International Research Journal of Marketing & Economics
ISSN (2349-0314) Impact Factor: 8.173
Vol. 11, Issue 06, June 2024

Website-www.aarf.asia,Email id : editoraarf@gmail.com

Accessibility to Healthcare Facilities by the Elderly in Challenging Economic Times in Nigeria: The Urban Planner's Perspective

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Being A Paper Presented at the 3rd Edition of Ibadan Public Health Conference, Faculty of Public Health, University of Ibadan, Ibadan, Nigeria.
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Abstract

Background: Ageing is a natural process in human development with social, physical, mental and homonal changes which are likely to impact their health status in Nigeria. In Nigeria, the population of the elderly group account for about 5 per cent and there is a need to understand their health-related outcomes especially with access to healthcare services.

Methods: A survey of 200 elderly people selected across the study area using multi-stage sampling techniques. The sample were possessively selected randomly throughout the 36 states in Nigeria but spread over the six geopolitical zones. Questionnaire were administered to obtain information on the age, income, common health challenges, amount spent on drugs and other coping mechanism adopted to survive in the Nigerian hard economic conditions.

Results: The data collected were analyzed using tables and percentages to measure the aging accessibility to healthcare services and distribution of health facilities in the study area. The result showed that 58.1% of the aging people lack access to health facilities due to rising cost of living, insecurity, poor health service, unemployment and no social infrastructure, lack of caregiver agency (62%), and distance to health facilities (71.1%) where people had to travel more than 2km to obtain healthcare. The elderly are frequently attacked by Blood pressure, Respiratory disorder, refractive errors, Cancer, Arthritis , and Alzheimer, obstructive pulmonary having 46.6% of respondents. The elderly adopted quarterly attendance to health facilities 76.7% while 44.2% used attending health care seminars.

Recommendation: There should be provision of more PHCs and mobile clinics to reduce the distance the elderly had to travel to receive care, professional town planners should be involved in the planning and location decision of healthcare facilities across Nigeria by all levels of government especially suburban and rural areas; application of location decision theories to healthcare planning rather than political exigencies; provision of health insurance to provide fund for the elderly to obtain care and conduct of health seminars for the elderly.

Keywords: Access to Healthcare, The Elderly, Challenging Economic Times.
Word count: 330.

1.0 **Introduction**

Human life cycle can be described with six main stages which are the foetus, baby, child, adolescent, adult and elderly (LibreTexts Medicine, 2020). Each of these stages has challenges which can range from physical to health. As human being grows, he develops a hierarchy of needs which may comprise of physiological, safety, love and belonging, esteem and self-actualization. The hierarchy of human needs model was first developed by Abraham Maslow pyramidal "Hierarchy of Needs" in 1968 which identified human basic needs and the most advanced ones. The main idea behind the postulation was that the most basic needs must be met before other needs can be attended to (Mcleod, 2024). The basic physiological need in the hierarchy include food, water, shelter, clothing safety and good health (Canada College, 2018).

The human needs and wants was further classified into five which according to William Glasser, may be woven into human genes amongst others to love and belong, to be powerful, to be free, to have fun and to survive. All these five basic needs are psychologically needed by an average human being, and are also required irrespective of one's age or race.

The healthcare giving for the elderly encapsulates the meeting of these five basic needs. The elderly need to enjoy love and belonging to the old family unit; required freedom in their choice of food, clothing and association; as well as to enjoy fun and survive within the immediate and larger community before their death.

The elderly have been considered to be people (men and women) in the age of 65 years and above (National Library of Medicine, 1987). These group of people continue to have health and other physiological needs as they grow older. The import of this situation is for them to have a structure (formal or informal) that will supply their physiological needs and to provide a healthcare giving system that will meet their needs. The provision of healthcare giving to the elderly can be through a formal health institution or through the traditional system where family members provide care to their aged members and offer support to them. The formal care giving for the elderly can be by Old Peoples' Homes or Nursing homes where the elderly will be accommodated to receive daily care. The formal homes have their advantages and disadvantages that could make it attractive to the elderly and the person to sponsor the care.

The population of the elderly is estimated to increase from 11% in 2000 to 22% in 2050 in United States of America (Animasaun and Chapman, 2017). According to the duo, the increase has some consequences on the outcomes of the health of the elderly which can manifest in a number of ways. In Africa, the population of the elderly is also increasing because of the improvement in mortality rate among the people through the support of aids from the global health agencies and improvement in healthcare delivery. Nigeria with a population of 206million people is experiencing an increase in elderly population that may reach 8.2% in 2031. The caregiving system in Nigeria is yet to be formal when compared to what obtains in the advanced nations such as America and Europe. This situation can be adduced to socio-cultural and economic factors notwithstanding the health challenges faced by the aging population. Thus, there is need to examine the accessibility of the elderly to healthcare services and the challenges that may hinder it in the current harsh economic environment in Nigeria.

2.0 **The Objectives of the Paper.**

This paper at the end of this presentation will achieve the following objectives: examination of the socio-economic characteristics of the sampled aging population of 65 years and above; to investigate the health challenges confronting them as elderly group; analysis of the challenging economic environment in Nigeria and the effects on the accessibility of the elderly to healthcare services; examination of the factors that determine the accessibility of the elderly to healthcare services; and to investigate the coping mechanism available through government policies and programmes towards provision of healthcare services for the elderly.

3.0 **Theoretical Consideration**.

The paper has explored some theories to locate the discussion on the train of knowledge. These are discussed briefly one after the other.

(i) **Maslow's Hierarchy of Human Needs.** The theory was developed by Abraham Maslow in 1943 when he wrote in his paper "A theory of human motivation. Maslow suggested a hierarchy of human needs which begins with basic needs before moving to other advanced needs (Cherry, 2022). Maslow suggested on what makes people happy and what they have to do to achieve that state of happiness. Maslow identified five levels of hierarchy of needs starting from physiological needs which may include food, water, breathing, shelter, clothing and sexual satisfaction. The second level of need is security and safety which may include financial security, health and wellness and safety against accidents and injury (domestic or external). There are social needs which include friendship, love and family relationships. These needs are germane to elderly or aging state of human life to avoid loneliness, depression and anxiety. The last two is self esteem and self- actualization needs.

Figure 1

The relevance of this theory to the theme of discussion is obvious. First, the elderly or the aging needs to meet some needs after 65 years of age which are located within physiological, security and safety, social and self-actualization. As aging individual, food, water, shelter, clothing, financial security, health and wellness are required to sail through the aging process. These needs may be collapsed into Deficiency needs and growth needs. Although some criticisms have been made against the theory that needs don't follow a single hierarchy in real life and the definition of self- actualization is difficult (Willingham, 2023); the theory is still relevant to help in the understanding of the accessibility to healthcare services by the elderly in harsh economic environment.

(ii) The Theory of Cause and Effect (Causality).

The theory was propounded by Aristotle (384 BC – 322 BC) which stated that there is a fundamental source of becoming in everything, and that everything tends towards some end or form (Kant,2021). The theory helped to understand human experience of physical nature and its impacts on human life (Alausa, 2023). Four types of causes were identified which are formal cause, efficient cause, material cause and final cause.

