Access to health care: Perspectives of Family Caregivers of the Elderly

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Abstract: The purpose of this study was to discuss the factors that impact on the family caregivers' access to health services. A qualitative grounded-theory methodology was used to interview 24 participants who were caring for an older person. The findings indicate that the factors which determined the access of caregivers to health services included: geographic barriers/transportation, distance to the health facility, poverty, healthcare system barriers such as health policy, attitudes of healthcare professionals, poor discharge planning and referral, shortage of medical supplies, and lack of knowledge. Implications for nursing education, nursing practice, and policy that address health care delivery system for older persons are discussed.

Introduction
Health needs and the use of health care services are more increased among older people (Arber & Cooper, 1999). Yet little is known about access to health care services among the elderly or caregivers of the elderly in Botswana. Access to health care services is a complex phenomenon that has been defined in many ways (Gulzar, 1999). According to WHO (1978):

Accessibility implies the continuing and organized supply of care that is geographically, financially, culturally, and functionally within easy reach of the whole community. The care has to be appropriate and adequate in content and in amount to satisfy the needs of people and it has to be provided by methods acceptable to them. (p. 58).

Rural-based older adults are in poorer health and have lesser access to health care services than urban older adults (Averill, 2002; Clark & Dellasega, 1998; Magilvy, Congdon, & Martinez, 1994). In developing countries, access to professional health services in rural areas is limited, especially for older people. In Tanzania oral health care services for older people are inadequate, especially in rural areas (Luhanga & Ntabaye...
In Zimbabwe, elderly people were reported as having inadequate access to health care. In Botswana the majority of the population, especially the elderly people live in the rural areas.

Poverty is widespread among rural African elderly and associated with unsatisfactory access to health care and poor health (Nordberg, Holmberg, & Kiugu, 1996; Oranga, 1997). The decision to use formal services by the caregiver of the elderly is also influenced by several reasons such as authority of the caregiver in the family (Yamamoto & Wallhagen, 1998). Other factors contributing to the problem of access to health care in Botswana have been cited as poverty and lack of transportation (Akinsola, 2001; Maganu, 1997; Tlou, 1997, WHO, 1998). Although, there are quite a number of health and social services in place for the elderly in Botswana, not all of them were found to be culturally acceptable (Shaibu & Wallhagen, 2002).

Botswana subscribes to the global strategy of Health for ALL as promulgated by the World Health Organization and Primary Health Care is used as a framework for the pursuit of the national objectives in the context of Vision 2016. Indeed, Botswana has made great strides towards the accomplishment of translating the objectives of the Primary Health Care. In recognition of the principle of equity, health resources are distributed throughout the country in an effort to make health care accessible to everyone. Botswana also recognizes that access to health care is a basic human right, and to this extent, the government publicly funds the health care system. According to Vision 2016 (Presidential Task Group, 1997) under the pillar of compassionate and caring nation, improvements in health facilities must ensure that all Batswana have an easy access to primary and hospital facilities.

Presently, there is a clinic within 5-8 km kilometers of every major village (Ministry of Finance & Development Planning, 1997). Yet, this distance is inaccessible to some elderly clients. Although these distances may seem reasonable, they present hardships for many people who are ill, or the caregivers who have to look after the sick, as they have to walk these distances or travel by donkey cart in the absence of conventional transport (WHO, 2000). The purposes of this paper are to explore and discuss factors that impact on access to health services by the family caregivers of the elderly.

Methodology
Details about the qualitative exploratory design that was utilized have been described in previous studies and could be located elsewhere (Shaibu, 2000; Shaibu & Wallhagen, 2002). The purpose of the study was to explore the experiences of the family caregivers of the elderly in Botswana and identify pertinent problems. Data were collected using grounded theory methodology from a convenient sample of 24 family caregivers of the elderly in 1997. Participants were drawn from two villages, Shoshong and Kalamare in the Central District and the capital city, Gaborone. Ten were from Gaborone and 14 were from the two villages. Their ages ranged from 23 to 74 years. Eligible caregivers were those who were caring for an elderly person who was 60 years of age or older. Informed consent procedures followed the University of California, San Francisco guidelines; in particular, data was analyzed to elicit the experiences of caregivers of the elderly in accessing health care services.
Results

