Review

Older adult care in Lebanon: towards stronger and sustainable reforms

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رعاية المسنين في لبنان: نحو إصلاحات قوية ومضمونة الاستمرار

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الخلاصة: قامت الباحثات بتقييم خدمات رعاية المسنين في لبنان من خلال الملاحظة المباشرة، ومراجعة التشريعات والنشريات بُغْيَة جذب الانتباه إلى الوضع الراهن، والحاجة إلى تحسينه، وتقديم الاقتراحات للتعاطي مع المشكلات. وتتمثَّل مواطن الضعف في رعاية المسنين في لبنان، والعوائق التي تعرقل الإصلاح، في كلٍّ من الوصمة المرتبطة بكِبَر السن، وعدم كفاءة نظام الرعاية الصحية، ونقص المتخصِّصين في طب الشيخوخة، والافتقار إلى الخدمات الاجتماعية التطوعية، وعدم كفاية دُور رعاية المسنين. وقد ركَّزت الباحثات على الحاجة إلى مناهَضَة المنظور السلبي للتشيُّخ، وتعزيز الرعاية الاجتماعية، وتجديد دُور رعاية المسنين، وتمكين الخدمات التطوعية، من أجل تحسين حياة المسنين وسُبُل رعايتهم. وأكَّدت الباحثات على ضمان استمرارية المبادرات من قِبَل الوكالات الحكومية، والأطباء، والخدمات التطوعية، والمجتمع المحلي، فضلاً عن حتمية توفير التمويل الكافي.

ABSTRACT We assessed elderly care in Lebanon through direct observation and review of the literature and legislation with the aim of drawing attention to the current situation and the need for improvement, and providing suggestions to address the problems. The weaknesses of elderly care in Lebanon and obstacles to reform include the stigma of age, an inefficient health care system, a lack of geriatric specialists and social/volunteer services, and inadequacies in nursing homes. Countering the negative perception of ageing, promoting social welfare, refurbishing nursing homes and empowering volunteer services are needed to improve the lives and care of the elderly. Sustained initiatives by governmental agencies, physicians, volunteer services and the community are essential. Adequate funding is also imperative.

Soins aux adultes âgés au Liban : vers des réformes plus importantes et plus durables

RÉSUMÉ Nous avons réalisé une évaluation des soins aux personnes âgées au Liban par l'observation directe et par l'étude des publications et de la législation, dans le but d'attirer l'attention sur la situation actuelle et la nécessité d'améliorer cette situation, et de proposer des solutions pour venir à bout des problèmes. Les points faibles des soins aux personnes âgées au Liban et les obstacles aux réformes comprennent notamment la stigmatisation de l'âge, un système de soins de santé inefficace, un manque de spécialistes en gériatrie et de services sociaux/bénévoles, et des insuffisances dans les maisons de retraite. Il est nécessaire de s'opposer à l'image négative liée au vieillissement, de favoriser la protection sociale, de moderniser les maisons de retraite et de donner des moyens aux services bénévoles pour améliorer la vie des personnes âgées et les soins qui leur sont prodigués. Le lancement d'initiatives durables par les organismes publics, les médecins, les services bénévoles et la collectivité est indispensable. Un financement adapté s'impose également.

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Introduction

Lebanon is a Mediterranean country with a population estimated at around 3 826 000 people. As a country in transition recovering from over 15 years of civil wars and strife from 1975 until 1991, its reform is marred with political turmoil, and economic and social instability. While the Lebanese population is relatively young (28% are under the age of 15 years), it is consistently ageing [*1*]. In 1995, 7.1% of the population was above the age of 65 years [*2*]. By the year 2025, older adults are expected to constitute 10.2% of the Lebanese population, replacing the younger population as the main economic dependants at the household level [*2*]. The majority (over 85%) of those over the age of 65 years live in urban areas and women, compared to men, are more likely to live alone (15% versus 5% respectively).

Ageing, traditionally seen as an issue of concern for developed countries, has never been an area of priority in Lebanon. This neglect is exemplified in the health care provided for older adults. For example, geriatric wards are virtually absent from both public and private hospitals, only one of the universities in the country includes geriatric medicine in its medical or nursing curricula, and social workers specialized in gerontology are completely lacking. General practitioners have to struggle singlehandedly to apply minimum standard of care for the elderly in their daily practice. It is because of this that we are addressing the elderly care system in Lebanon in this paper. We will first describe the situation within the prevailing health care system, including its strengths and weaknesses. Then we will look at how each problem may be alleviated and give recommendations accordingly. The paper is not intended to be a final stand on the issue but aims to trigger debate in Lebanon and similar countries with limited resources.

