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Ageing and Social Vulnerability in Algeria: A Sociological Study on the Reality of Healthcare Services for the Elderly in Djelfa and Hassi Bahbah

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Abstract :

Algeria, like many developing countries, is undergoing profound demographic transformations marked by an increasing proportion of elderly people. This demographic shift has placed significant pressure on the national healthcare and social protection systems. Simultaneously, the decline of the extended family and the rise in family fragmentation have weakened traditional mechanisms of care and support for older adults. This study aims to analyze the current state of healthcare services provided to the elderly in Algeria, focusing on the socio-demographic and economic factors that affect their health status.

The research adopts both quantitative and qualitative approaches, based on a field study conducted in the cities of Djelfa and Hassi Bahbah. Data were collected through structured interviews with a purposive sample of 160 elderly individuals. The study is built upon several hypotheses that assume statistically significant relationships between variables such as gender, age, marital status, living standards, and family support, and the quality of healthcare received.

Data were analyzed using SPSS software, and interpreted through various sociological theories of ageing, including the disengagement theory, activity theory, and demographic transition theory. The results indicate that an elderly person's health status is closely linked to their social and economic conditions. Furthermore, the lack of family support significantly affects the quality of care they receive. The study concludes with a call to re-evaluate elderly healthcare policies in Algeria, urging a shift from reactive measures to preventive, proactive, and integrated approaches that take into account social, cultural, and economic dimensions.

Keywords: Ageing; Elderly; Healthcare Services; Social Vulnerability; Family Disintegration; Demographic Transition; Inland Algeria.

Introduction

Algeria has experienced accelerated demographic transformations in recent decades, marked by a growing proportion of elderly people as a result of increased life expectancy and declining fertility rates. This new population dynamic has compelled society to reconsider patterns of care and support, particularly in light of the erosion of traditional solidarity networks and the declining role of the extended family. Social transformations associated with globalization, spatial mobility, and economic pressures have collectively weakened the family's role in protecting and caring for older adults, especially in inland cities and marginalized areas.

The cities of Djelfa and Hassi Bahbah represent two illustrative cases that clearly reflect this reality. Both suffer from weak health infrastructure and the absence of programs specifically tailored to older persons. Despite the rising number of elderly residents, healthcare services remain inadequate and are delivered according to a generalist logic that fails to take into account the specific nature of aging as a biological, psychological, and social phenomenon. Consequently, older individuals in these areas confront a complex triad: health vulnerability, poverty, and social isolation, rendering aging a harsh experience at both the individual and collective levels.

Accordingly, this study seeks to critically examine the reality of healthcare provision for the elderly in Djelfa and Hassi Bahbah through a sociological approach aimed at understanding the determinants that shape this care, drawing on the local demographic, social, and economic structure.

1. Research Problem

Aging in contemporary Algeria raises a set of social and health-related challenges, particularly in inland regions that suffer from structural marginalization. While national policies emphasize free healthcare and guarantees of medical coverage, the empirical reality often reflects the fragility of public health services, especially for the elderly population.

From this standpoint, the present study advances the following central research question:

What is the nature of the relationship between the demographic, social, and economic situation of older adults and the level of healthcare they receive in the cities of Djelfa and Hassi Bahbah?

This main question gives rise to a set of subsidiary questions:

- Are there statistically significant differences between the variables of gender, age, and marital status, on the one hand, and the health status of older adults, on the other?

- How do living standards and income influence the quality of healthcare provided to the elderly?
- To what extent does the nature of family relationships (solidarity, isolation, living alone) affect the health status of older adults?
- Is there a relationship between educational level and previous occupation and the elderly person's ability to access healthcare services?

2. Hypotheses

The following hypotheses can be formulated:

- There is a statistically significant relationship between demographic factors (age, gender) and the health status of older adults.
- The higher the standard of living, the better the healthcare indicators among the elderly.
- The decline of family solidarity and social relationships contributes to the deterioration of the health status of older adults.
- Educational level and previous occupation enhance the opportunities of older persons to access healthcare services.

3. The Theoretical Grounding of Aging and Health and Social Marginalization

3.1. Aging as a Demographic and Social Phenomenon

Statistical data derived from the various population censuses conducted in Algeria from independence up to 2008 indicate a steady upward trend in the number of older persons, reflecting the country's gradual entry into a demographic phase characterized by an increasing proportion of elderly individuals. The number of older adults (aged 60 years and over) rose from 793,000 in 1966 to more than 2.5 million in 2008[1], representing 7.5% of the total population.

