opportunity for any society. The points covered are by HelpAge are listed below.

- Income generation and financial support to their family
- Child care and care of other dependents and sick family members
- Housekeeping and guarding
- Disaster coping strategies
- Recovery and reconstruction
- A wide range of (indigenous) knowledge and experience
- Traditional healing and crafts
- Motivation of others and personal courage in adversity
- Preservation and transmission of cultural heritage, stories, and activities
- Family and community conflict resolution and
- Community knowledge that can assist in relief targeting and distribution.

**2.14 Role of non-government organizations**

There exist very few government and non-governmental agencies providing health services to elderly populations in Pakistan but these services cover a small proportion of ageing population. Pakistan is facing double burden of disease. The old age burden of diseases is surrounded by multiple severe diseases like hypertension, diabetes, musculoskeletal problems, cancers and

some infectious diseases. In Pakistan 60 percent deaths above age 60 are caused by diabetes, 59 percent due to cardio-vascular diseases and 29 percent due to cancer. This situation demands for a proper system of social health protection for ageing population which will protect elderly from these severe diseases by providing them proper means of health care.

### 2.15 Asia Specific Country Examples

Several Asian countries have adopted socio-economic policies to uplift and encourage family care for the ageing population. In Singapore, the children of elderly are legally responsible to support their elderly family members; In Malaysian government provides tax incentives to families who take the responsibility of elderly care. Some Southeast and East Asian countries are subsidizing adult day care and other support services that aim in helping children care for their elderly family members. Singapore and Malaysia have revised their public housing policies to accommodate elderly living arrangements (Westley et al. 2000).

### 2.16 Summary

Elderly population in Pakistan is vulnerable to health insecurity and physical care. There is no any mechanism, or policy for their social health protection. The Global Age Watch value for Pakistan is 8.3 out of the ideal values of 100. Healthy life expectancy at age 60 is only 13.8 years (HelpAge 2014). The world ranking of Pakistan for growing elderly indicates poor social health protection mechanism for elderly in Population, this situation demand for some quick policy actions to deal with the needs of elderly.

# Chapter 3

# Data and Methodological Considerations

The International Labour Organization (ILO) 2008, suggested to define social health protection as a series of "public or publicly organized and mandated private measures against social distress and economic loss caused by the reduction of productivity, stoppage or reduction of earning or the cost of necessary treatment that can result from ill health". Based on this definition, a new definition is formed for social health protection of elderly in Pakistan by setting the relevant indicators.

## 3.1 Definition of social health protection of elderly

Social health protection of elderly pertains to all socio-economic measures that protect the health of the elderly population. This definition has two parts

1. **Social measures of Health protection**
    - Under this measure this study looks at the extent of support elderly receive from family members
    - Health status of the elderly living in nuclear vs joint family
    - Availability of resources like safe drinking water and improved sanitation
    - Health care arrangements at government level
2. **Economic Measure of Social Health Protection**
    - Work status of elderly population
    - Proportion of elderly receiving pensions, benefits or health insurance
    - Household income

As stated in the abstract, the design for this thesis of health status and social health protection of ageing population in Pakistan includes two main study components: **a quantitative study** based on the in-depth analysis of Pakistan Social Living Standards and Measurement Survey (PSLM) 2012-13 data set and **a qualitative study** of perspectives of healthcare providers (male & female doctors). The thesis methodology adopted for the two components is explained below.

### 3.2 Quantitative Study

The quantitative study includes literature review and in-depth analysis of PSLM data set 2012-13. The literature on elderly reviewed for this thesis focused on the health status of elderly and differences according to different socio-economic subgroups. Furthermore it also looked into the health seeking behavior of elderly and satisfaction level from their health care consultations. A thorough literature review of relevant program and policy literature including the reports of donor funded projects (e.g. HelpAge International) helped to identify the key enabling factors and challenges in promoting social health protection of the ageing population in Pakistan.

#### Source of literature Review

The online search engines used for extracting literature for this thesis include Jstor, Google Scholar, Google, Population Reference Bureau, Research Gate, Books and Science Direct. Specific terms used in these searches included "elderly health status," "social health protection," and "ageing Pakistan and challenges". Different combinations of these keywords were used to extract optimal relevant literature. Statistics and material was also accessed through different websites of the government of Pakistan, World Health Organization, HelpAge international, World Bank and United Nations Population Fund (UNFPA). A complete list of references is presented at the end of this thesis.

## Data Sources

As stated earlier this thesis uses the data from Pakistan Social Living Measurement Survey PSLM (2012-13) for the analysis of health status of ageing population in Pakistan. The PSLM Survey is used by the government of Pakistan in formulating the poverty reduction strategy as well as development plans at different levels. The PSLM (2012-13) survey covers 75,516 households to collect data on education, health, economic and other related aspects. This survey covers the entire country, all urban and rural areas of the four provinces. The indicators are developed in the following areas.

1. Education
2. Health
3. Economic Status
4. Environment
5. Water Supply & Sanitation.

## Methodology

Analysis of PSLM 2012-13 data has been done on SPSS 20 to explore the health status of ageing population and their perceptions and behaviors apropos health care. The sample size for ageing population in PSLM 2012-13 is 28101 or 6 percent of total sample size. If we generalize this percentage on whole country's population then the total elderly population counts to around 11 million in Pakistan.

**Binary Logistic 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 in to 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 incudes, 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, X10 = Occupation of elderly.

### 3.3 Qualitative Study

The qualitative study was conducted in Islamabad Pakistan, and consisted of in-depth interviews with doctors in the public and private sector who are taken as key informants. The doctors were interviewed apropos the health status and social health protection scenario for elderly in Pakistan.

#### 3.3.1 Study Sample

The qualitative study was based on a sample size of 12 key informants (doctors). The informants were selected from both public and private sector. The numbers of key informants selected from public sector were 8 and 4 from private sector. All the doctors provided the enriched and

experienced based information, perspectives and suggestions on the study topic of social health protection of elderly population in Pakistan.

**Characteristics of Sample**

The doctors interviewed belonged to different fields and all the doctors have been dealing with elderly persons and degenerative diseases. Details about the 12 key informants selected are provided in Table 3.1.

**Table3.1: Characteristics of Sample**

| **Type of doctors interviewed** | **Number of doctors** |
|---|---|
| Nephrologists | 2 |
| Urologist | 1 |
| Causality medical officer | 1 |
| Dermatologists | 2 |
| Associate physician, medicine, neurologist | 1 |
| Orthopedic surgeon | 1 |
| Associate radiologist | 1 |
| Medicines | 1 |
| Physiotherapist | 1 |
| FRCS England consultant surgeon | 1 |
| **Total** | **12** |
| **Age groups** | **Number of doctors** |
| 25 – 34 years | 2 |
| 35 – 44 years | 7 |
| 45 – 54 years | 2 |
| 60 + years | 1 |
| **Total** | **12** |
| **Experience** | **Number of doctors** |
| Less than 5 years | 1 |
| 5 - 9 years | 2 |
| 10 – 14 years | 5 |
| 15 - 19 years | 1 |
| 20+ | 3 |
| **Total** | **12** |

### 3.3.2 Data Collection and Processing

In-depth interviews with service providers for the study were conducted using a structured guide. The responses from interviews were recorded in the mp3 file format. All the recordings were then transcribed and stored in Word format. The questionnaires were identified by personal identification numbers instead of participants' names to preserve anonymity. After a thorough review of transcribed data the matrices were developed. The data was sorted in the matrices according to the set indictors and subsequently analyzed.

## 3.4 Ethical Guidelines

All the data collected was kept confidential while informed consent was obtained from the respondents before they were interviewed. The time required for the interviews was also told to respondents. The Respondents of the interview were informed that their participation was voluntary therefore they may refuse to interview and terminate it at any time if they feel uncomfortable.

## 3.5 Limitations of the study

The social health protection of elderly has different dimensions like family care, facilities of health care delivery, pensions systems, health insurance and many other related socio-economic measures. Due to limited resources the qualitative study had a limited sample size therefore regional variations that may exist remained uncovered. In quantitative study the health status is measured based on elderly got sick or not, although it is a soft definition but this is due to the data limitation.

# Chapter: 4

# Socio-Economic and Demographic Profile of the Ageing Population

## 4.1 Introduction

This chapter gives an overview about the socio-economic and demographic profile of elderly in Pakistan. The demographic profile covers the elderly's population trends, life expectancy, old age dependency and support ratios and age sex composition. Social profile includes the level of education of elderly by gender and regions. Economic profile shows proportion of elderly working and not working, this profile also includes the occupational status of elderly who are working. The level of monthly income is also analyzed; monthly income includes pensions as well.

## 4.2 Demographic Trends

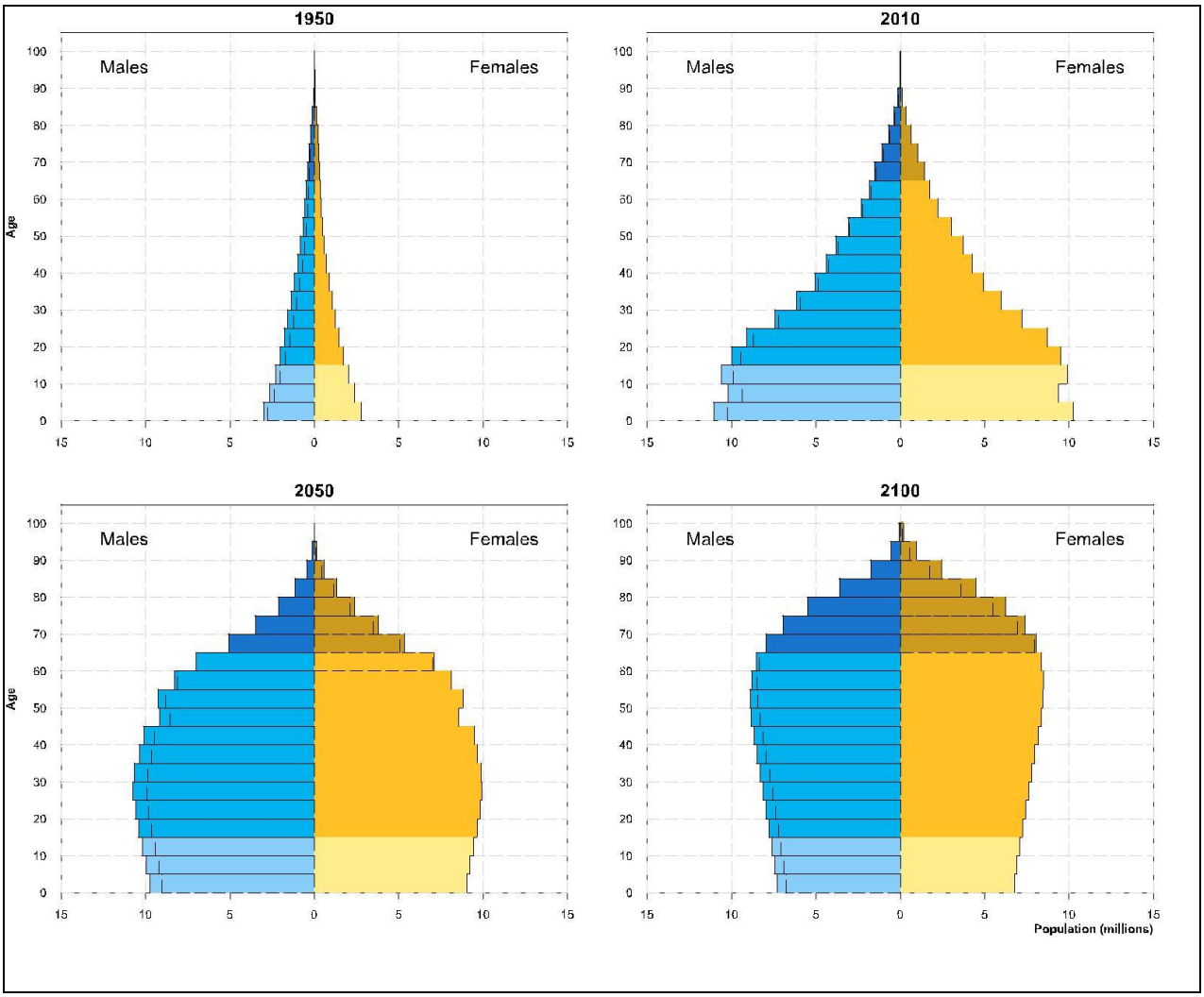
The proportion of ageing population is increasing every year followed by the ongoing fertility transition in Pakistan. According to Sathar and Casterline, (1998) "fertility has started declining and life expectancy of older people has been increasing and it is expected that in future both these processes will gain momentum, resulting into manifold increase in the population of elderly people".

