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FRAIL ELDERLY'S PERCEPTION OF QUALITY OF HEALTHCARE IN THE TEMA METROPOLIS, GREATER ACCRA

BY

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DECLARATION

I, Samuel Donkor, hereby do declare that except for references to other people's work, which have been duly acknowledged, this piece of work is my own composition and neither in whole nor in part has been presented for the award of a degree in this university or elsewhere.

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DEDICATION

I dedicate this dissertation to God the Father Almighty for his guidance and protection. I also dedicate it to my wife, Jemima Donkor and my two kids: Nkunim and Jonathan. Finally, I dedicate this work to my Mum and Dad, siblings and in-laws. God bless you all for your extraordinary love.

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LIST OF ABBREVIATIONS

ADL	Activities of Daily Living
AIDS	Acquire Immunodeficiency Syndrome
CMS	Centers for Medicare & Medicaid Services
DANIDA	Danish International Development Agency
EU	European Union
FE	Frail Elderly
GDP	Gross Domestic product
GHS	Ghana Health Service
HBM	Health Belief Model
HIV	Human Immunodeficiency Virus
HPPM	Health Policy Planning and Management
IDI	In-depth Interview
IFAD	International Fund for Agricultural Development
ISSER	Institute of Statistical, Social and Economic Research
LE	Life Expectancy
LMICs	Low- and Middle-Income Countries
MIAC	Ministry of Internal Affairs and Communications
MOH	Ministry of Health
NIPSSR	National Institute of Population and Social Security Research
POW	Programme of Work
PPP	Public Private Partnership
PWR	Participatory Wealth Ranking
SAGE	Study on Global Ageing and Adult Health
TDC	Tema Development Corporation
TMA	Tema Metropolitan Assembly
UHC	Universal Health Coverage
UN	United Nations
UNDESA	United Nations Department of Economic and Social Affairs
UNO	United Nations Organisation

USAID	United States Agency for International Development
WHO	World Health Organisation

DEFINITION OF TERMS

For the purpose of lucidity and constancy, key definitions used as fundamental concepts in this study are hereby presented below.

CHRONIC CONDITIONS: "Health problems requiring ongoing management over a period of years, even decades" (WHO, 2007; Day, Paul, Williams, Smeltzer & Bare, 2007, p. 149). These include: Non communicable diseases, some mental disorders, and, ongoing structural impairments such as joint disorders.

FRAILTY: A unique clinical syndrome using a set of five physical phenotypic components: unintentional weight loss, exhaustion, weakness, slow walking speed, and low physical activity with an underlying biological basis (Fried *et al*., 2001).

QUALITY: The degrees to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge.

SELF-CARE: The practice of activities that maturing and mature persons initiate and perform, within time frames, on their own behalf in the interest of maintaining life, healthful functioning, continuing personal development, and well-being, through meeting known requisites for functional and developmental regulations (Orem, 2001, p. 461).

SELF-EFFICACY: Perceived confidence in one's ability to conduct self-care interventions and about the future (Bandura, 1977; Frank-Strombod & Olsen, 2004).

SELF-ESTEEM: Trait or global self-esteem is a personality variable that represents the way people generally feel about themselves (Brown & Marshall, 2006, p.4).

ABSTRACT

Background: The World Health Organisation (WHO) statistics reveal that people worldwide are living longer; and currently, 125 million people are aged 80 years or older. However, the challenge is how to ensure the provision of a quality healthcare to the frail elderly.

Objective: This qualitative study explored the perception of the quality of healthcare among the frail elderly in the Tema Metropolitan Assembly.

Methods: A semi-structured interview guide was used to gather information on the perception of the quality of health care among fifteen (15) frail elderly within age 60+ years who were being assisted in more than two personal activities such as walking, and dressing. The interviews also explored the influence of health provider and socio-cultural factors on the perception of quality of healthcare among these frail elderly. The qualitative interview data was analysed using Nvivo after content analysis had been applied to identify the emerging themes from the transcripts. The findings of the study were explained using the health belief model and the health systems framework.

Results: The study found that the frail elderly acknowledged the imperative role that availability of facilities and equipment play in healthcare delivery. However, they did not know of any social policy existing to make their lives better or to improve their healthcare, considering their susceptibility to chronic and non-communicable diseases. It was evident that strong family attachments made the frail elderly fulfilled and felt healthier. The frail elderly felt a sense of feeling of wellness and hope of recovery.

Conclusion: The study concludes that there were inadequate nursing homes for the aged and that equipment were needed in frail elderly's nursing home to ensure their safety and quality of care. It was suggested that they would be much happier if there were policies that would provide the frail elderly with money or cater for their fundamental needs. The study further

concludes and recommends the involvement of the family and significant others as very important factors in the delivery of quality healthcare to the frail elderly.

