Original Article

Anthropology of Ageing

Income Status and Medical History of Older Persons in Rawalpindi: Anthropology of Ageing

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ABSTRACT

Objective: The aim of study is to highlight the hidden ageing population and its problems. The specific purpose of the study was to explore the interrelationship of ageing with income as well as the medical history among the older persons of Rawalpindi city.

Study Design: Cross Sectional

Place and Duration of Study: This study was commissioned to the research team on behalf of Help Age Pakistan. The data collection was done in various union councils of Rawalpindi city. The study duration was three months of 2013.

Materials and Methods: Structured questionnaire was developed to collect information on Older Persons' health, economic and psychological status. In this regard, an extensive questionnaire was designed and pre-tested vigorously. Number of researchers form PMAS-Arid Agriculture University was engaged to collect data.

Results: There is a strong relationship between the income statuses of OPs with their health physical conditions. The lack of permanent source of income leads to the high tendency of contracting various health problems among OPs. Similarly the inactive status of OPs also affects their health wellness which later on leads to create a multiplier effect regarding various health problems like heart problems, hypertensions, diabetes, arthritis, asthma, etc.

Conclusion: There is a strong relation of income stability with the various psycho-somatic problems. The sense of being actively involved in familial functions especially economic chores provide a sense of independence and psychological sense of control over life results in better health among OPs.

Key Words: Ageing, Older Persons (OPs), Income, Health Issues, Diseases, Heart Problems, Hypertension, Arthritis, Asthma

INTRODUCTION

Ageing though an important stage of human's life but yet unexplored in Pakistan has several implications regarding its productivity and contributions in the overall development of Pakistani society. Getting older in South Asian social environment is associated with a sense of getting senile as well as disappearing into a state of oblivion.

Anthropology is the scientific study of humankind's origin, biology, and culture. It encompasses a vast and some might say untidy-body of knowledge that has rarely been organized[1].

Anthropology is the only human science that explores the humanity in a systematic way while connecting the remote and recent past and connects it with the current scenario of man while explaining the change over various epochs of history. The life cycle of man includes conception, birth, adolescence, adulthood and ageing.

Biological anthropologists have contributed to the study of aging in numerous areas, with an emphasis on chronic disease, bone biology, reproductive biology, and body composition. Since aging and the processes of senescence clearly involve complex interactions among biological, environmental, and cultural domains, anthropologists with a bio-cultural and evolutionary perspective are well equipped to study variation in aging and senescence. Despite this advantage, relatively few biological anthropologists have focused on aging[2].

Income security during retirement is a primary social achievement of the 20th century. As individuals retired from work at younger ages and life spans increased, the period between the formal end of work and death became one of the most significant stages of life. This enormous accomplishment, however, was accompanied by fundamental public policy challenges associated with the risks posed by population aging. The two most basic challenges were (1) that individuals would have sufficient income security during their retirement years so that retirement did not necessarily imply a substantial decline in living standards and (2) that individuals would have protection against the increasing risks of falling into poor health. During the last century, industrialized nations responded to the problem of having sufficient income to achieve a decent standard of living during retirement by developing the now-familiar three-tiered system: the primary role of the public tier is to guarantee through governmental transfers at least a minimum income standard during

retirement; the second tier is based on employer-provided pensions; and the third tier consists of wealth accumulation through private household savings (National Academy of Sciences, 2001).

Health, although it is a factor of importance for both individuals and society as a whole, is a difficult entity to define. Culyer (1981) distinguishes between four main approaches to the definition of health: health as the absence of disease (a medical model approach); health as the absence of illness (a sociological perspective); health as an ideal state (the World Health Organization model); and health as a pragmatically defined entity[3].

The medical model of health focuses upon the identification, diagnosis and treatment of disease. The term disease is usually used to describe the medical concept of a defect or abnormality in function or structure of any part, process or a system of the body. This is the province of physicians and specialists in the treatment of older people. In this conceptualization individuals (or groups or entire societies) are healthy if they are characterized by the absence of disease. Hence health is defined by what it is not, i.e. health is not having a disease. If you are not `sick' then you are `healthy'. This is a rather limited conceptual framework for the study of ageing; the medical model offers only limited insights into the complex phenomena of health for three major reasons. First, this approach is highly reductionist. Explanation for the presence or absence of disease in individuals is sought in terms of physiological and biological functions without reference to the social or psychological context within which individuals' live[4].

