Population and Development Report
Issue No. 9
Building Forward Better for Older Persons in the Arab Region

UNITED NATIONS
الاسكوا
ESCWA

Shared Prosperity **Dignified Life**

UNITED NATIONS
الاسكوا
ESCWA

Shared Prosperity **Dignified Life**

VISION

ESCWA, an innovative catalyst for a stable, just and flourishing Arab region.

MISSION

Committed to the 2030 Agenda, ESCWA's passionate team produces innovative knowledge, fosters regional consensus and delivers transformational policy advice. Together, we work for a sustainable future for all.

E/ESCWA/CL2.GPID/2022/1

Economic and Social Commission for Western Asia

Population and Development Report Issue No. 9

Building Forward Better for Older Persons in the Arab Region

UNITED NATIONS
Beirut

United Nations publication issued by ESCWA, United Nations House,
Riad El Solh Square, P.O. Box: 11-8575, Beirut, Lebanon.

Website: www.unescwa.org.

Photo credits: © iStock.com

22-00321

Aknowledgments

The Economic and Social Commission for Western Asia (ESCWA) would like to thank everyone who contributed to this collaborative multi-agency endeavour and to acknowledge the support, advice and dedicated work of many individuals and organizations.

The present report was written under the vision and leadership of Ms. Sara Salman (ESCWA). The drafting of the report was supported by ESCWA staff members, namely Ms. Valéria Bankóová, Mr. Anton Bjork, Ms. Sumaya AlMajthoob, Mr. Milad Pournik and Ms. Nadine Chalak, as well as consultant Ms. Shereen Hussein (Professor of Health and Social Care Policy at the London School of Hygiene and Tropical Medicine, United Kingdom).

The report was reviewed by ESCWA staff: Ms. Mehrinaz El Awady, Mr. Mounir Tabet, Ms. Rouba Arja, Mr. Marco Schaefer and Mr. Salim Araji.

We would like to express our gratitude to the following for their contributions and revisions of the report and participation in the Experts Group Meeting (EGM) to review and validate the report: Ms. Huda Alnaeem and Ms. Talaat Alwazna (Family Affairs Council, Saudi Arabia), Mr. Hashim Balubaid (King Saud bin Abdulaziz University, Saudi Arabia), Mrs. Samah Refaat (Ministry of Social Solidarity, Egypt), Mr. Waddah Alrkkad and Mrs. Elham Safe (Commission for Family Affairs and Population, Syrian Arab Republic), Mr. Nabil Kronfol (HealthCare Management Association, Lebanon), Mrs. Manal Said (Balamand University, Lebanon), Mrs. Amal Chafai (Consultant, Morocco), Ms. Zeinab Khadr (Cairo Demographic Centre, Egypt), Mr. Chris McIvor (HelpAge), Mr. Hafiz Khan (University of West London, United Kingdom) and Mr. Ebrahim Ebrahim (Fintech Robos, Bahrain).

The present report was edited, translated and designed by the ESCWA Conference Services Section.

Executive summary

Most Arab countries will have an ageing population or will have become aged in the next 30 years. This statement would have been unimaginable a few decades ago, when the region was witnessing a massive population boom. While the number of older persons, aged 65 and above, in the Arab region increased by 16 million in the last 50 years, it is projected to increase by over 50 million in the next 30 years, reaching 71.5 million by 2050. Several Arab countries have already started the ageing transition and most countries will follow suit in the next 15 years.

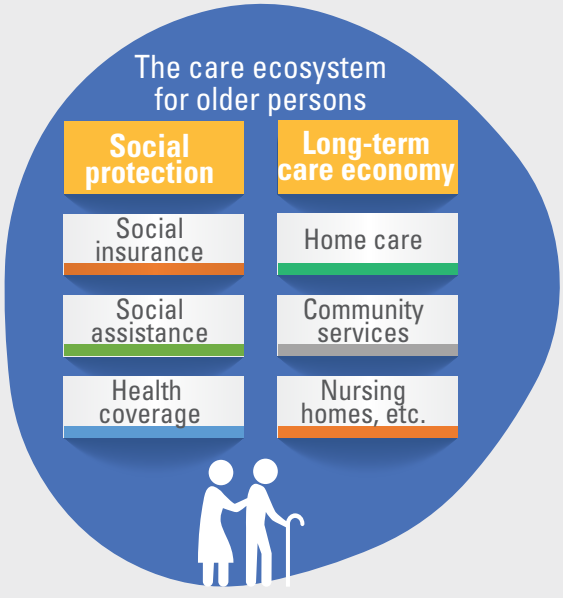
> The Arab region will on average take 36 years to complete the ageing transition, defined as the share of older persons in the population doubling from 7 to 14 per cent.

If prepared for, this demographic trend can provide the basis for transformative change and ageing with dignity. Otherwise, the socioeconomic vulnerabilities of older persons will be compounded, and future cohorts of older persons will be further marginalized.

Population ageing carries important economic and social implications. Adequate housing, quality and accessible healthcare and education are all important prerequisites for ageing with dignity, however significant gaps exist in Arab countries in these areas. The COVID-19 pandemic highlighted the existing vulnerabilities of older persons.

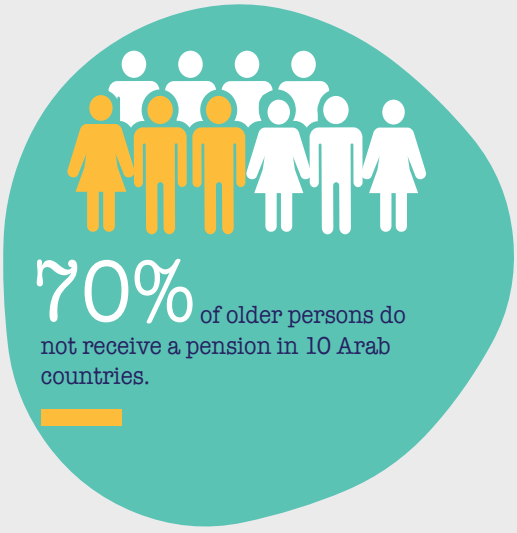
> Two out of every three older persons are illiterate in six Arab countries.

The ninth issue of the Population and Development Report (PDR9) focuses on the care ecosystem for older persons as an entry point to address older persons' priorities and ensure that all people can age with dignity in the region. The care ecosystem is comprised of two distinct yet closely related elements: social protection and long-term care (LTC).



Social protection

While the number of old-age pensioners covered by a selection of social insurance schemes in the region has increased, in 2020 only 38 per cent of older persons above retirement age in the region received a pension, less than half of the world average of 78 per cent. Although the proportion of older women receiving pensions is steadily increasing, the gender gap is significant, with male pension coverage rates being five times higher than female coverage rates in some Arab countries. Meanwhile, men in the Arab region do not consistently receive higher pensions than women.



Pension levels have increased, both nominally and at purchasing power parity, during the last two decades. Nevertheless, many pension schemes in the Arab region lack indexation mechanisms to ensure that pensions automatically increase to compensate for inflation. Instead, benefits are raised sporadically and with little predictability. Additionally, there is great inequality among pensioners, often with a considerable difference between pensions received by older and younger retirees.

As regards to health care, many countries have made considerable progress in extending legal health coverage to older persons, although in some Arab countries up to 70 per cent of older persons are still not covered by health insurance. Moreover, health care services may be inaccessible and/or of poor quality.

Long-term care (LTC)

LTC services go beyond meeting medical needs to providing means for older persons to live autonomously, continue participating in social, economic, and public spheres and receive support as their care needs change over time. Families across the Arab region, which have traditionally served as the primary care providers for older persons, are finding it increasingly difficult to carry this role due to evolving socio-cultural norms and family structures as well as urbanization and migration, among other factors.

Despite the continuing reliance on families for care and support, formal LTC markets are emerging in the Arab region. With culturally sensitive and high-quality LTC services in place, the burden on families is shared and reduced, and significant labour power is released for the benefit of individuals and the broader economy. Furthermore, LTC provision is reliant on human interactions and relationships and is one of few sectors that will continue to rely on human labour despite technological advances. Given the nascent state of the LTC economy across the region, Arab countries will require additional funding to initiate, pilot and expand new LTC services and markets.

The experiences in Egypt, Saudi Arabia and the Syrian Arab Republic confirm that, while families remain the primary providers of LTC, formal LTC markets are beginning to take shape. The case studies also identified a strong preference among older persons for home care services over residential care, consistent with other research from the region.

Building forward better

The report calls upon countries to seize the demographic window of opportunity and reflect on the recent lessons learned from the COVID-19 pandemic to ensure the protection and empowerment of older persons. Arab governments are starting to make progress in this pursuit. Nonetheless, more is needed.

Any successful strategy or initiative will require careful matching of priorities with resources and capacity. Differences within and between countries should be carefully considered when building forward better. The four dimensions below provide the foundations for a holistic approach. Taken together, these recommendations will help Arab countries to build forward better for older persons.

Data

Build comprehensive, integrated, and inclusive data systems that provide the necessary data to inform evidence-based policy making.

Life cycle

Adopt a life-cycle approach to address needs of older persons today as well as taking proactive measures to address the anticipated needs of future cohorts of older persons.

Social protection

Increase coverage, ensure adequacy, and strengthen sustainability of social protection systems that empower older persons to age with dignity.

Long-term care

Develop responsive, diverse, and sustainable LTC services to ensure high-quality, personalised care and support for older persons.

For a more detailed look at policy recommendations, see the PDR policy brief series, available at: https://www.unescwa.org/publications/population-development-report-9-policy-brief.

Content

List of tables

List of figures

Glossary

Aged population	A population is considered "aged" when the share of older persons exceeds 14 per cent.
Ageing in place	The opportunity for older people to remain in their home for as long as possible, without having to move to a long-term care facility.
Ageing population	A population is considered "ageing" when the share of older persons is between 7 per cent and 14 per cent.
Ageing transition	The period of time during which the share of older persons shifts from 7 per cent to 14 per cent.
Care ecosystem	Primarily composed of social protection systems, including social insurance, social assistance, and health coverage as well as the long-term care economy.
Contributory mechanisms	Social protection mechanisms where eligibility is based on contributions, in principle paid by employers and employees but in practice often subsidized by general government revenue.
Dependency ratio	The total dependency ratio is the ratio of the sum of the population aged 0-14 and aged 65 and above to the population aged 15-64. The child dependency ratio is the ratio of the population aged 0-14 to the population aged 15-64. The old-age dependency ratio is the ratio of the population aged 65 and above to the population aged 15-64. All ratios are presented as the number of dependents per 100 persons of working age (15-64).
Effective coverage	Refers to the proportion of the population who are in fact covered by social protection.
General fertility rate	The number of live births per 1,000 women aged 15-44 or 15-49 years in a given year.
Health insurance	Provision of health care through contributory mechanisms, meaning that eligibility is limited to the population covered by health insurance schemes.
Household	One or more persons occupying a housing unit.
Illiteracy rate	The proportion of persons in a given age group who cannot read with understanding and cannot write a short simple statement on their everyday life.
Indexation mechanisms	Mechanisms for pensions to automatically increase to compensate for inflation.
Informal care	Unpaid care provided by family, friends, and community members who support older people's care needs.
Long-term care (LTC)	Both the need for and supply of long-term care support including formal and informal care and services to assist older persons and support their independence, including services provided in the community and at home, as well as institutional care.
Long-term care (LTC) services	Formal services only, such as domiciliary care and residential care.
Labour force participation	The proportion of a given age group that is economically active, as a percentage of the total population of that same age group. The active population (or labour force) is defined as the sum of persons in employment and unemployed persons seeking employment.

Legal coverage	Refers to the part of the population entitled to be covered by social protection according to the legal framework in place.
Life expectancy at a specific age	The average number of years of life expected by a hypothetical cohort of individuals who would be subject during all their lives to the mortality rates of a given period.
Migration	The movement of a person or a group of persons across an international border. It encompasses any kind of movement of people, whatever its length, composition and causes; and includes migration of refugees, displaced persons, economic migrants and persons moving for other purposes, such as family reunification.
Mortality	Deaths as a component of population change.
Non-contributory mechanisms	Social protection mechanisms where eligibility is based on perceived need, citizenship or residency rather than contributions.They are financed through general government revenue.
Old-age dependency ratio	The ratio of older persons and the number of persons in the working-age population. For the purpose of pension schemes, the old-age dependency ratio refers to the number of older persons receiving pensions and the number of active contributors.
Older persons	In this report older persons are aged 65 years and above, unless otherwise stated.
Population	De facto population in a country, area or region as of the year indicated.
Population ageing	A demographic process where the number and share of older persons in a population increases, resulting from a decline in fertility and improvement in life expectancy.
Pension coverage	The percentage of older persons above the statutory pensionable age who receive periodic cash benefits (old-age pensions). Pension coverage is the total coverage, including contributory mandatory, contributory voluntary and non-contributory pension coverage.
Population growth rate	Average exponential rate of growth of the population over a given period.
Replacement ratios	Ratio of pensions to pre-retirement earnings.
Sex ratio	The number of males per one hundred females in a population, either for the total population or for a specific age group.
Social assistance	Non-contributory social protection interventions providing monetary and in-kind benefits, mainly to vulnerable groups.
Social insurance	Contributory social protection interventions providing monetary and in-kind benefits to the covered population, largely limited to formal workers and their households. Includes old-age pensions.
Social protection	A set of public policies and programmes intended to ensure an adequate standard of living and access to health care throughout the life cycle. Social protection benefits can be provided in cash or in kind through universal or targeted non-contributory schemes, contributory schemes such as pensions and complementary measures.
System connectors	Other services, individuals, practices or innovations that facilitate the utilization of services offered by the LTC market by older people or their informal caregivers.
Total fertility rate	The average number of live births a hypothetical cohort of women would have at the end of their reproductive period if they were subject during their whole lives to the fertility rates of a given period, and if they were not subject to mortality. It is expressed as live births per woman.
Vesting period	The period during which a person must contribute to a pension scheme in order to be eligible for an old-age pension upon retirement.
Working-age population	Persons aged between 15 and 64.

Introduction

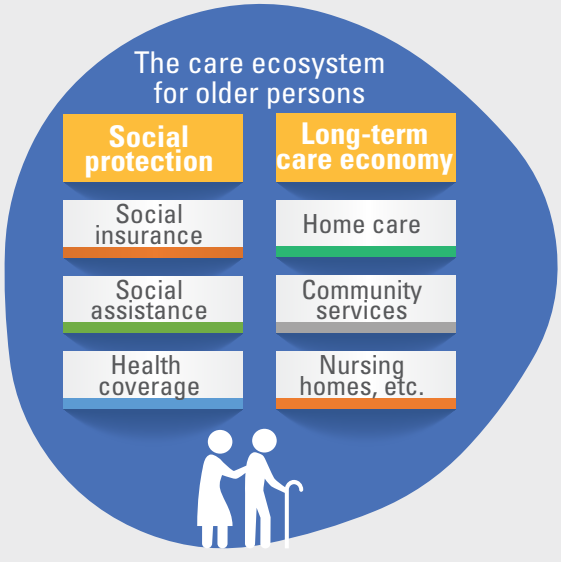
Most Arab countries will have an ageing population or will have become aged in the next 30 years. This statement would have been unimaginable a few decades ago, when the region was witnessing a massive population boom. Today, several Arab countries have already started the ageing transition and most countries will follow suit in the next 15 years. As a result, the number of older persons (aged 65 and above) is projected to increase from around 21 million today to exceed 71 million in 2050. Their percentage of the population will also increase from around 5 per cent today to more than 6 per cent in 2030 and nearly 11 per cent in 2050.

The fast-paced demographic changes, coupled with the alarming situation of older persons today and the projected situation of future cohorts of older persons, are advancing ageing as a priority policy item across the region. The COVID-19 pandemic and its devastating effect on older persons only served to highlight the existing vulnerabilities of older persons and the need to take prompt action to protect them and guarantee their rights. It has proven once again that business as usual and the fragmented policies of yesterday are no longer adequate. A paradigm shift is needed to change the bleak prospects of ageing in the Arab region.

In this context and building on ESCWA's earlier knowledge produced on ageing in the Arab region, as well as the insights gained from its ongoing work with member States, the ninth issue of the Population and Development Report (PDR9) focuses on the care ecosystem for older persons as an entry point to address older persons' priorities and ensure that all people can age with dignity in the region.

The model of the care ecosystem (figure 1) presented in this report is comprised of two distinct yet closely related elements: social protection and the long-term care (LTC) economy. Social protection is defined as a set of public policies and programmes intended to ensure an adequate standard of living and access to health care throughout the life cycle. Social protection benefits can be provided in cash or in kind through universal or targeted non-contributory schemes, contributory schemes such as pensions and complementary measures. Long-term care is defined as the need for and supply of long-term care support including formal and informal care and services to assist older persons and support their independence. It could include services provided in the community and at home, as well as institutional care.

Figure 1. The care ecosystem for older persons



Source: Prepared by ESCWA.

Non-inclusive social protection systems across the region continue to leave large groups of older persons vulnerable to poverty, disease, and heightened dependency. They hinder older persons from fulfilling their potential and being active agents in their societies who can contribute to its development. The underdeveloped long-term care economy is also undermining older persons' autonomy and increasing

their exclusion and isolation. Families, which traditionally are the primary care providers for older persons, are facing increasing difficulties to carry this role due to evolving socio-cultural norms and family structures, urbanization and migration, among other factors. Therefore, Arab countries are compelled to rethink and overhaul their social protection systems and invest further in the nascent long-term care economy for older persons, to adapt to the new reality and prepare to address the needs of their quickly ageing populations.

PDR9 reflects on the lessons learned from the COVID-19 pandemic and attempts to move from a diagnosis of the status quo towards offering a prognosis and solutions that can guide Arab countries in their efforts to build forward better for older persons and fulfil their commitment to leave no one behind. This report serves as both a call to action and a source of evidence-based policy recommendations to develop the care ecosystem across the Arab region. It reflects ESCWA's commitment to supporting member States in formulating sustainable and inclusive national policies and action plans responsive to older persons. Additionally, it complements ESCWA's efforts to address knowledge gaps on ageing, foster regional peer learning and build the capacity of member States.

PDR9 is rooted in the principles espoused in key international development frameworks, including the Programme of Action of the International Conference on Population and Development (ICPD), the Madrid International Plan of Action on Ageing (MIPAA) and the 2030 Agenda for Sustainable Development. To the extent possible, the analysis adopts a gender and disability-sensitive lens, and rests on life cycle and human rights-based approaches.

The present report employs a mixed-method approach that complements quantitative statistical analysis with in-depth qualitative data. Using United Nations data helps facilitate comparative regional analyses. Given the significant data gaps and the benefits of honing in on specific country experiences, PDR9 also uses data from national censuses, surveys and administrative sources. In terms of qualitative methods, it uses primary data gathered through interviews and surveys to inform the case studies presented.

While there is no universally agreed upon definition of older persons, this report defines them as individuals aged 65 years or above. This definition, which shifts from earlier definitions used (based on 60 and above), has been selected in line with the trend in the region and beyond to redefine who is considered an older person given that people are living longer and are enjoying better health. It also aligns with the retirement age used in many countries. Unless otherwise specified, the present report defines the Arab region as comprising 22 countries, the Member States of the League of Arab States.[1]

Chapter 1 offers a snapshot of demographic trends in the region and the socioeconomic situation of older persons based on the most recent available data and accounting for the effects of the COVID-19 pandemic. The chapter is intentionally brief given that the subject has been covered extensively in the previous issue of the Population and Development Report "Prospects of Ageing with Dignity in the Arab Region." The analysis in this chapter reflects the accelerating yet varied pace of ageing across the Arab region, and the alarming situation of older persons, highlighting the urgency of developing context-specific policies that promote ageing with dignity.

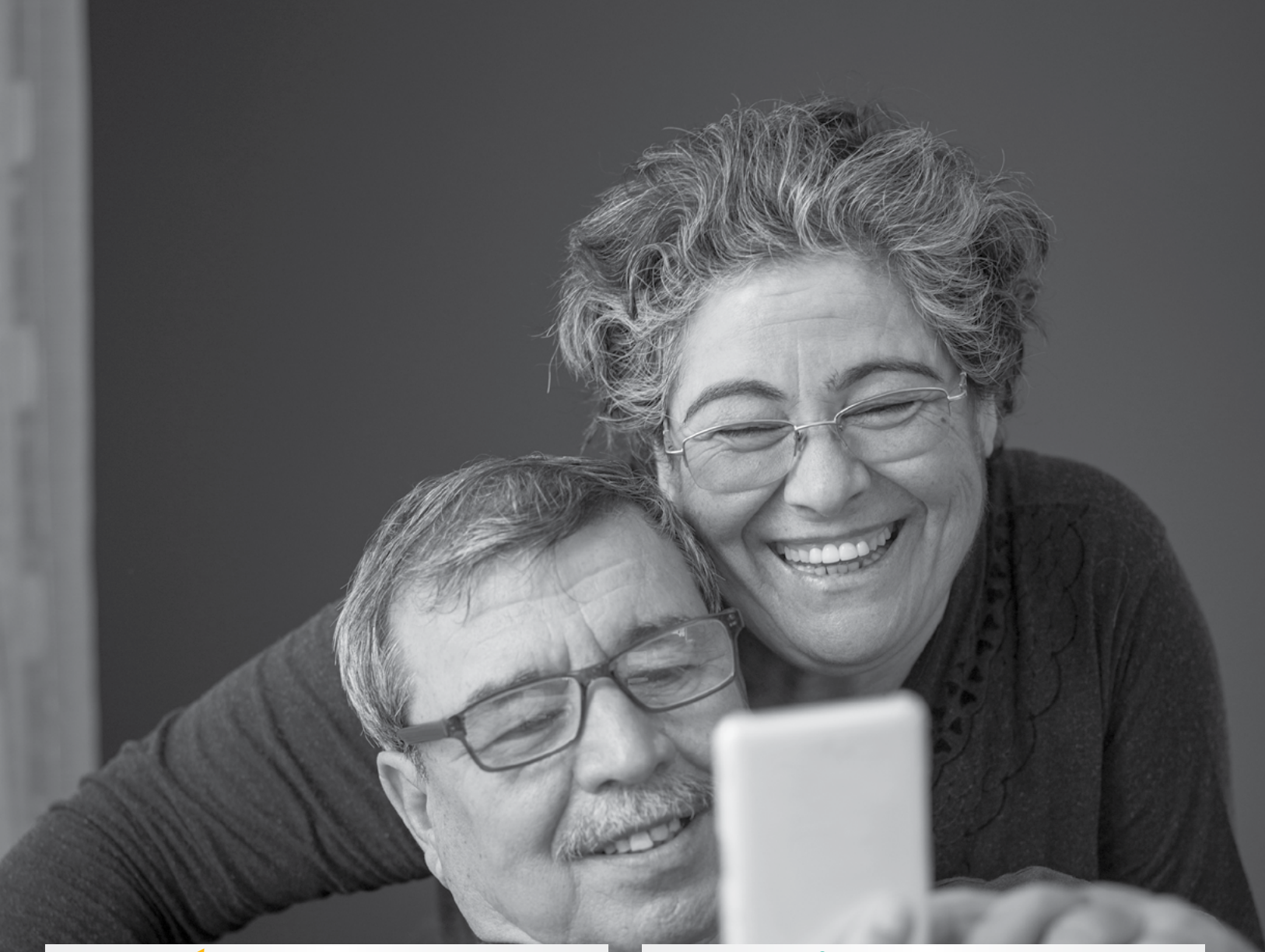
Chapter 2 focuses on social protection for older persons in the Arab region. It reflects on different social protection schemes across the region, focusing on their functions of providing income security and access to health care. The chapter considers the coverage of contributory and non-contributory social protection schemes (social insurance, social assistance and health coverage) in Arab countries. Going beyond coverage, the chapter looks at the adequacy of social insurance and assistance schemes. Chapter 2 also explores what Governments are doing to ensure the sustainability of social insurance schemes, and how those reforms affect the coverage and adequacy for older persons. Finally, the chapter looks at the economic cost of filling the coverage gap today, looking at the cost of social assistance packages in selected countries.

Chapter 3 explores the long-term care economy in selected Arab countries. The chapter explores the implications of the COVID-19 pandemic on older persons' living arrangements and care needs. Chapter 3 expands on two dimensions of the long-term care economy, providing services in older persons' own homes and building infrastructure for residential nursing care homes. It offers examples of care models outside the region before presenting three case studies of the Syrian Arab Republic, Saudi Arabia and Egypt. It also deliberates on the costs of developing an integrated long-term care economy.

Chapter 4 presents a roadmap for building forward better for older persons. While recognizing that each country will need to tailor these recommendations to their unique context and priorities, this chapter offers general guidance and specific forward-looking and phased recommendations of action items for Arab countries to consider. Chapter 4 focuses on four critical dimensions for reform: data, the lifecycle approach, social protection and the long-term care economy. Taken together, these reforms can help create care ecosystems that both protect and empower older persons to lead dignified lives.

The key takeaway messages from this report are:

- The demographic transition is a reality in the region that requires quick and proactive policy reforms to empower and protect older persons.
- Large groups of older persons today are at heightened risk of disease, poverty, exclusion and abuse. If no action is taken today, the potential for ageing with dignity in the Arab region is bleak.
- Reform of social protection systems is a priority to ensure the well-being of older persons and needs to go beyond coverage, to ensure an adequate standard of living in old age.
- Advancing the long-term care economy for older persons is of utmost importance considering changing social and cultural norms and trends.



The Arab region is ageing at a fast pace. The number of older persons is projected to increase from 20.8 million in 2020 to 71.5 million by 2050. Their percentage of the population will also increase from 4.8 per cent today to 6.2 per cent in 2030, and 10.6 per cent in 2050.

Countries in the Arab region are not ageing at the same pace, but most Arab countries will begin their ageing transition in the next two decades.

Lack of data disaggregated by age, sex, social status, living arrangements among other indicators is a significant limitation hindering countries' ability to produce evidence-based policies that are responsive to older persons.

National development plans and strategies of Arab countries should consider the changing demographic trends to better prepare for future generations.

1 Snapshot of ageing and older persons in the Arab region

A. Overview

Although the Arab region is characterized by a youthful population by global standards, the region needs to brace for a historic demographic transition. The proportion of older persons is set to more than double in the next 30 years, from around 5 per cent to nearly 11 per cent of the total population. The quickening pace of aging can be explained by a combination of declining childbearing and increasing longevity. Despite the unique demographic dynamics in each country, there are common socioeconomic implications of ageing that need to be considered across the Arab region.

This chapter offers a snapshot into the demographic trends and patterns of ageing across the region. The chapter is intentionally brief as the subject was covered extensively in the eighth edition of the Population and Development Report (2018). This chapter offers updates to the data that has been released since publishing the previous report.[2]

This chapter highlights the importance of ensuring the availability of reliable, accessible, and updated data to inform tailored responses to ageing across the region. In addition to presenting updated data on ageing-related indicators, namely fertility, mortality and migration, this chapter includes updated data on indicators related to the well-being of older persons including social protection, living arrangements, health and education.

While the COVID-19 pandemic has had a significant impact on the health and overall well-being of older persons, data in this regard remains limited. Anecdotal evidence shows how the pandemic has compounded pre-existing vulnerabilities of older persons. Besides the direct effect on the health of older persons, the pandemic resulted in increased isolation of older persons especially during lockdowns, with consequences for their mental health. It has also reiterated the importance of the care ecosystem in supporting older persons' resilience.

B. Definitions, methodology and limitations

This report defines older persons as the population over the age of 65. This is a departure from previous PDR reports and this change was made for the following reasons:

1. The ageing transition is demographically defined as those above the age of 65.
2. The retirement age in most Arab countries is closer to 65.
3. The global trend in the region and beyond is to push the brackets of who is defined as an older person given that people today are leading longer and healthier lives.

However, depending on data availability, some of the data in the present report are from sources that define older persons as individuals aged 60 and above. This discrepancy is noted in the chapter where relevant.

Data on demographic trends used in the present chapter are primarily taken from the World Population Prospects: The 2019 Revision produced by the United Nations Department of Economic and Social Affairs (DESA). Demographic data were analysed for each

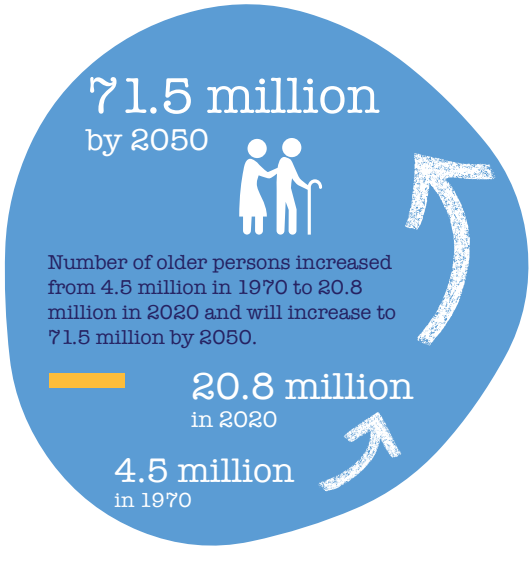
of the 22 countries in the Arab region.[3] It is worth noting that caution is required when considering demographic projections in the region, as they rest on several assumptions relating to demographic determinants including mortality and migration, both of which have witnessed significant changes in their trends in some countries in recent years due to increased human mobility, as well as increased mortality in countries witnessing conflict for example.

Data on socioeconomic indicators were collected from a variety of United Nations agencies, including the International Labour Organization (ILO), the World Health Organization (WHO) and the United Nations Educational, Scientific and Cultural Organization (UNESCO).

C. Demographic trends, patterns and prospects of ageing in the Arab region

1. The Arab region is ageing at an increasing pace

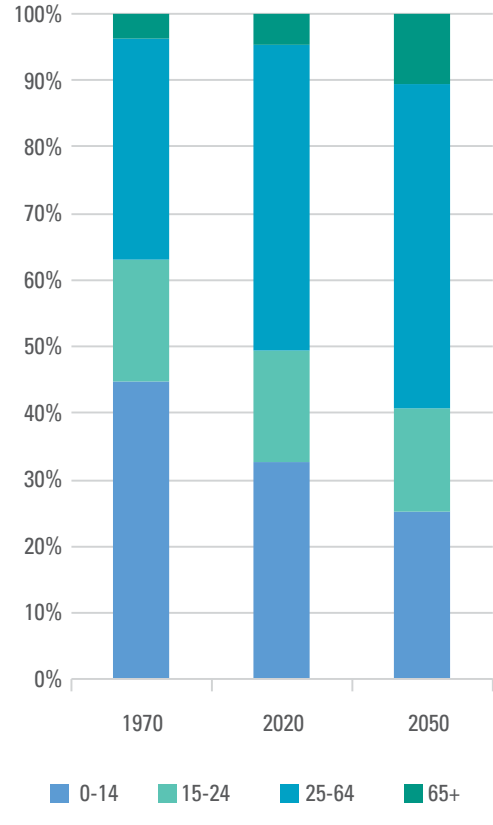
The number of older persons in the Arab region increased considerably in the last 50 years, from 4.5 million in 1970 to 20.8 million in 2020. This trend is set to continue with the number of older persons projected to triple to 71.5 million by 2050.



In proportional terms, the most significant shift is yet to come. In 1970, older persons made up less than 4 per cent of the population of the Arab region, which increased slightly to less than 5 per cent in 2020. However, the share of older persons is expected to more than double by 2050, to nearly 11 per cent.[4] Figure 2 visually depicts this demographic shift.