Current situation in Lebanon

Perceptions of ageing and older adults

Although not unique to the Lebanese culture, a predominant view is that beyond a certain age, the approach to older adult care is one of expectant management, pending the eventual outcome – death. Moreover, a displacement of decision-making occurs whereby family members often adopt a paternalistic approach and replace older adults in assuming responsibility for family issues, including health-related decisions. The intention of such an approach is usually benevolent. Nevertheless, the lack of involvement of elderly individuals in decision-making results in a sense of worthlessness and uselessness and lack of motivation. This "waiting approach" has a major negative impact on the level of satisfaction and the sense of reciprocity and autonomy, often leading to depression and accelerated ageing.

Furthermore, while there are no formal data, older adults often express that they have become a burden to their families, both physically and financially. Consequently, they isolate themselves and refrain from sharing their symptoms and concerns with family members. This delays medical treatment and increases co-morbidities. A vicious cycle thus ensues: the elderly person's health deteriorates, the sense of being a burden increases, the unhealthy family dynamic is perpetuated, culminating in a decrease in the quality of life of the elderly individual and his/her caregivers.

Legislation and the health care system

The primitive perception of age and ageing in Lebanon is unfortunately compounded by an inefficient and unorganized health care system. While Lebanon's total expenditure on health of some 12.3% of gross domestic

product is among the highest in the world, the overall performance of the health system lags far behind (Lebanon ranks 95th among 191 countries in the world) [*3*].

Lebanon does not have a uniform old-age/retirement pension plan. Rather, such plans are largely dependent on the type of employment. For example, whereas government employees and those in the military service are covered by pension plans and health insurance, those covered by the National Social Security Fund – the majority of whom are employees in the private sector – ironically lose such benefits upon retirement, at the time when they are much needed. Obviously, those who have never been employed, the majority being women, are not eligible for any type of pension plan or health care coverage [*2*]. Private insurance in Lebanon is costly and insurance companies refuse coverage to those requesting it above the age of 70 years at the time of initial enrolment.

The Permanent National Commission on the Elderly (PNCE), consisting of representatives of several ministries and delegates from the public and private sectors, was established in 1999 to address elderly care issues and ageism in Lebanon. Among its top priorities is the conduct of studies assessing elderly needs in Lebanon [*4*] and participation in the drafting of laws protecting the elderly and ensuring pension plans and health care as a basic right. In spite of its altruistic objectives, the Commission is marred with political interference hindering its productivity.

In addition, Lebanon does not have any written legislation about end-of-life issues and palliative care. The issue of life and death is stigmatized within the local social and religious culture, and the wishes of patients concerning resuscitation often remain unknown. Palliative care services are largely lacking and prolongation of life is pushed beyond reasonable limits when it is clearly futile. This is confounded by the lack of an official position statement by the Lebanese Order of Physicians (LOP) and the absence of clear laws and/or religious guidance on withholding life-saving measures and withdrawal of care.

Geriatrics in Lebanon

According to the LOP database, there are 10 430 physicians in Lebanon and only 7 geriatricians (unpublished data, Lebanese Order of Physicians, 2006). To the best of our knowledge, there are no geriatric psychiatrists. Geriatrics is a relatively new field for graduates from medical schools, and it lacks the glamour of other specialties and hence tends to be unappealing.

Currently, there are no fellowships offered in geriatrics in the country, and only 1 of the 6 medical schools in Lebanon includes geriatrics in its curriculum. In 2003, the Internal Medicine Department of the American University of Beirut Medical Center established a geriatric educational programme entitled, "The integration of outpatient geriatric curriculum into outpatient ambulatory training", targeting the needs of older adults in the community. This programme includes workshops on geriatric care for faculty members and the development of a curriculum for medical trainees. Residents at the Center rotate for 1 month each year in the inpatient geriatric service and attend outpatient geriatric clinics. This initiative is the first of its kind in Lebanon.