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. The ageing population of Pakistan is 11.6 million that is 7% of total population which is projected to become 43.3 million by 2050 (World Economic Forum, 2011). The proportion then will be 16% of the total population of

Pakistan. The demographic trends show that between 1990 and 2010, the ageing population has risen by 75%; this percentage is projected to increase in the coming decades.

The four population pyramids for Pakistan in Figure 4.1 demonstrates the estimated and projected change in age sex composition over the years.

**Figure: 4.1 Population by age groups and sex (absolute numbers in millions)**




*Source: United Nations Department of Economic and Social Affairs/Population Division, World Population Prospects: The 2012 Revision, Volume II: Demographic Profiles.*

*Note: The dotted line indicates the excess male or female population in certain age groups. The data are in thousands or millions.*

The population pyramid for 1950 shows the small number of people and extended pyramid in 2010 demonstrates a rapid increase in population. The age sex composition in 2010s pyramid shows most of the population is young age and elderly population accounts for 6 percent of total population in 2010. The pyramid for 2050 shows a massive bulge of working age population and also a big proportion of elderly population (16 percent). The age sex composition pyramid for year 2100 indicates a rapid increase in the proportion of elderly population (Figure: 4.1).

The elderly population in Pakistan in just two decades between 1990 and 2010 has increased by 75 percent (Husain 2014). Although we are still in the third stage of the demographic transition this percentage is expected to increase manifolds over the next decades. The estimations and projections of life expectancy for the coming 100 hundred years indicate a big increase in life expectancy in Pakistan (see Figure: 4.2). This increase in life expectancy is followed by increase in proportion of elderly population for same time period, which is from 8 percent elderly in 1950 to 16 percent in 2050 (see Figure: 4.3).

**Figure: 4.2 Life Expectancy over the years in Pakistan (1950-2050)**

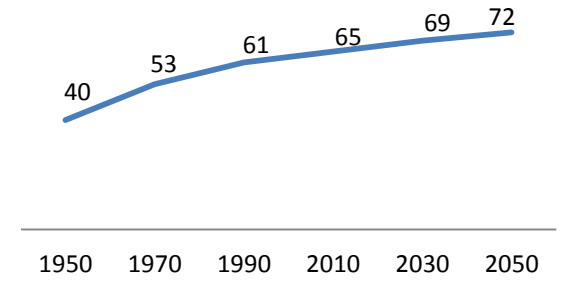
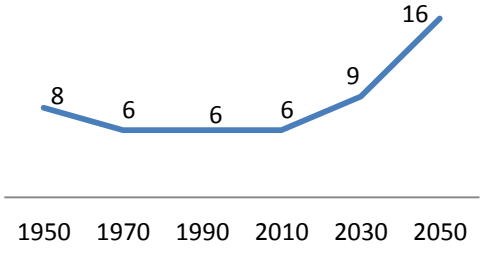



**Figure: 4.3 Percentage of population aged 60 and older in Pakistan (1950-2050)**

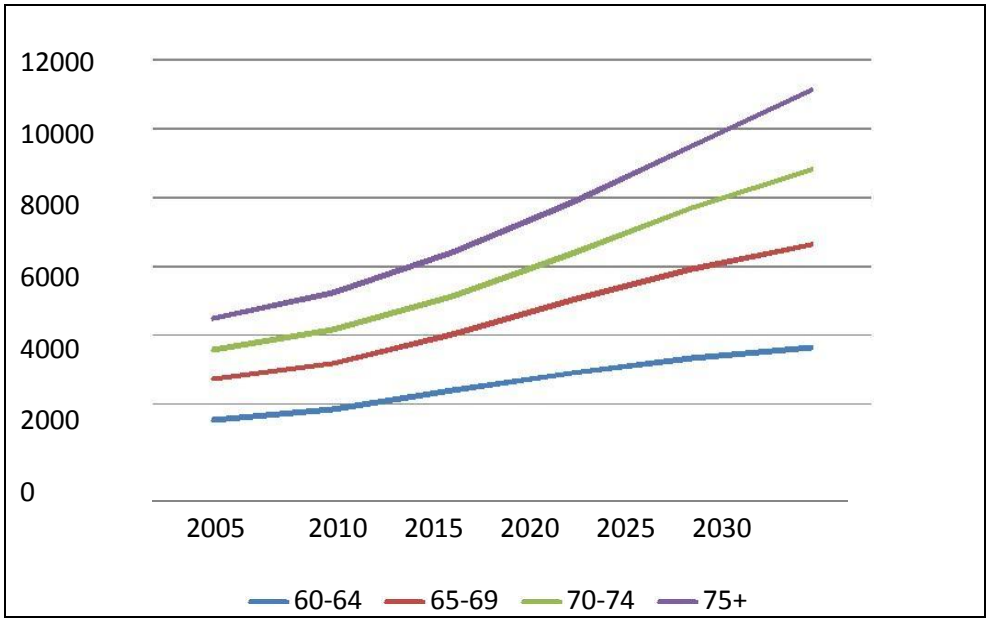



*Source: Global Population Ageing: Peril or Promise, Geneva: World Economic Forum, 2011.*

The estimated and projected population during the year 2005 to 2030 for different elderly age groups (see Figure: 4.4) indicates the proportion of the age group 75+ is rising rapidly that

accounts to medical advancements. The proportion and rate of increase in all old age groups will keep on increasing till 22nd century followed by declining fertility and increase in life expectancy.

**Figure: 4.4 Elderly Population by age groups in Pakistan (Projections in thousands)**




*Source: Economic survey of Pakistan 2009–2010. Page 240, Based on World Bank's World Development Indicators (WDI) database*

### 4.3 Old Age dependency and Support Ratios in Pakistan

Old Age dependency ratio in Pakistan is almost stagnant for the last three to four decades (see Figure 4.5). Although the number of elderly population is rapidly increasing in Pakistan but stagnated old age dependency ratios account to rapid increase in the working age population. The potential support ratios (PSR) as obvious are also in stagnation during last decades (see Figure: 4.6). PSR stands for population age 15-64 per one older person aged 65 or older.

**Figure: 4.5 Old age dependency ratio (ratio of population aged 65+ per 100 population 15-64) Pakistan**

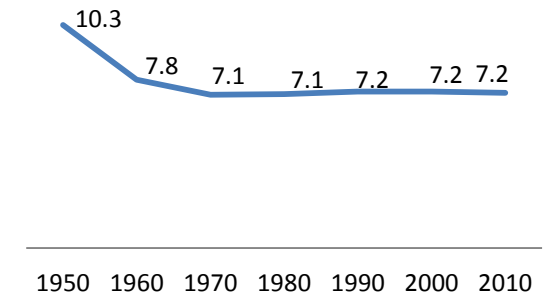
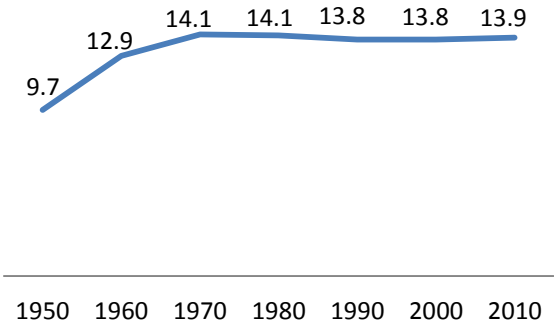



**Figure: 4.6 Potential support ratio (ratio of population aged 15-64 per population 65+) Pakistan**




*Source: World Population Prospects: The 2012 Revision. United Nations Population Division,*

## 4.4 Educational Profile

Education is an important indicator that directly affects ageing health. The majority of ageing population (72%) in Pakistan is uneducated and out of 28 percent educated elderly, 3 percent have under primary education, 9 percent primary, 5 percent middle, 6 percent middle and 5 percent have higher secondary or higher level of education (see Figure 4.7). Figure 4.8 shows huge urban/rural differences by level of education; the proportion of elderly within region indicates that more than double the elderly in urban area are educated; which is 20 percent and 46 percent respectively. The breakdown in the level of education shows that; the average urban/rural gap increases with the increase in level of education (see Figure 4.8).

**Figure: 4.7 Percent Elderly Population by Level of Education**

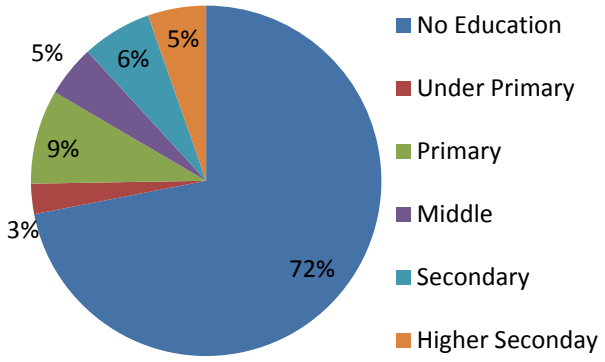
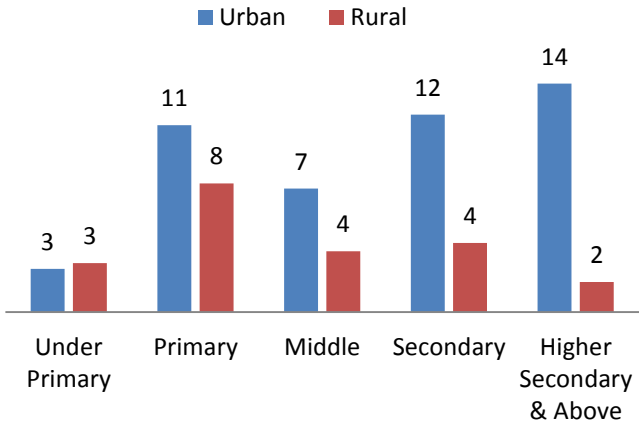



**Figure: 4.8 Percent Elderly Population by Level of Education and by Region**




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

### 4.4.1 Provincial Differences

Elderly is each province are mostly uneducated. The Figure 4.9 is representing the percentage distribution for provincial difference for uneducated elderly in Pakistan. The illiteracy rate is highest for Balochistan which is 89 percent followed by KPK 79 percent, Punjab 72 percent and lowest for Sindh 66 percent. This high level of illiteracy rates for elderly population in Pakistan are very challenging for state to form such polices for their health protection which considers their deprivation of understanding things which are possible if only being educated.

