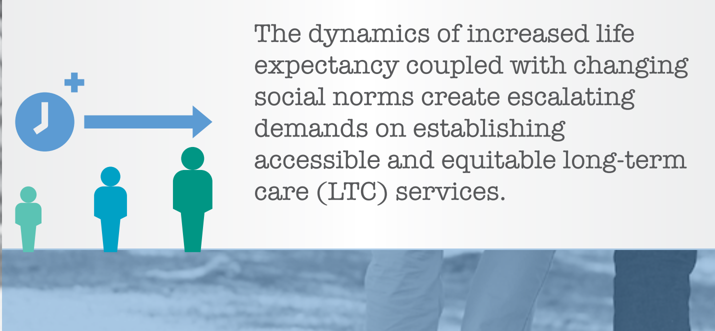
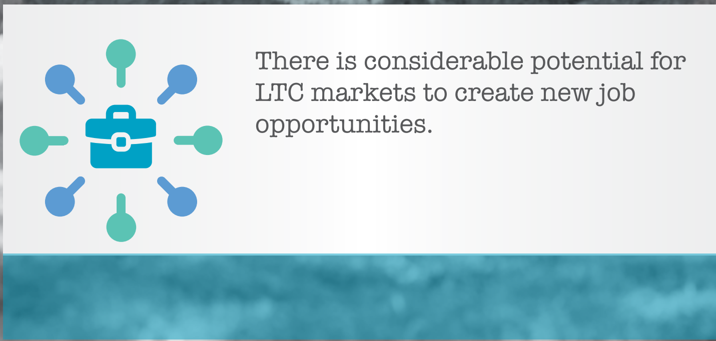
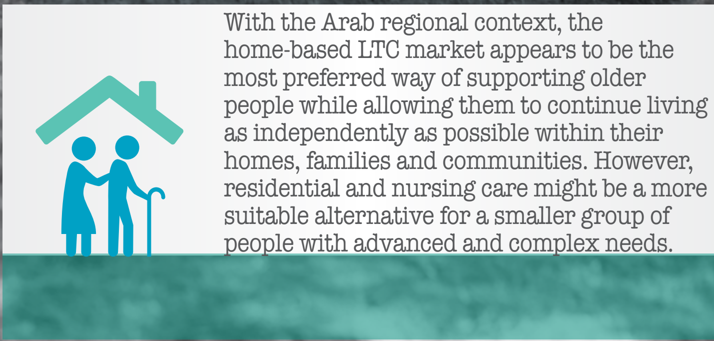

The dynamics of increased life expectancy coupled with changing social norms create escalating demands on establishing accessible and equitable long-term care (LTC) services.

In addition to the ongoing socio-demographic changes in the region, the COVID-19 pandemic has significantly affected the LTC market.

With culturally sensitive and high-quality LTC services in place, the burden on the family is shared and reduced, and older persons are better able to ‘age in place’.


There is considerable potential for LTC markets to create new job opportunities.


With the Arab regional context, the home-based LTC market appears to be the most preferred way of supporting older people while allowing them to continue living as independently as possible within their homes, families and communities. However, residential and nursing care might be a more suitable alternative for a smaller group of people with advanced and complex needs.

3 Ageing and the long-term care economy in the Arab region

A. Background

The population is ageing very quickly across the Arab region. Chapter 1 details the processes of population ageing and provides evidence of its speed, raising attention to the need for swift responses at the policy and practice levels. Many countries in the region have already entered the demographic transition or are set to begin them during the next few decades. However, unlike historical experiences in Europe and North America, the ageing transition process in the Arab region will occur in a relatively short period.

While longevity provides much to celebrate, it is essential to realize that not all additional years gained through longevity are healthy life years. These dynamics of increased life expectancy associated with slower increases in healthy life expectancy, and coupled with changing social norms and trends, create escalating demands for accessible and equitable long-term care (LTC) services.

What is LTC?

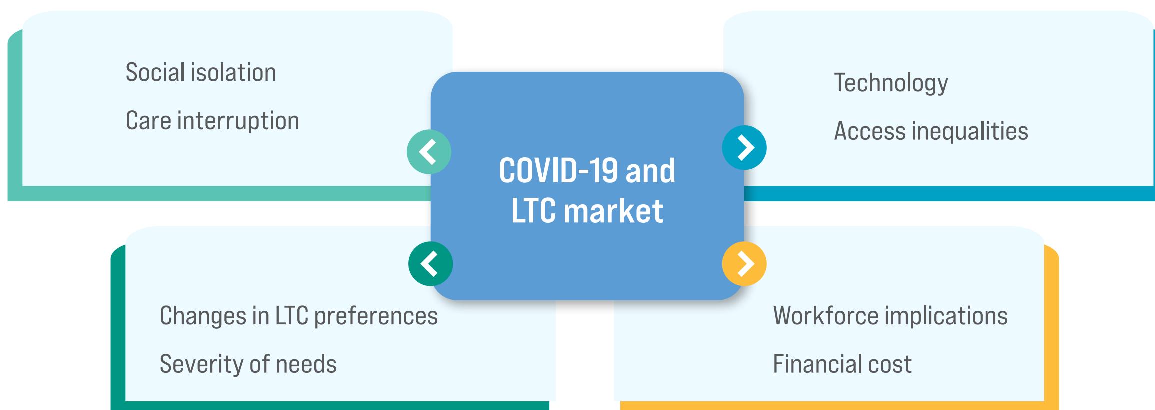
LTC is provided through care economies and markets that encompass various actors ranging from the close network of a person to formal services and community support mechanisms. LTC services can be provided at people's own homes, communities or residential and nursing care facilities. Furthermore, the LTC economy is guided by norms, preferences and cultural and social contexts.

The COVID-19 pandemic has changed the lives of everyone on the planet. However, older people are one of the most affected groups. The magnitude of impact on older people has different dimensions spanning all aspects of their lives, from social interactions to health outcomes and mortality. These effects were strongly pronounced in the LTC market, its vulnerability and (in)ability to mitigate or balance the risks associated with the pandemic and those related to the needs of older people. For example, a report from Jordan[67] lists the implications of COVID-related restrictions on LTC facilities to include a ban on most family visits to residential care facilities, increased burden on LTC staff, including staying on site for many days, increased workload associated with daily infection tests and related activities, with potential increases in cost associated with procuring personal protection equipment and other hygiene products. Thus, globally the impact of COVID-19 on the LTC market and older people has been immense, with considerable implications for many years to come.[68]

In addition to the ongoing socio-demographic changes in the region, the pandemic has affected the global LTC market significantly, as summarized in figure 33. The impact on older people was particularly evident in their reduced ability to access health and care services regularly. National and local infection control measures – such as shielding, lockdowns and curfews – have significantly reduced the opportunities for social interactions and have increased the levels of social isolation and loneliness among older people,[69] adversely impacting their cognitive abilities due to lack of stimulation[70] and increased levels of anxiety and depressive symptoms.

Globally, COVID-19 has forced a leap in adapting digital technology for everyday activities, including

Figure 33. Some implications of the COVID-19 pandemic for the LTC market



Source: Prepared by ESCWA.

health and care now being delivered virtually, with sudden expectations that patients and users can access and use such technologies.[71] This sudden reliance heightened health inequalities due to the differentials in preferences, accessibility and ability of various groups to use different technologies, highlighting the crucial role of digital literacy among older people.[72] Furthermore, older people who live alone or have no close family or friends to support their use of technology have been further isolated and disadvantaged. Digital technology has also replaced in-person visits of families for people living in care homes. This process was most difficult for certain groups of care home residents, such as those living with dementia or cognitive impairments. For the latter group of older people, prolonged periods of not seeing their relatives have led to the complete loss of memory of these individuals in their lives.[73] Reliance on virtual health care visits has added to LTC staff's workload in all settings and for those working in care home facilities and led to increased staff turnover.[74]

Perhaps one of the more subtle implications in the LTC market are the changes in care preferences. As the mortality rates were considerably higher among residential care,[75] there are some indications of a global shift in LTC preferences toward home care even when complex, round-the-clock care is required. The latter has increased demand for live-in care, where a formal care worker lives with the client to provide care for several weeks with regular breaks and substitute workers in between.

LTC is recognized as vital in ensuring the health and well-being of individuals in need of support, such as older people or those living with disabilities. When adequately designed, LTC services and support mechanisms are recognized as cost effective and complementing other often more expensive health care interventions such as hospital stays. Public policy in many high-income countries has recognized LTC as important in providing support in an individual and person-centred manner, enhancing the overall independence, well-being and quality of life of those receiving services. However, despite the increased awareness of the importance of LTC and its significance, it remains challenging to define. It is considered almost an 'invisible social welfare scheme' in Europe.[76]

Creating adequate measures, including LTC options and markets, is becoming even more urgent within the context of other socioeconomic changes such as changing family structures, migration, residency patterns and existing inequalities. While the family has been the central social and economic unit for care and support in the region, demographic changes, rapid urbanization and mobility bring new forms of household structures challenging the sustainability and effectiveness of the traditional familial care

model. While this is a challenge, it also paves the way for new forms of burden sharing within society where notions of individual, familial and community resilience, empowerment and cohesion take centre stage in policymaking.

The Madrid International Plan of Action on Ageing (MIPAA) affirmed the rights of older persons to age with dignity, maintain health, well-being and an enabling and supportive environment. In the Arab region, most older persons live at home or in the community, with a small minority in institutional settings. There have been successive policies, national strategies and action plans in the Arab region to address various aspects of population ageing and elderly care. These, in the main, build on society's value and respect for older people. These dynamics call for effective and sustainable LTC markets and economies to meet escalating demands for LTC needs in safe, dignified and person-centred manners. These markers will also provide powerful tools in creating job opportunities and enhancing labour participation rates. From such a perspective, strategic social policy development for the region would strengthen LTC markets that consolidate family and community solidarity and encourage shifts in patterns of thinking and care-seeking behaviour.

