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ALIGNING HEALTH CARE SYSTEM WITH ACUTE AND LONG TERM CARE NEEDS OF AGED PERSONS IN NIGERIA

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Abstract

Contemporarily for the first time in history a great number of people can hope to live into their 60s and beyond both in developed and developing nations as a result of advance in medicine. Again 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. This paper therefore explores the Nigeria healthcare system the existing organizational and delivering structures and how the acute healthcare can be aligned with the long term care particularly to the elderly. The paper observed that the Nigeria healthcare system is shrouded with problems and fundamental shift in alignment of care for older people is needed. And that Instead of trying to manage several diseases and symptoms associated with the aged in a disjointed fashion, the emphasis should be on interventions that optimize older people's physical and mental capacities over their life course. Therefore there should be more integration within the health system and between health and social services. However absence of political will, lack of *evidence demonstrating that integrated care for older people can produce cost saving are some of the challenges militating healthcare integration. Finally the paper concludes that the development of coherent health systems policy and normative guidance on the implementation, evaluation and great political will is required for integrated health care for older people.*

Key Words: Health Healthcare; Acute Care; Long Term Care & Aged People

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1.0 Introduction

Contemporarily for the first time in history a great number of people can hope to live into their 60s and beyond both in developed and developing nations. This is to a great extent the outcome of expansive decreases in mortality at more youthful ages, especially amid during childhood and childbirth, and from infectious diseases. Also the Elderly constitute vital individuals from society and are qualified for decent amount of the health and social services available. Besides it is evaluated that there will be 2 billion peoples beyond 60 years by 2050 and 80% of them will be resident in developing nations, Nigeria inclusive (Agbogidi, 2013). Again, with increasing age various hidden physiological changes happen, and the dangers for more elderly persons especially in developing perpetual infection and care reliance increment. Off-course the major population burden of disability and death of individuals more than 60 years emerge from age-related misfortunes in hearing, seeing and moving, and conditions, for example, dementia, coronary illness, stroke, perpetual respiratory issue, diabetes and osteoarthritis. These are not issues only for develop nations but also are by and large far higher in developing nations.

In addition 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. It was in this line that 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 (Nolte and Pitchforth, 2014). Therefore the need for aligning Health Care System with Acute and Long Term Care needs of older persons across the globe nay Nigeria has become imperative. Rather than attempting to deal with various infections and side effects in an incoherent manner, the emphasis should be on interventions that optimize older people's physical and mental capacities over their life course and that enable them to do the things they value. This, in turn, requires a change in the way health and social services are organized as there should be more integration within the health system and between health and social-care services. Put differently Health systems need to be transformed so that they can ensure affordable access to evidence-based medical interventions that respond to the needs of older people and can help prevent care dependency later in life.

This paper therefore explores the Nigeria healthcare system the existing organizational and delivering structures and how the acute healthcare can be aligned with the long term care particularly to the elderly. As a form of prelude to the discussion of the above it is pertinent that we clarify some key words associated with the paper.

2.0 Conceptual Issues

The concept of elderly or aged otherwise referred to as senior citizens like many other constructs within the social sciences do not have precise definition. However gerontologists have conceived the meaning in terms of four dimensions, Chronological, Biological, Psychological and Social aging. The chronological age is defined as the number of years since someone was born. The second dimension is biological aging which refers to the physical changes that "slow us down" as we get into our middle and older years. For example, our arteries might clog up, or

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problems with our lungs might make it more difficult for us to breathe. The third dimension, psychological aging refers to the psychological changes, including those involving mental functioning and personality, which occur as we age. Gerontologists emphasize that chronological age is not always the same thing as biological or psychological age. Some people who are 65, for example, can look and act much younger than some who are 50.

Finally the fourth dimension of aging is social which refers to changes in a person's roles and relationships; both within their networks of relatives and friends and in formal organizations such as the workplace and houses of worship (Moody, 2009).

It is observed that an ageing population tends to have a higher prevalence of chronic diseases, physical disabilities, mental illnesses and other co-morbidities. The health needs and health related problems of elderly people cannot be viewed in isolation. Scholars such as Hanks-Bell and Paice (2004); Biswas, et al. (2006) have argued that old age is associated with illnesses such as blood pressure, cardiac problems, diabetes, joint pains, kidney infections, cancer and tuberculosis that take a long time to heal. They maintain that the number of people affected by this health related problems increased gradually with age and that the old or aged need health care because old age is associated with pain and ill-health cited in (Diyoke, 2015).