**Figure: 4.9 Percent Elderly Uneducated by Province**

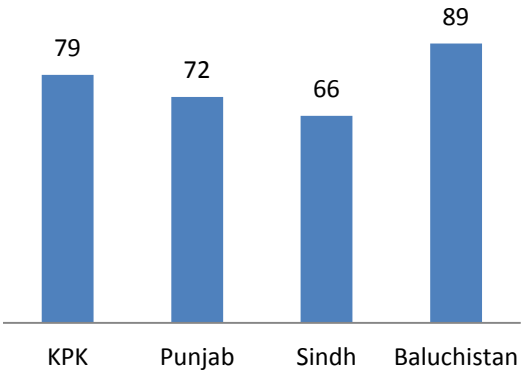
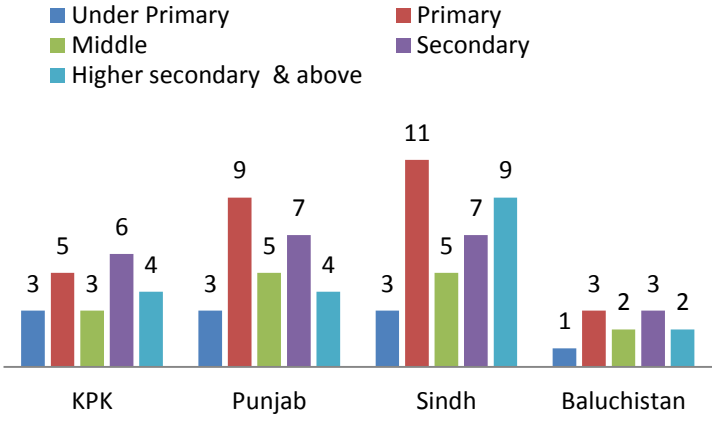



**Figure: 4.10 Percent Elderly by Level of Education and by Province**




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

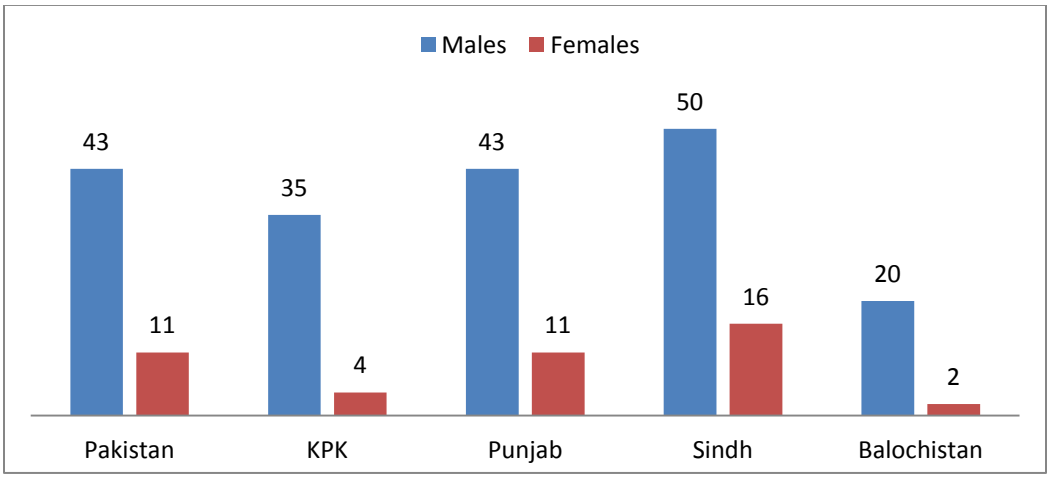
The elderly in all four provinces who are educated mostly have less than secondary education. The provincial differences for level of education among elderly population in Figure: 4.10 show that out of total elderly population in KPK 3 percent are under primary, 5 percent have primary education, 3 percent middle, 6 percent secondary, and only 4 percent elderly have higher secondary & above education. In Sind province 11 percent elderly have primary education, 9 percent have higher secondary and above, 7 percent secondary, 5 percent middle, and 3 percent are under primary. The comparative figures for Punjab are 3 percent under primary, 9 percent primary, 5 percent middle, 7 percent secondary, and 4 percent higher secondary and above.

The rates for level of education in Balochistan are lowest among other provinces where only 1 percent elderly were under primary, 3 percent primary, 2 percent middle, 3 percent secondary and 2 percent higher secondary or above. The sum of level of education for any province in figure 4.10 plus the percent figures for same province in figure 4.9 makes it 100 percent.

**Gender Differences**

There is a huge educational gap between elderly males and females in Pakistan. Among elderly males 43 percent are educated nationally while females are just 11 percent. This gap varies among provinces; in KP 35 elderly men are educated while elderly females are just 4 percent making the biggest gape among provinces. Punjab has second highest literacy rates for both men and women 43 percent and 11 percent respectively following Sindh with 50 percent males and 16 percent females(Figure 4.11).

**Figure: 4.11 Percent Elderly Educated by Gender and by Province**




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

**4.5 Economic Profile**

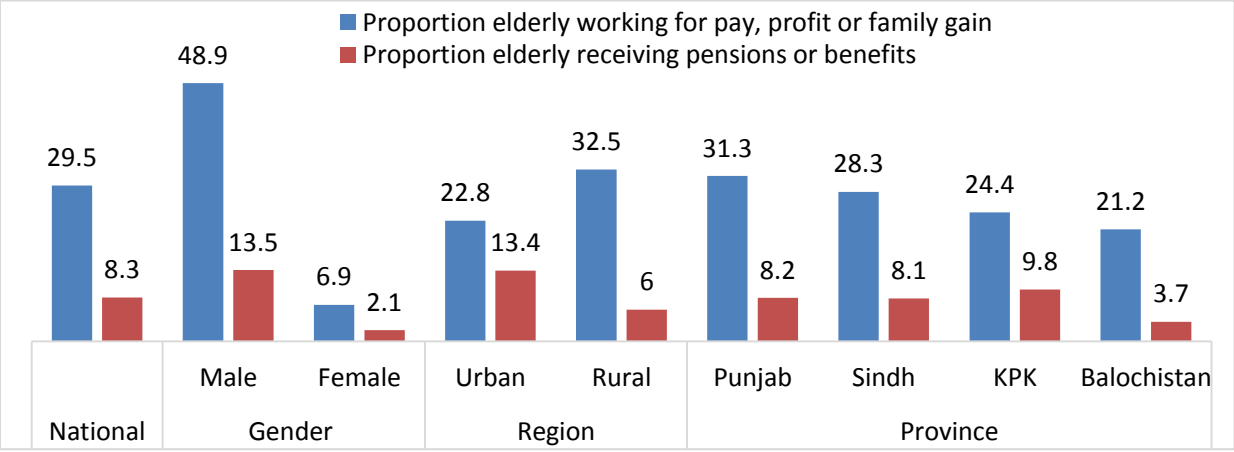
As stated in the introduction of this chapter economic profile in this study shows proportion of elderly working and not working, this profile also includes the occupational status of elderly who are working and their amount of monthly income. This profile gives an idea about the ability to pay by elderly for their health care.

### 4.5.1 Income and Employment status

The employment and income status of the elderly in Pakistan, shows high level of poverty. A very small proportion of elderly is getting any pension (8 percent) or working for pay, profit or family gain (29.5 percent) at country level. The gender difference is very striking, a very small proportion of elderly males receive any pension or benefits (13.5 percent), elderly females have very negligible proportion of just two percent. Forty nine percent of elderly males are working while among elderly females this proportion is just seven percent.

In rural areas, the proportion of elderly working is higher than urban areas; in urban areas the proportion receiving any pension or benefits is higher than rural areas. Only six percent of elderly in rural areas receive a pension or any benefits. The trends of elderly working at the provincial level shows variations with 31.5 percent working in Punjab, followed by Sindh (28.3 percent), KPK (24.4 percent) and Balochistan (21 percent). The proportion of elderly receiving pension or benefits is higher in KP (10 percent) followed by Punjab (8.2 percent), Sindh (8.1 percent) and Balochistan (3.7 percent) (see Figure: 4.12).

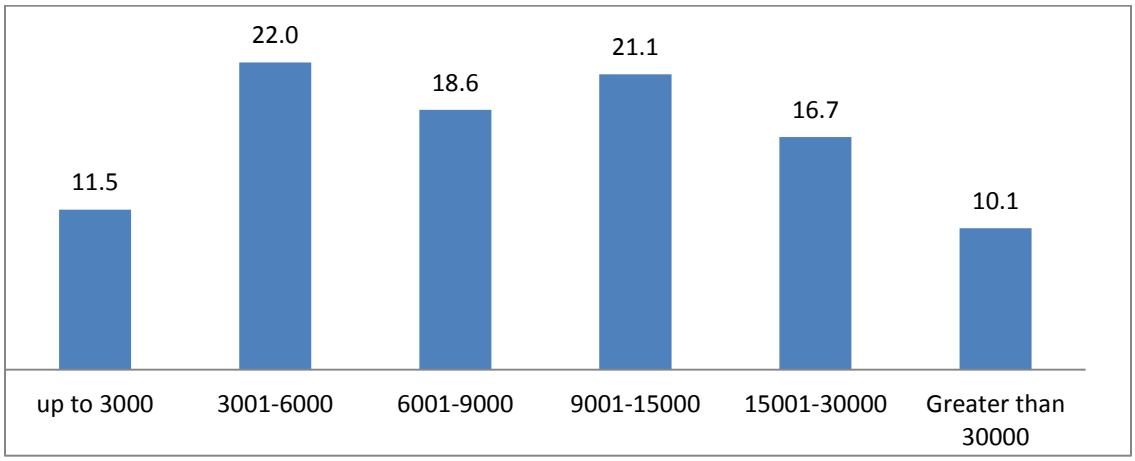
**Figure: 4.12 Proportion elderly working for pay, profit or family gain and proportion elderly receiving pension by Sex and Province**




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

As stated in section 4.4.1 the elderly getting any pension or working for any pay on monthly basis are just 29.5 percent. The distribution of elderly by their level of monthly income shows majority of elderly receives less than ten thousand rupees ($100) a month. Around twelve percent of the elderly receive up to three thousand rupees ($30) a month and twenty two percent receive more than three thousand up to six thousand rupees ($300-$600).In a same way income distribution is shown in Figure 4.13.

**Figure: 4.13 Percent distribution of elderly by monthly income**

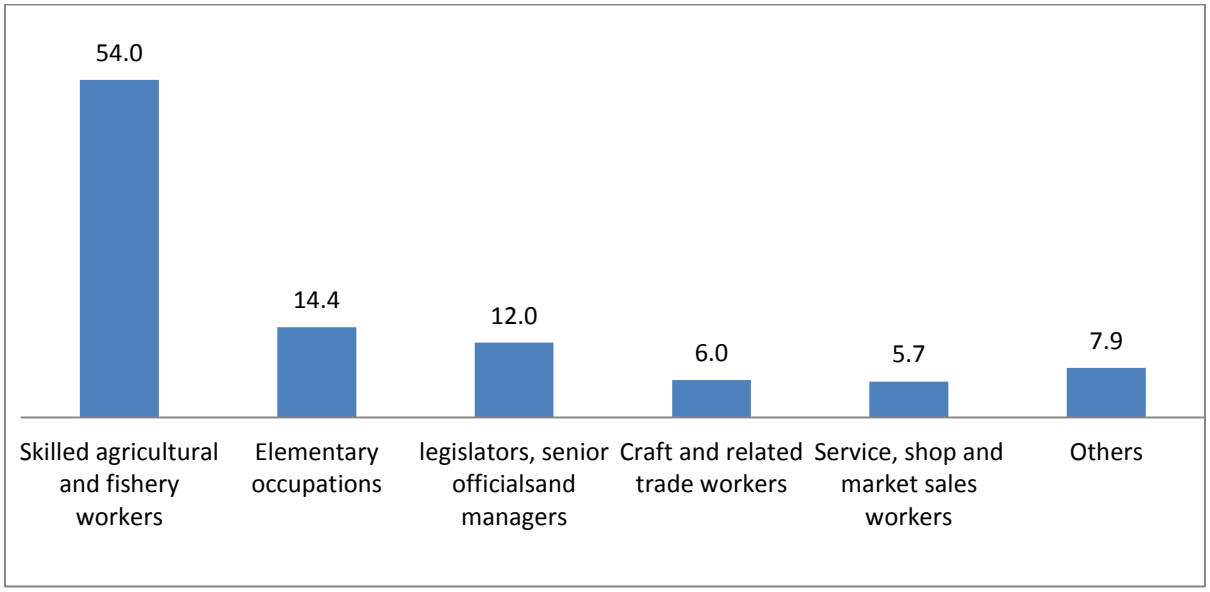



*Source: Pakistan Social Living Measurement Survey (PSLM) 2012-13*

### 4.5.2 Occupations of working elderly

Occupation of elderly is closely associated with their health status. The percent distribution of elderly by occupation groups show that in Pakistan majority of the working elderly fall in the group of skilled agricultural and fishery workers (54 percent). The second highest occupational group of elderly population is elementary occupation (14 percent), followed by legislatives, senior officials and managers (12 percent), craft and related trade workers (6 percent) and service, shop and market sales workers (5.7 percent). 7.9 percent of the working elderly fall in other occupational groups (Figure 4.14).

