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## **TECHNICAL PAPER**

### **HEALTH CARE OF THE ELDERLY IN THE EASTERN MEDITERRANEAN REGION: CHALLENGES AND PERSPECTIVES**

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## **EXECUTIVE SUMMARY**

The ageing of the population is a global phenomenon that demands international, national, regional and local action. Any plan of action on ageing and health care for older persons should be built upon three basic pillars: older persons and development (participation), which focuses on the need for societies to adjust their policies and institutions to promote the growing older population as a productive force for the good of society; advancing health and well-being into old age (health), which underlines the need for policies that promote good health from childhood and onwards throughout the course of life in order to attain a healthy old age; and ensuring enabling and supportive environments (security), which promote policies oriented towards family and community to provide the basis for secure ageing.

Despite the fact that the increasing numbers of older persons are not widely seen as a cause of alarm in the Eastern Mediterranean Region, the absolute and proportionate numbers of this group will increase rapidly in the next decade in the majority of the countries, pushing their unique, health and socioeconomic needs to the forefront. However, increased attention to the health and social care of the elderly is being realized in some countries.

The programmes and activities initiated in the early 1990s for the protection and promotion of the health of the elderly should be evaluated in order to enable the Regional Office and Member States to expand their objectives, build on achievements, develop new policies and revise the present strategies.

Member States are recommended to review current national policies and strategies regarding the comprehensive care of older persons; improve the integration and coordination of health and welfare programmes and services to effectively address the various needs of older persons; improve primary health care systems to protect and promote healthy lifestyles throughout the life course, and to cope with the chronic health problems among an ageing population; develop programmes that delay the onset of disability, ameliorate its trajectory and enhance older persons' capacity to take better care of themselves such as the active ageing approach; and support family and community caregivers of older people and promote the retention of appropriate traditional care and positive social and cultural values and practices for older persons, as well as the notion of adoption of older persons who have no relatives by families who can surround them with familial care.



## 1. INTRODUCTION

Population ageing is the process by which people aged 60 and over become a proportionally larger share of the total population, and the proportion of children and young people in the population declines. The report *World population ageing 1950-2050* [1], prepared as a contribution to the 2002 World Assembly on Ageing, presented four major findings:

- Population ageing is unprecedented, without parallel in the history of humanity.
- Population ageing is pervasive, a global phenomenon affecting every man, woman and child.
- Population ageing is profound, having major consequences and implications for all facets of human life.
- Population ageing is enduring. During the 20th century the proportion of older persons continued to rise, and this trend is expected to continue into the 21st century. For example, the proportion of older persons was 8% in 1950 and 10% in 2000, and is projected to reach 21% in 2050.

Countries of the Eastern Mediterranean Region are no exception to this phenomenon and have already begun to experience population ageing as ever increasing numbers of their populations survive to old age. Despite the fact that there are wide differences between the countries, both in regard to the current situation and to the population projections, older people are undoubtedly becoming a larger and more visible proportion of the general population [2]. The growing absolute and relative numbers of older people mean that more and more people are entering the age at which the risk of developing certain chronic and debilitating diseases is significantly higher. As such, population ageing and delivery of health care services to the elderly population present new and serious challenges for national and regional public health.

In the Eastern Mediterranean Region, dutifulness to parents and grandparents, and extending kind and respectful treatment to elders in general, are among the basic values. Because of this, most elderly people continue to enjoy home care, within their families. Nevertheless, better statistical information on demographic ageing and its specific features and causes in the countries of the Region and better analysis of this phenomenon in relation to the rapid health, economic and social development taking place are needed in order to provide evidence-based data on the real situation, and provide scientific guidance for policies and programmes on the health of the elderly. A comprehensive response to population ageing is also required in order to develop collaborative efforts and activities in all domains to make society “elder friendly”. This should include measures to provide integrated health, economic and social care, to enhance family and social support and to reduce the burdens of disease and disability.

The objectives of this paper are to:

- raise awareness and update knowledge in the Region with regard to the trends and implications of population ageing for socioeconomic and health systems.
- Provide a conceptual framework and action-oriented recommendations for developing collaborative programmes for health of the elderly in the Region.

