Review Article

ELDERLY MEDICAL CARE AND OUT-OF-POCKET MEDICAL SPENDING – A THORN IN THE FLESH OF SENIOR CITIZENS IN NIGERIA: REVIEW OF ARTICLES.

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Abstract

Introduction: Ageing is a global trend. The Nigerian population, alongside the world population, is following the pattern of demographic shift, characterized by increasing population of older people. The aged population is faced with health, economic and social challenges. Most Low-and- Middle- Income Countries including Nigeria are yet to provide solutions to the unmet health needs of the aged population as these countries do not have a functional geriatric care policy.

Materials and Method: The literatures under review were searched using the key words 'health insurance', 'out-of-pocket', 'elderly medical care' and the names of respective countries and continents as contained in this article, without limitation to year of publication.

Results: The major source of health care funding for elderly in Nigeria and other Low-and-Middle-Income-Countries is by out-of-pocket payment. This method of payment can lead to financial catastrophe. The method of health care financing greatly affects access and utilization of health care services by senior citizens.

Conclusion: The government of Nigeria and other countries in sub- Saharan Africa should consider the impact of out-of-pocket payment on access and utilization of healthcare services by senior citizens. Government should develop and implement policies on geriatric care models and health insurance scheme for the aged.

Key words: Out-of-pocket, ageing, health financing, elderly care, spending.

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INTRODUCTION

The world's population is ageing: virtually every country in the world is experiencing growth in the number and proportions of old persons in their population[1]. Most developed world countries have accepted the chronological age of 65 years as a definition of elderly or older person, but like many westernized concepts this does not adapt well to the situation of Africa[2]. While this definition is somewhat arbitrary, it is many times associated with the age at which one can begin to receive pension benefits[2]. At the moment, there is no United Nations (UN) standard numerical criterion, but the UN agreed cut off is 60+ years to refer to the older population[2].

There is inevitable increase in the share of older people[3]. Each of the 201 countries or areas with at least 90,000 inhabitants in 2017 is projected to see an increase in the population of persons aged 60 or over between 2017 and 2050[3]. The Nigerian population is undergoing demographic transition

with an increasing population of older people[4]. Data on medical admissions of elderly patients in Nigeria shows higher demand for inpatient facilities, and a higher incidence of premature discharge due to the high financial cost among poor elderly Nigerians[5]. The inadequately funded health care system has placed little emphasis on the care of older people and funding for older people is limited[4]. In Nigeria, many elderly people remain excluded from the National Health Insurance Scheme (NHIS) with little or no pension and income generating opportunities[5]. Over 70% of health spending is private and 96% of private health expenditure is made up of out-of-pocket expenditure. Like many low- and middle-income countries, out-of-pockets are the most prevalent method of financing health care cost in Africa[5].

In the absence of functional social security mechanism for elderly people in Nigeria, elderly people household are solely responsible for geriatric health costs which can lead to catastrophic health expenditure[5]. As the average age of populations continues to rise[3], it is pertinent to critically review literatures across the globe on elderly medical care, the methods of health financing and the influence of out-of-pocket medical expenditure on health care access and utilization among the elderly. The findings from this study would serve as recommendation to government for policy implementation to address the needs and interests of older persons, including those related to housing, employment, healthcare, social protection and other forms of intergenerational solidarity[3]. By anticipating this demographic shift, countries can proactively enact policies to adapt to an ageing population, which will be essential to fulfil the pledge of the 2030 Agenda for Sustainable Development that "no one will be left behind"[3].

MATERIALS AND METHODS

Four key words were selected for this literature search. The words are 'health insurance', 'out-of-pocket expenditure', 'medical care' and 'Elderly'. In addition to these key words are the names of countries and continents searched together with the words. Using the collections of these key words, the following data bases were searched: PUBMED, GOOGLE SCHOLAR, SOCIAL SCIENCE RESEACH NETWORK, BIOMEDCENTRAL, SCIENCE DIRECT. Titles and abstract of publications were used to select relevant literatures. In all, a total of 55 relevant literatures written in English language were harvested, with no limitation to year of publication.