This clear quantitative growth in the elderly population constitutes a significant indicator of what is commonly referred to as population aging. This phenomenon is manifested not only in the numerical increase of older persons, but also in the profound structural transformations affecting the configuration of the Algerian population pyramid.

The data further indicate qualitative shifts in demographic dependency indicators. The total dependency ratio—which expresses the proportion of dependents (under 16 years and over 60 years) relative to the working-age population (16–59 years)—declined markedly from 116.7% in 1966 to only 55% in the 2008 census. Likewise, the youth dependency ratio decreased during the same period from 102.4% to 43.5%. This trend reflects the contraction of younger age groups and the expansion of the economically active population, thereby

opening the way to what is commonly referred to as the **"demographic dividend."** At the same time, however, it foreshadows a future characterized by increasing burdens associated with elderly care.

With regard to the age and gender structure of the elderly population, the age group 60–64 accounts for the largest share (28.1%), followed by the 65–69 age group (24.9%), and then the 70–74 age group (19.9%). This confirms that the overwhelming majority of older persons are concentrated within what is termed the *third age* (60–79 years), which represents 87.4% of the total elderly population, compared to only 12.6% in the *fourth age* category (80 years and over)[2].

In terms of gender distribution, the data reveal a relative balance between men and women within the elderly population (49.6% men versus 50.4% women). However, female predominance becomes more pronounced at very advanced ages, where the masculinity ratio declines to 88.4 among those aged 85 years and over, reflecting higher mortality rates among men compared to women.

Taken together, these indicators point to a clearly defined demographic trajectory in which Algeria is moving toward a gradual yet undeniable aging of its population. This transformation calls for a strategic reassessment of its implications, particularly in relation to public policy planning in the areas of health, social protection, and pensions, as well as in addressing the challenges associated with growing demand for long-term care services and the weakening balance between productive and non-productive segments within the population structure.

This demographic shift constitutes a major challenge for health and social policies, as demand for healthcare services is increasing at a time when the public health system is experiencing structural pressure and a lack of specialized care for older persons, particularly in inland regions such as Djelfa and Hassi Bahbah.

3.2. Theories of Aging: Approaches to Understanding Marginalization

A. Disengagement Theory

Disengagement Theory is one of the earliest theories in the sociology of aging, offering an explanation of the adaptation process to advancing age. Developed by Cumming and Henry (1961), the theory posits that older adults gradually withdraw from their previous social roles and reduce their social activities and relationships as they age[3].

This withdrawal occurs due to biological, psychological, and social factors. However, it is not always voluntary; it can be imposed by societal marginalization and the lack of a supportive environment. According to the theory, this process is reciprocal: as the individual gradually disengages, society simultaneously

marginalizes the older person from their former roles (e.g., mandatory retirement), resulting in decreased social interaction.

While this withdrawal can be beneficial for both the individual and society under certain circumstances, in contexts lacking supportive networks and symbolic recognition, it can turn into forced exclusion. The theory also highlights that the patterns of disengagement vary across cultures and social contexts and differ according to the individual's previous occupation. A common critique is that the theory does not adequately apply to older adults engaged in fields such as literature, arts, or higher education, where they continue to produce work and participate actively in social life.

B. Activity Theory

Activity Theory, as discussed by Thorson (1995), presents a perspective contrary to Disengagement Theory. It is based on the central premise that the continuation of high levels of physical, social, and cognitive activity is a key indicator of successful adaptation to aging[4].

Field studies have shown that older adults who remain engaged in social activities, maintain previous hobbies, or develop new skills and interests tend to experience higher levels of life satisfaction, better mental and physical health, and greater longevity compared to peers who gradually withdraw from social and community engagement.

Therefore, **Schroots** emphasized that healthy aging implies maintaining older adults in a state of continuous activity regardless of their limited capacities. Such studies have underscored the importance of the *quality* of activities in which older persons engage rather than merely the frequency of participation (i.e., the repetition of activity)[5].

In the absence of structured social activities for older adults in marginalized cities such as those under study, marginalization becomes entrenched due to the lack of an "enabling structure" capable of activating the principles of this theory.