CHAPTER ONE

INTRODUCTION

1.0. Background to the study

The World Health Organisation (WHO) statistics reveal that people worldwide are living longer; and most people can expect to live into their sixties and beyond (WHO, 2018). The WHO (2018) document continues that by 2050, the world's population aged 60 years and older will total 2 billion, up from 900 million in 2015, as currently, 125 million people are aged 80 years or older. This also means that by 2050, there will be almost as many as 120 million living in China alone, about 434 million people in this age group worldwide; and 80% of all older people will live in low-and middle-income countries (WHO, 2018). Putting it in a different perspective, the World Health Organization, reports that the global population of elderly people aged 60 years or more was 600 million in the year 2000, and it is expected to rise to around 2 billion by 2050 (Hareven & Adams, 1982; Buckinx *et al*., 2015; WHO, 2018).

Indeed, there are variations, which are based on the economic status of a particular country's context (WHO, 2007, 2015). For instance, in low-and middle-income countries, this is largely the result of large reductions in mortality at younger ages, particularly during childhood and childbirth, and from infectious diseases; while in high-income countries, continuing increases in life expectancy are now mainly due to declining mortality among those who are older (WHO, 2007, 2015).

Notwithstanding the above promising evidence, it should be noted that all countries face major challenges in their attempt to ensure that the health of the aging population and social systems are ready to make the most of this demographic shift (WHO, 2018). Amongst the challenges to deal with in the growing number of aged population is the issue of frailty (Buckinx *et al*., 2015). This is confirmed by earlier studies, which observed that with an

aging population, there is a growing interest for frailty (Karunananthan *et. al.*, 2009; Buckinx *et al*., 2015).

The distinction between frailty and aged has caused a bit of controversy amongst the academia, professionals and researchers alike (Buckinx *et al*., 2015). Buckinx *et al*. (2015) confirm that even though the concept is almost universally accepted, its operational definition remains controversial. Other analysts also argue that frailty is a state of increased vulnerability to poor resolution of homoeostasis after a stressor event and increases the risk for adverse outcomes, including falls, delirium, and disability (Clegg *et al*., 2013; Morley *et. al*., 2013; Buckinx *et al*., 2015). Meanwhile, others also indicate that frailty is the consequence of accumulated age-related defects in different physiological systems (Xue, 2011; Buckinx *et al*., 2015). Another definition is that it is a unique clinical syndrome using a set of five physical phenotypic components: unintentional weight loss, exhaustion, weakness, slow walking speed, and low physical activity with an underlying biological basis (Fried *et al*., 2001). Nonetheless, it was still valid to have a working definition for this study. Thus, the definition by Buckinx *et al*. (2015) was accepted as they explain that frailty is a major health condition that is associated with ageing; and it is a geriatric condition, which represents a huge potential public health issue at both the patient and the societal levels because of its multiple clinical, societal consequences and its dynamic nature.

The resultant question to address in the light of the growing aged population with frail elderly was: 'how do health policy makers ensure the provision of a quality healthcare for the frail elderly either at a facility based or home-based setting? It has to be stated that the issue will also relate to the quality of the healthcare that is provided to the frail elderly. Some researchers postulate that societal ageing will affect economic and health systems in all nations, including the ability of states and societies to both maintain contributions from and also provide resources for older population groups (Kowal *et al*., 2010).

Before an understanding is thrown on the choice of a setting for the provision or access to healthcare for the frail elderly, it is important to know the causes first. The causes necessitating the decision to adopt a particular setting for the delivery or access to healthcare for the frail elderly are numerous (Van der Geest *et al*., 2004). Van der Geest *et al*. (2004) even looked at this phenomenon from the perspective of migration and old age care provision indicating at least, four ways in which old age and migration cross each other's paths as explained below.

In the first instance, there are people who migrated for economic reasons, usually at a relatively young age, and who have grown old in a foreign country (Van der Geest *et. al*., 2004). In the second instance, there are older people who migrate when (or because) they are old: in Europe, they are mostly from the affluent northern countries and travelled southward (Van der Geest *et. al*., 2004). In the third scenario, there is increasing employment of, and demand for, immigrant workers in old-age institutions in the northern countries (Van der Geest *et. al*., 2004). In the fourth strand, there is the out-migration of young people, mainly from rural areas, that results in older people being left behind without children to look after them (Van der Geest *et al*., 2004).

With the above understanding that people migrate and will therefore, have the need for the care of their aged relatives leads to the choice of the setting. Three types of settings could be used to deliver healthcare to the frail elderly in the case of Ghana: hospital based, home-based and nursing homes (Van der Geest, Mul, & Vermeulen, 2004). It needs to be emphasised that medically, most of the frail elderly receive healthcare in a hospital based setting (Van der Geest *et al*., 2004). It is only when they are discharged that the need for home-based care becomes relevant. This means that under normal circumstances, there should be a link between the hospital and the home-based carers in order to ensure continuity of care for the frail elderly (Veras *et al*., 2014).

Veras *et al*. (2014) showed that the services provided were based on primary care, including services within the home; and service users relied on the integration of primary and hospital care, day centres and in-home and social services. These researchers found that care plans and case management were key elements in care continuity. This approach was shown to be effective in reducing the need for hospital care, which resulted in savings for the system (Veras *et al*., 2014).

