Are the Elderly in Pakistan getting their due Share in Health Services? Results from a Survey done in the Pen-Urban Communities of Karachi

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Abstract

Objective: To assess the health, activity and social status of the elderly.
Methods: This Cross-sectional study with qualitative and quantitative designs was conducted in two areas of Karachi; one was a peri-urban squatter settlement and other a middle income commurtit . The students o second year at Jinnah Medical College were trained to collect data, which was then entered on database lV and analyzed on the SPSS statistical package.
Results: The average age of pen-urban respondents was 66 and urban was 69 years. Majority of the senior citizens were independent and 69% had active daily life (ADL), power of decision making for adults was related to their status in the family (p
Conclusion: In the present cultural set up of Pakistan although the elderly are taken care of by their families hut the majority want to continue working and be more independent. Most of the study population had one or the other form of ailment related to ageing which impaired their ADL indicator. I here is extreme deficiency of hea I Lb and social care services for the elderly hence the health care providers should start allocating and improvising for the specialized needs of the elderly. The social structure for elderly should be developed and jobs should also he created for the ones willing to continue working (JPMA 50:192, 2000).

Introduction

Ageing is an inevitable phenonmenon and with decline in mortality the number and proportion of elder! is increasing in both the developed and developing countries. Ageing is a complex phenomenon; demographically ageing is defined as increase in the mean age of the population. Some demographers focus on the increasing proportions of people above 60 years and decreasing proportions of persons below 15 years of age[1]. In the developing countries the proportion of elderly is increasing at a slower rate compared to the West. due to high fertility rates but the numbers however are on the rise [2].
Health problems are among the most frequent reasons for professional interventions with elderly. They range from simple chronic conditions causing some inconvenience to severely disabling illnesses. With ageing population the numbers of elderly with chronic conditions like heart disease, cancer, trauma dementia's and Alzheimer\'s disease etc. are also increasing[3]. Medical illnesses have been a major cause of suicide in the patients over 50 and 70 years of age [4].
As people age some are more successful than others in coping with the changing physical and social needs. The change requires more input from the society for meeting the additional demands for health and social wellbeing of the elderly population. As this population of elderly is increasing, the need for research in the health and socioeconomic context is compelling.
Research in the West has shown that the system has been improved by increasing the number of favorable outcomes for surgery and decreasing hospital utilization rates as assessed by their Medicare claims data [5-7]. The developed world has acknowledged this growing population of elderly and reforms in health care have been made or are in the process, despite the high cost of care for elderly[8]. Another

phenomenon that is adversely effecting the elderly globally is the rate of urbanization and the movement of the younger people to the cities for better jobs. In Pakistan the urban population has increased from 28 to 36% of the total population in 1997[9]. In the developing world and more so in Pakistan the emigration of young adults to Gulf countries for employment and Western countries for better quality of life, is effecting the elderly and the society at-large. This in the context of elderly leaves them at the mercy of neighbours [10].

The pleasure that elderly derive by the presence of their children and grand children is proven beyond doubt [11]. This added pleasure with soclo-economic support from their children keeps some of the elderly healthier and they cope better with their decreasing strength and capabilities. All these phenomena together cause deleterious effects on the health and soc jo-economic conditions of the elderly. both in the rural and the urban areas. To develop a plan for uplifting the health and socio-economic status of elderly reliable qualitative data is needed for appropriate policies/reforms. In the developing countries, including Pakistan, there is lack of relevant and reliable informations[12]. This study was conducted to get some insight into the health and sociodemographic status of the elderly in Pakistan.

The objectives of the study were to:

Assess the present health status and activity level of the elderly.

• Understand the health and socioeconomic problems faced by the elderly.

Comprehend the perceptions of the problems faced by the elderly.

• Evaluate the differences in availability and perception of health care services for elderly.

Methodology

This was a cross-sectional study conducted in one squatter settlement and two middle income communities of Karachi. The study used a mixture of qualitative and quantitative study designs and questionnaires had structured and open ended questions. The sample was a convenient sample of all the elderly present in the house at the time of the survey in the squatter settlement and the elderly conveniently available for interview by the students. The students of second year at Jinnah Medical College who were trained to conduct in—depth interviews.