**Figure: 4.14 Percent distribution of elderly by Occupational Groups**




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

## 4.6 Chapter Summary

This chapter was written with the purpose of showing a complete socio-economic and demographic profile of elderly population in Pakistan. The profile exhibits very poor status of socio-economic indicators; although life expectancy is increasing with the advancements in medical sciences but poor socio-economic backgrounds make elderly very vulnerable in the society.

# Chapter: 5

# Results of the Quantitative Study: Impact of Socio-Economic Variables on Health Status and Health Seeking Behavior

## 5.1 Introduction

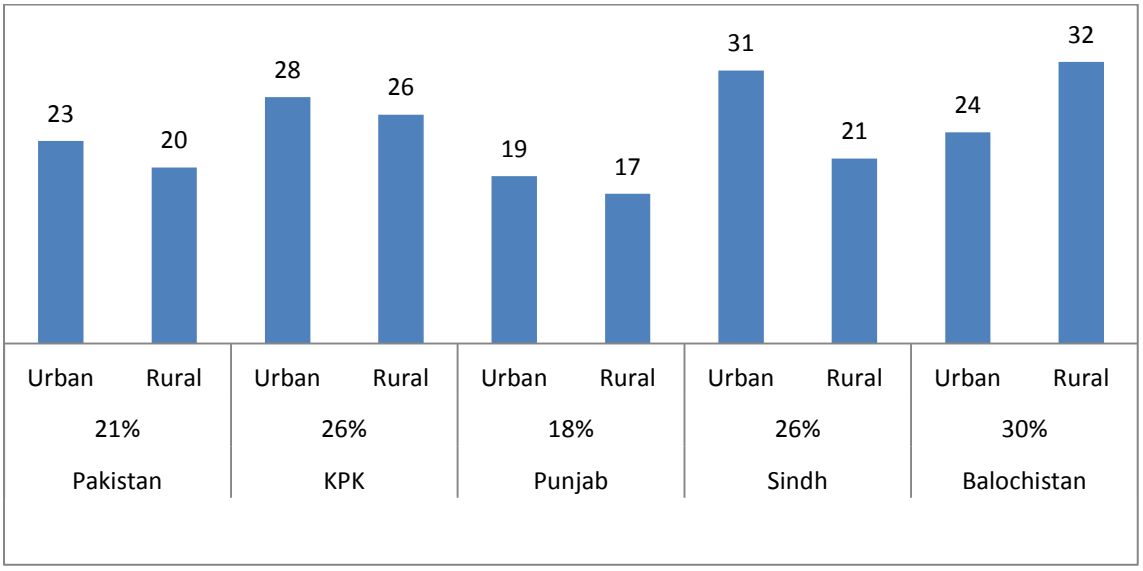
This chapter presents the findings of the quantitative study on the impact of socio-economic variables on health status and health seeking behavior of the elderly in Pakistan. The socio-economic variables selected in this study are; region, gender, marital status, source of drinking water, education, employment, Income and occupation. Looking at the level of impact of these variables on health status and health seeking behavior, will help in finding out the area of high interest to be focused from policy perspective. This chapter also presents the findings regarding the quality of care and level of satisfaction after receiving the health care from both public and private sector. The findings in this chapter also support the findings of previously conducted researches on elderly in Pakistan, mainly by Ul Haq (2012a, 2012b) and Mubashir and Kiani (2003), discussed in chapter 2.

## 5.2 Regional differences in health status of elderly

According to results of this study of 21 percent elderly in Pakistan got sick or injured in Past two weeks preceding the survey. Figure: 5.1 shows the provincial and regional variations for this variable where Balochistan has the highest figure (30%) followed by Sindh and KPK (26 % each) and Punjab with lowest percentage (17 percent) for elderly reporting sick in past two weeks. Unlike Balochistan the urban rural differences show that elderly in urban areas are more vulnerable to become sick as compared to elderly in rural areas. Figure: 5.2 shows the gender

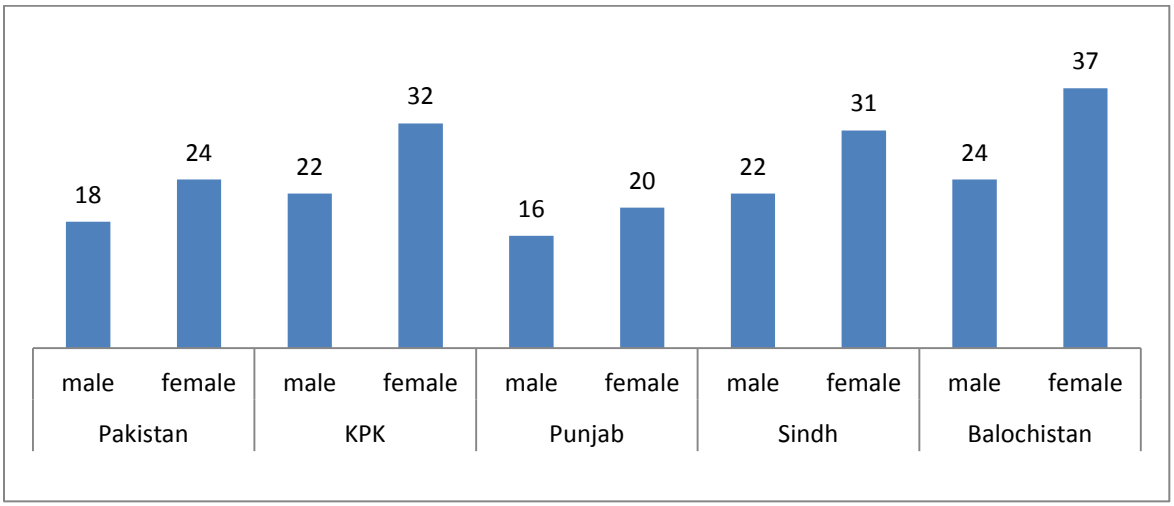
differences by region where elderly females are more vulnerable to become sick as compare to elderly males in each province. Around 37 percent of the elderly females in Balochistan got sick; highest among all provinces while Punjab has the lowest rate which is 20 percent (see Figure 5.2).

**Figure: 5.1 Percent elderly got sick in past two weeks by region and by urban/rural**




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

**Figure: 5.2 Percent elderly got sick in past two weeks by region and by gender**



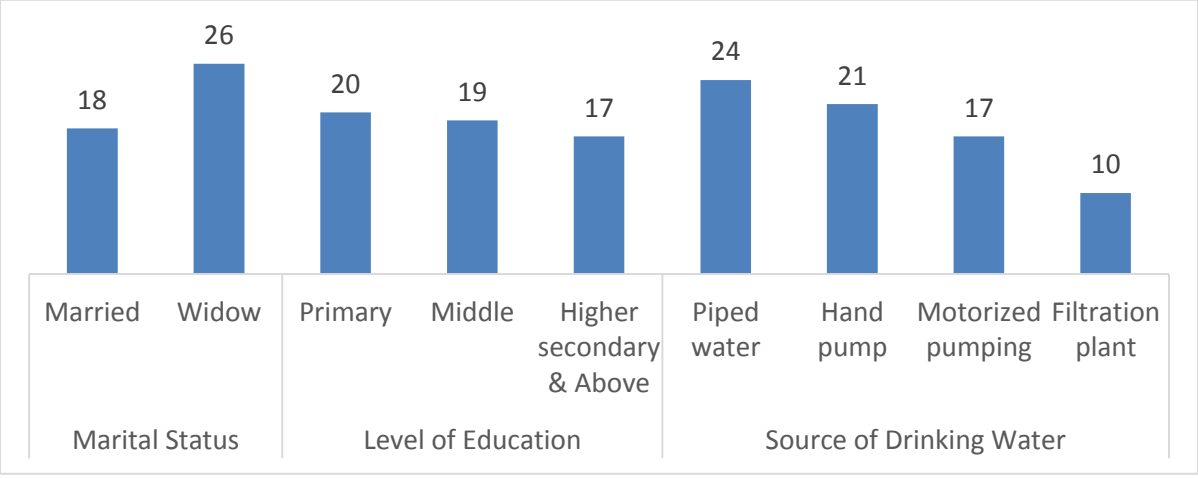

*Source: Pakistan Social Living Measurement Survey (PSLM) 2012-13*

### 5.3 Health status of elderly among social sub-groups

The social subgroups are closely association with health outcomes, marital status of ageing population in Figure: 5.3 indicate that widow elderly in Pakistan are too much vulnerable to illness and poor health as compare to married elderly. Around 26 percent of widow elderly got ill in just past couple of weeks preceding the survey, followed by married elderly with 17.7 percent. Level of education is also found to be effective in terms of health outcomes. There is negative relation between level of education and getting sick; the elderly with primary education more vulnerable to become sick (20 percent) as compare to high educational groups.

Safe drinking water is the prime concern of healthy life therefore the health protection of elderly population demands for safe drinking water. The impact of available source of drinking water on health of elderly population is very strong. Safer the source of drinking water more the health of elderly population will be protected. The elderly who drink safe water like from filtration plants are less vulnerable to become sick (10 percent) and more vulnerable if they drink piped water (24 percent) (see Figure 5.3).

**Figure: 5.3 Percent elderly got sick in past two weeks by Social Subgroups**



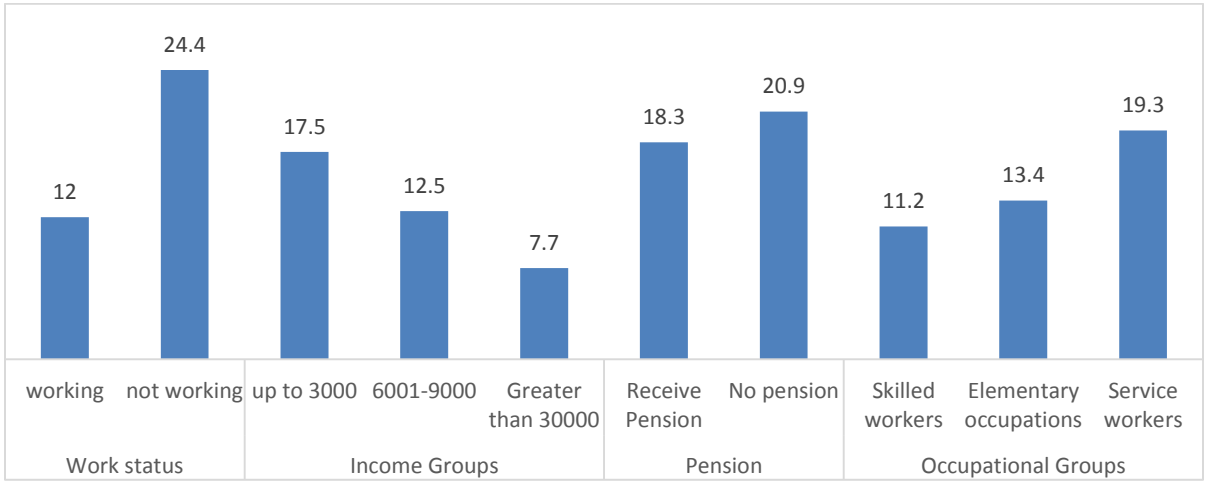

*Source: Pakistan Social Living Measurement Survey (PSLM) 2012-13*

### 5.3.1 Elderly's' Economic Background and Health Outcomes

The elderly population in Pakistan working for any income was found to be less at the risk of getting sick than those who do not work. According to the findings of this study relating work status (Figure: 5.4) 12 percent of working elderly got sick in last month while this percentage is double 24 percent for the non-working elderly. The income of elderly has a strong impact on their health. The results of this study show that as the level of income increases the proportion of elderly getting sick decreases. 17 percent of elderly got sick in past two weeks whose income was just up to three thousand rupees a month, while only 8 percent got sick with monthly income of thirty thousand rupees or greater

The elderly who receive pension or benefits are less likely to get sick (18 percent) as compare to those who do not receive pension (21 percent). The impact of occupation on the health of ageing population demonstrates variations. Among occupational groups the least vulnerable group is skilled workers. Among this group 11 percent elderly got sick in past two weeks. The most vulnerable group to get sick is that of service workers (19 percent) (see Figure 5.4).