C. Demographic Transition Theory

Demographic Transition Theory reflects the shift of societies from high birth and death rates to low birth and death rates, leading ultimately to the aging of the population structure. In Algeria, the country has entered an advanced stage of this transition since the 1980s.

Data indicate that during the 1980s Algerian society was among the youngest populations in the world. However, current and projected trends in fertility and mortality are expected to lead to a level of population aging above the global average. The elderly population aged 60 years and over—currently representing approximately 9.3% of the total population[6]—is projected to double

between 2030 and 2050 as the generations born during the demographic boom (1970–1980 cohorts) reach retirement age.

Demographic projections further indicate that older persons will represent 14.7% of Algeria's total population by 2030 and 22% by 2050. The number of individuals aged 60 and over, estimated at 2.2 million in 2002, increased to 2.8 million in 2010 and 3.8 million in 2017; it was expected to reach 4.3 million in 2020 and 6.7 million by 2030[7].

From the foregoing, it is evident that Algeria is undergoing a clear demographic shift toward population aging—a trajectory that is likely to become more pronounced in the coming decades, with a steady increase in the proportion of older persons within the population structure. This transformation is reflected not only in the age pyramid but also in profound challenges concerning the society's capacity for demographic renewal in the context of declining fertility rates and rising dependency ratios.

The financing of healthcare for the elderly is expected to impose a growing burden on the state budget, particularly given the increasing demand for specialized long-term healthcare services. Likewise, pressure on social security institutions and pension funds is anticipated to intensify due to the contraction of the economically active population and the rising financial obligations associated with supporting non-productive age groups.

Although Algeria has not yet formally entered the stage of an "aged society," current transformations indicate a gradual erosion of the demographic youthfulness that once characterized the country. This situation calls for rational and anticipatory public policy planning to address the forthcoming societal implications of aging.

4. Social Vulnerability and Structural Marginalization of Older Adults

The marginalization experienced by older adults in Algeria, particularly in inland cities, is associated with multiple socio-economic and structural factors:

- The disintegration of the extended family and the emergence of the nuclear family, which is less capable of caring for older adults.
- The lack of effective health coverage despite legal provisions, where free treatment often exists in form but not in practice.
- Poverty and weak pensions, which do not allow coverage of treatment costs or purchase of chronic medications, especially for widowed women.
- Geographic discrimination, as specialized healthcare institutions are concentrated in the capital and major cities, while marginalized cities such as Djelfa and Hassi Bahbah remain outside the spatial justice framework for health.

5. The Concept of Marginalization from a Sociological Perspective

From a sociological standpoint, marginalization is not merely the absence of care; it is the result of **"structural exclusion mechanisms"** that place certain groups outside social protection systems. In a marginalized city, older adults become victims of accumulated environmental, economic, and structural disadvantages, rendering them more vulnerable to illness and psychological and social neglect.

Consequently, an elderly person without an adequate pension or without children capable of caring for them faces a stark choice: self-neglect or institutional humiliation.

It can be argued that healthcare for older adults is not merely a medical issue but reflects a symbolic and material struggle between the center (major cities) and the periphery (inland cities), between the state and society, and between the individual and their family structure. Therefore, understanding the situation of older adults in Djelfa and Hassi Bahbah requires consideration of marginalization, demographic transition, and the decline of traditional solidarity networks.

6. Study Sample: Definition, Characteristics, and Selection Criteria

6.1. Sample Definition and Size

The study relied on a **non-probabilistic purposive sample** of 160 older adults (aged 60 years and over), distributed across two carefully selected cities: Djelfa and Hassi Bahbah. This sample forms the basis of both quantitative and qualitative analyses of healthcare realities, using structured interviews conducted individually with each participant.

6.2. Justification for Using a Purposive Sample

This method was adopted for several methodological and sociological reasons:

A. Social Nature of the Study

Older adults in Algeria constitute a *hidden population*, difficult to reach through probability sampling due to:

- The absence of updated databases,
- Lack of precise official local records on older adults,
- A large portion of older adults not enrolled in social security networks.

B. Specificity of the Population Studied

Older adults are not only an age category; they are part of a socially vulnerable reality, influenced by factors such as:

- Civil status (widows, divorced, unmarried),
- Living situation (with family, alone, or in precarious housing),
- Ability to communicate and level of health awareness.

