

# Experiences Of The Elderly Utilizing Healthcare Services In Edo State

J Agbogidi, C Azodo

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## Abstract

Background: The population of elderly is on the rise worldwide. The medical care of this group represent a significant unmet health need and thus utilization of health facilities is therefore very important. Objective: To determine the healthcare services experience of elderly in Edo state, Nigeria. Methods: This descriptive cross-sectional survey was conducted in Eyaen community in Uhunwonde Local Government Area of Edo state, Nigeria. The study population was 400 elderly recruited using multistage sampling technique. The data collection tool utilized was an interviewer-administered questionnaire. Results: There were more males (56.5%) than females (43.5%) giving a male: female ratio of 1.3:1, with a mean age of 71.3 years. Majority 95.3% had visited health facility, nine-tenth (90.3%) fall sick often but only 67.8% visit health facility when they are seriously sick. Waiting time was considered long and very long among 70.5% and 9.5% of respondents respectively. Sixty-six percent of the respondents attested that the number of doctors in health facility was insufficient and 72% felt that the consulted doctors were friendly. Effective communication with health workers was reported by 77% of the respondents. Appointment booking was easy for 51.3% of the respondents. The association of level of education and ease of appointment booking was statistically significant. The cost of health service received was deemed too expensive by 53% of the respondents. Musculoskeletal pain (40.5%) and malaria (29.0%) were the most common illnesses reported by the respondents. Conclusion: Data from this study revealed that most elderly had unpleasant health service experience as evidenced by long waiting time, insufficient number of doctors in health facilities, and expensive health services. Modeling healthcare delivery for elderly, devoid of these impediments is an obvious necessity.

## INTRODUCTION

Elderly constitute important member of society and are entitled to fair share of the health and social services available<sup>1</sup>. The population of elderly is on the rise due to advances in medicine and increased life expectancy<sup>2</sup>. It is estimated that there will be 2 billion people over the age of 60 years by year 2050 and 80% of them will be residents developing countries<sup>2,3</sup>. Elderly exhibit limited regenerative abilities and are more prone to disease, syndromes, and sickness<sup>4</sup>. Providing appropriate health services to the elderly is emerging as one of the major challenges of this century<sup>5</sup>. The medical care of elderly represent a significant unmet health need and thus utilization of health facilities is therefore very important. Older people experience a greater level of morbidity and are relatively frequent users of physicians' services and health services<sup>6-8</sup>. In the United States, the elderly visit their doctor an average of eight times per year, compared to the general population's average of five visits per year<sup>9</sup>. The healthcare expenditure for elderly is

a major economic issue in many societies around the world as it is increased due to loss of physical function and frailty<sup>10</sup>. Promoting the health and improving the ability and confidence of the elderly to live independently can reduce health care expenditures and increase the health of society as a whole<sup>11</sup>. Healthcare utilization has been found to be associated primarily with health and functional status<sup>12</sup>. Overall health care utilization appears to increase significantly with increasing age but it is unclear whether increasing health care utilization prevents morbidity, decreases mortality, or improves quality of life<sup>13</sup>. Regular source of care and continuity of care has been shown to significantly reduce the likelihood of hospitalization<sup>14,15</sup> and emergency room visits<sup>15</sup>.

Promoting good health and mental-well being are important areas of responsibility to elderly but difficulty in accessing good, proper and quality health care services remain farfetched<sup>16</sup>. Physical and financial constraints impede timely utilization of available health care services<sup>17</sup>. Impeded

access can lead to underutilization of primary and preventive health care services which in turn may result in unnecessary hospitalizations, increased morbidity and higher costs of the health care system than necessary<sup>17</sup>. Increased distance from health care provider reduces utilization as documented by a study among a group of elderly residents of rural Vermont<sup>18</sup>. A study that evaluated self-perceived access to healthcare showed the most common barrier to seeing a doctor as doctor’s lack of responsiveness to patient concerns rather than physical barriers such as cost or transportation<sup>19</sup>. Another study conducted on elderly American Indians in rural environment in Ponca and Pawnee tribe of Oklahoma about their perceived areas of difficulty in obtaining access health services indentified long waiting time as the most serious and lack of transportation as the least serious<sup>20</sup>. Several studies have found that barriers to care such as cost, transportation, lack of information, and caring for others prevent individuals from obtaining health care<sup>21,22</sup>. Waiting time in the office, cost, length of waiting lists and language barriers has also been identified as barriers to healthcare specifically dental care<sup>23</sup>. Data on health problems, health service utilization among elderly in Nigeria is scanty<sup>24-28</sup>. In this study, individual aged 60 years and above were considered as elderly which is the accepted globally as a lower chronological age threshold for older persons<sup>29</sup>.

