AGING IN LEBANON: PERILS AND PROSPECTS

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Abstract • Lebanon is currently experiencing unique and dynamic demographic shifts towards an aging population: past and present fertility are among the lowest in the Arab region and crude mortality rates have decreased in the past few decades from 9.1 to 7.1 per thousand. Increased waves of emigration of youthful adults seeking better work opportunities elsewhere, as well as counter-waves of ‘return migration’ of older Lebanese workers from neighboring host countries contribute further to the ‘rectangularization’ of the population pyramid. These trends are accompanied by an epidemiological transition towards non-communicable diseases, mental disorders and degenerative diseases as the leading causes of mortality and morbidity in lieu of communicable diseases. We examine in this paper the implications of these transformations on the health profile of older persons and on the social and health care available to them. Findings are discussed within the prevailing conflicts and political strife in the country, family transformations and structural settings including pension systems, health coverage, family support channels and social fabric, and nursing home care. The paper ends with recommendations and options for reforms.

Keywords: aging, health system, social support, nursing homes, Lebanon

INTRODUCTION

As in other countries of the world, Lebanon is experiencing dynamic demographic shifts towards an aging population. Decreased fertility and successes against child mortality and infectious diseases have resulted in improved overall survival rates and an increase in the number and proportion of the older population. People aged 65 years and older currently represent 7.3 percent of Lebanon’s population, the highest percentage in the region. This is projected to increase to 12.0 percent and 21.0 percent by the year 2030 and 2050, respectively. Those above 80 years will quadruple during the same period (from 1.1 percent to 4.6 percent, respectively) [1]. Population aging greatly challenges health and social care systems in countries with limited resources. Proactive planning is needed, and each country has to find its own path of reforms and interventions. To date, the health, social and economic implications of rapid aging in Lebanon have not been adequately acknowledged by healthcare providers and policy makers and remain relatively under-researched. This paper aims to give an overview, to the extent that available data allow, of the implications of demographic shifts and family transformations in Lebanon on the health profile of older persons and care available to them. Data presented are discussed within the prevailing structural settings and institutional arrangements, including pension systems, health coverage, and nursing home care, which may have contributed to some of the observed trends. The paper ends with recommendations and options for reforms.

Demographic Trends

Population aging has been underway in Lebanon for the last four decades. This is clear in the achievements made across several demographic indicators, including a considerable decrease in total fertility rate from nearly 3.8 in 1980 to 1.5 in 2010, a reduction in crude birth rate by half, a decrease in crude death rates from 7.2 per 1000
population in 1980 to a current value of 4.4, and a significant rise in life expectancy at birth from 68.4 years in 1980 to 79.8 in 2010 [2]. These transitions translate into a narrowing of the population pyramid base, an increase in the percentage and absolute number of older people, and an aging population. Increased waves of emigration of youthful adults seeking better work opportunities elsewhere, as well as counter-waves of ‘return migration’ of workers post-retirement mainly from Arab host countries – where there are no prospects for nationalization – contribute further to the rectangularization of the population pyramid. As elsewhere, these changes are the most salient of modern demography and have significant implications on national economies.

HEALTH TRANSITION AND ITS IMPLICATIONS
ON THE HEALTH CARE SYSTEM

Health Profile of Older People in Lebanon
Demographic trends of aging are accompanied by an epidemiological transition, with non-communicable (NCDs) and degenerative diseases replacing communicable diseases as the leading causes of death and morbidity.

The national Pan Arab Project for Family Health (PAPFAM) survey, conducted by the Central Administration of Statistics and the Ministry of Social Affairs in 2004, reveals that around three quarters of older persons in Lebanon report at least one co-morbid condition and one quarter perceive their health status as poor. Hypertension (36.7 percent), heart disease (23.1 percent) and diabetes (21.5 percent) constitute the leading causes of morbidity (Table I) [3].

As elsewhere, substantial gender disparities exist with women having longer life expectancy than men, but often spending their later years in more morbidity and functional disability. Twice as many older women than men report high cholesterol and musculoskeletal diseases, and 52.7 percent of older women are obese (BMI ≥ 30) as opposed to 35.7 percent of older men [4]. Also, community-based studies indicate that older women are at greater functional disadvantage in physical disability [5] and report higher prevalence rates of poor self-rated health [6].

