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Research Article

Assessing Elderly Care in Saudi Arabia: Evaluating Health and Social Support Programs through a Survey-Based Study

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Abstract:

As Saudi Arabia's elderly population grows, understanding the adequacy of health and social support services becomes increasingly critical. This study evaluates the accessibility, quality, and effectiveness of elderly care programs across different regions and sociodemographic groups in Saudi Arabia. A cross-sectional, survey-based study was conducted with 1,006 participants, including elderly individuals, caregivers, family members, and healthcare providers. A structured, bilingual questionnaire assessed healthcare access, service quality, social support availability, and perceived barriers. Descriptive and inferential statistics were used for analysis. Most participants (64.0%) found healthcare services somewhat accessible; only 6.9% considered them very accessible. Satisfaction with care was moderate, with 50.9% satisfied and 15.0% very satisfied. Key barriers included logistical issues (35.4%), cultural attitudes (30.1%), and lack of awareness (21.8%). Social support services were underutilized, with regional disparities observed—Asir had the highest use, while Riyadh had the lowest awareness. Significant associations were found between healthcare accessibility and age, region, and participant role ($P < 0.001$). While general satisfaction with elderly care services exists, notable disparities persist based on age, region, and service awareness. To improve outcomes, targeted outreach, better infrastructure in rural areas, and expanded access to social support services are essential.

1. Introduction

As the global population ages, nations are faced with the pressing need to adapt their healthcare systems to effectively support elderly individuals. This demographic shift is particularly pronounced in Saudi Arabia, where rapid economic development, advances in healthcare, and changing societal structures have contributed to an increasing life expectancy [1].

According to Saudi General Authority for Statistics, the population aged 65 and older is projected to increase rapidly in the coming decades. In 2020, this group constituted approximately 3% of the total population; by 2030, it is estimated to rise to around 6.9%. Such demographic shifts necessitate a strategic approach to healthcare planning and social support mechanisms for senior citizens [2].

Saudi Arabia boasts a well-established healthcare system, characterized by a mix of public and private providers. The Ministry of Health (MoH) plays a crucial role in delivering health services while also overseeing policies and regulations related to elderly care [3]. In recent years, the government has introduced reforms aimed at enhancing the quality of healthcare available to older adults. Key strategies include the expansion of primary healthcare services, which are pivotal in managing chronic conditions prevalent among the elderly, such as diabetes, hypertension, and cardiovascular diseases [4].

Several initiatives align with the National Transformation Program (NTP) and Vision 2030, aiming to improve the quality of care for older adults. This involves implementing more geriatric training for healthcare providers, deploying nurses and social workers specialized in elderly care, and establishing dedicated geriatric units in hospitals. Furthermore, the Kingdom has increasingly emphasized preventive healthcare, encouraging regular health check-ups and screenings for elderly populations to catch potential health issues early [5].

Beyond healthcare, social support programs play an integral role in fostering the well-being of elderly individuals. Saudi Arabia has developed various initiatives to enhance the quality of life for seniors [2]. The government, along with non-governmental organizations (NGOs), is working to provide social services that address not only physical health but also the emotional and psychological well-being of elderly citizens. Programs often focus on community engagement, accessibility, and support for families who care for older relatives [5].

Cultural attitudes towards aging and elderly care can also influence the effectiveness of existing programs. In Saudi society, traditional family structures historically underscore the role of family members in caring for older relatives [6]. However, with urbanization, increased participation of women in the workforce, and changing family dynamics, many families may find it increasingly difficult to provide adequate care. Thus, a growing demand for formalized caregiving services is emerging, necessitating expanded professional training in geriatric care [7].

The rapid aging of the population in Saudi Arabia presents significant challenges to the nation's healthcare system and social support networks. With projections indicating that the percentage of elderly individuals will continue to rise, the need for effective elderly care strategies becomes increasingly critical to enhance the quality of care for the elderly and ensure that their specific needs are met within the evolving socio-economic context of the country.

Despite the growing population of elderly individuals in Saudi Arabia, there remains a lack of comprehensive understanding regarding the adequacy and effectiveness of current health and social support programs. Many elderly individuals face challenges related to access, quality of care, and social isolation, leading to adverse health outcomes and diminished quality of life.