The objective of this study was to determine the health services experiences of elderly in Edo State, Nigeria.

**MATERIAL AND METHODS**

This descriptive cross-sectional survey was conducted in Eyaen community in Uhunwonde Local Government Area of Edo State, Nigeria between September, 2007 and August, 2008.

Eyaen community was selected out of 7 villages in ward 6 by balloting. Ward 6 is one of the 10 wards that make up Uhunwonde Local Government Area of Edo state. Out of the 450 houses systematic sampling was used to recruit the 400 elderly aged 60 years and above.

An interviewer-administered questionnaire which elicited information on demography, pattern of health service utilization, waiting time, opinion of doctor’s attitude and number, ease of communication and making appointment, their opinion of cost of health care received, and common illness experienced was the tool of data collection.

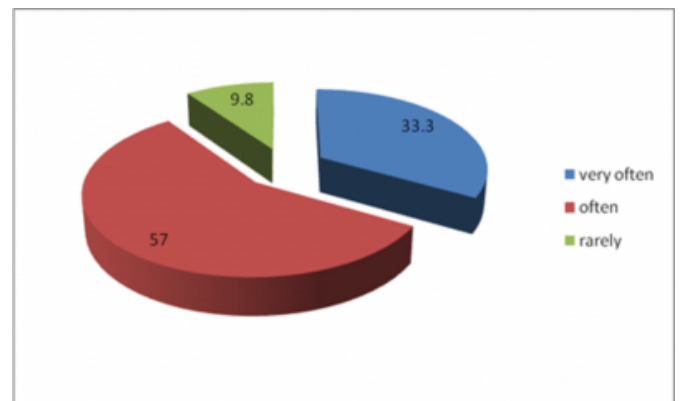
**RESULTS**

**DEMOGRAPHIC CHARACTERISTICS**

There were more males (56.5%) than females (43.5%) giving a male: female ratio of 1.3:1, with a mean age of 71.3 years. Sexagenarian (60-69 years) constituted 62.9%, Septuagenarian (70-79 years), 23.8% and those 80 years &above, 13.3%. More than half (57.8%) were married, 9.3% divorced, 32.3% widowed and 0.8% were never married. Bini was the predominant tribe making up 72.8%, Esan 13.3%, Etsako 5.8%, others include Owan 2.5%, Ibo 2.5% and Urhobo 1.3%. Only a few (1.5%) had tertiary education while 72.8% of the respondents had not attained more than primary education. Means of transportation to the health center revealed that 75.0% used public transport, 6.0% private transport and 19.0% by trekking.

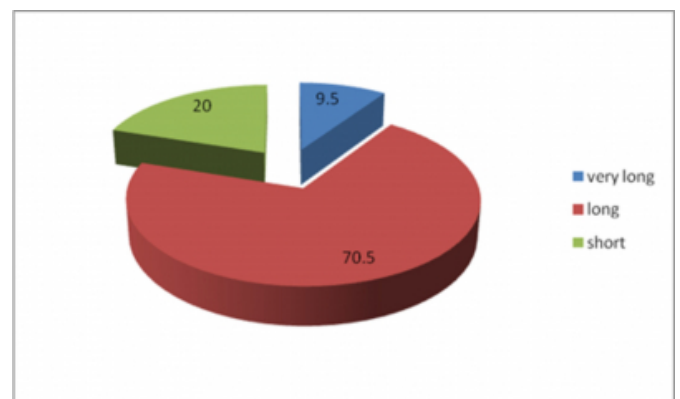
Majority 95.3% had visited health facility, nine-tenth (90.3%) fall sick often but only 67.8% visit health facility when they are seriously sick (Fig. 1).