Mental health problems are pervasive: dementia and lifetime prevalence of mood disorders afflict, respectively, 5.8 percent and 9.3 percent of older Lebanese persons [7]. Doumit and Nasser (2010) report notably higher lifetime prevalence of mood disorders afflict, respectively 5.8 percent and 9.3 percent of older Lebanese persons [7]. Doumit and Nasser (2010) report notably higher lifetime prevalence of mood disorders, respectively 5.8 percent and 9.3 percent of older women (59.8 percent) [8]. In a community-based study targeting underprivileged neighborhoods around Beirut, one in four respondents older than 60 years reported depression [9], while ‘probable’ depression approached 75 percent among older women [10]. Although psychiatric morbidities often improve with treatment, conditions are frequently overlooked because of lack of awareness and knowledge about signs and symptoms and the problematic dismissive belief that ill mental health constitutes a normal part of the aging process.

The Increasing Burden of Wars and Emergencies on Older People
In the midst of our wars and conflicts, older people in Lebanon are caught between pre-existing age-related challenges and other emergency-related stressors. As such, pre-existing challenges such as the burden of chronic diseases, reduced functional ability, and impaired mental and sensory conditions are compounded by emergency-related stressors such as deaths of beloved ones, weakening in the social fabric and losses of homes and properties.

Studies conducted following the July 2006 war on Lebanon revealed the vulnerabilities of older adults in emergencies. Impairments that are usually considered minor and result in little interference with daily living habits under normal circumstances develop into major handicaps during conflict. Key issues identified as handicapping were decreased mobility owing to breakage and losses of assistive devices (e.g. walking canes or eyeglasses), additional physical and mental challenges and augmented economic vulnerability or disadvantages [11, 12]. The more recent Syrian crises, with all of its transnational ramifications, divulged the perilous health profile of older refugees, providing further evidence of the dis-
Healthcare Insurance and Financing

While older persons constitute less than 10 percent of the Lebanese population, they consume over 60 percent of health care resources [15]. Compared to a national average of 3.4 outpatient visits and 4 prescriptions per person per year, older adults aged 60 years and over make 6.2 visits and are prescribed between 8 to 9 drugs per person per year [16]. Similarly, hospitalization rates among older people exceed 28 percent per person per year, and this is more than double the national average (12.5 percent) [16]. Healthcare access and utilization is central for older adults. Because health insurance in Lebanon is tied to employment, around 73 percent of the retired older populations have no insurance coverage [17]. On the other hand, ambulatory care is judged to be easily accessible. As early as the 1990s, the Ministry of Public Health introduced through the YMCA Primary Health Centers the ‘Chronic Disease Medicine Program’ (CDMP) that is directed to low-income patients and nongovernmental organizations (NGOs) and the importance of integrating “age-responsive” actions in planning for, responding to, and recovering from emergencies.

Nursing Homes

As with other nongovernmental organizations, nursing homes (NHs) and old-age centers flourished in number in Lebanon to fill the vacuum caused by the weakened role of the State. In the mid-20th century, NHs saw a transformation into faith-based organizations, and later, expanded to provide health, medical and nursing care [25]. The social dimension of nursing home admissions exhibits cultural norms and values starkly different than those seen in western countries. NH admissions in Lebanon are usually seen as a ‘last resort’ in cases of severe frailty, cognitive impairment or failing social support channels [26]; hence, institutionalization rates remain very low (10-15 per 1,000 older persons). Yet relative to the Arab region (< 5 per 1,000), Lebanon is characterized by having one of the highest institutionalization rates and one of the highest number of NHs relative to the size of the older people (1.6 per 10,000 persons older than 65) [1]. Currently, there are 49 NHs providing in-patient care and over 110 NGOs providing a variety of out-patient services to older adults in the community (Table II). Government subsidies cover a small proportion of the total cost for nursing home residents and only for 71.4 percent of the institutions [25]. Accreditation guidelines for the NHs in Lebanon are currently being developed by the Ministry of Social Affairs in collaboration with the United Nations Population Fund (UNFPA), and the standards are being examined for alignment with those issued by the Ministry of Public Health to ensure consistency. The guidelines will be pilot tested before final adoption and dissemination.
Informal Caregiving in the Home

