

Nigeria's demographic dividend: Contradictions and Priority Setting in Health for Older persons

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Abstract

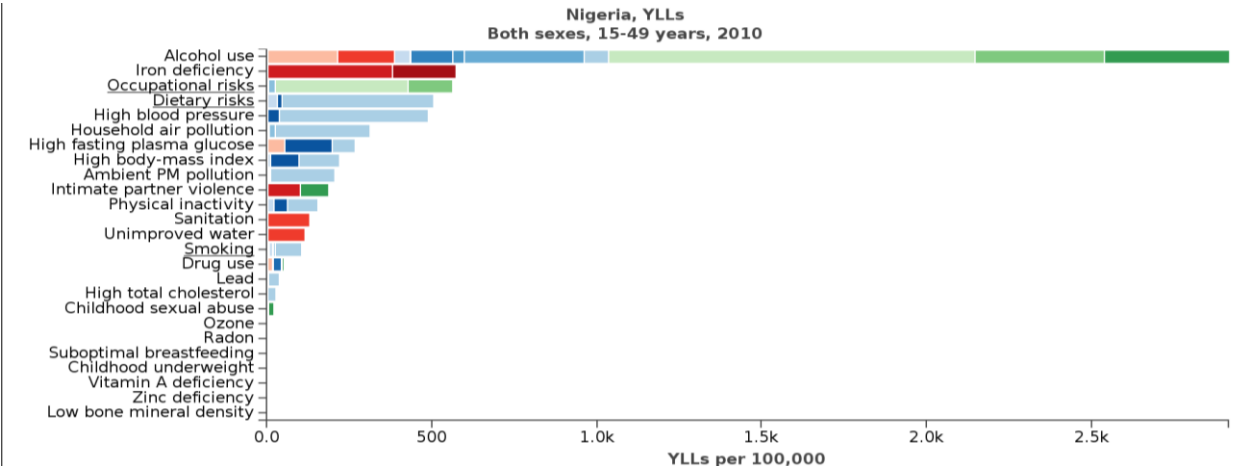
Health and epidemiological transitions are milestones that are symbolic of an epoch of dynamic population growth when the working population outstrips the dependent population. Substantively, Nigeria is entering the period of potential economic growth accruing from this demographic transition (demographic dividend). Consequently, health needs and challenges will be significant. This is because as epidemiological transitions occur (non-communicable diseases overtaking infectious diseases), health priorities are bound to change. These changes will negatively affect vulnerable people in the population. In view of this, health priorities and investments (preventive) in health which can improve the life expectancy of the working population are likely to overshadow the cost of treating older persons and sufferers of communicable diseases. Therefore, the preparedness of government and policy makers is important. The paper discusses imperatives of agenda setting and priorities that are not without ethical implications for vulnerable groups if the demographic dividend is to be maximized.

Introduction

As changes in population age structures, labor productivity and economic growth begin to emerge in Nigeria, scholars and demographers are beginning to relate these evidences to the era of the demographic dividend. While these dynamics play out in projections and assertions about the population of Nigeria, very significant issues are inherent in them. With all things being equal, declining birth rates and increased labour force supply is bound to raise the per capita income, but this is not without implication for other segments of the population. The consequence of declining mortality rate and rapidly increasing population of the elderly is a significant population scenario that adds a complex dimension to the demographic dividend discourse. To enumerate the benefits, it is acceptable that the elderly population will increase retirement investments in order to boost financial security. This will in turn reduce the burden of support for the elderly among the working population. This is a way of increasing assets; increasing workers' productivity as well as managing the cost of ageing. But on the flip side, where the burden of disease is increasingly shifting towards non-communicable diseases – NCDs, the capacity of savings, pre-retirement investments and support from the working population may not be able to match the cost of curative health. This is especially more dire when it is clear that treatment and health maintenance cost of NCDs are high and may not receive sufficient government intervention. Out-of-pocket spending in the population will be higher. This will occur when health priorities are focused on increasing the access of the young and working population to health care. Government and policy makers are also likely to consider the cost-effective way, in view of the assertion that \$1 dollar investment in health among the working population will yield about \$20 more. The overall effect of this on the per capita income is high, but not without consequence for the health of older persons which require hundreds and even thousands of dollars to settle. Realistically, in priority setting for health, ethical and cost related issues are germane contexts of discussions which are believed to shape health policies. It is imperative to note that governments' health agenda and priorities oscillate around the problems of cost-effectiveness, priority to the worst-off and financial risk protection.