## 2. POPULATION AGEING IN THE EASTERN MEDITERRANEAN REGION

### 2.1 Population growth

According to United Nations projections, as shown in Table 1, the total population of the Region will double in the first quarter of the 21st century and triple by 2050. In 2000 one in 12 of the world's population lived in the Eastern Mediterranean Region, but by 2025 one in 9 will and by 2050 one in 7. This means that a significant proportion of world population growth will take place in this Region. Some countries will experience higher rates of growth than others. For example, the population of Yemen, currently around 18.5 million, is projected to reach over 102 million in 2050. Yemen will then be the fourth most populous country in the Region after Pakistan, Islamic Republic of Iran and Egypt, compared with its current ranking of ninth.

### 2.2. Population age structure

Age composition, i.e. the proportion of children, young adults, middle-aged adults and older adults in any given country, is an important element for policy-makers to take into account [3]. Table 2 illustrates the trends in population age structure.

The population of the Region is ageing at an accelerated pace. Declining fertility rates (Table 3) combined with steady improvements in life expectancy in recent decades are producing visible growth in the proportion of the population that is ageing. Currently, the total fertility rate in the Region is 4.3 children per woman. In 2025 it will have decreased to 2.8 and in 2050 to 2.2. Currently, only 5.8% of the population is over the age of 60; but in 2025, older persons will account for nearly 8.7% and by 2050 nearly 15% of the population. In general, the proportion of the elderly will increase in all countries of the Region from now until 2025 and 2050, especially in the member countries of the Gulf Cooperation Council. For example, the percentage of the elderly in the United Arab Emirates was 5.1% in 2000 and is projected to reach 23.6% in 2025 and 26.7% in 2050. Conversely, the proportion of the population below 15 years of age will decline in all countries of the Region (Table 2).

**Table 1. Population growth (thousands)**

Region	1950	1975	2000	2025	2050
Eastern Mediterranean Region	131 988.7	245 429.1	484 845.8	815 577.2	1 236 763.2
World	2 519 495.1	4 065 508.1	6 056 714.9	7 936 740.8	9 322 251.2
More developed regions	813 573.9	1 048 264.9	1 191 428.6	1 218 834.3	1 181 108.1
Less developed regions	1 705 921.1	3 017 243.1	4 865 286.3	6 717 906.5	8 141 143.2
Least developed countries	197 450.2	347 742.2	658 192.3	1 186 273.7	1 829 541.6

Source: [1]

**Table 2. Trends in population age structure (%)**

Region	1950			1975			2000			2025			2050		
	Age (years)			Age (years)			Age (years)			Age (years)			Age (years)		
	0-14	15-59	60+	0-14	15-59	60+	0-14	15-59	60+	0-14	15-59	60+	0-14	15-59	60+
EMR average	40.5	52.8	6.7	43.6	51.1	5.3	41.1	53.1	5.8	32.2	59.1	8.7	25.6	59.4	15.0
World	34.3	57.6	8.2	36.7	54.7	8.6	30.0	60.0	10.0	24.3	60.7	15.0	21.0	58.0	21.1
More developed regions	27.3	60.9	11.7	24.2	60.4	15.4	18.3	62.3	19.4	15.0	56.8	28.2	15.5	51.0	33.5
Less developed regions	37.6	56.0	6.4	41.1	52.7	6.2	32.8	59.5	7.7	26.0	61.4	12.6	21.8	59.0	19.3
Least developed countries	41.1	53.5	5.4	44.7	50.3	5.0	43.1	52.0	4.9	37.9	56.2	5.9	29.1	61.4	9.5

Source: [1]

**Table 3. Total fertility rate (per woman)**

Region	1950-1955	1975-1980	2000-2005	2025-2030	2045-2050
EMR average	6.6	6.3	4.3	2.8	2.2
World	5.0	3.9	2.7	2.3	2.1
More developed regions	2.8	1.9	1.5	1.7	1.9
Less developed regions	6.2	4.6	2.9	2.4	2.2
Least developed countries	6.6	6.4	5.2	3.6	2.5

Source: [1]

### 2.3 Increase in life expectancy at birth

Over the past five decades, life expectancy at birth increased globally by almost 20 years, from 46.5 years in 1950-1955 to 66.0 years in 2000-2005. In the Eastern Mediterranean Region the increase was from 43.6 years to 66.7 years (Table 4). On average, the gain in life expectancy is 23.1 years in the Eastern Mediterranean Region compared with 9.4 years in the more developed regions. While in some countries of the Region, such as Bahrain, Cyprus, Jordan, Kuwait, Lebanon, Libyan Arab Jamahiriya, Oman, Palestine, Qatar, Saudi Arabia, United Arab Emirates, Syrian Arab Republic and Tunisia, life expectancy at birth is currently above 70 years, in Afghanistan, Djibouti and Somalia, it is still under 50 years.