In Lebanon and Arab countries, caregiving to frail older persons continues to be the responsibility of women in the family: the wives, daughters and daughters-in-law. Caregivers develop a personal sense of reward and satisfaction for fulfilling familial and religious obligations towards the aged [17, 27]. However, caregiving to a co-habiting frail and disabled older person carries significant physical health problems, emotional strain and foregone work and leisure opportunities. Consequently, middle and upper income families are increasingly opting for a new form of in-home caregiving by fulltime, live-in foreign domestic workers mainly from South East Asia and Africa [28]. Domestic workers often work under precarious conditions and frequently live with the older person in order to guarantee around the clock supervision. They play the role of caregiver as well as companion, and provide long-term care to immobilized older people, who are dependent on help in activities of daily living. Although this form of support retains the ‘family’ orientation for elder care, contributes to lowering institutionalization rates and provides an economic convenience, migrant caregivers have no formal qualifications and are often themselves subject to stringent and discriminatory labor practices. This situation is rife with the potential of abuse from both the care-giving and care-receiving parties, a factor which requires urgent exploration as the degree of frailty increases.

Aging in Place and Home-based Services

‘Aging in Place’, a term adopted by UN agencies, enables older people to maximize their self-fulfillment and preferred lifestyle within their own environment. Lebanese societal values, which strongly emphasize the centrality of the family institution and the reverence bestowed on older persons, provide a positive context in which to build strong ‘Aging in Place’ policies. In the absence of clear policies, however, the capacity of the family to sustain its older adult members within homes is being challenged by recent family transitions, urbanization, migration and economic difficulties. As a result, a number of NGOs and centers are increasingly providing services that support an infrastructure for home-based care in Lebanon, including 41 NGOs that provide ‘meals on wheels’ (Table II). Also, a total of 26 ‘mobile clinics’1, the largest in the region, provide health and social services to home-bound older people [29]. Additionally, Lebanon has been a pioneer in initiating two ‘Palliative Care Units’ for the terminally ill patients and two NGOs that provide home-based ‘End of Life Care’. Nevertheless, these initiatives fall short of the needs of the vast majority of older persons and their informal caregivers. Physicians, health administrators and policymakers need to capitalize on the existing familial intergenerational support system in the care of older relatives, and embrace the informal care givers, both family members and migrant workers, as a target for capacity building and as beneficiaries of care themselves. Initiatives such as respite from various care giving responsibilities, capacity building and training, and home-based palliative and medical care, would encourage older persons to remain in their communities and at their homes, for as long as possible, safeguard against isolation and marginalization, and avoid the costly option of unwanted institutional care.

PROSPECTS OF POPULATION AGING OPTIONS FOR HEALTH REFORMS

Population aging is now a global phenomenon. It has attracted the attention of many governments in both developed and developing countries as well as international agencies. In 2012, the World Health Organization dedicated its annual World Health Day to aging and the European Union designated it as the ‘Year of Active Ageing and Solidarity between Generations’2. The UN General Assembly High-Level Meeting in 2011 labeled NCDs, strongly associated with aging, as a threat to human health and global economy and prioritized it on the development agenda.

In Lebanon and following the UN proclamation of the year 1999 as the ‘International Year of Older Persons’, the National Commission for Elderly Affairs was established in Lebanon in the Department of Family Affairs of the Ministry of Social Affairs. In spite of its commendable achievements to date3, the Commission has had limited implementation power mostly due to insufficient financial resources and poor coordination between gov-

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1 In comparison, the number of agencies providing ‘mobile clinic’ services does not exceed 10 in Bahrain and 1-2 in Qatar, Oman and Libya.

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2 These initiatives build on the 2002 Framework for ‘Active Ageing’ developed by the WHO, defined as “the process of optimizing opportunities for health, participation and security in order to enhance quality of life as people age”.

3 Examples include mapping of services provided by elderly homes, centers and NGOs, workshops on elder abuse, training of caregivers of Alzheimer’s patients and studies on disability in old age.
ernmental agencies (Table III). A key element in the process of optimizing opportunities for older people’s welfare is adopting a multi-sectoral approach of mainstreaming aging issues into all plans and activities and across all sectors: health, social, and economy and at all levels, public and private. While prospects for interventions are many, we focus below on three interrelated issues directly implicated in the health of older people: endorsing a life-cycle approach for disease prevention, reforms in medical (Tohme & Hajjar, current issue) and nursing (Darwish et al., current issue) education as well as training programs, and a team-based approach in dealing with co-morbidity among older people.