A total of 130 persons over the age of 60 years were interviewed; eight questionnaires were not adequately filled out hence, not used for analysis. These 122 persons included 90 from a pen-urban squatter settlement and 32 from urban middle income areas like PECI-IS and North Nazimabad.

The socio-deniographic variables included questions regarding the perception of the senior citizens about their present mental and psychological state, decision making, control over famil and personal affairs retirement plans, feelings at the time of retirement, need for employment and self-satisfaction. The respondents were observed and questioned regarding their level of mobility and ability to perform usual chores.

For assessing the health status local terminology was used and medications/prescription were checked for confirmation. Probing was done about the ailments in the past 15 days, which included from falls to skin infections. When family members were present nearby, they were questioned regarding the present and past disease status.

Health seeking behavior variables included the attitude and behavior towards urgency of care, choice of health care provider, presence and distance of health services from residence. The respondents were also asked about the adequacy and quality of health care services in the community.

Data was entered on D-Base IV and analyzed on SPSS statistical package. Percentages and Chi-square statistics were used to compare the differences among groups for all of these responses.

Results

Socio-dernograph ics

The average age of peri-urban residents was 65.8j8.2 years and that of urban middle income residents

was 68.6±.6.6 years. The sex of the respondents varied significantly (p

Table 1. Differences in social and demographic variables amongst Peri-Urban and Urban residents.

Residence/Variable	Peri-urban (n=90)		Urban (n=32)		p-value
	No.	%	No.	%	
Sex: Male	33		23	71.9	0.00
Female	57		9	28.1	
Mean income	4253.3+4019.6		21890.6+16209		0.00
Employed (22.1%)	23	25.5	4	12.5	0.12
Head of household (82.3%)	74	82.2	26	81.2	0.51
Decision makers (80.3%)	70	77.7	28	87.5	0.38
Nuclear families (52.5%)	45	50	19	59.3	0.59
Own property (67.2%)	58	64.4	24	75	0.44
Savings (25.4%)	10	11.1	21	65.6	0.00
Regular income (67.2%)	56	62.2	26	81.2	0.10
Household memebrs	9±4		6±3		0.00
	(Range = 1-22)		(Range = 2-15)		
Live with children (91%)	83	92.2	28	87.5	0.32
Preference of living	Son	80 96.3	Son 28	100	0.05
with son/daughter	Daughter	3 3.3			
Want to be employed (46%)	48	53.3	8	25	0.00

Only 20.5% (12/90 peri-urban and 13/32 urban) said thev had made any retirement plans: the rest either were not sure or had no plans and this was significantly (p<0.O0); even at the time of retirement I 6% wanted to continue working with significant Pen Urban (n=90) Lrban (n=32) difference between the two groups (p<0.05). Only 8% had made any retirement plans in their young age (4/32 urban and 6/90 peri-urban with a significant (p(O.00) difference between the two residents. The feelings at retirement varied between the two groups (Figure 1).

