Health services to groups with special needs in the Arab world: a review

N.M. Kronfol

ABSTRACT This paper examines the health services provided to the older population (especially those with physical limitations) and the people with mental illnesses in Arab countries and their evolution over the past 3 decades. The paper reviews utilization issues related to morbidity, transportation, patient–provider relationship, cost, stigma and organizational barriers that often impede access and compliance with the care provided or recommended. Health systems in the region need to acknowledge the specific needs of these patients in their national programmes. Raising awareness is an important step in this regard.

Services de santé aux groupes ayant des besoins particuliers dans le monde arabe : revue

RÉSUMÉ Le présent article a examiné les services de santé fournis à la population de personnes âgées (en particulier celles affectées par des handicaps physiques) et aux personnes souffrant de maladies mentales dans les pays arabes, ainsi que leur évolution au cours des trente dernières années. La recherche a analysé l’utilisation des services en relation avec la morbidité, les transports, la relation patient-prestataire, le coût, la stigmatisation et les obstacles d’ordre organisationnel qui empêchent souvent l’accès aux soins fournis ou recommandés et leur observance. Les systèmes de santé dans la région doivent prendre en compte les besoins particuliers de ces patients dans leurs programmes nationaux. La sensibilisation est une étape importante à cet égard.

1Lebanese Health Care Management Association, Beirut, Lebanon (Correspondence to N.M. Kronfol: dino@cyberia.net.lb).
Introduction

This paper is the last in a series of five reviews about the health services provided to groups with special needs in the Arab world [1–4]. The challenges faced by older people as well as people with functional and mental disabilities are highlighted. The purpose of this paper is to outline the needs of these special groups of citizens and to describe the barriers facing their access to care. It is important to note that access to healthcare for dependent older people in the Arab region is an area where there are many gaps in the available data.

Older people with functional limitations

Older people with functional limitations are defined here as people aged 65 or older with at least one restriction in their activities of daily living. These refer to mobility and self-care activities that a person must perform every day, such as bathing, dressing, eating, getting in and out of bed or chair, moving around, using the toilet and controlling bladder and bowel movements [5].

Older people face many challenges such as a greater need for services due to increased morbidity and disability, limited capacity to finance co-payments, hurdles of access to services due to mobility restrictions, limited health literacy and bureaucratic, fragmented service organization that can be aggravated by age discrimination in service provision [6]. The help-seeking behaviour of older people may be influenced by their expectations of health status as they get older [7]. Even where help is sought, the existence of many comorbidities may make it difficult for older people to get across their problems in the consultation setting [8]. There is evidence that older people and their informal carers try hard to maintain their identity as being healthy and fit despite having health problems, “managing” their health accordingly [9].

There have been very few studies in and around the Arab region about the utilization patterns of the elderly with functional impairment. In Israel researchers found that the predisposing and enabling factors were only minimally associated with utilization rates, except for lower rates of emergency room visits by those who were living alone. Health care utilization was found to be associated primarily with health needs and functional status rather than by factors such as income and education [10].

The health status, mental well-being and functional capacity of senior citizens (above 60 years of age) were assessed in Jordan. Of the 300 subjects enrolled, 53.3% were women, 74.4% were affected by chronic diseases, 24.3% were classified as depressed and 44.0% had a negative health perception. Women were more likely to be depressed and suffer memory impairment and limitation on functional capacity than did men. Depression, poor functional capacity and memory impairment reinforced each other, resulting in a state of dependency [11].

Transport

Older people with functional limitations face difficulties using public transport, going shopping, finding their way outside their home or even communicating over the phone [6]. This can severely limit their capacity to access health care services in a timely fashion. A study on the use of primary health care services and satisfaction by elderly people in Asir, Saudi Arabia reported that the 3 leading causes of dissatisfaction were poor transportation (65.1%), long time spent in the centre (46.4%) and insufficient specialty clinics (42.5%) [12].

Dependency

Older people in the Arab region are living longer [13]. Improving health and social care for the growing number of older people with functional limitations who need constant support with basic activities of daily living should therefore be a major concern of both social and health policies in Arab countries.

Dependency in old age is usually defined by self-rated health status and functional status from survey data [6]. Subjective health status declines with age as it is linked to higher prevalence of chronic conditions and mental health problems [6]. Those affected by disability often suffer from several concurrent limitations such as visual impairment, hearing impairment and lower mobility [14]. These functional limitations put older people at risk of falls, injuries and accidents, social isolation and depression [15].

A study of 47 institutionalized older people in the United Arab Emirates (UAE) revealed that all except 1 had a neurological disorder and 89% had dementia. The cognitive deficits were severe, their functional status was poor and nutritional status was impaired. When compared with studies from the United States of America, this UAE group had a higher rate of neurological diseases and dementia, and were far more dependent and disoriented [14].