Causality is the influence which one event, process, state or object contributes to the production of another event, process or object. The law is an abstraction of how the world progresses (Stanford Encyclopedia of Philosophy, 2006, 2009). In the modern sense, the material and efficient cause have been considered more relevant to human behavior or decision making. The material cause depicts where human experience changes as they do because one source of becoming is the material of which a thing is made. For example, a tree is experienced as a tree because it is made of wood or the tree caught fire because its material is wood and wood is inflammable material. The efficient cause on the other hand explains that human experience changes in terms of what went before the present state. For example, a tree is now on fire because in the preceding state, it was hit by lightning.

The causality theory is relevant to the discussion on accessibility to healthcare services by the elderly in challenging economic times because aging and challenging times are material and efficient causes of elderly access to healthcare services.

(iii) Distance Decay and Accessibility Theory

It is a geographical concept used to explain the interaction between two objects. The theory stated that distance and interaction are inversely proportional, and that the shorter the distance the more the rate of interaction (Le, La and Tykkylainen, 2022). The distance decay concept was a further explanation of Waldo Tobbler's first law of Geography which stated that "Everything is related to everything else, but near things are more related than distant things" (Chen, 2005).

The distance exponent of the gravity model can be used to explain the concept of scaling and fractal dimensions; and two places can be measured with the gravity model: $I_{ij} = G\ Pi\ Pj\ /rij^{b}$ where I_{ij} denotes the gravity between places i and j, which can be represented wit the quantity of the flow from one place to the other.

The law is applicable to various phenomena relationship ranging from human settlements to geo-linguistics or ecology. The is relevant to the subject of discussion when one considers the impact of distance on the rate of interaction between the elderly and their health services or caregivers.

(iv) Progressive Utilization Theory (PROUT).

The theory was propounded by an Indian philosopher and spiritual leader Drabhat Ranjan in 1959 (ProutisBloc.india, 2018). The theory was a projection of the line of thought of Sarkar's Neo-humanist value which was devised to provide "proper care" to every being on the planet whether humans, animals and plants (Alausa and Oloukoi, 2023).

PROUT has been formally outlined in sixteen aphorism, but the last five are commonly referred to describe the fundamental principles of the theory. These principles are: there should be no accumulation of wealth without the permission of the society; there should be maximization and rational distribution of the crude, subtle causal resources; there should be maximum utilization of the physical, mental and spiritual potentials of the individuals and collective beings; there should be a well-balanced adjustment among the crude, subtle and causal utilization; and utilization vary in accordance with time, space and form and should be progressing. Thus, in the theory, all living beings belong to a universal family who deserve equal respect and care. The theory is therefore relevant to the subject of discussion since healthcare services are causal resources which must be progressively and maximally utilized by the aging population

4. 0 Review of Literature.

This section conducted a review of opinions of scholars on the different aspects of the subject which include: The Elderly or Aging group and health challenges; Accessibility to healthcare services; Challenging economic times; and Urban planner's Role and Thoughts in aging healthcare.

The Elderly and Healthcare Challenges

The elderly as they reach the age of 65 years experienced some changes in their body systems which are things of concern to their health status.

It has been observed that Nigeria will have the third largest elderly population of 65 years and above by the year 2030 (Rockgarden Homecare Agency, 2022). It has also been noted that changes in family structure and death of friends and families have great impact (negative) on the health of the family particularly the elderly or aging population. This group received care for household help for health or functioning reasons such as laundry, hot meals, shopping for personal items, paying bills/banking, and handling medication. The Elderly or aging group also receive care for daily chores such as bathing, dressing, eating, toileting or getting in and out of bed (American Committee on Family Caregiving for Older Adults, 2016).

The effect of changing family structure was noted since caregiving for older adults is dependent especially in the nearest future on the availability and capacity of their family members to offer help for their health needs. In the early years, older adults could rely on large extended families for help even with and functioning needs. The caregiver could be either a wife or adult daughter (Kasper, 2006).

Table 1 Family Relationship of Caregivers of Older Adults by Care Recipient's Level of Need by percentage, 2011 in America.

Table 1

Family Relationship	All Caregivers (%)	High-Need Caregivers(%)
Relationship to Recipient Spouse	21.5	18.1
Daughter, Daughter-in-law, Stepdaughter	33.6	38.0
Son	21.2	21.8
Others	23.7	22.1
Marital Status Married/partnered Separate/divorced Widowed Never Married	 66.6 11.6 5.9 14.3	 66.1 12.0 6.0 13.7
Lives with the Care recipients Yes Children younger than 18 None	 43.8 82.9	 42.2 81.0
Any	15.7	17.1

Marital status is closely associated with the availability of caregivers and social support for overall economic well-being of the elderly (Federal Interagency Forum on Aging-Related

Statistics, 2012). Older adults (women) are less likely to be widowed (West etal.,2014). This may suggest that spouses can be expected to play a greater role in caregiving.
Non-traditional household and complex family structure may make adult stepchildren to have weaker feelings of obligation to care for aging stepparents than their parents (Pew Research Center, 2010, van der Pas etal., 2013). The condition of aging and older age come with some health decline such as hearing and vision loss, cognitive recognition, balance issues, heart disease Cataracts and refractive errors, osteoporosis and osteoarthritis, respiratory disease, pneumonia, chronic obstructive pulmonary disease, domestic injuries, diabetes, blood pressure, demential, oral health problem and prostate cancer. The challenges faced by older people could be functional, physical and psychological (Animasaun and Chapman, 2017; Senior Home Companion, 2024). The authors noted four factors that impact the health status of the elderly in Nigeria which are changes in family structure, increased demand for healthcare services, increased economic stress and decreased functional independence.
It was noted that most of the research work on psychosocial health of the elderly were from Nigeria and South Africa. In South Africa, population growth of the elderly rose from 6.6% in 2002 to 8.0% in 2016. In Nigeria, life-changing stressors such as loss of material possessions or social network often contribute to social isolation among the elderly. The consequential effect is occurrence of high blood pressure or depression which may lead to permanent stroke or heart attack (Animasaun and Chapman, 2017). It was observed by the authors that older females may experience decrease libido due to emotional reactions after the death of her spouse but older males may be able to endure physiological sexual dysfunction (Akinyemi and Aransiola, 2010). The authors noted that Elderly people in Nigeria face multiple health challenges due to changes in family dynamics, increase demand for healthcare services due to reduced income sources and decrease functional independence as a result of reduced physical strength.
There are other health challenges that could emanate in the life of the elderly as a result of abuse and neglect when children or spouse did not consent to taking care of them. Nigeria reported a high rate of elderly abuse to 46.7% of physical abuse, 44.7% of lack of visitation and 49% were not comfortable with the environment they are living. Another study conducted in Enugu, Nigeria revealed that 88% of the elderly were denied of freedom of interaction for trivial cultural or religious beliefs. There is also gender imbalance and discrimination which affected more of women than men (Animasaun and Chapman, 2017). A greater percentage of an elderly person's needs are the psychological needs (Senior Home Companions, 2024). The author observed that the elderly usually confront eight common needs which are family support, home safety, medical needs, cognitive health, mobility, personal hygiene, meal preparation and social interaction. Thus, an elderly person will suffer emotional and physical needs especially when abandoned by family members. It was noted that when people age, their psychology, physical strength and behavioral patterns change and they become more unstable. A home care or nursing home care could be the way out to provide the needed care.
In the study of age-related disease and clinical and public health implication for the 85 years old and above population in America, Jaul and Barron (2017) submitted that hearing and vision loss, Cardiovascular disease, Osteoporosis (fragile bone), general body pains, arthritis, prostrate cancer, diabetes and dementia are common chronic disease noticeable among the elderly especially the ones above the age of 85 years.