RESULTS

DEFINING OLD AGE

The definition of "old age" is important to each of us as individuals, subject to the ageing process, and has wider implications for the aged care industries as well as for society at large[6]. Old age, also called senescence, in human beings, is the final stage of the normal life span[7]. Definitions of old age are not consistent from the stand points of biology, demography, employment, retirement and sociology[7].

The ageing process is of course a biological reality which has its own dynamics, largely beyond human control[2]. The United Nation agreed cut off for the older population is 60+ years[2]. It is also subject to the constructions by which each society makes sense of old age[2]. In the developed world, chronological time plays a paramount role, the retirement ages of 60 or 65 years are said to be the beginning of old age[2]. In many part of the developing world, chronological time has little or no importance in the meaning of old age[2]. Studies conducted in the late 1970's which included multiple areas in Africa defines old age in three categories-chronology, change in social roles, and change in capabilities[2]. Results from cultural analysis of old age suggested that change in social role is the predominant means of defining old age[2]. The WHO suggests that if a definition in Africa is to be developed, it should be either 50 or 55 years of age, but even this is somewhat arbitrary and introduces additional problems of data comparability across nations[2].

While a single definition such as chronological age, or social/cultural/ functional markers, is commonly used, it seems more appropriate in Africa to use a combination of chronological,

functional and social definitions[2].

WORLD POPULATION AGEING

The global population aged 60 years or over numbered 962 million in 2017, more than twice as large as in 1980 when there were 382 million older persons world wide[3]. Between 2015 and 2050, the proportion of the world's population over 60 years will nearly double from 12% to 22% [8].

Today, 125 million people are aged 80 years or older[8]. The older population of the developing countries is growing much faster than in the developed world [3, 8]. In 2050,79-80% of old people will be living in low-and middle-income countries[3,8].

Over the coming decades, the number of older persons is expected to grow fastest in Africa[3]. Africa is followed by Latin America and the Caribbean, where the older population is projected to increase more than two folds between 2017 and 2050[3]. Asia is also expected to experience a two-fold increase in the number of older persons[3]. Of the six major geographic regions, the population is expected to grow most slowly in Europe, with a projected increase in 35% between 2017 and 2050[3]. Although the process of population ageing is most advanced in Europe and in Northern America, where more than one person in five was aged 60 or over in 2017[3]. In general, older women are more likely than older men to live alone. Both in Africa and in Europe, older women were more than twice as likely as their male counterparts to be living alone[3].

Old age has been defined variously in different societies and cross culturally. It is a relative concept and different meaning have been attributed in different contexts[9]. To most, ageing implies physiological and psychosocial changes that are reflected in their reduced income, lesser activities, both in the family and in the society[9].

HEALTHY AGEING

The World Health Organization (WHO) defines healthy ageing 'as the process of developing and maintaining the functional ability that enables wellbeing in older age'[10]. Functional ability is about having the capabilities that enables all people to be and do what they have reason to value. Such as ability to meet their basic needs, learning, grow and make decisions, to be mobile, to build and maintain relationships and contribute to society[10].

SUCCESSFUL AGEING

Successful aging in old age is important. However, the determinants of successful aging vary across populations due to cultural differences, and only a limited number of studies have addressed these determinants[11]. The definition of successful ageing has long been the subject of vigorous inquiry and debate in gerontology[12]. One prominent model of successful ageing, developed in the 1990, proposed that it means; freedom from disease and disability, high cognitive physical functioning, and active engagement with life[12]. At the heart of debates about successful aging is whether it can be measured by objective criteria or is a value judgement, assessed by individual subjective evaluation[13]. Rowe and Kahn hold that people who age successfully show few or no age-related declines, where as those ageing usually experience disease- associated decrements[13].

FRAILTY

Frailty is a common clinical syndrome in older adults that carries an increased risk for poor health outcomes, including falls, incident disabilities, hospitalization and mortality[14]. It is theoretically defined as a clinically recognizable state of increased vulnerability resulting from ageing-associated decline in reserve and function across multiple physiologic systems such that the ability to cope with every day or acute stressors is compromised[14]. Fred et al proposed an operational definition for frailty, as meeting three out of five phenotypic criteria indicating compromised energetic. These are, low grip strength, low energy, slowed working speed, low physical activity and/or unintentional weight loss[14].

