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Ageing in Pakistan—A New Challenge

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Abstract With increasing life spans across the world, Pakistan is also experiencing a rise in its elderly population. With meager resources and a poor understanding of aging; Pakistan faces many challenges in caring for its elderly population. This article highlights the present infrastructure and systems in place for the aged in Pakistan with a special focus on health and medical issues. Future possibilities for improvement in the health and wellbeing of our elderly are also discussed.

Keywords Ageing · Pakistan

The worldwide rise in the elderly population has also made its impact on Pakistan. Despite its political and economic instabilities; Pakistan has succeeded in improving lifespan, a fact clearly evident by its rising older population. A WHO report in 1998 estimated that six percent of our population was over 60, with a likelihood of doubling by 2025. Life expectancy has risen by almost three decades in last 50 years and will reach close to 72 years by 2023.[1] At present in our hospital (The Aga Khan University Hospital Karachi), one out of every five inpatients is over 65. This may not be much compared to other countries but for a country with restricted resources, dealing with a medically and socially vulnerable population may pose a great challenge.

[1]International Data base IDB. International Programs center, Population division, US Bureau of Census 2004

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Many factors are responsible for making this a particularly complex challenge in our setting.

Despite being a socially cohesive society; the decline of extended family systems is evident (Itrat et al. 2007). This has not only affected the revered status the elderly enjoyed in their later years but the patriarchal and matriarchal system that allowed our elders to maintain positions of decision making has also declined, leaving their social standing diminished. In addition, with a rapid conversion of extended family systems to nuclear families, the elderly are put at a disadvantage, as the younger and more productive members of the family take over, marginalizing the elderly into positions of dependence both social and economic.

Another important change that has taken place over the last couple of decades is the significant brain drain of this country. This has led to the departure of an age group of younger individuals leaving behind parents who slowly age and decline with no one to look after their needs. Attempts at migration to join their children often fail as adjustments to a new lifestyle are often hard for such elders.

This often results in such elderly living alone. No population data on this is available at present. By observation alone it appears that at least 6–7% of elderly visiting geriatric clinics at the Aga Khan University Hospital are living alone with little assistance. About 12% of the elderly men live alone in rural India.[2] Our numbers are very likely to be comparable to India which has a similar socio-economic and cultural background.

The changing social milieu is compounded by the fact that economic independence after retirement is only enjoyed by a select few; retirement funds are scarce and government pension plans are only present for those employed in government sector jobs. The retirement age in Pakistan is 60 years after which most elders are unable to find alternative sources of income and thus become largely dependent on their families for financial support; all of this occurring in an environment where official inflation rates have been cited to be higher than 20%. When this gets compounded by illness; care options become very limited as no government system exists that subsidizes health or treatment for its elderly population.

There are close to 1,000 government hospitals and about 300 small and large hospitals in the private sector. Most patients pay for medical services out of pocket. Medical care is cheaper in government hospitals; however patients prefer private hospitals based on quality of service provision.[3]

The government designed a National Policy for the health of the Elderly in 1999. This comprehensive policy included training of primary care doctors in geriatrics, provision of domiciliary care, dental care and a multi-tiered system of health care providers for elderly including social workers, physical therapists. “Green Slips” for prescriptions was also devised. Unfortunately implementation of this policy is still being awaited.

The public system also offers no respite to our aged and no subsidized transportation system exists for our elderly.

[2] WHO regional office for South-East Asia 1999. Striving for Better Health in South-East Asia Selected speeches by Dr U M Rafei, Regional Director, WHO South-East Asia

[3] Health Systems Profile—Pakistan Regional Health Systems Observatory—EMRO

A few nursing homes exist in large cities and are primarily run by private or religious organizations. The Catholic Church runs three old people homes in Karachi, the largest city of Pakistan. These are run primarily by the church staff and supported by volunteers, which form the backbone of the infrastructure. People living in these old homes do pay a nominal fee whenever possible, but most other funds are generated through the church.

Some nursing home services are offered by other religious communities that operate primarily via their strong volunteer base and community donations. Most of these provide valuable services as they house those who are most dependent and vulnerable. Not much however is known about the quality of care being provided in such homes.