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

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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, (2015) 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

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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).

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3.0 Issues and Challenges the Nigeria Experience

Just like in many third world nations the Nigeria national health system 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).

Again, The National Health Insurance scheme that was enacted under Act 35 of 1999 has no provision for people with Long Term Care. The scheme only provided for those in formal, informal and vulnerable group social insurance scheme. The formal sector includes: federal, state and local governments, as well as the organized private sector. The armed forces, the police, other uniformed services and students of tertiary institutions. The informal sector covers:

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community-based social health insurance programme and the voluntary contributors' social health insurance programme. The third programme is the vulnerable group which covers, physically challenged persons, prison inmates, children under five years, refugees, victims of human trafficking, internally displaced persons, immigrants and pregnant women.

In underscoring the importance to align healthcare system with acute and long term care needs of older Diyoke, (2015) argued that as individuals age, their medical problems have a tendency to end up more unending and complex, and multimorbidity that is the nearness of numerous chronic conditions at the same time becomes the norm rather than the exception turns into the standard as opposed to the special case. Physical, tactile and psychological weaknesses turn out to be more predominant and older people can create complex health states, for example, feebleness, urinary incontinence and an expanded danger of falling. These health states can't be put in discrete sickness classes. The danger of having various non-communicable health conditions also increases with age and, if not properly addressed through robust care alignment these conditions can prompt polypharmacy, hospitalization and possibly death.

Providing care for older people with numerous medical problems is similarly complex. Various health workers might be included with a single person's care; particularly in nations were health experts are generally not accessible. However many existing health system oversees medical problems in a detached and divided way and there is an absence of coordination crosswise over care suppliers and settings and in the planning of the care provided. For instances in one survey of older adult in 11 developed nations, up to 41% revealed issues with the coordination of care in the course of recent years. Such fragmentation can result in health care that not only fails to adequately meet the needs of older people but also leads to substantial, avoidable costs, both for older people and for the health-care system (McIntyre, 2014). Older

people often find it difficult to use health services even when they are available. Especially in less developed countries such as Nigeria older people use health services fundamentally less much of the time than more young people notwithstanding enduring poorer health status.

Off-course the greatest barrier to utilization of care services appeared to be the of cost health care services, visits and troubles with transportation: over 60% of more aged persons in most third world nation's do not have access to health care because of the cost of the visit, the absence of transportation or an inability to pay for transportation. It is even more worry some among older person in rural areas may have specific issues with transportation because care services are often concentrated or located in large cities far from their homes and communities. Subsequently, multi-sectorial activity including the transportation sector notwithstanding social care is needed. Other far reaching hindrances to get access emerge from the failure of health services to take into account the constraints in physical limit normal in more aged persons. There might be an absence of available toilets, long lines, physical obstructions to access and correspondence hindrances coming about because of insufficient arrangement of data for individuals with hearing problems or visual debilitation. Long holding up times and lines can be especially trying for older persons with physical handicaps, confined portability or urinary incontinence. Another critical factor that disheartens aged individuals from looking for care or results in their separation from health services is the ageist dispositions that cut across many societies, even among health professionals (McIntyre, 2014).

Therefore delivering age-friendly, aligned health-care system requires a change in the way health system is outlined. Services should be situated around the necessities of older persons instead of around the requirements of the need of the services themselves. Furthermore, they should serve older individuals with a high and stable level of intrinsic capacity, those with a

declining limit and those whose limit has crumbled to the point where they require the care and support of others. Intrinsic capacity is defined by World Health Organization as the blend of the person's physical and mental (counting psychosocial) limits. Functional ability, conversely, identifies with the mix and communication of a person's intrinsic capacity and the attributes of the environment he or she occupies (World Health Organization, 2015).

A shift in the type of care older people receives is likewise required far from a particular spotlight on the administration of particular illnesses and conditions and towards care that intends to enhance older individuals' intrinsic capacity over their life course. The point isn't to downgrade good disease treatment, rather to emphasize that an older person's physical and mental capacity should be the focus of, and the starting point for, an aligned health services.