Geriatricians define frailty as a biologic syndrome of decreased reserve and resistance to stressors, resulting from cumulative declines across multiple physiologic systems, and causing vulnerability to adverse outcomes[15]. Understanding points of onset

of frailty is vital to early identification of at-risk individuals and intervention on those components that are first affected, when reversal may be most possible[14]

GERIATRIC SYNDROMES

Geriatric syndromes are quite clinical conditions in older people that do not fall into specific disease categories[16, 17]. The terminology is different from the traditional definition of a 'syndrome', they are further a symptom, or a fixed combination of several symptoms[16]. They have substantial implications for functionality and life satisfaction in older adults[17]. They are associated with increase morbidity, mortality and health care utilization[16]. In clinical practice, these conditions, such as cognitive impairment, falls, frailty, delirium, gait disturbance, incontinence, malnutrition, pain, polypharmacy, pressure ulcers, sarcopenia, sleep problems and tremors are named geriatric syndromes[16]. Older adults face many challenges, including behavioural and social issues, problems with functionality and activities of daily living, and the wide range of settings where care is provided[17].

Geriatric syndromes have common risk factors that are linked to each other within the cause and effect relationship. It is important to determine the changes that develop in the systems with ageing, to predict which syndrome may develop in which patient, and to develop person-based protection and treatment options. The frequency of geriatric syndrome should be known according to age groups to enable the healthcare providers to recognize the cases and refer patients to the necessary centres[16].

CHALLENGES OF AN AGEING POPULATION

Ageing comes with many challenges. The loss of independence is one potential part of the process, as well as diminished physical activities and age discrimination[18]. The elderly faces many challenges in later life, but they do not have to enter old age without dignity[18]. The ageing population face challenges in ensuring that their social, economic and health needs are met[19]. In developing countries, many older citizens are struggling to live independent lives for numerous reasons which include: inadequate infrastructure, limited access to health care professionals, unaffordable medical treatment for chronic conditions; and little, if any access is social security or pensions[19].

PHYSICAL AND MENTAL HEALTH

Physical and Mental aspect are both integral to health[20]. At the biological level, ageing results from the impact of the accumulation of a wide variety of molecular and cellular damage over time[8]. This leads to a gradual decrease in physical and mental capacity[8]. Common conditions in older age include hearing loss, cataracts, and refractive errors, back and neck pain, and osteoarthritis, chronic obstructive pulmonary disease, diabetes, depression and dementia[8]. Older age is also characterized by geriatric syndromes[8].

Mental health and well-being are as important in older age as at any other time of life[21]. Approximately 15% of adults aged 60 and over suffer from a mental health disorder and 6.6% of all disability among people over 60 years is attributed to mental and neurological disorders[21].Older people face special physical and mental health challenges which need to be recognized[21].

HEALTHCARE COST AND FINANCIAL ISSUES

It seems obvious that the relationship between age and health expenditures depends on health[22]. As individuals age, their health generally decreases and this in turns leads to increasing utilization of health care[22].

Increasing cost of healthcare is rising at a much faster rate than the overall rate of inflation [23]. Healthcare costs will most likely continue to rise as pharmaceutical companies and medical device manufacturers continue to churn out personalized therapeutic drugs and devices[23]. The high costs of health care along with any debt accumulated can make it very difficult for some seniors to make ends meet[23]. The rate of poverty is slightly higher among elderly women than males[23]. Those who

live in poverty have a much harder time paying medical bills and prescription drugs cost that address their health conditions than those who are more fortunate[23].

AGEISM

Ageism is the stereotyping, prejudice and discriminating against people on the basis of their age[24]. Ageism is widespread and an insidious practice which has harmful effect on the health of older adults[24]. Ageism or age discrimination has deeply permeated our culture, mindset and attitude[25]. It is so common that even the healthcare system one out of five older adults experience ageism in healthcare settings, and those who frequently experience it have higher risk of developing a new disability or worsening existing ones[25].