**Figure: 5.4 Percent elderly got sick in past two weeks by Economic Subgroups**



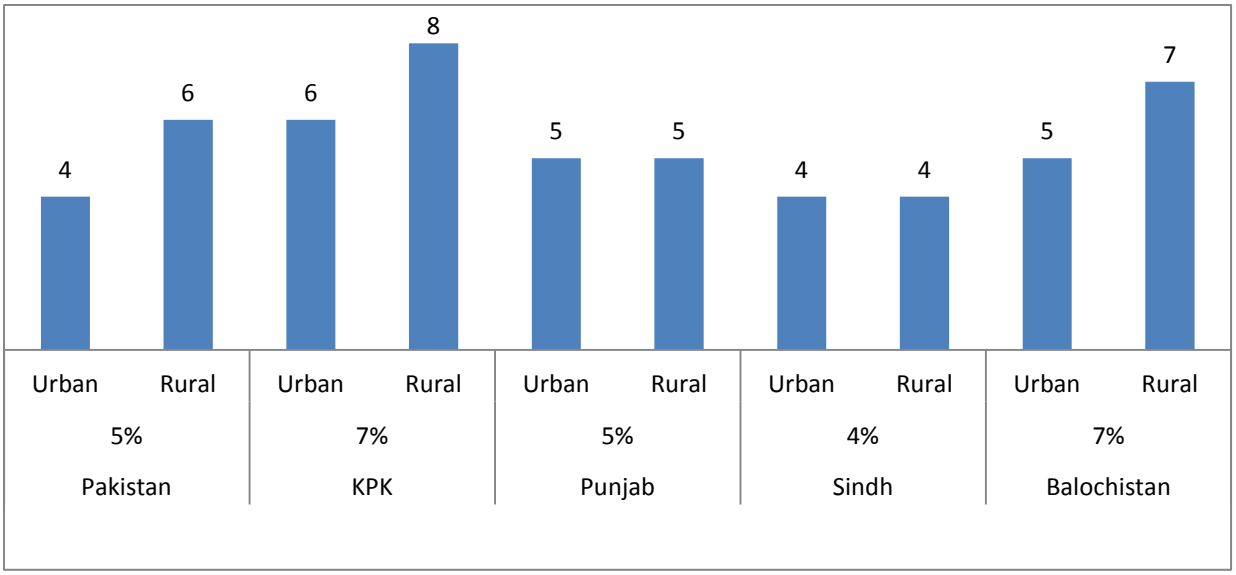

*Source: Pakistan Social Living Measurement Survey (PSLM) 2012-13*

### 5.4 Health Seeking Behavior of Elderly Population

The findings of this study show that 5 percent of the elderly in Pakistan did not consult for treatment even for a single time when they got sick (see Figure: 5.5). The statistics is highest in KPK and Balochistan with 7 percent each, followed by Punjab (5 percent) and lowest being in Sindh with 4 percent. The urban rural differences at national level show that 6 percent of elderly in rural areas did not consult for treatment when got sick as compare to 4 percent in urban areas.

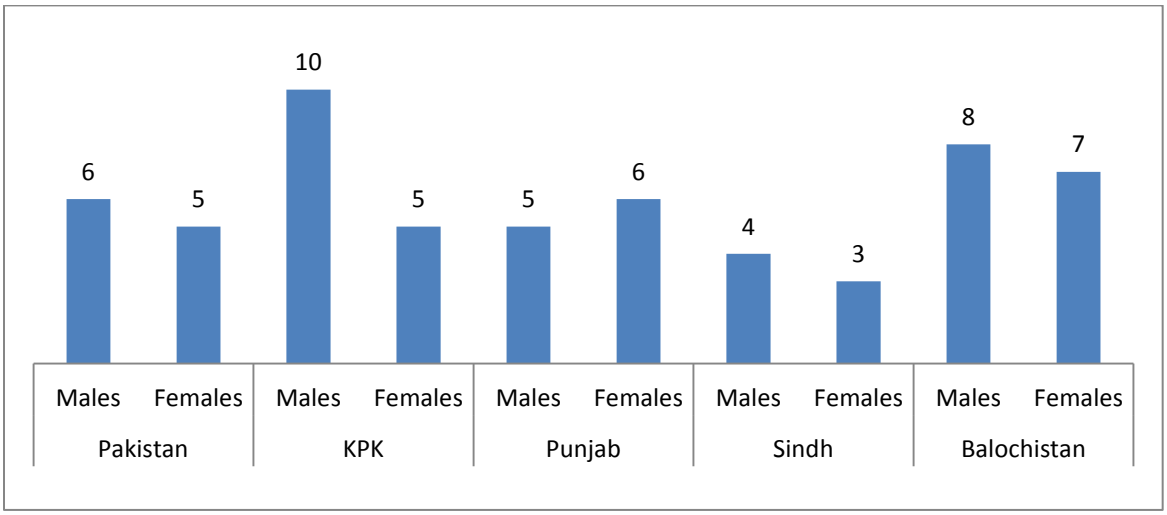
In rural KPK and Balochistan elderly are less likely to health consultation as compare to respective urban area, In Punjab and Sindh there is no urban rural difference (see Figure 5.5). Gender differences in health consultation (see Figure 5.6) show that elderly males are less likely to health consultation as compare to elderly females. Unlike Punjab provinces have the same trends as well.

**Figure: 5.5 Percent elderly did not consult for treatment by province and by urban/rural**




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

**Figure: 5.6 Percent elderly got sick and didn't consult for treatment by region and by Sex**

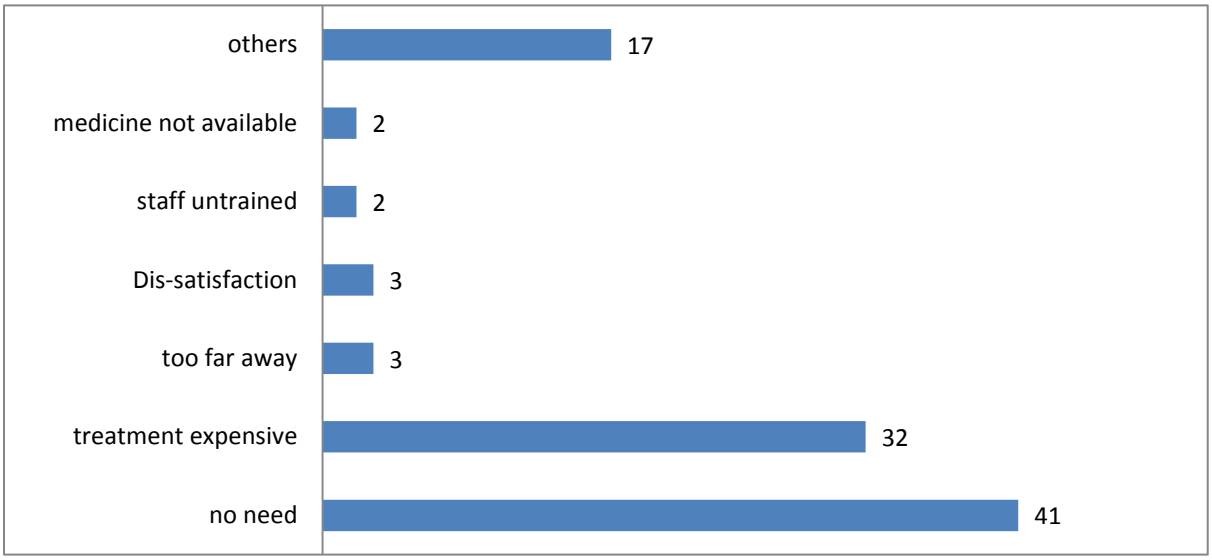



*Source: Pakistan Social Living Measurement Survey (PSLM) 2012-13*

### 5.4.1 Reasons for no Consultation with health Provider

The elderly state different reasons for not consulting any health provider for care (Figure: 5.7). One of the main reasons is lack of awareness among elderly about consulting for health care when they got sick, as 41 percent stated they did not consult for treatment because there was no need for it. The second main reported reason by elderly population for not consulting is expensive treatment 32 percent.

**Figure: 5.7 Reasons for no Consultation with a Health Provider by the Elderly in case of need**




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

The reasons for not consulting health care providers by elderly who got sick have also been extracted at the provincial level (Table: 5.1). Each province shows different tends for reasons of no health care consultation. Looking at KPK province we find majority of the elderly who did not consult for health care stated that there is no need for such consultation (57 percent). The second main reason is expensive treatment reported by elderly (26 percent). In Punjab the main reported reason was no need for consultancy (44 percent) followed by expensive treatment (34 percent). In Sindh other reasons were highly reported (41 percent) but most dominant reason in Sindh was expensive treatment (30 percent). Majority of elderly in Balochistan did not consult health care provider because of expensive treatment (60 percent) (see Table 5.1).

**Table: 5.1 Reasons for not consulting when got sick by Sex and Region (%)**

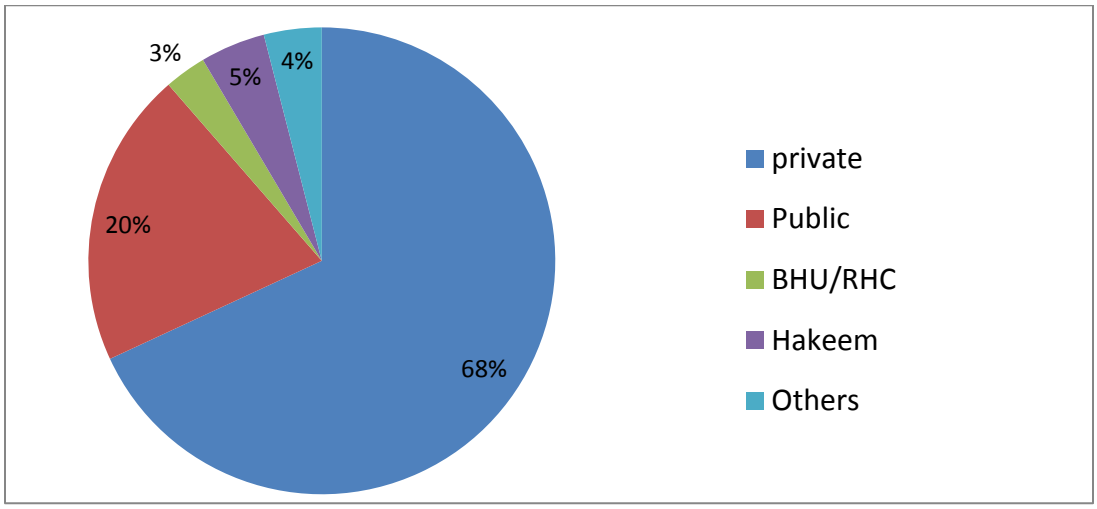
| | No need | Treatment expensive | Too far away | Dis-satisfaction | Staff untrained | Medicine not available | Others | Total |
|---|---|---|---|---|---|---|---|---|
| **Gender** | | | | | | | | |
| male | 39 | 31 | 2 | 5 | 1 | 4 | 18 | 100 |
| female | 43 | 34 | 4 | 1 | 2 | 1 | 15 | 100 |
| **Province** | | | | | | | | |
| KPK | 57 | 26 | 3 | 3 | 1 | 2 | 8 | 100 |
| Punjab | 44 | 34 | 2 | 2 | 3 | 3 | 12 | 100 |
| Sindh | 17 | 30 | 5 | 7 | 0 | 0 | 41 | 100 |
| Balochistan | 22 | 60 | 10 | 0 | 0 | 1 | 7 | 100 |
| **Place of Residence** | | | | | | | | |
| Urban | 40 | 26 | 0 | 4 | 1 | 0 | 29 | 100 |
| Rural | 42 | 35 | 4 | 2 | 2 | 3 | 12 | 100 |
| **Total** | 41 | 32 | 3 | 3 | 2 | 2 | 17 | 100 |

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

### 5.5 Source of Health Consultation by Elderly

The results show that majority of elderly went to private sector for health consultation when they got sick (68 percent), the reaming consulted public sector (20 percent), BHU/RHC (3 percent), Hakeems (5 percent) and other sources (4 percent) (see Figure: 5.8).