Over the next 50 years, life expectancy at birth is projected to increase globally, including the Eastern Mediterranean Region, by 10 years, to reach 76 years in 2045-2050 (Table 4). As mortality becomes more concentrated on older segments of the population, the gaps in life expectancy between regions will tend to decrease [1]. By the end of the next quarter century, life expectancy at birth is expected to reach, on average, 80 years in the more developed regions and 72.7 years in the Eastern Mediterranean Region.

**Table 4. Life expectancy at birth (years)**

Region	1950–1955	1975–1980	2000–2005	2025–2030	2045–2050
<i>Total</i>					
EMR average	43.6	57.1	66.7	72.7	76.6
World	46.5	59.8	66.0	72.4	76.0
More developed regions	66.2	72.3	75.6	80.0	82.1
Less developed regions	41.0	56.8	64.1	70.9	75.0
Least developed countries	35.5	45.3	51.4	62.8	69.7
<i>Female</i>					
EMR average	44.6	58.5	68.2	74.5	78.7
World	47.9	61.5	68.1	74.7	78.5
More developed regions	68.6	75.9	79.3	83.1	85.1
Less developed regions	41.8	57.8	65.7	73.0	77.3
Least developed countries	36.1	46.3	52.2	64.0	71.3
<i>Male</i>					
EMR average	42.7	55.8	65.3	71.0	74.6
World	45.2	58.0	63.9	70.1	73.7
More developed regions	63.6	68.6	71.9	76.8	79.0
Less developed regions	40.2	55.8	62.5	69.0	72.9
Least developed countries	35.0	44.4	50.6	61.6	68.0

Source: [1]

In Japan, female life expectancy at birth, at almost 85 years, is currently the highest in the world. In only one country of the Eastern Mediterranean Region, Cyprus, is female life expectancy at birth now around 80 years. In 14 countries, female life expectancy at birth exceeds 70 years (Bahrain 76.3, Islamic Republic of Iran 70.8, Jordan 72.5, Kuwait 79.0, Lebanon 75.1, Libyan Arab Jamahiriya 73.3, Morocco 70.5, Palestine 74.0, Oman 73.2, Qatar 72.1, Saudi Arabia 73.7, United Arab Emirates 78.4, Syrian Arab Republic 73.1, Tunisia 72.2). Over the next 50 years, female life expectancy at birth is expected to surpass 92 years in Japan and 85 years in 26 other countries of the world. Female life expectancy at birth is expected to surpass 80 years in 16 countries of the Eastern Mediterranean Region.

Reductions in mortality have been substantially higher among females than males in practically all age groups. As a result, the female advantage in life expectancy at birth increased from 2.7 years to 4.2 years globally over the past 50 years, and from 1.9 years to 2.9 years in the Eastern Mediterranean Region. By 2050, the global gap is expected to increase slightly to 4.8 years and to 4.1 years in the Eastern Mediterranean Region. [1]

## 2.4 Sex ratio

Because their life expectancy is higher than men's, women, in general, comprise a significant majority of the older population. In 2000, the sex ratio of the population of the Region aged 60 years or over was 86.0 males per 100 females (Table 5). For the population aged 60 years or over, sex ratios above 100 were found in 9 countries (Bahrain 117.1, Jordan 103.2, Kuwait 202.6, Libyan Arab Jamahiriya 118.6, Oman 107.0, Pakistan 100.3, Qatar 245.5, Saudi Arabia 115.4 and United Arab Emirates 246.7). Even for the population aged 80



**Table 5. Sex ratio (per 100 women)**

<b>Region</b>	<b>1950</b>	<b>1975</b>	<b>2000</b>	<b>2025</b>	<b>2050</b>
<i>Sex ratio 60+</i>					
EMR average	108.4	98.5	86.0	76.8	89.9
World	80.1	78.1	81.2	84.4	85.0
More developed regions	73.7	66.7	70.7	77.0	78.2
Less developed regions	85.9	89.3	88.4	87.6	86.8
Least developed countries	88.3	92.6	86.7	87.2	90.6
<i>Sex ratio 80+</i>					
EMR average	105.9	98.1	89.7	81.2	69.5
World	61.4	58.1	53.1	57.7	60.7
More developed regions	57.5	46.8	44.2	51.3	55.7
Less developed regions	68.2	77.3	64.9	63.0	63.0
Least developed countries	76.0	78.4	75.9	71.6	73.4

Source: [1]

or over, sex ratios above 100 were found in 5 countries (Bahrain 101.1, Pakistan 112.5, Qatar 151.9, United Arab Emirates 126.6 and Tunisia 101.4). This trend is projected to be the same in 3 countries for the population aged 80 or over in 2025 (Kuwait 161.9, Qatar 223.9, United Arab Emirates 278.5) and in 2050 (Kuwait 116.5, Qatar 159.8, United Arab Emirates 196.3).

