Ageing in the Middle East and North Africa: Towards a New Model of Care

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INTERNATIONAL
LONG TERM CARE
POLICY NETWORK

Acknowledgments and Disclaimer

This work was partially funded by the World Bank and the United Nations International Children's Emergency Fund (UNICEF)

It was also partially funded by the English Department of Health through core funding to the Social Care Workforce Research Unit

The authors are grateful to these organisations

The views presented are those of the authors alone and do not necessarily represent those of the funders

BACKGROUND AND CONTEXT

The Middle East and North Africa: .. How similar?

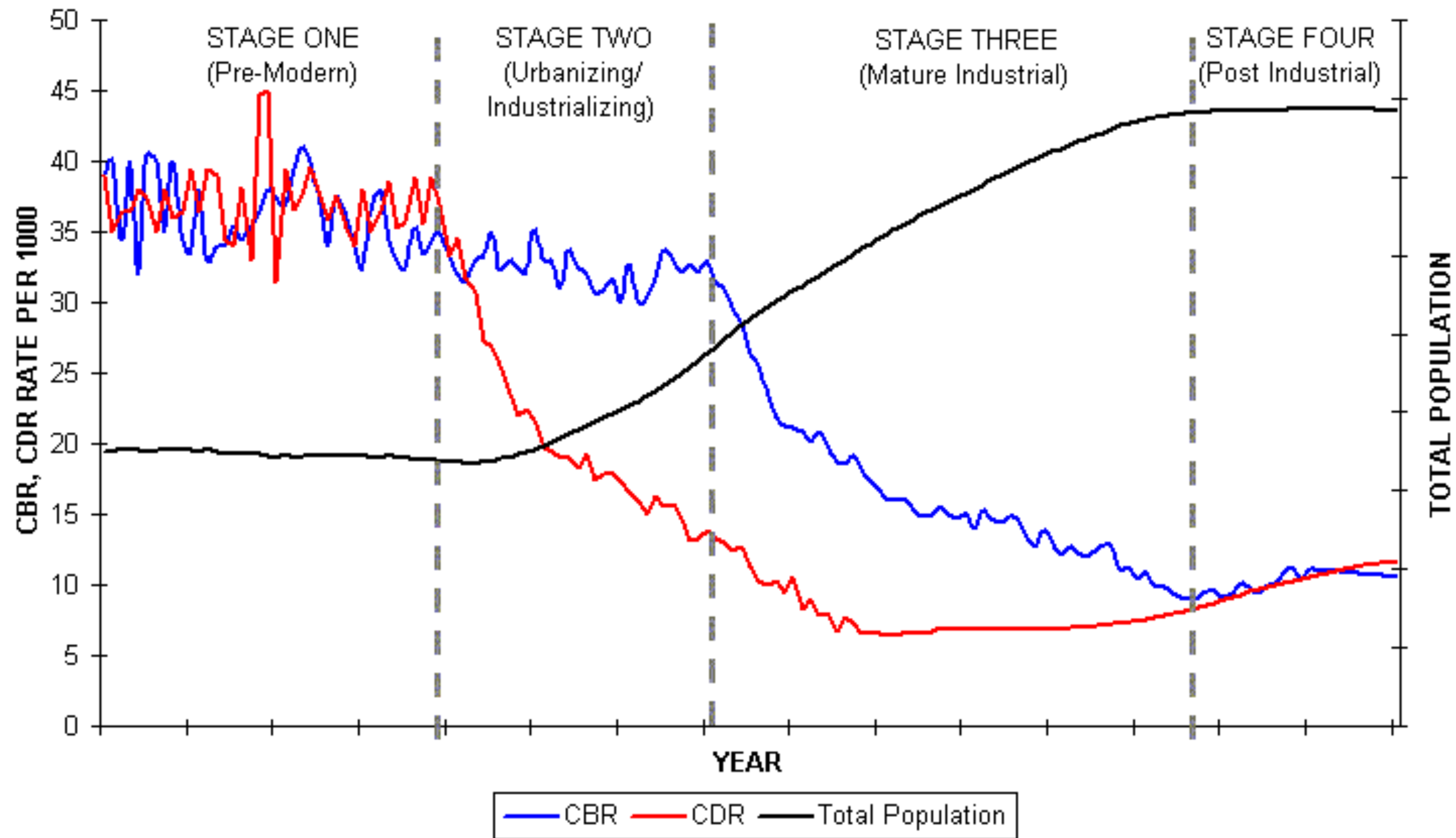
- 22 countries
- Share similar language (Arabic in the majority)
- Share very similar cultural norms based on religious/spiritual beliefs
  - governing family roles and ties- influencing both women and the aged
- Some geographical coherence with sub-groups
  - Arab Asia (Iraq, Jordan, Lebanon, Palestine, Syria, Yemen)
  - Gulf Cooperation Council (Bahrain, Kuwait, Oman, Qatar, Saudi Arabia, United Arab Emirates)
  - North Africa (Mauritania, Morocco, Algeria, Tunisia, Libya, Egypt, Sudan, Somalia, Djibouti, Comoros)

The Middle East and North Africa: .. How different?

- Huge variability in:
  - Poverty and per capita income
  - Population size
  - Literacy and unemployment rates
  - Migration, geographical mobility, co-residency arrangements and other socio-economic and socio-demographic characteristics
- While all experience some forms of demographic and nuptiality transition
  - Fertility: some at or near replacement levels, in others high fertility rates persist
  - At different tempo and stage of transition

Demographic changes.. What do we mean?

- Population changes:
  - Fertility
    - Crude Birth Rate: the number of live births occurring during the year, per 1,000 population estimated at midyear
    - Total Fertility Rate: is the average number of children that would be born to a woman over her lifetime
  - Mortality
    - Crude Death Rate: the number of deaths occurring during the year, per 1,000 population estimated at midyear
  - Migration (in, out and net migration)
  - Life expectancy (ill-health years of life expectancy)
- Population structure including Nuptiality patterns