**Figure 1**



Waiting time was considered long and very long among 70.5% and 9.5% of respondents respectively (fig. 2).

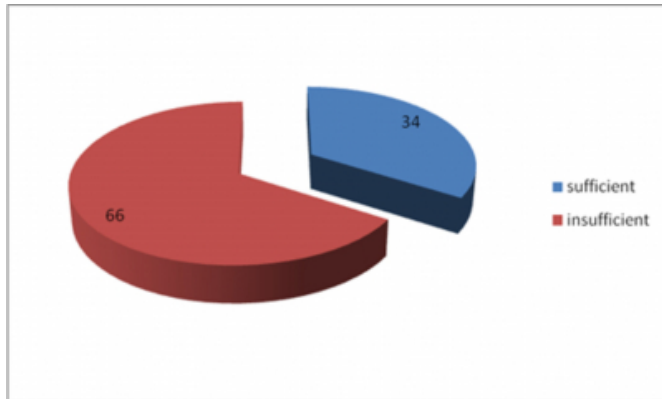
**Figure 2**



Sixty-six percent of the respondents attested that the number of doctors in health facility was insufficient and 72% felt

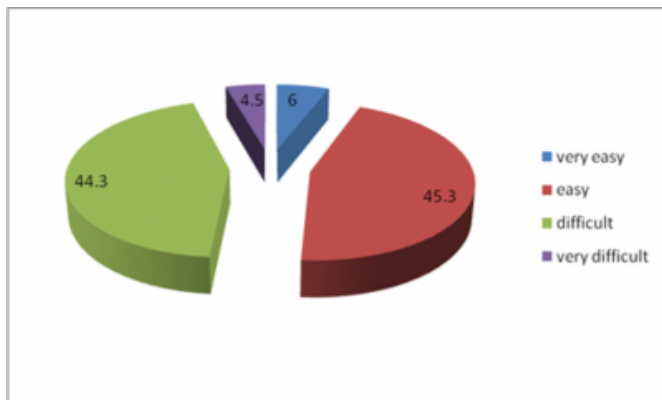
that the consulted doctors were friendly (fig. 3).

**Figure 3**



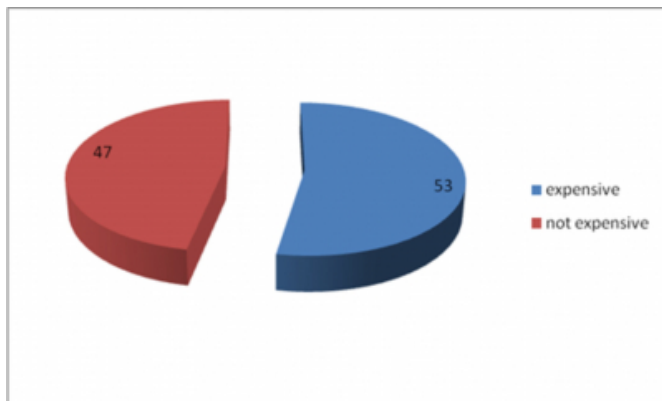
Effective communication with health workers was reported by 77% of the respondents. Appointment booking was easy for 51.3% of the respondents. The association of level of education and ease of appointment booking was statistically significant (fig. 4).

**Figure 4**



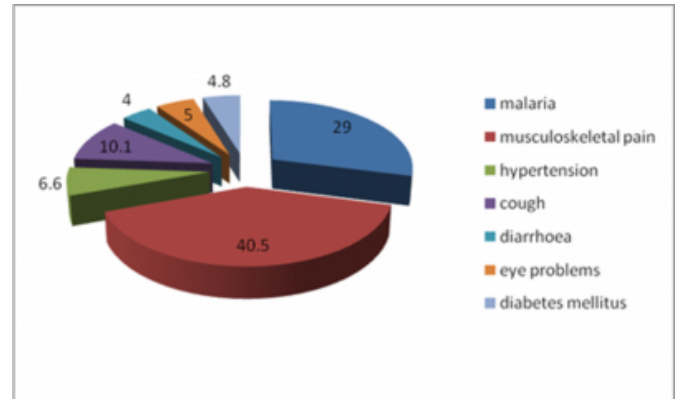
The cost of health service received was deemed too expensive by 53% of the respondents (fig. 5).