Recently a few privately owned assisted living facilities have been developed where older people live and get some help from their community volunteers which can range from medical care to social activities. These are again privately owned.

Catholic services also run a few assisted living facilities in other parts of the country. No daycare services or centers exist to provide partial or respite care.

Even though these "old homes" provide a haven to those most in need; they still do not provide a solution for the large majority of our elderly as our culture (despite its gradual transformation) still adheres to the value of caring for their elderly at home and nursing homes by and large are frowned upon.

In the medical environment of Pakistan, geriatrics or elderly care is not recognized as a separate specialty; older patients are seen and treated by general practitioners or other specialists. Care received is often fragmented and compartmentalized and comprehensive care is lacking. No inpatient rehabilitation centers exist for patients with strokes, fractures etc. Outpatient physical therapy services are however widely available but use is suboptimal.

The unique medical and psychosocial needs of our elderly are thus often unmet. The disease burden in our elderly is high and some data is available regarding common diseases in the elderly but by and large most numbers are observational.

The Population census of Pakistan of 1998 cites a 28% disability rate of people aged 60 and older. Disability was defined as crippled status, deafness (including mutism), blindness and mental retardation.

About 40 million people were estimated to have osteopenia while numbers with osteoporosis was approximated at ten million, in a large ultrasound study done in Pakistan.[4] One study identified five or more illnesses in the elderly population surveyed; citing hypertension, diabetes and arthritis as the most common illnesses (Zafar et al. 2006).

Very little information exists regarding common geriatric syndromes.

Elderly people in Pakistan lead a mainly sedentary lifestyle which may play a significant role in immobility disorders, loss of muscle mass(sarcopenia) and falls, which are common geriatric syndromes. There is little data on depression in the elderly because of the stigma associated to mental illnesses. Dementia may also be

[4] The Asian Audit of the International Osteoporosis Foundation.. Epidemiology, costs and burden of osteoporosis in Asia 2009

presenting later as most elderly patients depend on their families for shopping, transportation and financial interactions leading to a delayed manifestation of functional decline.

The need of the day is therefore to devise medical and social programs for our elderly that help meet their needs in the comfort of their homes. Such programs should also provide caregiver education, training and facilities to family members caring for their older relatives. This need was also highlighted by one study that surveyed local communities (Baig et al. 2000).

Some interest in geriatric health has recently been generated in the medical community. Articles citing the health problems of the elderly have been published (Itrat et al. 2007; Zafar et al. 2006; Baig et al. 2000). These have highlighted some medical and social problems faced by our elderly. In addition some media (both print and other) has also focused their attention towards the elders in our society.

One major change forward was the recognition of the need to teach geriatrics at an undergraduate and postgraduate level at a leading medical university. This was implemented as a phased in program in 2008. A separate outpatient clinical geriatric program was also developed and implemented in the same year.

We hope that more medical schools recognize the need for teaching/learning geriatrics so that physicians are trained to understand the unique needs of our elderly patients. Other medical providers like nurses, pharmacists, physical therapists should also receive training to make them cognizant of the common medical problems in the elderly.

The active role of the government through adequate implementation of The National Policy for the health of elderly would allow the most vulnerable to access medical care.

In addition public awareness towards the needs of the elderly has to be enhanced. This can be accomplished via the media (radio and television) to educate the public, free seminars at hospitals and universities and at an individual level via patient and family education. Community education programs targeting the medical needs of the elderly could be conducted to help families understand common illnesses seen in the elderly so that timely diagnosis and management can be sought for those in need.

Re-integrating elders in the societal mainstream through volunteer programs like part-time teaching and engagement in charity work would allow healthy elders to continue contributing towards society. Elders helping elders could be another low cost feasible program that would allow the more able elder to help their peers.

The status of the existing nursing homes could be reviewed and more resources at a societal level could be allocated to them via their own communities.

Another comprehensive approach that could be adopted for geriatric care in our country is to develop a program on the lines of the WHO vision for the health of elderly that emphasizes community participation and focuses on the combined role of government, institutional and community participation[2].

At the end however we hope to at least work toward improving medical care of our elderly via relevant knowledge and skill building of our medical professionals, increasing health awareness of our public and allowing better access to appropriate preventive and medical care for our elderly.

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