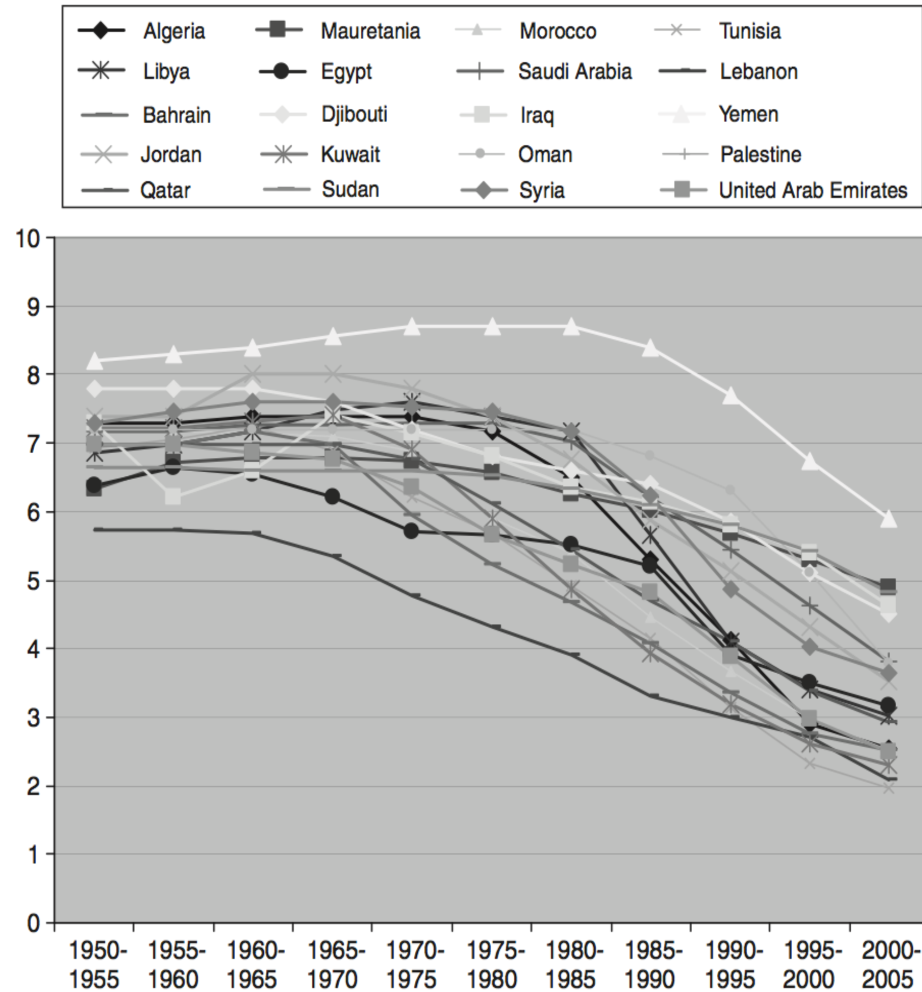


DEMOGRAPHIC TRANSITION

Demographic transition

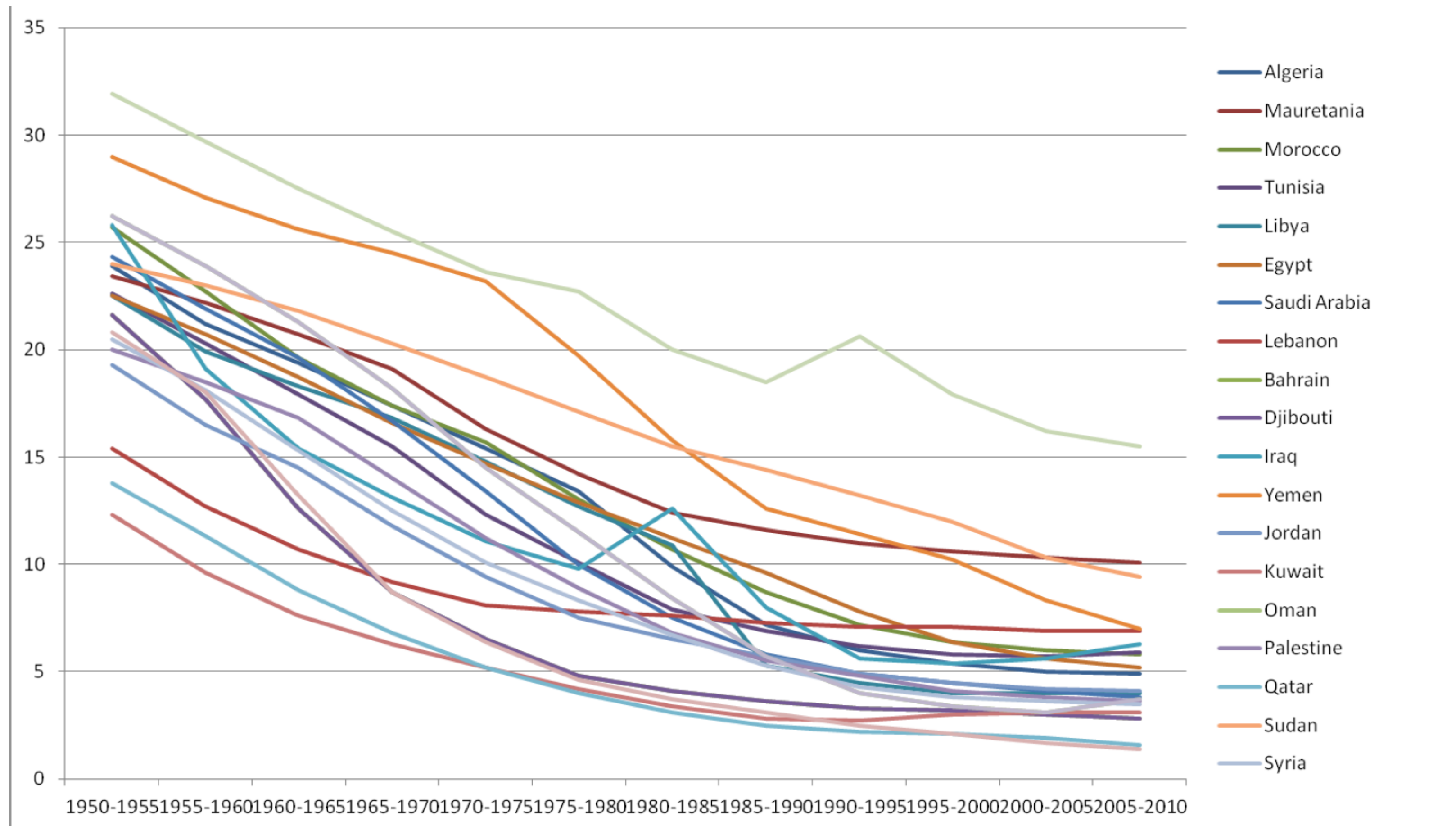
- The 'first' demographic transition theory is supposed to be universal,
  - all populations in the world sooner or later will experience a shift from high to low death and birth rates.
- Currently some countries have concluded the transition (e.g. Europe),
- In other countries, this shift is in full swing (e.g. North Africa and the Middle East)
- While other countries have only recently experienced some decline in mortality and fertility (especially Sub-Saharan Africa)

Trends in total fertility rate



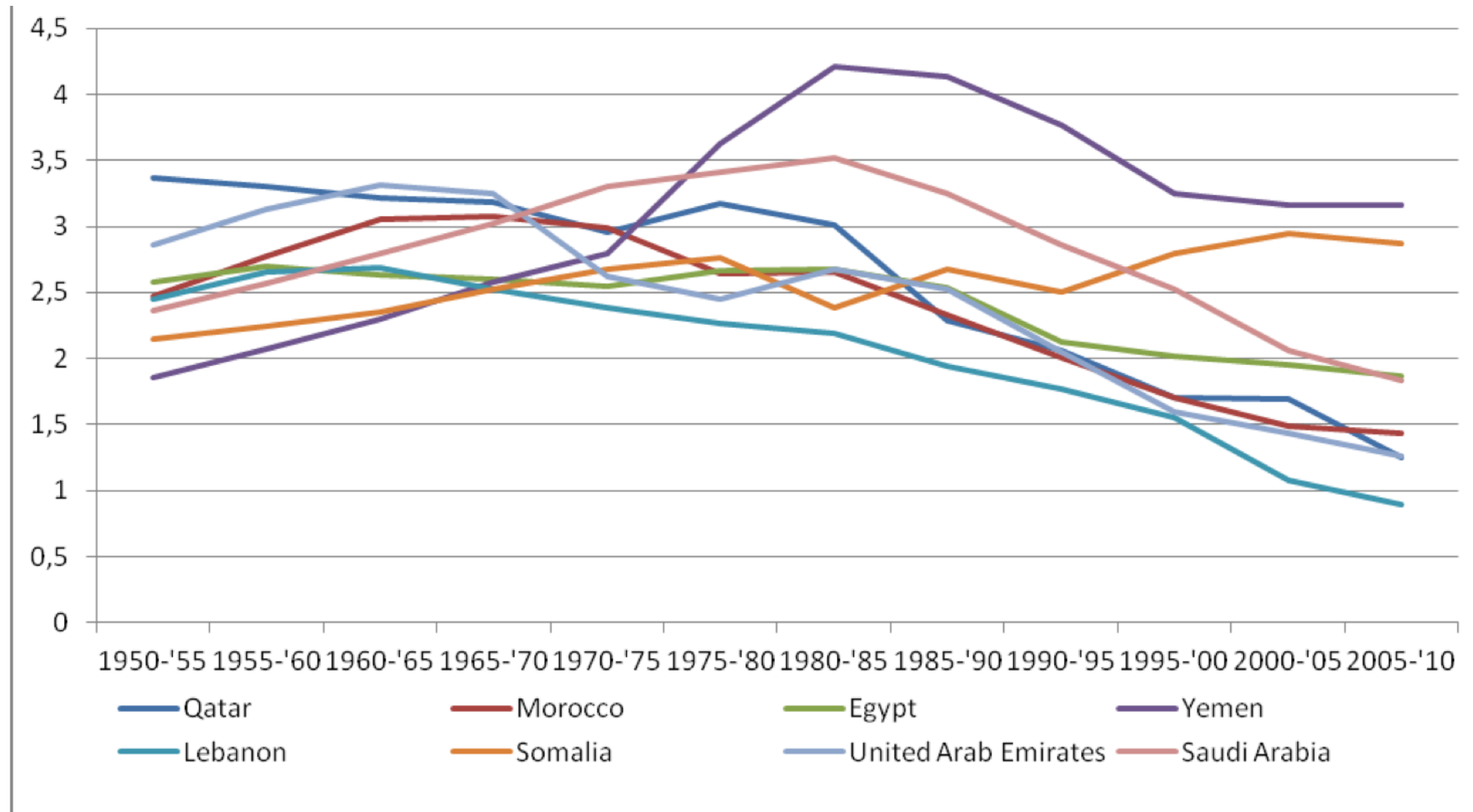
Source: Engelen and Puschmann (2011)