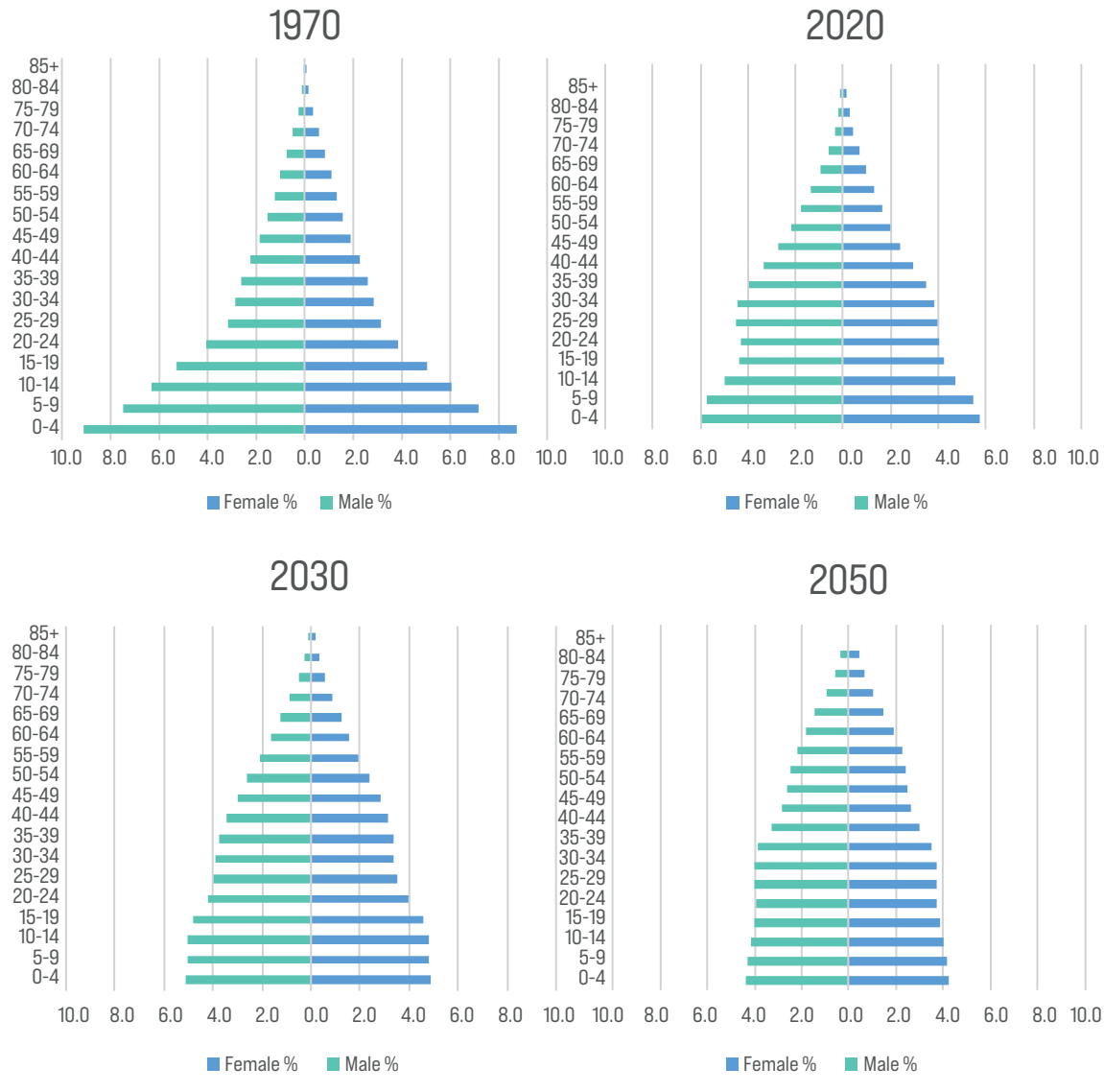
Looking at the demographic shift, figure 3 presents the change in the regional age pyramid from 1970 to 2020 and projects what the age pyramid will look like in 2030 and 2050. While the pyramid has flattened considerably in the last 50 years, the projected flattening that will occur in the next 10 and especially 30 years is even more stark.

Figure 2. Age structure in the Arab region (1970, 2020 and 2050)



Source: ESCWA calculations based on data from DESA, 2019a.

Figure 3. Age pyramids for the Arab region (1970, 2020, 2030 and 2050)

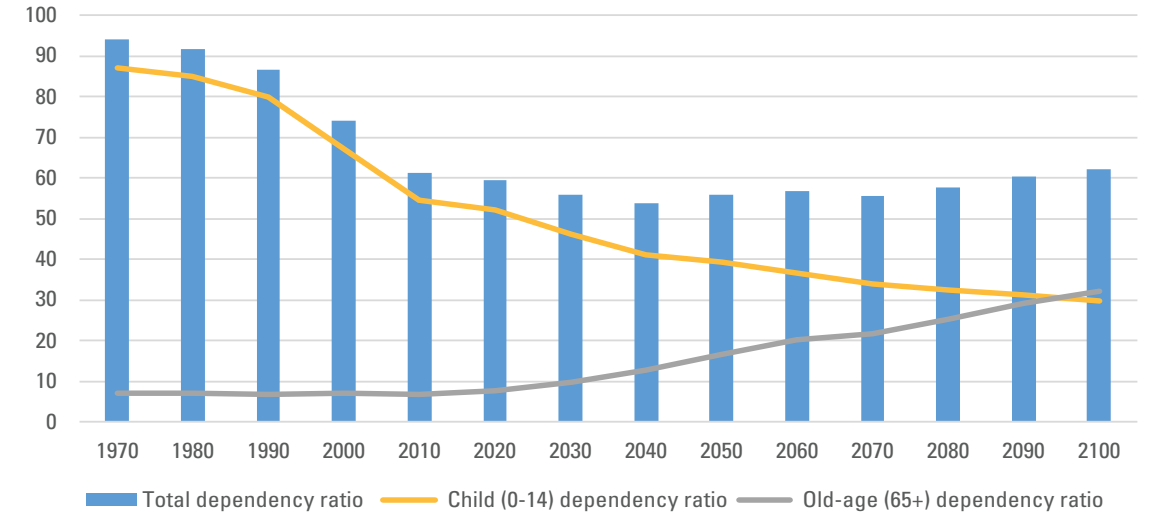


Source: ESCWA calculations based on data from DESA, 2019a.

The Arab region is relatively young, as there are approximately more than then times as many young people in the region than older persons today. But by 2050, this reality will change significantly as the number of older persons could make up around a quarter of the number of young people.[5]

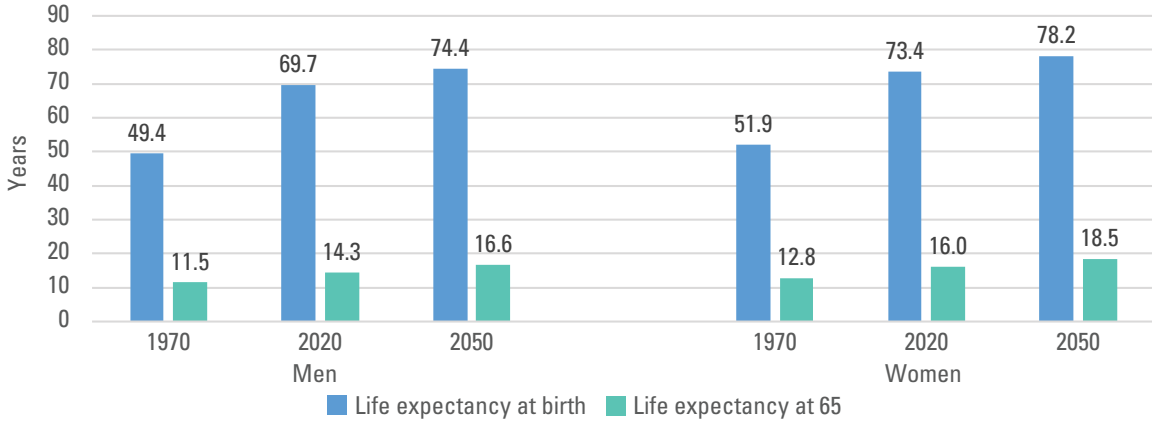
Examining the dependency ratios of older persons and children help shed further light on demographic shifts from another perspective. A high dependency ratio indicates that the economically active population and the overall economy face a greater burden to support and provide the social services needed by children and older persons who are often economically dependent. Figure 4 depicts the evolving dependency ratios as the demographic transition advances.

Figure 4. Dependency ratios in the Arab region (1970-2100)



Source: ESCWA calculations based on data from DESA, 2019a.

Figure 5. Life expectancy at birth and at age 65, by sex, in the Arab region (1970, 2020 and 2050)



Source: ESCWA calculations based on data from DESA, 2019a.

The decrease in dependency ratios, as a result of reduced fertility rates, indicates a demographic window of opportunity characterized by an increased proportion of working age population. During this period, societies could benefit from a higher number of producers relative to the number of consumers, thus constituting a demographic dividend that could be reaped before the dependency ratios increase again around 2045 due to the growing proportion of older persons.

2. This ageing trend is the combined result of declining fertility and rising life expectancy

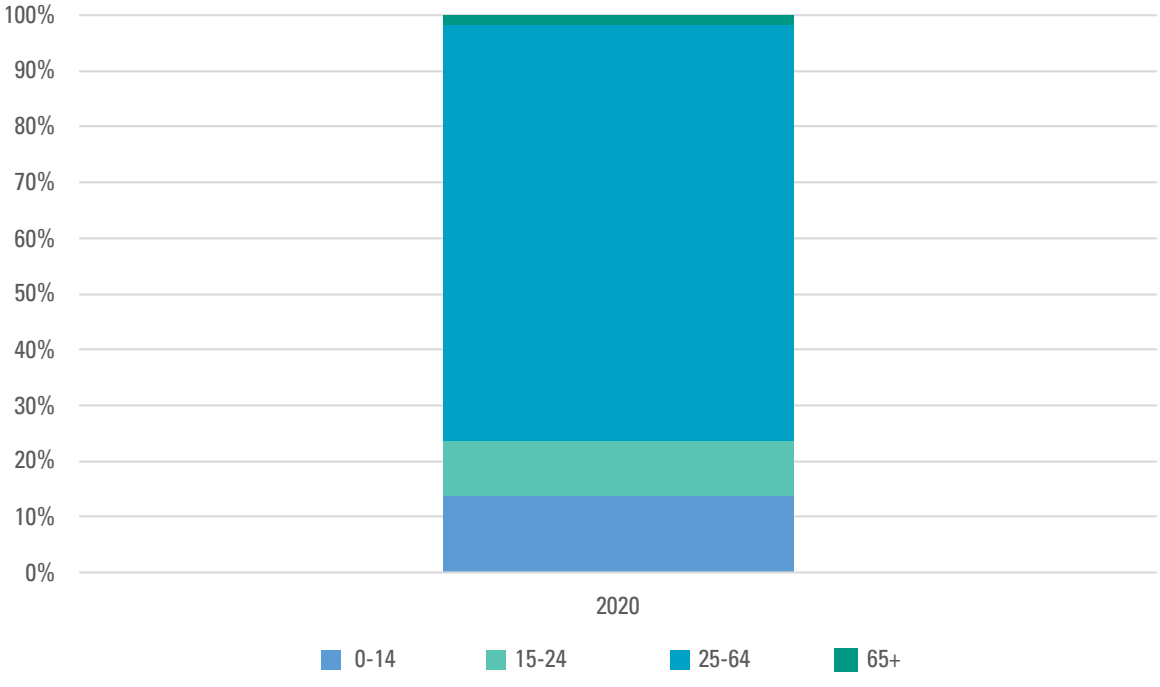
The average number of children per woman dropped from 7 in 1970 to 3.3 in 2020 and is projected to further decrease to 2.5 by 2050.[6] At the same time, the average number of years a 65-year-old man in the Arab region could expect to live increased from 11.5 years in 1970 to 14.3 years in 2020. Arab women's life expectancy at age 65 grew even more significantly from 12.8 years in 1970 to 16 years in 2020. Figure 5 shows that this positive trend is projected to

continue and Arab men's life expectancy at age 65 could reach 16.6 years by 2050, while women's life expectancy at age 65 is projected to reach 18.5 years.[7]

3. Migration is a major determinant of population ageing

Migration is a major determinant of population ageing, particularly in the Arab region that continues to host increasing numbers of migrants and refugees. In 2020, Arab countries hosted around 41 million migrants and refugees, 15 per cent of the global total. Migration is particularly important in GCC countries, where migrants make up as much as 53 per cent of the population. Most migrants tend to be of working age and seldom remain beyond retirement age (figure 6). Therefore, their presence is stalling the ageing transition, which is expected to start in most GCC countries in the next 10 to 15 years. The increasing efforts to reduce dependency on migrant workers and nationalize the GCC labour force could therefore accelerate the pace of the transition.[8]

Figure 6. Age structure of migrants in GCC countries (2020)



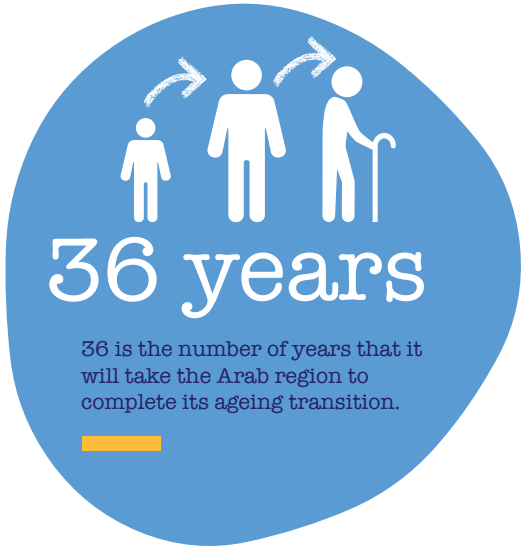
Source: ESCWA calculations based on data from DESA, 2020.

This dynamic is also relevant in non-GCC countries, especially those hosting high numbers of refugees. For example, the projections of Lebanon's ageing transition changed significantly over the past few years[9] given the high influx of Syrian refugees and their higher fertility rates, which delayed the onset of the ageing transition. In addition to impacting demographics in the host country, the countries of origin) can also have their age compositions greatly affected by sudden outflows of their population due to conflict and instability.

4. Countries in the Arab region are not ageing at the same pace, but most Arab countries will begin their ageing transition in the next two decades.

The 'ageing transition' is calculated based on the proportion of persons in a population aged 65 and above, which is in line with demographic research methodologies on population projections.
A population is defined as 'ageing' when the share of persons aged 65 and above is between 7 per cent

and 14 per cent of the total population. The 'ageing transition' refers to the period in which the share of older persons shifts from 7 per cent to 14 per cent.

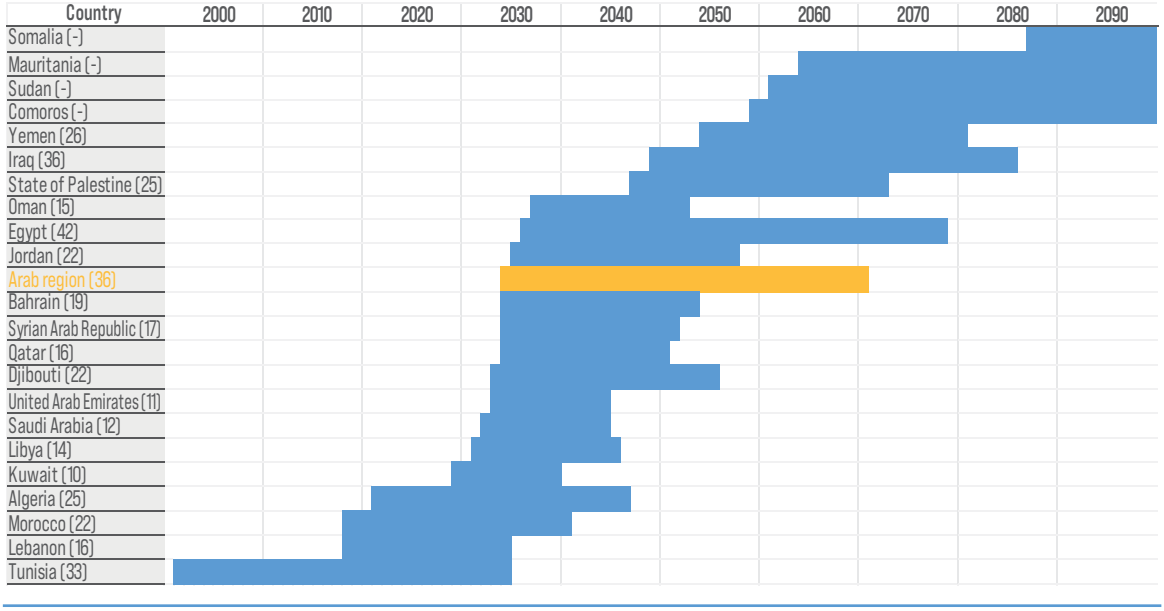


The Arab region is ageing much faster than regions that experienced this phenomenon before. For example, the ageing transition in European countries lasted between 50 to 150 years while the average for the Arab region is estimated at 36 years (figure 7).

There is substantial variation in how long the ageing process will take across Arab countries. For example, the GCC countries are expected to age very rapidly, as the ageing transition is projected to last only 13 years in the GCC subregion.[10] This can partly be explained by the aforementioned important role played by migrants in the demographic composition of GCC countries. The projected pace of ageing ranges from 10 years in Kuwait to 42 years in Egypt.

The Arab region is projected to start its ageing transition in 2034. Yet, there is considerable variation in the timing and pace of ageing across the region. One group of countries (Tunisia, Lebanon, Morocco and Algeria) have already begun their ageing transition. The majority of Arab countries will begin their ageing transitions in the 2030s. Meanwhile, five Arab countries (Yemen, the Comoros, the Sudan, Mauritania and Somalia) are only expected to enter the ageing transition in the second half of the 21st century.

Figure 7. Ageing transitions in Arab countries (2000-2100)



Source: ESCWA calculations based on data from DESA, 2019a.

Note: The estimated duration of the ageing transition is shown in brackets. The starting year of the ageing transition is the year the proportion of older persons reaches 7.0 per cent, rounded to one decimal place. If the share is above this (i.e. 7.05 or above), the preceding year is used as the starting date.

D. The socioeconomic situation of older persons in the Arab region

Population ageing carries important economic and social implications for Arab countries and societies. Social protection, adequate housing, quality and accessible health care and education are all important prerequisites for ageing with dignity, however significant gaps exist in Arab countries in these areas.

1. Non-inclusive social protection puts older persons at risk of being left behind

The right of older persons to income security is enshrined in human rights charters and international labour standards as well as international agreements such as MIPAA. The COVID-19 pandemic has highlighted the inadequacies of current social protection systems and reiterated the case for serious structural reform.[11] One way to guarantee income security is through an adequate pension, yet this right is still unfulfilled in the Arab countries. In most Arab countries for which data is available, only military personnel and workers in the public sector and the formal private sector are entitled to social security benefits.[12] On average, only 38 per cent of older persons above retirement age received a pension in the Arab region in 2020.[13] Even among those who are covered, they may not receive an adequate income to guarantee them a dignified life. This will be further discussed in chapter 2.

2. The trend of population ageing in the Arab region coincides with an important shift in the living arrangements of older persons

Over the last 30 years, the percentage of older persons who live with a child or a young person (below 20) has fallen sharply in several Arab countries. At the same time, the percentage of older persons living alone or only with a spouse has risen considerably.[14]

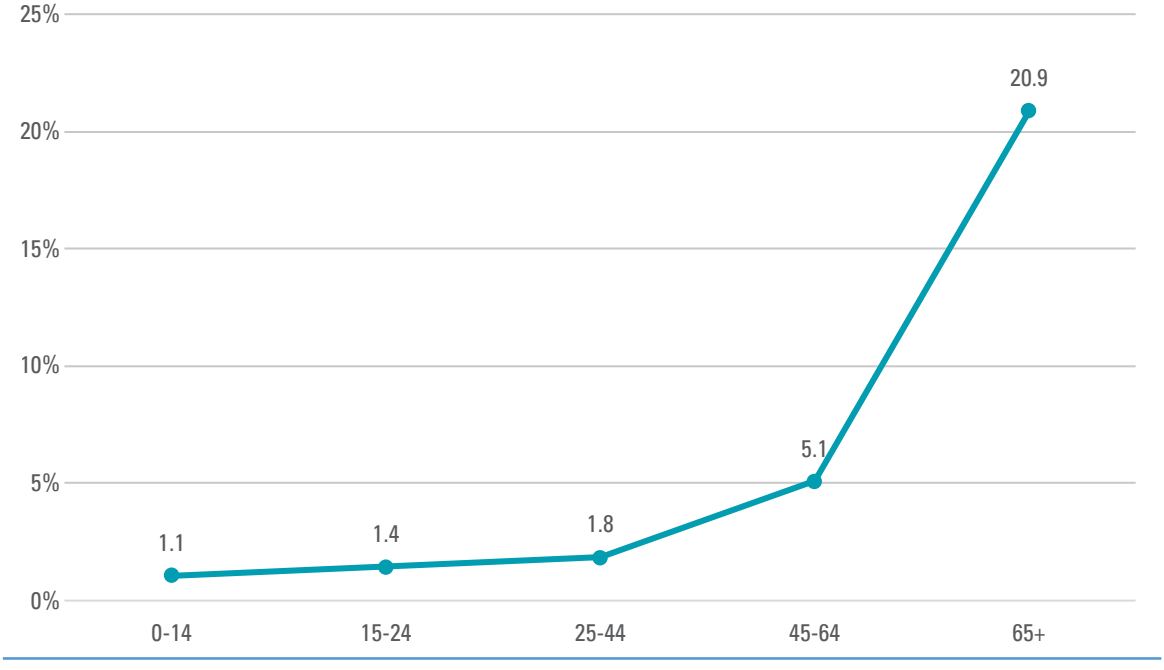
In countries where data is available, gender variation exists in older persons' living arrangements.[15] In Egypt, the latest data available from 2014 shows that 26.6 per cent of older women are living alone compared to 16 per cent living in a couple. By comparison, older men are more likely to be living in a couple (36 per cent) compared to living alone (7.4 per cent). This pattern holds among the older age group (80 and above) as well, within which 26.7 per cent of women are living alone compared to 12.3 per cent of men. Similarly, in Jordan, data from 2017 reveal that while 19 per cent of females aged 80 and above live alone, only 4.5 per cent of males aged 80 and above live alone.

The mortality data from the COVID-19 pandemic suggests a link between living arrangements and susceptibility to mortality risk. Indeed, global findings identify older persons who either live alone or in an institution to be at higher risk from death due to the pandemic compared to older persons living with a spouse or family member.[16] While this link may not be strictly causal it demonstrates the importance of older persons' living arrangements on their health and well-being.

3. Old age is generally correlated with a higher prevalence of disability

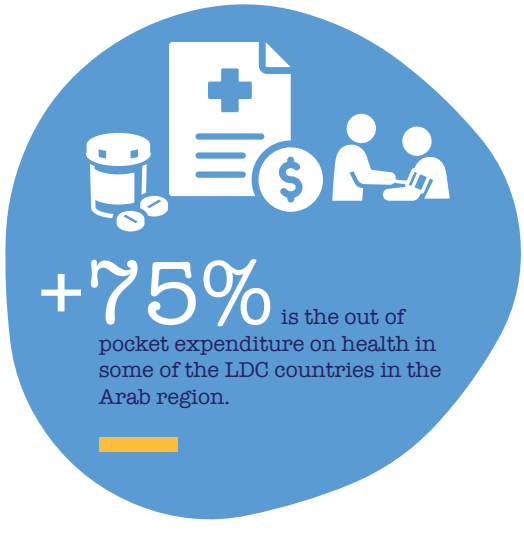
Figure 8 shows the disability prevalence rate by age group at the regional level. In the Arab region, the disability prevalence rate among the population aged 0-64 is below 5 per cent in every country where data is available, while it is consistently significantly higher in the 65+ age group, reaching up to 31 per cent.[17]

Figure 8. Disability prevalence by age group in the Arab region



Source: ESCWA, Disability in the Arab Region 2018.

At the same time, persons with disabilities are more likely to face unaffordable health expenditures, making them particularly vulnerable to diseases and compounding their risk of falling into poverty.[18] Based on data from WHO, out of pocket expenditure as a percentage of total health expenditures varies among Arab countries from as low as less than 7 per cent in Oman (5.78 per cent) and Qatar (6.86 per cent) to more than 70 per cent in the Sudan (75.52 per cent) and Yemen (76.42 per cent).[19] While these figures reflect the expenditures incurred by the general population, it is expected that such expenditures will constitute a compounded burden on older persons given the absence of adequate income security.

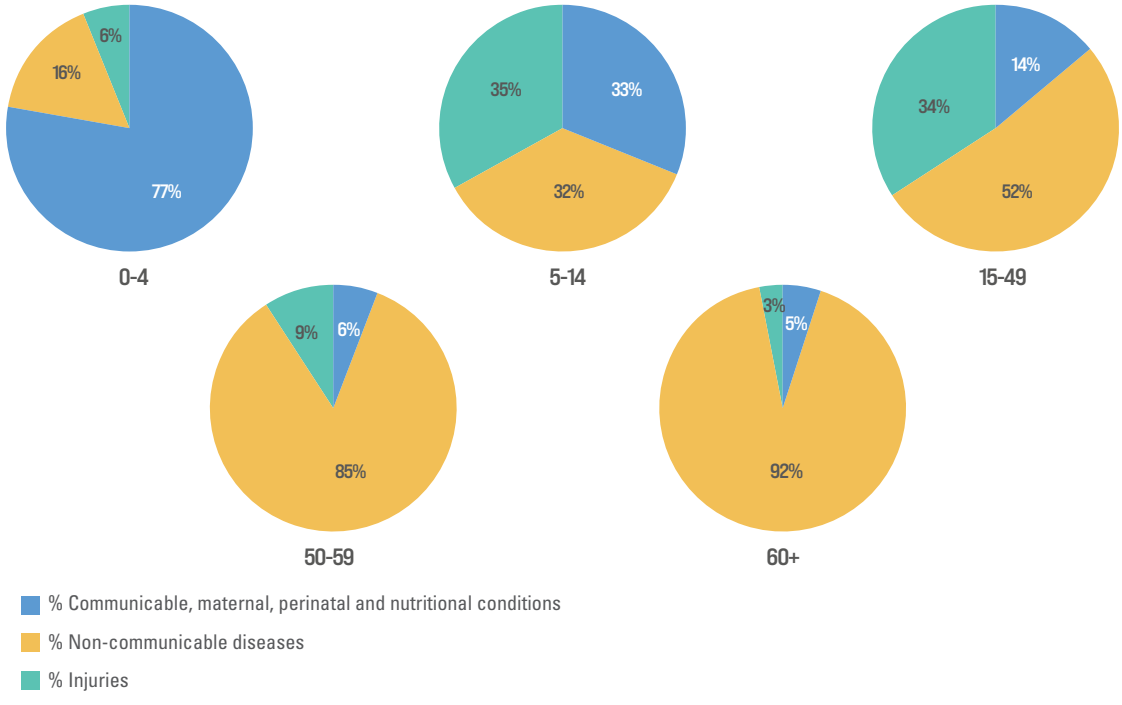


4. Non-communicable diseases are the leading cause of death among older persons in the Arab region

The main causes of death vary considerably across the lifecycle as figure 9 shows. Non-communicable diseases (NCDs) are increasingly the leading cause of death as people age, with a marked jump from 52 per cent in the 15-49 age group to 85 per cent in the 50-59 age group.

Indeed, NCDs appear among the ten top causes of death in all Arab countries.[20] WHO[21] estimates that in 2019 more than 3 million persons aged 60 and above died from non-communicable diseases,

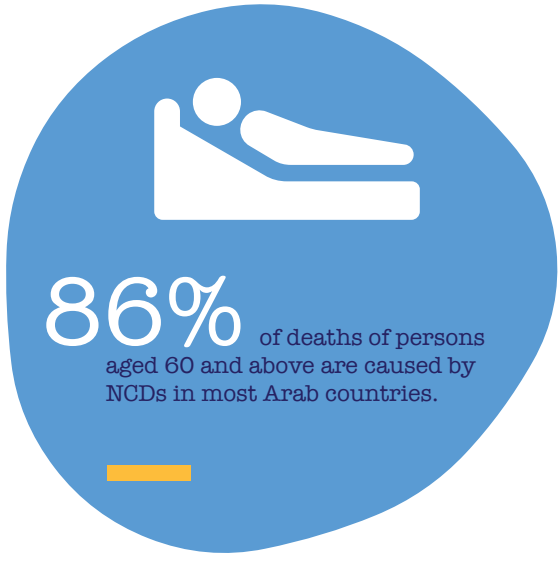
Figure 9. Cause of death as a percentage of all deaths, both sexes, in the Arab region (2019)



Sources: ESCWA calculations based on data from WHO, 2020. Global Health Estimates 2019: Deaths by Cause, Age, Sex, by Country and by Region, 2000-2019. Note: Data on the State of Palestine was not available.

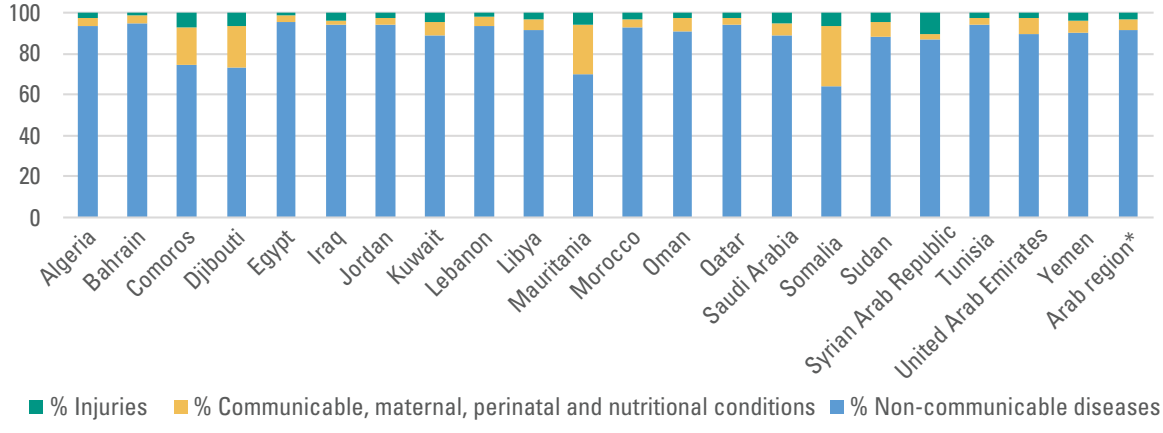
Note: Data on the State of Palestine was not available.

76 per cent of whom were between 60 and 69.[22] For persons aged 60-69 and those 70 and above, deaths from non-communicable diseases constitute more than 85 per cent of all deaths in most Arab countries except for the Comoros, Djibouti, Mauritania and Somalia, where communicable diseases are responsible for more than 25 per cent of deaths in both age groups (figure 10).The four main non-communicable diseases affecting older persons in the Arab region are cardiovascular diseases (including heart attacks and strokes), cancer (referred to as malignant neoplasms), chronic respiratory diseases (such as chronic obstructed pulmonary disease and asthma) and diabetes. Among these, cardiovascular diseases are the major cause of death in all Arab countries where data is available. It is worth mentioning that diabetes constitutes more than 15 per cent of deaths in Bahrain and Qatar among people aged 70 and above. Among the 60-69 age group, this number ranges from around 10 per cent in the United Arab Emirates, Oman and Qatar to as high as 22 per cent in Bahrain.



The COVID-19 pandemic further heightened the vulnerability of older persons in the Arab region.The mortality risk of COVID-19 increases with age, and older persons have a higher risk of suffering from acute symptoms and health complications.[23]

Figure 10. Cause of death as a percentage of total deaths for persons 60 years and above in Arab countries (2019)



Sources: ESCWA calculations based on data from WHO, 2020. Global Health Estimates 2019: Deaths by Cause, Age, Sex, by Country and by Region, 2000-2019.

Note: Data on the State of Palestine was not available.