Indeed Estes and Binney (1989) suggest that `ageing' has also been medicalised with the result that older people and old age are pathologised and ageing is constructed as a medical problem with a consequent emphasis upon medical research and medically based `solutions' to the problem of ageing. Emphasis is placed upon identifying the `abnormal' rather than the `normal' in the experience of ageing[5].

Many aspects of the experience of ageing, therefore, are `problematised' and become the domain of experts and problem solvers rather than being seen as part of a normal transition or changes that characterize the post-mature individual[6].

Talcott Parsons (1951) argued that those who are ill are not required to perform their normal social roles but adopt the `sick role' that is characterized by the adoption of a dependent rather than an independent status. This transition may be very distressing for the individual concerned given the heavy emphasis placed in our society upon remaining independent and autonomous. The sick role is not expected to be of long duration. The long-term sick, or those with particular illnesses such as epilepsy or various mental disorders, can come to acquire a highly stigmatized status because of the extensive duration of their illness. A similar stigmatizing status may be ascribed to older people because of the perceived widespread prevalence of chronic illness and its extensive and debilitating nature that can compromise independence and autonomy[7].

Illness behavior is a complex aspect of social interaction that involves the individual in monitoring their body, interpreting symptoms, taking curative action and seeking help from the health care system or other appropriate agencies. Even in Britain, which has a national health care service which provides care free of charge, the vast majority of illness is not presented for consideration by the health care services. Only an estimated quarter to one-third of all illness episodes result in a medical consultation[8]. The decision to seek medical aid is only one illness behavior strategy out of a whole range of possible options, which includes self-care, folk remedies, consultation with friends or relatives or use of `alternative' or complementary over-the-counter therapies.

Sociologists interested in illness behavior have largely focused upon the younger members of the population. Ford (1985) has attempted to review illness behavior in later life and its variation from that characteristic of younger age groups. One of the enduring stereotypes about old age is that treatable illnesses are mis-ascribed by older people to the process of ageing rather than being the manifestation of `disease'[8]. Consequently, it is argued, older people do not seek appropriate treatment. In support of this view; a variety of studies have demonstrated that there are a large number of previously unidentified medical conditions to be found among older people living at home[9].

Regardless of the age of individuals, attitudes towards health beliefs are complex and often, apparently, contradictory. Views of, and definitions of, health are culturally and historically rooted and related to the values and expectations of particular groups. Furthermore health related beliefs and attitudes almost certainly vary with regard to class, gender, age, and ethnicity[10] and, taking this complexity one stage further, a single individual may hold apparently conflicting, and mutually exclusive, beliefs at the same time[11].

Evandrou (2000) reports that rates of acute illness are elevated among elders from Bangladeshi/Pakistani backgrounds but that there are also gender variations within this overall pattern[12].

Chronic health problems are, by definition, long term and not usually characterized by a cure. Implicit within the term is also the notion of inevitable decline or deterioration. Medical intervention may (or may not) alleviate some, or all, of the associated symptoms and may halt (or slow down) the rate of decline. Examples of such long-term health problems are multiple sclerosis, dementia and arthritis. It is this type of health problem that is specifically identified by both the

general public and many professional health workers alike as an integral, inevitable, natural and universal feature of old age[4].

Christina R. Victor (2005) describes Ageism, it is argued, is not experienced equally by men and women for older women experience both ageism and sexism. They are discriminated against, or viewed negatively, because they are both old and female[4]. This double disadvantage is reflected in what has been termed the double standard of ageing. The notion that men and women differentially experience old age is not a new one: indeed it has a long historical pedigree. Hippocrates considered that old age started for men between the ages of 55 and 60 while for women old age started a decade earlier. In a similar vein Plato saw the prime of life as 30 years for man and 20 years for a woman. According to this widespread social view, old age for women starts earlier than for men and lasts for many more years. However, this discrepancy in the perceived onset of old age has no biological basis: life expectancy for a male is several years shorter than that of a female. Rather, this difference in the perceived onset of old age is socially defined, constructed, maintained and legitimized.