Ageism is everywhere, yet is the most socially 'normalised' of any prejudice, and is not widely countered-like racism or sexism[24]. These attitudes lead to marginalization of older people within our communities and have negative impacts on their health and well-being[24].

ELDER ABUSE

Elder abuse is an important public health problem[26] it is defined as a single or repeated act, or lack of appropriate action, occurring within any relationship where there as an expectation of trust, which causes harm or distress to an older person[26]. The World Health Organization (WHO) reports that around 1 in 6 people 60 years and older experienced some form of abuse in community setting during the past year[26]. The perpetrator is usually a family member, most often an adult child who is the older person's care giver[27]. Rates of elder abuse are higher in institutions such as nursing homes and long-term care facilities[26]. Elder abuse is predicted to increase as many countries are experiencing rapidly ageing population, these can be psychological abuse, physical abuse, financial abuse, sexual abuse and neglect.

Today, concern about elder abuse has driven a world wide effort to increase awareness of the problem and encourage development of appropriate prevention and assistance programmes[28] to prevent serious consequences of physical injuries and long-term psychological consequences[26].

HEALTH CARE FINANCING

Financing healthcare has evolved from personal payment at the time of service delivery to financing through health insurance (prepayment) by the employer and the employee at the work place[29]. This has progressed in most industrialized countries towards governmental financing through social security or general taxation, supplement of private and Non-Governmental Agencies (NGOs), and personal out-of-pocket expenditures[29]. The United States, data from the Medicare Current Beneficiary Survey (MCBS) which reveals medical spending of Americans aged 65 years and older, shows that the poor consume more medical goods and services than the rich and have a much larger share of their expenses covered by the government[30].

The typical elderly Americans receive far more medical services than those of younger ages[30]. Most of the elderly medical expenditures are financed by the government[30]. A notable feature of medical care in the elderly population is that virtually every American aged 65 or over is eligible for Medicare, a government-provided health insurance. Medicare pays much of the cost of short hospital stays, doctor visits and, since 2006, pharmaceuticals.

The elderly receives more medical attention than any other US demographic[30]. Senior citizens make up 13% of the US [30]. The average amount spent on medical care for an American in his or her 90's exceeds $25,000 annually, a cost based primarily on nursing home costs[30].

THE UNITED KINGDOM (UK)

More than two-fifths of national health spending in the UK is devoted to people over 65. The data shows that an 85 years old man costs the NHS (National Health Service) about seven times more on average than a man in his late 30's. Health spending per person steeply increases after the age

of 50, with people age 85 and over costing the NHS an average £7,000 a year. spending on health services across all age groups is £2,069, according to treasury analysis[32]. According to report from office for national statistics, healthcare expenditure in 2017 continue to be mostly influenced through government expenditure. This includes spending by the NHS, local authorities and other public providers of healthcare, accounted for 79% of total current health care expenditure. The remaining healthcare expenditure was financed through four categories of non-government expenditures-voluntary health insurance, charitable financing, enterprise financing, out-of-pocket expenditure[32].

Demographic changes in the UK, such as an ageing and expanding population, has led to an increase in the number of people with complex social care and health care needs. The establishment of programmes such as better care fund encourages greater collaboration between NHS and local authorities through pooled budget arrangements and integrated plans[32]. Long term care was mostly financed through government schemes in 2017. Around 66% of health -related long-term care was financed through government with 31% financed through out-of-pocket funds and the remaining expenditure financed through charities. Out-of-pocket financing consist of privately purchased services, as well as contributions to local authority-organised care[32]. The financing of long-term care (social) was more varied, with government still the largest contributors (48%), but with a greater proportion being financed through other means[32].

AUSTRALIA

Australia's health and aged system are complex. There are many types of services provided and a variety of funding mechanisms. The Australian government provides the majority funding for health and aged care services in Australia[33].

The Australian aged care system delivers services through a range of provider and care types within community based and residential settings[33].

