Emerging Burden of Frail Young and Elderly Persons in Oman
For whom the bell tolls?

Hamed Al-Sinawi,1 Mohammed Al-Alawi,2 Rehab Al-Lawati,2 Ahmed Al-Harrasi,3 Mohammed Al-Shafaee,4 *Samir Al-Adawi5

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ABSTRACT: Recent improvements in health and an increased standard of living in Oman have led to a reduction in environment-related and infectious diseases. Now the country is experiencing an epidemiological transition characterised by a baby boom, youth bulge and increasing longevity. Common wisdom would therefore suggest that Omanis will suffer less ill health. However, a survey of literature suggests that chronic non-communicable diseases are unexpectedly becoming common. This is possibly fuelled by some socio-cultural patterns specific to Oman, as well as the shortcomings of the ‘ miracle’ of health and rapid modernisation. Unfortunately, such new diseases do not spare younger people; a proportion of them will need the type of care usually reserved for the elderly. In addition, due to their pervasive and refractory nature, these chronic non-communicable diseases seem impervious to the prevailing ‘cure-oriented’ health care system. This situation therefore calls for a paradigm shift: a health care system that goes beyond a traditional cure-orientation to provide care services for the chronically sick of all ages.

Mortality is not a ‘disease’, and while Erikson has portrayed old age as time of culmination of ‘wisdom’ that could be a gift for the succeeding generation, ageing does have its own unique challenges. Every health practitioner will attest to the view that longevity and the resultant ageing process often herald not only decreased vitality and capability, but also increased impairment, disability and a compromised quality of life. The question is whether Oman should now be concerned with the welfare of the elderly even while its population...
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there is an unusual trend whereby youth people are seeking types of health care often perceived as only relevant for the elderly. Such a trend is likely to have been fostered by the following five interrelated factors.

**THE CHALLENGE OF NON-COMMUNICABLE DISEASES**

Oman has generally triumphed over communicable disease.10,11 The country now faces the challenges of a rising tide of non-communicable diseases, sometimes labelled ‘diseases of affluence.’7 These ‘elderly-onset’, intransigent, and debilitating diseases seem to be affecting Oman’s youngsters.12-14 Such an emerging pattern of disease would suggest the need for a different approach in order to ensure enlightened health care planning and resource allocation. As will become apparent below, many of these emerging diseases of affluence are triggered by lifestyle changes and combatting them will require concerted efforts in the domain of rehabilitation and remedial services rather than simply curative medicine.15

**ROAD TRAFFIC HAZARDS**

Another contributor to impairment, disability and handicap in Oman is what is referred to as ‘flying coffins’, the mishap that happens to motor vehicle and their occupants on the road.16 Unsubstantiated data published in the media reveal that the road accident rate in Oman is 28 per 100,000 of the population; if true, this is likely to be highest in the world.17 It has been well established that although an ‘accident is an accident’, road traffic injuries are a major public health problem in Oman disproportionately affecting the section of the population under 40 years of age.17,18 The type of health care provision needed, if the claim of a tsunami of road traffic accidents is substantiated, would parallel that often provided for the elderly.

**CONGENITAL DISEASES**

New reports suggest that Oman is not immune to congenital and inheritable genetic diseases as well those that are thought to be triggered by new mutations.19,20 As consanguinity is intimately embedded in Omani culture (due to the practice of first cousin marriages), this is likely to exacerbate the development of diseases that owe their origin to inherited genetic traits and health impairing...
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In general, in the countries labelled ‘emerging economies’, concerted efforts to improve the welfare and care of MCI due to CEBD are ostensibly absent. Instead, health care priorities are still the perceived enemies of health such as infectious diseases and reproductive, maternal, and child health conditions. This is similar to the situation in industrialised countries that have so far focused their attention on the prevention and treatment of cancer and heart diseases. However, such a prioritisation appears to be myopic when one considers the enormous negative repercussions of CEBD. Despite their protean nature, when defined using disability-adjusted life year (DALY), CEBD appears to outstrip all other medical conditions in term of number of years lost due to ill-health, disability or early death. This is consistent with the view that CEBD tend to compromise the very essence of being human, namely, the capacity to think and act rationally. It is worth noting that CEBD tend to peak when afflicted individuals are still at a young age, thus depriving them of meaningful existence for many years. This has obvious implications for society. In addition to impairment, disability and handicap, CEBD tend affect other areas of health. For example, emotional disorders tend to have a strong link with physical illness. The relationship between emotional disorders and physical illness has been unequivocally shown in emerging literature, including in Oman. In addition to this, there is strong evidence to suggest that some well known physical illnesses tend to create a psychological burden. For example, following diagnosis of cancer, some individuals may succumb to reactive depression which, in turn, can affect the prognosis. The Omani population, with its ‘baby boom’, ‘youth bulge’ and increased longevity, should therefore expect to see an exponential increase in the number of the people succumbing to CEBD. The available data are consonant with such a view. Although sometimes framed in the local idioms of distress, CEBD are widely recognised in Oman. The magnitude of some CEBD (e.g. deliberate self-harm, hyperkinetic disorder, depressive symptoms, factitious disorder and eating disorders in the form of deliberate food restriction) is much lower compared to international standards, but Oman is the ‘world leader’ in those distresses that owe their origin to social and cultural patterning (e.g. social
Possible Solutions to this Emerging Issue