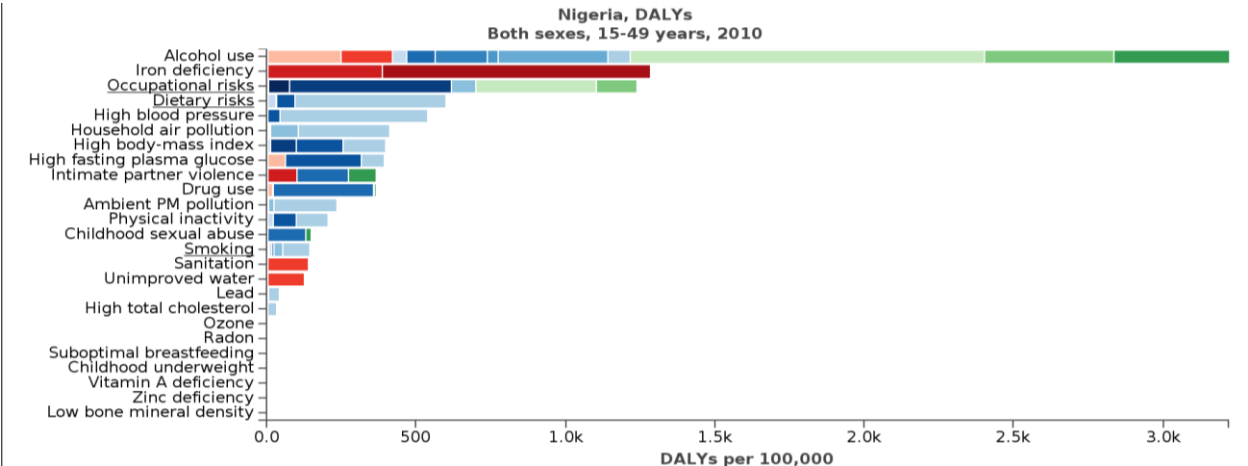
Taking direction from the arguments that have emerged from the Global Burden of Disease survey as presented by the Institute of Health Metrics and Evaluation, the range of disease conditions that predict the Years of Life Lost (YLLs) and DALYs (Disability-Adjusted Life Years) for young persons between the ages 15-49 years are similar. In Figures 1 and 2, selecting the big five YLLs and DALYs shows that alcohol use (2.5%), iron deficiency (.7%), occupational risk (about 0.6%), dietary risk (about .6%) and high blood pressure (about 0.5%) significantly constitute the burden of disease in the working population. Typically these conditions are all preventable and it reflects that health expenditure in the population lies within the domain of preventive health which is cheaper and easy to access. It also saves more lives. Because as the WHO has noted, health investment between \$1 and \$3 per person per year, will reduce the proportion of the population lost to premature deaths arising from NCDs from 38 million to about 16 million globally.

Figure 1: Nigeria– YLLs, both Sexes 15-49 years (Source: Calculated from GBD, 2010, Nigeria)



On the other hand, presenting the DALYs are the same set of disease conditions, which reinforces the fact that the cost effectiveness criteria focuses on the young/working population. Figure 2 reflects the same emphasis.

Figure 2: Nigeria– DALYs, both Sexes 15-49 years (Source: Calculated from GBD, 2010, Nigeria)



Thus, examining the global burden of disease among the elderly in Figures 3 and 4 (between ages 50 - 69 years; 70 years +), the disease conditions – high blood pressure, dietary risks, high fasting plasma glucose, household air pollution and alcohol use, are prevalent among persons of both sexes of the two

cohorts (50 – 69 and 70years +) calculated. In this regard, it is clear that the estimation of prevention and treatment alternatives are vital to health priority setting. This is because an estimation of the YLLs and DALYs shows the comparative advantage that the economic activities and labour force participation of the working population has, over the ageing population. In a developing country like Nigeria, premature death occurrence is to be classified as deaths before the age of 60 years, this is because of the social and cultural peculiarities of age classification. Most studies in Nigeria categorize the aged as beginning from 60, because it marks the statutory retirement age (Fayehun and Salami, 2014). Thus, if productivity and contribution to the labour force is to be discussed along this line, the basis for discussing cost effectiveness and focusing on the working population is justifiable.

Figure 3: Nigeria– DALYs, both Sexes 15-49 years (Source: Calculated from GBD, 2010, Nigeria)