Accessibility to Healthcare Services by the Elderly Population

Accessibility to healthcare services is the relative ease or comfort of getting medical care when needed (Public health Scotland, 2020). It is the determination of the number of people in a region or group population that can reach the appropriate healthcare services. Access to healthcare services also connotes the ability of the people to have healthcare services such as

diagnosis, treatment, prevention, and management of diseases and illnesses. This is premised on affordability and convenience which is primal to planning and allocation of resources. The determinants of access to healthcare may be grouped into individual, structural and systemic factors (Tzenios, 2019). The individual characteristics may include: socioeconomic status, lack of education and illiteracy about healthcare opportunities in the group environment. Other factors are lack of mobility and failure to recognize the value of preventive treatment in the process of healthcare delivery. The structural factors include availability and accessibility of healthcare professionals and facilities to the needy group which is dependent on geographic location, population density and allocation of healthcare resources within a specific geographic coverage. The systemic factors are concerned with government laws and regulations, healthcare expenditure and budgeting and healthcare system. Tzenios submitted that access to healthcare services can have cumulative effect on peoples' health status if not corrected and recommended amongst others implementation of universal healthcare coverage, expansion of primary healthcare services, improvement of healthcare infrastructure, expansion of public health education and the improvement in the overall design and funding of healthcare services. Alausa (2023) observed some factors that may influence healthcare accessibility to the people which are: price of healthcare products, the stigma attached to the product by the people, discrimination, availability of the services, physical location of health infrastructure, attitude and health information dissemination. Thus, accessibility is premised on affordability and convenience which is essential to planning and resource allocation. Accessibility to healthcare is important to prevent disease and disability by detecting and treat illnesses or other bad health conditions, increase the quality of life and reduce the occurrence of early death (MedicineNet, 2017).

In healthcare delivery, the relationship between the concepts of availability, accessibility, quality and acceptability always come to the fore.

Accessibility is achieved when health workforce characteristics and ability (sex, language, culture, age) to treat all patients with dignity and create peoples' trust and promotion of demand for the services are factored into assessment of health inequality (Office of Disease Prevention and Health Promotion (ODPHP), 2020. Therefore, availability of services and barriers to access should be considered and must be based on peoples' perspectives, health needs and cultural setting of the diverse people including the elderly or aging population.

It was noted that lack of access of the elderly to healthcare services amount to health inequality and inequity. Health inequality describes the variation in health status between different group of people which may be identified by race, age, education and location (Tugwell, etal. 2007). The basic social and economic structures within which the people grow, live and work can also be used to measure inequality within groups.

Nigeria Challenging Economic Times

The general economic environment globally or locally usually affects individual facets of life and well-being. The people globally are confronted by economic challenges such as increasing population growth, demand for resources and pollution. In economics, it was observed that the main economic problem in the world yet to have a final solution is scarcity of resources to meet the expanding needs of the people (StudySmarter, 2024). Human beings continue to increase in population often uncontrollably, the peoples' wants also increases proportionately, but the resources to meet the expanding wants remain limited. In the 21st century, scarcity of resource has been a fundamental challenge. There are two major types of resources; the renewable and non-renewable resources. Renewable resources can be replenished after it has been used for future use; but non-renewable are exhausted after use. Aging and time are non-renewable resources available to human beings. Health infrastructure is non-renewable resource which must be properly used for the benefit of the increasing population. Thus, an example of economic challenge is population growth (elderly people) that exceeds the available resources to meet their needs (healthcare services inclusive).

Nigeria is currently facing severe economic challenges as evidence by hyper-inflation of food items drugs and transportation services. Coupled with this is the unprecedented security challenges such as terrorism, armed robbery, banditry and unemployment. It was noted that the annual inflation average of prices is now 30% while the cost of food items has risen more than 35% (Ogbonna, 2024). The implication of this is wide spread anger and hardship. This has consequences on the health of the aging population especially when such population are in their retirement age and a reduced income. The ability to meet their healthcare expenses become difficult. The situation is more compounded and convoluted by the unstable exchange rate of Naira to international currencies such as U.S Dollar and British Pound. For example, in year 2023, N10,000 will buy a good which the foreign currency price is $22; but today the same amount will only buy a drug worth $6.40. Thus, if the price of a sick elderly person's drug is $45, and the current exchange rate of a dollar to naira is 1,560; then the cost of the drug to the sick person will be N70,200. In addition, to be able to use the prescribed drugs, the elderly must have enough food in his stomach. In a situation that either the fund is not available or the rising prices of food needed has reduced the quantity of food needed and can be purchased; the health of such individual is going to be threatened. The inflation rate as stated by National Bureau of Statistics (NBS) for March 2024 is 31.7% (Channels Tv, 2024). The World Bank however predicted that inflation rate will drop to 29.90% in January, 2024. A clear understanding of the effect of the rising inflation rate is demonstrated by the prices of food items between 2022-2024 are stated in the table 2 below:

Table 2

Item	Price/2022 N:00	Price/2023 N:00	Price/2024 N:00
Tinned Milk 170g	340	542	710
Egg I pc	84	110	4500
Bread 500g	496	815	1250
Tomatoes 1kg	458	814	1066
Palm oil 1 bottle	1024	1425	1867
Vegetable oil 1 bottle	1162	1710	2240
Beef 1 kg	2377	3147	4123
Yams 1kg	425	819	1073
Onions 1kg	436	972	1273
Rice 1 kg	506	918	1300
Brown Beans 1kg	586	871	1141
Garri 1kg	333	569	745
Potato 1 kg	-	-	1333
Lettuce	-	-	2000
Apples 1 kg	-	-	1653

Source: Nigeria National Bureau of Statistics, 2024 (adapted).

The prices of some basic drugs needed by the elderly to treat the common illnesses are in the table 3

Table 3: Prices of selected drugs commonly used by the elderly for their health needs.

Items	Drug	Price/2023 N: K	Price/2024 N: K
Cough	De-Coff, Azithromycin tablet	602 2150	700 2500
Diabetes	Insulin, glucophage, mepiryl	4214 2064	4900/pack 2400/pack
Osteoarthritis	Cataflam tablet, calgovit tablet	2322 4128	2700/set 4800
Respiratory disease	Ventolin inhaler, Seretide inhaler, prednisone tablet	8428	9,800
Osteoporosis	Calcium tablet, magnesium tablet	1204 8815	1400 10250
Prostate Cancer	Surgery if can't be managed		
Demential/Alzheimer	Cognitol tablet, neurozan tablet	1032 9073	1200 10550
Pulmonary Disease	Ventolin inhaler, Seretide inhaler	4828	9800

s

Healthcare Financing.

Healthcare financing is a primary component of health systems which is fundamental to achieving improved and effective service coverage. This involves mobilizing health funds, pooling the funds together to purchase healthcare services (ScienceDirect, 2017). At the micro level, healthcare financing evolved from personal payment at the point of service delivery through health insurance (prepayment) by both the employee and the employer at the place of employment. It was observed by the author that every country is faced with the challenge of funding healthcare either for the total population or for the vulnerable group such as the elderly and the poor. For example, in the USA, 50% of government expenditure goes to health care services. Health financing in not only the provision of fund for health care but also includes the allocation of the raised funds.