The primary aim of this study is to assess the effectiveness of health and social support programs for elderly individuals in Saudi Arabia. This will be achieved through a survey-based approach that captures the perspectives of the elderly on their care experiences and the adequacy of existing services.

Methodology

2. Research Design

A cross-sectional descriptive study was conducted to evaluate elderly care programs in Saudi Arabia.

Study Population

- **Inclusion Criteria:**
  - Participants must be directly involved in or beneficiaries of elderly care programs in Saudi Arabia.
  - Willingness to participate in the study.
- **Exclusion Criteria:**
  - Individuals under 60 years old (unless they are caregivers or family members).
  - Incomplete or inconsistent survey responses.

Sample Size and Sampling

The sample size was calculated to ensure statistical reliability and generalizability of the findings.

Using a confidence level of 95% and a margin of error of 5%, the required sample size was determined based on the estimated population of Saudi Arabia. Assuming a conservative response distribution of 50% to account for maximum variability, the sample size was calculated using the formula for estimating proportions in a large population. The target sample size was increased to 1,000 participants to allow for more robust subgroup analyses and enhance the validity of the study's findings. A stratified random sampling technique was used to ensure representation from different regions of Saudi Arabia.

Data Collection Tools

The primary data collection tool was a structured questionnaire, which includes closed-ended questions for quantitative analysis. The questionnaire covered key areas as:

1. **Demographics:** Age, gender, region, and role (elderly, caregiver, healthcare provider, etc.).
2. **Health Services:** Accessibility, quality, and satisfaction with healthcare programs.
3. **Social Support Services:** Availability and effectiveness of social support programs.
4. **Challenges:** Barriers to accessing care (e.g., financial, cultural, or logistical).

Before full deployment, the questionnaire underwent pilot testing with 20-30 participants to ensure clarity, reliability, and validity.

Data Collection Process

The data collection process began with obtaining ethical approval from institutional review boards (IRBs) and securing permissions from hospitals, primary healthcare centers, and elderly care facilities. Surveys were distributed online (using platforms like Google Forms or SurveyMonkey). To accommodate all participants, the survey were available in both Arabic and English. The data collection phase is expected to take 2-3 months, depending on the sample size and accessibility of participants.

Data Analysis

Quantitative data will be analyzed using statistical software such as SPSS, STATA, or Excel. Descriptive statistics (e.g., frequencies, percentages, means) will summarize the data, while inferential statistics (e.g., chi-square tests, t-tests, or ANOVA) will identify trends and relationships.

Ethical Considerations

The study adhered to strict ethical guidelines. All participants provided consent before participating, and their identities remained confidential. Data were stored securely to protect participants' privacy. Participation was entirely voluntary, and participants had the right to withdraw from the study at any time without consequences.

3. Results

A total of 1,006 participants were included in the study. The majority (42.4%) were under the age of 60 years, followed by 17.9% aged 60–65 years, 15.7% aged 66–70 years, 13.9% aged 71–75 years, and 10.0% aged 76 years and above. In terms of gender distribution, 55.2% of the participants were male, while 44.8% were female. Regionally, the highest proportion of participants were from Makkah (58.6%), followed by the Eastern Province (19.0%), Riyadh (16.3%), and Asir (6.1%). Regarding participant roles, the majority were elderly individuals themselves (74.2%). Additionally, 9.6% were healthcare providers, 8.9% were caregivers, and 7.3% were family members of elderly individuals **Table (1).**Regarding the accessibility of healthcare services for the elderly, 64.0% of participants reported that services were somewhat accessible, while only 6.9% perceived them as very accessible. Conversely, 23.3% considered services to be somewhat inaccessible, and 1.5% reported them as very inaccessible. A neutral stance was expressed by 4.4% of the respondents. When asked to rate the quality of healthcare services provided to the elderly, more than half (56.7%) rated the services as good, while 18.1% considered them fair, 13.5% poor, and 2.6% very poor. Only 9.1% of the participants rated the services as excellent. In terms of satisfaction with healthcare programs available for elderly care, 50.9% of participants were satisfied, and 15.0% were very satisfied. Meanwhile, 15.7% remained neutral, 15.4% expressed dissatisfaction, and 3.0% reported being very dissatisfied. In assessing the availability of social support services for the elderly, just over half (50.5%) of participants indicated these services were somewhat available, while only 11.2% perceived them as very available. In contrast, 27.4% reported services as somewhat unavailable, and 3.9% as very unavailable. A neutral view was expressed by 7.0% of respondents. Regarding the effectiveness of social support programs, 54.6% of participants considered them effective, and 11.8% found them very effective. However, 16.1% described them as ineffective, 3.5% as very ineffective, and 14.0% were neutral. As for the use of social support services by caregivers, 41.6% reported occasional