**Figure: 5.8 Percent distribution for source of health consultancy by elderly who got sick (National Level)**




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

### 5.5.1 Source of Health Consultation by Subgroups

The percentage distribution for **provincial differences** in source of health care consultation in Table: 5.2 indicate that majority of elderly in all four provinces go to private sector for health consultation. Punjab has the highest proportion of elderly who go to private sector (72 percent) followed by Sindh (70 percent). The proportion of health consultation from government sector is highest in Balochistan (29 percent) and lowest in Sindh (16 percent). From the perspective of **gender** and **marital status** there is no such difference in source of health care consultation. Elderly males and females either married or widows have almost same proportion for consultation from private and public sector (68 and 21 percent) (see Table 5.2).

.

**Table: 5.2 Distribution for source of health consultancy by elderly who got sick by subgroups (%)**

| | Private dispensary/ hospital | GovtDisp/ Hosp | BHU/ RHC | Hakeem | homeopath | chemist | others | Total |
|---|---|---|---|---|---|---|---|---|
| **Province** | | | | | | | | |
| KPK | 56 | 28 | 8 | 1 | 1 | 6 | 0 | 100 |
| Punjab | 72 | 20 | 1 | 4 | 1 | 2 | 0 | 100 |
| Sindh | 70 | 16 | 3 | 7 | 3 | 1 | 0 | 100 |
| Balochistan | 49 | 29 | 6 | 13 | 0 | 2 | 1 | 100 |
| **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 |

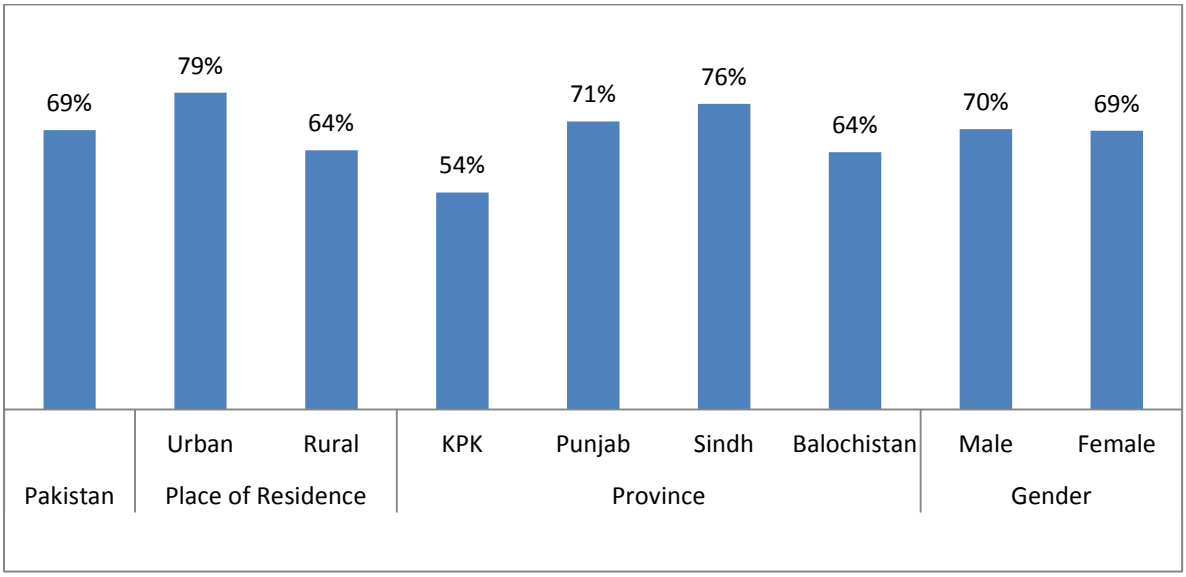
*Source: Pakistan Social Living Measurement Survey (PSLM) 2012-13)*

Despite the difference in **Income** levels of elderly majority go to the private sector for health consultation, however the average proportion of consultation from private sector increases with increase in **level of income**. At every **level of education** most of the elderly go to private sector for health consultation however again the average proportion of consultation from private sector increases with increase in level of education (see Table 5.2).

### 5.6 Level of Satisfaction with Health Consultation

The findings of the study show that quiet a high proportion of elderly population in Pakistan is not satisfied with the health consultation. About 31 percent at national level were not satisfied with the health consultation when they consulted the health care provider. The provincial level differences for satisfaction with health consultation shows lowest level of satisfaction in KPK (54 percent) followed by Baluchistan (64 percent) and Punjab (72 percent), elderly in Sindh had the highest level of satisfaction (24 percent) (Figure: 5.9). The urban elderly are more satisfied with health consultation as compared to their rural counterparts, 79 percent and 64 percent respectively: Gender has no difference in their level of satisfaction. These high levels of dis-satisfaction with health consultation show poor quality of health services provided to elderly population in Pakistan.

**Figure: 5.9 Level of Satisfaction with Health Consultation by Subgroups (% Elderly**

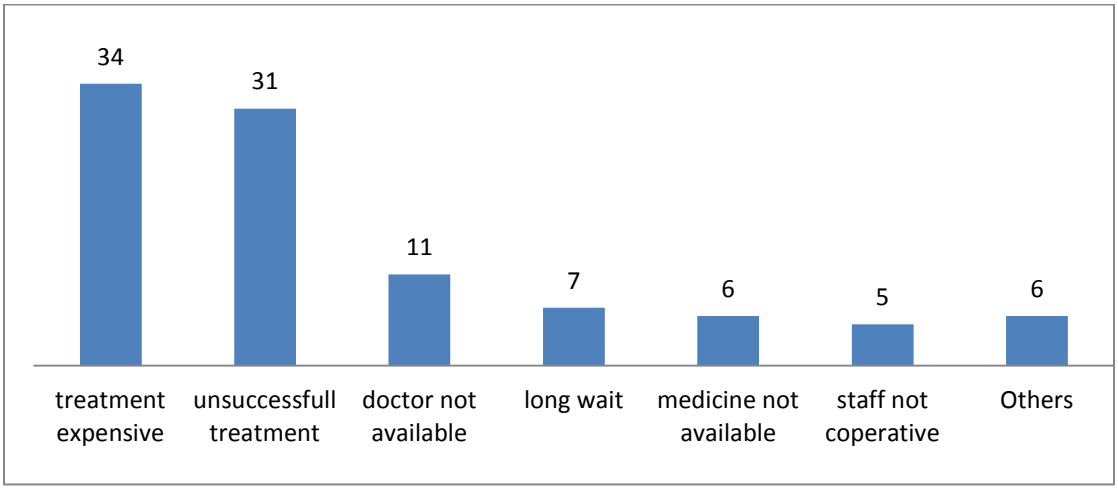



*Source: Pakistan Social Living Measurement Survey (PSLM) 2012-13*

## 5.7 Reasons for Dissatisfaction with Health Consultation

Expensive treatment is the major reason reported by elderly for dissatisfaction with health consultation (34 percent); unsuccessful treatment was the second major reason reported by elderly (31 percent). The other reasons were reported as 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 5.10).

**Figure: 5.10 Reasons for Dissatisfaction with Health Consultation (% Elderly)**




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

### 5.8 Reasons for Dissatisfaction by Sex, Region and Source of health Consultation

The reasons for dis-satisfaction of the elderly population from health consultancy by subgroups reveal 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 Punjab where the major reason was unsuccessful treatment. The elderly in Sindh reporting expensive treatment as major reason have highest proportion (50 percent).

In urban areas expensive treatment is the major reason (44 percent) but in rural areas unsuccessful treatment remains the major reason of dis-satisfaction from health consultation (32 percent). The source of health consultation shows elderly with health consultation from public sector report doctors' unavailability as the major reason of dis-satisfaction (22 percent). The elderly who had a health consultation with private health care provider report expensive treatment as the major reason of dissatisfaction (43 percent) (see Table 5.3).

**Table: 5.3 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 |
| **Province** | | | | | | | | |
| KPK | 32 | 26 | 18 | 7 | 7 | 6 | 5 | 100 |
| Punjab | 27 | 42 | 9 | 8 | 3 | 4 | 7 | 100 |
| Sindh | 50 | 17 | 8 | 4 | 6 | 9 | 6 | 100 |
| Balochistan | 33 | 6 | 18 | 8 | 4 | 16 | 15 | 100 |
| **Region** | | | | | | | | |
| Urban | 44 | 30 | 8 | 6 | 5 | 4 | 3 | 100 |
| Rural | 30 | 32 | 12 | 7 | 5 | 7 | 7 | 100 |
| **Source of health care 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

## 5.9 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 in to 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 5.4 using Level of Significance and Odd Ratios. The results 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 in rural. By marital status, married elderly are 0.5 times more likely to get sick than widows. As compare to Balochistan 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 are less likely to get sick. Elderly who receive pensions or benefits are 0.7 times less likely to get sick as compare to elderly who do not receive any pension or benefits. By source of drinking water, elderly who use motorized pumping water, are more less likely to get sick, while those who use piped water are more vulnerable to get sick. Increase in level of educations has a strong impact on health status of elderly, with the increase in level of education, elderly are less likely to get sick. As compare 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. Occupational status shows, as compare to elementary occupations, elderly 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 health status of elderly.

**Table: 5.4 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 |
| **Provinces vs. "Balochistan"** | | .000 | |
| Punjab | -.047 | .469 | .954 |
| Sindh | .350 | .000 | 1.418 |
| KPK | -.069 | .322 | .933 |
| **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*

## 5.10 Summary

The findings of quantitative study provided the evidence for poor social health protection of elderly in Pakistan. There is no any concept of geriatrics in Pakistan which is a broad area of health sector in western countries. Health Insurance is another missing part that is unknown to majority elderly. In Pakistan only eight percent of elderly receive pensions or benefits (PSLM 2012-13) and the amount of these pensions or benefits are insufficient to meet the basic needs of elderly. Socio-economic background matters a lot as we can see in the results that, higher the level of education less the chances of getting ill, in the same way higher the level of education higher the awareness about health care utilization. A high proportion of elderly even do not consult for treatment when they get ill. Those who consult health providers mostly go to the private sector. This indicates the poor health care service delivery at government level. The satisfaction level after consultation is also high at private sector. Family care is the only main source for health protection of elderly in Pakistan as stated in the previous chapter. The qualitative study in the next chapter based on the in-depth interviews of health care providers has provided enriched findings and complete picture of social health protection status in Pakistan.