In Nigeria, healthcare funds are sourced through public out- of- pocket payments, donor agencies and health insurance (OCED, 2017). Nigeria expenditure on health between 2019 and 2021 is presented as follows (Pharmaccess.org, 2022):

Year	Amount (N)
2019	1.191 billion
2020	1.330 billion
2021	1.478 billion

Nigeria spends 3.89% of GDP on health care in 2018. In the area of health insurance scheme, the formal sector has the greater percentage of enrollees with the scheme covering primary healthcare, referral care in accredited hospitals, and community- based health insurance for the poor and the rural areas (WHO, 2008).

Nigeria operates five functional health care financing strategies which are: revenue from public tax, social insurance, voluntary insurance, charitable donations and individual out of pocket expenses. (Nigeria Open University, 2023). The implementation of these programmes called for concern since the effects on the health of the people is thin.

The Urban Planners Role in Elderly Healthcare

The understanding the concept and philosophy of planning will assist in concise description of the roles of planners in the elderly health challenges and care. Thus, a few definitions of a planner, whether urban, town or regional were examined to give a clear perspective and expectation of the planners in elderly health challenges and solution. Planning is defined as the process of preparing a set of decisions for the action in the future directed at achieving goals by preferrable means (Dror,1973). Friedman (1964) described planning as a way of thinking about social and economic problems, oriented predominantly towards the future and deeply concerned with the relationship of goals to collective decisions; and it strives for comprehensiveness in policy and programme. Agbola and Oladoja (2004) defined planning as a purposeful action or decision taken beforehand to influence the course of action on a particular need. A synthesis of these few definitions of planning brought out some salient perspectives of planning that guide the planners' role. Planning is a decision tool, a future oriented activity, an activity with many alternatives and the making of preferable choice among the alternatives after careful consideration of the implication of the choices made. The involvement of a planner in human settlement presupposes that planning is a form of professional activity aimed at proffering decisions or actions that would impact on the course of action taken to provide maximum benefit for the people resident in the planning areas (local, state, national, regional or global). This planning line of thought on human settlement corroborated the aged long definition of planning which stated that planning is the spatial ordering of land uses at all levels (national, regional or local) for the purpose of creating a functional, efficient aesthetically pleasing and sustainable environment for living, working and recreation (Keeble, 1969).

The live of the elderly in their aging period is a cumulation of the environment which they were born, grow, work and retire. The elderly health condition at the aging stage of their lives is a reflection of their past living condition, genetic composition, environmental condition and the attitude to health education. The creation of a functional, efficient and aesthetically pleasing and sustainable environment within which the elderly lived and grew will dictate their health challenges and the accessibility to health care. According to Agbola et al, (2004), the planners' attention is demanded in the areas of development of plans and actions on rapid urbanization, transformation of the traditional cities, the resolving the conflicts from informality and illegality, urban and rural insecurity, tenure insecurity, urban sprawl and the need to evolve a sustainable and healthy city. The process of developing a functional and sustainable environment for the people (elderly inclusive) to grow, work and retire will require an intellectual and mental engagement that necessitated reflective thinking, astute imagination and accurate fore and hind sights. It has been noted that there is strong correlation between the peoples' health and the environment which they live; and the quality of the environment may determine the quality of health the people may enjoy (Alausa, 2023). In fact, the well-being of man is principally dictated by the physical environment which further confirmed the interaction between human beings and the environment which supports his well-being (Toppr, 2020). The health challenges when one is aging can be reduced by conscious planning previously carried out in the environment to shape the housing, transportation, provision and location of facilities and infrastructure, and the creation of elderly care giving homes. In the opinion of Hippocrates in the 4th century B.C (460 B.C – 377 B.C), submitted that a holistic investigation of diseases requires the consideration of time and season of the year. It was also observed among the various professional in human and environmental health, medical geography, urban planning that most health problems are environmentally related (Iyun, 1993).

The state of health of the aging population is dependent on the past, present and future plans, policies and programmes initiated by the urban and country planners and the allied professionals in human health and development that formed the basis of implementation of

the functional, aesthetic, environmentally pleasing and sustainable cities and neigbourhood within which the elderly will live the rest of their lives. The creation of these neighbourhood cannot be divorced from the state of the nation's economy both at the micro and macro level.

The Sampled Study Analysis.

Data were collected and analyzed to confirm the various assertions made in the course of this paper on a sample population of 200 respondents randomly selected in Nigeria. The respondents were people of 65 years and above and the types of health challenges they were confronting were analyzed. On health challenges confronting the elderly, 46.6% agreed that back pain, osteoarthritis, chronic obstructive pulmonary, prostate cancer and diabetes are the major health challenges. Respiratory, borderline type 11 DM, cataracts, refractive errors scored lower percentages (2.3%-7%) by the respondents. 7.3% suffered from hearing loss and dementia. In the aspect of coping mechanism by the elderly; 76.7% indicated quarterly attendance to healthcare centers while 44.2% attended healthcare seminars on quarterly basis. 34.9% never attended seminar. 100% of the respondents submitted that distance to healthcare facility and non-availability of facilities are the major challenges impeding accessibility of the elderly to healthcare facilities. In the area of conducting regular medical check -up and control food intake, 65.1% used this as coping mechanism. For the purpose of empirical study, some local governments in Oyo state were used to illustrate some issues of discussion in the paper and the data collected were analyzed and presented to show the distribution of healthcare facilities in Oyo State. The local government selected were Afijio, Kajola, Oluyole and Ibarapa North. There may be little variation in health challenges when the larger scope of regions is considered due to environmental, occupational and attitudinal factors. The data as analyzed showed the following information:

Table 4. Types of Heath Facility in Oyo State

Facility Type	**No of Health Facilities**
Basic Health Centre/Primary Health Centre	851
Clinic	120
Dispensary	7
Health Post	94
District/General Hospital	105
Regional Health Centre	14
Teaching/Specialize Hospital	98

Source: Oyo State Ministry of Health, 2022

The health facilities are spread all over the local governments in the state. The distribution of the health facilities on local government basis is shown in Table 4.5

Table 5. Number of Primary Health Facilities in the 33 local government of Oyo State

S/N	Local Government	No of Health facilities
1	Afijio	34
2	Akinyele	68
3	Atiba	34
4	Atisbo	26
5	Egbeda	59
6	Ibadan North East	46
7	Ibadan North	54
8	Ibadan North West	38
9	Ibadan South East	50
10	Ibadan South West	75
11	Ibarapa Central	27
12	Ibarapa East	25
13	Ibarapa North	21
14	Ido	31
15	Irepo	29
16	Iseyin	51
17	Itesiwaju	25
18	Iwajowa	25
19	Kajola	25
20	Lagelu	40
21	Ogbomosho North	34
22	Ogbomosho South	44
23	Ogo Oluwa	34
24	Olorunsogo	30
25	Oluyole	51
26	Oorelope	16
27	Ona-Ara	65
28	Oriire	43
29	Oyo East	35
30	Oyo West	35
31	Saki East	16
32	Saki West	57
33	Surulere	46

Source: Oyo State.gov. (2021). About Oyo State. Available on line https://oyostate.gov.ng>about