Chronic diseases and an aging population challenge the health care system and underline the importance of reforms. In Lebanon, this is additionally burdened by an increased orientation towards curative care, overuse of high-tech services and higher demand for interventions from informed patients. Studies have shown that health problems in old age have their roots in early life; and while it is ‘never too early and never too late’ to change behaviors, adopting healthier choices at an early age delay onset of disability and influence quality of life in old age [30]. Hence, lifelong health promotion and primary prevention efforts that aim at reducing the incidence of NCDs need to start in early adulthood. As such, health providers of all specialties and in various sectors, but notably primary care providers, have a vital role in conveying messages that address the causes of NCDs with a focus on behavioral factors. Health education material that teaches ‘self-care’ and advocates early screening lay the foundations of healthier lives in later years.

For the Lebanese health care system to sustain an aging population, a main intervention is mainstreaming aging issues and geriatrics and gerontology in our training programs and practice. Compared to the Arab world, Lebanon is one of the leading countries in geriatrics and gerontology programs. Yet, the number of geriatricians in the country does not exceed 15, yielding one geriatrician for every 20,000 older persons over 65 [1; Tohme & Hajjar, current issue]. To better address the longer life-span and larger number of older people, the nature of medical training needs to be directed towards a holistic model of patient-centered care integrated within primary health care and supported by coordinated referrals to specialized care and follow-up, as necessary [31]. Conditions among the old cannot be managed in isolation, and the need for interdisciplinary team-based approach becomes crucial in older adult care [32]. At one end of the spectrum, an age-friendly health care system demands that primary care and family physicians should be better trained to address the multiple and interrelated chronic co-morbidities among older people, who form the bulk of their pool of patients; on the other end, standards of geriatric care and principles of gerontology need to be integrated into medical and nursing schools curricula, and geriatrics fellowship programs ought to be promoted in teaching hospitals.

CONCLUSION

In spite of the above representation of older persons mostly as recipients of care, they constitute an important resource contributing directly and indirectly to the national and domestic economy and remain a valuable social and human resource. Population aging and a grey-ing society need not be viewed as a cataclysm in waiting [33], and it is not inevitable that aging coincides with morbidity and disability. Our older people are living longer and healthier lives than their parents and many want to remain professionally useful, intellectually challenged and socially connected in their communities. In order for us to reap the rewards of this ‘longevity dividend’, there is a need for several paradigm shifts in our approach to aging issues: the prevailing negative outlook of population aging as a societal challenge and economic burden needs to undergo a radical transformation into a positive viewpoint that values investments in older persons’ accumulated life experience and capabilities and recognizes the societal and economic opportunities associated with aging. To achieve this goal, the life-cycle, team-based, and integrated approaches for disease prevention and management need to replace the existing cure-based disease-focused modes of service delivery. Physicians are not only service providers but are also agents of change, advocating for healthier engaged aging. Studies confirm that active aging has a positive impact on the well-being of older adults and is the basis of healthy aging. As such, lifelong learning programs 4.

### TABLE III

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<tr>
<th>Policy issues for older persons</th>
<th>Phase</th>
<th>Leading Entity</th>
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<tbody>
<tr>
<td>Health coverage</td>
<td>Planning</td>
<td>Ministry of Public Health</td>
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<tr>
<td>Pension Plan</td>
<td>Planning</td>
<td>Multiple Agencies</td>
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<td>Poverty reduction</td>
<td>Planning</td>
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<tr>
<td>Income generation</td>
<td>Planning</td>
<td>Ministry of Social Affairs</td>
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<tr>
<td>Promoting a positive image of aging</td>
<td>Planning</td>
<td>Ministry of Social Affairs</td>
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<tr>
<td>Literacy/Education</td>
<td>Initiated</td>
<td>Ministry of Social Affairs</td>
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<tr>
<td>Elderly neglect</td>
<td>Initiated</td>
<td>Ministry of Social Affairs</td>
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<tr>
<td>Disability</td>
<td>Initiated</td>
<td>Ministry of Social Affairs</td>
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<tr>
<td>On-job training</td>
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<tr>
<td>Social coverage</td>
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<td>Housing</td>
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<td>Tax exemption</td>
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4The ‘University for Seniors’ at the American University of Beirut is a pioneering public health intervention made with and for older people. It offers life-long learning opportunities (study groups, lectures, educational trips and projects with AUB students) and thus addresses the needs and aspirations of a growing number of older adults to remain intellectually challenged and socially connected. It was established in 2010.
and policies catering to older persons’ desire for flexible work schedules, part-time job opportunities or phased retirement while having ‘something to retire to’ can be very inspiring interventions that influence when we age and how we age.

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