Accordingly, participants were selected based on precise purposive criteria, including:

- Age (60 years and over),
- Gender (male and female),
- Location (permanent residence in Djelfa or Hassi Bahbah),
- Presence of chronic diseases or prior experience with healthcare institutions.

6.3. Fieldwork Challenges

The specificity of the study population necessitated the use of a purposive sample due to the lack of a comprehensive statistical framework for older adults. Participatory observation and contact with local actors (e.g., imams, neighborhood associations) provided a gateway for sample selection.

A. Geographic Distribution of the Sample

The sample was divided as follows:

- 80 participants from Djelfa, selected from popular neighborhoods and the city center (e.g., Hay Al-Hada'iq, Hay Ben Jerma, Hay El-Borj).
- 80 participants from Hassi Bahbah, from various neighborhoods such as the center, Hay El-Wiam, and Hay Mohamed Boudiaf.

This distribution maintains spatial balance between the major city and its urban periphery, allowing analysis of healthcare disparities according to urban centrality.

6.4. Basic Social Characteristics of the Sample

According to data collected via structured interview forms:

- 56% of the sample were female, 44% male.
- Most participants were aged 65–74 years.
- 70% suffered from chronic diseases (hypertension, diabetes, heart disease).
- 66% were widowed or divorced.
- Only 28% had effective social coverage (CNAS or CASNOS).
- 41% lived with a child, while 13% lived alone.
- 82% had never visited specialized healthcare centers for older adults.

6.5. Importance of the Sample

Although non-probabilistic, the sample offers:

- Age, social, and urban diversity that provides an acceptable representation of local realities,
- Data collected through semi-structured and open-ended forms, offering significant qualitative depth to the statistical analysis.

*** Methodological Note:**

The following descriptive data were drawn from the purposive sample (160 participants) distributed across Djelfa (80) and Hassi Bahbah (80), based on structured interview forms.

Table 1: Distribution of Sample by Gender

Gender	Number	Percentage (%)
Male	70	43.75
Female	90	56.25
Total	160	100

The higher proportion of women in the sample (56.25%) represents an important demographic indicator associated with what is known as **"feminization of aging,"** a phenomenon observed in Arab societies where women outlive men. However, this increase does not imply an improvement in quality of life; widowed older women are more vulnerable to marginalization, particularly in the absence of children or when pensions are insufficient.

Table 2: Distribution of Sample by Age Group

Age Group	Number	Percentage (%)
60–64	25	15.6
65–69	52	32.5
70–74	46	28.7
75+	37	23.1
Total	160	100

These results indicate that the majority of older adults are aged **65–74**, a period characterized by higher prevalence of chronic diseases and declining physiological functions. Consequently, this age group represents the most in need of regular and specialized healthcare, highlighting how the absence of dedicated elderly care institutions in Djelfa and Hassi Bahbah signals **systematic institutional marginalization**.

Table 3: Distribution of Sample by Marital Status

Marital Status	Number	Percentage (%)
Married	45	28.1
Widowed	83	51.8
Divorced	18	11.2
Single	14	8.7

Total	160	100

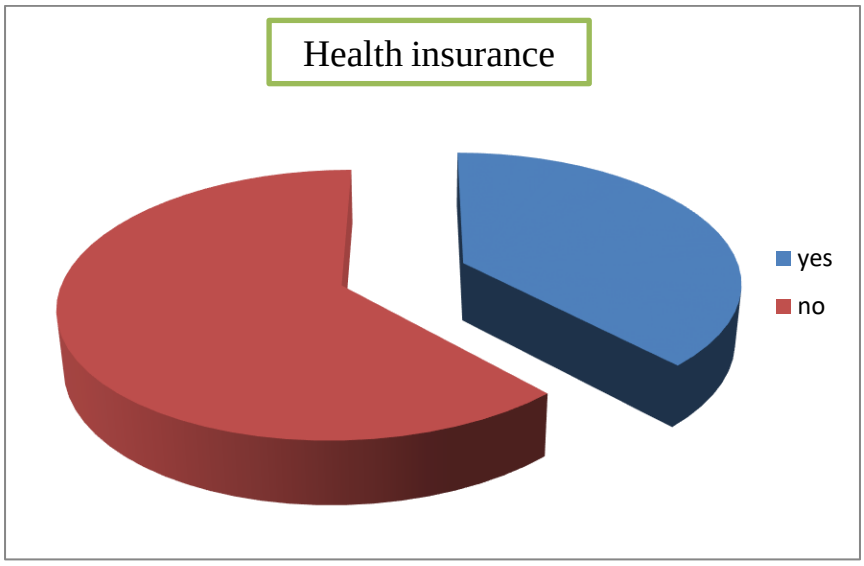
The high proportion of widowed participants (51.8%), particularly among women, reinforces the notion that the **loss of a spouse significantly increases social and health vulnerability**. Several sociological studies (including the dissertation, p. 13) indicate that living alone after retirement constitutes a risk factor for both mental and physical health.