Many caregivers expressed problems with accessing health care services for their elderly relatives because of lack of transport, health care policies, attitudes of health professionals, discharge planning, lack of information, health care system operations and shortage of supplies. Many of the caregivers were taking care of frail elderly relatives who suffered from chronic illnesses such as diabetes mellitus, hypertension, stroke, arthritis, joint pains, dementia and cancer of the prostate. These conditions required that the elderly persons should be receiving on-going medication and medical review. Unfortunately, caregivers often mentioned that elderly relatives were not receiving treatment because the elder was not able to walk to the nearest clinic.

Transportation

Transportation was a major reason for the lack of access to health care. Twenty one percent of the caregivers mentioned that the elderly people they were taking care of were not on treatment, particularly the stroke patients, because they lacked the means to take them to the clinic. Some of the caregivers were able to find means to hire transportation while others could not afford to do so. They described this situation with a sense of helplessness and despair as captured in these remarks:

When my sister used to come, she used to take mother's treatment card and go and request treatment for her at the clinic. Now the nurses refuse and say that they do not know the person we are talking about... if we had a wheelchair it would help us, because when she is unwell, we can push her in it and take her for her check-up.

Other caregivers expressed similar sentiments. They reiterated the need for wheelchairs for the bedridden older people.

Although transportation to the clinic could sometimes be requested, many caregivers seemed unaware of this. In the rural areas, the clinic vehicle is most often the cheapest transportation that can be hired. However, the vehicle was frequently in use, and most clinics had only one vehicle. Furthermore, staffing posed yet another related problem. Sometimes only a driver was available and sent out to pick up the patient when, in fact, an additional attendant would have been needed. One caregiver asked, “how can I lift my mother alone into the clinic vehicle?”

Even those who could afford to hire a vehicle to take an elderly relative to the clinic mentioned that it was problematic finding people to assist with lifting the elderly person in and out of the vehicle. For most who had very few resources, it was better to spend that money on food and medicine than on transportation.

One elderly man had been discharged from a hospital with instructions that he was to be taken to the nearest clinic daily for change of dressings. A week later, he had not been taken to the clinic. When the caregiver was reminded of the importance of changing the dressing, she replied that the elderly man was unable to walk and that she had no money to hire a vehicle.
Health care policies

Some family caregivers mentioned that they had not taken their elderly relatives to the clinic because they could not afford the consultation fee. The Ministry of Health has a policy that no one should ever be turned away for lack of funds, and all health preventive and promotive services should be free. However, it seemed that there were inconsistencies in the charging practices of clinics. In the referral and district hospitals, consultation and medication for chronic illnesses like hypertension is not paid for as this is considered promotive health. Yet, in some of the clinics, patients were expected to pay the consultative fee. This was confusing to some caregivers.

Although some caregivers were also sick, they had not gone to the clinic for their own treatment because they did not have money to pay for the consultation fee. This caregiver noted:

There is nothing which is better now. But, whenever I get some money, I go to the clinic when I feel unwell so that I can get treatment. Sometimes, many days elapsed before I can get treatment, because I do not have any money, and so cannot be treated by the clinic staff.

One woman would not take her mother to the clinic for her blood pressure medication. She still owed the clinic for her own consultation. Upon being told that she would not be turned away, she reported that the nurse had noted on her treatment card that she owed some money. She also mentioned that the nurse had been very unpleasant about it.

Nurses in the clinics explained that they were reluctant to prescribe medication without seeing the patients. Nurses operate according to the policies laid down for them, and some of these were not consistent with the needs of the caregivers. Many elderly patients were unable to access services being provided in the clinics. Consequently, those family caregivers who were looking after frail and bed-bound relatives often found themselves in a struggle with the health care system.

Attitudes of health professionals

Some health workers were reported to be unsympathetic and consequently alienating in their interactions with the caregivers. Some older persons believed that health workers practiced ageism. One caregiver who looked after her husband had this to say about health professionals:

They said to me that I was afraid of keeping him at home because he was old, and because I wanted to dump him on them. The hospital people refused to admit him. They were difficult. They have abandoned us...I just keep taking him to the hospital.