A psychosocial assessment of geriatric patients (65+ years) was carried out in Abha, Saudi Arabia. Depression was found in 17.5% of the subjects, more commonly in women than men (27.7% versus 12.7%). The combined effect of impaired perceived health status (52.4%) and functional capacity (26.6%), loneliness (4.5%), single status (24.3%) and lack of education (80.5%) explained the depression and the authors concluded that this needed to be addressed through periodic home psychosocial screening [15].

Sociocultural factors

Ethnicity plays a role as well in the status of older people. According to the Jewish–Arab Center at the University of Haifa, the percentage of Arab elderly who were disabled and need help with activities of daily living was twice as high as that of the Jewish elderly population.
Age discrimination in access to health services is emerging as a serious problem [25]. Access for dependent older people is negatively affected by the views and perceptions of health care practitioners [22]. The existence of this form of “age-ism” needs to be addressed.

Training in geriatric care

It has been acknowledged that training in geriatrics and gerontology in the Arab region is less than optimal and needs to be strengthened [26]. Efforts have been expanded and developments in the area of education and training are forthcoming.

Cost

As frequent users of health care services, older people often have a high financial burden from the cost requirements of health care, both for essential services and for pharmaceuticals and other medical goods, such as...
glasses and hearing aids [27]. A systematic review examined the effectiveness of interventions led by pharmacists in reducing polypharmacy. The most frequently reported outcome related to cost savings [28]. In Israel, application of a geriatric–palliative methodology to combat polypharmacy yielded a number of benefits such as a reduction in mortality rates and referrals to acute care facilities, lower costs and improved quality of life [29].

Out-of-pocket payment for essential services that are not covered by the public system may contribute to this financial burden in the Arab region [27]. Although there is a trend of increasing life expectancy in the region, there is still much uncertainty about what proportion of the additional lifespan is lived with the burden of disability among elderly people.

**People with mental health problems**

People with mental health disorders have overlapping disadvantages. In principle, people with mental health disorders are entitled to the same spectrum of health services as able-bodied people. However, many Arab countries gear services towards the needs of people with physical illness [30].

Many people with mental health disorders are not active in working life, due to unemployment or disability. In countries with a health insurance system based on employment, people excluded from the labour market face difficulties in access to health care [24]. Mental health disorders are associated with poverty and low socioeconomic status [31]. For many people with mental health disorders the only available route to access general health care is therefore through public services. This leads to a more restrictive coverage than people who can afford to pay out-of-pocket for health services [32].

**Transport**

People with mental health disorders may be particularly disadvantaged by geographical barriers of access to health care because of difficulties in use of transportation [33].

**Morbidity**

A recent literature review relating to inequalities in health status among those with mental health problems reported the following findings [34]. There were higher mortality rates among those with mental health problems, even after accounting for deaths from suicide and higher than average rates of physical illness among people with mental health problems, including cardiovascular disease (ischaemic heart disease, stroke, hypertension), diabetes, respiratory disease; sexually transmitted diseases (HIV/AIDS and hepatitis B and C) and poor oral health. Cancer rates have generally been found to be similar to the rest of the population.

A review of the literature was carried out to draw up a profile of the situation for mental health services and research in the region, and to suggest some measures for intervention. Although there are 22 Arab countries in the Arab League, the mental health services provided in those countries exhibit several variations. Economic, political, social and cultural factors seem to play a major role in determining the state of the psychiatric profession and the access of the service to citizens. Some Arab countries enjoy the highest *per capita* income in the world, yet this is inconsistent with the quality of mental health services available there. The *per capita* mental health services, the availability of a Mental Health Act and the space allocated for mental health in medical curricula are but just some of the concerns that have been expressed by colleagues from the different countries of the Arab region [35].

Elsewhere in the Eastern Mediterranean Region, in the Islamic Republic of Iran, the most common barriers to the utilization of mental health services were logistic, especially the cost of and inconvenient access to services. Barriers related to perceptions of mental health services were also important, such as lack of trust and perceptions of friends/family [36].

Depressive and adjustment disorders were the most often diagnosed psychiatric illnesses among inpatients referred for psychiatric consultation in Saudi Arabia [37]. Males were more frequently admitted for schizophrenia and females for mood and anxiety disorders. Most non-Arab expatriates were diagnosed with acute and transient psychotic, stress-related or dissociative disorders. Gender and immigration were the main determinants of variance in patient characteristics. Active family involvement improves compliance and might reduce re-hospitalization rates [38].

National hospitalization records from Israel revealed that Arab women utilized psychiatric services less than Arab men. The exact reverse occurred among Jewish patients. Moreover, Arab patients significantly underutilized mental health services, compared with Jewish patients. Possible reasons for these utilization patterns include: Arab health care utilization patterns in general; the availability of mental health services in Arab communities; the influence of the “cultural” over the “professional” in Arab mental health utilization; the lack of Arab mental health practitioners; Arab attitudes towards mental health; and gendered role constructs within Arab society. The findings emphasized the need for a policy of developing infrastructure and trained personnel who can provide services adapted to the special cultural characteristics of the Arab population [39].