Older Australians often bare a larger financial burden than younger Australians due to the management of multiple chronic conditions and being reliant on a reduced fixed income. However, Medicare system in Australia provides free access to public hospital services and pays a scheduled amount for private medical service, and ancillary health services. The Pharmaceutical Benefits Schedules (PBS) subsidizes the cost of pharmaceuticals to all Australians with the highest subsidies going to those on low income[34]. Both of these schemes aid in the affordability of health care for old Australians[34].

The aged care systems cater for Australians aged 65 and over (and indigenous Australians aged 50 and over) who can no longer live without support in their own home[35]. The Australians government is the primary funder and regulator of the system, providing approximately 95% of the funding[35].

ASIA

Demographic changes in Asia, are likely to exert unprecedented demand on care and health services for older people. Poverty is the most significant issue for older people in the region; without access to pensions or free health care, many cannot afford the services they need. There are gaps in care[36]. The emerging Asian economies have some common characteristics in their market. None of them have long-term care insurance market for elderly care, meaning expenses are borne by individuals and families. There is a severe region- wide shortage of qualified professionals, often made worse by this people emigrating to advanced economies where their skills are in high demands[37].

As is well known, china is a rapidly ageing society, and the population of its population aged over 65 will double between 2010 and 2030. The Chinese government has been rapidly developing policies and projects for an elderly care system that can address the needs of the population. Until recently, China had no elderly care system to speak of and no long-term care insurance. Three ministries have been studying and analysing elderly care system in countries like Japan, the Netherlands, Russia and Canada. As a result, the elderly care system in china is now developing rapidly[37]. China's

approach is guided by the so called 90:7:3 formula, according to which the goal is for 90% of elderly care to be provided at home, 7% in community centres, and 3% in institutions[38].

In India, home to 90 million elderly people, only 3% of the government budget was spent on overall health care in 2015 around the World Health Organization report[38]. Elderly care is largely left up to the families. More than 50% of health care spending in India is out-of-pocket[38]. Provision of long- term care in Asia is increasingly in demand, but supply is limited. In Thailand, the comprehensive long-term model includes both institutional and non- institutional services. At present, however, while there is free universal health care for older people, long-term care and rehabilitation services are not included[36].

Japan is the most aged society in the world. Japanese enjoys the world's longest and healthiest lives. The rate of population aging in Japan is much greater than in other developed countries. By 2020, one in four Japanese is expected to be over 65[39].
Japan has long been known for its widespread respect for its senior and a powerful obligation to care for them. The provision for care is increasingly seen as a social (and exclusively a family) concern. In 2000, Japan introduced Long-term care insurance (LTCI) designed to provide cover for all those over the age of 65, according to their needs. The system is one of the most comprehensive social care systems for the elderly in the world, built around the aim of reducing the burden of care for families[40].

In Japan, people above the age of 65 apply to their local government, and a complex test is done to access their needs. A care manager advises on how their needs may best be met, based on the budget they are allocated and a knowledge of local providers for community-based care[40]. The insurance is financed from premiums that are mandatory for all citizens aged 40 and above- the general revenue- and co-payments from users[40]. The Japanese government has been funding development of elder care robots to help fill a project shortfall of 380,000 specialised workers by 2025[41]

AFRICA

Sub-Saharan Africa is undergoing a rapid demographic change, with more people reaching old age. There is however, little information available about health care policies with regards to this age group in this region of the world[42]. Countries in sub-Saharan Africa including Ghana, Mozambique, South Africa, Uganda and Tanzania, have ratified national policies on the ageing population, while a few like Nigeria, Cameroon and Rwanda have drafted policies which are awaiting passage into law by their legislatures[42].

The current policies to promote access to health care for older persons in sub-Saharan Africa are not encouraging. With the exception of countries such as Senegal, Ghana and South Africa that have either implemented free health care or exempted the older people from paying health insurance premiums, the older in many other sub-Saharan countries are not covered by health insurance[42]. Nigeria has no functional national policy on the care and welfare of older persons. Changing demographic policies of Nigeria, in addition to the breakdown of the family structure and absence of a social security system, present unique challenges to the elderly in Nigeria.[43]

A major challenge facing most government in Africa is the development of policies and training of officials capable of understanding and responding to the current social priorities and complex needs of an increasingly ageing populations[43.]

