

Long Term Health Care Delivery In Nigeria: Issues And Challenges

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Abstract: Historically, public health systems have focused mainly on short-term health care for acute problems. This is basically on the grounds that transferable diseases were the main driver of morbidity and mortality also the long term care was an option that is generally too expensive. The paper examines long term health care delivery system in Nigeria juxtaposing the issues and challenges. The paper argued that as a result of advance in medicine people are expected they live longer , besides it is evaluated that there will be over 2 billion peoples beyond 60 years by 2050 and 80% of them will be residents in developing nations . So as a result of ageing and of the increase in non-communicable diseases, the demand for chronic medical care programmes started to grow globally. However it is observed that the Nigeria health care system is shrouded with problems and lacks the capacity to cater for long term care particularly the elderly the major recipient. The paper recommended that there should be legislation enforcing family responsibility for long-term care and with the State stepping in especially in the absence of family members. Further, that healthcare policy maker in Nigeria should incorporate the views and preferences of older persons themselves especially regarding the type and location of care, the quality of care provision.

Keywords: Health, Long Term Care, Nigeria, Elderly.

I. INTRODUCTION

Historically, public health systems have focused mainly on short-term health care for acute problems. This is basically on the grounds that transferable diseases were the main driver of morbidity and mortality also the long term care was an option that is generally too expensive. Therefore Care for chronically ill or disabled people was fundamentally given by the patients' immediate families and where the family was excessively too poor or generally unfit, making it impossible to convey care, government, religious and/or philanthropies organizations step in.

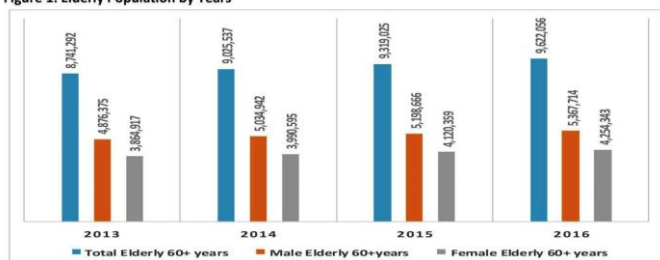
However Nursing homes for aged destitute and sanatorium for tuberculosis patients were among the earliest long term care organizations in many parts of the world (Moses, 2010). Today, long-term care is provided not only in

the form of institutional care, but increasingly in the home or community environment. The aim of this long term care, which often combines medical, nursing and social services, is to help frail older people and older adults to live a relatively normal life for as long as possible.

In addition, one of the main demographic changes across the world is that of population ageing, which has become a crucial challenge for the 21st century, people are living longer than expected as a result of advance in medicine, further the population of the elderly is additionally on the ascent because of advances in drug and expanded future, besides it is evaluated that there will be over 2 billion peoples beyond 60 years by 2050 and 80% of them will be residents in developing nations (Agbogidi, 2013). So as a result of ageing and of the increase in non-communicable diseases, the demand for chronic medical care programmes started to grow globally.

In Nigeria, the extent of the aged population has been expanding, before Nigeria gained independence in 1960, there was a population census conducted in 1952/53. Since independence, the country had only conducted three successful population censuses in 1963, 1991 and 2006. The total number of persons aged 60 years and above in 1952/53 was 2,448,000. In 1963, 1991 and 2006 population census the total number of persons aged 60 years and above was 3,617,000 and 8,227,782 and 19,580,204. However according National Bureau Statistics, (2017) the total number of older people, that is, those aged 60 years and above went up slightly from 8,741,292 in 2013 to 9,622,056 in 2016. Figure 1 indicates 1.8 per cent increase in the male ageing population between 2013 and 2014 compared to 1.4 per cent increase in the female ageing population between 2013 and 2014.