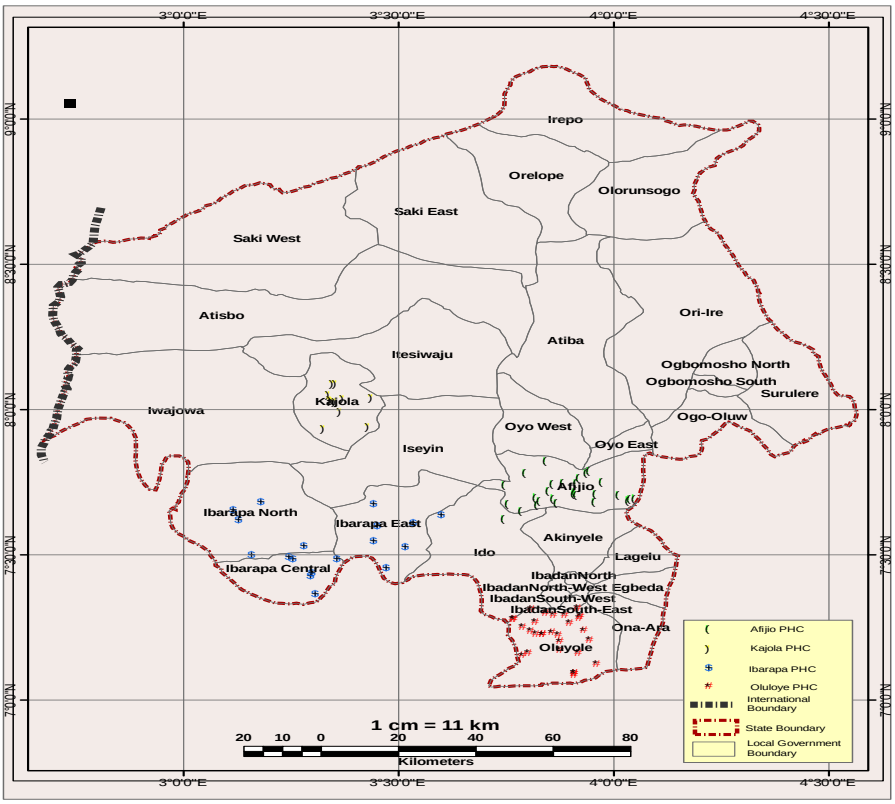

Figure 2. Distribution of Primary Healthcare Facilities in Oyo State, Nigeria
Source: Author's Fieldwork, 2023

Table 6: The health challenges experienced as an elderly person

Responses	**Frequency**	**Percent**
Borderline type ii DM	4	2.3
Body pain respiratory	4	2.3
Glaucoma, Prostate	9	4.7
back and neck pain, Osteoarthritis, chronic obstructive pulmonary	13	7.0
Prostate, diabetes, cataracts and refractive errors	4	2.3
back and neck pain, chronic obstructive pulmonary diabetes	29	16.3
Diabetes, body pain, blood pressure	4	2.3
Body pain, diabetes, prostate osteoarthritis	29	16.3
Cataract and refractive errors, back and neck pain osteoarthritis	25	14.0
Body pain, respiratory blood pressure	4	2.3
Diabetes, body pain, dementia	4	2.3
Dementia Diabetes, chronic obstructive pulmaring	13	7.0
Teeth caries, cataract and refractive errors,diabetes	4	2.3
hearing loss, prostate, diabetes, back and neck pain	13	7.0
hearing loss, dementia, diabetes	17	9.3
Depression,back and neck pain, body pain	4	2.3
Total	**180**	**100.0**

Table 7. Types of Diseases that had Affected Aging or elderly in the Last Six Months as Reported by the Respondents

Health Condition	1st Attack	2nd Attack	Frequent Attack	Total %
Diarrheal	33 (16.3)	85 (42.5)	82 (41.2)	**200 (100%)**
Blood Pressure	109 (54.2)	6 (3.3)	85 (42.5)	**200 (100%)**
Mental illness	58 (29.4)	56(28.2)	86 (42.5)	**200 (100%)**
Asthma or Respiratory	52 (26.1)	62 (31.4)	86 (42.5)	**200 (100%)**
Cancer	46 (22.9)	58 (29.4)	95 (47.7)	**200 (100%)**
Arthritis	6 (3.3)	85 (42.5)	109 (54.2)	**200 (100%)**
Alzheimer	62 (31.4)	53 (26.5)	86 (42.5)	**200 (100%)**
Kidney	58 (29.4)	56 (28.2)	86 (42.5)	**200 (100%)**
Heart Diseases	33 (16.3)	85 (42.5)	82 (41.2)	**200 (100%)**
Tiredness	10 (5)	95 (47.7)	95 (47.7)	**200 (100%)**
Hoarse Voice	58 (29.4)	56 (28.2)	86 (42.5)	**200 (100%)**
Fever/Malaria (chronic)	6 (3.3)	85 (42.5)	109 (54.2)	**200 (100%)**
Hernia	58 (29.4)	56 (28.2)	86 (42.5)	**200 (100%)**

Table 8: Distance of House of Respondents to Health Facilities

Distance	Afijio	Ibarapa North	Kajola	Oluyole	Total	Percentage of total
1.1-2Km	12	12	12	14	50	22.9
2.1-4Km	21	23	23	28	95	47.7
4.1-6Km	12	10	13	23	58	29.4
					200	100

Source: Field Survey, 2023

Table 9. Ratio of population to health care facilities in Oyo State

S/N	Local Government Area	Population Projection (2022)	No. of Health Facilities	No. of Facilities Per 1000 population
1	Afijio	193,782	34	5.7
2	Akinyele	310,515	68	4.57
3	Atiba	246,649	34	7.25
4	Atisbo	161,209	26	6.20
5	Egbeda	415,820	59	7.04
6	Ibadan North East	485, 897	46	10.56
7	Ibadan North	451, 702	54	8.36
8	Ibadan North West	225, 804	38	5.94
9	Ibadan South East	390, 626	50	7.81
10	Ibadan South West	415, 022	75	5.53
11	Ibarapa Central	151, 354	27	5.61
12	Ibarapa East	171, 789	25	6.87
13	Ibarapa North	147, 030	21	7.0
14	Ido	152, 592	31	4.92
15	Irepo	177, 738	29	6.13
16	Iseyin	374, 738	51	7.35
17	Itesiwaju	186, 755	25	7.50
18	Iwajowa	150, 774	25	6.03
19	Kajola	293, 974	25	11.76
20	Lagelu	217, 163	40	5.43
21	Ogbomoso North	291, 527	34	8.57
22	Ogbomoso South	147, 156	44	3.34
23	Ogo Oluwa	95, 580	34	2.81
24	Olorunsogo	119, 243	30	3.97
25	Oluyole	298, 274	51	5.85
26	Ona- Ara	389, 327	16	24.33
27	Ore lope	152, 470	65	2.34
28	Oriire	219, 032	43	5.09
29	Oyo East	181, 923	35	5.20
30	Oyo West	200, 046	35	5.72
31	Saki East	159, 731	16	9.98
32	Saki West	400, 611	57	7.03
33	Surulere	205, 737	46	4.50

Source: Authors Field Analysis as Extracted from the records of Oyo State Hospital Management Board, 2023.

Table 10. Estimated Primary Health Facility per population of the study areas.