Trends in mortality rates



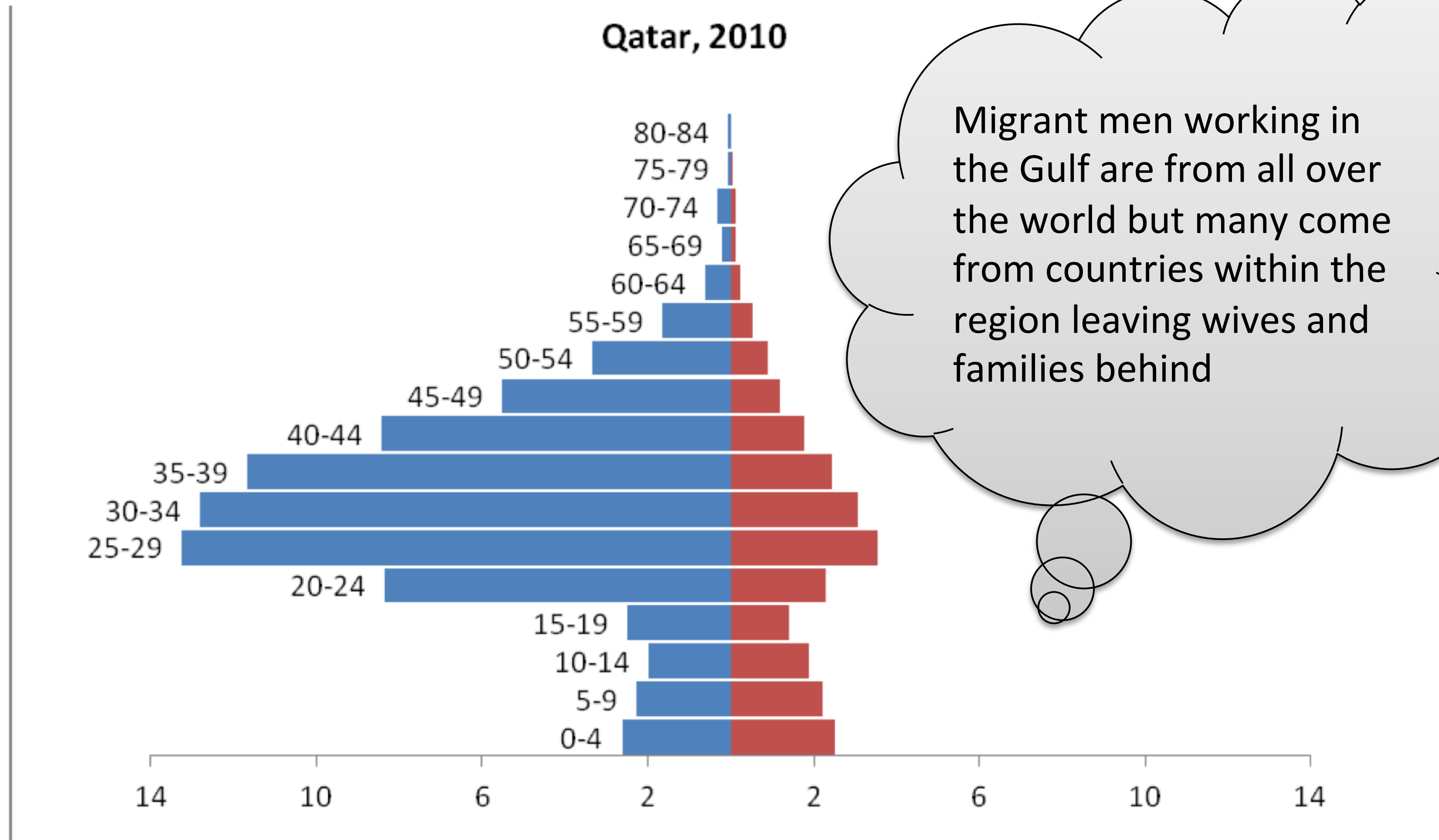
Source: United Nations, World Population Prospects, the 2010 revision

Population Growth: Rate of natural increase



Source: United Nations, Word Population Prospects

Population structure- skewed in some places due to migration



Source: UN, World Population Prospects 2010

POPULATION AGEING

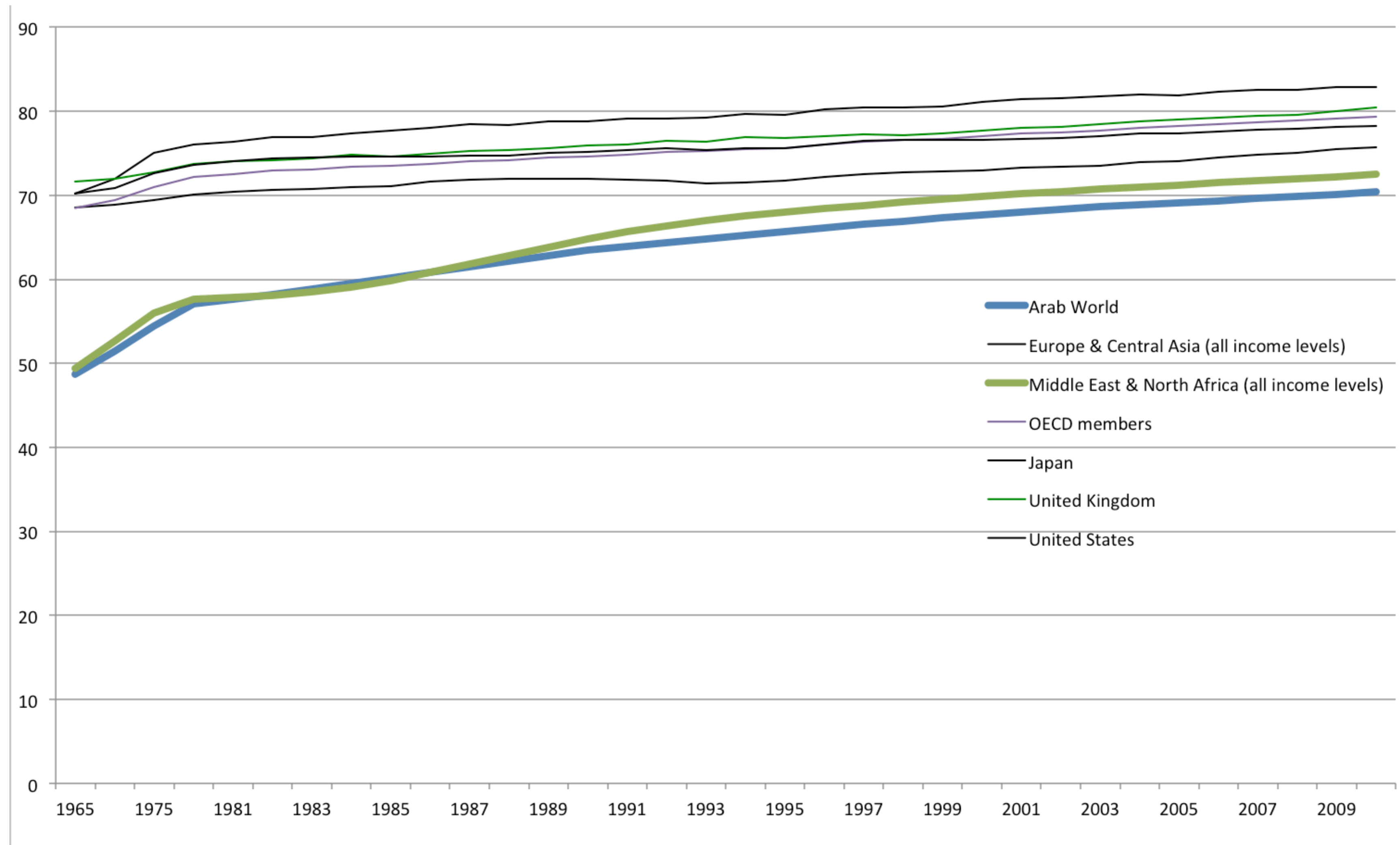
Ageing in the region

- From 1965 to 2010 ‘average’ life expectancy in the region increased from 48.7 years to 70.4 years
- Life expectancy is projected to reach 76.9 years in 2045-2050
- Percentage of the population 60 years or older to reach 17.2% in 2050
- Life expectancy is usually higher among women (with an average of 5 to 6 years)