Figure 1: Elderly Population by Years



Source: National Population Commission

Figure 1

Again, in spite of the fact that Government and the people of Nigeria are not oblivious of the need for conferred look for long term services particularly to the elderly, very little has been done to improved prosperity for long term health care delivery in the country, there is no social security scheme policy for the aged. Intergenerational relationships are also recognized as a fundamental source of support in later life and they function as a major medium of cultural continuity. However in most third world countries Nigeria inclusive do not have a formal support safety net for the growing aged population, majority of them had to depend exclusively on their children for support, the importance of which is enforced by cultural enthusiasm about filial piety.

Meanwhile the various cultural variables in the traditional institution that supported elderly care are highly threatened due to modernization and urbanization coupled with its accompanying labour force migration of adult children from rural to urban areas, intergenerational support in the form of hands-on help and co-residence has substantially weakened because of the reduced availability of children in proximity as well as changed norms and values (Ezeh, 2012).

In numerous traditional African societies and most countries in the world the family is charged with the responsibilities for the provision of support for the elderly. Such support prevails and it is given willfully with no compensation (Abiodun, (2010).

However Okon (2013) noted that various factors such as training, urbanization, industrialization, the formal economy which nowadays includes the two couples to go to work outside the family, have started to influence the status and method of activity of the family in Nigeria. These variables can be found in the light of the accompanying patterns of rural-urban migration, evolution of "new" family units,

adoption of western values and beliefs system and interaction of diverse cultural groupings.

Therefore this paper will attempt to examine the long term care health delivery in Nigeria particularly the existence or otherwise and compares to other advanced countries of Europe and America.

II. CONCEPTUAL ISSUES

Health according to the World Health Organization (WHO) is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity altered bodily state or processes to deviates from norms established by biomedical science. Health may also be defined as "a state whereby one is not perturbed by either physical, or spiritual (mental) illness, or by injury of any kind." The underlying supposition of this definition is that man is a composite being with two complementing aspects-body and soul-either or both of which may be affected by ill-health. That is why as we talk about physical health, we should not lose sight of the fact that mental health a necessity without which man's life will be atrophied (Uche & Uche, 2014).

In similar vein Health care is the maintenance or improvement of health via the diagnosis, treatment and prevention of disease, illness, injury, and other physical and mental impairments in human beings. Again WHO, (2004) define health care as services provided to individuals or communities by health service providers for the purpose of promoting, maintaining, monitoring or restoring health.

Long Term Care on the other hand according to World Health Organization, (2015) encompasses activities undertaken by others to ensure that those with a significant ongoing loss of physical or mental capacity can maintain a level of ability to be and to do what they have reason to value; consistent with their basic rights, fundamental freedoms and human dignity.

Put differently, Long-term care services include a broad range of health, personal care, and supportive services that address the needs of frail older people and other adults whose capacity for self-care is limited because of a chronic illness, injury, physical, cognitive, or mental disability; or other health-related conditions (HHS, 2013). It includes care services that involve help with activities of daily living (ADLs) e.g. dressing, bathing, and toileting, Instrumental activities of daily living (IADLs) such as medication management and housework and health maintenance tasks.

Long-term care services assist people in maintaining or improving an optimal level of physical functioning and quality of life, and can include help from other people and special equipment and assistive devices.

Moses, (2010) noted that Long term care is much more complicated and considerably more difficult to measure than the goals of acute medical care this is because while the primary goal of acute care is to return an individual/patients to a previous functioning level, long term care is aimed at preventing deterioration and promote social adjustment to stages of decline.

In addition Long term or chronic care includes a much broader range of services, emphasizing social as well as

medical services. While acute care is usually confined to specialty providers, on the other hand the providers of long term care as noted earlier are more wide ranging, they include traditional medical providers such as physicians and hospitals, formal community caregivers such as home care agencies, facility providers such as nursing homes and assisted living facilities, and informal caregivers such as friends or family members.