This chapter investigates the implications of population ageing for LTC needs. It discusses the emerging LTC markets in the Arab region, and investigates available LTC services in some countries in the region. The chapter also explores the economic cost of LTC in selected countries in the region.

This chapter follows a mixed methodology relying on qualitative research including narrative analysis and interviews with relevant stakeholders in the three countries selected as case studies: the Syrian Arab Republic, Saudi Arabia and Egypt, as well as quantitative analysis to estimate the current cost of LTC in the three case studies (for details on the methodology used, please refer to annex 2).

B. The long-term care economy

Social policy related to LTC has moved beyond providing safety nets, such as social protection mechanisms, to become a key instrument working in tandem with economic policies to ensure socially sustainable development that is equitable for everyone. With culturally sensitive and high-quality LTC services in place, the burden on the family is shared and reduced, and significant labour power is released and utilized for the benefit of individuals and the broader economy.

Globally, LTC markets have been shaped by rights-based approaches and concepts of independence and ageing in place. A rights-based approach to LTC attempts to anchor all policies and services to principles derived from international human rights treaties. In addition, a human rights approach to social policy brings particular attention to gender and the voices of excluded groups such as people with disabilities and older people living in poverty. Ageing in place is a core concept adopted by all European countries in their LTC and welfare policies. Grimmer and others (2015) define this as being mainly about the opportunity for older people to remain in their home for as long as possible, without having to move to a LTC facility. Others equate 'ageing in place' with a 'positive approach to meeting the needs of the older person, supporting them to live independently, or with some assistance, for as long as possible'. A recent systematic review identified 59 articles looking at the concept of ageing in place; they identified five themes that define the concept: 1. Place, 2. Social networks, 3. Support, 4. Technology and 5. Personal characteristics of older people,[77] thus highlighting the importance of the immediate and surrounding environment where the older person lives, the role of their social networks and support mechanisms and the increasing role of technology to continue ageing in place.

Care and support usually occur within caring relations comprising caregivers and care receivers, but it is also reciprocal, so the flow of relationships is two-directional. LTC can be organized within formal

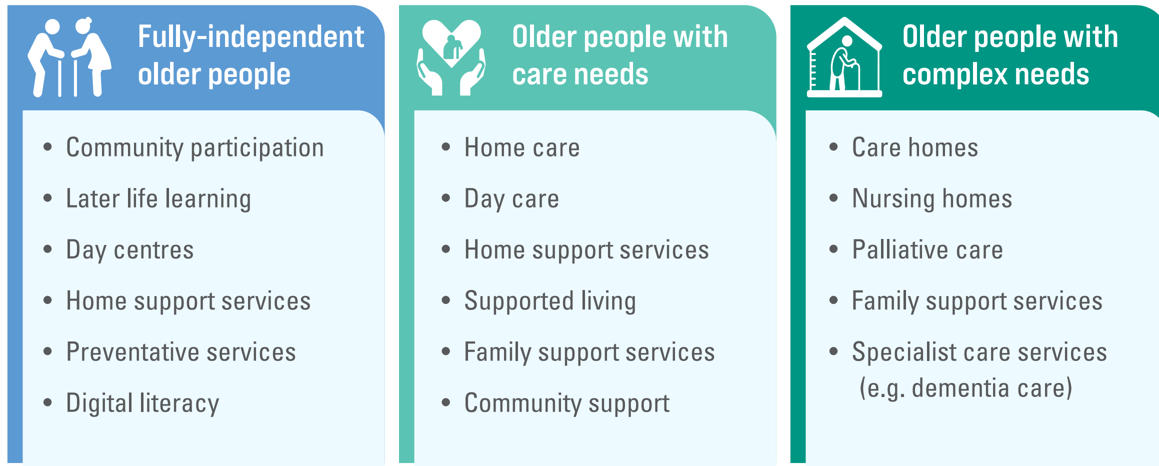
arrangements, such as domestic workers or a formal home carer (employee) and an older person (client), or informally through existing social networks such as the family, neighbours and the wider community. The former entails an agreement of specific tasks or outcome-based targets for the formal worker to achieve that have desired positive effects on the 'client'. On the other hand, the latter is based on informal arrangements and rely on intuitions and feelings of an obligation to meet some of the person's needs. Hence, the focus of informal care relations is likely to be different from, but overlapping with, formal care ties. For example, informal care might focus more on the nurturing and relational care, such as emotional well-being, of the person being cared for while formal care is organized around personal and health care needs. Informal caregiving is significant in providing LTC within aged populations. Most European social policy acknowledges the importance of creating social and economic support mechanisms to enhance families' abilities to continue caring for older people.[78] These include policies geared at reconciling work and family, flexible working and securing more substantial employment rights for workers who provide informal care.

The LTC market describes jobs and structures in response to increasing health and care needs of older people and those living with disabilities and long-term conditions. Figure 34 presents a proposed categorization of LTC services based on the types and complexities of older people's needs. LTC services are crucial in supporting older people through their life course and as their care needs change over time, from preventative services and targeting activities to enhancing the opportunities and abilities of older people to participate in societies socially and economically to specialist LTC services for people with complex health and care conditions. Home care services, for example, are usually structured to meet the needs of the individual and provide protective and preventive measures. These services are designed to support the active and independent life of the older person in a manner that is accessible and affordable, ensuring the dignity and quality of life of the older person. The most significant advantage to home-based care is that it allows older people to retain their independence despite their needs. In addition, the nature of home-based care is that it is fundamentally flexible and responsive to the older person's needs, which means it can be the perfect solution if the older person's needs are not the same over time.

Home care encompasses many services and varies according to older people's needs. In many cases, home care workers help with activities of daily living, such as dressing, bathing, or feeding. They also include companionship and befriending services or transportation to medical or leisure activities. There are various types of home-based care as illustrated in figure 35. These range from specialist care, specific to people with complex needs or certain conditions such as dementia, to companionship care where a limited care level is required. Day-care services are places for older persons who live in their home environment or with their family to receive care during the day. They are especially beneficial for individuals with specific care needs, where various activities are carried out to assist individuals with psychological, social and health needs to increase their quality of life and contribute to their leisure time. In addition, a combination of home and day-care services provides a sustainable alternative to residential nursing care for many older people, removing financial and social burdens such as the stigma associated with residential care homes in the region.[79]

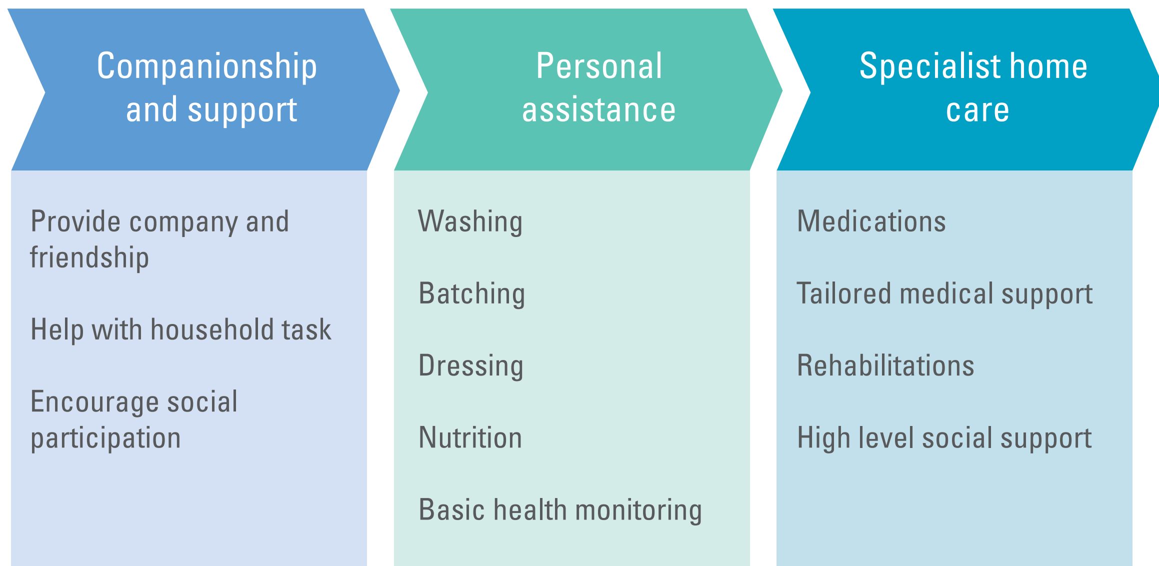
Residential care is one of the most expensive forms of care and is designed to meet the needs of older people with higher levels of care needs who cannot continue living at home or in the community. Care homes for older people may provide personal care or nursing care. The level of resources available to pay for residential care has a fundamental impact on the quality, scope and effectiveness of the services offered by the residential care sector. There are several issues around resourcing care services, including the balance between the contributions of individuals and the state in meeting the costs of care. These impact the ability of the sector to recruit, train and retain high-quality staff, modernize facilities, develop new models of care and deliver high-quality care.

Figure 34. Examples of LTC services according to older persons' needs



Source: Prepared by ESCWA.

Figure 35 Examples of types of home LTC services



Source: Prepared by ESCWA.

LTC services are provided in most cases by the private sector and non-profit organizations and rely on effective LTC markets with diverse options that can meet the needs of different groups of older people and their families. Nevertheless, Governments have a crucial role in shaping this market and ensuring it operates with high standards through regulation. Central governments and local municipalities are best positioned to shape the market primarily through commissioning quality, outcomes-based services that emphasize prevention and empowerment to reduce loneliness and social isolation and promote older people's independence. LTC outcomes, such as the quality of life and satisfaction of older people, should be used as core quality assurance measures.