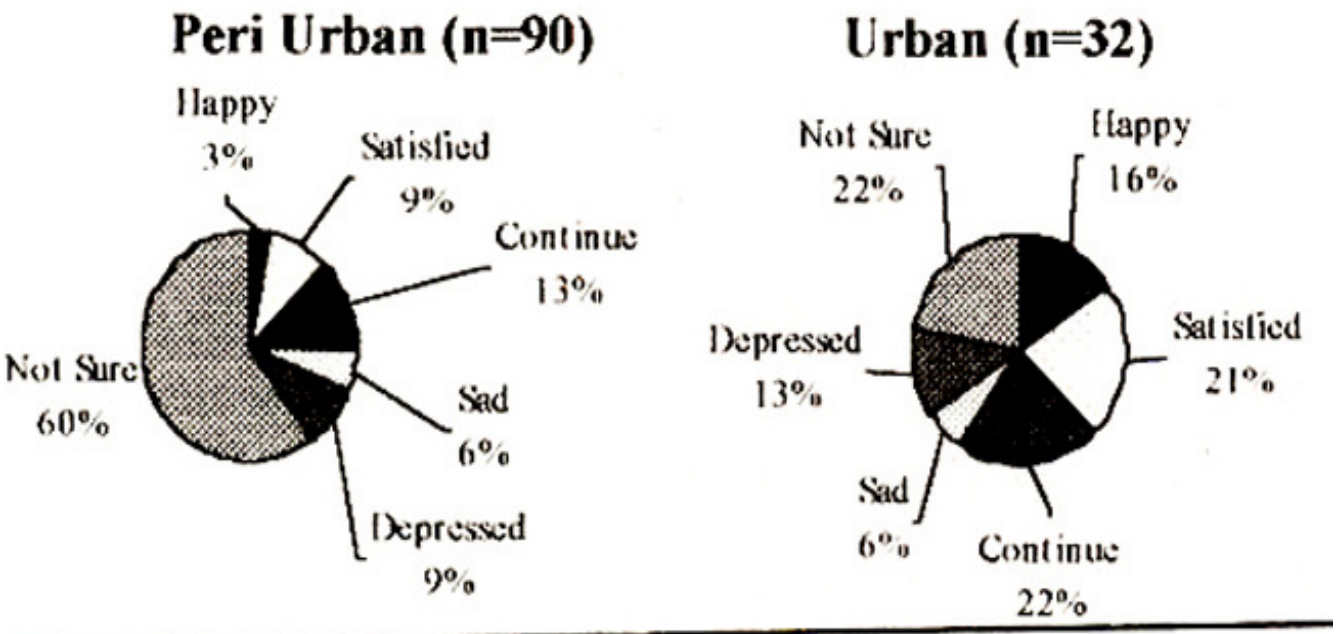

Figure 1. Feelings of senior citizens at the time of retirement

The majority of our respondents were independent and could take care of themselves however there were significant (p

Table 2. Household chores and senior citizens.

Residents/Chores	Peri-urban (n=90)		Urban (n=32)		p-value
	No.	%	No.	%	
Bathing (86.9%)	77	85.5	29	90.6	0.46
Cleaning (82.8%)	72	80	29	90.6	0.17
Brushing hair (77%)	65	72.2	29	90.6	0.03
Dressing (79.5%)	67	74.4	30	93.7	0.02
Changing shoes (66.4%)	53	58.8	28	87.5	0.00
Ironing (46.7%)	40	44.4	17	53.3	0.39
Cooking (54.1%)	54	60	12	37.7	0.02
Feeding Self (69%)	56	62.2	28	87.5	0.00
Shopping (59.8%)	52	57.7	21	65.6	0.43
House cleaning (55.7%)	53	58.8	15	46.6	0.23
Washing clothes (58.2%)	56	62.5	15	46.6	0.13

We also assessed the active daily life (ADL) indicators by combining the four internationally recognized variables. The results ascertained that 69% of the respondents could perform all the four activities and were active. When asked
Table 4.

Table 4. Disease Status by Residence of Senior Citizens.

Residence/Disease	Peri-urban (n=90)		Urban (n=32)		p-value
	No.	%	No.	%	
Hypertension (51.6%)	49	54.4	14	43.7	0.45
Hypertensive medication (41.8%)	39	43.3	12	37.5	0.00
Hyp. medication taken Regularly (20.5%)	14	15.5	11	34.5	0.00
Diabetes (15.6%)	10	11.1	9	28.1	0.05
Oral hypoglycemic (12.3%)	2	6.2	1	3.1	0.05
Insulin	1	1.1	0	-	0.05
Diet control (12.3%)	7	7.7	8	25	0.05
Swelling (8.2%)	7	7.7	3	9.3	0.41

Disease Status by Residence of Senior Citizens about support for self-care and house chores the peri-urban respondents said that their immediate family members (80%) and urban respondents said that servants provide assistance (70%).

The results regarding mental health status indicate that overall the seniors were generally alert, majority were happy and satisfied with life with no difference between urban and peri-urban residents (Table 3).