5. The vulnerability and the risk of poverty of older persons is increased significantly by a lack of formal education

SDG 4 includes a call for lifelong learning opportunities for all, yet the Arab region is lagging in meeting the educational needs of older persons. Indeed, illiteracy among older persons above 65 is widespread in the Arab region. Figure 11 shows the illiteracy rates of older persons across 14 Arab countries. Among the 14 Arab countries for which data is present from 2017 onwards, at least two in every three older persons are illiterate in six Arab countries: The Comoros, Mauritania, the Sudan, Egypt, Algeria and Morocco.[24]

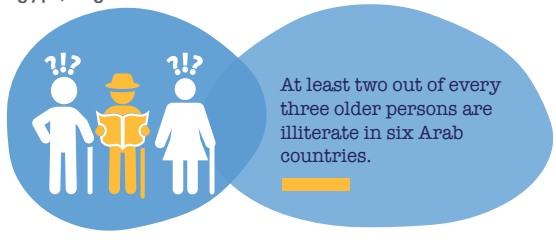
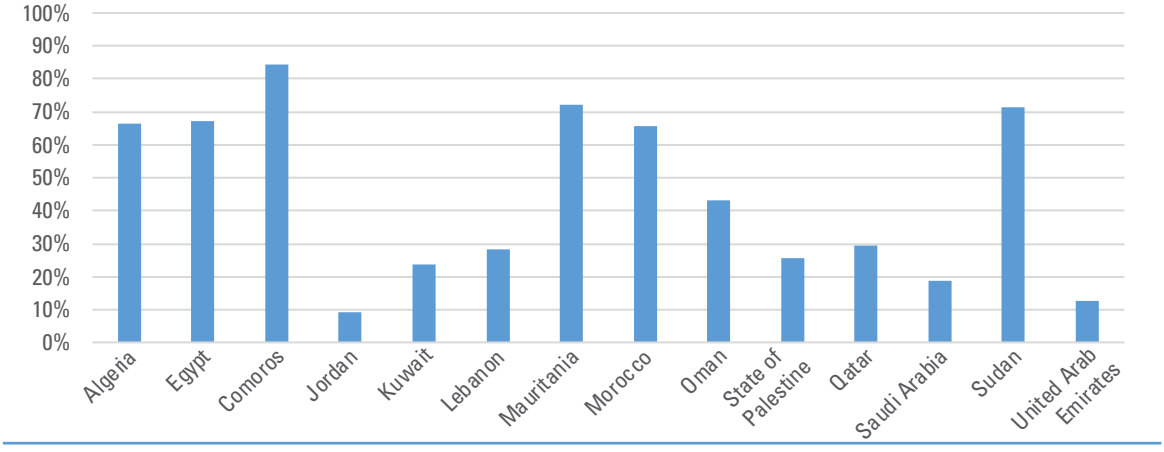


Figure 11. Illiteracy rates among older persons in selected Arab countries (2020 or latest year available)



Sources: UNESCO, 2021a.

Note: The data is taken from 2017 for Egypt, Mauritania and Qatar; 2018 for Algeria, the Comoros, Jordan, Lebanon, Morocco, Oman and the Sudan; 2019 for the United Arab Emirates; 2020 for Kuwait, the State of Palestine and Saudi Arabia.

Illiteracy particularly affects older rural women, of whom only less than 10 per cent are literate in some Arab countries.[25] Illiteracy has many ramifications, including increased financial vulnerability and limited access to health services and social support. Additionally, older persons tend to have lower rates of access to technology and digital literacy,[26] which limits their access to information in a growingly digitized world. It also limits their potential to benefit from new technologies and innovation.

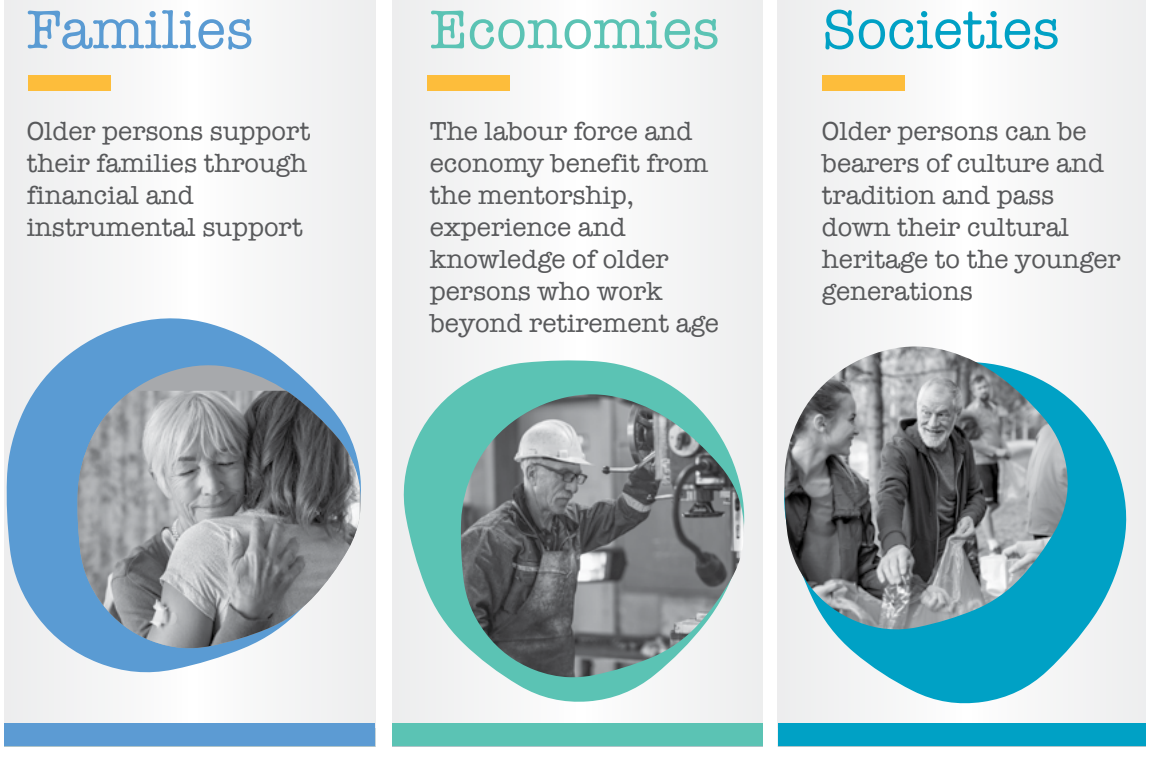
A UNESCO review of trends in adult learning and education in Arab States found that adult literacy programmes are increasingly common across the region.[27] Yet, other important areas of learning for older persons such as continuing education and professional development may be overlooked.

6. Older persons' contributions are often overlooked, and they are subject to ageism

Older persons enrich their families, economies, and societies but their contributions are often overlooked or underappreciated. Despite the strong tradition in the region for families to care for older persons, there also continue to be negative stereotypes portraying them as dependents and without lack agency and capacity.

Older persons support their families through financial and instrumental support such as taking care of grandchildren and other older adults and helping with domestic chores. Many older persons continue to work beyond retirement age and have a wealth of knowledge and experience that they transfer to the younger cohorts and enrich the workplace including in education, medicine, media and artisanal professions, among others. Older persons can also play an active role in the transmission of the tangible and intangible cultural heritage to the younger generations.[28]

A shift in mindset to a more progressive one that recognizes the social and economic contributions of older persons is critical to break the negative stereotypes and combat ageism. While there is no definitive data on ageism in the region, global data suggests that one in two people holds ageist attitudes towards older persons and it is likely that these rates are even higher in low-and lower-middle-income countries.[29]



The ongoing demographic transition in the Arab region and the recent COVID-19 pandemic have accentuated the need for inclusive persons social protection systems that cover the entire life cycle.

Older women are more excluded: the male pension coverage rate can be five times higher than the female coverage rate in some countries.

In many Arab countries, the sustainability of contributory pension schemes is imperilled as the proportion of beneficiaries increases relative to the population.

There is considerable inequality among older persons receiving contributory pensions, with a large number receiving very small amounts.

The value of cash transfers in many countries is low and has been further eroded by inflation.

Older persons are in many countries legally covered by contributory or non-contributory health care regimes. However, legal coverage often fails to translate into effective coverage.

2 Social protection for older persons in the Arab region

A. Introduction

As the previous chapter showed, the Arab region faces a demographic transition as the population ages. Consequently, provision of social protection to older persons is becoming increasingly critical. In some contexts, this is further accentuated by changing household compositions – since a larger proportion of older persons now live on their own rather than with their children or grandchildren – and by the partial disappearance of traditional and more informal solidarity structures. Smaller families also mean that there are less children to support their ageing parents. The COVID-19 crisis has further underlined the importance of comprehensive social protection systems covering the entire life cycle.

Ensuring that older persons enjoy income security and have access to health care has historically been a key purpose of social protection. The obligation to fulfil this objective is explicitly enshrined in several major international treaties, declarations and recommendations. For instance, the Universal Declaration of Human Rights affirms "the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood […]." Ensuring inclusive social protection is also critical for achieving the 2030 Agenda Sustainable Development Goals and delivering on the promise to leave no one behind.

For practical purposes, social protection is defined as a set of public policies and programmes intended to ensure an adequate standard of living and access to health care throughout the life cycle. This definition thus excludes many components of long-term care (LTC) that are further discussed in the next chapter.

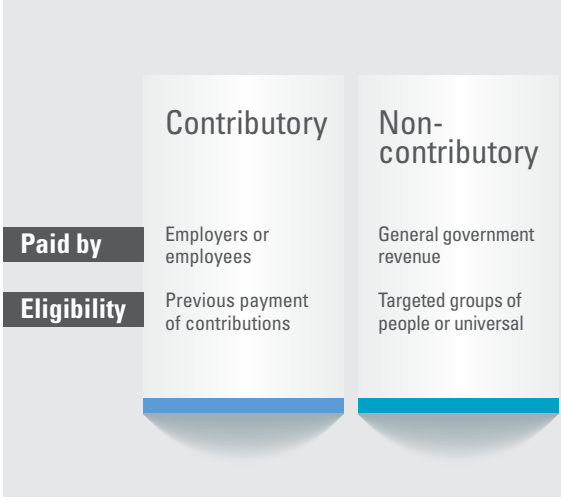
SDG 1.3

urges countries to "implement nationally appropriate social protection systems and measures for all, including floors, and by 2030 achieve substantial coverage of the poor and the vulnerable".

Social protection may be divided into contributory and non-contributory mechanisms providing income security and access to health care (figure 12). Contributory mechanisms are in principle financed through contributions paid by employers and employees. Eligibility is based on previous payment of contributions, meaning in practice that workers in the informal economy tend to be excluded from coverage. Non-contributory social protection mechanisms, on the other hand, are financed by general government revenue. Eligibility is either limited to selected groups of the population (for instance, the poor or persons with disabilities), meaning that the provision is targeted, or extended to the entire population, in which case the provision is universal.

Reflecting the regional diversity, social protection systems differ greatly from one Arab country to another. With the partial exception of Lebanon, all countries have in place contributory social insurance

Figure 12. Social protection mechanisms



schemes providing old-age pensions, but their degree of coverage varies enormously. The schemes are mainly financed on a pay-as-you-go basis, meaning that contributions are immediately used to finance pensions and other benefits. In practice, this entails that younger generations are paying for older generations.

The sustainability of many social insurance schemes in the Arab region today is in question. This is largely due to a combination of rapidly ageing populations and widespread economic informality, implying a higher dependency rate: the proportion of beneficiaries increases relative to the proportion of contributors. Adding to this, many pension schemes have relatively generous parameters, meaning that the retirement age is low and that pensions correspond to a large share of previous earnings. However, this does not mean that older persons covered by these pension schemes are necessarily well-off: there is a large degree of inequality among retirees, and many receive very small sums.

Non-contributory social assistance programmes also exist in all Arab countries, but their character and scope differ significantly. Recently, many countries have undertaken far-reaching reforms aiming to abolish general subsidies (especially on energy products such as fuel) and to replace these with more targeted forms of social assistance, such as cash transfer programmes.[30] The extent to which those programmes cover older persons varies depending on their eligibility criteria, as does the value of the benefits they provide.

Health care coverage is provided through a combination of contributory and non-contributory mechanisms. While older persons in some countries are disproportionately likely to be covered by health insurance schemes, this does not always in practice mean that they have access to adequate and affordable health care services. Meanwhile, their health care needs are often greater than those of the working-age population.

This chapter begins with an overview of social protection coverage among older persons in the region, looking in turn at overall coverage of older persons in social protection systems, as well as their inclusion in specific pension schemes. The chapter pays special attention to the inclusion of older women. It then turns to the issue of adequacy, again focusing first on social insurance before proceeding to social assistance. Thereafter, a separate section highlights the issue of health care. Lastly, a concluding section discusses the way forward.

The chapter is based on desk research in large part relying on administrative data reported by national bodies such as social insurance organizations and ministries. Detailed data relating to social insurance schemes have been found and analysed for five Arab countries: Tunisia, Morocco, Jordan, Kuwait and Bahrain. These data have as far as possible been harmonized to allow for a higher degree of comparability. The chapter also includes data from international organizations, notably ESCWA and ILO, as well as from surveys and other sources. For a detailed explanation of these data and of how they have been used, see annex 1.

B. Overall social protection coverage

Before delving into the discussion on estimating overall social protection coverage it is important to be mindful of some of the limitations that impact the ability to accurately assess social protection coverage. Some of the limitations include:

- **Difference between legal and effective coverage:** When discussing social protection coverage, whether for older persons or for any other group, it is essential to distinguish between legal coverage and effective coverage. Legal coverage refers to the part of the population who should be covered by social protection according to the legal framework in place. Effective coverage refers to the proportion of the population who are in fact covered. For instance, if legal coverage measures the population eligible to receive cash benefits, effective coverage measures the population that receive such benefits. For this chapter, coverage should unless otherwise stated be understood as meaning effective coverage.
- **Diversity of contributory as well as non-contributory schemes in one country:** There are often separate pension schemes for private and public sector workers as well as for the military. Countries generally have several social assistance programmes providing cash transfers and other benefits. While beneficiary data may be available for one or a few of the social protection schemes in a country, it can rarely be found for all of them, which complicates the task of calculating overall coverage rates. Even if beneficiary data were available for all social protection schemes in a country, accurately inducing the overall coverage rate would require knowing the extent of overlap between the schemes.[31] Thus, simply adding together the number of beneficiaries from each separate social protection scheme would generate an inflated overall coverage rate.[32]
- **Adequacy of the coverage:** Estimating effective social protection coverage is complicated by the more fundamental question of what "being covered" actually means to start with. For instance, some benefits provided through pensions or social assistance schemes may be set at such low a level that they do not come close to ensure an adequate standard of living. It is doubtful whether recipients of such benefits are in fact "covered" in any meaningful way. Thus, the question of coverage is interrelated with the one of adequacy.

1. Social protection coverage in the Arab Region

a. Overall coverage

Despite the above limitations, there have been significant efforts in recent years to calculate social protection coverage, including the proportion of older persons who receive a pension,[33] as part of efforts to measure progress on achieving the SDGs.[34]

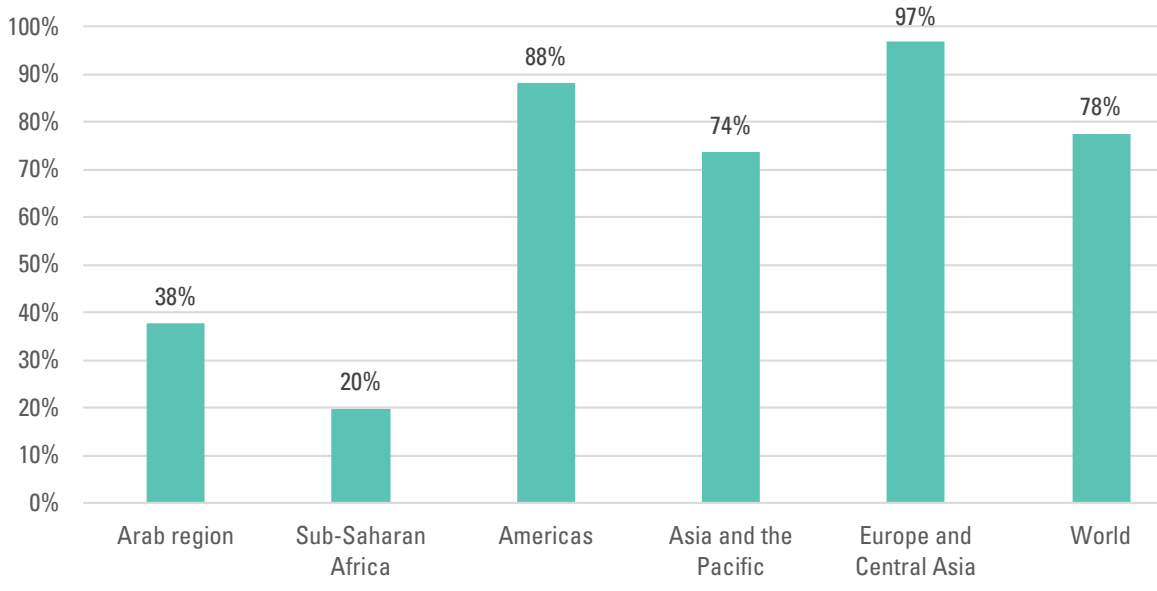
A very small proportion of older persons in the region receive a pension

The proportion of older persons (60 and above) receiving a pension in the region is the second lowest in the world, at a mere 38 per cent or half the world average (78 per cent). It is considerably lower than in the Americas (88 per cent), Asia and the Pacific (74 per cent) and Europe and Central Asia (97 per cent), and only higher than in Sub-Saharan Africa (20 per cent) (figure 13).[35]

In only one Arab country does the coverage rate exceed the world average, with 85 per cent of older persons in Tunisia receiving a pension. Meanwhile, 70 per cent of older persons do not receive a pension in 10 Arab countries, namely Yemen, the Sudan, Lebanon, Mauritania, the Syrian Arab Republic, Iraq, Qatar, the United Arab Emirates, Morocco and Kuwait (figure 14).

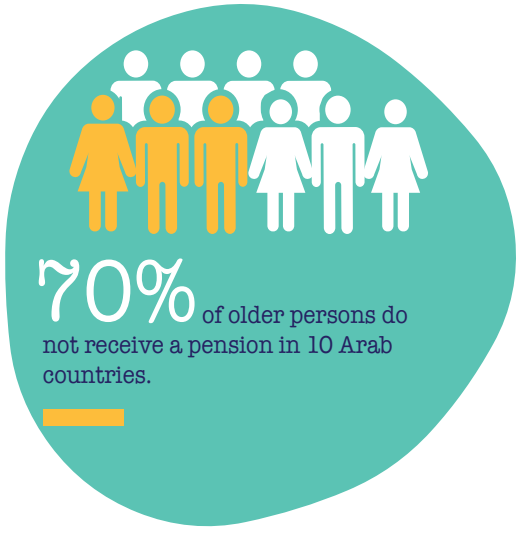
One surprising finding when examining the data for Arab countries is that contrary to what would generally be expected, pension coverage among older persons in the Arab region is negatively correlated with GDP per capita (figure 15). This is mainly due to the very low level of coverage in the GCC countries, except for Bahrain.

Figure 13. Proportion of older persons receiving a pension by region (Latest year available)



Sources: ESCWA Data Portal; ILO, 2021a; DESA, n.d.

Note: The average for the Arab region is an estimate – see the technical annex 1 for more information.

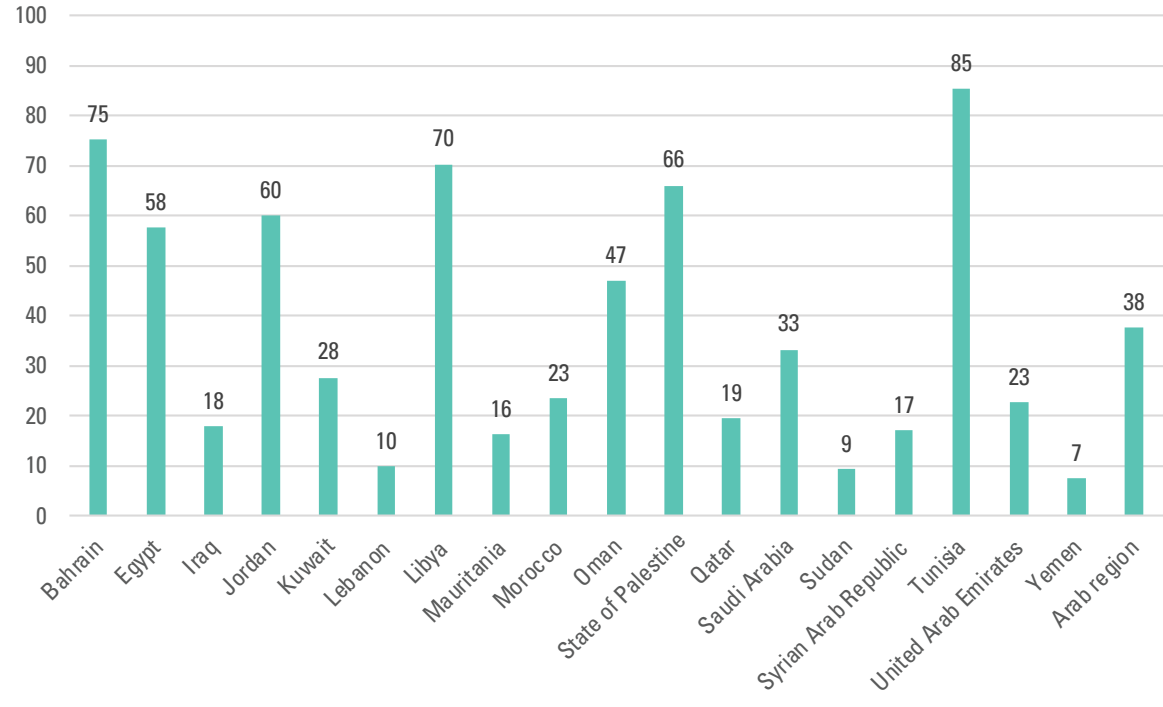


However, removing the GCC countries (figure 16) generates a pattern more in line with the global one, meaning that GDP per capita is positively correlated with the proportion of older persons receiving a pension. Yet, this positive correlation is still relatively weak, in large part due the fact that Lebanon – similarly to the GCC countries – has a much lower coverage rate than might be expected from its GDP per capita.[36] Unlike other countries in the region, Lebanon does not have a regular social insurance scheme covering the private sector. Workers covered by the National Social Security Fund merely receive a lump-sum payment upon retirement.[37]

b. Inclusion in specific social protections schemes

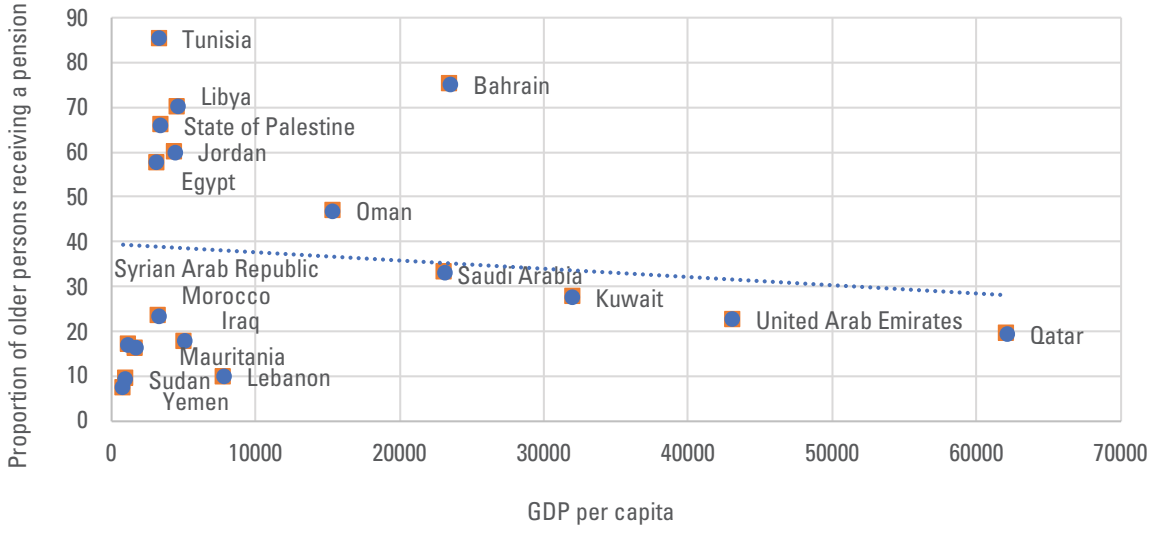
Given the limitations of the data on overall social protection coverage of older persons presented above, this section zooms in on the inclusion of older persons in specific social protection schemes and programmes. While the administrative data used in this section generally cannot be used to draw conclusions about the proportion of older persons covered by contributory or non-contributory social protection, it often has the advantage of being detailed, allowing for more in-depth analysis. Since it is often published on a regular basis, such data also makes it possible to study developments over time.

Figure 14. Proportion of older persons in Arab countries receiving a pension (Latest year available)



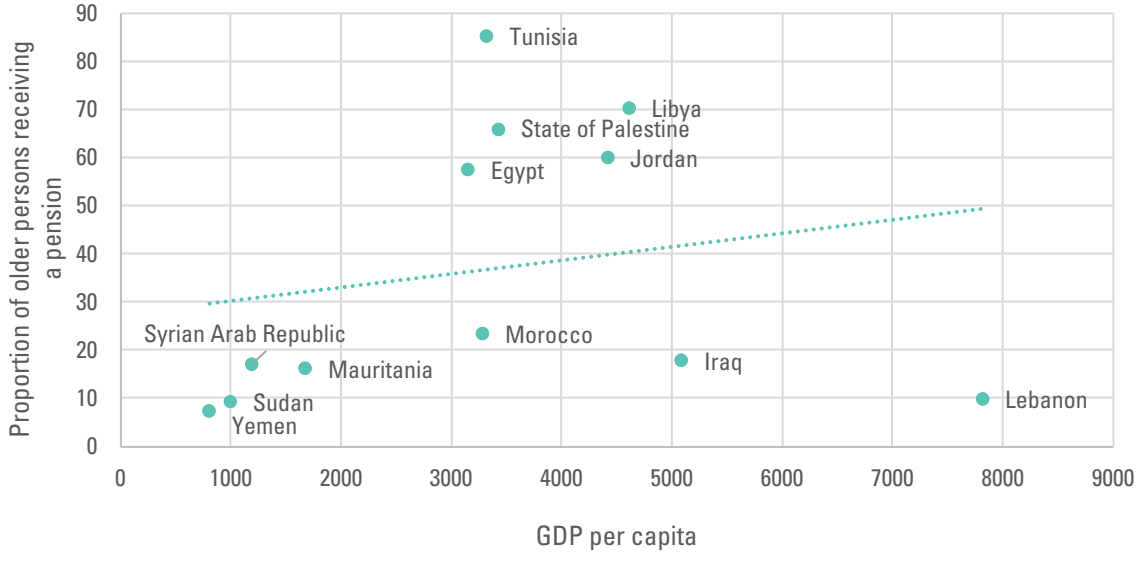
Sources: ESCWA Data Portal; ILO, 2021a. In case of variation between these two sources, data from the ILO World Social Protection Report has been used.

Figure 15. Arab countries by proportion of older persons receiving a pension and GDP per capita (Latest year available)



Sources: ESCWA Data Portal; ILO, 2021b..

Figure 16. Arab countries (excluding GCC) by proportion of older persons receiving a pension and GDP per capita (Latest year available)



Sources: ESCWA Data Portal; ILO, 2021b.

The number of old-age pensioners covered by select social insurance schemes in the region has increased

An initial analysis of administrative data shows an increase over time of the number of old-age pensioners covered by select social insurance schemes in the region (figure 17),[38] namely the Caisse Nationale de Sécurité Sociale (CNSS) in **Tunisia** (covering the private sector), the CNSS in **Morocco** (private sector), the Social Security Corporation (SSC) in **Jordan** (public and private sectors), the Public Institution for Social Security (PIFSS) in **Kuwait** (public and private sectors) and the Social Insurance Organization (SIO) in **Bahrain** (public and private sectors).

In the case of the Tunisian CNSS, the number of old-age pensioners has more than tripled during the last two decades: from 172,162 in 2000 to 549,477 in 2019. Meanwhile, the number of old-age pensioners covered by the Moroccan CNSS increased from approximately 292,800 in 2010 to 413,717 in 2019, and those covered by the CSS in Jordan from 41,335 in 2009 to 74,438 in 2020. In the two Gulf countries, the number of old-age pensioners also increased very rapidly: from 17,578 in 2007 to 43,955 for the PIFSS in Kuwait, and from 11,280 in 2011 to 28,838 in 2021 for the SIO in Bahrain.

2. Social protection coverage for older women

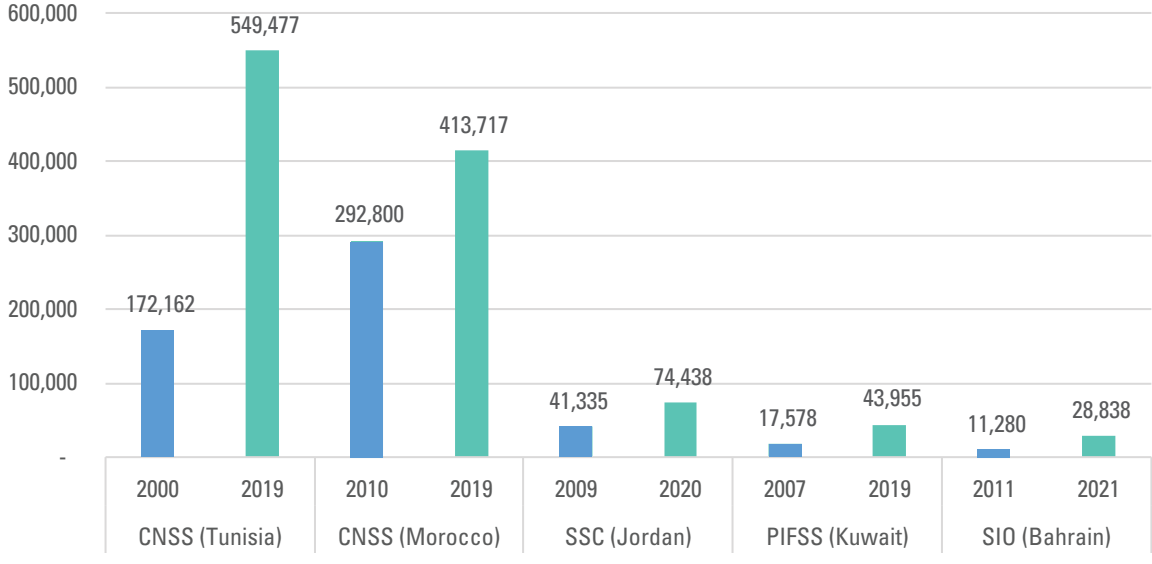
a. Overall coverage for older women

Today, the vast majority of older women are excluded from the coverage of social protection systems, largely due to their low participation in the labour market for the past several decades, as well as their likelihood to work in the informal economy in some countries.

Male pension coverage rate can be five times higher than female coverage rate in some countries

The lack of data on overall coverage disaggregated by gender in the Arab region continues to be a significant limitation for a deeper understanding of the exclusion of older women from social protection coverage. In the few Arab countries where data are available and accessible, namely Tunisia, Jordan and Qatar, older men are considerably more likely than older women to receive a pension, as shown by figure 18. The discrepancy is most pronounced in Tunisia, where the male coverage rate (94 per cent) is more than five times higher than the female rate (17.3 per cent).

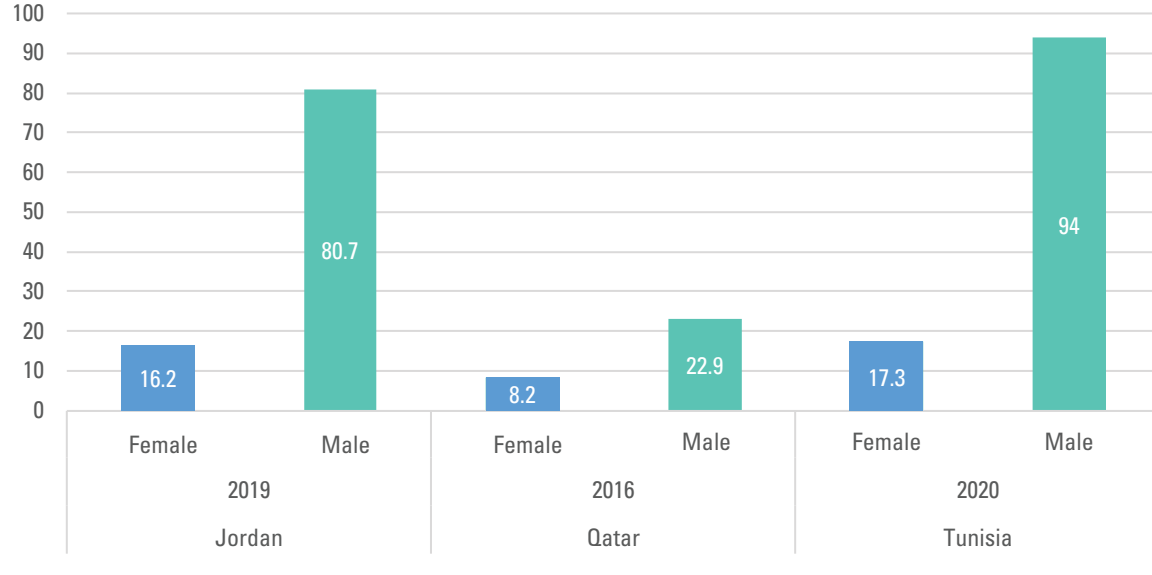
Figure 17. Number of old-age pensioners covered by various social insurance schemes in select Arab countries (Earliest and latest years available)



Sources: Tunisia, Caisse Nationale de Sécurité Sociale, (Annuaire Statistique 2017, 2021); Morocco, Caisse Nationale de Sécurité Sociale (Rapport Annuel 2010, 2019); Jordan, Social Security Corporation (Annual Report 2009), World Bank (Jordan Public Expenditure Review: Pension, n.d.); Kuwait, Public Institution for Social Security (Annual Statistical Collection 2007, 2019); Bahrain, Social Insurance Organization (Statistical Report 2011, 2021).