Furthermore, most Governments commission and fund LTC services based on care needs and financial assessments. When the government does not directly provide LTC through specific LTC benefits such as personal/health care budget, other State cash benefits can be used by individuals with care needs and their families to purchase appropriate care. Hence, for individuals to make well-informed decisions, in most European countries, the State (through local municipalities or integrated health and care teams) takes the lead in assessing older persons' care needs and advising on appropriate services according to their health and social needs as well as their and their families' wishes and abilities.[80] Once a person is assessed for eligibility to receive home-based care, they are usually entitled to have a care plan. A person-centred approach focuses on what the individual can or would like to do to maintain their independence through this process. All professionals working with the older person ensure that care is aligned with the individual's care plan.

C. Emerging LTC markets in the Arab region

In the Arab region, LTC is almost entirely provided through informal support by families, neighbours and friends.[81] Current evidence suggests that older persons in the Arab region have a clear preference for maintaining their independence and remaining in their own homes.[82] Home care is also perceived as a more cost-effective option of care while at the same time improving older people's well-being and continued contribution to their families, communities and the broader society.[83] However at the same time, specialist LTC facilities, including residential nursing care homes, are an integral part of the broader LTC market to meet the needs of the small proportion of older people with complex needs that cannot be supported at home or whose circumstances and preferences might be different.

Recent studies highlight that older people and others in need of care in the Arab region primarily rely on their families and informal forms of care and support through notions of respect and filial obligations.[84] The family assumes and respects the duty of caring for older people in the region. On the other hand, the informal care burden almost always falls on women in the family, who are usually at an age where they are in employment, have child care responsibilities and their own families and well-being to look after.[85] Such competing demands on women may lead to several adverse outcomes from economic losses due to forced exit from the labour market to provide LTC, negative health outcomes, psychological stress and burnout. There are further implications of the reliance on the family in terms of gender equity and the impact on female labour force participation trends, with income implications for women and girls and associated macroeconomic implications.

In addition to the emotional burden and the cost implications of providing informal LTC, especially for younger women, many other factors challenge this model's sustainability and feasibility. One crucial factor is the changing preferences and expectations at old age that require a rethink of the meaning and purpose of healthy living at the later stages of life. Moreover, further concerns relate to the quality of LTC provided within the family without support and information on what constitutes 'good' care, especially when older people have complex needs or suffer from certain conditions such as cognitive impairment. Hence, there is a recognition that family-provided LTC is not sufficient for various reasons, given changing social structures and the importance of creating mechanisms that ensure older people's quality of life.

Effective and sustainable care markets are powerful tools for creating job opportunities and enhancing labour participation rates. The mechanisms for achieving positive outcomes and reduced labour gender gaps in care economies act on two dimensions. First, a strong LTC economy lessens the informal care burden on women, enhancing their entry and retention within the labour market. Second, care services and facilities create jobs and provides training and skills that can lead to career progression within the fields of health and social care.

Despite the reliance on families for care and support, there is evidence that formal LTC markets

are emerging in the Arab region. The increasing numbers of older persons coupled with evolving living arrangements have created more demand for formal LTC services. Yet, the lack of structures and regulations in the current LTC economy in the region carries significant risks related to the quality of care and jobs. However, if the LTC market is well designed with clear policies and service delivery models, it will likely create a significant positive change for older persons, their families, workers and the broader economy.[86]

Demand for LTC services is related to morbidity. A high prevalence of non-communicable diseases in the region, including cardiovascular disease, diabetes, cancer and chronic respiratory diseases, points to increased needs for such services.[87] Furthermore, lifestyles that include physical inactivity, eating habits and smoking create additional determinants of adverse health outcomes, such as diabetes, hypertension and accelerated ageing, with associated health and care needs.[88] For example, the International Diabetes Federation (IDF) indicates that in 2019, 12 per cent of people with diabetes across the world are from the Arab region. However, statistical data on LTC provision in the Arab region is negligible, as it has historically been a niche segment served by fragmented service providers, mainly a few means-tested governmental services, charitable organizations[89] and a growing number of unregulated private agencies and domestic workers.[90]

1. Case studies

Given the scarcity of information and statistics on formal LTC services in the Arab region, this chapter employs a case study methodology to gain in-depth insights into evolving LTC markets within a specific context. The three case studies represent countries at various stages of the ageing transition, different levels of economic and social stability and distinct sub-regions, among other characteristics (see annex 2 for more details on case selection).

Case study 1: The evolving LTC market in the Syrian Arab Republic

The average life expectancy at birth was 73 years in 2019 (68 years for males and 78 years for females).[91] The percentage of people aged 65 or more in the Syrian Arab Republic was estimated to be 4.9 per cent in 2020 by the United Nations,[92] while the old-age dependency ratio was 7.6.[93] It is projected that the country will enter its ageing transition (when 7 per cent of its population are over 65 years old) in 2035 and will take around 17 years to complete this process (when the same percentage reaches 14 per cent).[94]

The Syrian Arab Republic was classified as a low-income country in 2020-2021 by the World Bank and has been witnessing political unrest and conflict since 2011. The conflict had significant repercussions on the health and well-being of the entire Syrian population, with rising mortality and compromised safety. The effects were dramatically pronounced due to the disintegration of social ties, which were previously crucial in ensuring the well-being of the population, especially older persons.

These declining health and well-being trends affected all age groups and directly affected the average life expectancy at birth in the Syrian Arab Republic. Data from the World Bank show that life expectancy at birth in the Syrian Arab Republic had steadily increased since 1960 from 52 years to 2010 when it reached 73 years. However, from 2011 the average life expectancy at birth started to decline to reach 69.9 years in 2015. Since 2016, as the country began to transition to a post-conflict state, improvements in the same indicator were observed, with the latest data

showing the average life expectancy at birth was 72.7 years in 2019.[95] Ismail and Hussein (2019) showed that according to 2013 data on health expenditure per capita and life expectancy, the Syrian Arab Republic shared a similar relative position of these two indicators with other countries in the region such as Egypt and Morocco.

The Government is paying attention to these changing demographics while recognizing the challenges ahead. In 2019, the Syrian Commission for Family and Population Affairs conducted a unique study to assess the needs of older people between 2011 and 2019, based on primary data from 94 in-depth focus group discussions (10 in each governorate) and four workshops with a total of 950 participants. The study provides detailed insights into the needs and perspectives of older people in the Syrian Arab Republic and fills a significant gap in the current knowledge base.

The Commission recognized the need to develop effective social protection mechanisms for various groups of the population who might be particularly vulnerable, including older people. Furthermore, in light of the socio-demographic transition affecting the Syrian societal structure, the study recognizes the need to start developing formal LTC services to complement family care. The report highlights the considerable transformation of the Syrian family structure, with trends towards nuclear families and a decline in multi-generation households, especially in urban areas. These transformations challenge the sustainability of traditional family care for older people, which necessitated developing alternative LTC services to meet their needs in a culturally sensitive and dignified manner.

However, the study points out that LTC services were limited to a few governmental and charitable residential care services. The study concludes by emphasizing the necessity of developing an array of services geared at supporting older people directly or indirectly by enabling families to take care of older people. They call for an LTC market that recognizes and encourages solidarity and kinship ties, with mechanisms designed to inform and ensure the views of older people as key partners in decision-making processes. The report also highlights inequalities among older people, especially in relation to low income, literacy and place of residence. LTC support can, therefore, go beyond the provision of personal care when combined with other welfare benefits, including financial aid, tax exemptions, home assistance and free training for low-income families on how best to care for older people and those with disabilities.

There were several common diseases among older people in the study, including diabetes, hypertension, arthritis, coronary heart disease and mental health issues. In addition, many older people did not have health insurance or adequate health care access, especially in rural areas. Participants indicated that older people's health status had considerably deteriorated compared to before the conflict, due to factors including a shortage of health care professionals, high prices of medicines, difficulty in accessing health care and the dispersal of families, displacement, loss of the home and loss of the primary family earners during the war. In addition, physical health status was directly linked to the mental health and well-being of older people, including depression and anxiety.

Health and LTC services were limited in some areas even when better access to child and maternity care was provided by charitable and non-governmental organizations (e.g. rural Homs). This might reflect the limited resources available within the Syrian health system and the need to prioritize certain groups of the population to receive care. Participants highlighted the lack of

a direct link between chronological age and care needs and the continued preference for LTC to be provided by the family and close social networks. Participants identified critical components of LTC to include dignity, respect and dedicating time to talk to the older person. Furthermore, the links between LTC and health were highlighted, and the ability of LTC providers to assist older people in accessing health care was considered essential. To ensure the dignity and well-being of older people, participants felt that older persons needed a suitable home environment where they could live independently and enjoy a balanced nutritious diet. While the preference was to receive LTC from the family, participants recognized that this was not always possible and hence desired to have accessible local LTC services.

Participation in the community, including through paid employment and social and recreational activities, was viewed as part of a holistic LTC system. Hence, social activities and opportunities to volunteer, learn a new skill or participate in community projects could be facilitated through community and day-care centres for older people. Participants recognized that the levels and types of LTC needs varied according to individual and local factors (for example, rural/urban, high conflict/more stable areas).