Nursing homes in Lebanon

Nursing homes (NHs) in Lebanon – as with other non-public agencies – grew in prominence during the years of war to fill the vacuum caused by the weakened role of the State and total lack of public services. In several developed countries, older individuals often choose to reside in NHs or assisted-living communities. In Lebanon,

the situation is quite different and the profile of NH residents is markedly different from that of Western countries. NH admission in Lebanon is usually seen as the "last resort" when an elderly individual has no one to care for him/her, or when she/he is so seriously ill or demented that families can no longer assume responsibility for health care.

A study conducted in 2005 identified a total of 33 long-term care NHs in Lebanon with around 2660 residents (800 males and 1860 females), representing around 1.4% of the total elderly population [*5*]. These institutions are distributed in all the 6 administrative units (*mohafazat*) across the country, but are heavily concentrated in urban areas. The majority of institutions (97%) are privately run and the rest are semi-private. While public institutions are completely absent, the Ministry of Public Health (MoPH) provides support in the form of 15 000 Lebanese pounds (equivalent to about US$ 10) per day for 42% of the beds and the Ministry of Social Affairs (MoSA) pays 4000 Lebanese pounds (approximately US$ 2.7) per day for 20% of the NH residents it covers [*5*]. This covers only a very small proportion of the total cost for each NH resident per day and has major implications for NHs, residents, families and caregivers.

The need for an improved NH system became obvious during our recent work among NH residents in the country [*6,7*]. Despite considerable efforts by NH directors to create and maintain optimal quality of life for NH residents, several key factors were found to be absent.

First and foremost, the teams caring for NH residents, including physicians and nurses, are mostly not trained in geriatric care. Nurses, and occupational, physical, and speech therapists are not specifically trained in geriatric rehabilitation. Because of the shortage of resources, the staff often relies on volunteers to provide activities and oversee general care. These volunteers enrich the lives of the NH residents and offer personalized support to each individual. However, their services are often intermittent.

Space is another important issue. As funding is limited compared to that directed towards institutions caring for disabled and/or underprivileged children, many NHs are unable to expand their facilities and are forced to place several residents in one room – in some homes, there are up to 8 individuals in a single room. Crowding in NHs increases the likelihood of infection, hinders privacy and puts the individuals' sense of self, dignity and respect at risk [*8,9*].

While one would hope that NHs are immune to neglect and/or abuse of the elderly, we found that elderly residents were often "left alone" in the corner, deprived of sensory stimulation [*6*]. Vision and hearing deficits were common in the elderly population screened. Such situations can lead to irreversible changes in mental status and depression [*10*].

Furthermore, due to the lack of staff needed to help NH residents to move around, many residents faced "forced immobilization" and the use of diapers was widespread and not restricted to incontinent, bedridden residents [*6,7*]. None of the NHs visited had instituted policies on the use of restraints. The use of restraints was often not indicated or was needlessly prolonged. A harsh attitude by the nursing staff in addressing the elderly was observed at times.

Sadly, many of the NH residents had been promised by their family that their placement was temporary but this was rarely the case. They were found to be "hanging on" to the hope of being "released" one day. This state of mind conveys a sense of un-

certainty, increases anxiety disorders [*11*], and contributes to worsening symptoms in a frail older individual.

Elderly care in the community and volunteer services

Despite Lebanon attending the 2002 Second World Assembly on Ageing and the MoSA taking steps to implement the goals and recommendations set forth in the Madrid International Plan of Action on Ageing, studies addressing the WHO minimum data set on ageing [*12*] are lacking, and governmental bodies do not have basic statistical data on the number of nongovernmental organizations (NGOs) or charities that care for older adults in the community. A positive step in this respect is that Lebanon was one of the 8 countries that participated in focus groups targeting abuse of the elderly as part of the WHO Global Response Against Elder Abuse Project (GRAEAP) [*13*].

There are several charities, associations and NGOs that target older adults as part of their services. However, the services provided are fragmented and non-sustainable. They cover a range of activities including provision of medical care within their centres, home-based nursing care, psychosocial assistance and services, guidance, entertainment activities, education, free medications and meals-on-wheels. These activities are widely delivered by volunteers who have a key, if not the most important, role in elderly care in Lebanon. The fact that MoSA is currently unaware of all these volunteer organizations indicates a lack of cooperation among the various potential sources of care and support to the elderly. With the exception of the Alzheimer Disease Lebanon Group launched in 2004, to the best of our knowledge, support groups for specific categories of afflicted elderly individuals are rare.