Table 3. Self-satisfaction of senior citizens.

Residence/Mental health status	Peri-urban (n=90)		Urban (n=32)		p-value
	No.	%	No.	%	
You feel healthy (67.2%)	58	64.4	24	75	0.47
Satisfied with life (72.1%)	64	71.1	24	75	0.27
Feeling happy today (76.2%)	70	77.7	23	71.1	0.86
Feeling depressed sad/helpless (23.8%)	20	22.2	9	28.1	
Control on your life decisions (80.3%)	73	81.1	25	78.1	0.54
Control over your life (78.7%)	73	81.1	23	71.1	0.54

Health Behavior

Half of the respondents (51.6%; ti=63) had hypertension. of these 80.9% (n=51) were on medication. Of these 33.3% (n=17) were unable to take medication for hypertension due to economic reasons, 5.8% (n=3) could not remember and 31.3% (n16) did not like drugs (Table 4). Diabetes was encountered in 15.6% persons of over 60 years of age. and majority were on some kind of therapy (Table 4). Ten subjects said they had an abnormal swelling for which they had seen a doctor and only one remembered that it was tumor.

Almost half of the respondents (46.7%) had difficulty in walking either due to arthritis or other locomotor system related diseases (Table 5).

Table 5. Presence of disability due to locomotor system hearing and vision.

Residence/condition	Peri-urban (n=90)		Urban (n=32)		p-value
	No.	%	No.	%	
Difficulty in walking (46.7%)	40	44.4	17	53.1	0.33
Use Support for walking (13.9%)	13	14.4	4	12.5	0.91
Some or extreme difficulty of vision (71.4%)	65	72.2	22	68.7	0.84
Use correcting lenses (35.2%)	41	45.5	2	6.2	0.00
Hearing impairment	122	100%	32	100%	

Amongst these very few were using support for walking due to socioeconomic reasons. For difficulty in vision 71.4% (ir'v87) had some or extreme difficulty of vision and out of these only 35.2% (ii=43) were using corrective lenses. The reasons for not using lenses were finances lack of time to change lenses, need not as great, not causing serious disability or aesthetics. The results of hearing impairment were based on student's judgment of the respondents and the answer was that all had sonic degree of hearing impairment.

All the respondents had had one or more ailments in the past 1 5 days with no significant difference between urban and peri-urban residents (Table 6).

Table 6. Past 15 Days History of Ailments in Senior Citizens.

Residence/Ailment	Peri-urban (n=90)		Urban (n=32)		p-value
	No.	%	No.	%	
Fractures (2.5%)	3	3.3	0	-	0.29
Falls (13.1%)	12	13.3	4	12.5	0.90
Dysuria (9%)	9	28.1	2	6.2	0.52
Polyuria (8.2%)	7	7.7	3	9.3	0.77
Pain on walking (50%)	46	51.1	15	46.8	0.68
Backache (46%)	43	47.7	13	40.8	0.48
Headache (53.3%)	49	54.4	16	50	0.66
Chest pain (33.6%)	35	38.8	6	18.7	0.03
Dizziness (32.8%)	35	38.8	5	15.6	0.01
Blurring or vision (35.2%)	36	40	7	21.8	0.06
Fever (36.1%)	35	38.8	9	28.1	0.27
Skin infections (14%)	12	13.3	5	15.6	0.74
Diarrhea (20%)	18	20	6	18.6	0.87

Regarding the timing of seeking health care there was no significant difference among the two groups (Figure 2).