# Chapter: 6

# Qualitative Study

# Providers' Perspective on Social Health Protection of Elderly in Pakistan

## 6.1 Introduction

This chapter presents the findings of the qualitative study regarding the health care providers' perspectives on health status, health seeking behavior, social and state level arrangements for social health protection of the elderly in Pakistan. The providers' recommendations for the social health protection of elderly and the challenges to providers while tackling elderly are also captured in this study. The qualitative study was conducted with the purpose of getting the missing information in quantitative; however to a great extent, the findings of the quantitative study regarding the social health protection of ageing population in Pakistan are also supported by the findings of the qualitative study. As stated earlier in the section on thesis methodology, the health care providers were interviewed from both public and private hospitals to see the difference if any regarding indicators listed earlier.

## 6.2 Health Status of Elderly from Provider's Perspective

When the interviewed health care providers were asked about the health status of elderly based on their examinations, most of the providers said health status of elderly is mostly poor. Some providers from private sector said elderly have better health status but public sector health providers consider very poor health status of elderly. The elderly who worked in government sector like in army have good facilities for their health care. There are military hospitals for them

where they get free treatments. The people who have not worked in any government sector and especially those living in villages are very vulnerable to poor health.

According to health care providers the state of both mental and physical health of elderly is poor. The socio-economic backgrounds determine the health status of elderly. Distance from health facility is another important indicator of elderly's health. According to health care providers elderly who come from far-flung areas are mostly in critical state of health as compare to elderly who live near health facility. All the providers have a common consensus that improvement is possible even within the present setup of health service delivery. Increase in resource will further bring improvements.

> *"The health status of elderly would be better, I'm not saying it's all that bad, but improvement would definitely come". Female nephrologist, age: government hospital*
>
> *"In our country not only the ageing population but every ones health conditions are not better". Male orthopedic surgeon, age: 40, private hospital*
>
> *"The elderly who come to hospital from areas nearby; are found to be at initial stage of disease but elderly who come from far-flung areas their health situation becomes worse". Female nephrologist, age: 50 years, government hospital*

Some Providers stated that there is lack of data about elderly's health in Pakistan therefore it is difficult to say something about their health status. Some providers closely linked the health status of elderly with their economic and social background. According to health care providers some of the elderly even do not go for health care at the time of illness; the quantitative study also reported a valuable proportion of elderly not having health consultation when they get sick (5 percent). One of the public sector health care providers considers a moderate health of elderly based on the joint family system in Pakistan. Another health care provider from private sector has a perspective that there is improvement in general but lot is left to be desired. There is

improvement compare to previous generations 50 years ago because the life span over the decades has increased. Increase in life span means there is improvement.

> *"We don't have any such data that would tell us the health status of 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 but stay at home". Female nephrologists, age: 50 years, government hospital.*

> *"Now there is media to create awareness therefore patients come from country side to cities for medical treatment; if they do not have money they borrow from someone". Male consultant surgeon, age: 81, private hospital*

### 6.3 Awareness on health care utilization among Elderly

The health care providers when asked about the awareness of elderly on health care utilization, most of the providers are of the opinion that most of the elderly are less aware of their proper health care. Unless there is any severe problem; they do not go to the doctor and ignore the illness. Only the educated and rich elderly have some awareness about what are the precautions and preventive measures to follow when they suffer from any illness. Poor and uneducated remains vulnerable to poor health all the times.

> *"The educated have awareness but not the poor class. The Rich people who come to us; know everything about their medicines and health care so they have proper awareness". Male CMO, (causality medical officer), age: 28, private hospital*

> *"Absolutely there is no awareness apropos healthcare among elderly. There should be special programs to create awareness among elderly, especially about their diet and health care". Male orthopedic surgeon, age: 40, private hospital*

The providers who consider elderly as aware of their health care; have different point of views to support their observations. They compare the elderly in this era with previous generations. The increase in life expectancy now gives the evidence of better health care utilization among

elderly. The most important determinant of better health care utilization is monetary power. Secondly education creates awareness about health care utilization.

Educated and rich elderly take good care of themselves like testing their diabetes; they have machines at homes, have awareness for skin care as well which was not there before. If elderly have no money then they go to hakeems or religious people. The elderly who have some more money go to homeopaths. One of the provider said if elderly have no debilitating disease which makes them dependent upon someone then they can take their own care. These elderly are very conscious about their health. They want to come to the hospital when feel ill or unhealthy, they are very well aware of what to be done when got sick.

> *"I think it is same all over the world. Everyone tries to keep themselves in an optimal state, no one deliberately harm themselves. They are quite aware of their health care and they care themselves as per their resources". Female dermatologist, age: 35, government hospital*
>
> *"Awareness is like fifty fifty. It also varies through education; educated people know enough how to take their own care. Those who are not literate do not have that much awareness". Male physiotherapist, age: 40, government hospital*

Some health care providers are of the view that elderly consider themselves to be less important and 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 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 provider said in our budget we include house rent, utility bills, food expenses, and educational expenses. In that budget we do not keep any share for health proportion. Our mindset as a nation is like this is 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 in such stage of age where they consider themselves to be less important for their families. Few of them are very good but this is like one in a thousand. Male physician (medicine), age: 38, government hospital*

### 6.4 Socio-Economic Issues of Elderly from Providers Perspective

The socio-economic issues faced by elderly in Pakistan are enormous. Based on the interviews with health care providers, this study finds that elderly in Pakistan are neglected part of age strata. There are no any arrangements for elderly for their social health protection. Most of our elderly population lives in rural areas; family is the only source for social health protection 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 qualitative study are supported of quantitative study as well.

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

*"Western people send their elderly to old homes now the same trend has started here in Pakistan". Male dermatologist/venereologist, age: 45, private hospital*

*"When I used to work in military hospital (CMH), the OC CMH used to tell us that do not admit any elderly on weekends until there is any genuine case, people have started a fashion that if they have to go somewhere on weekend, they admit their elderly in CMH". Male dermatologist/venereologist, age: 45, private hospital*

*"At state level elderly are neglected part of age strata; they are only taken care 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 could take elderly to hospital and if there is someone who can bring them to hospital then the 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 hospital. Degenerative diseases are mostly costly therefore poor elderly are unable to meet the expenses of expensive treatments.

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

> *"The social security system is not here, therefore the poor people come to hospital when the treatment becomes compulsory, otherwise they do not give importance to minor illnesses and do not spend money". Male physiotherapist, age: 40, government hospital*
>
> *'If we write something to buy from outside then that is a torture for patients, they insist for prescribing the medicine that is available within hospital". Female associate radiologist, age: 37, government hospital*
>
> *"We are sitting in a private hospital in Islamabad which is the most expensive hospital. We have elite class patients who have no as such issues. Even 80 to 85 years old elderly come to hospital themselves. They are financially strong so we do not have any issue" Male dermatologist/venereologist, age: 45, private hospital*

According to health care providers' perspective elderly care is not just about becoming ill and going to hospital but they need long term care because many people have multiple illnesses and many medications. The issues of nutrition are in all ages but it becomes more permanent at old age, there becomes deficiency of calcium and vitamins. Due to many reasons, as they are

dependent, some cannot prepare food for themselves, some cannot eat, and mostly have other problems like dementia.

> *"If for example someone has no children or not married and when they age then there is no one to take care of them. They themselves come to hospital; there is no one to support them". Male physician, medicine, neurologist, age: 40, government hospital*

> *Ageing population is totally thrown to side, they are just supposed to be stay at home just offering namaz (prayers) and go to receive the pension if government employee". Male physician, medicine, neurologist, age: 40, government hospital*

> *In our hospital there is no any such thing but there are some tests like hepatitis test which are free but for everyone. We personally have more regards for them as they are elderly". Female associate radiologist, age: 37, government hospital*

### 6.5 Source of Health Consultation

According to the health care providers government sector is lacking behind regarding the facilities and resources therefore elderly prefer to go to private hospitals. The quantitative study also revealed that most of the elderly go to private sector for health consultation (68 percent) and small proportion go to public sector (20 percent). Most of the elderly are poor and remain un-served, only the family care remains the hope and only source the elderly has family members. Most of the providers are of the view that joint family system is breaking down in Pakistan which was considered as the main source for elderly care. That is the reason state is also not considering any social health protection arrangements for elderly. Until our government setup will not give better health care facilities, the elderly will remain vulnerable to poor health because most of them being poor cannot afford private sector.

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

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

### 6.6 Elderly Diseases and health Issues

When the interviewed doctors were asked about the type of disease elderly are having in Pakistan; all the doctors reported diseases related to their field of specialization, in this way a lot of disease were reported but some diseases were commonly reported by all the sampled health care providers' (i-e)heart diseases, diabetes and bones related.

According to the providers elderly are surrounded by both physical and mental diseases. Among physical issues elderly have heart diseases; Parkinson's disease and diabetes, among mental health issues dementia patients are more in numbers. In dementia taking care of the patients is even more difficult, because dementia patients are totally dependent for care i- e. going to wash room, eating food and for many other life activities. One of the health care providers from physical medicine department of physiotherapy said that elderly most commonly have joints 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, and pneumonia and so on". Female nephrologist, age: 38, government hospital*

*"I think the current elderly diseases in Pakistan are same as western world. The diseases like cardiology diseases, diabetes, hepatitis, stone disease, kidney stones, and these all diseases are very common among elderly in Pakistan". Male urologist, age: 34, government hospital*

*"Elderly person has many constraints for example if older person fall ill there becomes chest infection, urine infection and clot in legs which are age related". Male urologist, age: 34, government hospital*

Gender of elderly also determines the types of degenerative diseases. The interviewed doctors also provide the sex related information apropos elderly diseases in Pakistan. One of the private sector health care provider said that among males gland prostate is very common while women have no gland prostate disease. Among female menopausal symptoms are more common, that means when their hormones stop it affect them so much causing night sweating and many other problems.

> *"Most of our elderly diseases or issues are age related changes in body like liver fatty, diabetes and hypertension. Secondly there is osteoporosis; very common among females, and other than that the changes come in bones. These all are degenerative disease". Female (associate radiologist), age: 37, government hospital.*

Malnutrition among elderly was reported by most of the doctors; the reason behind the poor health status and major illnesses. According to the providers malnutrition remains one of the major reasons of catching chronic illnesses. Due to malnutrition a diabetic patient in old age become too vulnerable. If any patient in old age is diagnosed as hypertonic then with the passage of time his hypertension becomes severe, because there is nobody to take care of his diet and his overall health. All the disease reported by healthcare providers so-far and associated factors like lack of resources for prevention and cure directly relates to social security of elderly.

### 6.7 Health Provider's challenges

This part presents the challenges of health care providers while providing health care to elderly. Majority of the providers said they have communication gaps with elderly. Most of the elderly do not understand what is been prescribed to them, it takes very long to communicate with then. While tackling elderly the other main problem is their physical health, most of the time they are physically weak. Other challenges are related to socio-economic background of elderly.

The challenges of male health care providers are almost same as female doctors. Regarding health system a non-serious attitude has been shown by the state. State has totally left ageing on family and by luck if their family is supportive then it is well and good but if not then they are so vulnerable.

> *"The elderly patients need sympathy, they are physically week". Male physician, medicine, neurologist, age: 40, government hospital*
>
> *"We face communication issue with elderly population. They don't understand what we are saying and prescribing". Female nephrologist, age: government hospital*

According to health care providers elderly who come to hospital without someone then it becomes stressful because elderly need support at different levels. There must be someone with them to make them understand especially about the medicine and diet prescriptions. Mobility is another issue especially from rural far-flung areas to cities for treatment. Time is another issue, we have to give them more time as compare to a young patients as it takes long time to examine them. Pocket power of elderly is another main issue faced by providers; if financial issues are resolved then the issue of family care emerges. According to health care providers treatment and medications are not enough; there must be nursing care to administer at specific time.