## 2.5 Ageing index

The ratio of people in the Region aged 60 or over to children younger than 15 (ageing index) is low and even decreased slightly from 1950 to 1975 (Table 6). Currently, it is around 13.9 per 100, but is projected to reach 26.9 per 100 in 2025 and 58.3 per 100 in 2050. A significant increase, exceeding 100 per 100, in ageing index is projected in four countries (Bahrain, Cyprus, Qatar and United Arab Emirates) in 2025. In 2050 half of the countries of the Region will have an ageing index over 100 per 100. In less than 50 years from now—for the first time in history—the world will contain more people over 60 than under 15 [4].

**Table 6. Ageing index**

<b>Region</b>	<b>1950</b>	<b>1975</b>	<b>2000</b>	<b>2025</b>	<b>2050</b>
EMR average	16.5	12.3	13.9	26.9	58.3
World	23.8	23.4	33.4	61.5	100.5
More developed regions	42.9	63.7	106.2	187.7	215.3
Less developed regions	17.2	15.1	23.4	48.2	88.6
Least developed countries	13.2	11.2	11.3	15.7	32.5

Source: [1]

**Table 7. Median age (years)\***

<b>Region</b>	<b>1950</b>	<b>1975</b>	<b>2000</b>	<b>2025</b>	<b>2050</b>
EMR average	19.3	18.6	21.7	27.6	33.9
World	23.6	22.0	26.5	32.0	36.2
More developed regions	28.6	30.9	37.4	44.1	46.4
Less developed regions	21.4	19.4	24.3	30.0	35.0
Least developed countries	19.5	17.6	18.2	20.8	26.5

Source: [1]

\*The median age of a population is that age that divides a population into two groups of the same size, such that half the total population is younger than this age, and the other half older.

## 2.6 Median age

The average median age for the Region was 21.7 in 2000 and is projected to rise to 27.6 in 2025 and 33.9 in 2050 (Table 7). The youngest population will be Yemen and the oldest population will Cyprus.

## 3. ISSUES AND CHALLENGES

### 3.1 The triumph and challenge of population ageing in the Region

Like many other parts of the world, the Region is witnessing an unprecedented pervasive, profound and enduring increase in the number and percentage of the population aged 60 years and over. The number of persons 60 years and over is currently 26.8 million. This is projected to grow to 65.4 million in 2025 and 182.9 million by the middle of the 21st century. The majority of the elderly population will live in the three largest countries (Pakistan, Islamic Republic of Iran and Egypt, respectively).

The demographic transition is a result, by and large, of improved living conditions and health care and should therefore be regarded as a triumph. However, the main challenge now is how to achieve the addition of meaningful life to the years gained and how to cope with the increased socioeconomic and health demands that the ageing populations will place on all countries.

The rapid growth of ageing populations challenges deeply the capacity and willingness of the social and health sectors to provide coordinated systems and sustained care. The socioeconomic implications of an ageing population go beyond demographic data. The increase in the elderly population will impose a greater burden on health services in countries of the Region and health policy-makers will need to plan now for changing age patterns of their populations. The significant increase in life expectancy implies not only a heightened demand for existing health and social services, but also for new services and alternative approaches to meet the varied and specific needs of older persons [2].

### **3.2 Implications of poverty**

Several countries of the Region are subject to specific economic, social and political pressures, including war and conflict. Older persons are exposed to many related risk factors, in particular poverty, as the main underlying cause of all ill health. While developed countries grew affluent before they became old, many developing countries are growing old before they get affluent [5]. In the absence of comprehensive policies on ageing, some countries may suffer from multiple demands upon their socioeconomic and health systems. The rapid increase in the number and proportion of older persons in these countries will have significant implications for both social and economic development, particularly in areas such as health care, financing of the needs of the growing number of older people (including accommodation), and the role of older people in a changing and increasingly urbanized society [6,7].