The ageing of individuals and populations and the changing position as well-being of older people in sub-Saharan Africa present a sort of key challenges for African nations to begin to address. Yet evidence and a strong knowledge base of information on the nature and dynamics of poverty, health, social support networks and the changing roles and responsibilities of older people and their implications are lacking[44.]

In Mauritius, long-term care is typically viewed as a family responsibility, although this is being

challenged as society undergoes change. The government acknowledges that family caregivers requires support and allocate a monthly allowance to caregivers of older people experiencing significant declines in capacity. Some efforts have been made to provide practical training to family caregivers[45].

In Seychelles, all citizens receive free health care and people over the age of 63 are entitled to a monthly retirement pension, in addition to a number of government long-term care services[45].

In South Africa, all older people can access primary health care services free of charge but hospital care is free only to those who are indigene. Traditionally, long-term care has been seen as a family responsibility yet few schemes are in place to support family caregivers[45]. Old age pensions are means-tested and distributed to people without financial means[45.]

UNIVERSAL HEALTH COVERAGE AND AGEING

Universal Health Coverage (UHC) is defined by WHO as ensuring that all people and communities receive the quality services they need, and are protected from all the threats, without financial hardship. Population ageing will have an impact on the ambition of universal health coverage, because without the health and social care needs of the ever-increasing number of older people, UHC will be impossible to achieve[45]. Mechanisms to ensure older people can access services without financial burden will be crucial, however, national health financial system must be designed not only to allow older people to access services when they are needed, but also to protect them from financial catastrophe by abolishing out- of-pocket spending for older populations[46].

OUT-OF-POCKET MEDICAL SPENDINGS AND MEDICAL CARE IN THE ELDERLY

All countries face major challenges to ensure that their health and social systems are ready to make the most of demographic shift[6]. Worldwide national health systems are challenged to build successful ageing models to prepare for biomedical, physiological and social changes[47].

Nigeria has no functional national policy on the care and welfare of older persons[43]. Access to health care is limited with paucity of health facilities, manpower and by out-of-pocket payment arrangements[47]. Elderly persons are significant users of medical services[47], and the pace of population ageing is much faster than in the past[8]. Older adults represent a highly significant group of users of the health care system, and their care has a major impact on health care cost[48]. Out–of–pocket cost burden falls most heavily on those with chronic health conditions and without the employer subsidized supplemental coverage[49]. This imposes substantial burden on the elderly especially the poor[50].

The burden of out-of-pocket health care cost is greater for low income elders. The cost of prescription medication can be prohibitive and lead to non-compliance with prescribed regimens[51]. Health care financing through out-of-pocket payment and inequalities in health care utilization are common in low and middle income countries[52]. The method used to finance health care service have important effect on the use of health care services by the elderly and their levels of health and wellbeing, as well as on the growth and development of the health sector itself[53].

In Nigeria, elderly persons who have retired from economic productive phases are most vulnerable to experiencing economic hardship. They are usually forced to cope with paradox of dwindling financial resources, increased health challenges, and a geometric rise in medical expenses[43]. Old people have to count on financial assistance from their children and relatives[43].

CONCLUSION

Out-of-pocket healthcare expenditure is an important feature of healthcare systems all over the world. Significant proportion of elderly households in Nigeria are having financial burden arising from health expenditure. Over 29 per cent of elderly households in the country face catastrophic out-of-pocket expenditure and 30 per cent of those in rural settlements experience the

phenomenon compared to 28 percent of urban dwellers[54]. Health care utilization among elderly households in Nigeria is below average at both national and zonal levels. More than 50 per cent of elderly people in Nigeria have unmet health care needs because they cannot afford it[54].

RECOMMENDATION

It is important for social and health policy makers to understand and anticipate the fiscal impact of such demographic change, and its attendant effect on health care access and utilization by the elderly[55]. Nigeria government should design and develop geriatric care model to promote health and social welfare of the elderly.

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