use, and 19.3% confirmed regular use. A further 28.5% did not utilize services but were aware of them, while 10.6% stated they were not aware of any services. When identifying the biggest barriers to accessing healthcare for the elderly, the most cited challenge was logistical issues such as transportation and distance (35.4%), followed by cultural attitudes (30.1%), lack of awareness of services (21.8%), and financial constraints (12.7%). In terms of how family responsibilities hinder access to elderly healthcare, more than half (55.8%) reported that responsibilities sometimes interfere, while 16.1% said very often. Others noted that it rarely (16.6%) or never (11.5%) poses an obstacle. Lastly, the primary sources of information on elderly care services were family and friends (35.6%), followed by healthcare providers (22.2%), community centers (22.0%), and the internet (20.3%) Table (2). There was a statistically significant association between age and perceived accessibility of healthcare services ($P < 0.001$). Participants under 60 reported the highest level of perceived accessibility, with 9.6% rating services as very accessible and 63.7% as somewhat accessible. In contrast, those aged 76 and above reported lower accessibility, with only 4.0% indicating services were very accessible and 29.7% stating they were somewhat inaccessible. No statistically significant difference was observed in perceived accessibility between males and females ($P = 0.140$), although a slightly higher percentage of females (7.8%) considered services very accessible compared to males (6.1%). Significant regional differences in healthcare accessibility were identified ($P < 0.001$). Participants from Riyadh showed the highest perception of accessibility (9.1% very accessible, 72.6% somewhat accessible), whereas those from Asir reported the lowest accessibility levels, with only 42.6% indicating services were somewhat accessible and 31.1% reporting them as somewhat inaccessible. Accessibility perceptions also differed significantly by the role of the participant ($P < 0.001$). Healthcare providers reported the highest rate of perceived accessibility (13.4% very accessible), while caregivers and family members of the elderly reported more limited access. Elderly individuals themselves reported 5.5% very accessible and 24.1% somewhat inaccessible access to healthcare services Table (3).No statistically significant difference was observed in the utilization of support services across different age groups ($P = 0.095$). However, individuals aged 60–65 years reported the highest percentage of regular use (23.9%), while those aged 66–70 years had the highest percentage of occasional use (46.8%). The youngest group (<60 years) showed a relatively high unawareness of services (9.4%). The difference in service utilization between genders was not statistically significant ($P = 0.258$). A slightly higher percentage of males (20.2%) reported regular use compared to females (18.2%), though females more frequently used services occasionally (44.1% vs. 39.5%). There was a significant variation in the utilization of social support services across regions ($P < 0.001$). Participants from Asir reported the highest regular use (19.3%) and occasional use (41.6%), while Riyadh reported the lowest levels across all usage categories, with only 13.1% using services regularly and 27.9% reporting complete unawareness. There was no significant association between participant role and the use of support services ($P = 0.773$). Among healthcare providers and caregivers, about one-fifth (20.6% and 18.9% respectively) reported regular use. Elderly individuals themselves reported a regular use rate of 19.3% and occasional use of 42.9% Table (4).