In support of this O'Shaughnessy, (2013) maintains that Individuals who receive long-term care services do so in a variety of settings, such as in the home from a home health agency or from family, surrogates and friends, in the community from an adult day services center, in residential settings from assisted living communities, or in institutions from nursing homes cited in (Vital and Health Statistics, 2013).

So there are basically three main types of long term care: community care, institutional care, and informal care. The Community Care comprises of Home Health Care, Adult Day Care and Hospice Care. The Home Health Care is provided to those recovering from an acute hospitalization (called sub-acute care) as well as to those with more chronic long term care needs. Home care involves a wide range of medical and social services providers, depending on the patient's needs. These services include skilled nursing care provided by registered or licensed practical nurses (LPNs); physical, speech, and occupational therapies; professional services provided by social workers, dieticians, case managers, nutritionists, and audiologists; home health aide services; and personal care, meals, and home-based personal support services such as help with homemaking and chores.

The Adult Day Care programs provide a variety of support services for impaired adults (mainly the elderly) in a protective setting during the day. According to data from Partners in Caregiving, more than half of adult day care programs offer medical services and rehabilitation therapy; more than three-fourths have nursing services, personal care services, and transportation; and more than 90 percent provide social services, meals, and recreational therapy/activities (Partners in Caregiving 2015).

Finally Hospice Care in addition to medical services provides emotional and spiritual services to terminally ill patients and their families. These services usually involve an interdisciplinary team that includes a physician, a nurse or nurse's aide, a social worker, a member of the clergy, and volunteers. The institutional care refers to nursing homes and supportive housing. Off course The Nursing homes offer care to people who cannot be cared for at home or in the community. They provide skilled care, rehabilitation services, meals, activities; help with daily living, and supervision. On the other hand the informal care talks about In-Home Care and Support by Friends and Family.

III. ISSUES AND CHALLENGES THE NIGERIA EXPERIENCE

Nigeria just like in many third world nations the national health policy is shrouded with problems and clearly lacks the capacity for long term cares services particularly to her senior

citizens. The national health policy was establish to have a comprehensive health care system, based on primary health care that is promotive, protective, preventive, restorative and rehabilitative to every citizen of the country within the available resources so that individuals and communities are assured of productivity, social well-being and enjoyment of living (National Health Policy, 2004). In addition the constitution of federal republic of Nigeria states in section 17(3) (c) and (d) states that "*the state shall direct its policy towards ensuring that the health, safety and welfare of all persons in employment are safeguarded and not endangered or abused and that the state shall direct its policy towards ensuring that there are adequate medical and health facilities for all persons*" cited in (Yunusa, etal, 2014).

Again in Nigeria, public health care is provided in three levels; the primary, secondary and tertiary all of which are managed by the local, state and federal governments respectively. While Primary health centers are the first point of contact for patients, providing preventive, curative, and health promoting and rehabilitative services. The secondary care level, patients are referred for specialized services from the primary health care level, through out-patient and inpatient services of hospitals for general medical, surgical, paediatrics, obstetrics, gynaecology and community health services. The tertiary level is the apex health care system in Nigeria consisting of teaching hospitals, federal medical centers and other specialist hospitals which provide care for specific disease conditions or specific groups of patients Yunusa, etal, (2014).

Further, the local governments have the main responsibility of managing the Primary Health Care all the three tiers of government and various agencies participate in the management of the Primary Health Care. This at times results in duplication, overlap, and confusion of roles and responsibilities (World Bank, 2010). Also many secondary and tertiary health facilities are crowded with patients that have simple ailments that can be managed at the primary health centers which typically have many idle health care workers (The Nigerian academy of science, 2009).