Regarding the availability of LTC services, the study highlighted that most LTC was shouldered by family members. However, neighbours and the wider community also provided regular care, including food and companionship, especially in rural communities (e.g. Latakia Governorate). Some residential care services organized by the civil society in Damascus served displaced older people with physical and psychological needs. More generally, houses of worship, charitable organizations and migrants' organizations were identified as providers of LTC and formal and informal support. For example, in Damascus and Jaramana, several charitable organizations provided regular services to older people, including hot meals, clothing and financial support. Also, in Al-Suwayda, some philanthropic organizations provided medications, however with limited coverage. Participants felt that while these services were critically needed, they had declined since the onset of the conflict, and their capacity did not meet the demand.

There was a general agreement on the lack of specialist LTC services, including dementia care, with few charitable organizations such as the Red Cross providing generic LTC services but not for people living with complex needs. In some areas, older people informally hired individuals with no LTC training to provide care and support (e.g. Tartous and Al-Hasakah). However, in most cases, older people relied on charitable donations from well-off individuals who could provide financial support for health and care services (e.g. Al-Suwayda Governorate). Many older people financially and socially supported other family members, especially if their family members had suffered injuries during the war. Some were also responsible for other older people in their communities. The needs of displaced older people, who did not always have access to such networks, were particularly acute.

A survey of the current role of care home services was performed through an independent questionnaire of 14 out of 20 residential care homes identified as part of this study in the Syrian Arab Republic. These care homes were affiliated with various civil associations across eight Syrian governorates: Damascus, Rif Dimashq, Aleppo, Homs, Lattakia, Hama, Al-Hasakah and As-Suwayda. Only a minimal number of officially licensed care homes was operating, and there were no such care homes at all in some governorates, such as Raqqa and Deir El-Zor in the eastern

region and Daraa and Quneitra in the southern region. In other areas, such as Tartous Governorate, there was one officially licensed care home, but it was not operational as of the date of this study.

The 20 care homes had 334 older residents; some care homes also housed younger adults with disabilities. Less than 7 per cent of older residents were married at the time of the study, with large proportions never married, widowed or divorced and around a third of residents illiterate. The average age at which older people entered care homes was 60 years old (this age was lowest in Al-Suwayda at 59 years and highest in Al-Hasakah at 77 years). Over a third sought admission to the care homes by themselves, and their families admitted 43 per cent of residents. Table 1 presents the main reasons for admission: in 61 per cent of cases, these were related to health conditions that required LTC support beyond what was possible from the family, followed by 38 per cent of residents who did not have any children or family members to look after them, 25 per cent whose children did not have enough time due to work, 22 per cent as a result of the international migration of the primary informal caregiver, 14 per cent because a lack of space at their children's homes and a similar proportion because their family members refused to look after them.

Field visits and documentary analysis indicated that about two thirds (n=9) of the care homes in this study were built within new residential developments, with an additional four in older residential areas and one considerably isolated from neighbouring communities. The size and capacity of these care homes varied markedly, with many allocating outdoor spaces like gardens and yards for the use of older people. Most care homes (n=13) in this study included a lounge area for receiving visitors, while one care home lacked any space for this purpose.

Table 1. Main reasons for admission to care homes

Reason for admission to care homes (multiple reasons permitted)	Percentage
Health conditions and lack of LTC at home	61
Do not have any children	38
Children too busy to provide care	25
Children emigrated	22
Lack of space in children's homes	14
Family members refused to look after the older person	14

Source: Syrian Commission for Family and Population Affairs, 2019.

In terms of capacity, two care homes had between five and ten residents; seven homes between 11 and 30; one home between 31 and 50; and four had more than 50 residents. The patterns of accommodation of older persons in these homes varied by the fees paid and residents' preferences, according to the capacity of the home. For example, in homes offering free services, two homes provided single rooms for each resident, three homes offered double rooms and four homes had rooms with capacity for four residents. In addition, many homes did not respect residents' privacy regardless of their health and care needs. The authors noted the latter to be particularly concerning when older people had complex needs, including cognitive impairments and dementia.

Focusing on the homes' staff, the study found considerable gaps between the actual levels and qualifications of staff compared to what was legally required. There was a significant shortage of

LTC workers and volunteers, who did not exceed half the required numbers to operate effectively. These shortages were across all departments and job roles. In particular, there were chronic deficits in the number of specialized and qualified workers in the social, health and medical fields and for psychiatrists. By examining the ratio of residents to workers in different specialities, the study found an average of one resident doctor for every 145 older persons, one visiting doctor in various medical specialities for every 44 older persons, one nurse for every 22 older persons, one social worker for every 145 older persons, one psychologist for every 300 older people and one night observer for every 21 older persons. On the other hand, there were enough ancillary care workers as these jobs do not require high educational attainment, specific skills or continuous training. Each cleaning worker supported nine older people, and each twenty older people had one cook.

Care home providers faced several challenges in delivering effective and compassionate care to residents. These include inadequate staff training, knowledge and skills to provide adequate care sensitive to residents' medical, social and cultural needs. For homes organized by charitable organizations, funding was a significant barrier, combined with complex laws and regulatory requirements. When a sample of administrators was asked about the most critical challenges to working in care homes, determining the most appropriate ways to respond to residents' needs, especially those with communication difficulties, were the most important. Staff shortages, especially among qualified staff, the lack of financial resources in homes and outdated buildings and their inadequacy for residents' needs were all identified as barriers to workers' ability to provide adequate care to residents.

The findings of this critical study highlight some similarities and differences in the situation of older people in the Syrian Arab Republic compared to other countries in the region. One main difference relates to the unique challenges associated with the conflict, including displacement, loss of home, family, social networks and material wealth with severe adverse effects on their physical and mental well-being. But, on the other hand, they also share commonalities in their experiences, including the importance of family in the provision of LTC, the perceived meaning of age and ageing and social norms of intergenerational and community support and exchange. The study highlights the growing health and care needs among older people in the Syrian Arab Republic and the lack of sufficient and accessible formal care services, especially in rural communities. The study concludes by calling for a care model that integrates older persons within society and ensures the availability and accessibility of LTC services and provisions. In addition, it highlights the role of social capital, community cohesion and charitable organizations in meeting some of these gaps and calls for tailored social policies and social protection mechanisms specific to the needs of older people.

Entrenched social norms of valuing and respecting older persons pave the way for social action and volunteerism to play a significant role in meeting older people's needs. This can go beyond the provision of LTC to provide inclusive opportunities for older people to participate within their communities to enhance their general well-being. Mobilizing this social capital in a structured and cohesive manner would require some policy direction to ensure LTC gaps are met in different groups of older people, paying attention to local and regional differences.

Case study 2: The evolving LTC market in Saudi Arabia

In Saudi Arabia, people aged 65 years or older are estimated to constitute 3.5 per cent of the population.[96] Chapter 1 highlights that this percentage will reach 7 per cent by 2033 (marking the start of the country's ageing transition). The analysis also indicates that Saudi Arabia will experience a rapid ageing transition, taking as little as 12 years for the same percentage to reach 14 per cent to conclude the ageing transition stage like other GCC countries.[97]

In 2019 the average life expectancy at birth 2019 was 75 years (74 for males and 77 for females).[98] In addition, the old-age dependency ratio was estimated to be 4.9 in 2020.[99] These changing demographics place considerable demand for new models of health and LTC delivery, and the LTC market is estimated to be a significant growth sector in Saudi Arabia (and other GCC countries). For example, Colliers International (2020) indicates that LTC services, including rehabilitation and home care, are critical for diversifying the health care system in Saudi Arabia and other GCC countries. The same market research suggests that by 2030, Saudi Arabia will require an additional 20,000-22,000 LTC and rehabilitative beds to meet expected demands.

The Saudi Government has been working for several decades to transform its health care policy and service delivery. The Ministry of Health provides care services at three levels: primary, secondary and tertiary. Primary health care centres deliver preventative and curative care services, in addition to referring cases that need advanced care to general hospitals or secondary care. Patients that require a more complex level of care are usually transferred to specialized or central hospitals, tertiary care.

Saudi Arabia recognizes the importance of developing policies and practices to address these demographic and social trends. Strategic policies have specifically targeted introducing home care for older people, recognized as both culturally accepted and economically cost-effective. In addition, the Saudi health care sector is witnessing a transformation as part of the 'Saudi Vision 2030'. This transformation aims to improve the type and quality of health care services and expand the privatization of governmental services.[100] In 2016, the National Transformation Programme (NTP) was launched to establish the infrastructure needed to achieve its 2030 Vision, aiming to introduce a range of LTC services (including rehabilitation, extended care facilities, psychiatric centres and home health care) by purchasing services from the private sector.