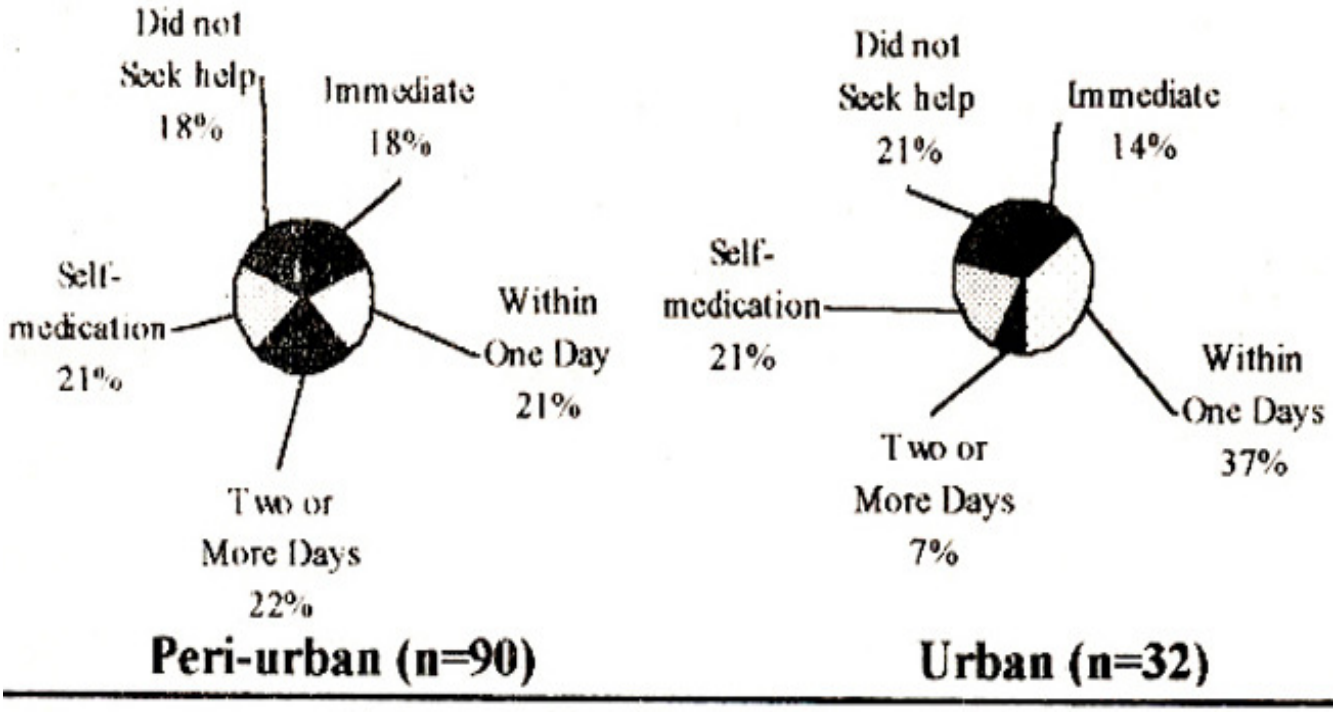

Figure 2. Health seeking behavior of senior citizens

The majority (41%; n=50) Preferred going to a registered medical practitioner, then specialists (26.2%; n32), homeopath (6.6%; n=8) and some went to the neighbors (4.1%; n5). The preference for specialists and medical practitioners was higher in the urban residents and the results were significantly (p

Availability of Health and Social Care Set-vices in the Corn munity

The majority had some form of service available close to home and there was no significant difference between peri-urban and urban reisdents (Figure 3).