Table 4: Health Status According to Respondents

Self-Reported Health Status	Number	Percentage (%)
Good	29	18.1
Moderate (Minor Problems)	56	35.0
Poor (Chronic Diseases)	75	46.9
Total	160	100

This table shows that nearly half of the sample (46.9%) suffer from chronic diseases requiring continuous medical care, while only 18% consider their health status "good." In the absence of effective health coverage, these figures reflect the structural health exclusion faced by older adults in these regions.

Pie Chart: Distribution of the Sample by Health Coverage



The pie chart illustrates that more than 60% of older adults lack any health coverage, reflecting the persistence of marginalization mechanisms within healthcare institutions, especially in the context of economic burdens and rising medication costs.

Partial Conclusions from Descriptive Analysis

- There is a relative predominance of women in the sample, necessitating a focus on gender in healthcare analysis.
- The majority of the sample falls within the health-critical age group (65–74), highlighting the need for preventive care programs.

- The high proportion of widowed and divorced participants indicates the erosion of traditional social support networks.
- A significant portion without health insurance suffers from dual vulnerability: economic and institutional.

2nd Stage: Hypothesis Analysis Using Cross-Tabulations and Statistical Treatment with In-Depth Sociological Interpretation

A- Analysis of the First Hypothesis

Hypothesis: There is a statistically significant relationship between demographic factors (age, gender, marital status) and the health status of older adults.

Table 5: Relationship Between Gender and Health Status

Health Status / Gender	Good		Moderate		Poor Chronic)		Total	
	n	%	n	%	n	%	n	%
Male	19	27.1	27	38.5	24	34.2	70	100
Female	10	11.1	29	32.2	51	56.7	90	100
Total	29	18.1	56	35	75	46.87	160	100

Interpretation:

- Older women are more likely to suffer from chronic diseases (56.7%) compared to men (34.2%).
- This gap reflects what the World Health Organization (WHO) terms the "unequal health burden" among older women, particularly in societies facing poverty and unequal access to healthcare services.
- According to WHO's 2020 report, "older women live longer but with lower health-related quality of life compared to men, due to lack of health coverage and structural poverty[8]."
- Additionally, data from the Office National des Statistiques (ONS, 2023) indicate that the life expectancy for Algerian women is 78.6 years, compared to 74.2 years for men, implying additional years of health challenges for women.

This evidence highlights the intersection of gender, age, and social vulnerability, showing that older women in Algeria are particularly at risk of chronic illness and inadequate healthcare access.

Table 6: Relationship Between Age Group and Health Status

Health Status	Good		Moderate		Poor Chronic)		Total	
	n	%	n	%	n	%	n	%

Age Group								
60 – 64	10	40	10	40	5	20	25	100
65 – 69	9	17.31	20	38.46	23	44.23	52	100
70 – 74	6	13.04	16	34.79	24	52.17	46	100
75+	4	10.81	10	27.03	23	62.16	37	100
Total	29	18.13	56	35	75	46.87	160	100

Observations:

- The likelihood of chronic disease increases with age.
- Among those aged 75 and above, 62.16% suffer from poor health, confirming the concept of "cumulative age-related frailty."
- A field study by Robert Butler, founder of gerontology, emphasizes that "aging is not merely a temporal stage but a system of accumulated health and social factors that determine individual frailty. [9]"

b- Analysis of Hypothesis 2

Hypothesis: The higher the living standard, the better the health care indicators among older adults.