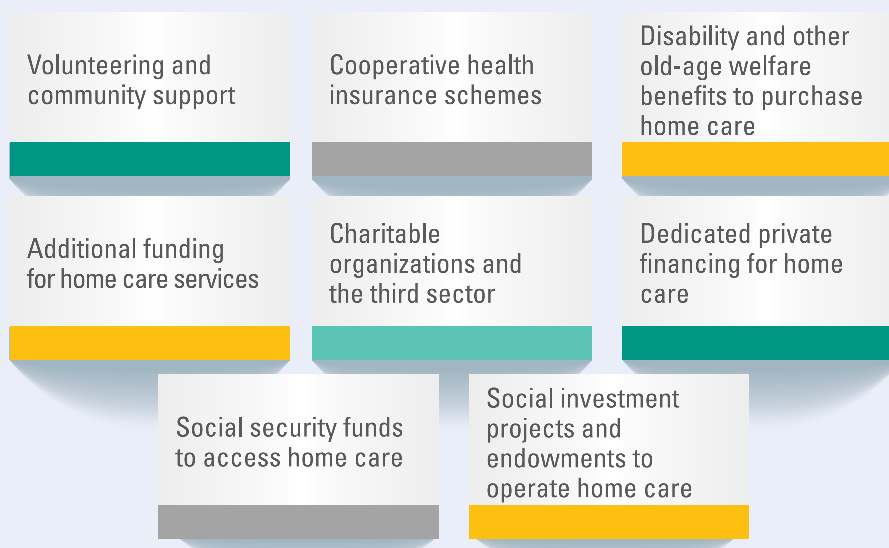
We conducted interviews and focus group discussions with key stakeholders from the Family Affairs Council, the Ministry of Health, the Ministry of Human Resources and Social Development and the Ministry of Education for this report. Primary qualitative data provided detailed insights into recent and current developments related to older people in Saudi Arabia. Stakeholders also provided the team with key policy documents on Saudi efforts to address older people's social, health, and economic needs. A report on home care activities for older people and people living with disabilities written by Talaat Hamza Al-Wuznah (undated) identified eight potential mechanisms to support the expansion of LTC delivery at home across Saudi Arabia. These are illustrated in figure 36 and include: 1. Activating volunteerism in delivering home care within the community through training programmes, awareness-raising and enhanced cost-efficiency; 2. Coverage of home care services by the cooperative health insurance schemes; 3. Utilizing some disability and other old-age welfare benefits to purchase home care; 4. Securing additional funding

for home care services; 5. Mobilizing charitable organizations and the third sector to contribute to home care delivery; 6. Partial financing obtained from the private sector through dedicated contributions to the home care programme; 7. Dedicating a percentage of social security funds for the disabled and sick to the home care programme; 8. Establishing social investment projects and endowments to operate the home care programme.

In this report, home care programmes are divided into two parts: one hospital-based care and the other focused on community-based care. The first part targets people with chronic diseases such as diabetes and hypertension to maintain their health care at home and reduce repeated hospital visits. Community-based rehabilitation aims to support the independence and functional abilities of individuals with LTC needs. The same report indicates that in the early 1990s Saudi Arabia started establishing day-care centres to provide rehabilitation services for people with disabilities and LTC needs and allow family care givers to participate in employment and other social activities. Activities at these day centres are designed to address individuals' behavioural, social and psychological needs and help improve their skills and ability to carry out daily living activities.

Saudi Arabia is developing a 'National Strategy for the Family' (NSF) to address the needs of the family as a social unit while paying particular attention to the rights and needs of older people. According to the Saudi national report for the Madrid International Plan of Action on Ageing (MIPAA) review,[101] the NSF identifies ten strategic targets for older people in Saudi Arabia (presented in figure 37). It also recognizes the need to enhance the safety and security of older persons by protecting them from abuse and neglect at home with high-quality LTC support when needed while also providing them with a safe built environment and accessible governmental buildings. Older people need to be supported in their financial sustainability through tools and information for an active and healthy lifestyle, lifelong learning through appropriate educational opportunities and facilities and an opportunity to participate in broader society through volunteering and other activities that capitalize on their knowledge and expertise.[102]

Figure 36. Key success criteria for LTC home care programmes in Saudi Arabia



Source: Prepared by ESCWA based on Al-Wuznah, n.d.

Figure 37. The Saudi 'National Strategy for the Family' and its strategic aims for older people

Source: Prepared by ESCWA based on Saudi MIPAA Report, 2021

Services and interventions for older people in Saudi Arabia are shared across different ministries and organizations. The Ministry of Education has been active in working to eradicate language and digital illiteracy among older people. Education and access to information have been identified as crucial social determinants for health among older people in Saudi Arabia.[103] The Ministry of Education has developed special programmes for adult education, "Adult Education and Literacy System in the KSA", issued by Cabinet Resolution No. 523, focusing on digital literacy. This is an initiative under the NTP stemming from Saudi Vision 2030 and targets adults of both sexes who hold a secondary school qualification or less and who are outside the education field to continue their training and professional development to engage in the labour market. Utilizing digital technology, the Ministry of Health has developed several health apps to access information and organize and conduct virtual health care appointments. Other Ministries, such as Human Resources and Social Development, have also provided digitalized services.

Different Saudi ministries offer specific services for older people. For example, the Ministry of Education designed a programme for summer campaigns to raise awareness and deliver digital and language literacy training. This programme mainly targets adults and older people living in remote and rural areas and works in partnership with other governmental bodies and civil society. In addition, the Ministry has put in place free of charge interventions specifically designed for older people in collaboration with the national electronic education portal "Ain".

The Saudi Government continues its focus on health care and has identified LTC and rehabilitation as critical interventions in the Health Transformation Strategy. The Strategy states: "*There is inadequate capacity in extended care services such as rehabilitation, long-term care and home*

care." One key LTC initiative, provided by the Ministry of Health, are home care services. This is, in part, a response to high occupancy rates of hospital beds by those requiring LTC support. Individuals eligible for LTC services do not usually require an acute care setting but limited health and care services specific to their conditions. However, due to the lack of such facilities, individuals with LTC needs occupy hospital beds unnecessarily, creating further pressures within the general health system. For example, in 2017, it was estimated that long-term care (LTC) patients occupied around 14 per cent of the Saudi Ministry of Health's hospital beds, compared to only 7 per cent in 2016.[104] The annual coverage of home care beneficiaries was estimated to be 32,000 people in 2018 and is expected to reach 90,000 beneficiaries by 2022.[105]

According to the Saudi report submitted for the MIPAA review (2021), the Ministry of Health has provided a range of services for older people. The Ministry launched a programme of support to provide logistical and home care services for people with disabilities and older people. The total number of beneficiaries in 2017 was 5,280 persons accessing 8,028 service activities. These services were available in six regions supported by ten hospitals: with three in Jeddah, two in each of the Northern borders and Hafr Al-Batin, and one in the rest of the regions. In total, 2,563 people with disabilities and 2,243 older persons benefited from these services, accessing 4,157 and 3,295 services, respectively. In addition, 474 people received home care with 576 services. The largest number of activities related to mobility assistance (2,730 activities) and appointment-making (2,728 activities), while the least utilized service was sign language interpretation (46 activities).

The Ministry of Health launched the Home Health Care programme in 2009 to provide medical home care services. Currently, these services are provided in the 22 health regions across the country via 505 trained home care medical teams. Each team is composed of physicians, nurses, physiotherapists, social workers, drivers and dietitians. The services are provided using the MOH fleet of 483 cars, and over 40,000 patients received home services across 235 hospitals, in addition to 726,000 home visits in 2021. As part of the national COVID-19 response, home care was pivotal in the national home vaccination programme and the special older adult's easy priority access home vaccinations programme. Home health care services are not limited to the elderly and also cover other age groups according to their needs.[106]

The Ministry of Health offers a financial aid programme to provide medical devices to older people and people living with disabilities based on eligibility criteria. Financial and in-kind assistance is also disbursed to older low-income people and their families through the Social Security Agency at the Ministry of Human Resources and Social Development. Furthermore, the Ministry of Health works within the NTP on initiatives to improve the quality of life of older people and raise the level of services provided to the highest standards by establishing oases for older people in different regions and expanding the contribution of the private and non-profit sector to LTC centres with nominal fees.

There are several active non-governmental organizations (NGOs) in Saudi Arabia with the core purpose of supporting older people. For example, the Saudi Society for the Support of the Elderly "*Waqar*" is a non-profit charitable association that helps provide LTC services to older people and advocates for their rights. It also plays an active role in raising public awareness by producing different accessible books and information leaflets. *Waqar* also launched various initiatives, such as awareness campaigns and workshops in collaboration with other Centres to mobilise

knowledge exchange between multiple stakeholders and older people. Another is the Saudi Alzheimer's Disease Society, which focuses on supporting people living with dementia and their families. One of the most valuable services is electronic training to enable formal and informal carers to effectively support people living with dementia through a person-centred approach. The association established a national registry and Alzheimer's database in which more than 30 specialized centres partner with King Faisal Specialist Hospital. It also established five initiatives: 1. '*Iraqq*' (recognition) to recognize prominent individuals for their charitable work related to Alzheimer's disease through special awards; 2. *Mou'ien* (helper) to provide training to enable carers of people living with dementia to provide adequate care; 3. '*Teriq*' (antidote) to provide free specialist medical care, equipment and prescription medicines; 4. '*Mobader*' (initiator) to target volunteering capacity, community mobilization and fundraising; 5. '*Wain wa Raiin*' (aware and protector) to provide international representation and train professional health care staff.

Another vital effort revolves around reducing the neglect and abuse of older people in their homes. In partnership with different governmental and non-governmental institutions, the National Family Safety Programme launched the "*Ehsan*" programme to raise awareness of elder abuse among the public and professionals working with older people. As part of this work, the programme issued recommendations on mechanisms for reporting concerns or cases of abuse.

The COVID-19 crisis in Saudi Arabia was reported to have been managed through an integrative approach across governmental departments, civil and voluntary organizations. A Supreme Committee with members drawn from 24 government bodies in partnership with 494 hospitals was formed in January 2020 to provide guidelines on prevention and control measures. This Committee builds on the cumulative experience in managing risks of epidemics and human crowds during the Hajj and Umrah seasons and expertise gained during the 2012 outbreak of the Middle East Respiratory Syndrome (MERS).

To mitigate the adverse impact of the pandemic on the population, the Government guaranteed 60 per cent of the salary of affected citizens working in the private sector and allowed business owners to postpone payment of value-added, production and revenue taxes for three months. In addition, free treatment was offered to all infected people in addition to large-scale random testing of the population. The Ministry of Health announced an impressive vaccination rate of 98 per cent among older people (60 years and over).