Cardiovascular disease (defined for these purposes as history of myocardial infarction, angina pectoris, coronary insufficiency, intermittent claudication, or congestive heart failure) and diabetes mellitus are among the leading causes of death in the elderly, while the other CVRFs also are strongly associated with mortality[13]

As reviewed by Hayward (1995), several older studies found associations between depression and cardiovascular disease, hypertension, or hypercholesterolemia. However, interpretation of most of these studies must be tempered by methodological issues, including retrospective design, samples from long-term psychiatric institutions, or depression assessments using solely self-report scales or non-standardized diagnostic schemes[14].

Despite this, there is substantial evidence that disability is associated with depression as well as with CVRFs[15-17]. Psychological models can be invoked to explain how external disability may lead to the changes in mental experiences that are part of depression. For example, disability may be viewed as representing a breakdown in primary control processes[18].

Disability was independently associated with depressive symptoms and syndromes in primary care elderly[19].

Older depressives, as compared to both younger depressives and age-matched non-depressed controls, demonstrate both a breadth and severity of neuropsychological abnormalities that may reflect underlying brain dysfunction[20,21].

A review of the current literature on the relationship between aging and depression consistently implicates a third variable, functional disability; persons with more disability tend to be more depressed, and functional disability tends to increase with age[22,23].

MATERIALS AND METHODS

To collect the data of Older Persons' of Rawalpindi a Structured questionnaire was developed including their health, economic and psychological status. To gather the data in this regards, an extensive questionnaire was designed and pre-tested to improve the quality of the tool.

Questionnaire consisted on the areas of bio-informatics including demographic information of clients and the second area covered base-line information, third area contained information on economic status, fourth area was about the medical histories of the older persons, fifth section comprised information on Social and Psychological profile of OPs, and the last & sixth part consisted information about legal and social protection issues of OPs.

Questionnaires were administered through a research team that comprised the graduates of department of Anthropology of PMAS-Arid Agriculture University along with professionals of Regional Development Network (RDN) as well as field staff of Pakistan National Center on Ageing (PNCA).

RESULTS

Below chart co-relates the source of income with disease status. The table proves that OPs who did not have any permanent source of income had the tendency to catch more diseases as compared to the OPs with somewhat defined source of incomes.

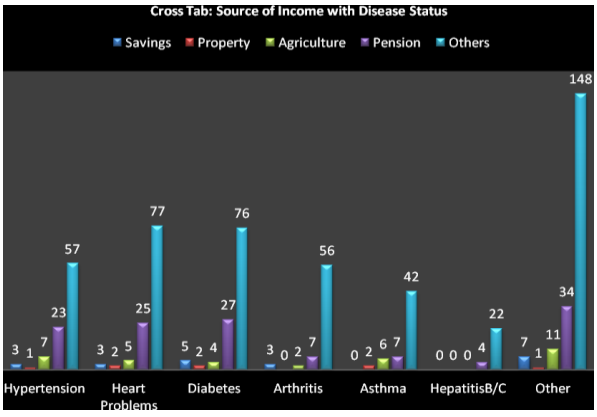

Chart: Source of Income with Disease Status

The current table clearly establishes the co-relation of older persons' economic status and the diseases contracted by them. It strongly proofs that economically inactive OPs possess highest tendency to catch health problems as compared with the ones who are still economically active and earning their living.

Table No. 1: Comparison of OPs economically active status with Disease Status

Still Economically Act	Disease Status								Total
	Hypertension	Heart Problems	Diabetes	Arthritis	Asthma	Hepatitis B/C	Other	NA/ No disease	
Yes	34	44	49	24	19	9	91	173	443
No	62	75	67	47	40	18	114	134	557
Total	96	119	116	71	59	27	205	307	1000

DISCUSSION

The older persons' study and the intensive interviewing revealed that the economic turmoil of the down trodden segments of the society has negatively affected them. The rising tide of employment in the national scenario is creating a multiplier effect that directly results in the socio-economic instabilities of the families. The low income of families leaves them in compromising to extreme compromising situation in which the health is the domain that is usually ignored or thrown in adjournment due to the non-negotiating status of the families that are poverty stricken. The poor economic situation further affects the health of OPs who usually sacrifice or are expected to sacrifice their health wellness as the cost of other family members especially the earning hands. This finding fully reinforces the argument presented by Ford who says 'even in Britain, which has a national health care service which provides care free of charge, the vast majority of illness is not presented for consideration by the health care services. Only an estimated quarter to one-third of all illness episodes result in a medical consultation[8].