Note: Data for Morocco 2010 is approximate. The data for the PIFSS (Kuwait) does not include the military scheme.

Figure 18. Proportion of older persons receiving a pension, disaggregated by sex in select Arab countries (Latest year available)



Sources: ESCWA Data Portal.

b. Inclusion of older women in specific social protection schemes

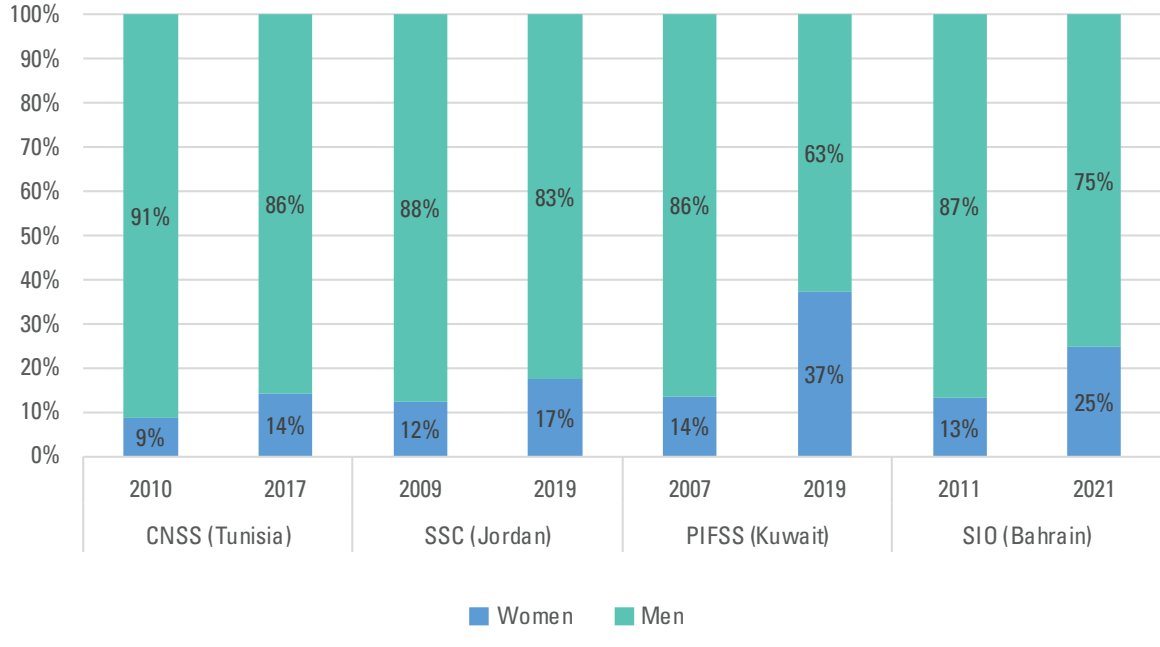
However, there is a noticeable change underway. Although the proportion of women among older persons covered by pension schemes is very small, this proportion is steadily increasing and is expected to continue to grow in the coming years (figure 19).

This trend is largely a consequence of the increasing level of female labour market participation in the last five decades or so, and in some cases the transition of women from the informal to the formal economy during this period.

In Tunisia, the proportion of women among CNSS old-age pensioners went up from 9 per cent in 2010 to 14 per cent in 2017, while in Jordan the proportion of women among SSC old-age pensioners increased from 12 per cent in 2009 to 17 per cent in 2019. With regard to the PIFSS in Kuwait, the share of women among old-age pension beneficiaries increased from merely 14 per cent in 2007 to 37 per cent in 2019. In Bahrain meanwhile, the female proportion of SIO old-age pensioners increased from 13 per cent in 2011 to 25 per cent in 2021.

Figure 20 gives a more detailed overview of the development with regard to the SSC in Jordan. In addition to the increasing share of women among old-age pensioners, the female proportion of new old-age pensioners increased from 17 to 31 per cent, and the female proportion of active contributors from 25 to 29 per cent. This suggests that the female proportion of old-age pensioners will continue to increase in the coming years. The same pattern can be found around the region: in Oman, for instance, the female proportion of old-age pensioners in 2019 (the latest year for which data are available) was only 20 per cent, but the female proportion of new old-age pensioners and of contributors were 28 per cent and 27 per cent respectively.

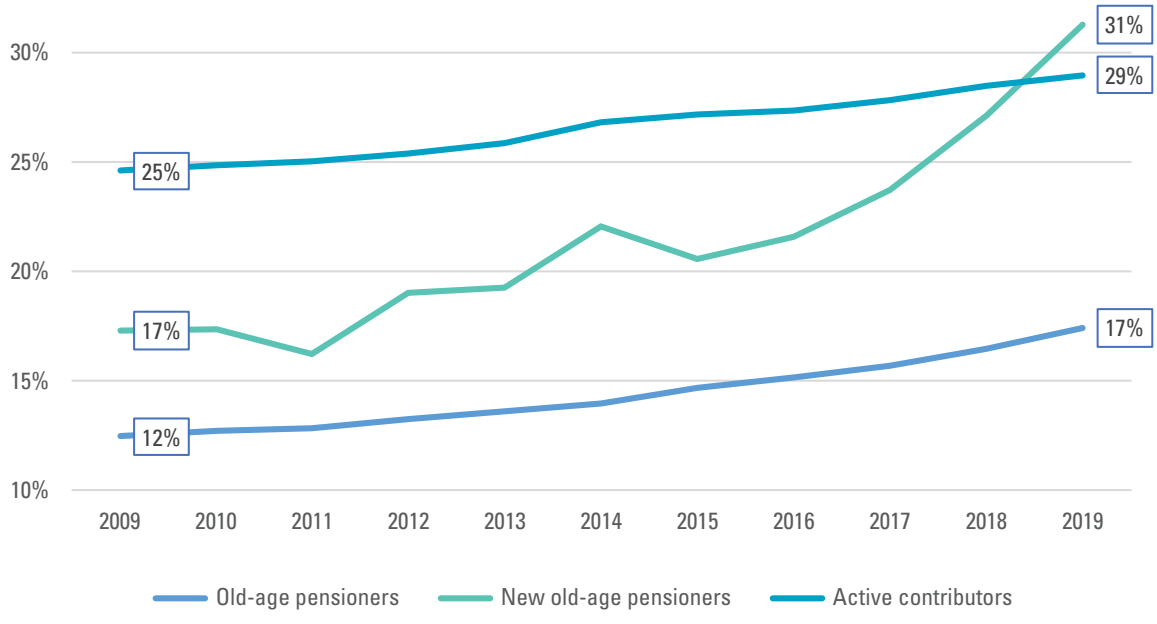
Figure 19. Gender distribution of old-age pensioners in select Arab countries (Earliest and latest years available)



Sources: Tunisia, Caisse Nationale de Sécurité Sociale (Annuaire Statistique 2017); Jordan, Social Security Corporation (Annual Report 2009, 2019); Kuwait, Public Institution for Social Security (Annual Statistical Collection 2007, 2019); Bahrain, Social Insurance Organization, (Statistical Report 2011, 2021).

Note: The data for the PIFSS (Kuwait) does not include the military scheme.

Figure 20. Women as proportion of SSC old-age pensioners, new old-age pensioners and active contributors in Jordan (2009-2019)



Sources: Jordan, Social Security Corporation (Annual Report 2009, 2010, 2011, 2012, 2013, 2014, 2016, 2017, 2018, 2019).

In a number of countries, women are particularly underrepresented among private sector old age pensioners. This is essentially a consequence of the female preference for employment in the public sector and/or their exclusion from the formal private sector. For instance, in Bahrain as of 2021, women make up 33 per cent of old-age beneficiaries covered by the ISO public sector scheme, but merely 16 per cent of those covered by the ISO private sector scheme.[39] However, this is nevertheless a much smaller difference than in 2011, when merely 4 per cent of private sector old-age beneficiaries (as compared to 21 per cent of public sector old age-age beneficiaries) were women.[40]

Inclusion of women in social protection schemes varies significantly across countries and within countries

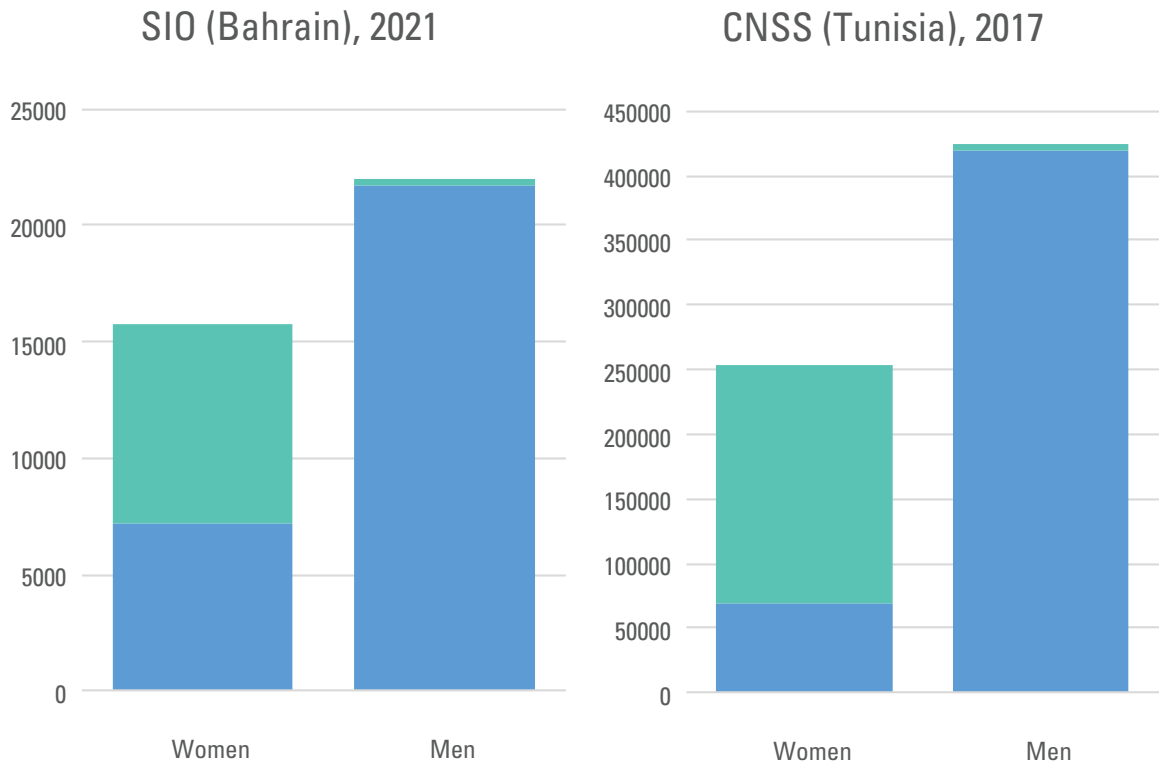
In addition to the variation across countries, it is important to note that the inclusion of women in social protection schemes vary even within countries based on socioeconomic strata and geographic location. In Tunisia, for instance, women as of 2017 represented 29 per cent of CNSS old-age pensioners in the Governorate of Monastir, but less than 4 per cent in the Governorates of Tatouine and Seliana.[41]

c. Survivor benefits

While the above discussion has focused on old-age pensions, it may be noted that many older women in Arab countries receive survivor benefits – in other words, benefits given to the widows, orphans or other relatives of deceased beneficiaries (figure 21).

In Bahrain, for instance, the number of older women receiving survivor benefits (8,577) is considerably higher than the number of older women receiving old-age pensions (7,169). Meanwhile, the number of men receiving survivor benefits is very limited (349). Consequently, the gender balance among older persons covered by the SIO is considerably greater when both old-age pensions and survivor benefits are considered (42 per cent women, 58 per cent men).

Figure 21. Number of older persons receiving old age pensions and survivor pensions in Bahrain and Tunisia, by sex (Latest year available)



Sources: Bahrain, Social Insurance Organization (2021); Tunisia, Caisse Nationale de Sécurité Sociale (n.d.).

In Tunisia, the number of women receiving survivor benefits (183,941) is fully 2.6 times higher than the number of women receiving old-age benefits (69,435), meaning that women make up around 37 per cent of the total population covered by either. However, as further discussed below, survivor benefits should not be seen as a substitute for old-age pensions, given that they tend to be much smaller.

3. Inclusion of older persons in social assistance programmes

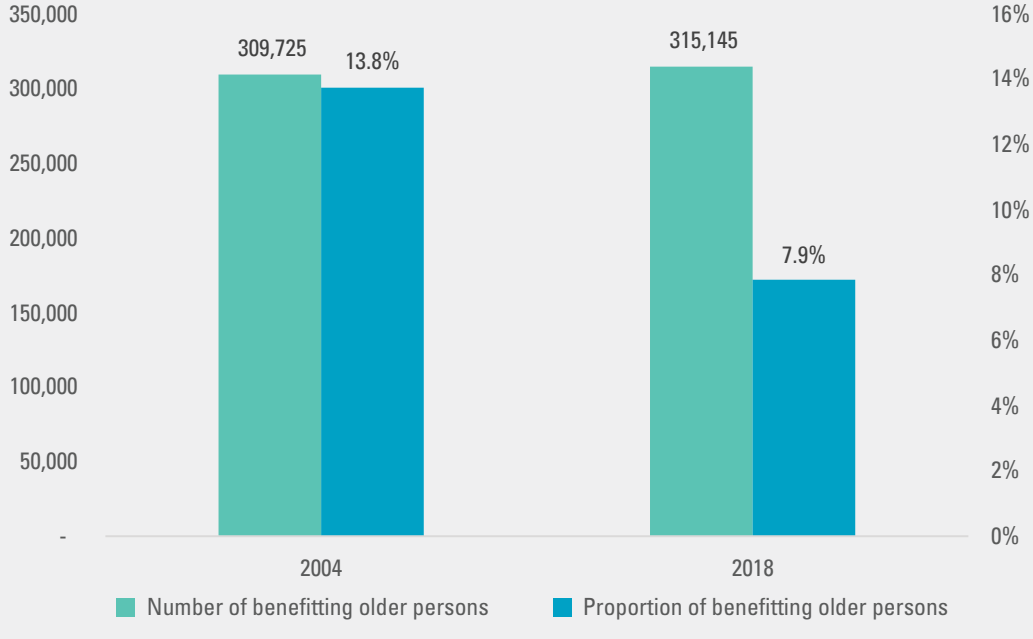
Countries often offer social assistance programmes as part of their social protection systems. These programmes provide monetary and in-kind benefits to vulnerable population groups. This section will look briefly into the inclusion of older persons in social assistance programmes in selected Arab countries where data is available: Algeria, Tunisia, Egypt and Jordan.

The extent to which older persons are covered depends in large part on the scope and the eligibility criteria of the programmes in place. These criteria can be specific and complex. Certain programmes target beneficiaries solely on the basis of demographic characteristics – meaning, for instance, that all older persons, all persons with disabilities or all households with disabilities are eligible, regardless of other factors. Other programmes take into account the poverty level of households or individuals. This is increasingly done through so called proxy means testing. Most programmes use a combination of different targeting approaches.[42]

Algeria. Despite the significant increase in the number of older persons, the proportion of older persons benefiting from social assistance has decreased

The Algerian social assistance scheme Allocation Forfaitaire de Solidarité (AFS), set up in 1994, is targeted at vulnerable older persons, persons with disabilities, families of children with disabilities and female heads of household. As of 2018, the programme had 962,710 beneficiaries, of whom 315,145 (171,958 women and 143,187 men) were older persons (figure below). Notably, the number of older persons covered by the programme has hardly increased since 2004 – when it was 309,725 (167,358 women and 142,367 men) – even though the total number of older persons in the country has almost doubled. Consequently, the proportion of older persons receiving AFS transfers decreased from 13.8 per cent in 2014 (14.3 per cent among women and 13.2 per cent among men) to 7.9 per cent in 2018 (8.5 per cent among older women and 7.2 per cent among older men).

Number and proportion of older persons benefitting from the AFS (2004 and 2018)



Sources: Algeria, 2010, p. 12; Eddine, 2018.

To capture the complexity and variation of inclusion of older persons in social assistance programmes across countries and in some instances within countries, this chapter relies on country case studies presented in boxes below. However, fully measuring the extent to which older persons are included in social assistance programmes is difficult. One main challenge is the ability to capture older persons that benefit indirectly from social assistance programmes, for example older persons that live in households that receive social assistance. However, changing household compositions – entailing a lower degree of inter-household co-habitation – could be expected to reduce the extent of indirect coverage.

Tunisia. Older persons are strongly represented in social assistance programmes

The Tunisian social assistance scheme Programme Nationale d'Assistance aux Familles Nécessiteux (PNAFN), set up in 1986, targets beneficiaries on the basis of various factors including self-reported revenue and incapacity to work. As of 2020 around 260,000 households were covered by the PNAFN. Although the programme is not explicitly targeted at older persons, they are strongly overrepresented among beneficiaries: As of 2016, the PNAFN coverage rate was 7 per cent among the overall population but 11.7 per cent among households aged 62 and above.

Egypt. A specific social assistance programme targets older persons and persons with disability

The Takaful and Karama programme in Egypt, set up in 2015, consists of two sub-programmes: Takaful, targeted at households with children, and Karama, targeted at vulnerable older persons and persons with disabilities. As of 2021, the Karama component had around 1.3 million beneficiaries of whom approximately a quarter (more than 300,000) were older persons. It is worth noting that there is a high possibility of overlap between persons with disability and older persons, given that people are more prone to disability as they age.

Jordan. Inclusion of older persons varies among different social assistance programmes

Almost a quarter of the 105,642 families benefitting from the monthly cash transfers provided by the National Aid Fund during 2020 were headed by older persons. On the other hand, older persons are strongly underrepresented among beneficiaries of the NAF programme Takaful, which was launched in 2019.

C. Adequacy of social protection systems for older persons

The coverage of social protection measures providing monetary benefits – whether it be a contributory pension scheme or a non-contributory cash transfer programme – is meaningful only in so far as it guarantees an adequate standard of living. A key factor to take into account when evaluating the adequacy of pensions or cash transfers is whether they are increased in line with inflation.

Although social insurance and social assistance are based on different logics, meaning that the level of benefits are largely determined by different factors, rising prices risk undermining the purchasing power of older persons covered by either type of scheme. One way of catching this aspect, adopted below, is to consider the value of benefits both in local currency and under purchasing power parity (PPP).

Pension schemes in the Arab countries are generally seen as rather generous, indeed as overly generous. This is notably due to the fact that the retirement age and the

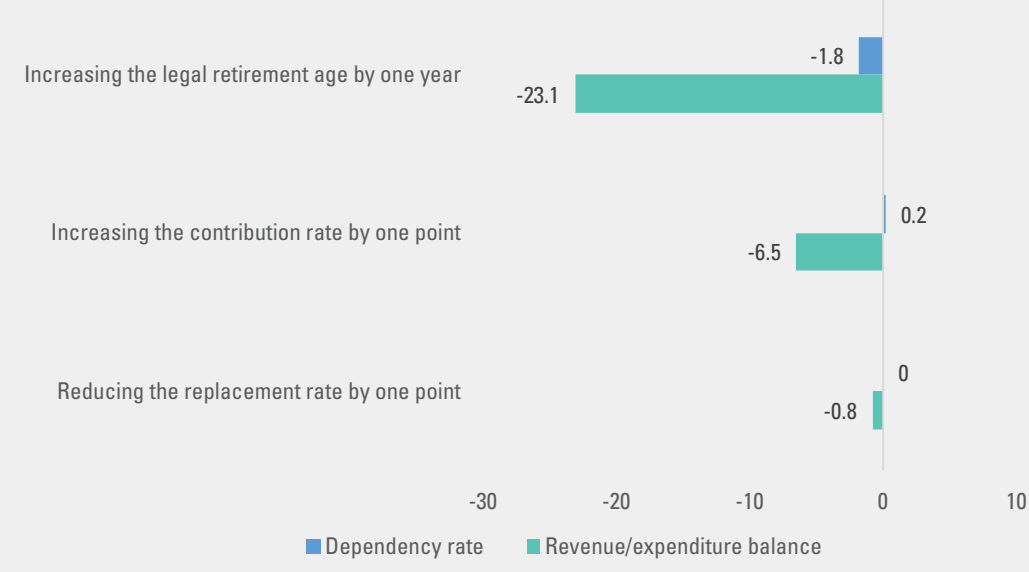
required vesting periods tend to be rather low, making it possible to retire at a relatively young age and/or after having paid into the system during a relatively limited number of years. The replacement ratios are also high, meaning that pensions on average amount to a comparatively high proportion of pre-retirement earnings.[43]

The CNSS in Tunisia: Sustainability and reform options

A recent ESCWA study analysed the sustainability of the Tunisian pension system and, using a heterogenous agent model, projected the impacts of possible parametric reforms. If no reforms are undertaken (the "business as usual" scenario), the number of contributors continues to increase at a much slower pace than the number of pensioners. Consequently, the dependency rate goes up from 27.6 per cent in 2019 to 33.9 per cent in 2025. Meanwhile, CNSS revenues stagnate and expenditures increase, such that the deficit widens from 1.33 to 1.55 per cent of GDP.

The projections consider the effects of three possible reforms: increasing the legal retirement age by one year, increasing the contribution rate by one point, and reducing the replacement point by one year (figure below). It appears that the first of these three reforms would have by far the biggest impact on the dependency rate (which would decrease by 1.8 points cumulatively as compared to the baseline scenario) as well as on the revenue/expenditure balance (which would be reduced by 23.1 per cent cumulatively, the equivalent of 0.35 per cent of GDP). Increasing the contribution rate or reducing the replacement rate would have marginal or no impacts on the dependency rate. The respective impacts of these reforms on the revenue/expenditure balance would be a reduction of 6.5 and 0.8 per cent cumulatively.

CNSS,Tunisia: Projected cumulative impact of parametric reform scenarios over the period 2019-2025 (Relative variation vis-à-vis no reform)

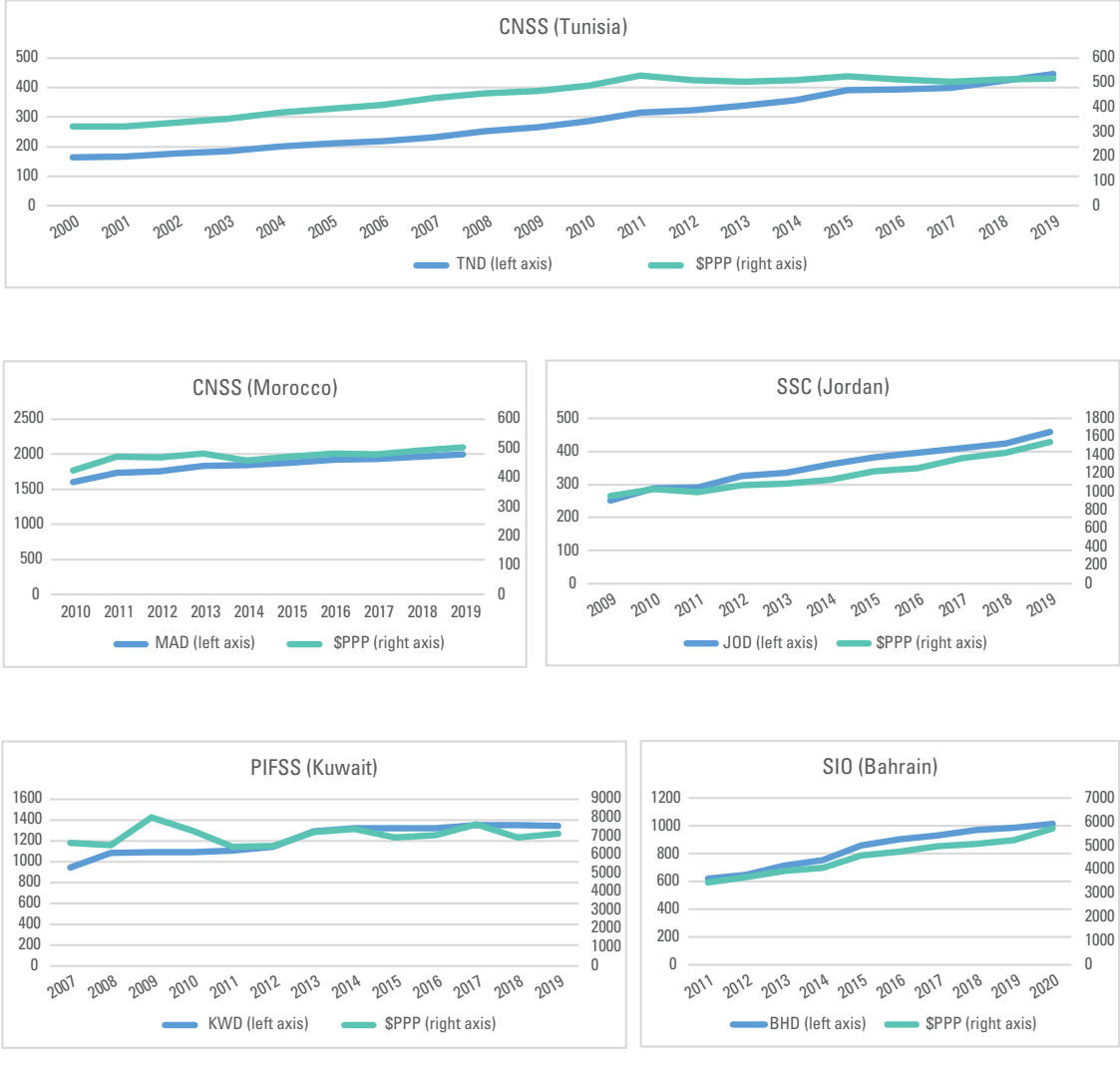


Source: ESCWA (2018). A Model with Heterogeneous Agents to Study Pension Reforms: A Theoretical Presentation and Application using Tunisian data E/ESCWA/EDID/2018/TP.7. Available at: https://www.unescwa.org/publications/model-heterogeneous-agents-study-pension-reforms-theoretical-presentation-and.

The available data – covering social insurance schemes in five Arab countries during different timespans between the years 2000 and 2020 (figure 22) – suggest that pension levels during the last 1-2 decades have tended to increase both nominally and when converted to PPP. Regarding the CNSS in Tunisia, the average pension rose from 163 TND in 2000 to 447 TND in 2019. However, due partly to high inflation, this increase did not reflect growth in real terms since 2011.

Among the other four countries, the increase has been the largest in Jordan (where average pensions rose from 252 JOD in 2009 to 450 JOD in 2019) and Bahrain (from 620 BHD in 2011 to 1,013 BHD in 2020). Meanwhile, the increase has been more modest in Morocco (from an estimated 1599 MAD in 2010 to 1992 MAD in 2019) and Kuwait (from 943 KWD in 2007 to 1,344 KWD in 2019). In all these countries apart from Kuwait, the nominal increase has largely been accompanied by a corresponding increase in real terms.

Figure 22. Average old-age pension value (Local currency and PPP) in select Arab countries (Available years)



Sources: Tunisia, Caisse Nationale de Sécurité Sociale (Annuaire Statistique, 2017); Morocco, Caisse Nationale de Sécurité Sociale (Rapport Annuel 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019); Jordan, Social Security Corporation, (2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019); Kuwait, Public Institution for Social Security (Annual Statistical Collection 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019); Bahrain, Social Insurance Organization (Statistical Report 2011, 2012, 2013, 2015, 2016, 2017, 2018, 2019, 2020, 2021).

It should also be noted that other countries in the region have experienced considerably higher levels of inflation. While data pertaining to the value of pensions in these countries are not available, anecdotal evidence suggest that rising prices have in many cases – at least temporarily – severely undermined the purchasing power of retirees. An extreme example is Lebanon, where rampant inflation since 2019 has diminished the value of pensions in both the private and public sectors.[44]

Many pension schemes in the Arab region lack indexation mechanisms to automatically increase pensions to compensate for inflation. Instead, benefits are raised sporadically and with little predictability. Notably though, certain countries in the region have recently introduced indexation mechanisms or revised their existing ones. In Egypt, for instance, pensions have hitherto been increased at an ad-hoc basis. However, the Unified Pensions Law adopted in 2019 stipulates that they should henceforth be raised in line with inflation at the middle of each year, though not by more than 15 per cent.[45]

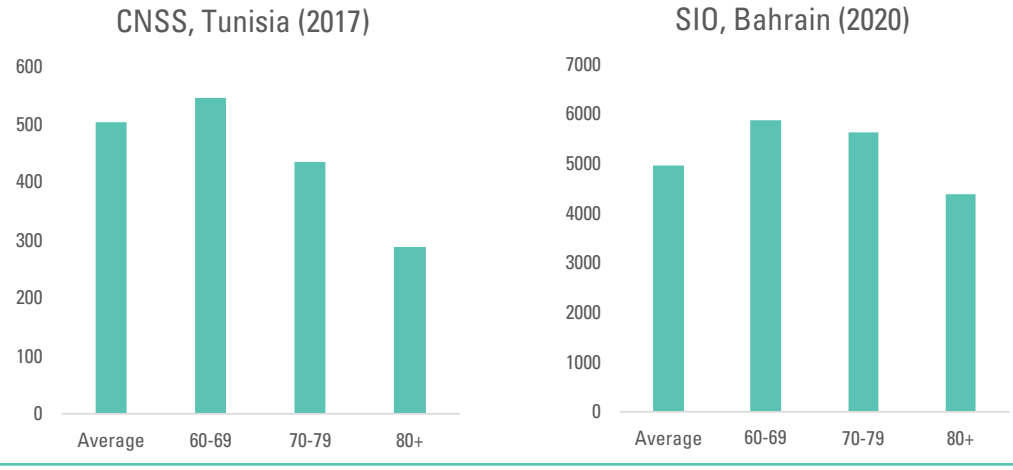
In Jordan, pensions were previously revised in May of each year on the basis of inflation or average wage growth, whichever was lower, though with a maximum increase of 20 JD per year. In 2019, however, a new indexation mechanism was introduced whereby a total increase is calculated and thereafter divided equally amongst all old age-pensioners, meaning that all pensions, regardless of their level, are increased by the same amount.[46] This should entail a higher degree of equalization.

1. There is high inequality among old age pensions even within the same country

Within each country and pension scheme for which data are available, considerable inequality exist among pensioners, making the average levels somewhat deceptive to use as a measure of overall adequacy. The available data suggest that a relatively small number of older persons covered by the schemes receive very large pensions (far above the average), while a large majority receive rather low ones (below the average). Thus, the median old-age pension is much lower than the average pension.[47] Differences in pension levels can be discerned along various lines, including age, gender, region and sector of employment.

In Tunisia, the difference between pensions received by older and younger retirees is considerable (figure 23). As of 2017, old-age pensions distributed to people in the 60-69 age bracket were 9 per cent higher than the overall average. Meanwhile, those received by pensioners aged 70-79 and above 80 were 14 and 43 per cent lower, respectively. In Bahrain, retirees belonging to these three age brackets received pensions 18 per cent higher, 13 per cent higher and 12 per cent lower than the national average.

Figure 23. Average monthly pension (PPP) in Tunisia and Bahrain (Latest year available)



Sources: Tunisia, Caisse Nationale de Sécurité Sociale (Annuaire Statistique 2017); Bahrain (Social Insurance Organization, 2021).