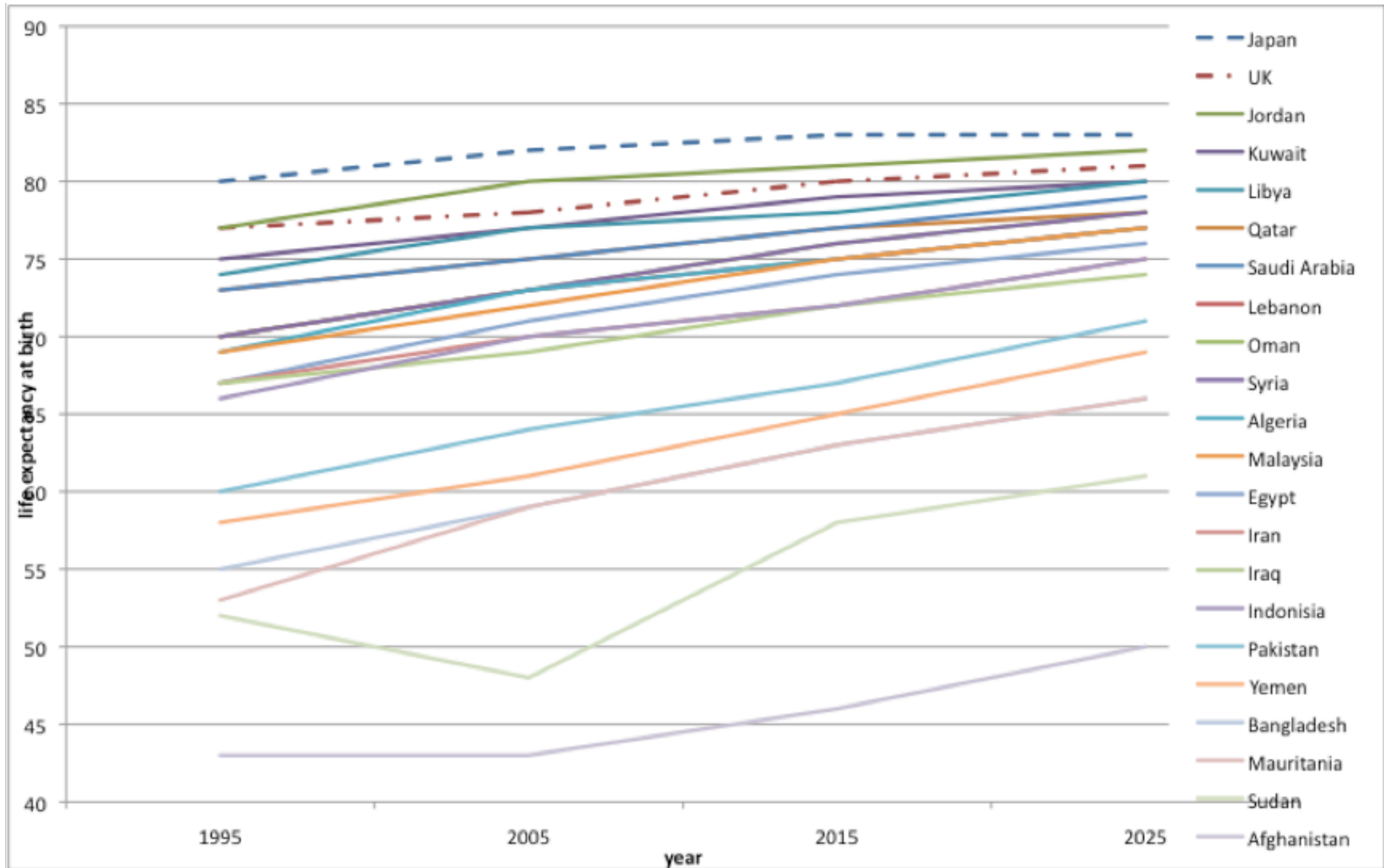
Population Ageing

- The tempo, or speed, of the population ageing process is different for some countries in the region
- Some identified as having 'fast', others as 'medium' and 'slow' tempos
  - Within the 'fast' or rapidly ageing group are the United Arab Emirates, Tunisia, Bahrain, Kuwait, Morocco, Algeria, Bahrain, Libya and Lebanon
- Many countries are also experiencing epidemiological and health transitions, with non-communicable diseases replacing communicable diseases as the leading causes of morbidity and mortality

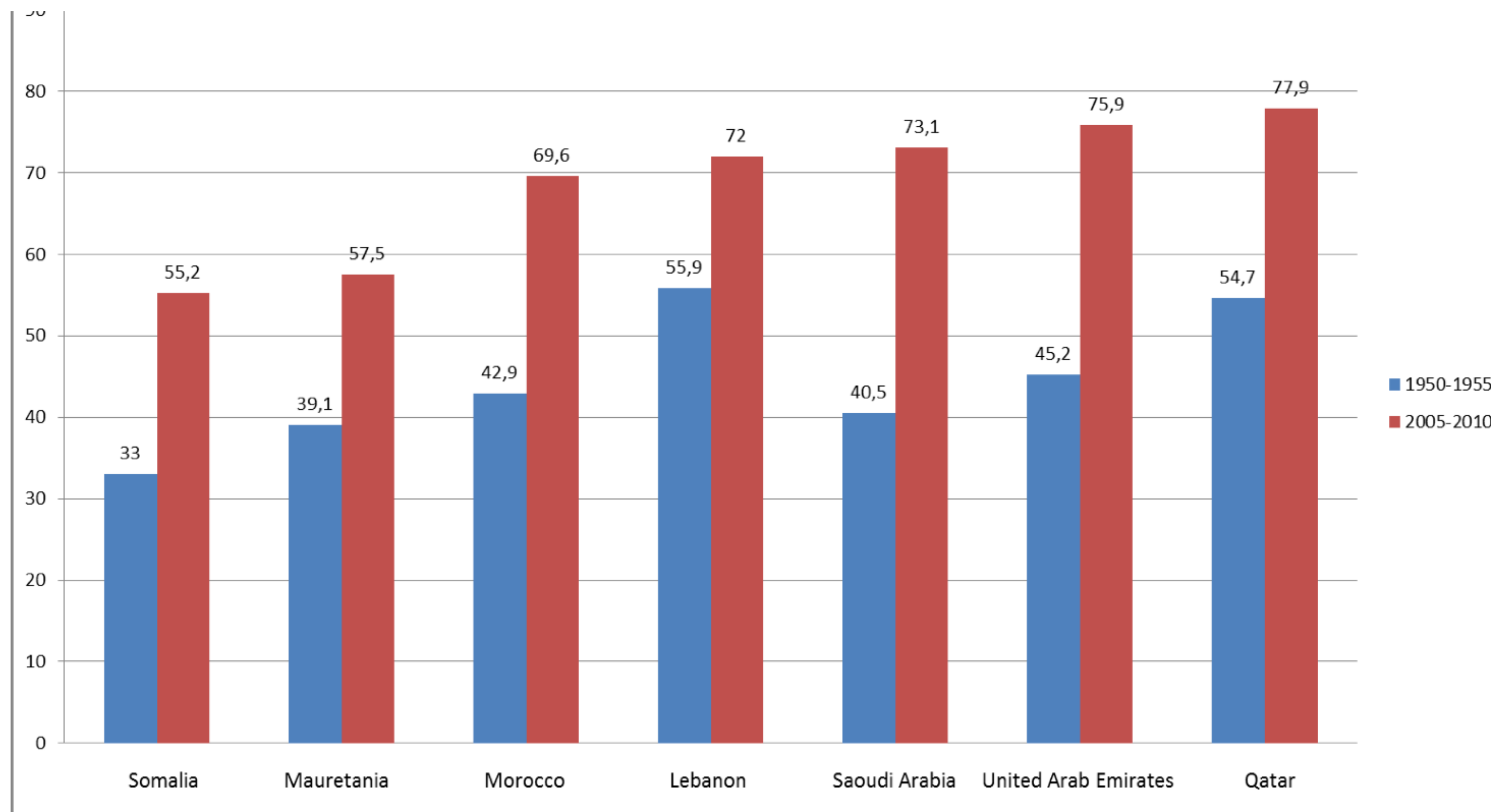
Life expectancy trends



Actual and predicted life expectancy at birth from 1995 to 2025 in the Arab and Islamic world compared to those in Japan and United Kingdom



Life Expectancy at Birth in Several Arab Countries (both sexes) : From 1950-2010



Source: United Nations World Population Prospects: The 2010 Revision

Ageing context in the region

- Ageing is associated with several socio-demographic changes
- Increased trends in labour participation of 'traditional' informal care givers (usually women)
- Increased trends in 'lone-residency' at old age (usually women)
  - Due to higher widowhood prevalence among older women; off-spring migration (internal or international); co-residency and social changes etc.
- Changes in 'expectations' of old age and quality of life

Dependency ratio and demographic dividends

- dependency ratio can be measured in several ways
  - Usually defined as the population aged 0–19 plus the population aged 65+ divided by the population aged 20–64
- Demographic 'dividends' relates to:
  - Increased supply of working age group resulting from declined mortality and fertility rates
  - Not permanent – 'a window of opportunity'

Dependency ratio

Countries	2000			2050		
	Dependency			Dependency		
	Old Age (65+)	Oldest Old Age (80+)	Aging Index	Old Age (65+)	Oldest Old Age (80+)	Ageing Index
Algeria	6.8	0.9	12.3	27.5	5.3	97.1
Bahrain	4.2	0.7	10.4	28.6	7.5	114.1
Comoros	4.5	0.3	5.6	12.6	1.7	33.9
Djibouti	4.6	0.2	6.3	12.4	1.6	36.1
Egypt	7.5	0.8	12.5	20.7	3.9	66.5
Iraq	5.2	0.6	6.6	12.7	1.9	35.2
Jordan	4.9	0.6	7.0	20.7	4.1	71.6
Kuwait	1.5	0.3	2.8	30.7	12.6	68.7
Lebanon	10.8	1.4	22.2	27.4	6.2	99.2
Libya	5.2	0.6	10.3	28.0	5.5	93.7
Mauritania	6.5	1.0	8.5	14.1	2.4	39.3
Morocco	7.6	0.9	13.9	25.5	5.1	88.9
Palestine	7.0	1.1	7.4	11.1	2.1	27.6
Oman	3.5	0.5	5.8	15.2	2.0	50.2
Qatar	2.0	0.2	5.7	24.8	4.8	108.7
Saudi Arabia	4.6	0.5	7.1	19.2	3.9	67.1
Somalia	4.9	0.5	5.9	8.4	1.1	18.1
Sudan	6.1	0.7	7.9	12.7	1.9	35.1
Syria	5.4	0.6	7.4	21.1	3.8	72.2
Tunisia	9.2	1.2	19.3	33.1	7.4	124.8
U.A.E	1.4	0.2	4.5	27.2	4.3	128.2
Yemen	4.8	0.6	4.9	9.0	1.1	21.0