In an attempt to address the precarious and dismal situation in the health sector, and provide universal access to quality health care service in the country The National Health Insurance Scheme (NHIS) was established. The National Health Insurance Scheme (NHIS) is a policy attempt by the Nigerian federal government to adopt universal health coverage (UHC) for her citizens. The NHIS operate through three broad categories of stakeholders- government, the private sector as well as other agencies appointed by government and international donor agencies. A breakdown of these stake holders include government at all levels, employers (both public or private sectors), self-employed, Rural Community Health Insurance Program agency, health maintenance organizations, board of trustees, health providers, commercial banks, NGOs, community leaders and the media (Executive Secretary NHIS, 2009). However an overview of the provisions of NHIS shows that, there is virtually no provision made for the healthcare needs and social security of the elderly population in Nigeria. There are no overt programs and services for the elderly in Nigeria because there has not yet been a policy for the care of seniors in Nigeria.

According to Etobe and Etobe, (2013) Nigeria has the highest out-of-pocket health spending and poorest health indicators in the world. Apart from a few states in Nigeria that are implementing a free health policy for elderly persons 65 years and above, the rest are left at the mercy of their families and most often times providing health care for the elderly is not a priority for family members especially if there are children who also need medical services, coupled with many other competing needs.

Regrettably the highest levels of long term care needs are found in third world country like Nigeria particularly lower ages due to lower longevity rates combined with higher rates of chronic non-communicable diseases. According to World Health Organization (2015) this will continue to increase in these countries unless there is a serious improvement in healthcare services throughout the life-course (including at older ages) to address this growing rate of non-communicable disease and age-related disabilities.

Xenia, (2015) observed that globally, the availability of formal long-term care services is practically low. The scholar noted that Forty-eight per cent of older persons are not covered by any type of formal provision of services while 46 per cent are excluded from any coverage that does exist and only 5.6 per cent of older persons worldwide are covered by legislation that provides coverage for all. This is reflected, for example in statistics for the United States that show 123 informal care givers per older person versus 6.4 formal care givers (Xenia, 2015:23).

Furthermore, there is a critical shortage of trained personnel. In 2017, it was estimated that there was already a global 13.6 million shortfall of formally employed caregivers. This shortage is mostly severe in third world countries, where the largest numbers of older persons reside and from where many caregivers leave to work in developed countries because of better pay and conditions of services.

In fact, in some countries (mostly third world countries) where long-term care is lacking, the continuous use of acute care hospital services and emergency rooms is higher, and costs are therefore higher, too. Even in developed countries, cases of older persons residing for long periods in hospital beds due to lack of long-term care placement arrangements are not unusual.

Therefore the majority of care givers are informal, and majority of them has little to no training and/or practical or financial experience to support, help and ensure sustainability or quality. The significant majority are still immediate family members. However, due to smaller family sizes and economic and social changes, older persons in some urban areas of developing countries as obtainable in Nigeria currently rely upon a large number of untrained and poorly-paid home care workers mainly women with low levels of formal education. On the other hand, some are also cultivating other alternatives such as volunteer social organizations, community-based care and mutual support groups (UNESCAP, 2015).

This also brought the issues of gender dimension of informal care because the giving and receipt of long term care is overwhelmingly a female issue as majority of caregivers both at the informal and formal level are women and, due to the fact that women live longer, they are also the majority of care recipients too.

The International Labour Organization (2016) maintains that gender discrimination as evident in the dependent on unpaid care by female family members pointed to the hidden costs of informal care that lead to higher rates of poverty and low social protection coverage rates for those out of the formal workforce. Again it observed that even within countries that provide financial incentives to family care givers and have low rates of institutionalization, studies have shown that the pressure in reconciling care and labour force activities is overwhelming the availability of family care and that more community services are urgently needed to address the growing problem (United Nation, 2016). There is also the problem of economic cost to societies as a result of over dependent on informal caregivers that causes, among other things, loss in productivity and labour market distortions, particularly for women.

United Nation, (2016) also pointed out that a large proportion of cases of abuse and neglect of older persons occurs whether within the home or at an institutional setting. This includes issues of neglect, physical and sexual abuse and financial, psychological and emotional abuse. While physical and sexual abuse are easily categorized, what passes for “normal operational practice” are often violations of the rights of older persons, such as use of restraints, locking of doors, social isolation, inappropriate use of medication and regimented enforcement of schedules.