The situation is similar in Morocco and Jordan, where recently retired older persons receive considerably larger pensions than those who belong to the higher age brackets and left the workforce longer ago.[48] In Kuwait, however, the pattern is reversed, such that retirees in their sixties receive lower pensions than those aged 70 and above.[49]

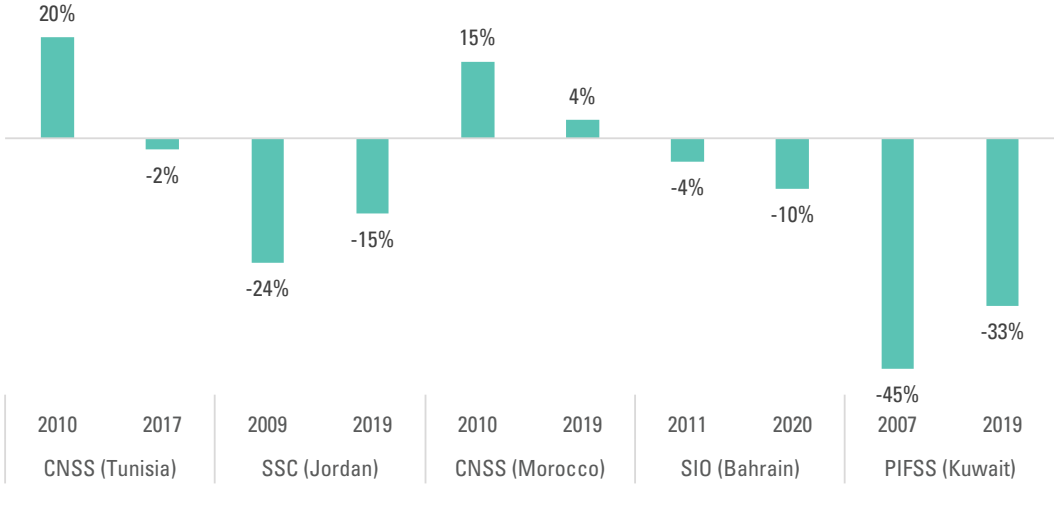
In several cases, there are also considerable differences in pension levels between male and female retirees. However, contrary to what may be expected, older men do not consistently receive larger pensions than older women. In some cases, furthermore, the difference has been reversed over recent years.

Tunisia and Morocco appear to be the countries where the level of pensions is most equal between women and men (figure 24). In both cases, this has come about subsequent to a fall of the average female pension relative to the male one: As of 2017, women in Tunisia received on average 2 per cent less than men, while in 2010 they had received fully 20 per cent more. In Morocco as of 2019, the average female pension exceeded the male one by 4 per cent, whereas nine years earlier it had been 15 per cent larger.

Jordan and Kuwait have also witnessed a levelling of the average pensions received by women and men, though in these countries the outset situation was reversed, meaning that men received more than women. This remains the case, though the discrepancy has decreased. While as of 2009 the average pension received by women in Jordan was 24 per cent lower than the received by men, this difference had by 2019 decreased to 15 per cent. A corresponding decrease from 45 to 33 per cent occurred in Kuwait between 2007 and 2019. Only in Bahrain does the gender difference appear to have widened, as the average female pension went from being 4 per cent lower than average male one in 2011 to being 10 per cent lower in 2020.

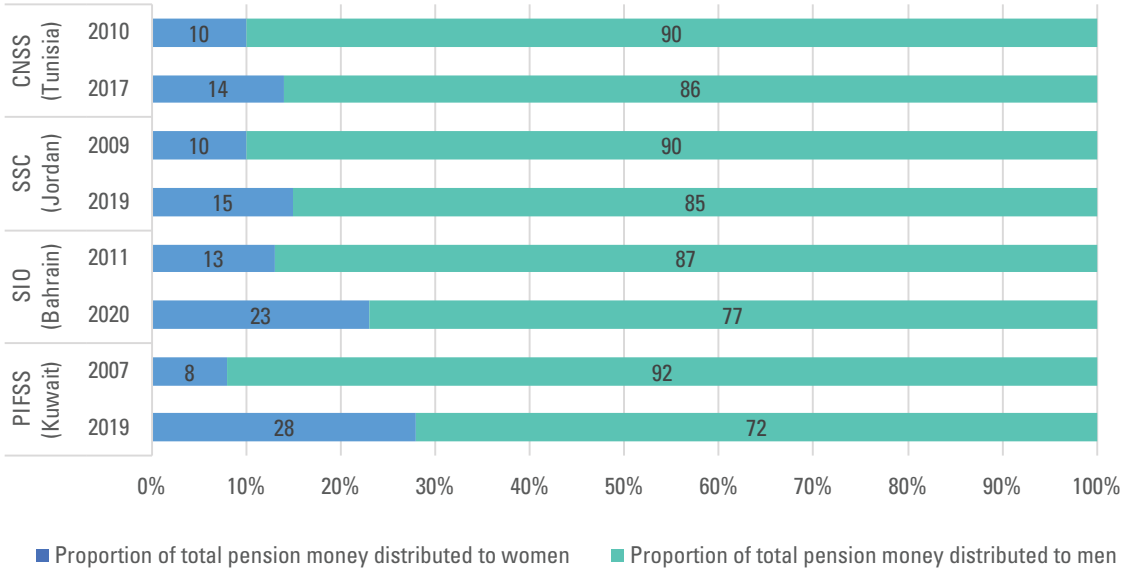
While the reasons behind these developments may be many and complex, a key factor to consider is the concomitant increase of female old-age pensioners relative to male ones. Due to that trend, an increasing portion of the total money disbursed as pensions has gone to women. Figure 25 shows that the female share of total pension spending rose from 10 to 14 per cent in Tunisia between 2010 and 2017, from 10 to 15 per cent in Jordan between 2009 and 2019, from 13 to 23 per cent in Bahrain between 2011 and 2020 and from 8 to 28 per cent in Kuwait between 2007 and 2019.

Figure 24. Pension gender gap: Average female pension percentage higher/lower than average male pension in select Arab countries (Earliest and latest years available)



Sources: Tunisia, Caisse Nationale de Sécurité Sociale (Statistical Guide 2010, 2017); Jordan, (Social Security Corporation, Annual Report 2009, 2019); Morocco, Caisse Nationale de Sécurité Sociale (Rapport Annuel 2010, 2019); Bahrain, Social Insurance Organization, (Statistical Report 2011, 2020); Kuwait, Public Institution for Social Security (Annual Statistical Collection 2007, 2019).

Figure 25. Distribution of total old-age pension money between men and women in select Arab countries (Earliest and latest years available)



Sources: Tunisia, Caisse Nationale de Sécurité Sociale (Statistical Guide 2010, 2017); Jordan, (Social Security Corporation, Annual Report 2009, 2019); Morocco, Caisse Nationale de Sécurité Sociale (Rapport Annuel 2010, 2019); Bahrain, Social Insurance Organization, (Statistical Report 2011, 2020); Kuwait, Public Institution for Social Security (Annual Statistical Collection 2007, 2019).

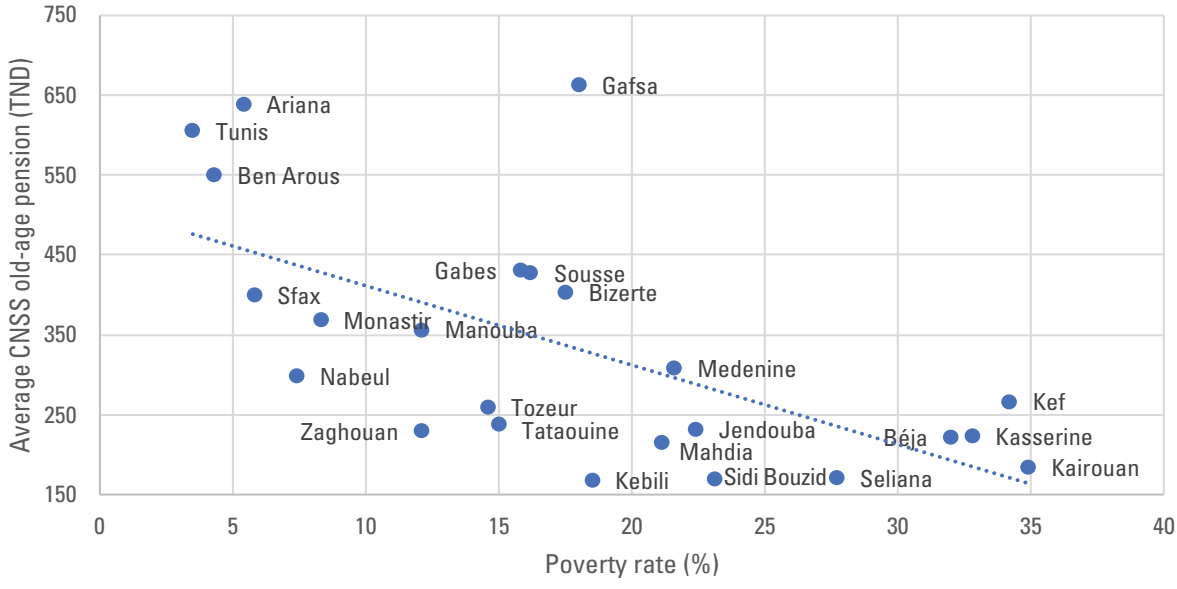
It is noticeable that the share of total pension disbursement going to women has increased even in the countries where the average female pension decreased relative to the average male one (Tunisia and Bahrain). This came about since the proportion of female old-age pensioners increased faster than the proportion of total pension money allocated to them (unlike in Jordan and Kuwait, where the opposite occurred).

As mentioned above, many older women in the Arab region, especially widows, receive survivor pensions. There are however considerably smaller than old age pensions. For instance, in Tunisia survivor pensions distributed to older persons amount on average to less than half the value of old-age pensions. In Bahrain, they amount to around a third.

The amount of old-age pensions often differs from one area to another within a country. A good example of this is Tunisia, where average old-age pensions range from around 170 TND in the poorest governorates to above 600 TND in the richest ones (figure 26). A notable exception to this pattern is the governorate of Gafsa, which despite a poverty level of 18 per cent – above the national average of 15.2 per cent – has the highest average level of CNSS pensions – 663 TDN.

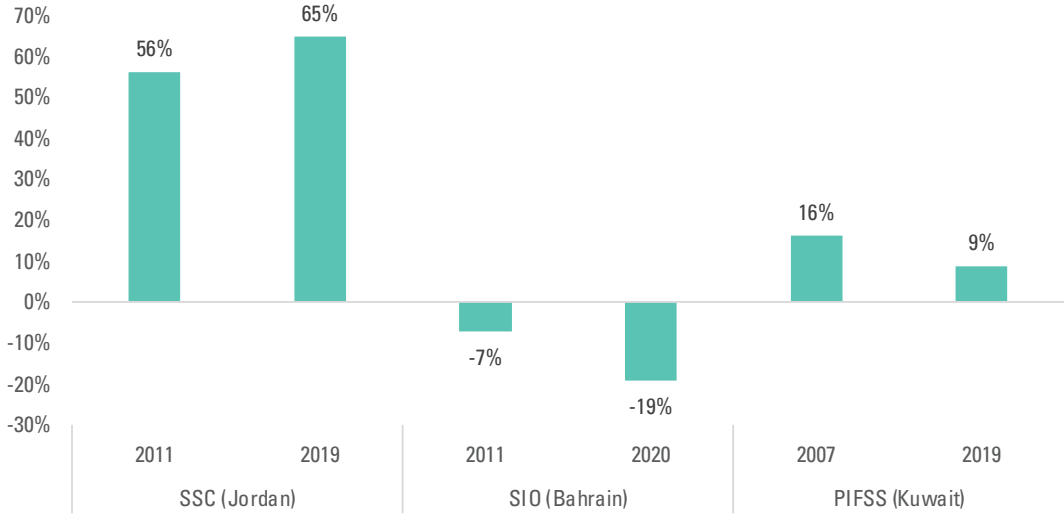
There is furthermore a certain difference in the level of old-age pensions depending on whether the retirees have worked in the public or private sector (in the case of social insurance schemes covering both groups). As with gender though, the regional pattern is uneven (figure 27). In Jordan as of 2020, private sector pensioners on average received 65 per cent more than public sector pensioners, having increased from 56 per cent in 2011. In Kuwait, retirees from the private sector receive on average 9 per cent more than their counterparts from the public sector. Unlike in Jordan, however, this gap is closing, having decreased from 16 per cent in 2007. In Bahrain the picture is reversed: average private sector pensions were in 2020 19 per cent lower than average public sector pensions. The discrepancy has widened since 2011, when it was merely 7 per cent.

Figure 26. Tunisia: Governorates by average CNSS old-age pension (2017) and poverty rate (2015)



Source: Caisse Nationale de Sécurité Sociale (Tunisia), n.d.

Figure 27. Average private sector pension percentage higher/lower than average public sector pension, in selected Arab countries (Earliest and latest years available)



Sources: Jordan, Social Security Corporation (Annual Report 2011, 2019); Bahrain, Social Insurance Organization (Statistical Report 2011, 2021); Kuwait, Public Institution for Social Security, (2007, 2019).

In Tunisia, private sector workers are categorized into a number of schemes depending on their type and domain of employment. While old-age pensioners covered by the schemes for salaried non-agricultural private sector employees as of 2017 received on average 462TND ($581 at PPP) per month, those covered by the one for

self-employed agricultural workers received on average less than a third-147 TND ($186 at PPP).

2. The adequacy of non-contributory cash transfers range across the region but for the most part falls behind

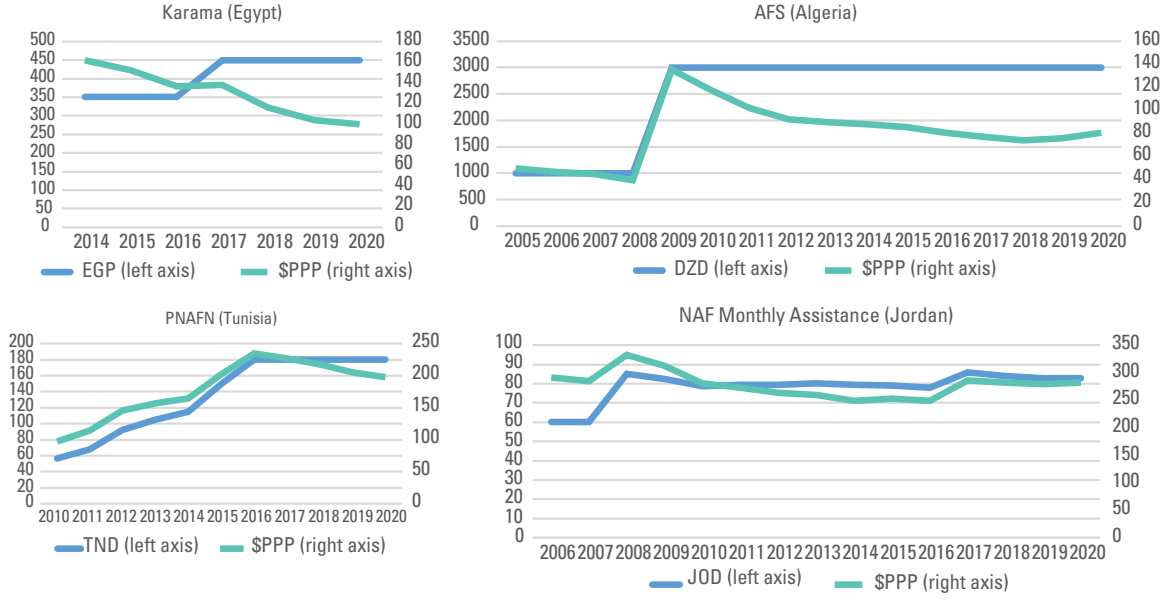
With regard to the adequacy of non-contributory cash transfer programmes targeting older persons, the picture is also somewhat mixed (figure 28). In Egypt, Karama benefits were set to 350 EGP at the launch of Takaful and Karama in 2015. At that time this corresponded to $162, though strong inflation during the following years caused the real value to fall considerably. In 2017, the level of benefits was raised to 450 EGP, though this hardly sufficed to compensate for the rapid price increases that year, and the real value had fallen to $100 by 2020.

In Algeria, the level of AFS cash transfers was raised in 2009 from 1000 DZD to 3000 DZD, a real increase from 40 to $135 at PPP. Since then, however, the benefit has not been adjusted to compensate for inflation, and by 2020 it corresponded to merely $81. Notably, Law 10-12 Relating to the Protection of Older Persons, adopted in 2010, stipulates that vulnerable older persons are entitled to a monetary benefit equal to at least two thirds of the minimum wage.[50] However, the AFS benefit has never come close to this level: having reached 25 per cent of the minimum wage in 2009, it has since fallen back to around 15 per cent.[51]

In Tunisia, the value of the PNAFN transfer gradually increased from 57 TND in 2010 to 180 TND in 2016. This more than compensated for inflation during this period, meaning that the real value more than doubled, from $97 to $235. Since then, however, the level of the transfers has remained unchanged, and by 2020 the real value had fallen to $198.

The level of assistance provided through the NAF monthly cash transfers differs depending on the needs of the household. Having risen from 60 JOD in 2007 to 85 JOD in 2008, the average monthly benefit has since remained relatively constant. The real value gradually declined from $333 in 2008 to $249 in 2016 but by 2020 had increased again to $282.

Figure 28. Average monthly value of social assistance benefits (local currency and $PPP), in selected Arab countries (available years)



Sources: Egypt: Ahmed, 2018. Algeria: El Watan, 2009. Tunisia: ESCWA, 2019b. Jordan: Data available on the NAF website [http://www.naf.gov.jo].

Note that while these numbers provide an approximate idea of how the benefit levels have changed over time, they cannot be used as easily to compare the generosity of cash transfers across programmes and countries. One reason for this is that they are in many cases provided to households rather than to individuals, and that the average size of beneficiary households may differ considerably.[52] Another reason is that certain programmes – such the PNAFN in Tunisia – do not only provide cash transfers, but also other benefits in the form of, for example, subsidized health coverage. Focusing on the cash transfer alone could thus underestimate the overall scope of the programme.

D. Health coverage

Health coverage can be provided either on a contributory or non-contributory basis. The groups covered by contributory health insurance tend largely speaking to be the same as those covered by contributory pension schemes – in other words, formal workers and their households. This means that in those countries where a relatively large proportion of older persons receive a pension from the social insurance system, a similarly large proportion are covered by contributory health insurance.

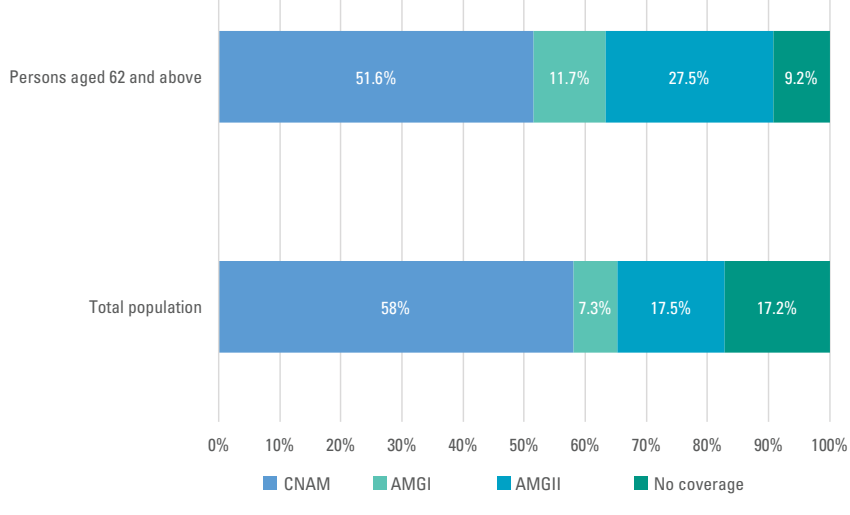
Non-contributory health coverage can take various forms. While some countries allow certain groups to be covered by the regular health insurance scheme on a partly or fully subsidized basis (meaning in effect that the contributions are not paid by the individuals or households themselves but by a third party), others have set up specific non-contributory schemes or provide health services free of charge to all citizens or residents.

1. The majority of older persons in some Arab countries remain without health coverage

Tunisia, for instance, have a contributory health insurance regime, CNAM, covering both the public and private sectors. There is a non-contributory health coverage regime called Assistance Médicale Gratuite I (AMGI), which provides free health coverage to the households covered by the cash transfer programme PNAFN. In addition, AMGII provides subsidized health coverage to households deemed vulnerable but not sufficiently poor to qualify for the PNAFN.[53]

In 2016, it was estimated that while 58 per cent of the total population in Tunisia were covered by CNAM, merely 51.6 per cent of persons aged 62 or above were (figure 29). However, fully 39.2 per cent of older persons were covered by AMGI or AMGII, whereas the corresponding number for the total population was 22.8 per cent. Consequently, the coverage gap was substantially lower among older persons (9.2 per cent) than among the overall population (17.2 per cent).

Figure 29. Tunisia: Estimated health coverage for total population and persons aged 62 or above (2016)



Source: Centre de Recherches et d'Etudes Sociales, 2019.

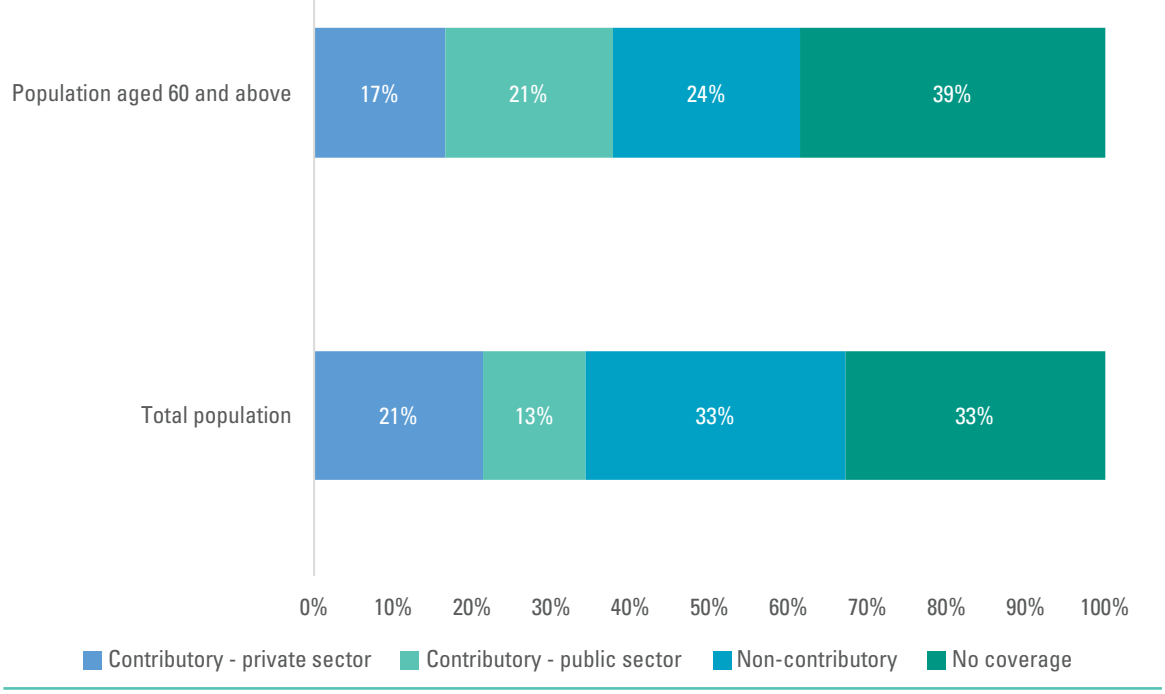
Figure 30 shows that the estimated health coverage through the contributory system in Morocco is higher among persons aged 60 and above (38 per cent) than among the overall population (34 per cent). Meanwhile, coverage of the non-contributory health insurance scheme Ramed is substantially lower among older persons (24 per cent) than among the overall population (33 per cent) than among the overall population.

A closer look reveals that fully 21 per cent of older persons are covered by one of the contributory public sector regimes, whereas the corresponding number for the total population is merely 13 per cent. A possible explanation for this is that employment in the public sector was easier to access in the past, i.e. when those who are now old were economically active. Coverage through the contributory private sector scheme regime, on the contrary, is higher among the overall population (21 per cent) than among those aged 60 and above (17 per cent). This is probably due to the recent increase of social insurance coverage among private sector workers described above.

In Egypt as of 2018, fully 70 per cent of the population aged 65 and above were not covered by health insurance (figure 31). Of the remaining 30 per cent, the overwhelming majority (26 per cent) were covered by the public Health Insurance Organization (HIO). While the pattern was largely similar for the 50-64 age range, the insurance gap was considerably wider for younger persons of working age: 78 per cent for those aged 30-49, and fully 90 per cent for those aged 25-29. The reason for this is probably in largely part that employment opportunities in the public sector dwindled in the 1990s and afterwards and were only to a small extent replaced by employment opportunities in the formal private sector.[54]

Certain countries have taken specific measures to ensure health coverage for older persons. Jordan, for instance, has extended subsidized health insurance coverage for all citizens aged 60 and above.[55] Algeria, similarly, has legislated that all persons aged 60 and above should have free access to publicly provided health care.[56]

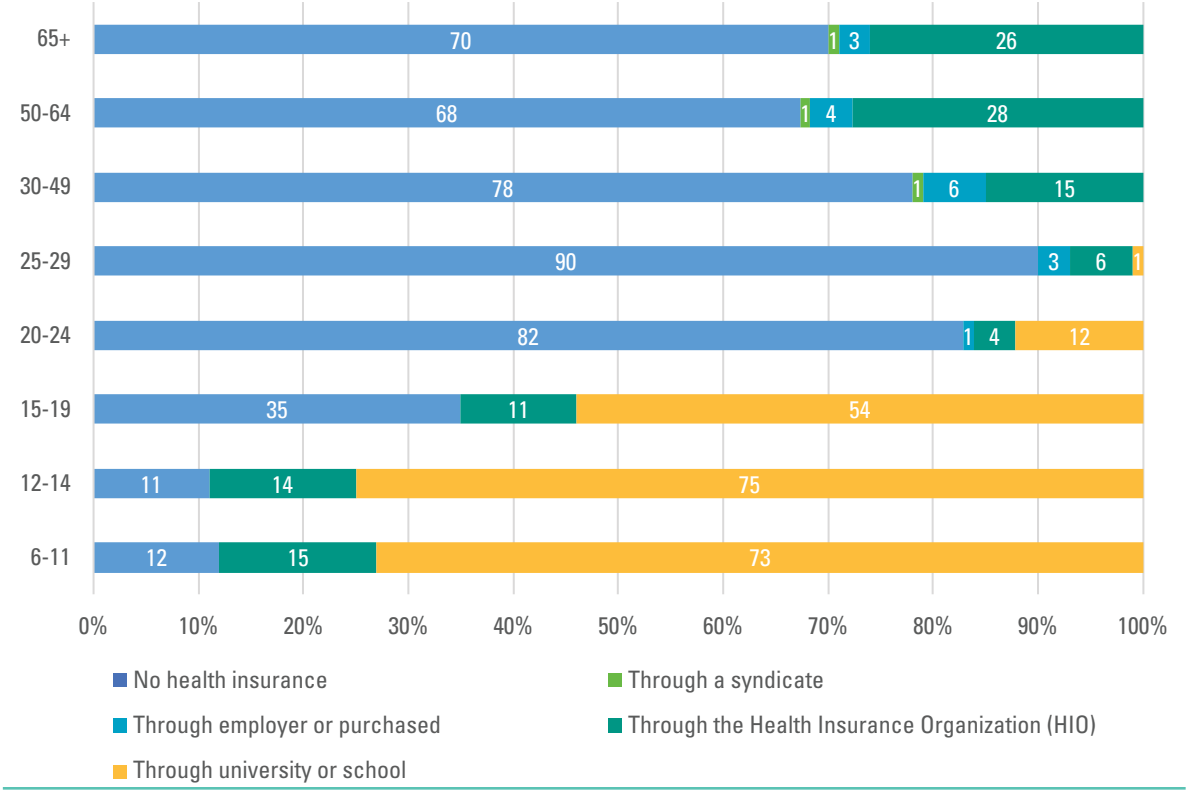
Figure 30. Morocco: Approximate health coverage for total population and persons aged 60 or above (2018)



Sources: Estimated on the basis of L'Agence Nationale de l'Assurance Maladie, n.d.; Caisse Nationale de Sécurité Sociale (Morocco), n.d.; Moustatraf, 2019.

Note: Due to incomplete administrative data for certain Moroccan health insurance regimes, these estimates should be seen as approximate.

Figure 31. Egypt: Health insurance coverage by age span (2018)



Source: Selwaness and Ehab, 2019.

2. Legal health coverage does not always translate to effective health coverage

However, it is critical to bear in mind that legal health coverage does not always translate into effective coverage. In other words, even when older persons are covered by health insurance or when they are entitled to benefit free of charge from publicly provided services, they may not in practice be able to access the health care they need when they need it without incurring financial hardship.

For instance, the care packages provided through health insurance schemes may not include the types of services that older persons need. Sometimes health insurance schemes require the covered population to pay high user fees (co-payments). In certain cases, the quality of services may be of such low quality that the covered population resorts to other alternatives. Accessibility may in practice be restricted by prohibitive geographical distances to health clinics and hospitals – especially in rural areas – or by long waiting times.

Findings from a number of Arab countries suggest that households that include older persons face a higher degree of catastrophic health expenditures.[57] While this can result from a lack of legal health coverage among older persons, there is much to indicate that shortcomings in terms of adequacy and accessibility play a large role as well. In Egypt, as noted above, a comparatively high proportion of older persons are covered by health insurance through the HIO. However, it has been found that an overwhelming majority of covered households in rural areas purchase privately provided care, and that households including an insured older person are no less exposed to catastrophic health expenditures than households including an uninsured older person.[58]

E. Costing expanding social protection to include larger proportions of older persons

While there is widespread agreement on the importance of extending social protection to all older persons, it is more challenging to say how this should be done. A key question concerns whether coverage ought to be achieved by means of contributory or non-contributory mechanisms, or by some combination of the two. In all cases, it ought to be remembered that attaining higher coverage rates is meaningful only in so far as benefits and services are at an adequate level. Therefore, ensuring the political as well as financial sustainability of social protection is essential.

As shown above, the number of persons receiving old-age pensions has increased considerably over the last two decades. While this could to an extent be attributed to the growing number of older persons in the overall population, it is also in large part a result of past endeavours to increase social insurance coverage among private sector workers. The COVID-19 crisis has given new impetus to such efforts by clearly exposing the vulnerability of excluded older persons.