### **3.3 Double burden of disease**

Changing patterns of living and working are inevitably accompanied by a shift in disease patterns. Increasingly unhealthy lifestyles are leading to changes in dietary patterns, increased prevalence of obesity, increased numbers of smokers and less physical activity. These changes, in turn, are resulting in higher rates of noncommunicable disease, such as coronary heart disease, hypertension, stroke, cancer, chronic obstructive lung disease and diabetes [8]. Therefore, countries of the Region, while continuing the struggle with infectious diseases, malnutrition and complications from childbirth, have also to struggle with the rapid growth of noncommunicable diseases which are quickly becoming the leading causes of morbidity and disability among older persons.

### **3.4 Physical and mental disability**

Many people develop disabilities in later life, especially the “old-old”, those over 85 years, the fastest growing age-group worldwide. These disabilities are related to the wear and tear of ageing, such as arthritis, or the onset of a chronic disease. Physical or mental disabilities can seriously threaten older peoples’ independence, making them unable to carry out the activities of daily living. Other common age-related disabilities include loss of vision or hearing.

As populations age, there is an increase in certain mental disorders. Recognition that significant memory impairment is not a normal part of ageing is the foundation of assessment of cognitive functioning in later life. For older adults, dementias and depression are two key areas that require increased attention. Alzheimer’s disease is the most common type of dementia, and the most misdiagnosed.

### **3.5 Health care approaches**

One of the greatest challenges in setting health policy for the elderly population is to ensure a balance between support for self-care (people looking after themselves), informal support (care from family members, friends and local community) and formal care (health and social services) [3]. Formal care includes both primary health care (delivered mostly at the community level) and institutional care (either in hospitals or nursing homes).

### *Self-care*

Self-care, broadly defined as the decisions and actions individuals take with regard to their own health, has long been recognized as a major facet of health care. It is a key mechanism for health promotion and prevention. Self-care can also be considered as an important determinant of health, concerned with the development and use of personal health practices and coping skills [9].

Older individuals are the most important decision-makers in terms of both medical self-care (actions concerning medical problems) and health self-care (actions aimed at maintaining and improving health) because only the individual can attach a value to the benefits or risks of the actions under consideration [10].

Providing older persons with information about their own health situation and what they can do about it may facilitate self-care capacity-building interventions. Unfortunately, elderly people are often unaware of many of the resources that are available for health enhancement [11].

### *Informal support*

In all countries of the Region, family members, friends and neighbours (most of whom are women) provide the bulk of support and care to older persons that need assistance. But those caregivers need to be well informed about the condition they are faced with and how it is likely to progress, and about how to obtain the support services that are available. Some of them may be older persons themselves and they must be supported if they are to continue to provide care without becoming ill themselves [3].

Economic changes in the Region have affected the traditional family structure. Young adults are moving away from their traditional occupations in the villages to cities and larger towns in search of jobs, while women are entering the workforce in large numbers and nuclear families are replacing the traditional extended families [12,13]. Therefore, increasing difficulties in provision of familial care for the elderly may be expected, although the strong traditional values and religious teachings continue to exert positive effects and to bind the generations together. This is amply demonstrated in several countries of the Region that have achieved high economic growth, yet have managed to maintain traditional family values and practices [12].

In general, the ageing of the population, added to other social and demographic factors, has transformed the contemporary family [11,14,15]. Today, families have multiple elders, parents, parents-in-law, step parents, aunts and uncles, to whom they may have some level of responsibility. Overall, families are smaller today but have more generations represented. The increased longevity and smaller family size has resulted in potential gaps in an older person's traditional social support network. In some extreme cases, older persons may face the prospect of ageing without any son or daughter upon whom they may depend for care. In order to enable all families to undertake this responsibility, it is essential that support should come from all quarters: the State, the community, nongovernmental organizations and religious and philanthropic organizations [13].

More studies on the actual role of the contemporary family in caring for older persons in the Region are needed in order to provide the facts and evidence that policy-makers need to develop policies and strategies that empower the carers of older persons and enable them to cope with the complex issues of ageing.

#### *Formal care*

Most older people in the Region who are in need of care prefer to be cared for in their own homes. To keep elderly parents at home is also regarded as an essential obligation and not to do so is regarded as a sin [13,16]. People in the Region are proud of the fact that duty to parents and grandparents, and extending kind and respectful treatment to elderly people in general, are among their basic values, which they are keen to maintain. But, an important question to be asked is, how long can this be maintained with mounting economic pressure? What about older persons who have no one to take care of them? [17].