Local Government Suburban Areas	No. of Houses Identified	Estimated Population based on 6 persons/ Hsd	PHC facility provided by the government.	
			Existing	Estimate
Afijio	8,074	48,444	0	6
Ibarapa North	5,193	31,158	0	6
Kajola	5,975	35,850	0	6
Oluyole	27,527	165,162	0	6

The Implication of the Analysis for Planning of Health Facilities for the Elderly

(i) There has been a noticeable increase of the elderly in Nigeria with a limited designated healthcare facilities to meet their specific health needs in the face of hard economic condition.

(ii) The spatial distribution of health care facilities indicated a shift from threshold population framework which led to under-utilization of some existing facilities in some areas and over-utilization of some facilities in other areas.

(iii) There are few policy recommendations and non- involvement of urban and regional planners in the planning and design of distribution policy of healthcare facilities in all the various tiers of healthcare delivery in Nigeria.

(iv) There are few caregiver agencies in Nigeria and there is urgent need for the establishment of more Care giving agencies by private organizations in Nigeria to meet the needs of the elderly population which is increasing continually in recent times as a result of improved mortality of the people and reduction in socio-cultural affinity among the people.

Conclusion. This paper has been able observed that the aging or the elderly are confronted with health challenges in their aging period such as back or general body pain, obstructive pulmonary, prostate cancer, diabetes and respiratory diseases. The harsh economic condition such as rising cost of food and basic drugs, low provision of social insurance and low-income source for the elderly made life unbearable for them at old age. Therefore, there must be put in place government policies and programmes that will address the challenges. Families nuclear and extended must be ready to offer help while more private caregiving agencies are needed to take care of the elderly in the present hard economic condition in Nigeria.

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RESULTS

This chapter presents results of gathered data on accessibility of healthcare by the elderly in challenging economic Times in Nigeria from the urban and regional planners perspective. Data was gathered from 180 respondents and the result is presented in sub-sections.

4.1 Demographic Information

Table 4.1: Demographic distribution of respondents

SN	Variable	Response	Frequency	Percentage
1	Age	50-59 years 60-69 years 70-79 years 80-89 years 90 years and above	4 59 80 33 4	2.3 32.6 44.2 18.6 2.3
2	Sex	Male Female	105 75	58.1 41.9
3	Location	None Ibadan	172 8	95.3 4.7
4	State of location	None Oyo	172 8	95.3 4.7
5	Number of years of stay in current neighbourhood	5-9 years 10-14 years 15 years above	33 17 130	18.6 9.3 72.1
	Total		**180**	**100**

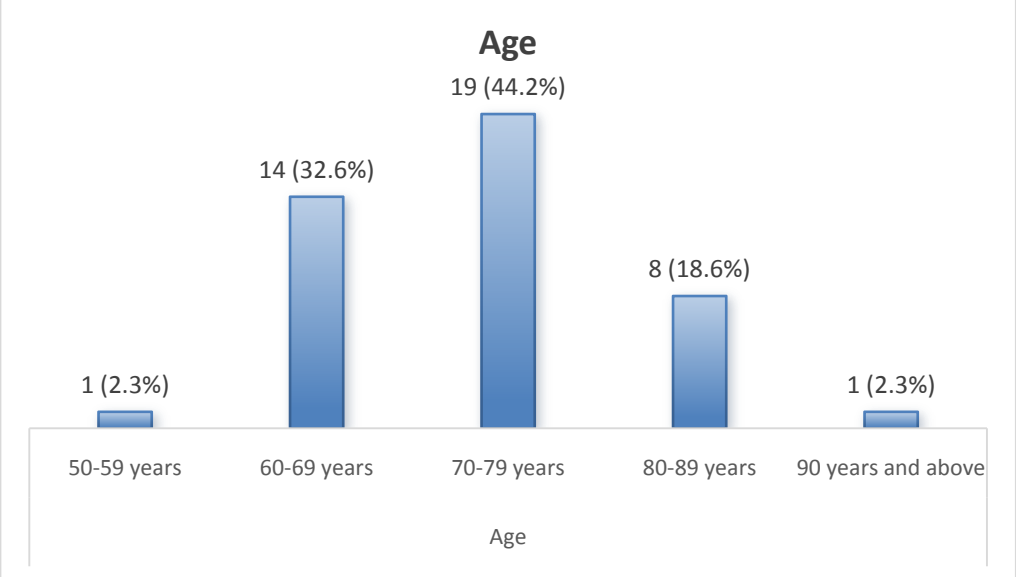

Figure 1: Age distribution

Table 4.1 and figure 1 presents results of the frequency distribution on age of respondents. It is shown that more of the respondents 19 (44.2%) were between 70 and 79 years old, 14 (32.6%) were between 60 and 69 years old, 8 (18.6%) were between 80 and 89 years old, while 1 (2.3%) a piece indicated to be between 50 and 59 years old and 90 years old and above.

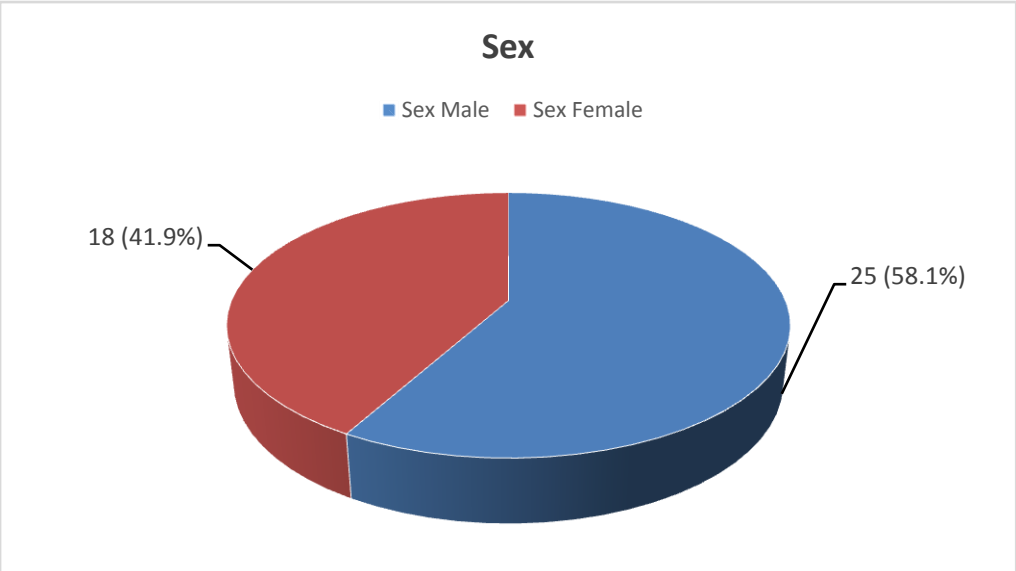

Figure 2: Sex distribution

Table 4.1 and figure 2 presents results on sex distribution among respondents. It is shown that more of the respondents 25 (58.1%) were males, while the other 18 (41.9%) were females.