The lack of resources at providers' level is another main challenge while examining elderly. This is mainly the issue of public sector health care providers. Doctor to patient ratio is remains very high at private sector consequently the patients do not get proper time for examination. Public sector doctors are of the view that their hospitals have few doctors and more burdens. Elderly patients needs more time for their proper examination because their cognitive functions are not good and they do not understand properly.

Elderly are more sensitive like infants therefore they need especial care. They take too long to get recover from any illnesses. They have their own perceptions and expectations and want to be

treated the way they want. According to providers perspective elderly need proper Post-operative and pre-operative care. During operation everything needs to be 100 percent accurate because even for a small mistake the elderly has no ability to overcome while a younger person can easily overcome.

> *"The number of doctors at public hospitals is small even they are leaving the hospital". Male urologist, age: 34, government hospital*
>
> *"In our department we do not have CT and MRI which are mostly needed for elderly. We then have to refer them to other hospitals. Government has to set their priorities especially regarding elderly and their needs". Female associate radiologist, age: 37, government hospital*
>
> *"In ageing if any health problem happens then it takes time to recover; the health providers become stressful especially in operation". Male consultant surgeon, age: 81, private hospital*

Private sector health care providers do not face that much challenges as compare to government doctors, this is because the patients at private sector are mostly financially strong. The only issues in this category are related to old age disabilities. According to the health care providers elderly's brain has not that much capacity to understand what we say, they have eye sight issues, hearing issues and their immunity is weak. If he/she is from a wellbeing family where all things are available, kids are educated, elderly are educated, and then all these things become much better otherwise if a person has no money; falls in a circle of poverty.

Health care providers said that institutional connectivity of elderly has a strong impact on health protection of elderly whole life. Health insurance was considered as complicated by health care providers as it holds too many complications regarding illness to be covered and not.

> *"There are not that much challenges or issues while providing health care to elderly people. Here the elderly patients know about everything and are well-educated". Male CMO (causality medical officer), age: 28, private hospital*

### 6.8 Gender Differences in Elderly's Health Care Utilization

Most of the health care providers reported gender difference in health care utilization, public doctors answered elderly males come to hospital more frequently as compare to elderly females. Most of private providers answered other way round and some of them reported the equal frequency. The reasons were based on socio-economic background of elderly. According to one of public sector health care providers, at old ages females have less frequency of health consultation as compare to males but at younger ages females have higher frequency. Among social issues older females cannot go to hospital alone so this remains the traditional barrier. Public health care providers consider elderly females as ignorant about health consultation; they ignore the normal illness and only consult a doctor when the illness becomes severe.

> *"Elderly men come early on time, while female elderly come when the illness becomes severe. Elderly females have mostly serious conditions as compare to males". Female nephrologist, age: 38, government hospital*

### 6.9 Providers' Perspective on Social Health Protection of Elderly Population in Pakistan

The providers' perspective on the plight of social health protection for elderly in Pakistan is the most important part of qualitative study. This section tells us about what is happening at all levels and what the missing part is. When the doctors were asked about the status of social health protection system in Pakistan, all the doctors have common answer that the concept of social health protection for elderly is missing in Pakistan; elderly are totally neglected part at state level with no social security . At hospital level there are no specific arrangements for elderly like in western countries. The geriatrics concept is totally missing in Pakistan; doctors have their personal adjustments for elderly.

According to the providers the social health protection for elderly might be in documents but not practically implemented. We have not been able to generate resources or formulize any system to classify the elderly as per geriatric needs. The family system is the only source for providing elderly care which is still not sufficient as compare to developed countries. Most of the health care providers consider social health protection of elderly especially the single elderly as state's responsibility.

> *"If there is any single senior citizen then his/her social and health protection is the responsibility of the state. In western countries social health protection is provided by state because those elderly have spent their whole life for state and in return the state does payback. In Pakistan there is no any such concept". Male physician, medicine, neurologist, age: 40, government hospital*

In the absence of government institutions, some local social welfare organizations are trying to cover elderly but unserved elderly are much higher in numbers. The elderly in rural areas remain totally unserved. All the providers said at government level a separate institution for elderly is not there but non-governmental charities either belong to religious groups or social welfare groups basically provide for the poor and vulnerable groups like elderly. At government level there are not much funds available to provide adequate health care to elderly but government has its own limitations because people do not pay taxes in our country. If people will pay taxes then there will be enough money available for government to spend on social welfare of general public.

### 6.10 Financial Arrangements for Elderly

Financial arrangement is one of the main sources of social health protection; without economics this concept is incomplete. In Pakistan elderly are suffering a lot and the main reason is the absence of financial support in shape of pensions or old age stipends. In Pakistan a very small

proportion of elderly receive pension from government. Section 4.4.1 gives the statistics that only 8 percent of elderly receive any pension or benefits on monthly basis. In western countries every elderly either retired from any institution or not receive monthly stipends in the shape of social pensions but elderly in Pakistan are underprivileged from these benefits. One of the health care providers shared his personal observation that elderly age 65, 70 and even 75 go early morning at 6 o clock to collect their pension which takes them 12, to 2 pm in queue. The amount of pension they receive is only 2500, 3200 and 4500 rupees.

> *"Elderly receive very small amount of pension that has to be spent for a whole month while we spend same amount on one day meal. I am not satisfied with the elderly health care system in Pakistan". Male dermatologist/venereologist, age: 45, private hospital*
>
> *"There are no financial arrangements, even if government would expect something from elder". Male orthopedic surgeon, age: 40, private hospital*

One provider stated the reasons for lack of financial arrangements but also pointed out the pathways to get through this issue. According to the provider the situation is different in Pakistan. We are trapped by terrorism therefore we have to spend more money on security therefore health and education remains ignored. Still this situation could be better if people will pay taxes. There is a need to promote health insurance especially for the elderly who have no earning capacity. All of the health care providers have a common point of view that family remains the major source of elderly care in Pakistan.

### 6.11 Country Examples of Proper Social Health Protection System for Elderly

Almost every health provider presented the examples from western countries where ageing is a big topic because of high proportion of elderly in overall population. According to the providers we need to adopt the models of western countries to protect our elderly. Western countries have a complete setup of geriatrics which is totally missing in Pakistan. That is the main solid thing

that can be implemented in Pakistan. The other main important point picked from provider's perspective is taxes. Most of the providers emphasized that taxes are not been properly paid in Pakistan unlike western countries. Taxes make the State able to provide better social security nets to people. Western countries spend a big amount on social welfare including elderly. According to the providers west have big budgets to spend on welfare of public. Elderly receive their share in shape of pensions or old age benefits on monthly basis. The person who is paying tax should be given all types of benefit is future and west do same. We also pay tax but an elderly is not getting that much as he should get.

> *"In western countries there is elderly medicine center, their departments are separate, carers are separate and doctors are separate too, first of all these things need be implemented in Pakistan.*
>
> *West has too many taxes but they also give best social and health protection services". Male dermatologist/venereologist, age: 45, private hospital*

### 6.12 chapter's Summary

The interviews with health care providers make us to conclude in a way that the health status of elderly in Pakistan is mostly very poor. Elderly with strong socio-economic background have better health status but majority of the elderly are poor and uneducated. The government will have to start from the beginning for social health protection of elderly. First of all elderly have to be recognized as responsibility of State and secondly priorities need to be set. The concept of geriatrics is the most important aspect of elderly care to be introduced in Pakistan. Old Age benefits or social benefits and health insurance are second most important things for social health protection of elderly. If the government will not do something for elderly today it will put an enormous pressure in future because of increase in proportion of elderly's population.

# Chapter 7

# Conclusions and Policy Recommendations

## 7.1 Conclusions

Findings from both quantitative and qualitative study reveal that elderly in Pakistan are neglected at government level and remains dependent on family. Unlike western countries the concept of social health protection remains totally missing in Pakistan. The health status of elderly varies according to different socio-economic subgroups, but gender and urban rural differences remain huge. Women especially living in rural areas are more vulnerable to ill health. The quantitative results also exhibits, higher the level of education less the chances of getting ill, in the same way higher the level of education higher the awareness about health care utilization.

Very small proportion of elderly receive pensions or benefits but majority not. The concept of health insurance is almost unknown to elderly in Pakistan. Social health protection of elderly demands for pensions, old age benefits, family care, health insurance, and most importantly the concept of geriatrics. Some of these mechanisms are totally missing and some are poorly functioning in Pakistan.

A high proportion of elderly in Pakistan do not consult for treatment when they get ill. Those who consult health provider mostly go to the private sector. This indicates the poor health protection arrangements at government level. The satisfaction level after consultation is also high at private sector compare to public sector. Family care is the only main source for health protection of elderly in Pakistan.

Qualitative study also provided the evidence regarding the poor health status of elderly in Pakistan. Financial problems are the main obstacles and elderly have no awareness to their own health protection.

Until our government setups do not give better health care facilities, the elderly will remain vulnerable to poor health because most of them being poor cannot afford private sector. Joint family system was an asset for elderly but now it is getting weaker. Due to this family breakdown elderly become prey to loneliness and depression.

With the onset of year 2016 the Prime Minister's National Health Insurance Program has been launched that offers free of cost treatment to poor people, mainly with degenerative diseases. This program is currently running in federal capital and Muzaffarabad to be extended to Punjab and Baluchistan only, this program too does not talk about elderly.

The government will have to start from the beginning for social health protection of elderly. First of all elderly have to be recognized as responsibility of state, secondly priorities need to be set. If the government will not do something for elderly today; it will put enormous pressure in future on state as the proportion of ageing population is increasing day by day.

### 7.2 Policy Recommendations

In this section the policy points are written based on the findings of quantitative and qualitative study. The main recommendations are listed below

- First of all the state needs to consider elderly as their responsibility because they have spent their life serving for state. Arrangements should be made according to the needs of elderly for the better social health protection of elderly.

- Government will have to do from the beginning because the current health setup that our government is running is nothing.
- Every elderly person either he/she has served any government institution or not; should be given monthly old age benefits in shape of social pension like in western countries.
- Health insurance should be promoted and awareness regarding savings for old age should be generated among young population

*"The youth that is working actively should save some money for their old age health care. Insurance companies need to popularize themselves and create awareness among people. Male consultant surgeon, age: 81, private hospital*

- NGO sector should be brought up and existing social safety nets like Edhi should be financially supported by government to provide social health protection to elderly.
- Instead of giving charity at personal level which affects the self-respect of receiving person give funding to social organizations
- All the public and private hospital should establish geriatrics department so that the elderly will properly be treated by covering malnutrition, poor mental health, and week memory.
- State should ensure better utilization of taxes and should include elderly separately in social welfare plans for their social health protection.
- If the hospitals are not able to create a setup of geriatrics then at least wards should be separated for elderly
- At hospital level there should be a separate section where a hospital representative will screen elderly and send them to proper place in hospital.
- Every institution should take the responsibility for social health protection of their retired employees

- At medical level everything should be free for elderly or subsidized by government
- Adopting lady health workers' model nurses (male, female) should be hired by government to provide health care services to elderly at their door step.

*"Nurses either male or female can go to homes to checkup as they are specifically for this purpose and they are trained". Male physician, medicine, neurologist, age: 40, government hospital*

- Counseling of elderly by government sector should be a part of service provision; this will create awareness among elderly for better health care utilization.
- Social health protection of elderly should be one of the mandates of politicians during elections and they should work on it as well.
- Government has to setup a senior citizens enrollment cell and a proper streamline to ensure the priority for elderly care.

### 7.3 Potential Beneficiaries and Policy Implication

The beneficiaries of this research at national level are political leaders. At second level the beneficiaries are managers and policy makers in the health and population sectors in a country who require evidence and answers for policy change. The other beneficiaries include civil society, non-government organization and international community who are concerned about the nonexistence of social health protection for the ageing population in Pakistan. This study can fill a void in knowledge among policy makers regarding the elderly issues and needs.

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