Table 1: *Sociodemographic characteristics of the included participants (n=1006).*

Parameter		Frequency	Percentage (%)
Age, y	**Under 60**	427	42.4
	60-65 years	180	17.9
	66-70 years	158	15.7
	71-75 years	140	13.9
	76 and above	101	10.0
Gender	**Male**	555	55.2
	Female	451	44.8
Region	**Makkah**	590	58.6
	Eastern Province	191	19.0
	Riyadh	164	16.3
	Asir	61	6.1
Role	**Elderly individual**	746	74.2
	Family member of elderly	73	7.3
	Caregiver	90	8.9
	Healthcare provider	97	9.6

Table 2: *Elderly care assessment (n=1006)***.**

Parameter		Frequency	Percentage (%)
Health services			
Accessibility of healthcare services for the elderly in my area	**Very accessible**	69	6.9
	Somewhat accessible	644	64.0
	Neutral	44	4.4
	Somewhat inaccessible	234	23.3
	Very inaccessible	15	1.5
The rate the quality of healthcare services provided to the elderly	**Excellent**	92	9.1
	Good	570	56.7
	Fair	182	18.1
	Poor	136	13.5
	Very poor	26	2.6
Satisfaction with the healthcare programs available for elderly care	**Very satisfied**	151	15.0
	Satisfied	512	50.9
	Neutral	158	15.7
	Dissatisfied	155	15.4
	Very dissatisfied	30	3.0
Social Support Services			
Availability of social support services for the elderly in your region	**Very available**	113	11.2
	Somewhat available	508	50.5
	Neutral	70	7.0
	Somewhat unavailable	276	27.4
	Very unavailable	39	3.9
Effectiveness of the social support programs are in meeting the needs of the elderly:	**Very effective**	119	11.8
	Effective	549	54.6
	Neutral	141	14.0
	Ineffective	162	16.1
	Very ineffective	35	3.5
Support to the elderly individual you care for using any social support services:	**Yes, regularly**	194	19.3
	Yes, occasionally	418	41.6
	No, but I am aware of some services	287	28.5
	No, I am not aware of any services	107	10.6
Challenges			
The biggest barrier to accessing healthcare for the elderly	**Financial constraints**	128	12.7
	Cultural attitudes	303	30.1
	Logistical issues (transportation, distance, etc.)	356	35.4
	Lack of awareness of available services	219	21.8
How often do family responsibilities hinder your ability to access healthcare services for the elderly?	**Very often**	162	16.1
	Sometimes	561	55.8
	Rarely	167	16.6
	Never	116	11.5
The primary source of information on elderly care services:	**Community centers**	221	22.0
	Healthcare providers	223	22.2
	Family and friends	358	35.6
	Internet	204	20.3

Table 3: *Accessibility of healthcare services according to sociodemographic variables.*

Parameter		Accessibility of healthcare services for the elderly in the area					P-value
		Very accessible	Somewhat accessible	Neutral	Somewhat inaccessible	Very inaccessible	
Age, y	**Under 60**	41 (9.6%)	272 (63.7%)	31 (7.3%)	79 (18.5%)	4 (0.9%)	

	60-65 years	10 (5.6%)	122 (67.8%)	1 (0.6%)	45 (25%)	2 (1.1%)	**<0.001**
	66-70 years	6 (3.8%)	101 (63.9%)	7 (4.4%)	43 (27.2%)	1 (0.6%)	
	71-75 years	8 (5.7%)	89 (63.6%)	3 (2.1%)	37 (26.4%)	3 (2.1%)	
	76 and above	4 (4%)	60 (59.4%)	2 (2%)	30 (29.7%)	5 (5%)	
Gender	**Male**	34 (6.1%)	372 (67%)	26 (4.7%)	117 (21.1%)	6 (1.1%)	0.140
	Female	35 (7.8%)	272 (60.3%)	18 (4%)	117 (25.9%)	9 (2%)	
Region	**Makkah**	30 (5.1%)	380 (64.4%)	14 (2.4%)	157 (26.6%)	9 (1.5%)	**<0.001**
	Eastern Province	17 (8.9%)	119 (62.3%)	18 (9.4%)	35 (18.3%)	2 (1%)	
	Riyadh	15 (9.1%)	119 (72.6%)	5 (3%)	23 (14%)	2 (1.2%)	
	Asir	7 (11.5%)	26 (42.6%)	7 (11.5%)	19 (31.1%)	2 (3.3%)	
Role	**Elderly individual**	41 (5.5%)	492 (66%)	20 (2.7%)	180 (24.1%)	13 (1.7%)	**<0.001**
	Family member of elderly	7 (9.6%)	36 (49.3%)	10 (13.7%)	19 (26%)	1 (1.4%)	
	Caregiver	8 (8.9%)	55 (61.1%)	7 (7.8%)	19 (21.1%)	1 (1.1%)	
	Healthcare provider	13 (13.4%)	61 (62.9%)	7 (7.2%)	16 (16.5%)	0	