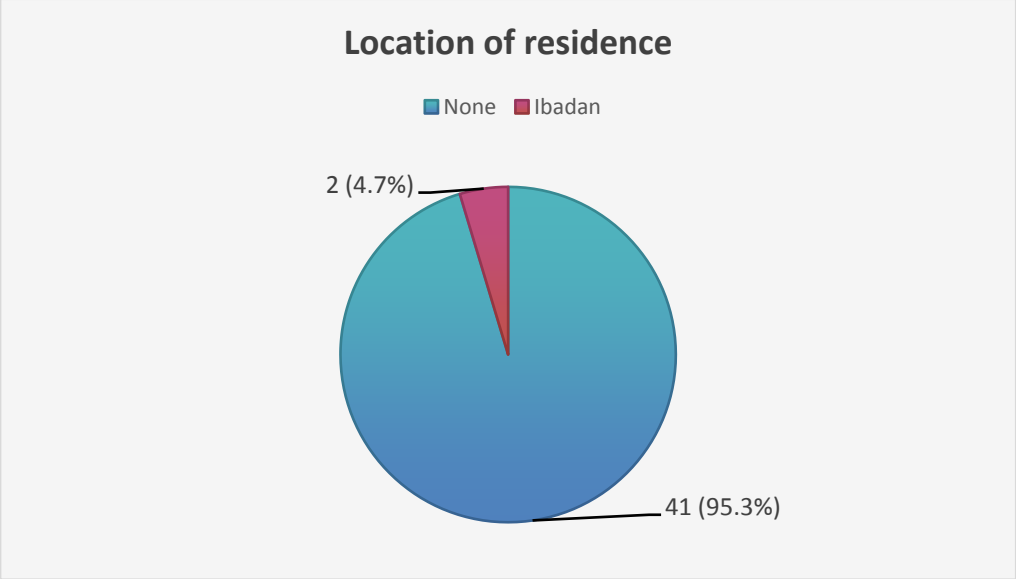

Figure 3: Location of residence

Table 4.1 and figure 3 presents results on distribution of respondents according to location of residence. It is shown that more of the respondents 172 (95.3%) did not give any response, while the other 8 (4.7%) indicated to stay in Ibadan.

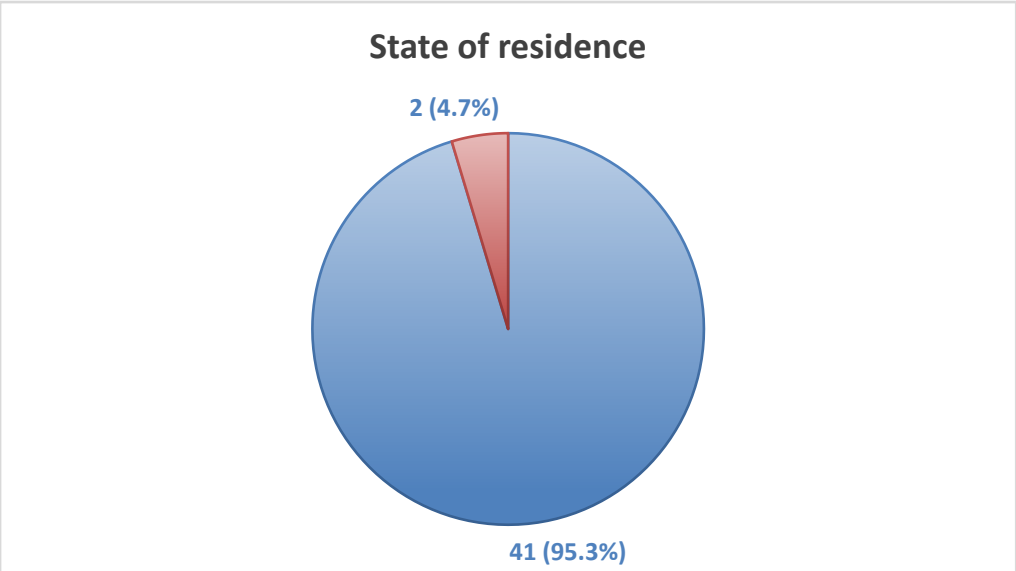

Figure 4: State of residence

Table 4.1 and figure 4 reveals frequency distribution according to state of residence. It is shown that only 8 (4.7%) indicated to stay in Oyo state, while the other 172 (95.3%) did not give any response.

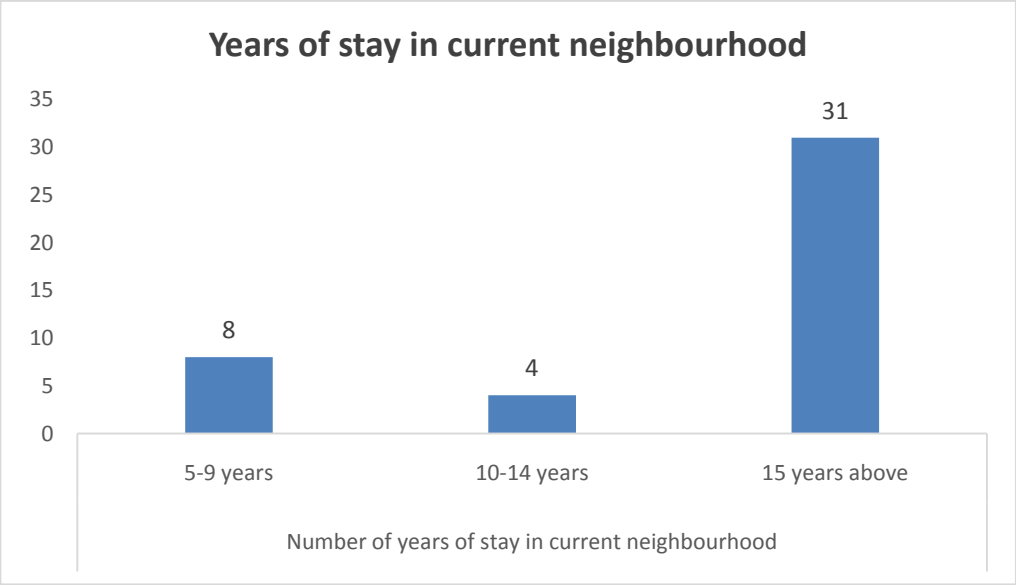

Figure 5: Years of stay in current neighbourhood

Table 4.1 and figure 5 presents results on distribution according to length of stay in their current neighbourhood. It is shown that more of the respondents 130 (72.1%) indicated to have stayed in their current place for at least 15 years, 33 (18.6%) indicated to have been staying in their current place for between 5 and 9 years, while the remaining 17 (9.3%) have stayed in their current location for between 10 and 14 years.

ss4.2 Socio-economic information

Table 4.2: Socio-economic distribution of respondents

SN	Variable	Response	Frequency	Percentage
1	Occupation	None	59	32.6
		Employed	29ss	16.3
		Self-employed	25	14
		Artisan	4	2.3
		Trader	17	9.3
		Retired	46	25.6
2	If retired, previous occupation (n = 11)	Registered homecare	16	9.1
		Civil servant	164	90.9
3	Monthly income	Less than N10,000	13	7
		N10,001-N50,000	88	48.8
		N50,001-N100,000	29	16.3
		N100,001-N150,000	50	27.9
	Total		**180**	**100**

Table 4.2 presents results on the socio-economic distribution of respondents. It is shown that more of the respondents 59 (32.6%) indicated that they are currently not working, while 17 (9.3%) were retired. Among those currently working, 29 (16.3%) indicated to be self-employed, 25 (14%) were self-employed, 17 (9.3%) were traders, while the remaining 4 (2.3%) indicated to be an artisan. Among the retirees, majority of them 164 (90.9%) indicated to be a retired civil servant, while the other individual (9.1%) indicated to be a retired registered home-carer.