Home care in Lebanon is limited to 2–3 organizations that provide part-time nursing staff and physical therapists for homebound elderly individuals with chronic medical conditions. These are private organizations providing fee-for-service care; home-care expenses are not covered by either governmental or private health insurance schemes in Lebanon.

Senior citizen centres and other venues for leisure activities have only recently been established (in the past 5 years). MoSA has launched a pilot project aimed at establishing senior citizen centres as part of the 65 centres for services and development already present across the country. So far, 33 such senior citizen centres have been established. These day care centres are intended to be venues for elderly individuals to be educated in various fields such as sewing and computer skills, thus enabling them to participate in various projects. Present at each centre is 1 primary care physician or family physician and 1 nurse. Few rehabilitative services are available and there are no services to facilitate transportation to these centres.

Steps to implementing changes in Lebanon

While there are many shortcomings to the health care system for the elderly, we remain strong believers that the care of an older adult goes far beyond financial support and official government input. In this section we will address steps needed to implement changes to improve the situation (Table 1). While steps to reform the health care system in Lebanon as a whole are beyond the scope of this paper, tackling the issue of elderly care need not wait for a global reform to take place either.

Accommodating the needs of our increasingly ageing population in Lebanon should occur simultaneously at several levels: in the community (at home and in NHs),

Table 1 **Challenges in the elderly care system in Lebanon, pivotal players of change[a], suggestions and recommendations**

Challenge	Pivotal players	Suggestions and recommendations	Resources needed[b]
Perception of ageing in Lebanon			
•Paternalistic approach	Community, media, immediate family members of elderly individuals	•Educate physicians and society: school programmes media campaigns	+
•Ageism and negative, stereotypes		•Involve elderly in health care decisions	
•Lack of autonomy for the elderly		•Involve elderly in community projects	
Health care system			
•Lack of universal social welfare and health care plan for all elderly individuals	MoPH, private insurance companies	•Implement 2000 "old-age pension plan" proposal •Establish special private insurance plans for the elderly	+++
Geriatrics in Lebanon			
•Lack of geriatricians	Academic institutions, Order of Physicians	•Incorporate geriatrics into university and medical/ nursing school curricula across Lebanon	++
•Lack of geriatric paraprofessionals		•Make attendance of CME events for all physicians mandatory	
•Lack of knowledge among PCPs and various specialists		•Establish geriatrics fellowships	
Nursing homes			
•Lack of specialists staff	NH Directors, MoPH, MoSA, PNCE	•Increase specialists among staff	+++
•Over-crowding		•Secure funding for refurbishment of buildings	
•Uncomfortable, unsafe environment		•Create "homey", comfortable but safe environment	++

Table 1 **Challenges in the elderly care system in Lebanon, pivotal players of change[a], suggestions and recommendations *(concluded)***

Challenge	Pivotal players	Suggestions and recommendations	Resources needed[b]
Community care			
•Not enough day-care centres	Municipalities, NGOs, MoPH, MoSA, volunteers	•Establish day-care centres	++
•Not enough volunteers		•Promote the role of volunteers	+

[a]Those people or institutions whose role in instituting changes is pivotal in initiating the process.
[b]Resources needed are designated as symbols indicating relative need of personnel and funding. Absolute resources needed are not indicated as needs-assessment and cost-analyses are not available for the suggestions made.
+ denotes personnel and resources are already present but require development, with the government involvement primarily at the municipal level.
++ denotes need for specifically trained personnel and a moderate amount of funding, with government involvement primarily by MoSA and Ministry of Health.
+++ indicates need for specialists in the area of elderly care, involvement at several levels of government, and extensive funding.
MoPH = Ministry of Public Health; CME = continuous medical education; PCPs = primary care physicians; MoSA = Ministry of Social Affairs; PNCE = Permanent National Commission on the Elderly; NGOs = nongovernmental organizations.

in clinics and at the governmental level. Similarly, the health care system should be directed towards 3 different categories of older adults: individuals living alone, those living with their families and NH residents. We have the luxury of learning from the experiences of elderly health care systems in other countries and can tailor them to the specific needs of the Lebanese population.