In the same vein Age discrimination in access to long-term care services is also a point of concern. The unequal treatment of older persons versus younger disabled persons in accessing similar care services has been raised as an age discrimination issue, particularly in light of the adoption of the Convention on the Rights of Persons with Disabilities, which is often cited as a possible source of human rights law for older persons. Globally older persons with disabilities are not entitled to the same care allowances and benefits as younger persons with disabilities (European Age Platform, 2016). For instance, in France there are different benefit schemes for a disability acquired before and after age 60, with the old age disability benefit being less generous, referred to as an example of intersectional discrimination on the basis of age and disability.

Recently a study in Norway also pointed to the unequal distribution of resources between younger and older persons in need of long term care. The study notes that some of the employees of the municipal authorities responsible for allocation of resources had an unconscious bias against persons over age 60 with disabilities. These assumptions were often linked to ingrained ageist views which hold that priority that should be given to younger people with more “potential” for future development (Ulmanen and Szebehely, NS).

Although it must be observed that in nearly every country, to varying degrees, the underlying question of who is responsible for the provision of and financing of care for older persons is a negotiated balance that involves issues of cultural expectations and the specific political and social environment, as well as availability of funding. The International Labour Organization, (2016) asserts, however, that the right to social security and health care also includes the right to long-term care, which clearly puts the onus on Governments to provide a comprehensive policy framework.

World Health Organization also notes that throughout discussions on Government or family responsibility and the proportion thereof, little attention is paid to quality of care or the quantification of the benefits of care provision and funding by the State only the cost to gross domestic product (GDP). It is observed that the global average public expenditure on long-term care is less than 1 per cent of GDP. It is highest in Europe, but varies widely among countries, for example, from a high of 2 per cent in the Netherlands and Norway, to 0 per cent in Slovakia. In North America it stands at 1.2 per cent in the United States, and 0.6 per cent in Canada (Ulmanen and Szebehely, NS).

In some countries such as Germany, Japan and the Netherlands there are mandatory public long-term care insurance systems that are in place although it is currently undergoing adjustments in benefits and premiums to ensure sustainability of the systems. However, for the majority of older persons who want to or even can access any type of formal care services, they must utilize savings, or “spend down” their assets to qualify for government-funded services—either institutional or in home. There are also often different Government funding mechanisms and qualifying rules for social and medical in-home care services, with more burdens generally put on the individual to self-fund “social” care in support of activities of daily living. Such out-of-pocket expenditures can have adverse financial outcomes both for the older persons themselves and often, their families. Finally, while a limited market exists in some developed countries for self-insurance policies against possible long-term care costs in the future, the take-up rate are low and policy premiums expensive.

For instance in Sweden the policy of keeping elderly person at homes has led to reduction in residential care space but has not accentuated an increment in the provision of formal home care rather increase demand on informal family care. In addition, unpaid family care remains more common among families of older people with less education and, therefore, setback in formal services affect working class families more negatively (Ulmanen and Szebehely, NS).

IV. CONCLUSION AND RECOMMENDATIONS

Therefore, in the light of the above issues surrounding Long Term Care services there should be legislation enforcing family responsibility for long-term care, with the State stepping in especially in the absence of family members, particularly given the glaring evident that older persons who needs help with basic tasks such as getting out of the bed, washing and dressing but don't get it as result of lack of care givers (both formally and informally) are on increase.

Policies development and Strategies advancement should therefore include the views and preferences of older persons themselves regarding the type and location of care, the quality of care provision (formal and informal), and the tangible and intangible “costs” to Governments, the individual and families in the provision of care. In this respect, it has been argued

many social commentators that long-term care should be described as a societal and political public good, the neglect of which will only leads to more social and economic costs (World Health Organization, 2015).

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