In the developed world, where this transition has been taking place for several decades, measures for coping with this transition have developed deep roots. Institutional and hospital care of older persons is widely prevalent and, at the same time, the preference of parents and grown-up children to live separately has become a cultural norm. For most Eastern Mediterranean Region countries, institutional care of older persons remains largely unaccepted, both for economic reasons since it is very expensive, and for cultural reasons.

Nevertheless, formal care is needed in many cases. Therefore, professional caregivers also need training and practice in enabling models of care that recognize the strengths of older persons and that empower them to maintain even small measures of independence when they are ill and frail. Unfortunately, primary health care workers are rarely trained, either to advise their families about their vulnerability to hazards and how to overcome this, or to identify early cases of disease and disability in older persons for appropriate referral and management [3,13,18].

### **3.6 Feminization of ageing**

Women are more likely than men to live to very old age, when disabilities and multiple health problems are more common. Because of women's longer life expectancy and the greater tendency of men to marry younger women and to remarry if their spouses die, widows dramatically outnumber widowers in all countries. Older women who are alone are highly vulnerable to poverty and social isolation [2,3,12].

### **3.7 Ethical considerations**

As populations age, a range of ethical considerations comes to the fore, including age discrimination in resource allocation, employment, long-term care and the human rights of poor and disabled older citizens [3].

### **3.8 Economic issues related to ageing**

Perhaps more than anything else, policy-makers fear that rapid population ageing will lead to an unmanageable explosion in health care and social security costs. While there is no doubt that ageing populations will increase demands in these areas, there is also evidence that

innovation, cooperation from all sectors, planning ahead and making evidence-based, culturally-appropriate policy choices will enable countries to successfully manage the economics of an ageing population [3,6,7].

Research in countries with ageing populations has shown that ageing per se is not likely to lead to health care costs spiralling out of control. In fact, the major causes of escalating health care costs are related to circumstances that have nothing to do with the demographic ageing of a given population. Rather, inefficiencies in care delivery, building too many hospitals, payment systems that encourage long hospital stays, excessive numbers of medical interventions and the inappropriate use of high cost technologies are the key factors involved [3,7].

The costs of long-term care can be managed if policies and programmes address prevention and the role of informal care. In many countries, the bulk of spending is on curative medicine. Care for chronic conditions leads to an improved quality of life. However, it is both preferable and more cost-effective if such can be prevented or delayed until very late in life [3,7].

### **3.9 Social security systems**

Another, major concern for policy-makers is the demand that an ageing population may place on social security systems. Alarmists point to the growing proportion of the “dependent” population that has retired from the formal labour force. The idea that everyone over the age of 60 years is dependent is, however, a false assumption. Many people continue to work in the formal labour market in later life or would choose to do so if the opportunity existed. Many others continue to contribute to the economy through informal work and voluntary activities, as well as intergenerational exchanges of cash and family support. For example, older people who look after grandchildren allow younger adults to participate in the labour market [3].

Nevertheless, population ageing does require governments and the private sector to address the challenges to social security and pension systems. A balanced approach to the provision of social protection and economic goals suggests that societies who are willing to plan can afford to grow old [3].

### **3.10 Myths and misconceptions**

#### *Older people cannot work*

Traditionally, old age has been associated with retirement, illness and dependency. Policies and programmes that are stuck in this outdated conceptual framework do not reflect reality. Indeed, most people remain independent into very old age [3]. In the Eastern Mediterranean Region especially, many people over 60 continue to participate in the labour force in one way or another.

Reliable data from several countries demonstrate an increasing probability with age of chronic diseases, such as cardiovascular disorders, musculo-skeletal disorders, respiratory diseases and cancer, which implies that a high percentage of the older workforce experiences limitations in functional capacity, including work capacity, and cannot carry out all the tasks expected of the younger worker without some adaptation of the work environment. This does

not mean that older people are less valuable workers, but it does indicate the need for job adjustment and special occupational health and safety arrangements for the protection and promotion of their health at work [19].

Older workers may have specific strengths, such as greater dedication to work, better routine skills as a result of long experience, and a more stable character because of experience and age-related intellectual and personality development. These make them particularly suitable for certain jobs for which they are indeed in demand and society should make better use of these capacities, which are often lacking in younger workers [19].

Older people, in general, are more active in the informal work sector, such as domestic work and small scale, self-employed activities, although this is often not recognized in labour market statistics. As already noted, older people's unpaid contributions in the home, such as looking after children and people who are ill, allow younger family members to engage in paid labour. In all countries, the voluntary activities of older people provide an important economic and social contribution to society.