**Figure 5**



Musculoskeletal pain (40.5%), malaria (29.0%), cough (10.1%), hypertension (6.6%), eye problem (5.0%), diabetes mellitus (4.8%) and diarrhoea (4.0%) were the most common illnesses reported by the respondents (fig. 6).

**Figure 6**



**DISCUSSION**

The social and biological characteristics of the elderly make them a unique population as manifestations of ill health are sufficiently distinct from the rest of the population. The utilization of health services in this unique group is therefore very important. In this study, health service utilization is high and can be ascribed to the location of health center in the community.

About nine-tenth (90.3%) of respondents fall sick often but only 67.8% visit health facility when they are seriously sick. This confirms that health services utilization tend to be less for elderly reporting health problems<sup>30</sup>. The explanation lies in the fact that motivation and choice about using medical care is dependent individual level of health need<sup>12,31</sup>.

Communication is an important component of patient care<sup>32</sup>. Effective communication is particularly important with older adults, as less-than-optimal communication with them may have more negative consequences<sup>33</sup>. The elderly expect more information and more personalized attention from the health care providers<sup>34</sup>. Studies have shown that even though older patients desire more information from their physicians they eventually get less information from physicians when compared to younger patients<sup>35,36</sup>. In this study, effective communication with health workers was reported by 77% of the respondents.

The most common complaint patients have about their doctors is that they don't listen<sup>37</sup>. Elderly person's perception of the physician's lack of responsiveness was a greater disincentive to seeking care than more tangible barriers<sup>19</sup>. In

this study, 72% of respondent felt that the consulted doctors were friendly. This may account for easy appointment booking by 51.3% of the respondents. The ease the appointment booking was higher with increasing level of education. This association was statistically significant ( $p < 0.05$ ).

Waiting time was considered long and very long among 70.5% and 9.5% of respondents respectively. Long time spent in health center has been documented as the second leading indicator of dissatisfaction with primary health care utilization among elderly<sup>1</sup>. In a study, the main reasons among one third of elderly in a survey for not visiting their primary health care doctors are bad organization aspects of work-like crowd in the waiting room<sup>38</sup>. The explanation for the long and very long waiting time lies in the fact that 66% of the respondents attested that the number of doctors in health facility was insufficient.

In model devised by R. Andersen and L. A. Aday, factors influencing health care utilization are: characteristics of individuals and populations at risk, the availability and quality of availability services, economic factors such health insurance, and additional access factors such as the location of health services and the availability of transportation<sup>31</sup>. Older persons living in rural counties within reasonable driving distance of urban counties with major medical centers used health services as frequently and were as satisfied with their health care as persons in urban counties<sup>38</sup>. Three quarters (75.0%) of the respondents attended the health center through public transport which confirmed health service in the community as accessible.

In this study, more than half (53%) deemed the cost of health service received as too expensive. Cost of care is a significant and persistent barrier among rural elderly people<sup>30,39</sup>.

In this study, musculoskeletal pain (40.5%), malaria (29.0%), cough (10.1%), hypertension (6.6%), eye problem (5.0%), diabetes mellitus (4.8%) and diarrhoea (4.0%) were the most common illnesses reported by the respondents. This is comparable to a study finding in which visual and auditory losses as well as respiratory conditions and chronic degenerative disorders were the commonest illness<sup>40</sup>. The prevalence of diabetes mellitus in this study concurs with is 4.76% previously documented among Nigerian family practice population<sup>41</sup>. Musculoskeletal problem was the commonest health complaint in this study which is consistent with the findings of previous elderly study in

Nigeria<sup>24</sup> and other African countries<sup>42</sup>. The prevalence of hypertension increases with ageing. In this study, the prevalence of hypertension was 6.6% which was lower than that documented 19% documented in Botswana<sup>42</sup>.

## CONCLUSION

Data from this study revealed that most elderly had unpleasant health service experience as evidenced by long waiting time, insufficient number of doctors in health facilities, and expensive health services. There is need to model the provision of health services for elderly devoid of the recognized impediments in order to attain equity in health service utilization.