Table 4: *Utilization of social support services: sociodemographic analysis.*

Parameter		**Support to the elderly individual you care for using any social support services:**				**P-value**
		Yes, regularly	**Yes, occasionally**	**No, but I am aware of some services**	**No, I am not aware of any services**	
Age, y	**Under 60**	87 (20.4%)	166 (38.9%)	134 (31.4%)	40 (9.4%)	0.095
	60-65 years	43 (23.9%)	64 (35.6%)	55 (30.6%)	18 (10%)	
	66-70 years	24 (15.2%)	74 (46.8%)	40 (25.3%)	20 (12.7%)	
	71-75 years	22 (15.7%)	71 (50.7%)	34 (24.3%)	13 (9.3%)	
	76 and above	18 (17.8%)	43 (42.6%)	24 (23.8%)	16 (15.8%)	
Gender	**Male**	112 (20.2%)	219 (39.5%)	169 (30.5%)	55 (9.9%)	0.258
	Female	82 (18.2%)	199 (44.1%)	118 (26.2%)	52 (11.5%)	
Region	**Makkah**	108 (18.3%)	275 (46.6%)	155 (26.3%)	52 (8.8%)	**<0.001**
	Eastern Province	39 (20.4%)	62 (32.5%)	63 (33%)	27 (14.1%)	
	Riyadh	8 (13.1%)	15 (24.6%)	21 (34.4%)	17 (27.9%)	
	Asir	194 (19.3%)	418 (41.6%)	287 (28.5%)	107 (10.6%)	
Role	**Elderly individual**	144 (19.3%)	320 (42.9%)	207 (27.7%)	75 (10.1%)	0.773
	Family member of elderly	13 (17.8%)	25 (34.2%)	23 (31.5%)	12 (16.4%)	
	Caregiver	17 (18.9%)	36 (40%)	29 (32.2%)	8 (8.9%)	
	Healthcare provider	20 (20.6%)	37 (38.1%)	28 (28.9%)	12 (12.4%)	

4. Discussion

This study revealed that while the majority of participants (64.0%) found healthcare services for the elderly somewhat accessible, only a small fraction (6.9%) perceived them as very accessible, indicating room for improvement in service reach and ease of access. Regarding the quality of care, most participants (56.7%) rated it as good, though a notable proportion considered it fair or poor, suggesting variability in service standards. Satisfaction levels followed a similar trend, with 50.9% expressing satisfaction and only 15.0% being very satisfied, while approximately 18%