A conceptual framework is needed in the Region that views older people as active participants in an age-integrated society, and as active contributors to, as well as beneficiaries of development. Such a conceptual framework would take an inter-generational approach that recognizes the importance of relationships and support among and between family members and generations. It reinforces "a society for all ages"—the central focus of the 1999 United Nations International Year of Older Persons [3].

#### *Older people cannot learn*

A new conceptual framework would also challenge the traditional view that learning is the business of children and youth, work is the business of mid-life and retirement is the business of old age. It calls for programmes that support learning at all ages and allow people to enter or leave the labour market in order to assume caregiving roles at different times over the life course. Such an approach would support inter-generational solidarity and provide increased security for children, parents and people in their old age [3].

#### **4. REGIONAL PROGRAMME ON HEALTH OF THE ELDERLY**

In 1991, the Regional Office brought health care of the elderly to the attention of the Regional Committee at its thirty-eighth session with technical discussions on health of the elderly and problems of the handicapped elderly [16]. Resolution EM/RC38/7 urged both the Member States and WHO to take urgent measures in promoting and protecting the health of the elderly population so that they could lead active lives. The discussions and resolution created considerable awareness of the issues involved among decision-makers and senior administrators in the health sectors of Member States.

Also at that time focal points for health of the elderly were appointed in the ministries of health of a number of countries and a rapid questionnaire survey was conducted in 11 countries on the socioeconomic and health status of the elderly population. As a result, countries began to develop national programmes for care of the elderly, and this was facilitated by publication of the regional strategy for health care of the elderly 1992–2001 and

a manual for training in health care for the elderly aimed at those working in primary health care services [20,21].

As part of the celebrations of the International Year of Older Persons and of World Health Day in 1999, the Regional Office supported a health promotion approach to ageing successfully, and focused on the value of physical activity for preventing chronic disease and disability in old age. Active ageing was the theme of World Health Day 1999, with the slogan "Active ageing makes the difference", which recognizes that older people must go on playing a part in society. In collaboration with Member States, the Regional Office initiated extensive activities to celebrate this important event aimed at advocating the special health and social needs of the elderly in the Region. Advocacy campaigns were conducted with the direct support of senior leadership in several countries including Bahrain, Cyprus, Egypt, Saudi Arabia, Syrian Arab Republic and United Arab Emirates. In response to promotion of the concept of physical activity for the elderly in recent years, about one-third of countries have included physical activity as part of social, cultural and religious programmes for the elderly.

In April 2001 an intercountry workshop on promotion of the health of the elderly in the Eastern Mediterranean Region was held in Beirut, Lebanon. The workshop concluded that the programmes and activities initiated in the early 1990s for the protection and promotion of health of the elderly should be evaluated in order to enable the Regional Office to expand its objectives, build on achievements, develop new policies and revise the present strategies. It was also suggested that programmes for older persons should adopt a life-course perspective, since yesterday's children are today's adults and tomorrow's older persons, and that health-care programmes for older persons need to be enhanced and integrated with other sectors. New programmes should be developed where there are gaps in service as well as a more holistic approach to ensure that the public and private sectors are meeting the needs of older persons [2].

## **5. CONCLUSIONS AND FUTURE DIRECTIONS**

1. The demographic and associated epidemiological transition taking place in the Region means that many countries are confronting a double burden of disease, fighting emerging and re-emerging communicable diseases in parallel with the increasing threat of noncommunicable diseases. Prevention and control of noncommunicable disease from an early age and throughout life will ensure healthier and more meaningful life for older persons. Policies, programmes and intersectoral partnerships are therefore needed to confront the massive expansion of chronic noncommunicable diseases. While not necessarily easy to implement, those that focus on community development, health promotion, disease prevention and increasing participation are more likely to be effective in controlling the burden of disease. Furthermore other long-term policies that target malnutrition and poverty will help to reduce both chronic communicable and noncommunicable diseases. Support for relevant research is urgently needed.
2. Despite the fact that the increasing number of older persons is not widely seen as a cause for alarm in the Region, the absolute and proportionate numbers of this group will increase rapidly in the next decade in the majority of the countries, pushing their unique



health and socioeconomic needs to the forefront [2,22]. However, increased attention to the health and social care of the elderly is being realized in some countries.