Source: Computed from United Nations (2007)

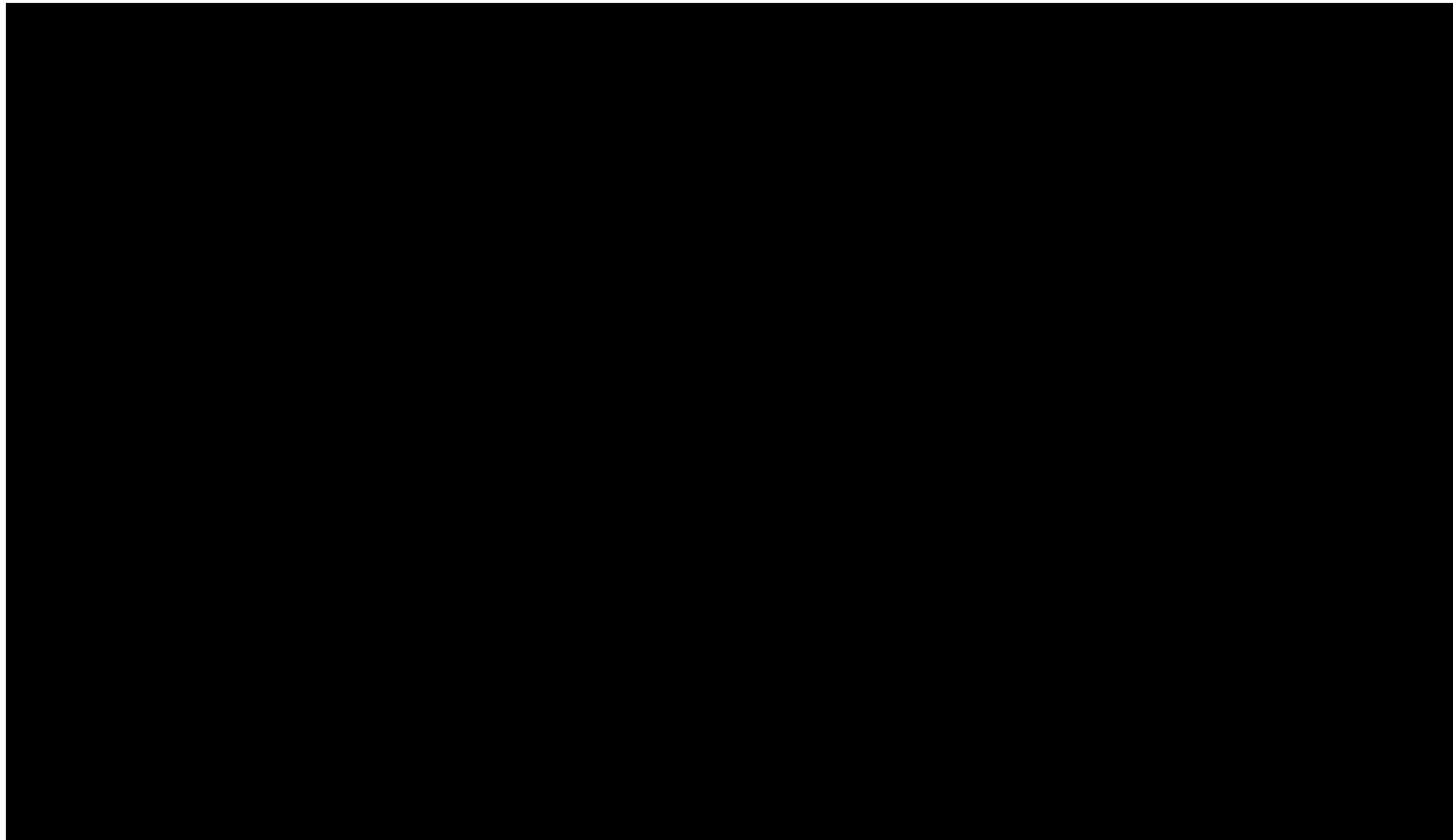
Adults 50+ widowed by gender

		Age Group in Years														
		≥ 50			50–59			60–69			70–79			≥ 80		
Country	Year	M	W	W-M	M	W	W-M	M	W	W-M	M	W	W-M	M	W	W-M
Egypt	1988	6.9	50.9	44.0	3.0	32.9	29.9	7.1	62.3	55.2	17.6	80.1	62.5	22.0	90.5	68.6
	1992	7.1	47.5	40.4	1.8	30.8	29.0	7.0	55.9	49.0	19.3	74.8	55.5	30.4	91.3	61.0
	1995	7.4	52.3	44.9	2.6	34.2	31.6	6.6	61.0	54.4	18.3	83.3	65.0	34.0	89.4	55.4
	2000	7.1	47.6	40.6	2.7	29.4	26.7	8.2	55.6	47.4	14.7	81.2	66.5	31.2	88.5	57.3
	2003	8.2	45.5	37.3	3.0	27.0	24.0	7.6	54.4	46.8	21.3	82.1	60.8	34.7	90.7	56.0
	2005	6.8	43.8	37.0	2.1	26.4	24.3	7.5	53.6	46.1	16.4	76.2	59.8	31.4	87.8	56.5
Jordan	1990	3.2	33.5	30.4	0.0	16.9	16.9	2.3	37.9	35.6	6.0	69.3	63.4	23.6	81.1	57.5
	1997	4.1	34.8	30.7	0.5	17.0	16.6	3.4	41.6	38.2	11.9	61.8	49.9	24.6	87.5	62.9
	2002	3.3	34.7	31.4	0.9	18.8	17.9	2.9	40.2	37.3	7.3	57.4	50.1	17.5	79.1	61.6
Lebanon	1996	5.5	32.8	27.3	1.3	16.6	15.3	4.1	33.3	29.3	10.6	55.6	45.0	28.9	77.1	48.1
Morocco	2003	5.4	42.3	36.9	2.7	25.7	23.1	4.0	43.6	39.7	9.5	67.0	57.5	18.4	84.4	65.9
Tunisia	1988	5.6	37.3	31.7	1.1	18.2	17.1	4.6	43.5	38.9	10.7	69.4	58.7	27.8	90.4	62.6
Yemen	1991	6.4	32.4	26.0	2.7	17.8	15.1	5.4	35.0	29.7	10.6	51.4	40.8	15.8	67.2	51.4

Source: Estimates were computed by the authors from the Demographic and Health Survey for each country and year, or from a comparable national survey in the case of Lebanon.
Note: All gender differences are signficant at the $p \leq .001$ level, adjusted for sample design.

Population Ageing as a Policy Issue in the Region

- The region has historically shown a strong commitment to social welfare
  - Post independence
  - Majority linked to employment
    - E.g. pensions and retirement schemes, however, favouring public sector and can be regarded as gender biased
  - Universal health and education service
    - but actual delivery is relatively poor in most countries
- No 'formal' aged policy strategic vision
  - However some attention to the phenomenon in recent policy discussions
- The role of charity and religious institutions



LONG TERM CARE

Long term care in the region

- There are two main (often parallel) systems of long-term care
  - informal care providers, such as unpaid family members
  - formal care providers, such as nursing aides, home care assistants, and other paid care workers.
- Most care is provided by family members, mainly women, or by other informal caregivers
- Family-based aged care model
  - Indications of increased use of formal care, especially among urban older people are emerging
  - Limited available statistics to establish the volume of or trends in the use of formal or paid care