## References

1. Mahfouz AA, Al-Sharif AI, El-Gama MN, Kisha AH. Primary health care services utilization and satisfaction among the elderly in Asir region, Saudi Arabia. *East Mediterr Health J.* 2004; 10(3):365-71.
2. WHO. Elderly people: Improving oral health amongst the elderly. [http://www.who.int/oral\\_health/action/groups/en/index1.html](http://www.who.int/oral_health/action/groups/en/index1.html)
3. United Nations Population Division 2003. *World Population Prospects: The 2002 Revision*. New York: UNPD.
4. Old age. [http://en.wikipedia.org/wiki/Old\\_age](http://en.wikipedia.org/wiki/Old_age)
5. Stone RI. Long-Term care for the elderly with disabilities: Current Policy, Emerging Trends, and Implications for the Twenty-First Century. August 2000. <http://milbank.org/reports/0008stone/index.html>
6. British Geriatrics Society. *The Older Person in the Accident & Emergency Department BGS Best Practice Guide 3.2* (Revised March 2008) [http://www.bgs.org.uk/Publications/Compendium/compend\\_3-2.htm](http://www.bgs.org.uk/Publications/Compendium/compend_3-2.htm)
7. Iecovich E, Carmel S. Differences in Accessibility, Affordability, and Availability (AAA) of medical specialists among three age-groups of elderly people in Israel. *J Aging Health* 2009; 21(5): 776-797.
8. Wolinsky FD, Johnson RJ. The use of health services by older adults. *J Gerontol* 1991; 46:S345-57.
9. Thompson TL, Robinson JD, Beisecker AE. The older patient-physician interaction. In: Nussbaum JF, Coupland J, eds. *Handbook of Communication and Aging Research*, 2nd ed. Mahwah, NJ: Lawrence Erlbaum Assoc; 2004.
10. Taunton JE, Martin AD, Rhodes EC, Wolski LA, Donnelly M, Elliot J. Exercise for the older woman: choosing the right prescription. *Br J Sports Med.* 1997; 31(1):5-10.
11. Chen IJ, Chou CL, Yu S, Cheng SP. Health services utilization and cost utility analysis of a walking program for residential community elderly. *Nurs Econ.* 2008; 26(4):263-9.
12. Walter-Ginzburg A, Chetrit A, Medina C, Blumstein T, Gindin J, Modan B. Physician visits, emergency room utilization, and overnight hospitalization in the old-old in Israel: the cross-sectional and longitudinal aging study (CALAS). *J Am Geriatr Soc.* 2001; 49(5):549-56.
13. Nie J, Wang L, Tracy S, Moineddin R, Upshur R. Health care service utilization among the elderly: findings from the Study to Understand the Chronic Condition Experience of the Elderly and the Disabled (SUCCEED project). *J Eval*

Clin Pract. 2008; 14 (6): 1044-1049.