With the rising tide of non-communicable diseases; impairment, disability and handicap triggered by road traffic behaviour, some of the consequences of the modern medical revolution, and the enduring cultural patterns that may sustain genetically determined disorders, Oman needs to contemplate a new direction for its health care system. Rather than focusing on environment-related and infectious diseases, an integral part of Oman’s health system should be meeting the needs of MCI through remedial services—since it would be an untenable aspiration to find a cure for all the causes of impairment, disability and handicap in Oman.

NEW TYPES OF HEALTH CARE SERVICES

The importance of improving neurobehavioural rehabilitation in Oman was previously highlighted; here, it is worthwhile discussing the relevance of the compensatory efforts needed to support MCI with persistent and debilitating medical conditions. Health care services should enable MCI to reach and maintain their optimal levels of physical, sensory, intellectual, psychological and social functioning in order to achieve a measure of self-determination and meaningful and independence existence. Due to their focus on chronic disease, modern cure-based hospitals may be the least attractive option. Rehabilitation or remedial services need multidisciplinary medical teams, with a range of skills from social work to neurosurgery, which are also supported by educational/vocational institutions and other social agencies.

If the available data circulating in the media would bear scientific scrutiny, it appears that 0.3 to 0.4% of Omanis are likely to incur impairment, disability and handicap arising from road accidents. This trend dovetails with the present discourse that Oman is likely to experience an increased number of youngsters with MCI. Extrapolating from this trend, it could be thought that some MCI are likely to use acute hospital beds as a ‘care home’. Extended hospital stays for MCI can often trigger bed shortages for other clinical populations and result in increased health care expenditure. Some of the MCI who tend to ‘over-stay’ are likely to be too frail to be discharged home—as has been found in other Arab countries.

CARE IN THE FAMILY

Care for MCI often depends on the prevailing Zeitgeist and history is full of approaches to helping those who are deemed unfit or dependent. Nowadays, health care facilities are mushrooming in different parts of the world to cater to the needs of MCI. These are specifically designed to provide a place of abode for MCI who cannot independently undertake their activities of daily living. In the present discussion, such health care facilities aim to provide a compensatory mechanism so that MCI can have a meaningful existence.

Thesiger fondly praised Omanis for “…their sense of fellowship, … their generosity and sense of hospitality; their dignity and their regard which they have for the dignity of others as fellow human beings.” (Cited in Smith p.541). It is not clear what impact modernity (as result of acculturation) has had in recent times on such an ideal humanity. Nonetheless, in family-oriented societies like Oman, interdependence is still encouraged. Such cultural patterning means that MCI will be cared for in the realm of the family. It is a widely held belief (though one that lacks empirical support) that given this type of society the fate of MCI is likely to be favourable. The question, however, is whether the modern Omani family is equipped to provide the family care needed by MCI. It has been indicated that recent affluence in Oman has resulted in the nuclear family supplanting the traditional extended family leading to a reported emergence of socially valued individualism and the erosion of interpersonal relationships that stems from modern education systems. There are also anecdotal reports indicating that the young generation “has little time for elderly people”.