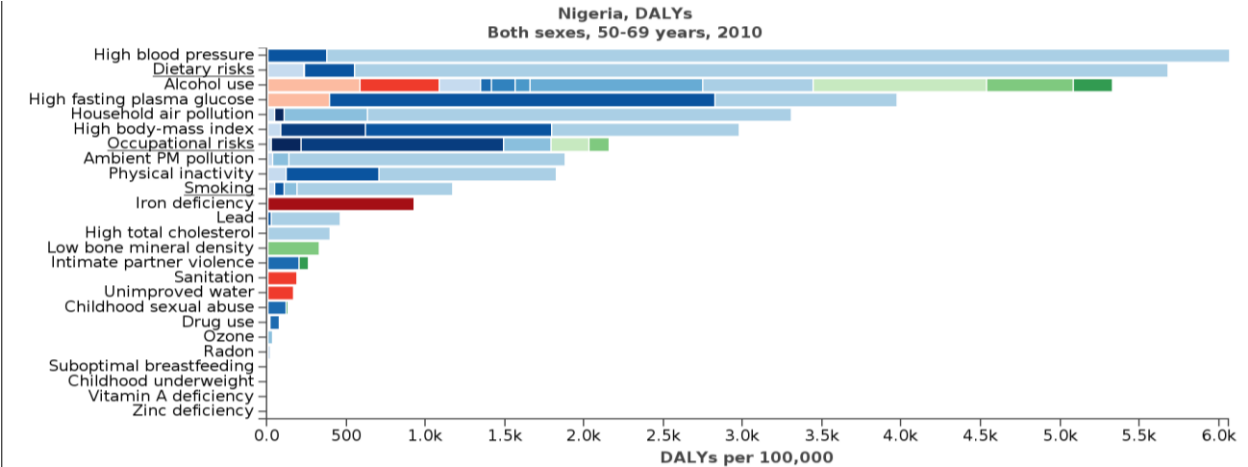
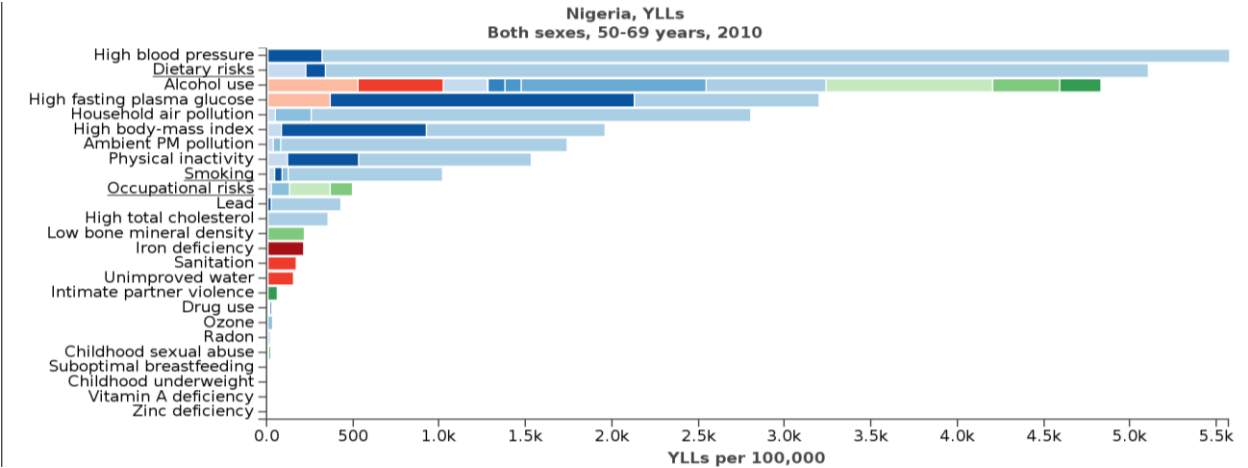


Figure 4: Nigeria– YLLs, both Sexes 15-49 years (Source: Calculated from GBD, 2010, Nigeria)



Substantively, this will hold if other issues that inform health priorities are not to be considered. In this regard, we refer to the conditions of giving priority to the worst-off and financial risk protection. Therefore, the paper argues for the inclusion of the elderly in the scheme of health care policies, notwithstanding their status and condition in the society.

Theoretical Focus

The theoretical focus of the paper is to expand the engagement of the **Political Economy of Ageing** as discussed by Estes and Binney (1989). In explaining the political economy of ageing, the process of

biomedicalization of aging is in fact central. This is in the light of the structures of social stratification in society and the socially and culturally defined ways of conceptualizing ageing. Emerging fundamentally from the classical works of Karl Marx and Max Weber, the political economy of ageing theory according to Estes, Linkins and Binney, 1996 in Quadagno and Reid (2008), analyzes the structural conditions that create inequality in old age and to emphasize the relevance of these struggles to how the aged are defined and treated. This theoretical background provides the basis for discussing the theoretical and empirical dimensions of how the socioeconomic status of older people shape their experiences of ageing as well as the role of policy interventions in shaping the outcome of ageing. Thus the theory examines the political and economic processes that facilitate the inequality that old people on the basis of age, gender and race experience. These are engaged within the context of access and utilization of the elements of distribution (social insurance, social assistance and fiscal welfare) in various forms of societies – capitalist or welfare societies. Within this theoretical framework, the paper discusses the roles of policies and the ways health priorities can deliver a measure of policy coherence that will ensure universal health coverage.

Data and research methods

In this paper, secondary data will be critically engaged. In the discussions, the paper will draw from a range of secondary databases and information set. Using the global burden of disease profile, the paper will identify the cohort health challenges in Nigeria. Also, in discussing country health priorities and policies, country data-bases, budgetary allocations and National Health Accounts database will be utilized. Life table calculations from World Population Prospects – 2012 Revision will be used for projecting and highlighting the demographic changes in Nigeria across the period of the demographic dividend. Using the life-table calculations, the paper will highlight the impact of reducing health investments among old people (with focus on non-communicable diseases) and how it will affect the life expectancy of the elderly population. Literature on ethics will also be used in discussing the ethical bases for prioritizing child/maternal health and the prevention of communicable diseases over curative health care needs – especially among older persons.

Expected findings

Expected findings are to deliver clear ideas about the future of the population structure changes that are gradually emerging and to develop fact based policy ideas which can ensure a balance in Nigeria's health system, while delivering Universal Health Coverage to all, irrespective of age, gender, and or ethnicity.