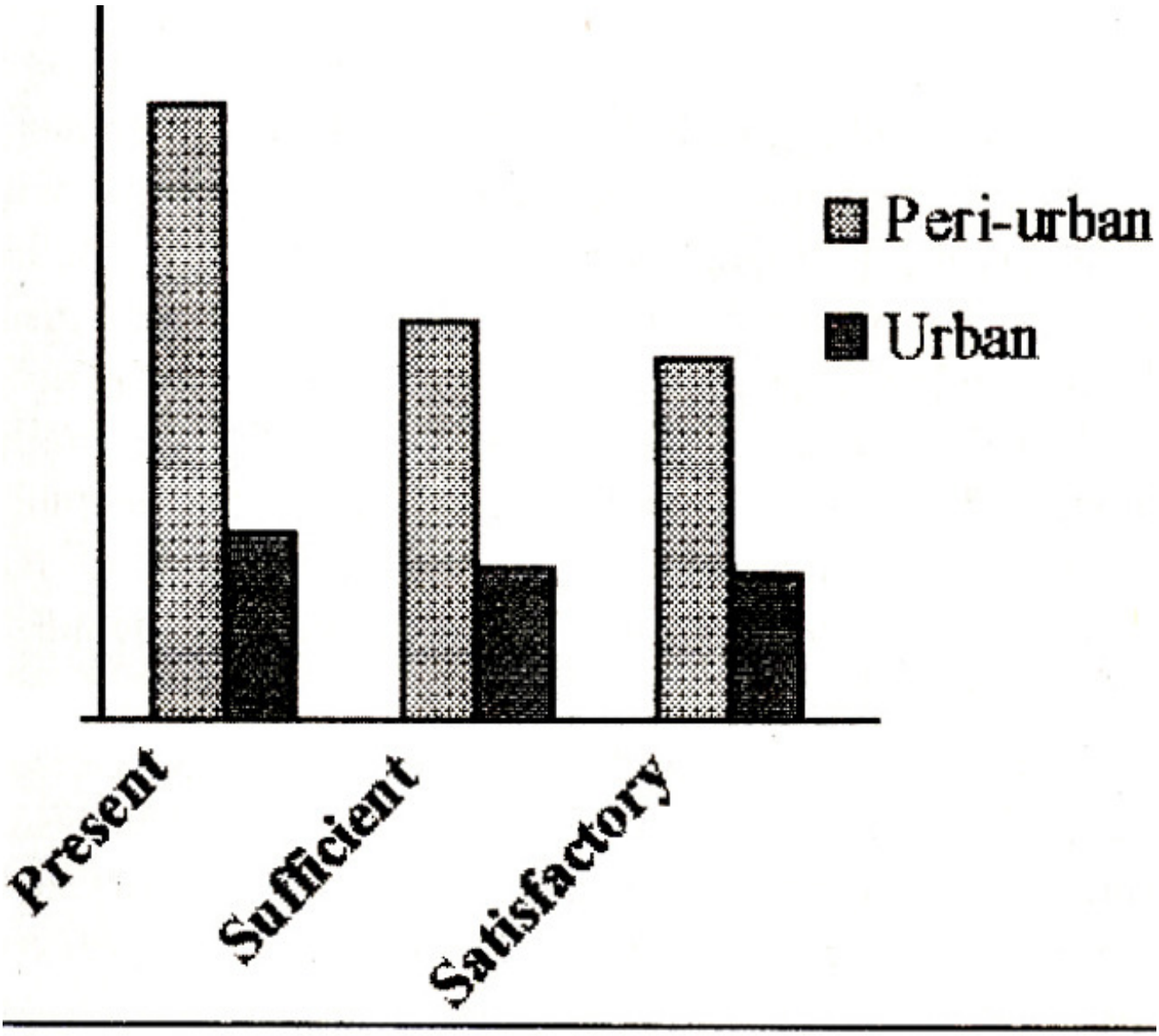

Figure 3. Health care services and the senior citizens.

There was a significant association between the perception of seniors regarding presence of services (p<0.OO) with their level of satisfaction. Seventy four percent had some form of services present close to home; 51% said in their opinion they were capable 10 deal with their health care and 47% said they were satisfied wiith the quality of care; there was no significant difference of opinion between urban and periurban residents. The health care service close to home varied from dispensaries to secondary level and tertiary level hospitals with no difference between the two groups.

When asked about the social services and if they had a place to go like, recreation centers, senior citizen homes and day centers; there were none.