14. Gill JM, Mainous III AG. The role of provider continuity in preventing hospitalizations. *Arch Fam Med*. 1998; 7:352-357.
15. Falik M, Needleman J, Wells BL, Korb J. Ambulatory care sensitive hospitalizations and emergency visits: experiences of Medicaid patients using federally qualified health centers. *Med Care*. 2001; 39(6):551-61.
16. Rohrer JE, Kruse G, Borders T, Kupersmith J. Realized access to physician services among the elderly in West Texas. *J Rural Health*. 2000; 19(1):72-8.
17. Mobley LR, Root E, Anselin L, Lozano-Gracia N, Koschinsky J. Spatial analysis of elderly access to primary care services. *International Journal of Health Geographics* 2006, 5:19.
18. Nemet GF, Bailey AJ. Distance and health care utilization among the rural elderly. *Soc Sci Med*. 2000; 50(9):1197-208.
19. Fitzpatrick AL, Powe NR, Cooper LS, Ives DG, Robbins JA. Barriers to health care access among the elderly and who perceives them. *Am J Public Health*. 2004; 94:1788-1794
20. Hong G, Hong S. Health Care of American Indian Elderly: Determinants of the Perceived Difficulty Obtaining Access to Health Care. *Journal of Family and Economic Issues* 1997; 18(1): 33-47
21. Janes GR, Blackman DK, Bolen JC, et al. Surveillance for use of preventive health-care services by older adults, 1995-1997. *MMWR CDC Surveill Summ*. 1999; 48:51-88.
22. Ahmed SM, Lemkau JP, Nealeigh N, Mann B. Barriers to healthcare access in a non-elderly urban poor American population. *Health Soc Care Community*. 2001; 9:445-453.
23. Mariño R, Wright C, Schofield M, Calache H, Minichiello V. Factors associated with self-reported use of dental health services among older Greek and Italian immigrants. *Spec Care Dentist*. 2005; 25(1):29-36.
24. Bella AF, Baiyewu O, Bamigboye A, Adeyemi JD, Ikuesan BA, Jegede RO. The pattern of medical illness in a community of elderly Nigerians. *Cent Afr J Med*. 1993; 39(6):112-6.
25. Baiyewu O, Bella AF, Adeyemi JD, Bamigboye EA, Jegede RO. Health problems and sociodemographic findings in elderly Nigerians. *Afr J Med Sci* 1997; 26: 13-17.
26. Owotade FJ, Ogunbodede EO, Lawal AA. Oral diseases in the elderly; A study in Ile-Ife, Nigeria. *J. Soc. Sci*. 2005; 10(2): 105-110.
27. Abdulraheem IS. Health needs assessment and determinants of health-seeking behaviour among elderly Nigerians: A house-hold survey. *Annals of African Medicine* 2007; 6(2):58 -63.
28. Ogunniyi A, Baiyewu O, Gureje O, Hall KS, Unverzagt FW, Oluwole SA, Farlow MI, Komolafe, Hendrie HC. Morbidity pattern in a sample of elderly Nigerians resident in Idikan community, Ibadan. *West Afr J Med*. 2001; 20(4):227-31.
29. WHO. Definition of an older or elderly person: proposed working definition of an older person in Africa for the MDS project. <http://www.who.int/healthinfo/survey/ageingdefnolder/en/index.html>
30. Travassos C, Viacava F. Access to and use of health services by rural elderly, Brazil, 1998 and 2003. *Cad Saude Publica*. 2007; 23(10):2490-502.
31. Encyclopedia of Public Health: Health-Related Behavior. <http://www.answers.com/topic/health-related-behavior>
32. Teutsch C. Patient-doctor communication. *Med Clin North Am*. 2003; 87(5):1115-45.
33. Robinson TE 2nd, White GL Jr, Houchins JC. Improving communication with older patients: tips from the literature. *Fam Pract Manag*. 2006; 13(8):73-8.
34. Shank MD, Rupich RC, Griffin MG, Avioli LV. Evaluating health care services from the perspective of the elderly. *J Hosp Mark*. 1992; 6(2):127-47.
35. Haug MR, Ory MG. Issues in elderly patient-provider interactions. *Res Aging*. 1987; 9:3-44.
36. Beisecker AE. Aging and the desire for information and input in medical decisions: patient consumerism in medical encounters. *Gerontologist*. 1988; 28:330-335.
37. Meryn S. Improving doctor-patient communication: not an option but a necessity. *BMJ*. 1998; 316(7149):1922.
38. Matejic B, Bjegovic V. Needs assessment among elderly population in Serbia. Available at [http://www.ijic.org/portal/publish/articles/000035/article\\_print.html](http://www.ijic.org/portal/publish/articles/000035/article_print.html)
39. Blazer DG, Landerman LR, Fillenbaum G, Horner R. Health services access and use among older adults in North Carolina: urban vs rural residents. *American Journal of Public Health*, 1995; 85(10): 1384-1390
40. Barker JC. Health and functional status of the elderly in a Polynesian population. *Journal of Cross-Cultural Gerontology*. 1989; 4(2): 163-194
41. Oyegbade OO, Abioye-Kuteyi EA, Kolawole BA, Ezeoma IT, Bello IS. Screening for diabetes mellitus in a Nigerian family practice population. *SA Fam Pract* 2007; 49(8):15
42. Clausen F, Sandberg E, Ingstad B, Hjordt Dahl P. Morbidity and health care utilisation among elderly people in Mmankgodi village, Botswana. *J Epidemiol Community Health* 2000; 54:58-63.

**Author Information**

**J. Agbogidi**

Department of Dentistry, University of Benin

**C.C. Azodo**

Department of Periodontics, University of Benin