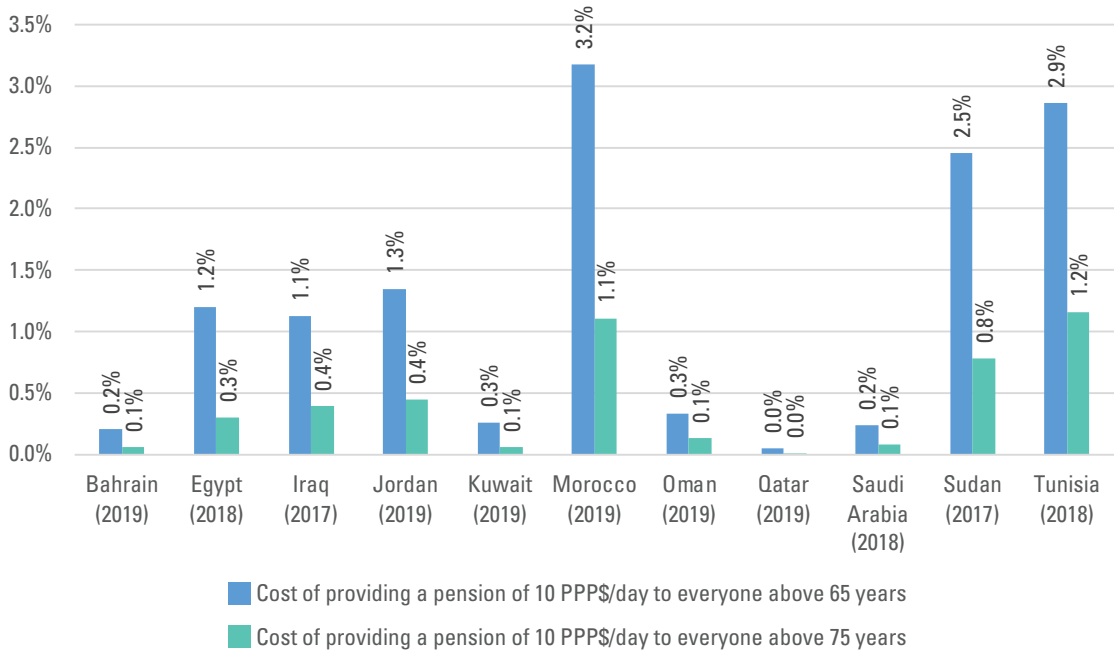
In the Arab region, Tunisia is a good example of a country having extended both legal and effective coverage. This has in large part been achieved through the creation of new schemes for specific professional groups. A scheme for agricultural employees was set up in 1981, two schemes for self-employed workers in the agricultural and non-agricultural sectors in 1982,[59] an "enhanced" scheme for agricultural employees as well as one for Tunisian workers abroad in 1989, one for low-income workers and one for artists, creators and intellectuals in 2002. A bit more than a quarter of CNSS old-age pensioners are covered by one of the newer schemes, while the remaining three quarters are covered by the original schemes for private sector employees set up in 1961.[60]

In Morocco, effective coverage among private sector employees has increased rapidly during the last 15 years due to a combination of factors including the establishment of a mandatory health insurance regime, workplace inspections and technological innovations facilitating registration and contribution payments.[61] More recently, the country has also set up a social insurance regime (comprising health insurance in addition to old-age and survivor benefits) for self-employed workers, thereby extending legal coverage to this group. Efforts to extend social insurance to self-employed workers and other previously uncovered groups have also been made or are ongoing in e.g. Oman, Egypt and Jordan.[62]

It is important to bear in mind that social insurance coverage extension has a dual objective. On the one hand, it ensures future social protection coverage of older persons, since workers contributing to a social insurance scheme will be eligible for a pension upon retirement. At the same time, it is essential to ensure the financial sustainability of the social insurance system, especially in a time of population ageing. In the Arab region, continuing to increase the proportion of women engaged in formal employment could thus serve the double purpose of enhancing social coverage within this group and sustaining the social insurance system. However, enabling a larger number of women to take up paid employment would in many contexts require that they be relieved of domestic burdens. Thus, it is contingent upon the provision of complementary social policies, including long-term care (LTC) services as further discussed in the next chapter.

As for the expansion of non-contributory social protection, a key policy option would be to introduce a social pension – in other words, an unconditional non-contributory cash benefit categorically targeted at older persons. Figure 32 shows how much this would cost, as a percentage of GDP,[63] if the transfer amounted to PPP $10 per day and was provided either to everyone aged 65 years and above or 75 years and above. Naturally, this cost is positively correlated with the proportion of older persons in the overall population. It is furthermore negatively correlated with GDP per capita. The cost would thus be highest in Morocco, the Sudan and Tunisia, where it would be 3.2 per cent, 2.9 per cent and 2.5 per cent of GDP, respectively, with an eligibility threshold set to 65 years. If the threshold was set to 75 years, the cost would be highest in Tunisia, at 1.2 per cent of GDP, followed by Morocco, at 1.1. per cent of GDP, and by the Sudan, at 0.8 per cent of GDP.

Figure 32. Cost of providing a social pension of $10/day at PPP to older persons above 65 and above 75 years as a percentage of GDP in selected Arab countries (Available years)



Source: ESCWA calculations based on DESA, 2019a.

In Jordan, Egypt and Iraq, the cost would be considerably lower: between 1.1 and 1.3 per cent of GDP with an eligibility threshold set to 65 years, and between 0.3 and 0.4 per cent of GDP with a threshold set to 75 years. Meanwhile, in the GCC countries the cost would not exceed 0.3 per cent of GDP with an eligibility threshold set to 65 years or 0.1 per cent of GDP with an eligibility threshold set to 75 years.

The direct overall cost could theoretically be reduced by targeting the provision to a selection of the older population rather than providing assistance on a universal to everyone within this group. For instance, eligibility could be restricted to all older persons living below the poverty line. However, this would inevitably entail a certain degree of inclusion and exclusion errors, since targeting methodologies are never perfect. Furthermore, poverty targeting is administratively costly and risks undermining political support among the politically influential middle classes. The results of this may be social division and limited pressure on Governments to ensure the adequacy of benefits.[64]

Another alternative could be to provide non-contributory cash transfers only to older persons who are not covered by contributory pension schemes (so called pension testing). In countries such as Tunisia this would manifoldly reduce the cost, but it would also entail some considerable drawbacks. As shown above, there is a high level of inequality among retirees: even if pension systems in the region are often described as "generous," many older persons covered by them receive very small sums of money. In Egypt, households covered by the social insurance systems are automatically deemed ineligible for the Takaful and Karama programme, a criterion that has been found to exclude a large number of very poor households.[65] Thus, treating all older persons covered by contributory social insurance as in group and categorically excluding them from non-contributory assistance hardly appears advisable.[66]

As regards health care, many countries have made considerable progress in extending legal coverage. The main challenge ahead may thus be ensuring that this translates into effective coverage – in other

words, that health care services are in practice accessible and of adequate quality. This will doubtless require massive investments in human capital as well as infrastructure. Experience shows that the political will to make such investments are unlikely to materialise if the health care services are destined specifically for the poor. Therefore, whether the health care is provided on a contributory or non-contributory bases, Governments should work to ensure effective resource pooling and prevent the emergence of stratified health care systems.

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?

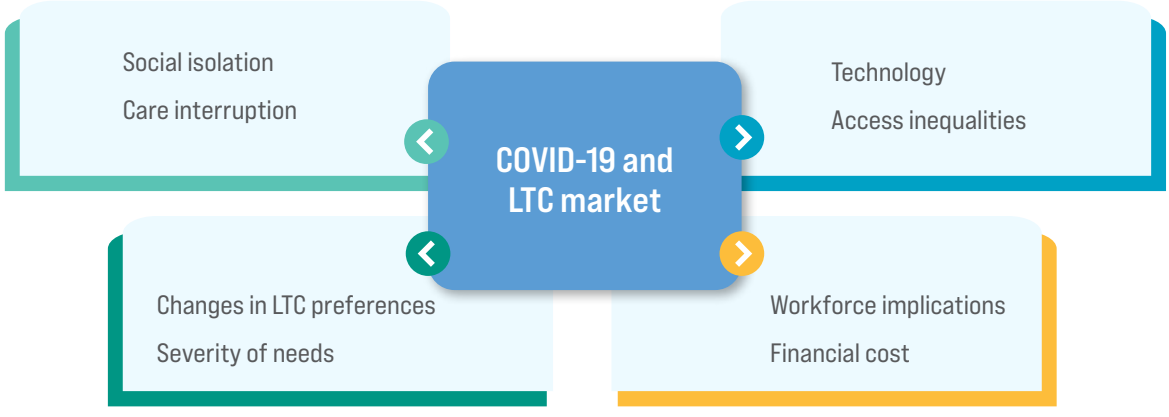
LTC is provided through care economies and markets that encompass various actors ranging from the close network of a person to formal services and community support mechanisms. LTC services can be provided at people's own homes, communities or residential and nursing care facilities. Furthermore, the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

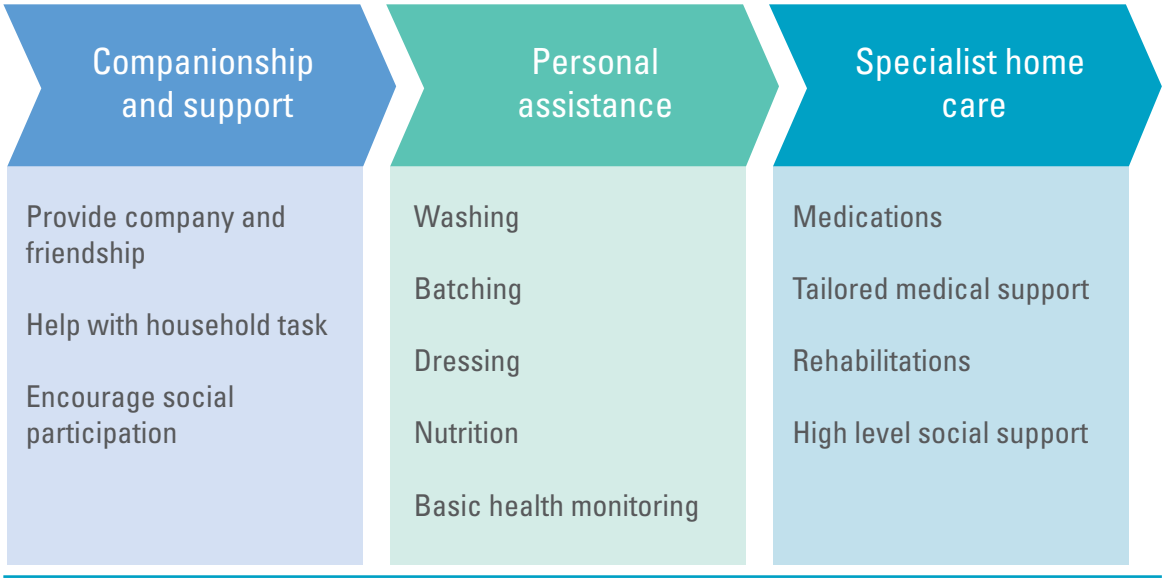
Home care encompasses many services and varies according to older people's needs. In many cases, home care workers help with activities of daily living, such as dressing, bathing, or feeding. They also include companionship and befriending services or transportation to medical or leisure activities. 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.

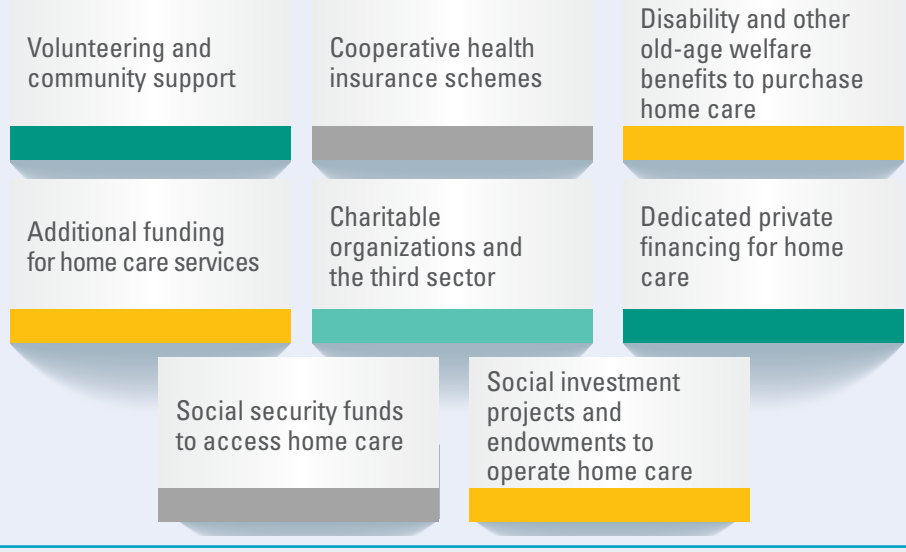
We conducted interviews and focus group discussions with key stakeholders from the Family Affairs Council, the Ministry of Health, the Ministry of Human Resources and Social Development and the Ministry of Education for this report. Primary qualitative data provided detailed insights into recent and 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.

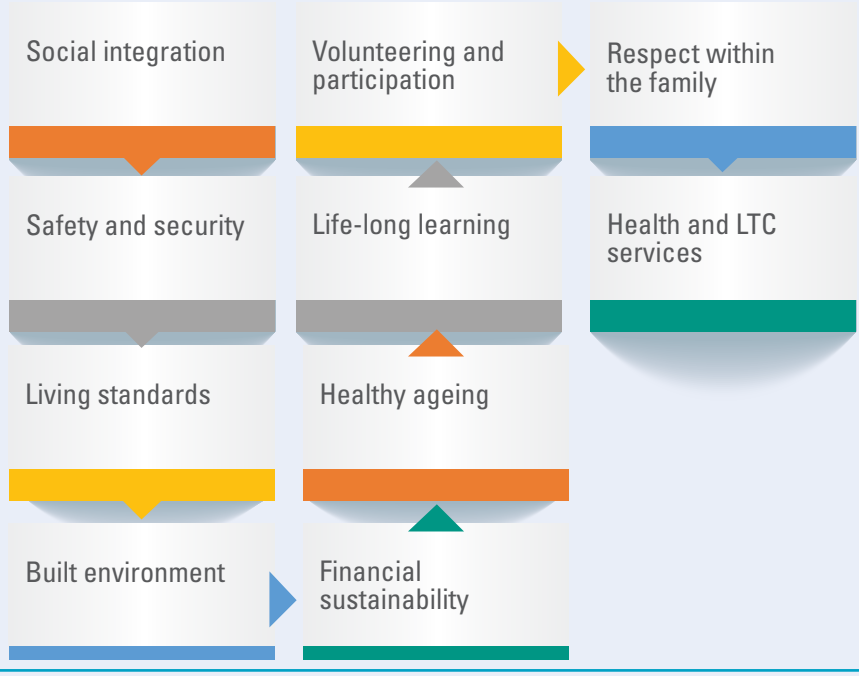
Saudi Arabia is developing a 'National Strategy for the Family' (NSF) to address the needs of the family as a social unit while paying particular attention to the rights and needs of older people. According to the Saudi national report for the Madrid International Plan of Action on Ageing (MIPAA) review,[101] 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]

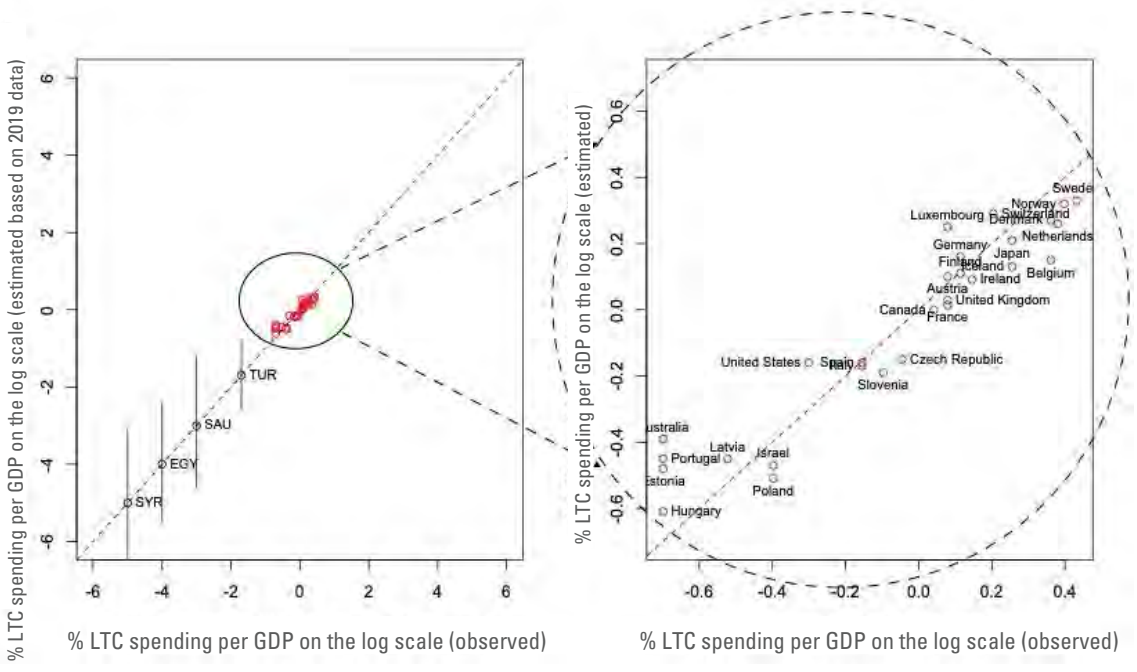
On the other hand, residential care is one of the most expensive care services worldwide. In the United Kingdom, residential care is only cost effective if an older person requires care from multiple professionals around the clock. For example, receiving up to 14 hours of care per week at home would 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



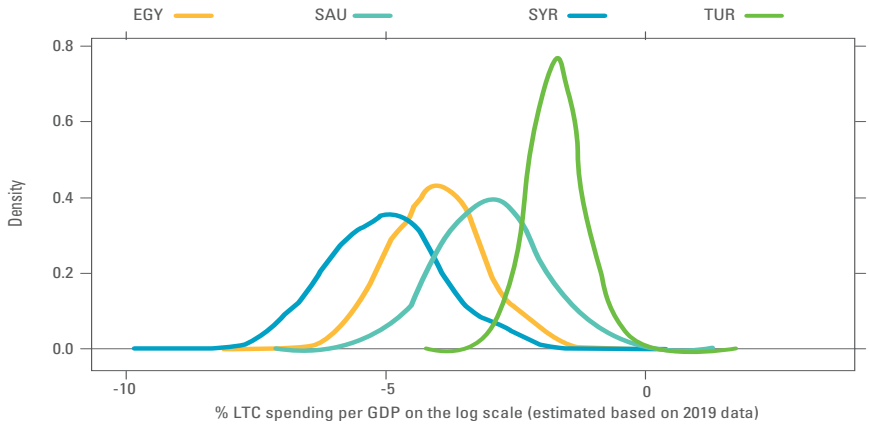
Source: Calculated by ESCWA.

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]

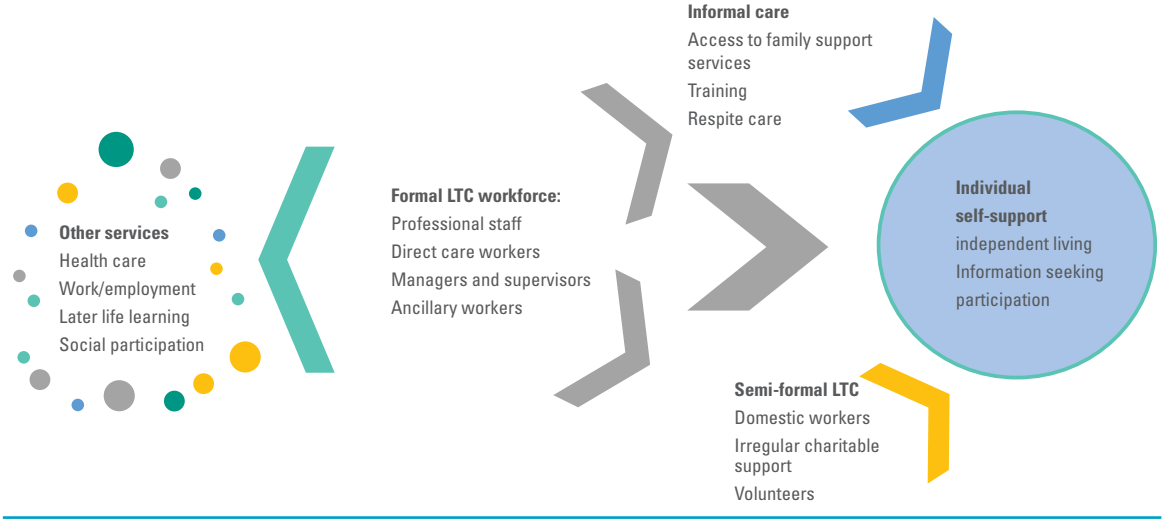
Globally, it is estimated that nearly 40 per cent of projected job opportunities in the coming three years will be in the care economy.[134] The ILO estimates care markets (both child and elderly care) to include 215 million workers in care sectors (in health and social work and education) and 70.1 million 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.

Arab countries and relevant organizations should make available updated, reliable and accessible data disaggregated by age, sex, and location to help inform context-appropriate policy development.

Governments should not only work towards improving the lives of current older persons but can adopt a life-course approach to policymaking.

Social protection schemes should be more inclusive and responsive to older persons.

While the family remains an important caregiver, alternative options need to be explored and expanded, including professional home care and institutional care.

4 Building forward better for older persons

A. Introduction

This chapter offers practical steps Arab Governments can take to empower and protect older persons. Previous chapters have highlighted key structural barriers to older persons' pursuit of a dignified life. Anticipating potential vulnerabilities can help inform progressive policies that prepare Arab countries to ensure as smooth a demographic transition as possible. Supporting the elderly is in line with the 2030 vision of 'leaving no one behind'. Moreover, harnessing the contributions of older persons can be invaluable in ensuring that SDG targets are met. The concrete actions in this chapter are proposed in the pursuit of operationalizing the global frameworks at national levels.

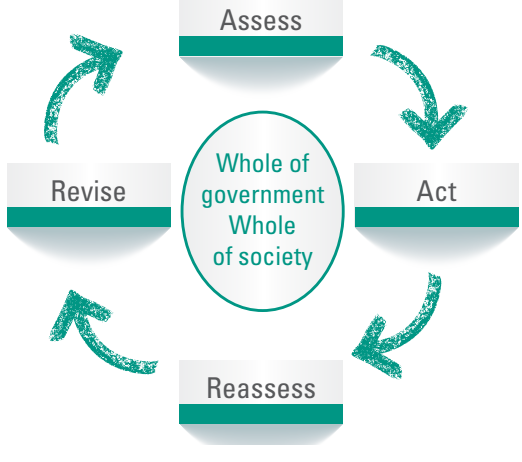
Recognizing that there is no one-size-fits-all approach, the recommendations in this chapter should be taken as a roadmap to be tailored based on national priorities and contextual nuances. Any successful strategy or initiative will require careful matching of priorities with resources and capacity. It should also be noted that differences within as well as between countries should be carefully considered when building forward better.

This chapter introduces four key areas for intervention: data, life cycle approach, social protection and the LTC economy. The chapter is organized by these intervention areas, beginning with a general discussion of each before presenting specific objectives and actions in tables. To further guide policymakers, these recommendations are distributed according to time horizons of short (0-5 years), medium (5-10 years) and long (10-20 years). These time horizons signify the start phase of the recommendations, however these suggested time frames are fluid as actions that begin in the short-term, for example, may need to continue into the medium and even long term.

Figure 41 outlines the general policymaking process that underpin the detailed recommendations offered in each intervention area in this chapter.

The first step involves activities aimed at providing the evidence base to inform appropriate policy responses. These include situational analyses to identify key gaps and opportunities as well as underlying dynamics. Second, member States need to develop and implement appropriate policies in light of the situational analysis. This requires considering different policy options and implementing the most promising one(s). Third, to ensure long-term sustainability and responsiveness of policies, stakeholders must conduct assessments of implementation as well as the relevance of policies considering evolving developments. Monitoring and evaluation mechanisms are critical here. Finally, policies may need to be revised based on the findings from the reassessment stage. This cycle is then repeated to ensure continuous learning, adaptation and progress in policy formulation.

Figure 41. Schematic policymaking process



Source: Prepared by ESCWA.

Throughout all stages, a wide range of stakeholders should be engaged, including the relevant government ministries and entities, civil society organization, private sectors and older persons. Adopting a whole of government and whole of society approach at all stages of the policymaking process will help ensure that policies are inclusive and responsive.

B. Data

Arab countries and relevant organizations should make available updated, reliable and accessible data disaggregated by age, sex and location. Age-disaggregated data remains limited and where it does exist, it often only offers one age range covering all older persons, which makes it difficult to distinguish between different sub-age groups among the elderly. Each country has its own unique data collection capacity and system, which will need to be assessed and strengthened. The variety in data quality and the lack of unified data standards across the region also make it hard to compare data across the countries.

- First, efforts need to be made to develop more comprehensive data systems that capture socioeconomic indicators that are disaggregated by age, sex, location and a host of other factors including education and health. Developing capacities in this pursuit will help better understand the needs of older persons and support Governments in developing responsive policies that promote the inclusion of older persons.
- Second, the fragmentation of data systems limits the ability for the collected data to be used. Gap assessments will be needed in each country as well as capacity-building workshops to facilitate the creation of integrated data systems. There is a need to mainstream data collection on ageing. Moreover, Arab countries can work to develop better systems for data sharing between national statistical offices (NSOs) and line ministries that collect their own sector-specific data.
- Third, given the modifications in data collection efforts that the pandemic has necessitated, older persons are at risk of being further marginalized given the challenges they face in terms of digital literacy and access.[138] It is thus imperative that older persons are included in evolving data initiatives. Understanding the data needs of older persons and supporting them in accessing and understanding the available data is critical.
- Finally, indices need to be developed that capture the unique contributions that older persons make to their families, economies and societies to provide the evidence base to combat ageist misconceptions.

Taken together, these reforms will ultimately lead to the creation of comprehensive, integrated and inclusive data systems that are age sensitive. This will in turn provide the necessary data to inform evidence-based policymaking throughout the Arab region.

Short-term (next 5 years)		Medium-term (5-10 years)		Long-term (10-20 years)	
Objectives	**Actions**	**Objectives**	**Actions**	**Objectives**	**Actions**
Goal: Build comprehensive data systems to capture socioeconomic data that is disaggregated by age, sex and other characteristics					
Identify key data gaps on socioeconomic indicators (health, education, living arrangements, etc.)	Conduct gap assessment of national statistical offices (NSOs) and sectoral data centres to identify what data is not being captured and understand why this is the case	Establish comprehensive regular and ad-hoc data collection practices	Include modules on older persons' socioeconomic situation into existing regular surveys	Ensure the sustainability of data systems	Devote specific budget lines to data collection for NSOs and sectoral data centres
	Hold multi-stakeholder meetings, including older persons, to identify how to address the identified data gaps		Develop specific surveys to fill data gaps as needed		Provide regular training opportunities for NSOs and sectoral data centres
Develop data capacities to fill the identified gaps	Conduct capacity building workshops for national statistical offices and sectoral data centres			Ensure the data system is responsive to current needs, especially for older persons	Review data systems responsiveness through holding multi-stakeholder meetings, including older persons
	Conduct sensitivity workshops for NSOs and sectoral data centres to promote good practices in the collection of disaggregated data				Update data systems as necessary

Short-term (next 5 years)		Medium-term (5-10 years)		Long-term (10-20 years)	
Objectives	**Actions**	**Objectives**	**Actions**	**Objectives**	**Actions**
Goal: Build integrated data systems					
Identify data system fragmentation	Conduct assessment of the level of integration of current data systems looking at current practices and mapping out the actions of all stakeholders involved in data processes	Create integrated data systems that make data readily accessible to the public as well as other governmental offices	Organize systems for centralized and standardized management of data		
Adopt a solutions-oriented approach to identified issues	Conduct multi-stakeholder meetings to develop proposal to address data integration issues				
	Implement necessary reforms to build more integrated data systems		Facilitate interaction between different stakeholders who are responsible for data collection, management and analysis		
Mainstream ageing into NSOs and sectoral data centres	Conduct mainstreaming workshops for NSOs and sectoral data centres		Conduct outreach campaigns to ensure data is accessible and clear for data users, especially older persons		
Goal: Include older persons in data systems					
Develop a better understanding of older persons' data needs	Conduct a baseline survey of older persons' data needs	Support older persons to better access and use data	Provide training opportunities on digital literacy for older persons	Incorporate older persons' perspectives and expertise in data systems	Facilitate interactions between national statistical offices and older persons
	Involve older persons in all multi-stakeholder meetings and trainings regarding data systems		Conduct outreach to ensure older persons can engage with evolving data systems		Update data systems to be responsive to older persons' evolving priorities
Provide the evidence base to capture older persons' contributions	Develop indices that capture the contributions of older persons				

C. Life cycle approach

Governments should not only work to improve the lives of current older persons but can adopt a life course approach to policymaking. Such an approach aims to enhance the lives of current populations from early ages to ensure decent futures for the next generations of older persons. It works on multiple fronts, addressing the short-to medium-term needs of older persons today as well as taking proactive measures to address the anticipated needs of future cohorts of older persons. Adopting such a holistic approach can help facilitate positive contributions from all citizens as they age. Addressing inequalities from an early age is critical given that disadvantages compound and reinforce one another, ultimately materializing in especially pronounced manners in old age.[139] Adopting such an approach will help Arab countries as they strive to build sustainable and resilient societies.

- First, promoting healthy lifestyles and habits from a young age can build the necessary foundation for healthy ageing. The availability, accessibility and affordability of health care services throughout the life cycle is equally important, including both mental and physical health needs.
- Second, inclusive societies help to make optimal use of the expertise and knowledge accumulated by older persons throughout their lives. An enabling environment for people of all ages to participate in society helps ensure that people remain connected and active throughout the lifecycle. This includes educational activities to promote age-sensitive attitudes from a young age as well as legal reforms to combat ageism. It also includes building age-friendly cities that have the necessary infrastructure, transport and housing options to facilitate older persons' inclusion in society.
- Third, encouraging and supporting savings from younger ages can help guarantee the financial security of future generations of older persons. Providing knowledge about savings schemes and incentivizing longer-term financial planning can encourage more sustainable lifestyles and consumption patterns.
- Lastly, the deficiencies in education of older persons compel countries in the region to consider strengthening lifelong learning opportunities. Continuing and lifelong educational opportunities are critical to addressing adult illiteracy, including digital and financial illiteracy. Given the rapidly changing labour market and growing demand for upskilling, training opportunities can help older persons, and younger individuals, to keep their skills in line with contemporary demands.[140] Moreover, strengthening public education systems can help address the illiteracy issue from a young age and for the most vulnerable population groups.

Short-term (next 5 years)		Medium-term (5-10 years)		Long-term (10-20 years)	
Objectives	**Actions**	**Objectives**	**Actions**	**Objectives**	**Actions**
Goal: Prepare generations for healthy ageing, physically and mentally					
Promote healthy habits	Promote physical activity among all (in schools, community centres, etc.) through community outreach	Incentivize healthy habits	Introduce legal measures to support healthy habits and disincentivize unhealthy habits		
	Promote healthy eating habits (nutrition and more) through community outreach		Invest in public spaces and resources that facilitate physical activity (parks, community centres, summer camps, etc.)		
	Combat negative behaviour (drinking, smoking, etc.) through media campaigns				
Diagnose the responsiveness of the current health system	Conduct a gap assessment on the availability, accessibility and affordability to all, and sensitivity to older persons, of primary, secondary and tertiary health care centres	Provide access to health	Invest in health care institutions that are age-friendly	Build reliable, inclusive and responsive health care systems	Conduct periodic assessments of the age responsiveness of health care systems
			Increase access to information on available health resources		
			Ensure that health care institutions are affordable, including providing free primary health care		
	Conduct multi-stakeholder meetings, including older persons, to develop reform proposals to address identified gaps	Improve the quality of health services	Develop quality standards		Implement necessary reforms considering periodic assessments
			Implement quality standards		
			Enforce quality standards		
Ensure age-sensitive sectoral polices	Assess the sensitivity of the sectoral policy in terms of its inclusion of older persons and life cycle approach				
	Conduct multi-stakeholder meetings, including older persons, to develop reform proposals to promote more responsive sectoral policies				
	Implement reforms agreed upon at multi-stakeholder meetings.				

Short-term (next 5 years)		Medium-term (5-10 years)		Long-term (10-20 years)	
Objectives	**Actions**	**Objectives**	**Actions**	**Objectives**	**Actions**
Goal: Promote an inclusive society for all ages					
Build an enabling environment for older persons	Promote age-friendly workplaces by engaging with the private sector	Establish age-friendly cities	Establish infrastructure that supports older persons' involvement in public life		
	Encourage inter-generational volunteering by creating programmes offering opportunities for inter-generational exchanges		Improve transportation options for older persons		
	Encourage the development of community spaces (such as parks, other day centres, etc.) to facilitate increased inclusion of older persons in societies		Provide housing arrangements for older persons that support them in leading dignified and productive lives		
Promote age-sensitive attitudes	Develop an age-sensitive school curriculum	Build peaceful societies that combat ageism	Introduce legislation against all forms of violence, abuse and neglect of older persons		
	Institute community advocacy campaigns (schools, community centres, etc.) to combat ageism and promote greater recognition of the contributions of older persons				
	Implement national media campaign to combat ageism and promote greater recognition of the contributions of older persons				
Goal: Prepare future generations for financial security in old age					
Encourage investment and savings throughout the life cycle	Conduct outreach campaigns to different age groups to better understand their current investment and savings behaviour	Incentivize investment and savings	Introduce legal measures to reward saving for old age, e.g. tax breaks for investing in retirement funds		

Short-term (next 5 years)		Medium-term (5-10 years)		Long-term (10-20 years)	
Objectives	**Actions**	**Objectives**	**Actions**	**Objectives**	**Actions**
Promote financial literacy from a young age and throughout the life cycle	Incorporate financial literacy training in school curriculums	Promote diversified investment to manage risk and optimize returns	Conduct investment strategy trainings for adults, including older persons		
	Conduct financial literacy trainings for adults, including older persons				
Goal: Provide opportunities for learning throughout the lifecycle					
Address adult illiteracy	Conduct an assessment of the extent of adult illiteracy and the underlying dynamics	Improve access to and quality of public education	Invest more in public education, including reducing out of pocket expenses for public education		
	Scale up adult education programmes, especially in areas with the highest rates of adult illiteracy		Hold regular training sessions with teachers and educational administrators		
Provide skills development opportunities	Establish regular training sessions on modern skills for interested persons, including older persons				

D. Social protection

While there is widespread agreement on the importance of extending social protection to all older persons, it is more challenging to say how this should be done.There are three central elements that need to be considered.