Discussion

Although this is a study with a large sample. the results can not be generalized for the whole city or country. However, the feeling of the researchers is that the results will not be very much different if a study is done with probability sample for the whole city. The study did not include the rural residents and the probability of the rural residents being poor cant be ruled out. The majority was living with their fhmily members and preferred living with their children preferably sons. Due to culture—bound

customs the majority of the elderly were still heads of households and most of them had either retired or had no regular income.
Retirement was not taken well by all the respondents. The majority were depressed, sad or not sure o1 future plans at the time of retirement, probably due to decreased awareness. In most cases they did not even know of any such planning, which is the major difference from the Western population. The most interesting finding was that given an opportunity. the majority wanted to continue working and was not ready to retire.
Most of the elderly could take care of themselves routinely however for some of the daily activities they needed assistance. The difference between urban and pen-urban in assistance for daily activities reflects the differences in the lifestyle of these communities. In the urban middle income residents these were perfornied by servants and in the periurban residents the family members took care.
The majority was 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. This was also related to their living with their children and that added to self-satisfaction as seen in some Western studies. The complete absence of any social services for our senior citizens points towards our ignorance of the need. Our respondents were generally satisfied with their life and were not expecting a whole lot from life at this age. This does not mean that they should be denied the available therapeutic and restorative care of the modern world. Additionally they should also be made aware of the available amenities and enjoyments of the present century.
The prevalence of diseases was no different from the national figures. although it was not a population based randomized study. F-however, the distressing part is that the majority irrespective of the resident status, were non-compliant with medication either due to lack of resources or not understanding the importance of regularity.
There was a fairly high prevalence of disabilities related to walking, hearing and vision. Another distressing finding is that almost all had suffered from some sort of disease in the past 15 days and the majority did not seek immediate help and also resorted to self-medication. These findings point to the fact that continuous health care close to home is a necessity and should also include health education and social services. The health services were available to the majority of residents but they were insufficient to deal with the elderly and additionally the elderly did not have a high image of these services. The quality of these services was considered unsatisfactory by more than half of the elderly.
Due to lack of resources we could not assess the disability free life expectancy and also were unable to get a probability sample for the whole city or province. However in conclusion one could say that although the elderly were generally happy with their lifestyle and status bitt they had hopes and aspirations for improving themselves. The majority wanted to he employed and independent. The senior citizens are not completely healthy and are not getting their due share in health and social services. The findings of this study are not variedly different from the data available for health and socio-demographic status of elderly internationally.

References

1. wolfgang L. Data and research needs in the context of agemg ICPD Technical fleeting on population ageing session 6 Brussels, October 6—9. 1998.
2. Sen K. The presentation of frailty and dependence among the elderly people in developing countries. ICPD-5 Technical fleeting on population ageing Brussels, October 6-9, 1998.
3. Newcomer R, Clay T, Luxemberg JS, ct at. Misclassification and selection bias W lien dentifying Alzheimer\'s disease solely from Medicare claims records ds .1. Am. Gcriatr. 5oc., 1999;47:215-19
4. Hendin 11. suicide assisted suicide and medical llness J . Chn Psvehiatr., I 999:60(Suppl 2):46-50.
5. K irsch M, Guesnie 1,. Lel3esneraus P et al. Cardiac operations in octogenarians preoperat se risk factors for death and imparied autonomy Am. Thoracic. Sing, 1998:66:60-67.
6. Nsa W, l3ratzler OW, Miller iS. Characteristics and hospital utilization of the Oklahoma Medicare

population: 1994-96. J. Okla. State Med. Assoc., 1998:9160-67.
7. Katz NM. Uannan RL. Hopkins RA. et al. Cardiac operations in patients aged 70 years and over: mortality length of stay and hospital charge. Ann. Thorac. surg l995:6(t:96-l00.
8. Shapiro MB, 1)echert RE.. Colwell C, et at. Geriatric trauma: aggressive intensive care unit management is justified Am. Sing., 1994:60:695—98, New York, USA
9. Statistical tables. State of the world children. UNICEF I leadquarters 1999, iw. 91-127.
10. Hasan KZ. llealth status and service needs of the eldery ait NGO perspective. ICPD 5 Technical meeting on population ageing Brussels, October 6-9, 1998.
11. Spruytte N. Verschuere K. Mareocim A. Grandparents their experience of the rchatioiiship with the oldest grandchild amid their psychological well being. Tijdschr Gerontol Geriatr 1999:30:21-30.
12. Antony HB de Bono Ageing and health in the commonwealth ICPD+5 Technical meeting on population ageing. Brussels, October 6-9, 1998.