It is not clear, however, what implication this sociological observation has on the welfare of MCI. Despite such caveats, the family plays a central role in Omani society. On these grounds, it would be essential to contemplate a health care model that has affinity to Omani socio-cultural teaching.

Although, to our knowledge, there is published work, relating to the elderly, articles in the popular media indicate that the country is “not encouraging the establishment of such homes because we still
believe that the Omani community will be able to take care of their elderly population as our religion and tradition teaches us to do so.\textsuperscript{52} Given the lack of organised services in Oman for the MCI, some individual initiatives have already been seen in the community. To cope with the burden of caring for MCI, with their complex physical and emotional needs, some families employ private carers who undertake the physical aspect of caring (feeding and washing). However, employing an in-house carer is limited to those who have sufficient disposable income and may not apply to the majority of Omanis. Nevertheless, the presence of private carers spares family members from the task of constant physical caring for their MCI.

**SUPPORTED HOME AND COMMUNITY CARE**

Within the context of a family-oriented society, one approach that might be appropriate for MCI in Oman is outreach services similar to home health care, otherwise known as domiciliary care or social care. As the term implies, home health care serves the myriad needs of MCI in their homes by outreach teams that include all types of health care professionals such as nurses, occupational therapists and social workers. This type of care has some subtle benefits that outweigh other approaches. First, the services will be tailor-made for the MCI's functional limitations. Second, the MCI not need to travel outside for help which may be difficult due to their medical complications. Third, the MCI will be protected from psychological trauma—the feeling of unfamiliarity that can heighten anxiety and the feeling of being uprooted from home and having to part with possessions that are usually experienced by those put in care homes. This means MCI have their health needs met within their own community which mean they are likely to remain closer to their social network of friends, neighbours and family thus mitigating loneliness, depression and other existential dilemmas. International surveys show that over 95% of MCI would prefer to stay in their own home for as long as possible.\textsuperscript{53}

Finally, for the family and society in general, such a care model is likely to be more cost effective than hospital care. There is evidence to suggest that even if MCI tend to be marked by a high level of dependency, home care is likely to be cost-effective. Such a view is supported by studies carried out in Denmark, Ireland and Italy where home-based care is generally more cost-effective for such MCI.\textsuperscript{54}

Another alternative approach is a non-residential facility that provides activities for the MCI during the day. This would mean that MCI could spend 10–12 hours per day in a setting possibly with access to a medical facility. Under this scheme, meals, social and recreational outings, and general supervision are provided by a team of experts. There are several advantages to such a proposal. First, regular proximity to health care delivery is likely to prevent re-hospitalizations as medical assessments and medications are readily available. Second, the benefit of social stimulation will emerge. MCI who would otherwise stay at home are provided with recreational activities and other social stimulations that maybe therapeutic on their own right. There are some empirical studies suggesting that social stimulation can ward off the emergence of cognitive impairment and other debilitating emotional conditions common in MCI.\textsuperscript{55} Relevant to this, while such centres could provide remedial education and rehabilitation for MCI, in the interim, caregivers would get much needed respite to seek employment or simply to recuperate from the stress of caring for MCI with their particular problems. It is worth noting in this context that many MCI are marked by erratic behaviour and a rigidity of personality that may exhaust their caregivers.

**Conclusion**

Oman has been internationally lauded for taking vigorous action to combat disease and to improve the condition of its people. Such a health service 'miracle', associated with an increased standard of living, has led to the progressive demographic transformation of society. Recent socio-economic trends have reduced the occurrence of environment-related and infectious diseases. Instead, there is a rising tide of death, morbidity, handicap and disability due to genetically determined disorders and other sequelae of acculturation and modernisation including road traffic accidents and the very success of the medical revolution. This has occurred in the midst of a 'baby boom', a prevailing youth bulge and increased life expectancy. As result of such socio-demographic trends, the country is
witnessing a rising tide of MCI among both young and elderly populations. Due to their persistent, pervasive and refractory nature, the emerging health conditions appear to be impervious to the benefits of the modern ‘cure-oriented’ health care system which was effective for the environment-related and infectious diseases of the previous era. This therefore calls for a paradigm shift: a health care system that goes beyond strict adherence to the traditional ‘comfort zone’ of cure-oriented health care system. New pragmatic solutions need to be found to meet the new challenge of the increasing numbers of MCI in Oman.

References

293:1595–6.