Finally, more of the respondents 88 (48.8%) indicated to earn between N10,001 and N50,000 every month, 50 (27.9%) earns between N100,001 and N150,000 every month, 29 (16.3%) earns between N50,001 and N100,000 every month, while the remaining 13 (7%) indicated to earn less than N10,000 every month end.

4.3 Objectives

4.3.1 Objective 1: Socio-economic factors that affect elders' access to health care in harsh economic situation in Nigeria.

Table 4.3: What economic challenge do you face as an elderly person

Responses	Frequency	Percent
No income, increase in price of food and necessities, high cost of transportation	9	4.7
reduced income, increase in price of food and basic necessities, high cost of drugs for the health challenge	25	14.0
Reduced income, high cost of transportation, high cost of drugs for the health challenge t	21	11.6
increase in price of food and necessities, high cost of transportation, high cost of drugs for the health challenge	9	4.7
No income, increase in price of food and necessities, high cost of transportation, high cost of drugs	67	37.2
Reduced income, increase in price of food and basic, necessities, high cost of transportation, high cost of drugs	50	27.9
Total	180	100.0

Table 4.3 presents results on the economic challenges elderly persons face in Nigeria. It is shown that more of the respondents 16 (37.2%) indicated economic challenges related to the

combination of lack of income, increase in price of food and necessities, high cost of transportation, and high cost of drugs, 12 (27.9%) indicated to experience economic challenges related to the combination of reduced income, increase in price of food and basic necessities, high cost of transportation, high cost of drugs, 6 (14%) indicated a combination of reduced income, increase in price of food and basic necessities, high cost of drugs for the health challenge, 5 (11.6%) indicated a combination of reduced income, high cost of transportation, and high cost of drugs.

Table 4.4: What socio-cultural challenge do you face as an elderly person

	Frequency	Percent
Reduce network of friends, Neglect by the extended family	155	86.0
Total loneliness, Neglect by the children	4	2.3
Reduce network of friends, Neglect by the children, Neglect by the extended family	21	11.6
Total	180	100.0

From table 4.4, it is shown that more of the respondents 155 (86%) indicated that they experience reduced network of friends and neglect by extended family members, 21 (11.6%) indicated that they face challenges of the combination of reduced network of friends, neglect by children and neglect by extended family members, while the other individual (2.3%) indicated challenges related to loneliness and neglect by the children.

4.3.2 Objective two: Coping mechanism of the elderly people to access health care in harsh economic environment in Nigeria

Table 4.5: Coping mechanism of the elderly people to access health care in harsh economic environment

SN	Variable	Response	Frequency	Percentage
1	How often do you attend healthcare centre in your neighbourhood	Monthly Quarterly Yearly/Annually	21 138 21	11.6 76.7 11.6
2	How often do you attend healthcare seminar	Monthly Quarterly Annually Never	21 80 17 63	11.6 44.2 9.3 34.9
3	How do you cope with your healthcare challenges	Regular medical check up, control food intake, regular use of medication Regular medical check up, control food intake, regular use of medication, prayer Regular medical check up, control food intake, attending health seminar, regular use of medical, prayer	21 42 117	11.6 23.3 65.1
	Total		**180**	**100**

Table 4.5 presents results on the coping mechanisms of elderly people to access healthcare in harsh economic environment in Nigeria. It is shown that more of the respondents 138 (76.7%) indicated to attend healthcare centre in their neighbourhood every quarter, 21 (11.6%) attends once every year, while the remaining 21 (11.6%) attends every month.

Also, more of the respondents 80 (44.2%) indicated that they attend healthcare seminar every quarter, 63 (34.9%) never attended any healthcare seminar, 21 (11.6%) attends healthcare seminar every month, while the other 17 (9.3%) attends every healthcare seminar every year.

Finally, more of the respondents 117 (65.1%) indicated that they cope with their healthcare challenges by doing regular medical check up, control for their food intake, attending healthcare seminar, regular use of medicines and prayer, 42 (23.3%) cope with their medical challenges by doing the combination of regular medical check up, control food intake, regular use of medication, and prayer, while the remaining 21 (11.6%) indicated that they cope with their healthcare challenges through the combination of regular medical check up, control food intake, regular use of medication.

4.3.3 Objective 3: The health challenges confronting the elderly in their ageing period.

Table 4.6: What type of health challenge do you experience as an elderly person

Responses	**Frequency**	**Percent**
Borderline type ii DM	4	2.3
Body pain respiratory	4	2.3
Glaucoma, Prostate	9	4.7
back and neck pain, Osteoarthritis, chronic obstructive pulmonary	13	7.0
Prostate, diabetes, cataracts and refractive errors	4	2.3
back and neck pain, chronic obstructive pulmonary diabetes	29	16.3
Diabetes, body pain, blood pressure	4	2.3
Body pain, diabetes, prostate osteoarthritis	29	16.3
Cataract and refractive errors, back and neck pain osteoarthritis	25	14.0
Body pain, respiratory blood pressure	4	2.3
Diabetes, body pain, dementia	4	2.3
Dementia Diabetes, chronic obstructive pulmaring	13	7.0
Teeth caries, cataract and refractive errors,diabetes	4	2.3
hearing loss, prostate, diabetes, back and neck pain	13	7.0
hearing loss, dementia, diabetes	17	9.3
Depression,back and neck pain, body pain	4	2.3
Total	**180**	**100.0**

Table 4.6 presents results on the health challenge that elderly persons experiences. It is shown that more of the respondents 29 (16.3%) indicated experiencing the combination of body pain, diabetes, prostate osteoarthritis, another 29 (16.3%) indicated experiencing a combination of back and neck pain, chronic obstructive pulmonary diabetes, 25 (14%) experiences a combination of cataract and refractive errors, back and neck pain osteoarthritis, 17 (9.3%) experiences a combination of hearing loss, dementia and diabetes, 13 (7%) experiences a combination of back and neck pain, osteoarthritis, chronic obstructive pulmonary, another 13 (7%) experiences a combination of dementia diabetes, chronic obstructive pulmonary, another 13 (7%) experiences a combination of hearing loss, prostate, diabetes,back and neck pain.

Table 4.7: What are the challenging economic environment confronting you in Nigeria

Response	Frequency	Percent
Rising cost of living, insecurity, no social infrastructure	4	2.3
Rising cost of living, insecurity, poor healthcare service, no social infrastructure	71	39.5
Rising cost of living, insecurity, poor healthcare service, no social infrastructure, unemployment	105	58.1
Total	180	100.0

Table 4.7 presents results on the challenging economic environment confronting the elderly

Table 4.8: What are your challenges as an elderly person in accessing healthcare service

	Frequency	Percent
Distance to healthcare facility,non availiability of healthcare facility	180	100.0

in Nigeria. It is shown that more of the respondents 105 (58.1%) indicated that the combination of rising cost of living, insecurity, poor healthcare service, lack of social infrastructures and unemployment are part of the economic challenges confronting them in Nigeria. Also, 71 (39.5%) indicated that a combination of rising cost of living, insecurity, poor healthcare service and lack of social infrastructures were some of the economic challenges confronting them in Nigeria, while the remaining 4 (2.3%) indicated that the combination of rising cost of living, insecurity and lack of social infrastructure were part of the economic challenges confronting them in Nigeria.

From Table 4.8, it is shown that all of the respondents indicated that distance to healthcare facility and nonavailability of healthcare facilities are challenges that makes an elderly person to access healthcare service in Nigeria.