reported dissatisfaction or strong dissatisfaction. Studies reviewing patient satisfaction indicate that the most influential aspects of healthcare delivery include accessibility, continuity of care, compassion, the provision of information, and the comprehensiveness of services provided [6, 7]. **Mahfouz *et al.*,** reported that the ongoing demographic shifts in Saudi Arabia are expected to result in a growing proportion of healthcare resources being dedicated to the elderly population. To enhance elderly care, adopting an outreach strategy could be beneficial in raising awareness among both service users and providers about the availability and value of diverse programs designed to address their specific needs [8].We found that the main barrier to elderly healthcare was logistical issues (35.4%), followed by cultural attitudes (30.1%) and lack of service awareness (21.8%). Financial constraints were less commonly reported (12.7%). Family responsibilities interfered with access sometimes for 55.8% and very often for 16.1% of participants. Information about elderly care was mainly obtained from family and friends (35.6%), with less reliance on healthcare providers (22.2%), community centers (22.0%), and the internet (20.3%). **Mai *et al.*** found that difficulty in mobility was cited by some participants as the primary reason for not seeking hospital care when ill [9]. **Frumence *et al.*** conducted a similar study in Tanzania and found that reported barriers included the absence of specialized physicians for elderly patients, insufficient dedicated consultation areas, shortages of essential medications and medical equipment, limited funding, delays in the delivery of medical supplies to healthcare centers, and poor awareness of the eligibility criteria for healthcare fee exemptions for the elderly [10].This study reported that age significantly affected perceived healthcare accessibility ($P < 0.001$). Participants under 60 reported the highest access, while those aged 76+ had the lowest, with only 4.0% finding services very accessible and 29.7% reporting them as somewhat inaccessible. Trust in others is often viewed more positively among the most vulnerable groups—particularly older adults with lower education and income levels, poorer health status, and multiple chronic conditions [11]. Research suggests that as individuals age, their social networks tend to shrink, becoming more family-centered and geographically close [11]. Older adults also become more selective in their social interactions, prioritizing emotionally meaningful relationships, which results in less frequent contact, mostly limited to relatives [11, 12]. Furthermore, individuals aged 80 and above are more likely to experience social isolation due to declining health, functional impairments, and retirement, whereas those between 60 and 64 often show a greater need for support [13].This study concluded that regional differences in healthcare accessibility were significant ($P < 0.001$). Riyadh participants reported the highest access, while those in Asir had the lowest, with 31.1% finding services somewhat inaccessible. This could be due to the fact that Riyadh benefits from better healthcare infrastructure and more concentrated services. Asir faces rural challenges, including limited facilities, staff shortages, and transportation barriers. Moreover, social support service use varied significantly by region ($P < 0.001$); Asir had the highest usage, while Riyadh had the lowest, with 27.9% unaware of any available services. **Aly *et al.*** reported a statistically significant relationship between the place of residence and the availability of healthcare services for the elderly. Significant differences were observed in the type of services provided and the waiting time to receive care. Moreover, there was a highly significant difference regarding health insurance coverage and the cost of medications and diagnostic procedures. These disparities may be attributed to the higher proportion of elderly individuals residing in rural areas compared to urban ones, as well as the lower prevalence of health insurance among rural elderly compared to their urban counterparts [14]. Also, **van Gaans & Dent** reported that nearly half of rural residents visited urban hospitals, mainly due to the limited and inadequate healthcare services available in rural areas [15].We also found that perceived healthcare accessibility varied by participant role ($P < 0.001$); healthcare providers reported the highest access, while elderly individuals perceived lower access, with 24.1% finding services somewhat inaccessible. Healthcare providers are directly involved in service delivery. They are familiar with the system, know how to navigate it efficiently, and may have internal access to care. This insider position likely influences their perception, leading them to view services as more accessible [16].There was a significant variation in the utilization of social support services across regions ($P < 0.001$). Participants from Asir reported the highest regular use (19.3%) and occasional use (41.6%), while Riyadh reported the lowest levels across all usage categories, with only 13.1% using services regularly and 27.9% reporting complete unawareness.

Strengths and limitations

This study is among the first large-scale, cross-sectional investigations assessing elderly healthcare and social support services across multiple regions in Saudi Arabia. A major strength is the robust sample size, ensuring statistical reliability and

enabling subgroup analysis by age, gender, region, and role. The study also utilized a carefully designed and pilot-tested bilingual questionnaire (Arabic and English), improving accessibility and clarity for diverse respondents. Despite its strengths, the study has limitations. The use of a self-reported survey introduces the risk of response bias, particularly in rating service satisfaction and accessibility. Additionally, while the sample was regionally stratified, certain regions (e.g., Asir) were underrepresented, potentially limiting generalizability. The cross-sectional design also restricts causal inference, and qualitative data were not collected, which could have provided deeper insight into the personal experiences of elderly care.

5. Conclusion

This study emphasizes the complexity of elderly care delivery in Saudi Arabia. While many participants view healthcare services positively, notable disparities exist by age and region, particularly in terms of accessibility and awareness. Social support services show promise but remain underutilized and poorly communicated in certain areas. Key barriers such as logistical limitations, cultural perceptions, and caregiver burden must be addressed through multifaceted interventions. Future studies should explore the effectiveness of intervention programs and delve deeper into the lived experiences of older adults and their caregivers to develop more person-centered strategies.

Author Statements:

- **Ethical approval:** The conducted research is not related to either human or animal use.
- **Conflict of interest:** The authors declare that they have no known competing financial interests or personal relationships that could have appeared to influence the work reported in this paper
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