It was observed that the OPs of Rawalpindi city preferred to work even beyond the call of duty just to make sure that they earn something for the family which indirectly wins social approval and protects them from social exclusion in various matters of family concern. It was also noted down that the OPs generally wished to keep themselves busy in order to avoid certain tensions and mental stresses that directly bears upon their health. The sample of the study presented important statistics regarding the health wellness and its relation with the income earned by the family and especially the OPs.

The respondents with savings, property, agricultural land, pensions and other alternate sources of livelihood scored better on their health status. On the contrary the OPs with no such options suffered from heart related complications, arthritis, asthma, and hypertensions. This observance confirms the contention advocated by Talcott Parsons who adds that sickness is a kind of social behavior is a behavior that is 'not expected to be of long duration.

It is important to understand that the 'long-term sick, or those with particular illnesses such as epilepsy or various mental disorders, can come to acquire a highly stigmatized status because of the extensive duration of their illness.

The lack of appropriate knowledge regarding health well-being among older persons is rightly stated by the scholar Ford who says that various medical complications are simply interpreted in terms of ageing process instead of seeking proper medical advice on it. Similarly, Williamson et al. (1964) seemed true that 'there are a large number of previously unidentified medical conditions to be found among older people living at home[9].

The important observations made during the study emphasize that the overall poor health performance of the older persons is directly related to the instable and irregular income of the families. The situation goes more worth noticing that among OPs the older females scored very low and alarmingly poor within the respondent group. Though medically, socially and religiously the older persons are graded at a high level but the miserable material conditions make it inevitable for them to keep economically active. This trend on the contrary seemed positively responsive in relation to the healthy status of OPs. The review of literature contends that various psychoneurosis issues are also related to the psychosomatic problems. As in case of findings presented by Broadhead, Blazer, George, & Tse, (1990); Kennedy, Kelman, & Thomas (1990); as well as with CVRFs (Bush et al.,1990); Schulz, Heckhausen, & O′ Brien (1994) and Lyness et al. (1998).[15-19]

The Pakistan Economic Survey 2012-13 though surveys the main health related interventions planned on behalf of the government but unfortunately lacks any mentionable interventions aimed at the welfare of the Older Persons. The health insurance sector in Pakistan is still in its infancy and does not at all guarantees its universal coverage to all Pakistanis irrespective of their age, area or any other special requirements. Similarly, the health targeted programs like Individual Financial Assistance (IFA), Child Support Programs (CSP) and Special Friends of Pakistan Bait-ul-Maal (PBM) severely lack any quantitative or qualitative data to ensure the transparency of the initiatives and its universal access. Even during the phases of data collection, the respondents revealed that Benazir Income Support Program (BISP) is highly politicized and accused of political nepotism. Even the monetary support provided to the so-called poor does not make any plausible and arguable difference in the lives of beneficiaries' families[24].

Pakistan being a third world country is entangled with numerous developmental challenges ranging from

political instability, poor economic performance, serious violations of human rights, low regional and continental as well as international performance on health, education and gender indicators. Ageing is relatively a new topic for the development intelligentsia, development champions, legislators, policy makers, development and human rights agencies and media. There is a need to mainstream ageing into the so-called development agenda of the Pakistan especially in an international scenario where the world has recently adopted the Global Age Index in recent October 2013 to evaluate the countries' performance on Global Age Index.

CONCLUSION

The income or the material assets of a person or a family is a social guarantee of material gratifications. The older persons are usually the victims of adverse economic clutch that is directly responsible for their poor health status. There is direct interrelationship between the income and the health indicators. Similarly, the OPs still economically operational report less health issues but the sub-indicators of lack of awareness and health sensitization also play its role in health issues faced by OPs.

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