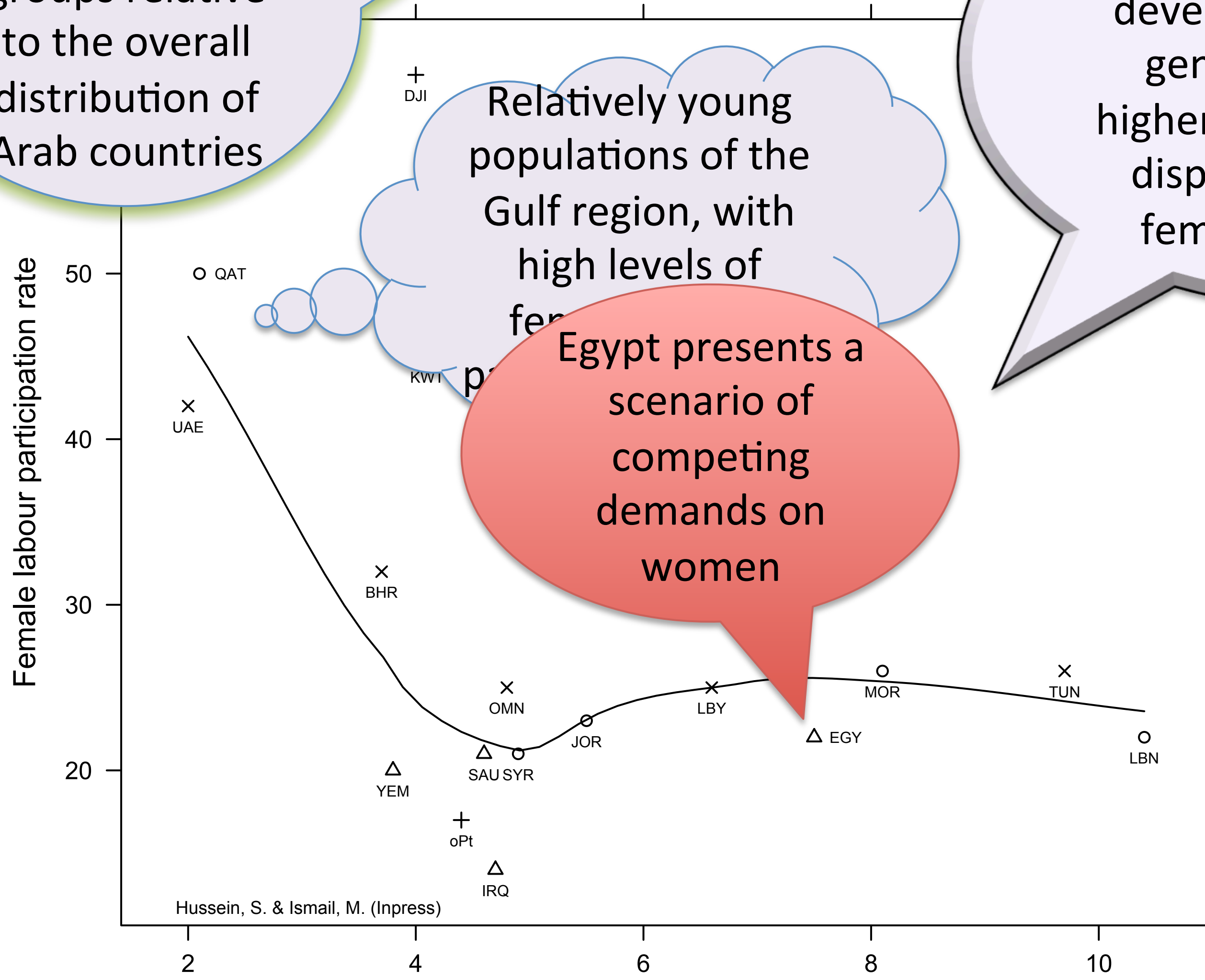
Some 'formal' care provisions

- Mainly through NGOs and civil society movements but some state funded
- Egypt: 'Regular Medical Caravans': providing free medical consultation and services - including minor surgeries at homes in rural areas
- Bahrain: ten government-sponsored mobile clinics
- Tunisia: 'Union of Social Solidarity' offers free home-based health services for the elderly for little or no fees
- Kuwait: free of charge home-based care (state funded)
- Morocco: free medication through NGOs
- Jordan: 53 private companies registered to provide home care for older persons.
- Lebanon: 26 mobile clinics for older people living at home
- Oman: state funded home help for older people with health needs

The interplay between various socio-demographic factors

- Gender equality:
  - Gender Inequality Index measures the human development costs of gender inequality
  - the higher the GII value the more disparities between females and males.
  - GII values range from 2.1 percent to 73.3 percent.
- Labour participation
  - Documented and undocumented
- Ageing
  - Proportion of people aged 60 or more as one measure

GII distributed into three groups relative to the overall distribution of Arab countries



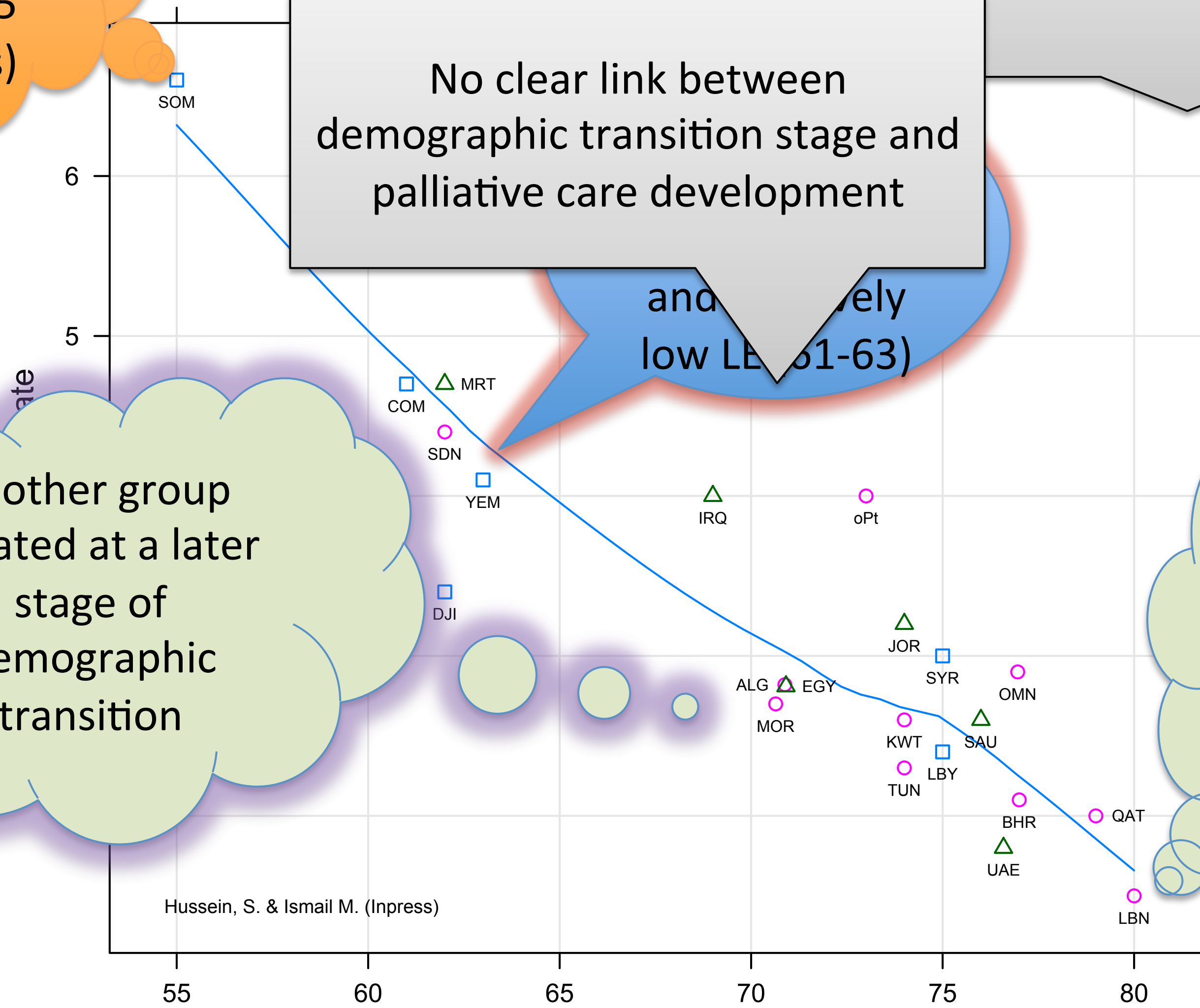
Gender Inequality Index measures the human development costs of gender inequality, higher the GII the more disparities between females and males

GII range from 2.1% to 73.3% in the region

Source: Hussein and Ismail (2016)