Furthermore, different ministries have taken special measures to reduce adverse impacts on older people. For example, the Ministry of Health promoted several mobile applications to facilitate access to health care during social distancing and lockdowns. These apps allowed individuals to book, amend, or cancel health care appointments; book COVID-19 tests; provide safety-related information; and ensure the delivery of medicines by linking hospitals and primary health care centres with community pharmacies so patients can collect their medication from the nearest community pharmacy or have it delivered directly to their homes for free. Older people were prioritized to receive COVID-19 vaccinations at home.

Case study 3: The evolving LTC market in Egypt

The World Bank classifies Egypt as a lower middle-income country (along with Algeria, the Comoros, Djibouti, Mauritania, Morocco, the State of Palestine and Tunisia). The United Nations estimated the percentage of people aged 65 or more to be 5.3 per cent in 2020, and it is projected that this percentage will reach 7 per cent in 2036 (marking the country's entry into the ageing transition). It is estimated that it will take Egypt somewhat longer than other countries to complete its ageing transition stage (when 14 per cent of the population are aged 65 years or more).

In 2019 the average life expectancy at birth in Egypt was 72 years (70 for males and 74 for females).[107] Unlike the Syrian Arab Republic and Saudi Arabia, which are projected to take 17 and 12 years respectively to complete their ageing transitions, Egypt is projected to take 42 years to complete this process, allowing some time to capitalize on its demographic dividend. Egypt's large population, with over 100 million people and another 10 million living abroad,[108] presents both challenges and opportunities in managing the ageing transition. Egypt's over-65s in 1960 totalled just over one million, but in 2020 numbered 5.4 million and are estimated to reach 15 million by 2050.[109] Therefore, the demand for ageing-related services, including LTC services, is escalating significantly.

The Universal Health Insurance (UHI) plan was launched in 2018 to reform the fragmented health care system in Egypt. The comprehensive health care insurance scheme aims to cover all governorates by 2032, with implementation over six phases, each focusing on a different geographic area. To meet current and projected demands, Colliers International (2021) estimates that by 2030 Egypt will need an additional 88,000 doctors, 73,000 nurses and 18,000 pharmacists. In addition, the same report predicts that Egypt will require almost 62,000 dedicated LTC beds by 2050. This research acknowledges the escalating demands for LTC services, but does not estimate the human resources necessary to meet this demand.

In terms of social protection for older people, Egypt has schemes called '*Takaful*' (solidarity) and '*Karama*' (dignity), launched in 2015 through the Ministry of Social Solidarity (MOSS) with financial support from the World Bank. Takaful targets low-income households with dependents under 18, while Karama targets low-income older people, orphans and people with disabilities. The schemes operate in 27 Egyptian governorates (with a coverage of 5,630 villages), serving nine million individuals.[110] Most beneficiaries are women (85.6 per cent), with 6.7 per cent people with disabilities and 2.1 per cent older people. Talaat (2020) explains that the low level of coverage among older people relates to the eligibility criteria of these schemes, as those who already receive state pensions are generally not eligible. Hence, older people supported by these schemes are expected to have very low incomes.

There have been several recent policy developments in Egypt, such as the Older People's Rights Law of 2021,[111] which was drafted by the Egyptian Ministry of Social Solidarity, approved by the Egyptian Cabinet in September 2021 and under consideration by the Egyptian House of Representatives when the present report was being prepared.[112] Article 22 of the law would place the responsibility of LTC for older people firmly within the immediate family, with husbands and wives being legally responsible for caring for their partner if they need LTC in old age. If an older person does not have a partner (in widowhood, for example), one of their relatives who is resident

in Egypt and willing and capable should provide informal care according to the following order: children, grandchildren then siblings. If there are several family members, they choose the one to take care of the older person. The law would provide for punishment for caregivers who are shown to have abused or neglected an older person. Furthermore, the law would prohibit ageism and any form of discrimination based on age or religion. A recent news article mentions that the Senate discussed establishing more retirement homes free for eligible older people.[113]

In 2017, MOSS established a higher committee for elderly care (resolution number 432) chaired by the Minister of Social Solidarity and with representation of interested parties. According to information provided by MOSS, the committee aims to: develop an integrated plan for care for older persons; develop legislation regulating the status and services of older persons; organize and coordinate long-term care programmes initiated by ministries and other agencies; propose programmes and activities geared at raising awareness and participation of older people in the wider society; and establish and update a database of long-term care services.

To facilitate social participation among older people and reduce travel costs, in 2021 MOSS confirmed a new proposed initiative, the 'Golden Card'. This free benefit exempts all older people (over 70 years old) from public transportation costs and offers a 50 per cent discount for people between 65 and 70 years old.[114] Furthermore, the Ministry of Social Solidarity oversees 194 clubs and day care services benefiting around 37,000 older persons. Eighteen of these organizations have units providing health checks and medical services for reduced fees.

The continued efforts of the charitable, community-based and not-for-profit sectors in meeting some of the needs of older people in Egypt (and other countries in the Arab region) is well documented in the literature.[115] The involvement of charitable organizations in supporting older people and their families dates to the late 1800s and early 1900s. One of the earliest older people care homes, 'Old People's House', was established by the Greek community in Alexandria.[116] Kemmet Organization, established in 2014, is a current charitable organization concerned with the welfare of older people in Egypt. In a workshop organized in 2019 by the Middle East and North Africa Research on Ageing Healthy (MENARAH) network,[117] the organization's director provided a historical overview of residential care for older persons in Egypt dating back to 1890, with the first State-funded facilities established in 1961.[118] In 2017, Kemmet issued a paper on the rights of older people in Egypt that included several recommendations such as developing an Egyptian national strategy for older people; establishing a dedicated aid fund for older people; developing specialist services for those living with dementia and other chronic conditions; launching a media campaign to raise public awareness of the rights and needs of older people and conducting a national survey to understand the current status, perceptions and LTC gaps among the older populations in Egypt.

A recent public opinion poll conducted by '*Baseera*'[119] focused on Egyptians' perceptions of the LTC economy and its impact on women's economic participation. The study was based on telephone interviews with 2,016 Egyptians from the 22 March to 4 April 2020.[120] Nineteen per cent of participants (n=383) indicated that an older person lived within their household. Most respondents in this group (96 per cent) were the primary informal caregiver for the older person (usually their parent or mother-in-law. Over half (52 per cent) of respondents who indicated they were providing informal care for an older person were males, and 48 per cent were female. However, the intensity

of care provision varied by gender, with 84 per cent of women indicating they provide informal care all day compared to only 43 per cent of men (women provided an average of 7.5 hours of care per day compared to 5 hours by men). The average number of hours of care among women did not differ according to whether women were employed or not, but the times of care provided during the day varied.

Table 2 summarises some of the survey results and presents the level of agreement of participants with different statements. Over half of respondents stated that it was essential to have formal LTC options for older people (58 per cent of females and 45 per cent of men). Participants preferred LTC services provided at home over residential care homes; 68 per cent agreed that home care workers could be hired if families were unable to look after older people compared to only 28 per cent agreeing to admit older people to residential care homes in similar circumstances.

One of the interesting findings of this study is the low level of willingness to hire formal care workers immediately to care for their elderly relatives if that option was available. On average, only 3 per cent indicated they would take up this option (1 per cent among women and 5 per cent among men). The latter percentage increased among respondents with higher educational attainment, but no differences were observed by geographical region. The limited acceptance of hiring formal LTC workers relates to several concerns and perceptions of the quality of LTC services in Egypt. For example, informal caregivers stated that they would require formal LTC workers to have received specialist training in elderly care. At the same time, the majority felt that existing formal LTC services in Egypt were not specialized, and that workers were not offered necessary training. Additional concerns related to a lack of trust to leave older persons alone with informal LTC workers.

Table 2. Agreement of Egyptian participants with different statements

Statement	Response (percentage)				
	Totally agree	Agree	Neutral	Disagree	Totally disagree
If someone is not able to take care of their parents, they may put them in a nursing care home.	6.2	21.3	3.0	12.6	56.8
If someone is not able to take care of their parents, they may hire a formal LTC provider.	18.9	48.5	2.2	10.7	19.7
A formal home care worker can be left alone with the older person.	10.1	34.1	5.0	20.7	30.1
Having formal LTC services for older people is essential.	20.0	31.4	4.1	24.9	19.6
Most formal LTC workers do not have specialized training.	15.8	27.2	37.4	14.2	5.4
Formal LTC services must be specialized.	66.1	19.3	3.2	10.4	1.0

Source: Baseera, 2021.
Note: Sample size = 2,016; reproduced by ESCWA.

Furthermore, almost all respondents who were willing to hire formal LTC workers preferred that person to be female. Thus, nearly all new job opportunities within the LTC market in Egypt would attract females. Therefore, even with very modest initial demand, formal LTC job opportunities will increase female labour participation in Egypt. However, even with this low percentage, the report estimates around 107,000 LTC jobs were required to meet this level of demand.

The study provides new insights into Egyptian preferences concerning formal LTC services. While hiring formal LTC workers was not that popular, this was influenced by concerns related to the quality of LTC services available in Egypt and the levels of training of formal LTC workers. Despite this, there was an explicit acknowledgement of the need to develop the LTC market and ensure the availability of these options for families if they cannot look after their older relatives. Furthermore, there was a significant preference for home care services over residential care, consistent with other research from the region. There is also a potential role for a regulated LTC market to provide a safe care option and create a considerable volume of new job opportunities for women to enter the labour market.