**Stigma**

Stigma underlies many of the barriers to access, and is relatively well documented. A recent indepth review of
the issues of stigma and discrimination faced by those with mental health problems concluded that on the basis of global evidence about stigma “there is no known country, society or culture in which people with mental illness are considered to have the same value and to be as acceptable as people who do not have mental illness” [40].

Health care for people with mental health disorders tends to be under-funded throughout the Arab region, which could be explained by stigma and discriminatory attitudes [33]. Evidence suggests that stigma lessens the responsiveness of the health services, and that the fear of being labelled may cause individuals with mental health problems to delay or avoid seeking treatment altogether [25]. Those already labelled by the health services may decide to distance themselves from the label, forgoing treatment or becoming noncompliant. There is evidence also that the responsiveness to physical health problems of people with mental health disorders is severely undermined by prejudices and discriminatory attitudes of health care staff[41].

Self-stigmatization is also a factor, which in combination with previous bad experiences of health care (e.g. compulsory admissions or humiliating treatment), makes it difficult for the person with a mental health disorder to seek help and assert his/her rights to care [6]. Health staff may be more paternalistic and less likely to share decision-making than they would with patients without a mental disorder [41]. A paternalistic and derogatory health provider approach will add to previous disappointing encounters with the health system, and further decrease the user’s incentives to seek help for health problems. Many health professionals also seem to have the false perception that achieving health and wellness is not feasible among people with mental health disorders [41].

**Cost**

Data indicates that mental health problems are associated with low socioeconomic status, including low income, unemployment and low education levels [35]. The ensuing poverty means that cost constitutes a particular barrier of access to health care for the group of people with mental health disorders.

**Organizational barriers**

Many general organizational barriers in access to health care, such as waiting lists, may constitute an even higher barrier for people with mental health disorders because of their lack of resources to enable them to utilize alternative pathways to care (e.g. private health care) [6]. Mental health disorders are also often correlated with poor health literacy [40].

Research from several countries and international studies indicate that physical and mental morbidity often go hand in hand [42]. Excess morbidity from physical disease may, in part, be related to common underlying factors. These include poverty, direct disease influence (e.g. depression leads to increased risk of cardiovascular disease), adverse treatment effects and unhealthy lifestyles. It is a challenge for general health services to recognize psychiatric comorbidity. Likewise, it is a challenge for mental health services to recognize physical comorbidity [40,41].

Access to services may also be restricted if health care professionals believe that specific types of interventions are ineffective for people with mental health problems [41]. This may be particularly the case for health promotion and prevention therapies, where evidence of effectiveness is generally limited [41]. There may be a belief that people with mental health problems are even less amenable than other population groups to such interventions, because they are not good at adhering to long-term behaviour changes for example [40]. However, current evidence indicates that health promotion among people with mental disorders is feasible and effective [40].

In working to overcome these barriers, reports suggest that clinical practice guidelines are one useful tool to support the recognition of physical illness in people with mental health disorders [40]. It is reported that practice guidelines for mental health disorders incorporate recommendations to support improved recognition of physical comorbidity [41]. To ensure proper identification and treatment of physical diseases of people with mental health disorders, mental health care staff also need to be adequately trained.

**Coordination of care**

Evidence indicates that a general health policy supporting integration of health and social services and mainstreaming of mental health services will also offer better access to general health care [40]. There is also evidence that a multi-professional team-based approach is an effective method of providing services to deprived people with mental health disorders and complex problems [41].

Measures to improve the capacity of staff to recognize and treat physical and mental disorders are needed in the Arab region, as well as a radical change in the attitudes of staff of institutions is needed. Research suggests that the organization of services is the key to success in meeting the needs of people with mental health disorders, with integration, coordination, communication and seamless provision across health and social care sectors being of vital importance [40]. A transformation of the mental health care system towards a multidisciplinary, coordinated and holistic approach is required. It should be noted, however, there have been several recent reports on mental health in the Arab countries [43–55]. This trend highlights a change in attitudes among health professionals as well as the public concerning mental health and wellness.
Summary

Governments in the Arab region need to acknowledge the specific needs of older people with impairments and people with mental health disorders and centrally target the needs of these groups in national health inequalities programmes, providing incentives to providers and managing performance to ensure targets are met. Specific treatment guidelines need to be developed where needed. Raising awareness the health needs of such groups is a crucial measure that ought to be undertaken in close collaboration with users’ groups, civil society organizations and the media.

References

32. Maternal, child and adolescent mental health: challenges and strategic directions for the Eastern Mediterranean Region. Cairo,