Life expectancy and fertility rates

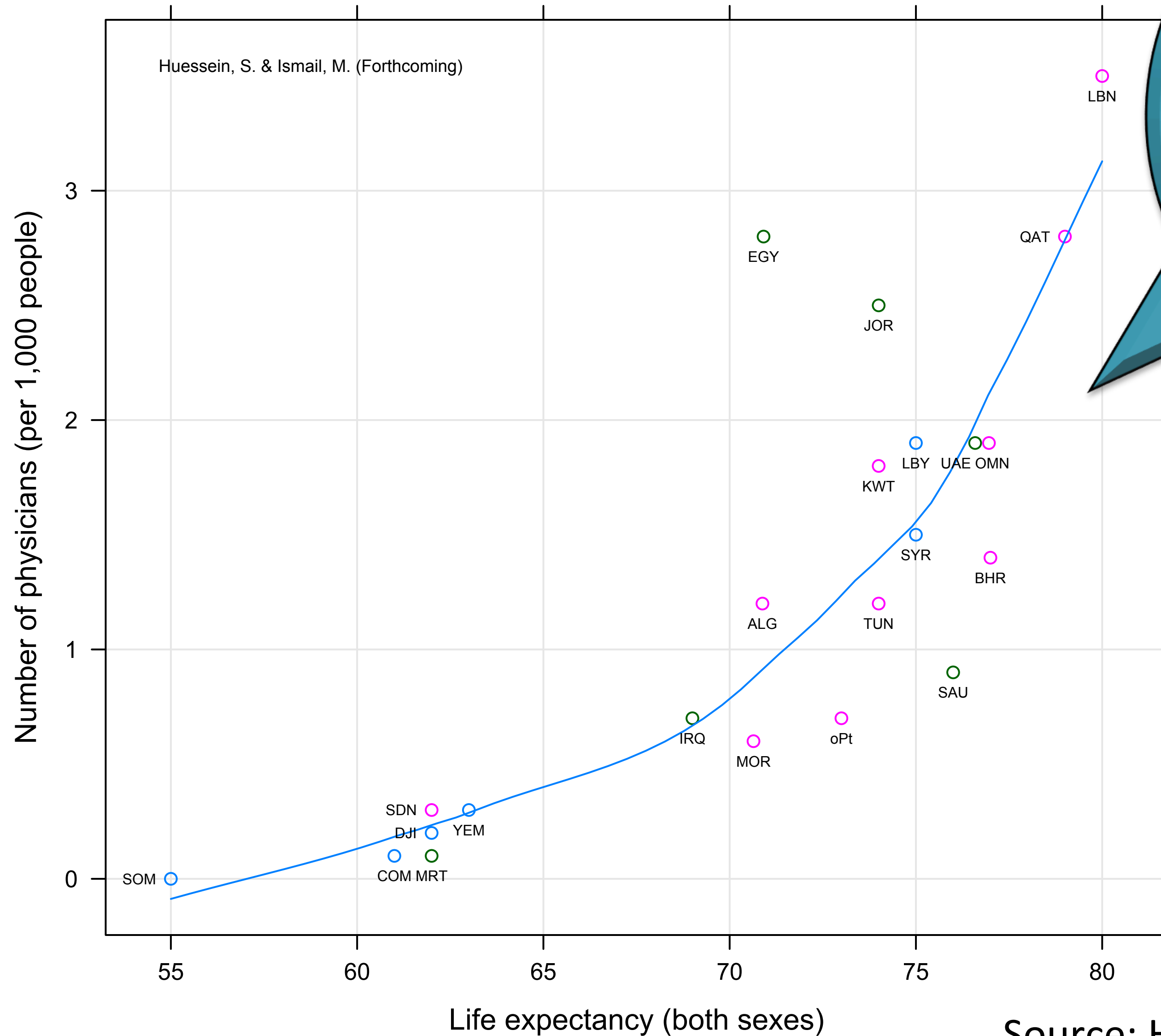
- Through the demographic transition both fertility and mortality rates decline
- Increased life expectancy; not all countries experience similar patterns
- Provision of aged care within such context
  - Palliative care as a proxy of LTC provision
  - Clark and Wright world map of palliative care:with four main groups of countries:
    - 1) no known palliative care activity,
    - 2) countries with palliative care capacity building activity,
    - 3) countries with localized provision of palliative care,
    - 4) countries where palliative care activities are approaching integration with the wider public health system



Source: Hussein and Ismail (2016)

Health services and ageing

- What is the relationship between number of physicians per 1000 (as a proxy of health care coverage) and life expectancy
- What is the relationship between health care coverage and palliative care provision
- A positive relationship between number of physicians and LE in general; but with some outliers
- Palliative care provision does not follow an expected pattern



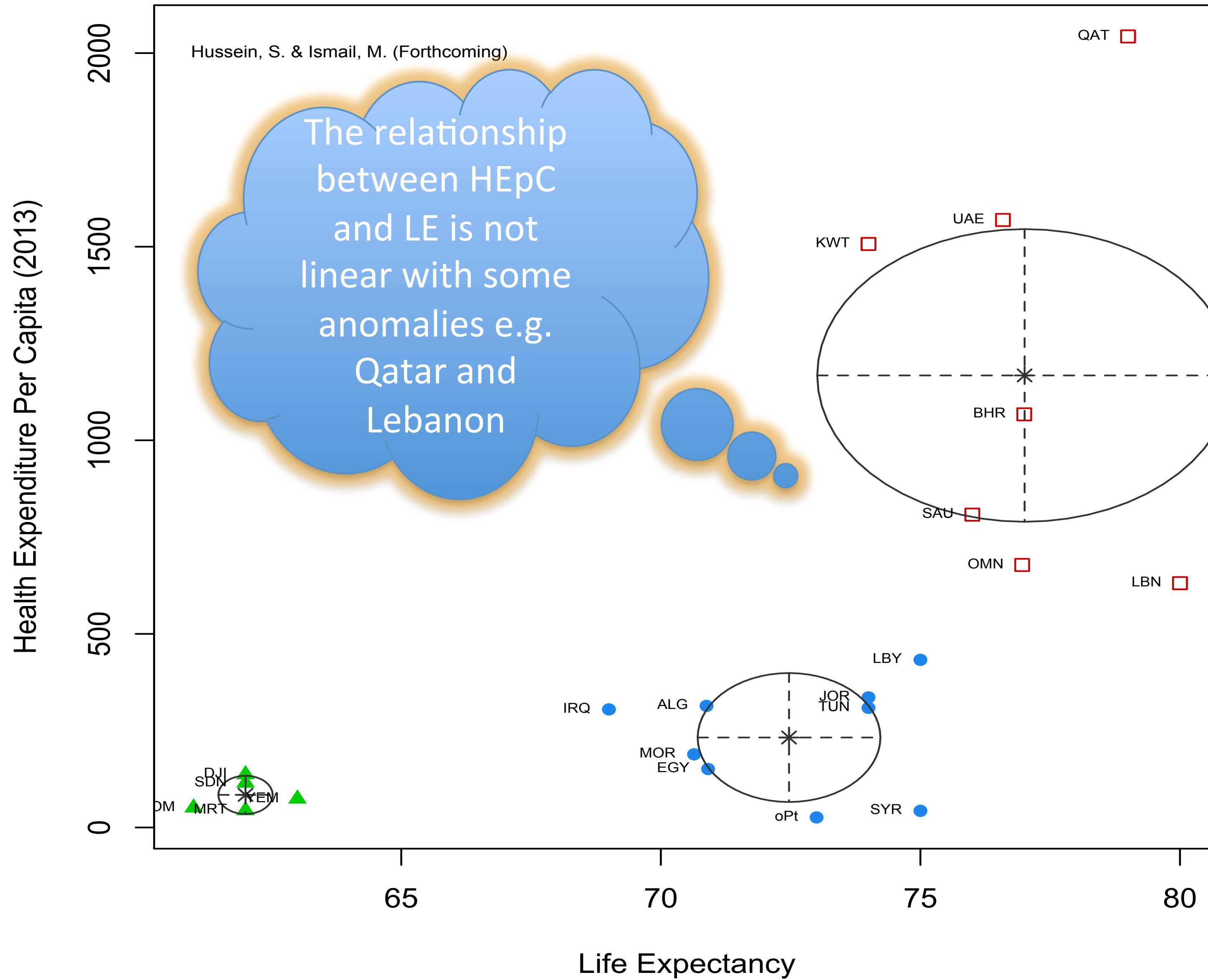
While the relationship between NoP and LE is almost linear; this is not directly translated into PCD

Source: Hussein and Ismail (2016)

Health expenditure and life expectancy

- One would expect a strong relationship between health expenditure per capita and life expectancy
- To some extent true when health expenditure per capita is quite low but not necessary when it grows
- The countries within the region form sub-groups in terms of their experience

Model-Based Clustering for Arab Countries According to Health Expenditure Per Capita and Life Expectancy



Major Population Concerns of Governments in the Arab region

Issues of significance to at least half of governements

Issues	Percentage of Governments reporting issue as significant
Infant and child mortality	77
Maternal mortality	77
High level of immigration	62
HIV/AIDS	57
Large population of working age	57
Pattern of spatial distribution	57
High rate of population growth	52