Table 7: Relationship Between Monthly Income and Health Status

Health Status / Monthly Income (DZ)	Good		Moderate		Poor Chronic)		Total	
	n	%	n	%	n	%	n	%
<15,000	4	6.67	17	28.33	39	65.00	60	100
15,000–30,000	11	22	20	40	19	38.00	50	100
>30,000	14	28	19	38	17	34.00	50	100
Total	29	18.13	56	35	75	46.87	160	100

Interpretation:

- Among the lowest-income group (<15,000 DZD/month), 65% suffer from chronic diseases.
- Conversely, in the highest-income group (>30,000 DZD), 28% report good health—nearly four times the rate of the poorest group.
- This aligns with WHO's statement:

"Poverty is the strongest predictor of health frailty in old age. Malnutrition, irregular treatment, and social isolation intersect in low-income populations" [10].

c- Analysis of Hypothesis 3

Hypothesis: Decline in family solidarity and social relations exacerbates the health status of older adults.

Table 8: Relationship Between Living Arrangements and Health Status

Health Status	Good		Moderate		Poor Chronic)		Total	
Living Arrangement	n	%	n	%	n	%	n	%
Lives with children	21	31.82	29	43.94	16	24.24	66	100
Lives with spouse	6	16.22	13	35.14	18	48.65	37	100
Lives alone	2	5.13	14	35.90	23	58.97	39	100
Lives with extended family	0	0	0	0	18	100	18	100
Total	29	18.13	56	35	75	46.87	160	100

Interpretation:

- 58.97% of those living alone suffer from poor health.
- Only 24.24% of those living with children are in poor health.
- As Ellen Idler notes, "Social isolation among older adults is directly linked to premature mortality and weakened psychological and physical resilience[11]".
- In Algeria, the breakdown of extended families and the shift toward nuclear households has intensified isolation among older adults, especially in interior cities like Djelfa with weak alternative care institutions.

d- Analysis of Hypothesis 4

Hypothesis: Educational level and prior occupation improve older adults' access to healthcare services.

Table 9: Relationship Between Educational Level / Previous Occupation and Access to Health Services

Healthcare Services	Regular Access		Irregular Access		No Access		Total	
Education / Occupation	n	%	n	%	n	%	n	%
No education / manual jobs	10	14.08	36	50.70	25	35.21	71	100

Primary / simple employee	11	30.56	17	47.22	8	22.22	36	100
Secondary / public employee	18	58.06	10	32.26	3	9.68	31	100
University / former professional	18	81.82	3	13.64	1	4.55	22	100
Total	57	35.63	66	41.25	37	23.13	160	100

Interpretation:

A close reading of the table reveals a striking gradient in access to healthcare services by educational attainment. Older adults with a university education exhibit the highest rate of regular access to healthcare (81.82%), compared with only 14.08% among those with no formal schooling.

The data further indicate that uneducated respondents are considerably more inclined to forgo healthcare services altogether: 35.21% of this group report never seeking care, whereas the corresponding proportion among university-educated older adults is merely 4.55%.

This disparity can be interpreted through several interrelated sociological mechanisms. First, as argued by Pierre Bourdieu, education constitutes a central form of cultural capital, endowing individuals with the cognitive competencies and symbolic resources necessary to navigate institutional fields effectively—including the medical field. Educational attainment enhances the capacity to understand administrative procedures, interpret medical information, and engage confidently with healthcare professionals.

Second, educated older adults are generally better equipped with communicative skills and health literacy, which increase their likelihood of adhering to preventive care and sustaining regular medical follow-up. In this regard, the World Health Organization has consistently emphasized that health empowerment is closely associated with educational level, noting that individuals with higher education are more aware of health risks and more proactive in seeking periodic medical care.

Education also plays a structural role in the formation and maintenance of social networks. In contexts where traditional forms of familial solidarity are eroding, these networks may function as alternative channels facilitating information, guidance, and access to care.

Accordingly, the hypothesis that educational level and prior occupation enhance older adults' opportunities for accessing healthcare services is substantiated both by the empirical findings and by sociological analysis. The table shows that seniors with university education and former professional or managerial positions record higher levels of regular healthcare access (24

individuals), compared with only 12 among the uneducated group. This pattern can be attributed to the cumulative effect of cultural and professional capital, which enables older adults to comprehend the healthcare system, communicate effectively with physicians, and mobilize social resources to secure appropriate services.