- First, coverage is the best place to start. Understanding who is currently not being protected by current systems, and why this is the case, is critical before developing appropriate policies to fill the gaps. In this pursuit, Arab countries should consider implementing universal or semi-universal non-contributory pension schemes, bearing in mind that this would considerably reduce the degree of exclusion errors, and that providing non-contributory social protection to a larger section of society could enhance political support for social spending.
- Second, the adequacy of social protection schemes needs to be ensured. This involves ensuring that benefits provided to older persons through contributory as well as non-contributory social protection schemes are regularly adjusted in line with inflation or with wages.

- Third, the complementarity of contributory and non-contributory programmes needs to be strengthened. Arab Governments should abstain from categorically excluding older persons covered by contributory social insurance mechanisms from non-contributory mechanisms such as cash transfer programmes.

Short-term (next 5 years)		Medium-term (5-10 years)		Long-term (10-20 years)	
Objectives	**Actions**	**Objectives**	**Actions**	**Objectives**	**Actions**
Goal: Extend coverage of schemes to include all older persons					
Attain a better understanding of who is excluded and the reasons behind undercoverage of contributory and non-contributory social protection schemes	Collect and analyse relevant data, both administrative and survey-based, in order to better understand the characteristics of excluded older persons	Ensure periodic monitoring of the implementation of reforms	Conduct periodic monitoring using the established mechanisms		
			Identify good practices as well as areas requiring reform		
	Undertake studies relating to undercoverage among older persons and make these available to policymakers and other stakeholders	Ensure that social protection benefits reach all older persons	Adjust eligibility criteria and targeting mechanisms to extend coverage to those who have been left behind		
			Reduce the level of exclusion errors of social assistance programmes for older persons		
Enhance coverage of social insurance	Draft new proposals for reform of social protection systems				
	Organize multi-stakeholder consultations to ensure proposed reforms are responsive and inclusive				
	Adopt proposed reforms				
	Establish a monitoring mechanism				

Short-term (next 5 years)		Medium-term (5-10 years)		Long-term (10-20 years)	
Objectives	**Actions**	**Objectives**	**Actions**	**Objectives**	**Actions**
Goal: Ensure adequacy of benefits for older persons					
Attain a better understanding of the adequacy of contributory and non-contributory social protection schemes	Conduct studies to understand adequacy and reasons for inadequacy	Ensure that social protection benefits continue to increase and/ or remain at an adequate level	Increase the level of social protection benefits provided to older persons, particularly those who are poor or vulnerable		
	Propose options for enhancing complementarity of contributory and non-contributory mechanisms				
	Organize multi-stakeholder consultations to ensure proposed reforms are responsive and inclusive				
Ensure that social protection benefits are adequate, especially for the poorest and most vulnerable	Revise indexation mechanisms (ensuring benefits correspond to levels of inflations or wages) and propose adjustments		Monitor benefit levels to ensure they do not dwindle in face of inflation or other factors, and make necessary adjustments if needed		
	Review regulations (parameters and indexation mechanisms) governing contributory pension schemes		Undertake studies focusing on the direct and indirect effects of social protection provided to older persons, including on other members of their households		
	Reform regulations governing contributory pensions schemes				

Short-term (next 5 years)		Medium-term (5-10 years)		Long-term (10-20 years)	
Objectives	**Actions**	**Objectives**	**Actions**	**Objectives**	**Actions**
Goal: Ensure complementarity and responsiveness of social protection systems					
Attain a better understanding of the interactions between contributory and non-contributory mechanisms for older persons	Evaluate the interplay between contributory and non-contributory mechanisms	Ensure the sustained complementarity of social protection schemes	Review the complementarity of social protection schemes	Enhance the responsiveness of social protection systems to the needs of older persons	Conduct periodic assessments of the age-responsiveness of social protection systems
	Propose options for enhancing complementarity of contributory and non-contributory mechanisms		Make necessary adjustments, for instance by more closely integrating contributory and non-contributory social protection mechanisms for older persons as the coverage gap closes		
	Organize multi-stakeholder consultations to ensure proposed reforms are responsive and inclusive				
Ensure the integration of contributory and non-contributory mechanisms	Study how to establish an integrated system based on complementarity between contributory and non-contributory mechanisms				Update social protection systems to be responsive to older persons' evolving priorities
	Adopt proposed reforms				
	Establish a monitoring mechanism				

E. Long-term care economy

LTC markets are crucially needed in the Arab region, especially given the fast pace of population ageing. Chapter 3 described how existing efforts in this regard are fragmented and require a more holistic approach. Building partnerships, harnessing advances in technology, raising awareness and collating accurate data on demand and preferences are critical success criteria to achieve high-quality LTC markets, based on person-centred and human rights approaches, that benefit all involved.

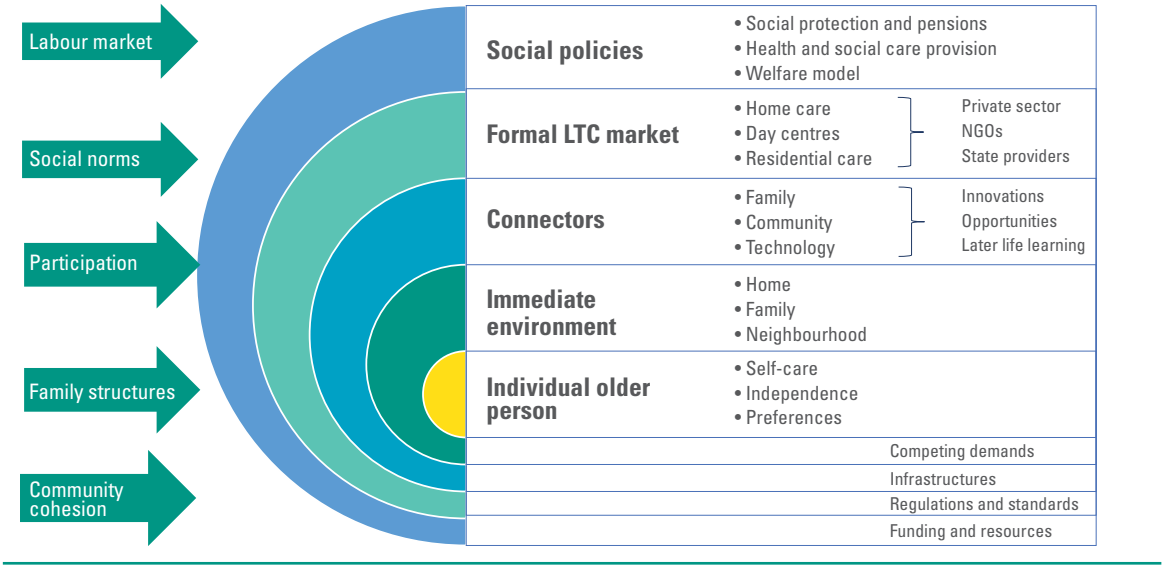
Figure 42 illustrates a care market framework that could apply to the Arab region. This conceptualization recognizes the interaction between the formal LTC market with a broader structure that encompasses actors at different levels from the individual to the overall national health and care systems. The specific types and design of the LTC market, and services, are influenced by the preferences and perceptions of individual older persons, their immediate environment and intergenerational support within their families. It is also governed by the country's social policy and welfare models, infrastructure, regulations and standards and levels of funding and resources. It is essential to view the evolving LTC market as an integral part of broader national strategies to support older people and their families in the region.

Governments must take the lead role and responsibility for achieving a responsive, diverse and sustainable LTC market to ensure high-quality, personalized care and support that best meets the needs of people, regardless of who pays for care. Nevertheless, families and informal caregivers will continue to have a significant role in the provision of LTC in the region. Hence, it is essential for Governments to design and adopt policies that reduce the financial burden on family caregivers and enable older people to purchase LTC services from a well-regulated market.

Below are six key elements for reform, each elaborated in the table that follows.

- First, social policy must establish a framework to govern LTC markets. This includes creating a legal framework and institutionalizing government buy-in.
- Second, formal LTC systems require culturally sensitive LTC models, quality control protocols, regulation and staff training.

Figure 42. A conceptualization of the LTC market



Source: Prepared by ESCWA.

- Third, a whole-of-government, whole-of-society approach will be necessary. The LTC market should find ways to incorporate informal caregivers and promote innovation with use of technology to serve older persons' needs.
- Fourth, an accessible and COVID-19 responsive environment is needed to facilitate older persons' access to needed LTC services.
- Fifth, older persons should be empowered through the promotion of their self-care and independence.
- Finally, to support all the other elements it will be fundamental to secure adequate funding for LTC.

Short-term (next 5 years)		Medium-term (5-10 years)		Long-term (10-20 years)	
Objectives	**Actions**	**Objectives**	**Actions**	**Objectives**	**Actions**
Goal: Establish a framework to govern LTC markets					
Ensure government buy-in	Establish communication strategies with common goals across relevant governmental departments and agencies	Agree on government commitments and responsibilities	Implement governance frameworks	Integrate support across different departments	Monitor and review responsibilities to relevant government bodies
Assess legal frameworks	Assess current legislations and laws related to rights and eligibility for LTC support	Reform legal frameworks	Draft new proposals	Adopt legislative reforms	Ensure effective implementation
Propose additional legal frameworks	Identify gaps		Consult with relevant bodies and the public		Address gaps

Short-term (next 5 years)		Medium-term (5-10 years)		Long-term (10-20 years)	
Objectives	**Actions**	**Objectives**	**Actions**	**Objectives**	**Actions**
System 'connectors'					
Goal 1: Ensure effective partnerships					
Develop collaborative mechanisms	Identify relevant non-governmental partners	Strengthen partnerships	Continue to foster public-private partnerships	Ensure a cross-sectoral, whole-of-government approach	Increase accessibility and inclusivity
	Consult on different collaborative mechanisms in relation to a variety of partners across different governmental bodies, non-governmental agencies, and the private sector		Build capacity of non-governmental bodies and agencies		Continue to support and expand partnerships
Goal 2: Recognize the role of informal caregivers					
Assess the suitability of different mechanisms to support informal caregivers	Evaluate the following options:	Implement a range of supporting policies	Work with employers	Expand existing mechanisms and introduce new ones	Continue working in partnership with different agencies
	Potential social protection and welfare benefits (both in-kind and cash benefits)		Coordinate activities across different governmental departments		Ensure a consultative approach
	Employment benefits such as LTC leave		Employ a consultative and evidence-based evaluative process		
Provide services to families	Assess the needs for respite care	Establish services for informal carers	Pilot services such as respite care	Expand and enhance services for family caregivers	Monitor, evaluate and improve services
	Provide training and information to facilitate informal LTC provision		Expand training programmes for informal family caregivers		Identify training needs and gaps
	Professional support with care coordination		Facilitate access to support from professionals such as social workers and care-coordinators		Regularly review needs through recurrent assessment processes

Short-term (next 5 years)		Medium-term (5-10 years)		Long-term (10-20 years)	
Objectives	**Actions**	**Objectives**	**Actions**	**Objectives**	**Actions**
Identify the best means to communicate with informal caregivers	Assess the needs of informal caregivers	Establish mechanisms to share information	Establish databases of services including information on cost, eligibility criteria and quality ratings	Review and improve information sharing mechanisms	Invest in knowledge translation and mobilization
			Establish helplines for informal carers		
Goal 3: Promote innovations					
Explore the potential role of technology in LTC provision	Assess the current role of digital technology in self-care and formal LTC provision	Support innovations	Work with industries and entrepreneurs to promote new designs specific for LTC service delivery	Expand the use of assistive technology for LTC delivery	Assess, expand and enhance the role of assistive technologies
	Assess gaps in accessing technology (e.g. digital literacy, infrastructure, digital divide, accessibility)		Enhance access to technology		
	Assess the preferences of older people and their informal caregivers		Work with the industry to create tools specific to the preferences of older people		
Adequate environment					
Goal 1: Mitigate the effect of the COVID-19 global pandemic					
Recognize the effect of COVID-19	Conduct studies and surveys to understand the effect of COVID 19 on older people	Respond to the medium-term effects of COVID-19	Facilitate and prioritize health care and LTC for older people	Develop strategies to address future system shocks	Identify effective responses
Respond to the immediate needs of older people due to COVID-19	Identify priorities for short-and medium-term actions to respond to the needs of older people		Design specific initiatives to facilitate unpaid family caregiving		Develop strategies and response mechanisms
Goal 2: Ensure an accessible environment					
Understand facilitators and barriers for an accessible environment for older people	Assess the suitability of infrastructure (including the built environment and transportation) for older people's needs	Modify and improve environmental infrastructure	Establish a working group to support planning departments for new building and road designs	Achieve a built environment suitable for all	Foster investments in green accessible environments

Short-term (next 5 years)		Medium-term (5-10 years)		Long-term (10-20 years)	
Objectives	**Actions**	**Objectives**	**Actions**	**Objectives**	**Actions**
Formal Long-Term Care Market					
Goal 1: Design a culturally sensitive LTC market model					
Tailor proposed model for LTC markets to local and national needs	Review current policy goals and strategies	Review and amend as necessary	Adopt a multi-sectoral consultative approach	Review and amend as necessary	Adopt a multi-sectoral consultative approach
	Conduct consultations to ensure a participatory approach		Ensure the input of older people and their informal caregivers		Ensure the input of older people and their informal caregivers
	Approve an action plan		Review action plan		
Goal 2: Implement LTC services and markets					
Assess the current provision of LTC services	Conduct diagnostic studies and situational analyses	Establish equality in access to and utilization of LTC services	Establish effective reporting mechanisms (including IT systems)	Ensure effective LTC services	Establish effective integration mechanisms across different services
	Achieve an in-depth understanding of older people's preferences and gaps in provision		Implement quality assurance tools		Encourage investment in research on geriatrics and long-term care
	Conduct LTC demand and supply models		Ensure that services are registered		
Goal 3: Design new LTC initiatives					
Design pilot programmes	Focus on home-care support	Pilot, implement and evaluate a diverse set of services	Employ data and models developed under the short-term goals	Scale-up and expand LTC services	Adopt a recurrent process of evaluation and improvement of LTC services
	Community care		Re-evaluate and enhance		
	Day-care services		Expand services across geographical locations and population groups		

Short-term (next 5 years)		Medium-term (5-10 years)		Long-term (10-20 years)	
Objectives	**Actions**	**Objectives**	**Actions**	**Objectives**	**Actions**
Design pilot programmes	Determine the demand for residential care	Introduce new services and initiatives	Improve and expand home-care services	Continue to design new services to meet emerging needs	Adopt a recurrent process of consultation, needs-assessment and piloting
	Understand the demand for new forms of supported retirement housing		Implement community-based care and day-care services		
			Introduce new forms of residential care including retirement home		
			Establish services for complex care, including advanced dementia care		
Goal 4: Regulate the LTC market					
Assess current formal provision of LTC	Conduct survey of currently available services	Implement regulatory measures	Set prices and commissioning processes for LTC services	Develop a coherent LTC market	Build infrastructure for specialized LTC services
	Design a database of services		Set quality assurance measures		
Goal 5: Ensure the supply of well-trained LTC workforce					
Design LTC training programmes	Set minimum training requirements and curriculum	Implement and expand on LTC training programmes	Ensure the diversity of the LTC workforce	Ensure training programmes meet emerging needs of older people	Work in partnership with training institutions, older people and the workforce to enhance training programmes
	Establish career pathways		Create a range of job roles and career opportunities		

Short-term (next 5 years)		Medium-term (5-10 years)		Long-term (10-20 years)	
Objectives	**Actions**	**Objectives**	**Actions**	**Objectives**	**Actions**
Assess current informal paid LTC staff	Conduct surveys to assess the level of care provision from informal workers e.g. domestic workers	Ensure career pathways	Set standards for approved training courses	Establish effective career pathways	Design diverse routes of career development Ensure transferability of certificates and skills
	Design short training courses for existing workers		Identify relevant professional regulatory bodies		
	Set standards for training courses		Establish connections and 'bridge' courses to the health care profession		
	Identify relevant professional regulatory bodies		Set-up and expand registration and regulatory standards		
	Agree on initial career pathways		Review and amend potential career development opportunities		
Goal: Promote self-care and independence					
Raise awareness of healthy ageing behaviours and habits	Design and pilot public awareness campaigns	Establish proactive and preventative services	Work with multi-disciplinary teams across different departments and agencies	Expand preventative and proactive services	Work in partnership with other agencies, older people and informal caregivers
	Conduct regular opinion polls		Pilot, monitor and evaluate services and campaign		
Improve public awareness	Undertake media and social campaigns	Expand public awareness	Act throughout the educational and employment life-course and every-day media	Normalize messages of healthy ageing	Establish public awareness message as a core element of communications
Empower older people and ensure their voices are heard and acted upon	Identify groups of older people at risk of exclusion from relevant debates	Support capabilities of older people	Create adequate opportunities for older persons to contribute to the wider society through paid and volunteer work	Expand opportunities for older people to participate	Create new opportunities for social, societal and economic participation
	Identify mechanisms to reach older people from different backgrounds		Set policies to reduce ageism in the workplace and facilitate re-employment of older people		

Short-term (next 5 years)		Medium-term (5-10 years)		Long-term (10-20 years)	
Objectives	**Actions**	**Objectives**	**Actions**	**Objectives**	**Actions**
Reduce literacy rates among older people (including digital and financial literacy)	Assess the level of needs among older people	Enhance and expand on services	Set up local initiatives	Expand and create new initiatives	Continue working in partnership with different agencies
	Design new initiatives in partnership with governmental and non-governmental agencies		Coordinate with educational institutions and local organizations to improve recruitment to training programmes		Modify services according to emerging needs
	Consult with older people and their families				
Enhance awareness at younger ages (40+)	Work with employers to provide at-work training on healthy ageing	Target individuals who might be at higher risk	Identify groups at higher risk through research	Expand and create new initiatives	Emphasize the life-course approach to health at the national and local levels
	Work with community-based organizations to promote independence and healthy ageing		Develop tailored and targeted initiatives		
LTC funding					
Goal 1: Identify and protect the LTC budget (current and projected)					
Estimate current and projected LTC cost	Conduct LTC cost modelling	Enhance projections of cost estimates	Conduct cost-effective analysis for different services	Develop sustainable funding models	Revise and develop mechanisms to enhance funding
	Identify gaps in data and information		Model costs based on different funding scenarios		
Goal 2: Implement funding models					
Evaluate different LTC funding models	Assess the suitability and viability of existing funding models	Propose and consult to implement a desired LTC funding model	Assess the following (and other) components: The State's role in funding The potential value of contributory LTC insurance schemes The role of charitable organizations in the provision of LTC services Incentives and contributions of the private sector	Implement LTC funding model	Undertake fiscal reforms to address budget requirements

F. Building forward better

To realize the promise of 'leaving no one behind', Governments need to prioritize older persons. Arab Governments are starting to make progress in this pursuit, but more is needed.

This report provides a one-of-a-kind roadmap to support member States' efforts. Taken together, these recommendations will help Arab countries build forward better for older persons. Countries need to adopt holistic approaches and mainstream ageing and older persons' issues across the policy sectors and processes.

Comprehensive, integrated and inclusive data systems will provide the information required to develop appropriate policy responses. A life-cycle approach is a critical element in the creation of age-inclusive societies that respond to the evolving needs and harness the unique contributions of individuals throughout the different stages of their life.

Strengthening social protection systems is an integral policy imperative to provide the necessary support needed to the most vulnerable. A robust LTC economy is also an important element of a care ecosystem that protects and empowers older persons.

An integrated and comprehensive care ecosystem for older persons is a work in progress and can take decades. The evidence presented in this report has highlighted that the time for action is now, lest current and future cohorts of older persons continue to be marginalized and at risk of vulnerability.

The present report calls upon countries to shift the narrative from one of dependency to one that recognizes the unique contributions of older persons, seize the demographic window of opportunity and reflect on the recent lessons learned from the COVID-19 pandemic to build forward better for older persons and ensure their protection and empowerment.

Annex 1: Technical note on social insurance data

Data relating to overall pension coverage (SDG 1.3.1, data series g) are from the ILO Social Security Inquiry and have been collected from the ESCWA Data Portal as well as from the ILO World Social Protection Report 2020-2022 (published in September 2021). In certain cases, the data between these two sources converge, though in other cases they do not (for instance, the ILO data available on the ESCWA Data Portal suggest that pension coverage in Egypt is 38 per cent while the World Social Protection Report 2020-2022 sets the number at 57.6 per cent). When the sources differ, the data from the ILO World Social Protection Report 2020-2022 have been used.

It should be noted that the ILO World Social Protection Report 2020-2022 does not specify years in relation to the data on pension coverage, nor whether coverage includes both contributory and non-contributory mechanisms or merely one of the two. For these reasons, the ILO data on overall pension coverage should be interpreted with great caution.

Since ILO does not publish an average coverage rate for the Arab region (including the North African countries), that number has for the purpose of this report been estimated on the basis of the country data and the total population aged 60 or above in 2020 (as reported by DESA). This threshold was used across the board since the actual statutory age differs not only from one country to another, but also frequently between different schemes within a single country as well as for men and women. For this reason, the estimated regional average should be seen as approximate.

Data relating to specific social insurance schemes presented in the chapter largely come from the funds and institutions administering the schemes, notably from their annual reports. Due to the features and parameters of the schemes as well as how data are reported in the sources, full comparability between the data reported for different schemes cannot be ensured. Interpretations should therefore be made with caution.

CNSS in Morocco, CNSS in Tunisia and PASI in Oman are limited to the private sector, while public sector workers are covered by other schemes for which no data are available. SSC in Jordan, on the other hand, covers both public and private workers, though older persons having previously worked in the public sector are in large part covered by two special pension regimes that are now being phased out. PIFSS in Kuwait and SIO in Bahrain also cover both the public and private sector. However, gender-disaggregated data are not available for PIFSS military pensioners, who have therefore been excluded from calculations.

Since the statutory retirement age varies between countries and schemes, and since in some cases it has been revised in the recent past, the exact scope of the group "old-age pensioners" is fluid. Furthermore, this category may in some cases include a number of early retirees.

In cases where sources report data for old-age pensioners and early-retirement pensioners separately, namely SSC in Jordan and PASI in Oman, the data for the former group have been used. In the case of CNSS in Tunisia, old-age pensioners include individuals aged 50 years and up, though the overwhelming majority (91 per cent as of 2017) are older than 60. Data for old-age pensioners in Morocco, similarly, might include early retirees (aged 55-60), but they should not be expected to constitute a large portion of the total given the average age of new pensioners (61 as of 2018).

PIFFS in Kuwait and SIO in Bahrain report data on pensioners of all ages without distinguishing by type of entitlement. However, the sources provide disaggregation by age span, which has allowed for all individuals younger than 61 (PIFFS) or 60 (SIO) to be subtracted. Thus, with regard to these two schemes, "old-age pensioners" does mean pensioners above those thresholds.

Data on older persons receiving survivor benefits have in the cases of CNSS in Tunisia and SIO in Bahrain been limited to persons older than 50 and 60, respectively, to ensure the highest possible degree of comparability with the group old-age pensioners.

Annex 2: Chapter 3 methodology

This chapter employs a narrative analysis of policies and debates reflecting the emerging LTC markets in the Arab region. It draws from the experience of countries in Europe and the OECD, where care markets, structures and principles have been evolving for several decades. The analysis employs a case-study approach, which helps explore the phenomena of LTC demands and emerging markets within specific contexts. The research focuses on three country case studies from the region: the Syrian Arab Republic, Saudi Arabia and Egypt to reflect on their experiences with ageing and LTC provision. To gain an in-depth understanding of issues related to ageing populations and evolving LTC markets in the three selected country case studies, desk research included review of published statistics and data, synthesis of relevant published academic literature and a media and news search for relevant articles and commentaries in Arabic.

In addition to the desk review, the research team collected primary data. For Saudi Arabia, a workshop with key stakeholders from the Ministries of Social Development, Family Affairs, Health and Education was conducted in November 2021, followed by review of several internal documents (in Arabic) provided to the team by Saudi Government stakeholders.

For Egypt, several interviews and social media communications were conducted (during October and November 2021) with charitable organizations concerned with the welfare of older people who shared further documents, articles and announcements. A workshop was also held with stakeholders from the Ministry of Social Solidarity in November 2021.

Finally, for the Syrian Arab Republic, we consulted a recent fieldwork study conducted by the Syrian Commission for Family Affairs and Population (2019) evaluating the needs of older people in the country between 2011 and 2019.

To estimate the current cost of LTC in the three case studies, a costing model proposed by Ismail and Hussein (2021) was used, which improves an existing estimation model previously adopted by the Organisation for Economic Co-operation and Development (OECD). The earlier OECD attempt used a regression model to estimate the likely cost of LTC for its members.[141] The same model was followed by Costa-Font and others (2015) to estimate the impact of GDP on LTC spending. The model by Ismail and Hussein (2021), used for the analysis in this chapter,[142] improves over the previous models by first adopting Bayesian estimation methods instead of a maximum likelihood approach to cope with the small sample size. Bayesian estimation methods are known to cope well with small sample sizes, assuming a proper choice of prior distributions.[143] Second, the model assumes that even though there are commonalities between all countries in the sample, there are cultural and policy differences. These differences are reflected in the modelling by employing a hierarchical random intercept. Each country has its intercept to reflect its individuality. However, all intercepts are related to each other as they are all drawn from a joint distribution.

The model variants sought to estimate the share of long-term care expenditure in GDP (source OECD stats) as a function of the following determinants:

- GDP per capita is used to represent total productivity.
- The female labour force participation rate is used to proxy informal care provision.
- The population aged 65 (OECD uses the 80 years threshold) and above relative to the total population is a control parameter.

Based on the model proposed by Ismail and Hussein (2021), we carried out estimations on the log scale, and we used leave-one-out cross-validation (LOO) and the widely applicable information criterion (WAIC) to compare several models. We implemented additional calculations of the log-likelihood evaluated at the posterior simulations of the parameter values as explained in Vehtari and others (2017). All model variants and comparison calculations were developed using CmdStan (Stan DevelopmentTeam, 2018). All other calculations and graphs were generated using the R statistical environment (R CoreTeam, 2020).

Case selection

Figure 38 presents key demographic and socioeconomic factors for the three selected case studies. The Syrian Arab Republic presents a case of moderate ageing, low income and relatively low health care expenditure per capita, transitioning from a prolonged conflict. In comparison, Egypt presents a case of a low-middle income populous country in the North Africa region. Finally, Saudi Arabia represents the experience of a high-income GCC country. Figure 38 shows that of the three case studies the average life expectancy at birth (in 2019) was highest in Saudi Arabia at 75 years, while the old-age dependency ratio and percentage of the people aged 65 or more were highest in Egypt (in 2020). Both Egypt and the Syrian Arab Republic had high levels of out-migration in 2017, linked to economic emigrants in the case of Egypt and refugees and asylum seekers in the case of the Syrian Arab Republic. On the other hand, Saudi Arabia had positive net migration with more people immigrating into the country than emigrating out. However, the three countries are projected to start their ageing transition by the middle of the next decade (mid-2030), with different ageing speeds. Saudi Arabia presents a situation of a relatively short duration of only 12 years, while Egypt is projected to take a considerably more extended period of 42 years, linked to observed and projected higher fertility rates than in the other two countries.

Demographic and socioeconomic characteristics for the three case studies

Characteristics	Syrian Arab Republic	Saudi Arabia	Egypt
Average life expectancy at birth (2019) Total Males Females	 73 years 68 years 78 years	 75 years 74 years 77 years	 72 years 70 years 74 years
Percentage of the population 65+ (n) in 2020	4.9% (853,056)	3.5% (1,217,949)	5.3% (5,456,144)
Old age dependency ratio in 2020	7.6	4.9	8.8
Total fertility rate (2019)	2.8	2.3	3.3

Female employment rate in 2019	16.7%	15.8%	20.6%
Net migration (2017)	-2,136,954	674,895	-190,164
GDP per capita (2019)	$1,194	$23,337	$3,153
Health care expenditure as a percentage of GDP (year)	3.57% (2012)	6.36% (2018)	4.95% (2018)
Year ageing transition start (years to complete)	2035 (17 years)	2033 (12 years)	2036 (42 years)
Context	Low income; political conflict; Levant region	High income; high levels of in-migration; Gulf region	Low-middle income; most populous; North Africa

Sources: Chapter 1, DESA (2019a); World Bank, n.d.

References

Abdel-Rahman, S. and others (2021). Predictors of catastrophic out-of-pocket health expenditure in rural Egypt: application of the heteroskedastic probit model. Journal of the Egyptian Public Health Association, 96(23). Available at https://jepha.springeropen.com/articles/10.1186/s42506-021-00086-x.

Agence France-Presse (2021). Au Liban, les retraités démunis face à l'effondrement monétaire. Challenges, 29 March. Available at https://www.challenges.fr/societe/au-liban-les-retraites-demunis-face-a-l-effondrement-monetaire_757958.

Ahmed, W. (2018). Escaping the poverty cycle? 3 years of Takaful and Karama. Mada Masr, 4 April. Available at https://www.madamasr.com/en/2018/04/04/feature/economy/escaping-the-poverty-cycle-3-years-of-takaful-and-karama/.

Algeria, Ministry of National Solidarity, Family Affairs and the Status of Women (2018). Available at https://www.msnfcf.gov.dz/fr/?p=allocation_forfait_solid.

Algeria (2010). Contribution du Gouvernement algérien au questionnaire de l'Experte indépendante sur les questions des droits de l'homme et de l'extrême pauvreté, portant sur la protection sociale des personnes âgées, s.l.: s.n. Available at https://www.ohchr.org/Documents/Issues/EPoverty/older/Algeria.pdf.

AlMasry AlYoum (2019).(التفاصيل) «التضامن تطرح 150 فرصة عمل كـ«رفيق مسن» . Available at https://www.almasryalyoum.com/news/details/1379745.

_____ (2021a). (نصوص المواد) تنشر مشروع قانون المسنين. Available at https://www.almasryalyoum.com/news/details/2285275.

_____ (2021b). التضامن : إعفاء المسنين فوق الـ70 عامًا من دفع قيمة المواصلات العامة والقطارات والمترو. Available at https://www.almasryalyoum.com/news/details/2367507.

Al-Wuznah (n.d.). Home care programmes for older people and those living with disabilities. Ministry of Social Affairs, Kingdom of Saudi Arabia (in Arabic).

Arab Monetary Fund and World Bank (2017). Arab Pension Systems: Trends, challenges and options for reforms, s.l.: s.n. Available at https://openknowledge.worldbank.org/handle/10986/28221.

Ayadi, I. and Zouari, S. (2017). Out-of-pocket health spending and equity implications in Tunisia. Middle East Development Journal, 9(1), pp. 1-21. Available at https://www.tandfonline.com/doi/abs/10.1080/17938120.2017.1293362.

Baladna El Youm (2019). "التضامن" تعلن عن وظائف لرعاية المسنين" بمرتب 4000 جنيه". Available at https://www.baladnaelyoum.com/news/5d763345a24321309e6bc143/تغطيات-ومتابعات/بمرتب-4000-جنيه-التضامن-تعلن-عن-وظائف-لرعاية-المسنين.

Baldwin, S. A., and Fellingham, G. W. (2013). Bayesian methods for the analysis of small sample multilevel data with a complex variance structure. Psychological Methods, 18(2), 151-164.