Changing the perception of ageing in Lebanon

Unfortunately, physicians are often themselves the culprits of the attitude that beyond a certain age certain symptoms are attributable solely to age. Negative stereotyping of older adults is endemic in the Lebanese culture. Educating the elderly themselves, their families, caregivers and physicians about the process of ageing will ensure a better quality of life and empower older people, allowing them to participate in the decision-making regarding their own health. Furthermore, interaction of younger people with elderly individuals increases positive attitudes towards ageing and addresses ageism in younger individuals [*14–16*].

Within the context of perceptions, the mass media is an efficient means for transmitting information and positive images to large portions of the population. Dedication of television programming to issues that increase public awareness on a particular topic is common in Lebanon. The media currently dedicates 2 days each year free of charge, one on the National Grandparents' Day (21 February) and another on the International Day of the Elderly (1 October), to broadcasting programmes particularly targeting ageism. While this initiative is commendable, it surely is not enough. We propose the model of an Annual Elderly Care Awareness week that includes campaigns, talk shows, interviews and documentaries highlighting aspects of elderly care, in addition to ongoing advertisements and programmes educating the population about ageing and older adult issues throughout the year. Funding of these activities could be sustained from private donors, banks, foundations and, if possible, with MoPH and MoSA sponsorship.

Educating professionals and promoting research

In order to better accommodate the ageing population, it is key to understand all aspects of this population. Therefore, the first step in reform is the planning and implementation of studies that address the information gap about age and the elderly at various levels among decision-makers, physicians, health professionals and the community. Researchers should be given the incentive, through facilitation of grants, to pursue such research. The coordination of data collection and analysis is most efficient if centralized. The establishment of an organized body similar to the United States National Institute of Aging is an important step in that process. In order to optimize the benefit and knowledge collected from research, an efficient means to transmit information is necessary. Continuous medical education (CME) activities, conferences and workshops organized by the LOP and MoPH to present the findings would facilitate such a process.

The most feasible step to promote a change in the Lebanese system is to pass and implement legislation for the incorporation of geriatrics into the curricula of medical schools, residency training programmes, fellowships, paramedical institutions, undergraduate programmes in sociology, psychology, social services and nursing schools. In the long term, such interventions will promote this specialty and encourage internists to take it up, and ideally will improve the delivery of health care to the elderly. With proper education, primary care physicians in Lebanon can assume a key role in the health care of the elderly, referring them to geriatric specialists as necessary. In addition, community clinics for the elderly can be established which include primary care physicians specialized in geriatrics; these have been shown to optimize patient care and comfort [*17,18*]. Interdisciplinary teams consisting of a geriatrician, nurse practitioner, physical, occupational, and recreational therapists, social worker, and dietitians specialized in geriatric care are best suited to assess the medical, psychosocial, nutritional, and environmental needs of an elderly person.

Improving nursing homes and intermediate care centres in Lebanon

Through our exposure to NHs, it is clear that they need a complete overhaul of their system and services.

First and foremost, NHs need extensive funding to improve their facilities and increase the number of rooms and beds. They must be able to increase the medical services they offer and establish services with different levels of care, to accommodate fully-functional elderly individuals, those who need assistance with activities of daily living, and those with dementia and/or chronic medical illnesses. Facilities must be modified to make the NHs comfortable while providing a safe environment that takes into account elderly individuals' limitations. Accordingly, NHs need to be architecturally modified to allow each resident his/her personal space, provide for common rooms for socializing and leisurely activities, and ensure safety [*19*].

Second, an adequate number of qualified nursing staff is necessary to ensure optimal care. Recruiting and training geriatric specialists in all fields (physicians, nurses, psychologists, dietitians, occupational therapists, physical and speech therapists and pharmacists) is essential [*20*].

Third, each NH has to set clear statements of purpose, policies and guidelines, and ensure all staff are fully aware of them. A zero-tolerance policy toward disrespectful, inhumane and abusive treatment of the NH residents has to be enforced. Restraints should only be used when absolutely neces-

sary. Causes for agitation, such as pain, disorientation and delirium, are often not sought in NHs in Lebanon. Educating staff and enforcing policies will ensure that an NH resident is restrained only after full evaluation detailing all correctable causes of agitation [*20*]. The means of restraint should minimize any physical and emotional discomfort.