3. As older people in the Region are becoming a larger and more visible proportion of the general population, better statistical information on demographic ageing and its causes, consequences and specific regional and country aspects is urgently needed to guide policies and programmes.
4. Due to continuous urbanization and the disintegration of extended families, the conventional assumption that the elderly are largely supported by the traditional extended family, in terms of care, shelter and useful roles, should be reviewed.
5. National policies for care of the elderly exist in the majority of countries of the Region. In most instances, however, national policy has not extended beyond the creation of a national coordinating committee for care for the elderly, usually administered by the Ministry of Social Affairs (or the Ministry of Health). Most of these committees were established between 1996 and 1997, in line with the regional strategy for health care of the elderly in the Eastern Mediterranean Region. The effectiveness of the existing policies and the role of national committees need to be evaluated in order to ensure effective partnership and use of all resources available in the countries. All necessary steps must be taken to keep up those extended families that have not disintegrated, to encourage keeping the elderly within their family, living with their children and grandchildren, and to promote the notion of the adoption of older persons by families not related to them by ties of kinship but who would be related to them by ties of care.
6. Policies that promote lifelong health, including health promotion and disease prevention, assistive technology, rehabilitative care, when indicated, mental health services, promotion of healthy lifestyles and supportive environments, can reduce disability levels associated with old age and effect budgetary savings [23].
7. “Active ageing” is a term and concept adopted by the World Health Organization to express the vision that if ageing is to be a positive experience, longer life must be accompanied by continuing opportunities for health, participation and security. Active ageing applies to both individuals and population groups. It allows people to realize their potential for physical, social and mental well-being throughout the life course and to participate in society according to their needs, desires and capacities, while providing them with adequate protection, security and care when they require assistance [3].
8. Any plan of action on ageing and health care for older persons should be built on three basic pillars, as proposed by WHO in its policy framework for active ageing: participation, health and security [3]. In the follow-up report to the Second World Assembly on Ageing these are elaborated as follows [23]:
  - older persons and development (participation), which focuses on the need for societies to adjust their policies and institutions to promote the growing older population as a productive force for the good of society;

- advancing health and well-being into old age (health), which underlines the need for policies that promote good health from childhood and onwards throughout the course of life in order to attain a healthy old age; and
  - ensuring enabling and supportive environments (security), which promote policies oriented towards family and community to provide the basis for secure ageing.
9. To reach old age in good health and well-being requires individual efforts throughout life and an environment within which such efforts can succeed. The responsibility of individuals is to maintain a healthy lifestyle; the responsibility of government is to create a supportive environment that enables the advancement of health and well-being into old age [23]. When risk factors (both environmental and behavioural) for chronic diseases and functional decline are kept low while the protective factors are kept high, people will enjoy both longer life and quality of life; they will remain healthy and able to manage their own lives as they grow older; and fewer older persons will need costly medical treatment and care services [3].
10. Other important partners, in particular nongovernmental organizations, can provide support for individuals in maintaining a healthy lifestyle while cooperating closely with governments and families in creating a supportive environment. This approach requires action in a variety of sectors in addition to the health and social services, including education, labour, finance, social security, housing, transportation, justice and rural and urban development. These sectors can enact “age-friendly” policies and enabling programmes for older persons, including those with disabilities.

## **6. RECOMMENDATIONS**

### **Member States**

1. Continue to give due attention to population ageing, and review systematically current national policies, strategies and plans of action regarding the comprehensive care of older persons.
2. Establish, develop and improve the integration and coordination of the health, welfare and other concerned sectors to develop comprehensive programmes and services that address effectively the various needs of older persons.
3. Update and improve national primary health care systems to protect and promote healthy lifestyles throughout the life course, and to cope with the chronic health problems among an ageing population.
4. Develop programmes that delay the onset of disability, ameliorate its trajectory and enhance older people’s capacity to take better care of themselves, such as the active ageing approach.
5. Support, encourage and accommodate family and community caregivers of older people and promote the retention of appropriate traditional care and positive social and cultural values and practices for older persons, as well as the notion of the adoption of older persons who have no relatives by families who can surround them with familial care.

## WHO

6. Promote the creation of multidisciplinary regional and national networks among agencies, organizations, academic institutions and individuals concerned with and interested in providing care for older persons.
7. Update the regional strategy on the health care of elderly people in line with recent research and regional and national priority areas.
8. Continue to support Member States in promoting quality of life and well-being of older persons through approaches such as active ageing and community-based programmes or services for older people.
9. Improve the collection and standardization of data on ageing and health, and develop a computerized database on the status of the ageing population in the Region.

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