Several individuals reach a point in old age when they are unable to play out the fundamental undertakings of everyday existence without help. They achieve the phase of care-reliance, which is principally tended to through long term care system. In any case, healthcare service is as yet critical for individuals with a genuine loss of limit these individuals may be progressing infection administration, recovery, or palliative and end-of-life care. Again healthcare system must guarantee convenient access to ensure timely access to primary, specialty and acute care when needed. Evidence shows that specialist; acute, geriatric wards can deliver higher-quality care with shorter hospital stays and lower costs (Aboderin, 2010).

World Health Organization provided a model for integration of health care service to the elderly populace. They include the macro level (i.e. at the policy or sector level), (ii) the meso level (i.e. at the organizational or professional level); or iii) the micro level (i.e. at the clinical or interventional level).

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Although WHO's approach to integrated health care for older populace spans all these levels, it emphasizes integration at the level of clinical care. In addition, it is also older person-centred, which means it adopts the perspective that older people are more than vessels for their health disorders and conditions; they are instead individuals with unique experiences, needs and preferences. People are also seen in the context of their daily lives, as part of a family and a community. Moreover, instead of being confronted by ageist attitudes, older people should have their dignity and autonomy respected and embraced in a culture of shared decision-making.

Despite the above several challenges appear to be inhibiting the widespread adoption of integrated or well aligned care for older people. This include an absence of political will, gaps in general knowledge about integrated care, problems with implementation and inadequate sharing of experiences with integrated care globally nay Nigeria.

For instance the inherent complexity of organizing and delivering coordinated care for a large older population can be disheartening and can undermine endeavors to present and scale up programs. In addition as older individual change significantly in their level of natural capacity an extensive variety of clinical mediations must be made accessible and suitably focused on. Further, According to Aboderin, (2010) the more aged person's ability can change quickly, implies that the care system must have the capacity to react rapidly to changes in require with refreshed care designs and administrations. Moreover, any change of the care system intended to give genuinely integrated, individual focused care for older individual must include a scope of various associations and suppliers, including both medicinal services and social care suppliers and suppliers in areas, for example, transportation.

A further intricacy is the absence of evidence demonstrating that integrated care for older people can produce cost savings. To date, studies have shown that organized care is cost-neutral issue;

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individual focused care can be conveyed for generally indistinguishable cost from standard care. The absence of a certifiable effect on cost may settle on leaders significantly more hesitant to consider coordinated care. In any case, it is imperative to take note of that, in spite of the fact that an underlying venture (e.g. for training and additional personnel) is important, over the medium to long term, cost savings are not out of the ordinary, due, for instance, to less duplication and better coordination of services. Integrated care ought to be viewed as a protracted excursion that requires a long term perspective (Aboderin, 2010).

Another challenge is inadequate sharing of knowledge amongst between progrmmes and nations. At the worldwide level for instance, WHO and other different bodies have begun to gather data on result pointers as a major aspect of endeavors to establish a measurement basis for WHO's system on integrated, people-centred healthcare services. In any case, knowledge about the implementations and spread of activities in the field of aging does not flow freely. This is partly due absence of agreement on the meanings of generally utilized concepts, for example, integrated care, person-centred care and people-centred care, and a lack of measurement tools. Thusly, there are no reasonable criteria or measures for deciding if, and to what degree integrated care for older people is actually being delivered in any particular setting (World Health Organization, 2015).

There is likewise an absence of consensus on what constitutes a positive outcome for older people. Traditionally, health-care research has utilized indicators of infection, incapacity, life span, patient and provider satisfaction, health care use, hospitalization, standardization and cost. Conversely, the primary point of aligning healthcare for older people is not to manage disease or prolong life but is, rather, to streamline older person's intrinsic capacity over their life course and, subsequently, guarantee healthy aging. An alternate arrangement of indicators is needed that

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would reflect intrinsic capacity, functional ability, quality of life and the attainment of goals defined by the older person.. A few pointers as of now exist however others have still to be produced. Moreover, it is pivotal that any estimation instruments utilized with older people are validated in developing countries of Africa nay Nigeria.

4. Conclusion and Recommendation

Finally, only a few easily accessible, strategy policy direction and implementation tools for nations at various levels of development exist. Policy guidance documents and implementation tools have been developed mainly in developed countries and their applicability to other countries and regions particularly to Third world countries remains unclear.

In conclusion aligning the health care system and plan of action on ageing and health requires a great political will and commitment to integrate health care for older people, the development of coherent health systems policy, and normative guidance on the implementation and evaluation of integrated care both in the country and across the world.

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