MOSS has recently piloted an initiative called Al-Tadamun to develop a formal LTC market. Since 2019, it has focused on training job seekers with at least intermediate education to become formal LTC workers. This programme is part of a broader initiative to support ‘older people companions’. Two news articles (dated 19/3/21[121] and 9/9/2019[122]) state that 51 individuals completed previous training courses, and new courses aim to recruit 150 job seekers with a promised monthly salary of 4,000 EGP. Information on this pilot scheme was confirmed during a workshop with stakeholders from the Ministry of Social Solidarity in November 2021, and further information from the Ministry indicated that the programme would initially be piloted in four governorates: Cairo, Giza, Al Qalyubia and Alexandria. The pilot aimed to recruit 150 unemployed (20-45) men and women to train as home care workers. A total of 51 individuals completed the training, with the high turnover rate attributed to an initial misunderstanding of the purpose of training, where some recruits thought they were joining public service jobs; refusal of some to work with charitable organizations; while others already had other jobs.[123] This programme was delivered in partnership between the Ministry, the National Institute of Geriatric Sciences, Beni Suef University and several charitable organizations.

Participants in the workshop indicated that there are developments underway to scale up this initiative. This includes standards and regulations to govern these services, eligibility and access criteria and a recruitment campaign with the Ministry of Manpower. Furthermore, the next stage of the programme aims to expand its partners among higher education institutions and NGOs supporting it.[124] Data gathered through interviews with the Ministry indicated that there are 164 residential care homes in 22 governorates in Egypt registered with the Ministry, serving around 3,000 older people. The Ministry has also redeveloped three residential care homes: *Um Kalthum* in Hilwan; *Dar Al Saada* in Tanta and *Darr Al Amal* in Suez. These recent efforts also included training of 141 care professionals working in 72 residential care homes in 10 governorates.[125]

According to information gathered from the workshops with MOSS, a total of 856 older people residing in care homes and 174 residents in homes designated for older homeless people have been vaccinated against COVID-19. The Ministry has also issued infection control guidance and provided personal protection equipment to residential and nursing care homes and other organizations supporting older people.

2. Estimating current LTC costs

The primary cost of home-based elderly care is labour for technicians and other care staff. There are also costs related to needs assessment, which is performed by trained professionals such as social workers and health providers. Some of this cost is likely to be shared between different government ministries and departments. Finally, there is a minimal cost of infrastructure, buildings, and equipment. Research shows that flexible, personalized care may not cost much more than conventional institutional care. Home-based care for older people should be preventative to reduce unplanned hospital admissions and unnecessary accidents and emergency visits. To make home-based care most cost-effective, it is essential to ensure that services are well integrated with effective multi-disciplinary teamwork and communications.[126]

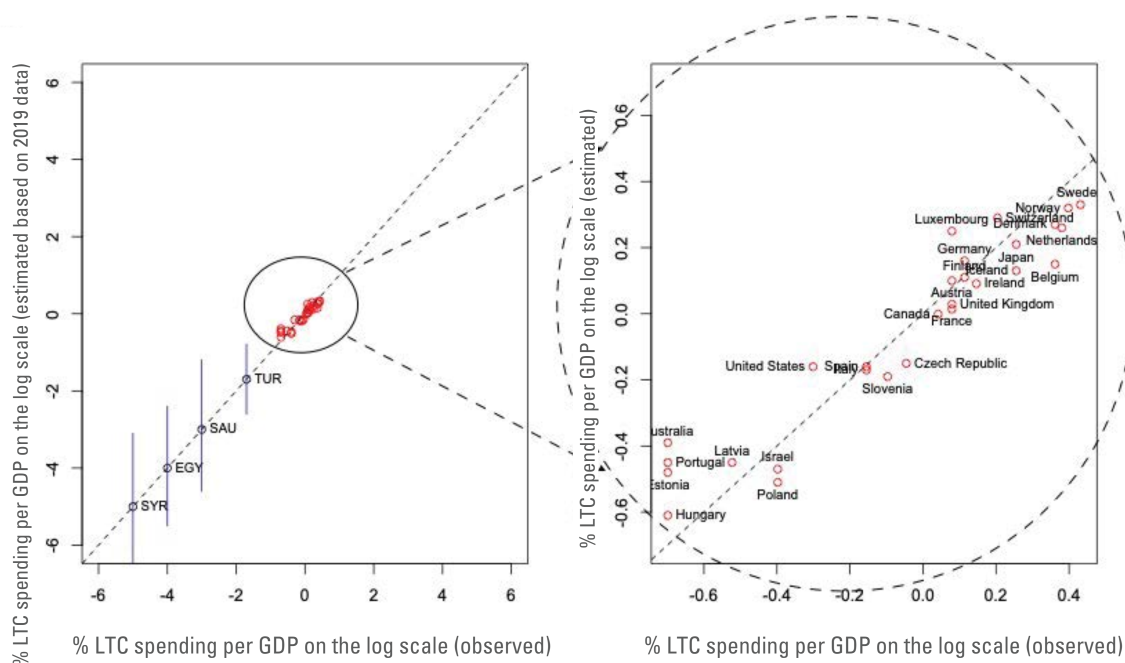
On the other hand, residential care is one of the most expensive care services worldwide. In the United Kingdom, residential care is only cost effective if an older person requires care from multiple professionals around the clock. For example, receiving up to 14 hours of care per week at home would cost roughly half the amount in residential care services. The core residential care home costs are three-fold: staffing, other non-staffing costs and capital costs. In the United Kingdom, staffing costs account for 45-60 per cent of care home fees. Non-staffing costs include utilities, supplies, registration fees, grounds maintenance and maintenance capital expenditure (the latter in place of depreciation), accounting for 12-16 per cent of care home fees.[127] Finally, capital costs account for the balance of care home fees.

There is no available information or data on the actual cost of LTC in the three case studies. This is primarily due to the scarcity of formal LTC services provided directly by the State, with most care and support provided informally by families or charitable organizations. Furthermore, the few LTC services provided are usually funded by several ministries and government bodies. This section presents estimates of current LTC costs as a percentage of GDP of the three case study countries based on a novel modelling technique explained in annex 2.[128] We acknowledge that such estimates are likely to underestimate the actual cost required to initiate an LTC market from almost scratch, as they do not consider the cost of infrastructure and logistics required to set up and promote new services. The model also estimates spending based on indicators in 2019 and hence does not provide a projected cost based on future trends. Given the very fast pace of the ageing transition highlighted in this report, these figures are forecasted to rise considerably in the coming decades. The model is based on macro-level indicators, namely GDP, the proportion of the population aged 65 or more and female unemployment. This lack of detailed data forces the use of proxy country-level indicators to estimate costs relying on various assumptions, which might not be fully representative of the actual cost of LTC.

Figure 38 shows the model's estimates for the three case-study countries, Turkey and OECD countries against observed spending of LTC as a percentage of GDP in OECD countries. The closer the estimates are to the 45-degree diagonal line, the better the ability of the model to estimate the actual costs for different countries. The values for the Syrian Arab Republic, Egypt, Saudi Arabia and Turkey are all presented on the line as they are all estimated with no observed values.

Figure 38 shows the three countries' expected current spending to be considerably lower than in OECD countries,[129] reflecting their young populations with substantially lower percentages of people over 65 than in the OECD countries. The very low female employment rates also contrast those observed in OECD countries since the model acknowledges the role of informal care and assumes that formal employment is the main competing factor for informal care. This assumption is supported by the common observation in many OECD countries that most formal and informal care is given by female caregivers. However, it does not account for other competing demands such as other family responsibilities, informal work, migration or, in some situations, the unwillingness to provide LTC for older people. This level of detail would require access to more granular survey data.

Figure 38. LTC spending as a percentage of GDP as estimated by the Ismail and Hussein costing model for selected countries against the values observed in the OECD on a logarithmic scale



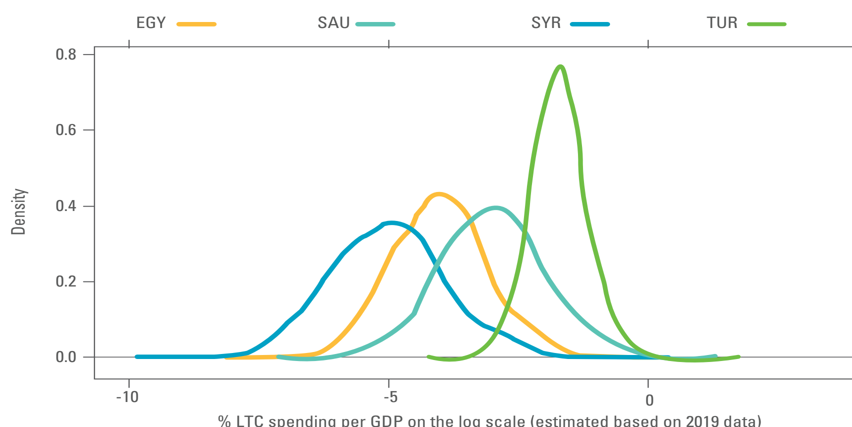
Source: Calculated by ESCWA.

Note: The left panel shows the mean values of the percentages of LTC spending as a percentage of GDP as estimated by the Ismail and Hussein costing model against the values observed in the OECD on a logarithmic scale. The right panel shows the same information with a zoom-in on the OECD countries. The Ismail and Hussein modelling technique is explained in annex 2 of the present report.

Figure 38 (right panel) shows that Hungary is the nearest European country to our case studies in terms of its percentage spending on LTC. Yet, Hungary has 17.8 per cent of its population over 65 years old, compared to 3.4 per cent in Saudi Arabia. The difference in the estimated percentage of LTC spending is further magnified by the significantly higher female labour force participation in Hungary at 62.2 per cent compared to 15.8 per cent in Saudi Arabia. Given that, the female labour force participation is used in the model as a proxy for the availability of informal care. Hence, the higher the female labour force participation rate, the lower the availability of unemployed women as a resource for informal care, and the higher the expected spending on LTC. To further contrast these values, GDP per capita also plays a role in the estimation; this is also higher for Hungary than for Saudi Arabia. The main difference, however, relies on the former two indicators. Should either female labour participation or the percentage of older people increase in the future for any countries under study, this will lead to higher estimates of LTC spending as a percentage of GDP. At the time of the study, OECD countries' LTC spending as a percentage of GDP ranges from 0.2 per cent (Estonia, Hungary, Australia) to 2.7 per cent (Sweden).