Baseera (2021). Care services for older people and their impact on women economic participation. The Egyptian Centre for Public Opinion Research, The National Council for Women and the World Bank Group. https://en.enow.gov.eg/Report/155.pdf (accessed 5/11/21).

Black, J. (2020). Jordan: Managing COVID-19 and protecting care homes. Available at https://ltccovid.org/wp-content/uploads/2020/07/Jordan_ltccovid_updated-country-report-26-July-2020-1.pdf.

Boggatz, T., and Dassen, T. (2005). Ageing, care dependency, and care for older people in Egypt: a review of the literature. Journal of clinical nursing, 14, 56-63.

Booth, F. W.and others (2012). Lack of exercise is a major cause of chronic diseases. Comprehensive Physiology, 2(2), 1143-1211. https://doi.org/10.1002/cphy.c110025.

Breisinger, C. and others. (2018). Impact Evaluation Study for Egypt's Takaful and Karama Cash Transfer Program. Part 1: Quantitative Report, s.l.: IFPRI. Available at https://www.ifpri.org/publication/impact-evaluation-study-egypts-takaful-and-karama-cash-transfer-program-part-1.

Brooke, J., and Jackson, D. (2020). Older people and COVID-19 isolation, risk and ageism. Journal of clinical nursing.

Budreviciute, A.and others (2020). Management and prevention strategies for non-communicable diseases (NCDs) and their risk factors. Frontiers in public health, 8, 788.

Caisse Nationale de Sécurité Sociale (Morocco) (n.d.). Rapport Annuel 2010, s.l.: s.n.

_____ (n.d.). Rapport Annuel 2011, s.l.: s.n.

_____ (n.d.). Rapport Annuel 2012, s.l.: s.n.

_____ (n.d.). Rapport Annuel 2013, s.l.: s.n.

_____ (n.d.). Rapport Annuel 2014, s.l.: s.n.

_____ (n.d.). Rapport Annuel 2015, s.l.: s.n.

_____ (n.d.). Rapport Annuel 2016, s.l.: s.n.

_____ (n.d.). Rapport Annuel 2017, s.l.: s.n.

_____ (n.d.). Rapport Annuel 2018, s.l.: s.n.

_____ (n.d.). Rapport Annuel 2019, s.l.: s.n.

Caisse Nationale de Sécurité Sociale (Tunisia) (2021). La CNSS en chiffres. Available at https://www.cnss.tn/web/guest/qui_sommes_nous/-/asset_publisher/PTz2/content/la-cnss-en-chiffres.

_____ (n.d.). Annuaire Statistique 2017, s.l.: s.n.

_____ (n.d.). Statistical Guide 2010 (2010 الدليل الإحصائي), s.l.: s.n.

Centre de Recherches et d'Etudes Sociales (2017). Évaluation de la performance des programmes d'assistance sociale en Tunisie : Pour optimiser le ciblage des pauvres et freiner l'avancée de l'informalité, s.l.: s.n. Available at http://www.cres.tn/uploads/tx_wdbiblio/Rapport_CRES_mai_2017.pdf.

Centre de Recherches et d'Etudes Sociales (2019). Études de faisabilité des garanties du Socle National de Protection Sociale, s.l.: s.n. Available at http://www.cres.tn/uploads/tx_wdbiblio/resume-socle-final.pdf.

Cheung, F., and others (2020). The impact of the Syrian conflict on population wellbeing. Nat Commun 11, 3899. https://doi.org/10.1038/s41467-020-17369-0.

Chomik, R., and Piggott, J. (2018). Demographic and technological change: Two megatrends shaping the labour market in Asia.

Colliers International (2020). Insights into long-term care, rehabilitation and home care in Saudi Arabia. Available at https://insights.omnia-health.com/hospital-management/insights-long-term-care-rehabilitation-and-home-care-ksa (accessed 25/09/21).

Comas-Herrera, A. and others (2020). Mortality associated with COVID-19 in care homes: international evidence. Article in LTCcovid.org, international long-term care policy network, CPEC-LSE, 14.

Costa-Font, J. and others (2015). Financing long-term care: ex-ante, ex-post or both? Health Econ. 24 Suppl 1:45-57.

Deeksha, K. and others (2020). Impacts of COVID-19 on Household Welfare in Tunisia, World Bank. Available at https://www.worldbank.org/en/country/gcc/publication/impacts-of-covid-19-on-household-welfare-in-tunisia.

De Henau, J. and others (2017). Investing in the Care Economy: Simulating Employment Effects by Gender in Emerging Economies, International Trade Union Confederation (ITUC).

De la Maisonneuve, C., and Martins, J. O. (2013). Public spending on health and long-term care: a new set of projections. OECD Library.

Deniz Eroğlu, U., Unutulmaz, K.O. and Sirkeci, Í (eds) (2017). Turkey's Syrians: Today and Tomorrow. Transnational Press London.

Eddine, S. B. (2018). Solidarité: plus de 315.000 personnes âgées bénéficiaires d'allocation forfaitaire en 2018. Algérie Presse Service, 24 December. Available at https://www.aps.dz/societe/82749-allocation-forfaitaire-de-solidarite-plus-de-315-000-personnes-agees-beneficiaires-en-2018.

Egypt Today (2021). Egypt's Senate approves draft law ensuring the rights of senior citizens, penalizing negligent caregivers. Available at https://www.egypttoday.com/Article/1/110141/Egypt-s-Senate-approves-draft-law-ensuring-the-rights-of.

El Watan (2009). La pension mensuelle passe à 3000 dinars. 4 January. Available at https://www.elwatan.com/archives/actualites/la-pension-mensuelle-passe-a-3000-dinars-04-01-2009.

Fernández, J. and others (2020). European Long-Term Care Models and Compatibility with Social Investment Approaches. Social Protection Investment in LTC HORIZON.

Fitzpatrick, J. M. and others (2021). Protecting older people living in care homes from COVID-19: a protocol for a mixed-methods study to understand the challenges and solutions to implementing social distancing and isolation. BMJ open, 11(8), e050706.

Gadbois, E. A. and others (2021). "I don't know how many nursing homes will survive 2021": Financial sustainability during COVID-19. Journal of the American Geriatrics Society.

Gemayel, F. (2020). Les indemnités de fin de service laminées par la dévaluation. Le Commerce du Levant, 21 September. Available at https://www.lecommercedulevant.com/article/30047-les-indemnites-de-fin-de-service-laminees-par-la-devaluation.

Georgiadis, A. (2013). Efficiency wages and the economic effects of the minimum wage: Evidence from a low-wage labour market. Oxford Bulletin of Economics and Statistics, 75(6), 962-979.

Greek Community of Alexandria (n.d.). History. Available at https://ekalexandria.org/en/establishment/history/#.YZJHkC2l1aI.

Grimmer, K. and others (2015). Consumer views about aging-in-place. Clinical Interventions in Aging 10, 1803.

Hodge, H. and others (2017). Using Internet technologies in rural communities to access services: The views of older people and service providers. Journal of Rural Studies, 54, 469-478.

Hussein, S. and Ismail, M. (2017). Ageing and Elderly Care in the Arab Region: Policy Challenges and Opportunities. Ageing International, 42(3), 274-289. DOI: 10.1007/s12126-016-9244-8.

Hussein, S. (2019). Regional Workshop on Ageing, Cairo, April 2019. Available at https://www.menarah.org/resources/blogs/regional-workshop-on-population-ageing-in-the-middle-east-cairo-april-2019/.

Hussein, S. and others (2020). COVID-19 and the Wellbeing of the Adult Social Care Workforce: Evidence from the UK. The Personal Social Services Research Unit, University of Kent.

Ibrahim, S. E. (2019). Oil, migration and the new Arab social order. In Rich and poor states in the Middle East (pp. 17-70). Routledge.

International Labour Organization (ILO) (2018). Care Work and Care Jobs For the Future of Decent Work. Available at https://www.ilo.org/wcmsp5/groups/public/---dgreports/---dcomm/---publ/documents/publication/wcms_633135.pdf.

_____ (2019). Minister of Labour and ILO officials discuss designing a pension system for Lebanon and reforming the labour law. Available at https://www.ilo.org/beirut/media-centre/news/WCMS_675188/lang-en/index.htm.

_____ (2021a). ILOSTAT, ILO Modelled Estimates. Available at https://www.ilo.org/ilostat.

_____ (2021b). World Social Protection Report 2020-2022, s.l.: s.n. Available at https://www.ilo.org/global/research/global-reports/world-social-security-report/2020-22/lang--en/index.htm.

Ismail, M. and Hussein, S. (2019). Long-Term Care Policies in the Gulf Region: A Case Study of Oman. Journal of Aging and Social Policy. 31(4): 338-357.

Ismail, M., and Hussein, S. (2021). An Evidence Review of Ageing, Long-Term Care Provision and Funding Mechanisms in Turkey: Using Existing Evidence to Estimate Long-Term Care Cost. Sustainability, 13(11), 6306. doi:10.3390/su13116306.

Kane, T. and others (2020). Dementia caregiving in the middle east and north Africa: A scoping review. Transcultural .Psychiatry, 13634615211036404.

Khan, H. and others (2017). Nexus between demographic change and elderly care need in Gulf Cooperation Council (GCC) Countries: Some policy implications. Ageing International, 42 (4):466-487.

Kingdom of Saudi Arabia Family Affairs Council (2021). The National Review Report on the progress made in the Madrid International Plan of Action on Aging 2021. In Arabic.

Knight Frank (2019). Healthcare in Saudi Arabia, Opportunities in the Long-term Sector 2nd Edition. https://content.knightfrank.com/research/1526/documents/en/healthcare-in-saudi-arabia-opportunities-in-the-sector-2019-6706.pdf (accessed 5/11/21).

Kyu, H. H. and others (2018). Global, regional, and national disability-adjusted life-years (DALYs) for 359 diseases and injuries and healthy life expectancy (HALE) for 195 countries and territories, 1990-2017: a systematic analysis for the Global Burden of Disease Study 2017. The Lancet, 392(10159), 1859-1922.

L'Agence Nationale de l'Assurance Maladie (n.d.). Rapport Annuel Global de l'AMO 2018, s.l.: s.n. Available at https://anam.ma/anam/wp-content/uploads/2021/07/RAG2018-VF.pdf.

Looman, W. M. and others (2019). The (cost-) effectiveness of preventive, integrated care for community-dwelling frail older people: A systematic review. Health and social care in the community, 27(1), 1-30.

Lotfalinezhad, E. and others (2021). Crucial Role of Respite Care in Supporting Informal Caregivers: A Challenge for the Care of Older Adults in the Middle East and North Africa. Gerontology, 1-5.

Maltese, G. and others (2020). Frailty and COVID-19: a systematic scoping review. Journal of Clinical Medicine, 9(7), 2106.

McNeish, D. (2016). On Using Bayesian Methods to Address Small Sample Problems, Structural Equation Modeling: A Multidisciplinary Journal, 23:5, 750-773.

Mkandawire, T. (2005). Targeting and Universalism in Poverty Reduction, s.l.: UNRISD. Available at https://www.unrisd.org/unrisd/website/document.nsf/(httpPublications)/955FB8A594EEA0B0C12570FF00493EAA?OpenDocument.

Moustatraf, A. (2019). Le Régime d'Assistance Médicale au Maroc, Critique Holistique et Pistes de Réforme, s.l.: s.n. Available at http://ao.um5.ac.ma/xmlui/handle/123456789/17913.

National Aid Fund and UNICEF (2020). National Aid Fund Takaful Programme, s.l.: s.n. Available at https://naf.gov.jo/EBV4.0/Root_Storage/EN/EB_List_Page/NAF_EN_FINAL.pdf.

National Aid Fund (n.d.). Annual Report 2020, s.l.: s.n. Available at https://naf.gov.jo/EBV4.0/Root_Storage/AR/EB_List_Page/%D8%A7%D9%84%D8%AA%D9%82%D8%B1%D9%8A%D8%B1_%D8%A7%D9%84%D8%B3%D9%86%D9%88%D9%8A-2020.pdf.

Ostner, I. (2018). The politics of care policies in Germany. In Gender, social care and welfare state restructuring in Europe (pp. 111-137). Routledge.

Oudmane, M. and others (2019). The impact of out-of-pocket health expenditure on household impoverishment: Evidence from Morocco. International Journal of Health Planning Management, 34(4). Available at https://pubmed.ncbi.nlm.nih.gov/31332829/.

Pani-Harreman, K. and others (2021). Definitions, key themes and aspects of 'ageing in place': A scoping review. Ageing and Society, 41(9), 2026-2059. doi:10.1017/S0144686X20000094.

Public Institution for Social Security (2007). Annual Statistical Collection, s.l.: s.n.

_____ (2008). Annual Statistical Collection, s.l.: s.n.

_____ (2009). Annual Statistical Collection, s.l.: s.n.

_____ (2010). Annual Statistical Collection, s.l.: s.n.

_____ (2011). Annual Statistical Collection, s.l.: s.n.

_____ (2012). Annual Statistical Collection, s.l.: s.n.

_____ (2013). Annual Statistical Collection, s.l.: s.n.

_____ (2014). Annual Statistical Collection, s.l.: s.n.

_____ (2015). Annual Statistical Collection, s.l.: s.n.

_____ (2016). Annual Statistical Collection, s.l.: s.n.

_____ (2017). Annual Statistical Collection, s.l.: s.n.

_____ (2018). Annual Statistical Collection, s.l.: s.n.

_____ (2019). Annual Statistical Collection, s.l.: s.n.

Robalino, D. (2005). Pensions in the Middle East and North Africa: Time for Change, s.l.: World Bank. Available at https://openknowledge.worldbank.org/handle/10986/7427.

Robinson, K. (2020). Housemaids: The effects of gender and culture on the internal and international labour migration of Indonesian women. In Intersexions (pp. 33-51). Routledge.

Saudi Health Council (2020). The current situation of Long-Term Care in the Kingdom of Saudi Arabia 2020. Available at https://shc.gov.sa/Arabic/Documents/The%20current%20situation%20of%20Long%20Term%20Care%20Last%20version.pdf.

Saudi Ministry of Health (2021). Home Health Care Services Available at https://www.moh.gov.sa/en/awarenessplateform/Patientsrights/Pages/HomeHealthCare.aspx.

Selwaness, I. and Ehab, M. (2019). Social Protection and Vulnerability in Egypt: A Gendered Analysis, ERF. Available at https://erf.org.eg/publications/social-protection-and-vulnerability-in-egypt-a-gendered-analysis/.

Skills for Care (2020). The state of the adult social care sector and workforce in England. Available at https://www.skillsforcare.org.uk/adult-social-care-workforce-data/Workforce-intelligence/documents/State-of-the-adult-social-care-sector/The-state-of-the-adult-social-care-sector-and-workforce-2020.pdf.

_____ (2015). Statistical Report 2014 – Quarter 4: Civil and Private Sectors, s.l.: s.n.

_____ (2016). Statistical Report 2015 – Quarter 4: Civil and Private Sectors, s.l.: s.n.

_____ (2017). Statistical Report 2016 – Quarter 4: Civil and Private Sectors, s.l.: s.n.

_____ (2018). Statistical Report 2017 – Quarter 4: Civil and Private Sectors, s.l.: s.n.

_____ (2019). Statistical Report 2018 – Quarter 4: Civil and Private Sectors, s.l.: s.n.

_____ (2020). Statistical Report 2019 – Quarter 4, s.l.: s.n.

_____ (2021a). Statistical Report 2020 – Quarter 4, s.l.: s.n.

_____ (2021b). Statistical Report 2021 – Quarter 1, s.l.: s.n.

_____ (n.d.). Statistical Report 2011 – Quarter 4: Civil and Private Sector, s.l.: s.n.

_____ (n.d.). Statistical Report 2012 – Quarter 3: Civil and Private Sector, s.l.: s.n.

_____ (n.d.). Statistical Report 2013 – Quarter 4: Civil and Private Sectors, s.l.: s.n.

Social Security Corporation (n.d.). Annual Report 2009, s.l.: s.n.

_____ (n.d.). Annual Report 2010, s.l.: s.n.

_____ (n.d.). Annual Report 2011, s.l.: s.n.

_____ (n.d.). Annual Report 2012, s.l.: s.n.

_____ (n.d.). Annual Report 2013, s.l.: s.n.

_____ (n.d.). Annual Report 2014, s.l.: s.n.

_____ (n.d.). Annual Report 2015, s.l.: s.n.

_____ (n.d.). Annual Report 2016, s.l.: s.n.

_____ (n.d.). Annual Report 2017, s.l.: s.n.

_____ (n.d.). Annual Report 2018, s.l.: s.n.

_____ (n.d.). Annual Report 2019, s.l.: s.n.

Soto-Perez-de-Celis, E. and others (2018). Functional versus chronological age: geriatric assessments to guide decision making in older patients with cancer. The Lancet Oncology, 19(6), e305-e316.

Spasova, S. and others (2018). Challenges in long-term care in Europe. Eurohealth, 24(4), 7-12.

Syrian Commission for Family and Population Affairs (2019). Assessment of the protection needs of the elderly: 2011-2019. Damascus. (in Arabic).

Talaat, W. (2020). Social Protection And Older People In Egypt During The COVID-19 Pandemic. Available at https://corona-older.com/2020/06/02/social-protection-and-older-people-in-egypt-during-the-covid-19-pandemic/.

Ting, D. S. W. and others (2020). Digital technology and COVID-19. Nature medicine, 26(4), 459-461.

United Nations Department of Economic and Social Affairs (DESA) (n.d.). Database on Household Size and Composition 2019. Available at https://www.un.org/development/desa/pd/data/household-size-and-composition.

_____ Disability and Development Report. Available at https://social.un.org/publications/UN-Flagship-Report-Disability-Final.pdf.

_____ Population Division (2019a). World Population Prospects 2019. Available at https://population.un.org/wpp/.

_____ Population Division (2019b). Database on Households and Living Arrangements of Older Persons 2019. Available at https://www.un.org/development/desa/pd/data/living-arrangements-older-persons.

_____ Population Division (2020). International Migrant Stock 2020. Available at https://www.un.org/development/desa/pd/content/international-migrant-stock.

_____ (2021). Harnessing longevity in the future of work, Policy Brief No 112. Available at https://www.un-ilibrary.org/docserver/fulltext/27081990/10.18356/27081990-112/27081990-112-en_web.pdf?expires=1640260392&id=id&accname=ocid195767&checksum=038F54B341DD4108E590BE7D22BD6199.

United Nations Economic and Social Commission for Western Asia (ESCWA) (2018a). Population and Development Report Issue No. 8: Prospects of Ageing with Dignity in the Arab Region. Available at https://www.unescwa.org/publications/population-and-development-report-issue-no-8-prospects-ageing-dignity-arab-region.

_____ (2018b). Disability in the Arab Region. Available at https://www.unescwa.org/publications/disability-arab-region-2018#:~:text=It%20is%20based%20on%20data,5.1%20per%20cent%20in%20Morocco.

_____ (2019a). Inclusion of older persons policy implications for the Arab region. Report for the 12th session of the Committee on Social Development (CSD).

_____ (2019b). Social Protection Reform in Arab Countries, s.l.: s.n. Available at https://www.unescwa.org/publications/social-protection-reform-arab-countries#:~:text=%EF%BB%BFSocial%20protection%20systems%2C%20their,shocks%20in%20any%20given%20society.

_____ (2020). The Impact of COVID-19 on Older Persons in the Arab Region. Available at https://www.unescwa.org/publications/impact-covid-19-older-persons-arab-region.

_____ (2021a). Data Portal. Available at https://data.unescwa.org/.

_____ (2021b). Targeted Social Protection in Arab Countries before and during the Covid-19 Crisis, s.l.: s.n. Available at https://www.unescwa.org/publications/targeted-social-protection-arab-countries-covid-19.

United Nations Educational, Scientific and Cultural Organization (UNESCO) (2020). Trends in Adult Learning and Education in the Arab States: Findings from the 4th Global Report on Adult Learning and Education. Available at https://uil.unesco.org/adult-education/trends-adult-learning-and-education-arab-region.

_____ (2021a). Institute for Statistics. Available at http://data.uis.unesco.org.

_____ (2021b). Transmission. Available at https://ich.unesco.org/en/transmission-00078.

United Nations General Assembly (2021). Report of the Secretary-General: Follow-up to the International Year of Older Persons: Second World Assembly on Ageing. Available at https://undocs.org/A/76/156.

United Nations High Commissioner for Refugees (UNHCR) (2017). Syria Worst Man-made Disaster since World War II. http://www.ohchr.org/EN/NewsEvents/Pages/DisplayNews.aspx?NewsID=21373.

World Health Organization (WHO) (2020a). Decade of Healthy Ageing: Baseline Report. Available at https://www.who.int/publications/i/item/9789240017900.

_____ (2020b). Global Health Observatory: out of pocket expenditure as a percentage of total expenditure on health. Available at https://www.who.int/data/gho/data/indicators/indicator-details/GHO/out-of-pocket-expenditure-as-a-percentage-of-total-expenditure-on-health.

_____ (2020c). Global Health Estimates 2019: Deaths by Cause, Age, Sex, by Country and by Region, 2000-2019. Geneva, World Health Organization. Available at https://www.who.int/data/gho/data/themes/mortality-and-global-health-estimates/ghe-leading-causes-of-death.

World Bank (n.d.). Jordan Public Expenditure Review: Pension, s.l.: s.n.

_____ (n.d.). Life expectancy at birth, total (years) – Egypt, Arab Rep. Available at https://data.worldbank.org/indicator/SP.DYN.LE00.IN?locations=EG.

_____ (n.d.) Life expectancy at birth, total (years) – Syrian Arab Republic. Available at https://data.worldbank.org/indicator/SP.DYN.LE00.IN?locations=SY.

_____ (n.d.). Life expectancy at birth, total (years) – Saudi Arabia. Available at https://data.worldbank.org/indicator/SP.DYN.LE00.IN?locations=SA.

_____ (n.d.). GDP (current US$) – Saudi Arabia, Syrian Arab Republic, Egypt, Arab Rep. Available at https://data.worldbank.org/indicator/NY.GDP.MKTP.CD?locations=SA-SY-EG.

World Economic Forum (2021). 40% of all projected job opportunities will be created in this sector. And it's not technology. Available at https://www.weforum.org/agenda/2021/05/care-economy-emerging-job-opportunities/#:~:text=Almost%2040%25%20of%20all%20projected,from%20the%20World%20Economic%20Forum.

Yusuf, N. and others (2015). A Determinant of Healthy Ageing Women Education In Saudi Arabia. International Business and Economics Research Journal (IBER), 14(2), 355-366. https://doi.org/10.19030/iber.v14i2.9168.

Endnotes

1. The member States are: Algeria, Bahrain, the Comoros, Djibouti, Egypt, Iraq, Jordan, Kuwait, Lebanon, Libya, Mauritania, Morocco, Oman, the State of Palestine, Qatar, Saudi Arabia, Somalia, the Sudan, the Syrian Arab Republic, Tunisia, the United Arab Emirates and Yemen.
2. For a detailed discussion on the demographic trends and the socioeconomic situation of older persons, please refer to PDR8. https://archive.unescwa.org/sites/www.unescwa.org/files/publications/files/population-development-report-8-english_0.pdf.
3. DESA produces “estimates” of demographic trends from 1950 till present, and “projections” of future trends from present till 2100, using a variety of assumptions concerning population dynamics.
4. Based on data from DESA, 2019a.
5. Ibid.
6. Ibid.
7. Ibid.
8. Based on data from DESA, 2020.
9. In PDR8, the ageing transition was estimated to have begun in the late 1990s. However, the high influx of migrants and refugees due to instability in neighboring countries, who today constitute nearly 25 per cent of the total population of Lebanon, delayed the projection of the onset of the ageing transition till the late 2010s.
10. Based on DESA, 2019a.
11. United Nations General Assembly, 2021.
12. ESCWA, 2018a.
13. Based on ILO, 2021. See chapter 2 and annex 1 for details.
14. Based on DESA, 2019b.
15. DESA, 2019b.
16. United Nations General Assembly, 2021.
17. ESCWA, 2018b.
18. DESA, 2018.
19. WHO, 2020b.
20. Except for the State of Palestine for which data was not available.
21. WHO, 2020c.
22. Ibid.
23. ESCWA, 2020.
24. UNESCO, 2021a.
25. Ibid.
26. United Nations General Assembly, 2021.
27. UNESCO, 2020.
28. Ibid., 2021b.
29. United Nations General Assembly, 2021.
30. ESCWA, 2019b.
31. For instance, older persons who during their working lives have practiced different professions or worked in different sectors may be covered by two or more pension schemes (and thus obtain "half" a pension from each). Others may be simultaneously covered by contributory and non-contributory social protection, or by more than one non-contributory programme.
32. An additional hurdle is that beneficiary data are frequently reported using different age-spans.
33. For example, as part of the overall SDG data collection effort, ILO regularly collects data from national sources on the proportion of older persons (defined for this purpose as persons above statutory retirement age).
34. The proportion of older persons receiving a pension is one of the data series used to measure the progress on SDG indicator 1.3.1 “Percentage of the population covered by social protection floors/systems disaggregated by sex, and distinguishing children, unemployed, old age, people with disabilities, pregnant women/new-borns, work injury victims, poor and vulnerable”. For more information, see https://unstats.un.org/sdgs/.
35. However, some country data may pertain to coverage of both contributory and non-contributory schemes, whereas other country data may be limited to contributory schemes. ILO data should therefore be interpreted with caution.
36. It may be noted that Lebanon's GDP per capita has since 2019 declined considerably.
37. ILO, 2019.
38. With regard to certain countries, the data include earlier retirees and thus are not strictly speaking limited to older persons.

39. Social Insurance Organization, 2021.
40. Ibid., n.d.
41. Caisse Nationale de Sécurité Sociale (Tunisia), n.d.
42. For more details about targeting methodologies in Arab countries, see ESCWA, 2021b.
43. See, for instance, Arab Monetary Fund and World Bank, 2017; Robalino, 2005.
44. Gemayel, 2020; AFP, 2021.
45. Law 148 of 2019, Article 35.
46. Law 1 of 2014, Article 90; Law 24 of 2019, Article 14. See also World Bank, n.d.
47. For instance, in 2019, almost 60 per cent of SSC old-age pensioners in Jordan received a pension below JOD 300 ($1,000 at PPP) – less than two thirds of the average 450 JOD ($1,545 at PPP). In Tunisia, similarly, more than 60 per cent of old-age pensioners as of 2017 received pensions of less than three fourths of the average level. See Social Security Corporation, n.d.; Caisse Nationale de Sécurité Sociale (Tunisia), n.d.
48. In Morocco as of 2019, CNSS pensions received by newly retired older persons were on average 9 per cent higher than those received by older persons overall (Caisse Nationale de Sécurité Sociale (Morocco), n.d.). In Jordan, new retirees received pension that were fully 29 per cent higher than the overall average (Social Security Corporation, n.d.).
49. Public Institution for Social Security, 2019.
50. Law 10-12 of 2010, Article 24.
51. As of 2009 the Algerian monthly minimum wage stood at 12,000 DZD. By 2020, it had been increased to 20,000 DZD.
52. The Karama programme in Egypt is an exception in the sense that the benefit is an individual entitlement.
53. ESCWA, 2019b.
54. Selwaness and Ehab, 2019.
55. ESCWA, 2019b.
56. Law 10-12 of 2010, Article 14.
57. See, for instance, Ayadi and Zouari, 2017; Oudmane and others, 2019; Selwaness and Ehab, 2019.
58. Abdel-Rahman and others, 2021.
59. These two schemes were merged in 1995.
60. Ibid.
61. Ibid.
62. Ibid.
63. Current GDP at market prices.
64. For a discussion, see for instance Mkandawire, 2005.
65. According to an evaluation undertaken by IFPRI, "the leading exclusion factor for the poorest quintile was receiving a government pension or having a government job". (Breisinger and others, 2018, p. 84).
66. For an extended discussion, see ESCWA, 2019b.
67. Black, 2020.
68. Gadbois and others, 2021.
69. Brooke and Jackson, 2020.
70. Maltese and others, 2020.
71. Ting and others, 2020.
72. Hodge and others, 2017.
73. Fitzpatrick and others, 2021.
74. Hussein and others, 2020.
75. Comas-Herrera and others, 2020.
76. Spasova and others, 2018.
77. Pani-Harreman and others, 2021.
78. Ostner, 2018.
79. Lotfalinezhad and others, 2021.
80. Fernández and others, 2020.
81. Weatherly and others, 2020; Hussein and Ismail, 2017.
82. Lotfalinezhad and others, 2021.
83. Looman and others, 2019.
84. Kane and others, 2020; Hussein and Ismail, 2017.
85. Boggatz and Dassen, 2005; Hussein and Ismail, 2017; Kane and others, 2020.
86. World Economic Forum, 2021.
87. Budreviciute and others, 2020.
88. Booth and others, 2012.
89. Ismail and Hussein, 2019.
90. Robinson, 2020.
91. World Bank, n.d.
92. DESA, 2019a.
93. Ibid.

94. Chapter 1.
95. World Bank, n.d.
96. DESA, 2019a.
97. Khan and others, 2017.
98. World Bank, n.d.
99. DESA, 2019a.
100. Khalil and others, 2018.
101. Saudi Arabia, Family Affairs Council, 2021.
102. Information provided by the Family Affairs Council.
103. Yusuf and others, 2015.
104. Knight Frank, 2019.
105. Colliers International, 2020.
106. Saudi Ministry of Health, 2021; Saudi Health Council, 2020.
107. World Bank, n.d.
108. Ibrahim, 2019.
109. DESA, 2019a.
110. Talaat, 2020.
111. AlMasry AlYoum, 2021a.
112. Information provided directly by the Egyptian Ministry of Social Solidarity.
113. Egypt Today, 2021.
114. AlMasry AlYoum, 2021b.
115. Boggatz and Dassen, 2005; Hussein and Ismail, 2017.
116. Greek Community of Alexandria, n.d.
117. Hussein, 2019.
118. https://www.pssru.ac.uk/pub/shblog/SessionII1200A.pdf.
119. https://en.enow.gov.eg/الصفحة%20الرئيسية/.
120. Baseera, 2021.
121. AlMasry AlYoum, 2019.
122. Baladna El Youm, 2019.
123. Information provided directly by the Ministry of Social Solidarity (January 2022).
124. Direct communications with the Ministry of Social Solidarity (1 December 2021).
125. Information provided directly by the Ministry of Social Solidarity.
126. Looman and others, 2019.
127. Georgiadis, 2013.
128. Ismail and Hussein, 2021.
129. There is no available information on LTC spending in any country in the Arab region nor in other LMICs, hence in the absence of these the model is made against countries with available information (i.e. OECD countries).
130. World Bank, n.d.
131. Chomik and Piggott, 2018.
132. De Henau and others., 2017.
133. Hodge and others, 2017.
134. World Economic Forum, 2021.
135. ILO, 2018.
136. Skills for Care, 2020.
137. ILO, 2018.
138. United Nations General Assembly, 2021.
139. ESCWA, 2019a.
140. DESA, 2021.
141. De la Maisonneuve and Martins, 2013.
142. The author is grateful for the contribution of Mohamed Ismail, Affiliate Research Fellow, University of Oxford, the UK. Mr. Ismail conducted the cost estimation model for the three country case studies included in this report based on the model in Ismail and Hussein, 2021.
143. Baldwin and Fellingham, 2013; McNeish, 2016.

Most Arab countries will have an ageing population or will have become aged in the next 30 years. This statement would have been unimaginable a few decades ago, when the region was witnessing a massive population boom. While the number of older persons, aged 65 and above, in the Arab region increased by 16 million in the last fifty years, it is projected to increase by over 50 million in the next thirty years, reaching 71.5 million by 2050. Population ageing carries profound economic and social implications.

The present report focuses on the care ecosystem for older persons as an entry point to address older persons' priorities and ensure that all people can age with dignity in the region. The care ecosystem is comprised of two distinct yet closely related elements: social protection and long-term care (LTC). This report sheds light on the status quo in the Arab region, characterized by weak social protection systems and underdeveloped long-term care systems. The COVID-19 pandemic has further heightened the vulnerability of older persons and revealed the limitations of the care ecosystem. To support member States, the report provides a one-of-a-kind roadmap to building forward better for older persons. It calls upon countries to seize the demographic window of opportunity and reflect on the recent lessons learned from the COVID-19 pandemic to ensure the protection and empowerment of older persons.

22-00321