Fourth, state-dictated, national standards for NH care in Lebanon are an important part of ensuring a high level of quality care for NH residents. Mandatory regulations are needed to address technical issues such as the safety of NH buildings and facilities, record keeping, availability and quality of medical care, a standardized level of training of all staff, and the availability of professional staff at NHs. Homes unable to meet these requirements independently should be offered the necessary support to do so. We invite the MoPH, MoSA and PCNE to commission a task force to look into these aspects of elderly care in all NHs, after which they will be able to set standards, offer help to NH directors and staff and swiftly correct any aberrations noted in the system, as exemplified in other countries [*21*].

Lastly, intermediate care centres to rehabilitate elderly individuals in temporary need of medical care and physical therapy/occupational therapy are of great importance. A recent field study by the Department of Epidemiology at the American University of Beirut surveyed the available intermediate rehabilitation services for older adults in Lebanon, finding many deficiencies in these services yet a great demand for them (Chaaya et al. unpublished data, 2006). Such facilities, when accompanied by a system of continuity of care, can offer the elderly the option of living at home while receiving all necessary medical care and social support [*22*].

Optimizing elderly care in the community

The establishment of services that cater to elderly individuals living in the community and their caregivers is an essential component of improving the quality of elderly care in Lebanon. The efforts of MoSA are exemplary but to sustain and develop these services, mobilization of volunteers is important [*23*]. To ensure sustainability and efficiency, services should aim at becoming self-sufficient and independent of long-term governmental financial and logistic support. While government support is necessary for the establishment of social services, the community provides the backbone and the extension of government initiatives. Empowering the community to deliver these services is key to successful programmes. The establishment of various volunteer organizations with clear statements of purpose and goals will allow for specialized services and will address multiple aspects of elderly care. An elderly care system "by the people" will reflect standards of care based on the authentic needs of the community as its members perceive them.

As to elderly persons living alone, a home-based system of social, financial, nutritional and medical support is needed. Volunteer involvement could be of great benefit at many levels. Volunteers can establish and run senior citizens centres, elderly day-care centres and elderly services such as transportation, provision of meals to the elderly in their homes and support groups. Several models proven successful in other countries could be used as templates for Lebanon, such as the extra care housing system operating in the United Kingdom [*21*].

Last but not least are the strong family bonds and sense of duty and respect with which families regard their elderly family members in Lebanese society. This is

indeed a great benefit for the Lebanese elderly. They continue to live at home for a longer period of time compared to older adults in Western countries. Educating caregivers on the behavioural disturbances inherent in dementia, end-of-life issues and chronic illness will provide emotional and psychological support to caregivers, and enable them to care for their loved ones as long as possible [*22*]. For that purpose, support groups can be very helpful to the community. They are rare in Lebanon and respite care to relieve caregivers is non-existent. To change this, we invite all sectors to join forces in a national education campaign to implement these changes. We also recommend establishing telephone "hot-lines" and user-friendly websites that provide information on all aspects of ageing (including its causes, consequences and treatment), resources (as they become available) and medical care.

Conclusion

In this article, we have illustrated the shortcomings of the medical and social elderly care system in Lebanon and suggested steps that can be taken to improve it. We perceive that the changes proposed would occur at several equally important levels: government, medical/nursing community, NHs and the community. We acknowledge that Lebanon is a country in transition with limited resources. Thus, in terms of reform, we ought to implement changes needing the least resources first. Such changes can affect the system at several levels and start a chain reaction for further change. Later, the system could be modified by building on these primary changes, paralleling them (when resources become available) and complementing them when the moment is ripe. Key to the success of reforms is an in-depth analysis of the current situation, strong teamwork, the availability of grants for research, the refurbishment and improvement of existing facilities and the establishment of new ones. Lebanese society and physicians alike must be educated in all aspects of elderly care, and geriatric specialists from all fields are needed in numbers large enough to accommodate the increasingly ageing population. Lebanese society should embrace the elderly community and be their advocates, by establishing senior citizens programmes, senior transportation systems, efficient and sustainable volunteer programmes, and calling for legislation that guarantees each elderly individual his/her rights. The authors invite everyone to join the debate to establish a national charter for the elderly in Lebanon.

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