The World Health Organization further notes that cognitive disparities in old age are closely linked to educational inequalities, helping to explain the limited uptake of healthcare programs among less-educated groups. From a Bourdieusian perspective, education forms the basis of what may be described as symbolic health capital—a set of accumulated dispositions and competencies that allow individuals to move strategically and effectively within the medical field.

First: Education and Regular Access to Healthcare

The table clearly demonstrates that regular access to healthcare services increases markedly with higher levels of educational attainment:

- Only **14.08%** among the non-educated report regular access.
- The proportion rises dramatically to **81.82%** among university graduates.

This pattern is consistent with the theoretical framework advanced by Pierre Bourdieu concerning *cultural capital*. The educated older adult possesses:

- A greater capacity to comprehend the structure and functioning of the healthcare system.
- Enhanced ability to engage in social negotiation within healthcare institutions.
- Broader knowledge of rights related to insurance coverage and preventive services.

Second: The Impact of Previous Occupation

Retired executives and former teachers display higher levels of regular healthcare utilization. This is largely because they:

- Maintain professional relationships and support networks (*cercle professionnel*).
- Possess administrative experience that facilitates navigation of institutional procedures.
- Benefit from relatively strong health insurance schemes (e.g., CNAS, CASNOS).

Professional trajectory, therefore, operates as an extension of accumulated social and symbolic capital, reinforcing healthcare access beyond retirement.

Third: Vulnerable Groups

Older adults originating from manual labor backgrounds and lacking formal education constitute the most health-marginalized group:

- Approximately **30%** of them never access healthcare services at all.

- This reflects a condition of *compound vulnerability*—social, health-related, and cognitive.
- These individuals often lack both supportive networks and the informational tools necessary to secure adequate care.

Theoretical Interpretation

The findings may be interpreted through the theoretical lenses adopted in this study:

A. Demographic Transition Theory:

Older adults in Algeria are, in part, products of a society that, during certain historical phases, offered limited access to formal education and structured employment. The demographic transition thus necessitates a restructuring of public services to accommodate these historically disadvantaged cohorts.

B. Activity Theory:

The more actively engaged an individual was in social and professional life in earlier stages, the greater the likelihood of sustaining an active and health-conscious life in old age. University graduates and former professionals exemplify this "active aging" profile.

C. Disengagement Theory:

Non-educated older adults are more prone to withdrawal from public life—including healthcare participation—often due to diminished feelings of efficacy and social relevance.

Broader Findings of the Study:

The hypothesis testing conducted in this research reveals that aging in the cities of Djelfa and Hassi Bahbah is not experienced as a natural life transition. Rather, it constitutes a dual predicament—both health-related and social—stemming from structural imbalances in public policy on the one hand and the erosion of traditional solidarity patterns on the other.

The findings indicate:

- Women and individuals over the age of 74 represent the most vulnerable category, as biological frailty intersects with social marginalization.
- Low income and insufficient health coverage function as key socioeconomic determinants of deteriorating health status.
- Family disintegration, solitary living arrangements, and high rates of widowhood and singlehood in later life exacerbate chronic illness and psychological isolation.
- The geographic marginality of interior cities such as Djelfa and Hassi Bahbah produces what may be termed **"dual health exclusion"**: the state provides

insufficient healthcare infrastructure, while society offers diminishing familial support.

- Educational level and prior occupation play a decisive role in enhancing access to healthcare services; university graduates and retirees from formal professions benefit significantly more than the uneducated or those employed in informal sectors.

The Concept of Compound Vulnerability:

Within this framework emerges the concept of compound vulnerability, integrating:

- **Demographic factors:** age and gender
- **Socioeconomic factors:** income and social protection
- **Family and social factors:** relationships and isolation
- **Cultural factors:** educational attainment

Together, these dimensions form an interwoven network of determinants that push older adults toward what may be described as the margins of social and health existence. They are increasingly perceived as consumers of resources rather than as active social agents—an evolution that poses a silent threat to social cohesion in Algeria.

Policy Recommendations

- Establish public geriatric health centers in interior cities such as Djelfa and Hassi Bahbah, staffed by specialized medical professionals.
- Implement free healthcare coverage for economically disadvantaged older adults through an integrated national information system linking health and social protection administrations.
- Revitalize local solidarity mechanisms (associations, mosques, municipalities, neighborhood committees) to perform mediation and community care functions.
- Support sociological research on aging and vulnerability to inform evidence-based public policy.
- Promote *active aging* programs integrating older adults into social, cultural, and volunteer activities, thereby strengthening dignity and a sense of purpose.
- Reform media discourse concerning older adults through local awareness campaigns that combat stereotypes and highlight their societal value.