Another caregiver, whose husband was mentally ill, went back to the clinic to inform the nurses that her husband had chewed up all the tablets that they had given him. The nurses' response to this woman's problem was: "It's not our problem if he has chewed up all the tablets."
Access to information

Lack of access to information served as a barrier to the role fulfillment of caregivers, as it impeded the fulfillment of certain tasks or failed to facilitate taking care of the elderly person. This lack of access to information often manifested in communication problems in health care services—there was lack of information about how the health care delivery system operated (referral) as well as lack of information related to caregiving tasks. Family members lacked knowledge of where to go for follow-up care and were upset when they inadvertently went to the wrong facility and were turned away. This misunderstanding often created resentment on the part of the family and the elderly person.

Lack of client education by health care providers also created a barrier which strained relations between the relatives of the elderly person and the health care delivery system. A caregiver who was taking care of a stroke patient noted as she was changing his position: “I wish someone would show me what to do. I do not even know if I am doing the right thing”. Yet another caregiver was observed incorrectly teaching her daughter how to give an insulin injection to her diabetic father. Her husband had recently been discharged from hospital.

Discharge planning

Some of the caregivers and older persons needed follow up visits in the community. The nurse in charge of one clinic blamed lack of discharge planning and referral services for this. The nurses in the clinics explained that there was no communication between the hospital and the clinics regarding the patients who were discharged. One nurse noted:

When patients are discharged home, we sometimes only learn about them when we see them coming to the clinic to seek assistance for their patients.

If the hospital informed us about them we would ensure that the Family Welfare Educators visited them to facilitate their care at home.

Consequently, the clinic staff had no way of knowing who urgently needed to be seen at home.

Shortage of supplies

The government clinics also had a problem of shortage of medical supplies. On such occasions, it meant that the caregiver had to go back to the clinic to collect medicines. In some instances where the caregiver had to walk long distances to the clinics, it seemed cumbersome to return to the clinic to check for supplies or travel further to check the supplies at another clinic. In some instances when this occurred, some elderly patients were reported to go without treatment for some days.

Discussions

Caregiving of the elderly is inextricably linked to several salient issues: the poverty within which the families are situated, a culture that assumes that the family is the
institution for the care of the elderly, when this should not necessarily the case, and a health care delivery system that lacks outreach programs for the elderly. Consequently, older persons often found themselves without access to health care services.

The caregivers in this study were mostly steeped in poverty, and had a poor educational background (Shaibu, 1997). According to Afifi (1997), poverty, education and social problems are so inextricably linked to health concerns that they should not be addressed in isolation of each other.

One of the important findings of this study is the extent to which poverty permeated all aspects of family caregivers’ lives and contributed to the poor health of many elderly people and their caregivers. The socio-economic status of households determined among other things, whether families could afford transportation to gain access to health care. In the rural areas, the public transportation is not as developed and available as in urban areas. In the city, for example, the City Council operates ambulance services and charges a nominal fee. Such a service does not exist in the rural areas. A Catholic nun also visits urban-based elderly destitute and transports them to the nearest clinic. However, the City Council department provides transportation to health facilities for those elderly people who had been registered by their families as destitute. The poor are the most affected by the transportation dilemma in Africa in terms of both the cost and their dependence on it for employment as well as to obtain services (Hope, 1997). Lack of financial resources among the elderly in Botswana was mentioned as a major barrier to seeking health care (Tlou & Sandberg, 1994).

In rural Africa generally, formal clinic-to-hospital referrals were very low for the following reasons: poor access to transport, patients’ inability to pay user fees, transport outlays and other expenses (Nordberg, Holmberg, & Kiugu, 1996). Extreme poverty causes great suffering and ill health across the globe. People who are really wealthy are healthier, have food, sanitation, and access to both government and even expensive private health care. In some instances, the poor can not even afford eyeglasses. This becomes even more important when caregivers rely on their sight to give medications- like insulin. Often, simple low-cost measures to some problems of the elderly can make a difference to the morbidity and disability of the elderly (Allain et al. 1997).