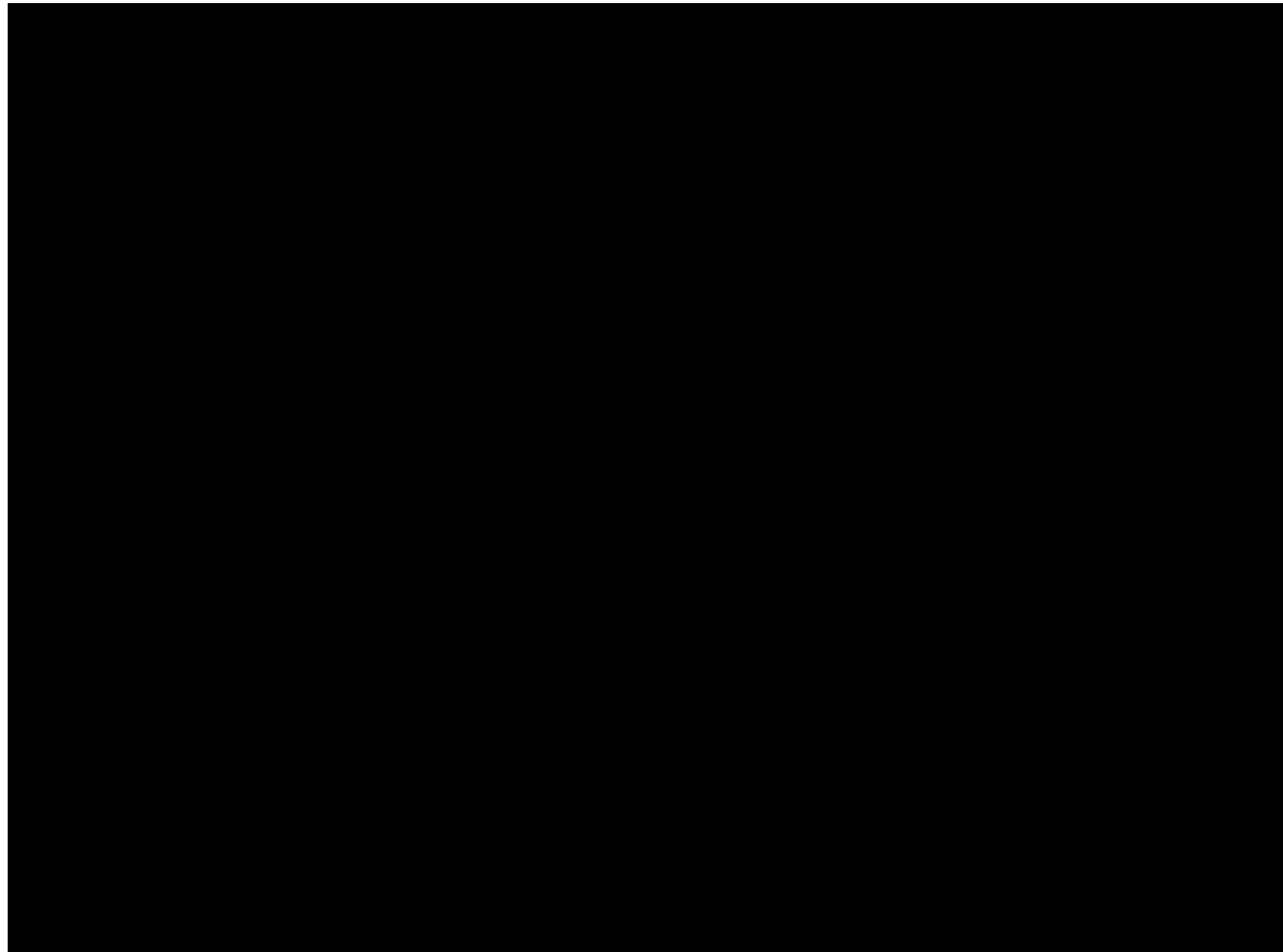
Source: United Nations (2008b).

Aged-care model in the region

- Mainly a family-based model
  - Embedded within religious beliefs and duty of care to the elder
  - A two way beneficial model
  - Gender imbalance of expectations of financial, physical, emotional and personal care
- Absence of formal long term care provision
  - With limited availability and use of residential care and care home
- Charitable (voluntary) sector is an important provider of social activities for the elderly
- A model based on certain assumptions around family structure and women's availability sustained by strong cultural and religious ideology

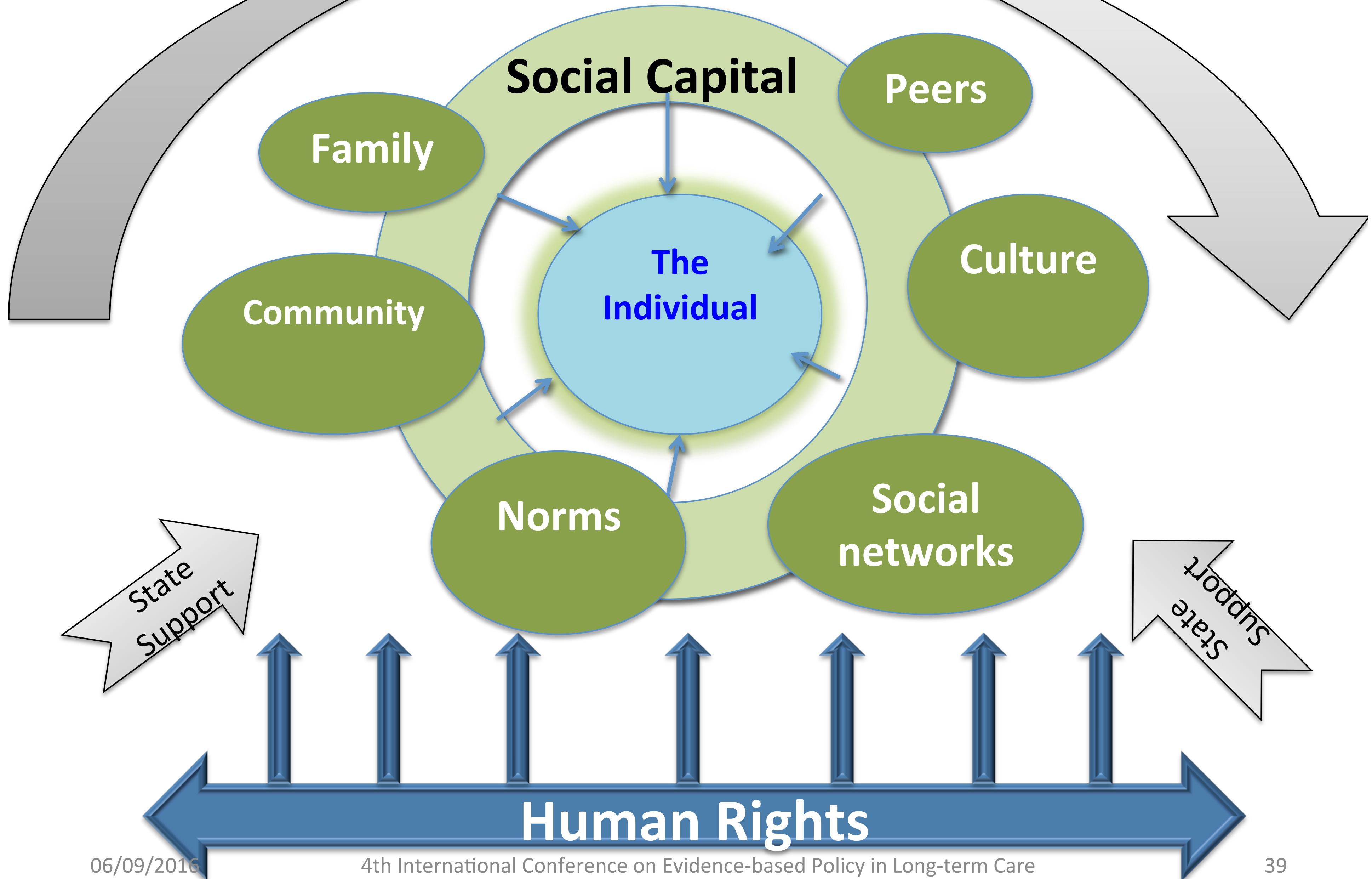
Viability of current family-based care model

- Assumes a certain family and societal structure
- Women are key players in providing care
- Other demographic and social changes challenging such structure on a number of ways:
  - Family unit availability and ability to provide increasing care
  - Competing demands on women time, emotional strengths, and finance
- Lack of vision to link with existing charitable and societal activities
- Lack of awareness of old age care needs including dementia and associated risks
- Lack of capacity building



TOWARDS A NEW MODEL OF CARE

Towards a New Formal Social Care systems



Proposed new model of care

- Takes into account differences and current challenges of
  - Demographics
  - Economics
  - Cultural context
- Based on three recognised care models
  - Person-centred Care (widely adopted in Western Europe)
  - Social Capital: (e.g. co-operative models observed in Italy)
  - Human Rights
    - Including concepts of equity- in health and wellbeing encompassing the right to access health and care services

Conclusion

- Similarities and differences
  - Among different countries in the region
  - In relation to demographic transition stages when compared to other parts in the world
- The importance of various demographic changes on ageing- especially migration and marriage
- Gender differences and implications at old age
- Availability of aged care not necessarily linked to demographic transition stage or other factors such as wealth etc.
- Variable socio-economical and political context
  - Current political turbulence is likely to change many of the indicators we have used

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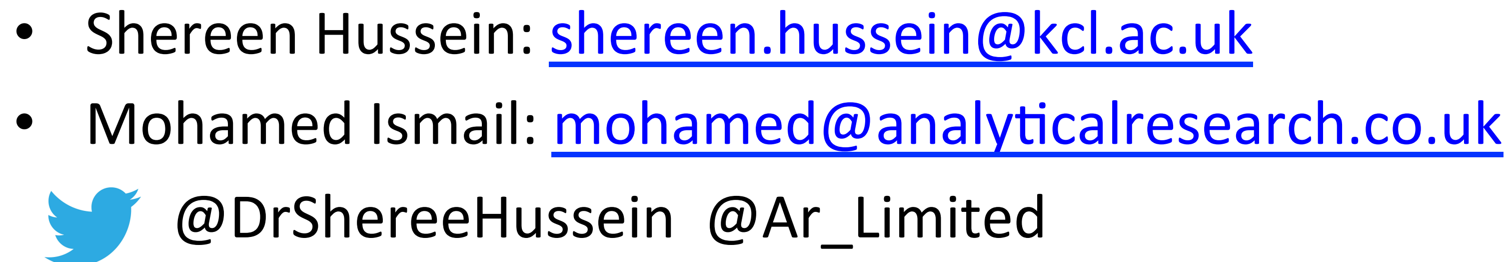
Thank you for listening



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