Conclusion

Aging is not merely a biological transformation in the life course; it is a profoundly social experience reflecting an individual's position within the structural and normative framework of society. The deterioration of health and social conditions among older adults revealed in this study does not simply signal

individual frailty; it exposes broader shortcomings in value systems, public policy, and traditional care structures.

Healthcare for older adults, therefore, cannot be reduced to pharmaceuticals and hospital services alone. It calls for a comprehensive societal project—one that restores the older person to their rightful status as a bearer of memory, wisdom, and social equilibrium.

Bibliography List :

1-Books:

1. Mohamed Khalifa Abdel Latif, *Studies in the Psychology of Older Adults*, Dar Gharib for Printing, Publishing and Distribution, Cairo, 1997.
2. Jake Harwood, *Understanding Communication and Aging: Developing Knowledge and Awareness*, Sage Publications, Los Angeles, 2007.
3. Nabil El-Hadj Mohamed, *Aging: Its Characteristics and Disorders*, 1st edition, Dar Al Nahda Al Arabiya, Lebanon, 2019.
4. Butler, R.N., *The Longevity Revolution: The Benefits and Challenges of Living a Long Life*, PublicAffairs, 2008.
5. Idler, E., *Religion and Aging Health*, Rutgers University Press, 2014, p. 59.

2- Journal Articles:

6. Karima Bouaziz, "Population Aging in Algeria: Current Situation and Future Trends," *Istishraf Journal for Future Studies*, Arab Center for Research and Policy Studies, Special Issue on Implications of Demographic Transformations in the Arab World, Qatar, 2020.

3- Dissertation Articles:

7. Karima Bouaziz, *Health Status and Living Conditions of the Elderly Population in Algeria and Their Relationship with Certain Demographic, Social, and Economic Factors*, PhD dissertation in Demography, University of Algiers 2, 2014.

4- Reports:

8. Office National des Statistiques (ONS), *Démographie algérienne 2019*, No. 890, Algiers, 2019.
9. Office National des Statistiques, *Algeria in a Few Figures*, No. 47, Statistical Series Collection: Ordered Series / Time Series / Statistical Distribution, Algiers: ONS, 2018.

Institutional Reports:

10. WHO, *Global Strategy and Action Plan on Ageing and Health*, 2020.
11. WHO, *Ageing and Health Report*, 2021.

[1] Office National des Statistiques (ONS). Démographie algérienne 2019, No. 890, Algiers, 2019, p. 15.
[2] Karima Bouaziz, "Population Aging in Algeria: Current Situation and Future Trends," Istishraf Journal for Future Studies, Arab Center for Research and Policy Studies, Special Issue on Implications of Demographic Transformations in the Arab World, Qatar, 2020, pp. 157–158.
[3] Mohamed Khalifa Abdel Latif, Studies in the Psychology of Older Adults, Dar Gharib for Printing, Publishing and Distribution, Cairo, 1997, p. 35.
[4] Jake Harwood: Understanding communication and aging ,developing knowledge and awareness, Sage Publications, Los Angeles, 2007, P 14.
[5] Nabil El-Hadj Mohamed, Aging: Its Characteristics and Disorders, 1st edition, Dar Al Nahda Al Arabiya, Lebanon, 2019, p. 24.
[6] Office National des Statistiques, Algeria in a Few Figures, No. 47, Statistical Series Collection: Ordered Series / Time Series / Statistical Distribution, Algiers: ONS, 2018.
[7] Karima Bouaziz, "Health Status and Living Conditions of the Elderly Population in Algeria and Their Relationship with Certain Demographic, Social, and Economic Factors," PhD dissertation in Demography, University of Algiers 2, 2014, p. 2.
[8] WHO: Global Strategy and Action Plan on Ageing and Health, 2020, P 23.
[9] Butler, R.N. (2008). The Longevity Revolution: The Benefits and Challenges of Living a Long Life. PublicAffairs, p 41.
[10] WHO, Ageing and Health Report 2021, P 33.
[11] Idler, E. (2014). Religion and Aging Health, Rutgers University Press, p 59.