Information was lacking at both the levels of the family caregivers and the health care professionals who plan and deliver health care services for older people. Family caregivers lacked information on facts pertaining to normal ageing. There were such myths as blindness being a natural process and consequence of ageing. Consequently, older persons who contracted trachoma or developed cataracts were not assisted to go to the clinic as this was attributed to old age. From this discussion, some suggestions are made which inform future health care access for family caregivers of the elderly.

Implications for health and social policy

Several key points related to the formulation of a health policy that is age sensitive emerge from the data and results of this study. First, appropriate health care policy for the elderly requires an understanding of family functional activities and limitations, as well as recognition of the resources available to family caregivers. Top-down
approaches to policy formulation will not address some of the problems central to the caregivers and the needed modifications to the health care delivery system. Therefore, a participatory approach will be more empowering and more in line with the dictates of primary health care. The availability of a clinic within a radius of 8-15 kilometres, while commendable, is meaningless to the health and quality of life of the elderly if there is lack of access to these facilities.

Presently, sources of health and social services for the elderly in Botswana fall under three government ministries, the Ministry of Labour and Home Affairs (MLHA), Ministry of Health (MOH), and Ministry of Local Government (MLG). The MOH is responsible for health policy and planning, the MLHA is responsible for social security and social welfare, while the MLG implements health and social welfare services through local authorities. However, the functions of these ministries regarding aging issues are uncoordinated (Mugabe, 1994). Clearly, a more integrated approach to provision for the elderly is clearly advocated— an approach that will utilize an intersectorial collaboration as advocated by the PHC model.

Access to health services is a basic human right for all human beings (Help Age International, 2000). The achievement of better outcomes is dependent upon making effective health care services more accessible to those with health care needs (Alonso et al. 1997). While Botswana recognizes this need and is in the process of strengthening the methods of providing health services for the elderly, there is need to recognise pertinent problems of access to health care towards devising better methods of addressing them. The health sector in Botswana does not lack good plans and policies, but the challenge comes in implementing them (Maganu, 1997).

Most elderly patients usually present chronic conditions. The implication is that health care institutions need to invest in a health care system with a chronic care perspective. The Community Home Based Programme should also be strengthened to assist in the care of the elderly as advocated in Vision 2016. While currently most of these programmes target elderly patients, some of them are incapacitated in their functions by lack of manpower and transportation. Therefore, addressing the issue of human resources is crucial for health care policy makers.

Implications for Education and Practice
Nurses in Botswana are being challenged to care for those clients who are socially and economically disadvantaged. Lack of outreach programs for elderly patients defies the tenets of Primary Health Care- a philosophy that not only underpins Botswana’s health care delivery system, but one that also advocates acceptability and accessibility of health care services to all people.

Alternative models of health care delivery such as the mobile health care outreach programme can increase access to health by the elderly and improve the general health status of bed ridden and frail older persons. Re-training of health care professionals to understand and respond to the evolving needs of the elderly although necessary, may not be easy given the many other competing training needs. Educational programmes on normal ageing and primary prevention programmes such as exercise and nutrition need to reach not only health care providers and social service providers, but also older people and caregivers (Pelaez & Kalache, 2001).
It is important for nurses to understand the issues and constraining environmental factors that affect older peoples’ access to health care services in order to play a more effective advocacy role. Nurses need to influence policy that focuses on those clinical interventions that will provide access to all age groups. They also need to understand the complex social, political and economic forces that shape people’s lives in order to promote the health of individuals and groups (Butterfield, 1990). This should be reflected in all nursing curricula both at diploma and undergraduate levels. The preparation of nurses requires an understanding of these issues to assist them to plan for preventive and health promotion programmes.

Conclusion
In conclusion, the study revealed that access to health care is problematic for family caregivers of the elderly. Healthcare services for the elderly need to be strengthened. Community-based participation in healthcare delivery may help in identifying problem of access to care that are specific to vulnerable populations. Such problems can be addressed through action research (Higgs et al., 2001). However, whatever solutions are designed must be culturally relevant and acceptable to the people.

References