Figure 39 reflects a mutual intersection of the credible intervals of the estimates of LTC spending, on the log scale, among the three case studies with that for Turkey, implying relatively close estimates for the four countries. However, when the values are transferred from the log scale, the model indicates that the estimated current LTC spending as a percentage of GDP is considerably small in the three case studies. For example, it is estimated that Saudi Arabia currently spends between 0.001 per cent and 0.06 per cent of its GDP on LTC (at 50 per cent and 95 per cent of the credible interval, respectively), while the corresponding figures for Egypt are between 0.0001 per cent and 0.004 per cent and for the Syrian Arab Republic between 0.00001 per cent and 0.0008 per cent.

Figure 39. Density plots of the estimation of LTC spending as a percentage of GDP resulting from employing the hierarchical Bayesian model of Ismail and Hussein (2021)



Source: Calculated by ESCWA.

These figures may appear small, but they reflect the current low GDP for the Syrian Arab Republic, combined with a low female labour participation rate and a small proportion of people aged 65 years or more. However, even with these small estimates, based on World Bank data[130] of current GDP of these countries, it is estimated that current LTC spending is $319,200, $14,450,156 and $441,774,378 in each of the Syrian Arab Republic, Egypt and Saudi Arabia to meet the LTC demand as of 2019.

The costing model indicates that countries in the region will need to outlay considerable funds as to respond to changes in their population structures. These estimates, while they may appear low, present a new cost element not currently considered within Governments' budgets. It should be stressed that these estimates are likely to be underestimates of the actual cost required to design, implement, evaluate and scale up new LTC services and models that are sensitive to older people's needs. This is because the estimates are modelled on the current spending of different OECD countries. These countries have already established a strong infrastructure in LTC services and markets, and have previously spent considerable funds to establish, promote and enhance services. For countries in the Arab region, there will be additional funding required to initiate, pilot and expand new LTC services and markets. Furthermore, the current LTC cost estimates also employ assumptions around family responsibilities and informal care availability and hence the demand for formal LTC services and the associated costs are likely to be much higher than estimated. Finally, these estimates present past experiences (based on 2019 data) and do not reflect projected escalating increases in the proportions of older people and associated LTC needs. Full demand and supply projection models for each country are required to estimate LTC costs, accounting for each country's specific stage and speed of change through the ageing transition as well as other cultural, socio-demographic and economic factors.

D. Job opportunities in LTC markets

Changing demographics, including population ageing and high unemployment rates, especially among youth and women, bring opportunities for emerging LTC markets[131] since LTC is reliant on human interactions and relationships. It is thus one of the few sectors that will continue its reliance on human input despite technological advances that have replaced many jobs with machines and robotics. Assistive technology is also assuming increasing importance in LTC services, but the human touch remains essential.[132] Older people themselves prefer personal interaction and have voiced concerns about over-reliance on digital technology in delivering health and LTC services.[133]

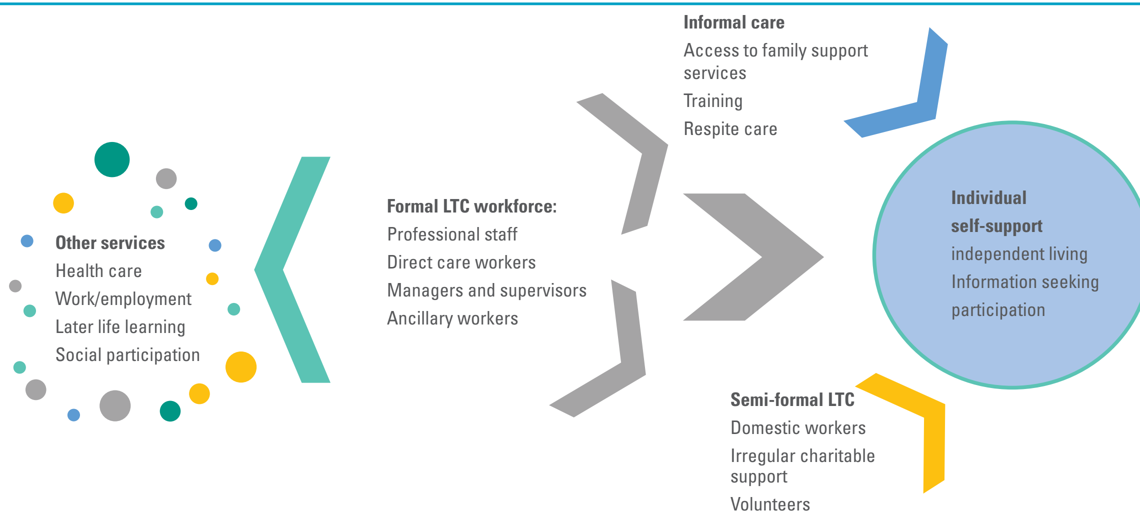
Globally, it is estimated that nearly 40 per cent of projected job opportunities in the coming three years will be in the care economy.[134] The ILO estimates care markets (both child and elderly care) to include 215 million workers in care sectors (in health and social work and education) and 70.1 million domestic workers in the world, with women constituting 65 per cent of this vast workforce.[135] Women provide an even larger percentage of care for older people and those with disabilities. For example, 80 per cent of the LTC workforce in the UK are women.[136] Hence, there is considerable potential for LTC markets to create new job opportunities, especially for women, but it is essential to ensure that these jobs are formalized and adequately renumerated.

LTC workers include various jobs with different training, qualifications and skills requirements and pay levels. These jobs include specialist nurses, care managers, social workers, occupational therapists, psychologists, allied health professionals, care workers and ancillary staff such as cooks, drivers and cleaners, supported by administrative and IT professionals. LTC workers also include domestic workers as essential providers of personal and household services in private homes.[137] The exact size and skill mix of this workforce are influenced by the need and demand for LTC at a given time and place. They also depend on the system and service design and delivery, workforce supply and government regulations.

The training needs of LTC workers vary by group and context. For example, for home care, training should emphasize the importance of older people feeling safe and comfortable. On the other hand, in residential care homes, all medicines, including controlled drugs, are administered by appropriately trained staff, with another staff member witnessing them. Therefore, staff responsible for administrating medicines must receive formal training including knowledge of how drugs are administered and how to respond to potential problems.

Figure 40 presents a schematic illustration of the different professional roles within the LTC workforce and how they interact and support other groups within the LTC economy. The formal LTC workforce, as explained, consists of an array of workers with different qualifications and skills from professional staff with registered bodies such as nurses and social workers; direct care workers including support workers and personal assistants; managers, supervisors, IT staff and administrators and ancillary workers such as drivers, cleaners and cooks. These groups directly support older people through different LTC facilities and interventions. They also support informal caregivers, and potentially semi-formal caregivers, such as domestic workers, by providing support services, respite care and training, assessment and information. The formal workforce also connects older persons and their families to a broader set of health, education and social services.

Figure 40. The interactive role of the LTC workforce with others within the LTC economy



Source: Prepared by ESCWA.

E. Conclusion

This chapter highlights some of the challenges and opportunities associated with the rapid ageing transition underway in the Arab region. The aims and analysis focused on the pressing need to establish well-regulated and high-quality LTC markets to meet the growing needs of older people, reduce the burden of care on informal caregivers and create job opportunities. For these markets to be effective they need to be guided by rights-based and person-centred approaches, with older persons as active agents. The proposed framework defines the LTC markets through a holistic lens where LTC services go beyond meeting medical needs associated with ill health and co-morbidity to provide means for older people to continue participating in the social, economic, and public spheres.

The three in-depth case studies presented provide rich and detailed insights into the evolving LTC markets in the region, their strengths and weaknesses, and potential opportunities. It is clear that in the Arab regional context, home-based LTC market is the most preferred way of supporting older people while allowing them to continue living as independently as possible within their homes, families and communities. However, residential and nursing care might be a more suitable alternative for a smaller group of people with advanced and complex needs.

LTC markets are complex and encompass various actors, including the state, multiple organizations, individuals, families and communities. Moreover, LTC markets operate within and interact with other structures and systems like health care, employment and migration. Thus, LTC markets are dynamic and informed by structural and interactive landscapes of ideological positions, resources, and fiscal constraints. Unlike childcare, the exact timing of the onset of LTC needs is unpredictable and varies from one circumstance to the other. On average, however, the typical timing when an older person might require LTC is when their children, women in most cases, are in their 40s and 50s, a life stage at the peak of external responsibilities such as employment and their own teenage children.

Finally, the chapter provided an overview of the cost components of home and residential care services and provided estimates of LTC spending as a percentage of GDP in the three case studies. Based on 2019 data, it is estimated that current LTC spending is $319,200, $14,450,156 and $441,774,378 in the Syrian Arab Republic, Egypt and Saudi Arabia. While current estimates of LTC spending might appear small when compared to spending in OECD countries, spending is likely to escalate considerably as countries age, which is expected to occur remarkably quickly in the region. Furthermore, more funding is required to initiate and establish LTC markets at the outset. Further detailed modelling and analysis, based on local and national demand and supply for LTC, are highly recommended to plan future spending in the context of the rapid projected ageing transition. Doing so would require collecting detailed primary data and expert opinions to provide reliable parameters for models. However, estimating current spending is highly useful in planning LTC market expansions and future developments and currently are encouraged to identify and protect budgets specific to LTC services and markets.