Bauer *et al*. (2009) examined the available evidence concerning hospital discharge practices for frail older people and their family caregivers and the most beneficial practices for this group. These researchers concluded that hospital discharge planning for frail older people could be improved if interventions addressed family inclusion and education, communication between healthcare workers and family, interdisciplinary communication and ongoing support after discharge - interventions should commence well before discharge.

Other researchers also explain the need for home-based care for different health conditions affecting the frail elderly such as dementia (Dias *et al*., 2008; WHO, 2015). It is explained that home-based support for caregivers of persons with dementia, which emphasises the use of locally available, low cost human resources, is feasible, acceptable and leads to significant improvements in caregiver mental health and burden of caring (Dias *et al*., 2008; WHO, 2015). Despite the reality that this evidence was related to dementia, the concept of home based support could be adopted for frail elderly who have other medical conditions as well (WHO, 2015).

Associated with the provision of either hospital based or home based healthcare for the frail elderly is the issue of the quality of care. Veras *et al*. (2014) found that there was reduced prevalence of functional loss and improved satisfaction and quality of life on the part of service users and their families. These researchers argued that the findings reinforced the

need for change in the approach to health care for older adults and the integration and coordination of services was an efficient way of initiating this change.

In view of the above evidence that the aged population is growing and that there will be the need to ensure that health systems are improved to be able to address their needs, one fact that remained to be examined was the issue of provision of a quality of healthcare for the frail elderly in the Ghanaian communities. It was in this direction that this study was set out to explore the quality of care for frail elderly persons in the Tema Metropolitan Assembly area of the Greater Accra Region.

1.1. Problem Statement

People of today live longer lives on average than at any other point in history (WHO, 2015). Globally, life expectancy (LE) has increased from 64.5 years in 1990 to 71.7 years in 2016 (United Nations Department of Economic and Social Affairs (UNDESA), 2015). There is a projection of a 55.7% increase in the number of persons aged 60 years and older by 2030 (UNDESA, 2015). In China, for instance, healthy life expectancy at age 60 years was 16.5 (LE 20.8 years) for women and 14.2 years for men (LE 18 years) by the year 2016 (WHO, 2016). However, many older adults develop chronic diseases and disability as they age, and have poor quality of life in their later years (Fried *et al*., 2004; Abellan *et al*., 2008).

It is therefore, important to know that frailty and disability are common in older age, which are an inevitable part of ageing. The prevention or postponement of frailty and disability is therefore, necessary to maintain the health and functioning of ageing populations. Factors that mitigate both frailty and disability operate not only at the individual level, but are also present in the supporting environment, community and networks (Satariano, 1992; Abellan *et al*., 2008).

In lower-income countries or in resource poor settings around the world, access to health services is often limited (Beard *et al*., 2009). Health workers may have little training in how to deal with issues commonly in older ages, such as dementia or frailty, and opportunities for the early diagnosis and management of conditions, such as high blood pressure, which is a key risk factor for the biggest killers of older people, heart disease and stroke may be missed. This can be seen in findings from the WHO Study on Global Ageing and Adult Health (SAGE), which drew on nationally representative samples of older people from China, Ghana, India, Mexico, the Russian Federation and South Africa (Beard *et al*., 2009; WHO, 2015).

In discussing the quality of healthcare, much greater attention needs to be paid to the working conditions of nurses, care assistants and home care workers. In the hospital and at home, the majority of staff providing the physical and emotional care for older people have very few qualifications, are on low pay and have low social status, and there is widespread acceptance of these very poor working conditions that would be unthinkable for staff in other areas of healthcare (Dunkley & Haider, 2011). Dunkley and Haider (2011) assert that in the community, the number of district nurses was falling and there was concern that the workforce was ageing. The issue is that district nurses are being replaced by general qualified nurses and care assistants and, indeed, untrained care assistants deliver most care in patients' own homes.

Despite the fact that nursing frail older people with complex needs require knowledge and skill, as well as empathy, emotional reserve and common sense, there is no specialist qualification in nursing care for older adults (Department of Health, 2011). To address the challenge in the United Kingdom, the government announced minimum standards for training and a code of conduct for healthcare support workers and adult social care workers (Department of Health, 2011). A Department of Health (2011) document emphasised that

assessing the quality of healthcare for the frail elderly patients with complex needs is hard and testing, that is physically, psychologically and emotionally. The World Health Organisation (WHO) outlines four challenges for policy development regarding the health of the aging population (WHO, 2015). However, studies have examined some of the problems associated with the delivery of quality healthcare to the frail elderly as discussed below.

The problems related to socio-demographic / economic factors in health care acquisition exist in most countries and in general, wealthier people are more likely to use health care services - there is an evidence of a positive association between wealth and use of healthcare in rich and poor countries (Albanese *et al*., 2011; Rodin *et al*., 2012). Generally, economic factors, such as higher economic or wealth status, financial support, and health insurance, are associated with healthcare utilization among older adults (Roy & Chaudhuri, 2008; Wong & Dı´aoz, 2007; Li *et al*., 2006). Older adults in lower income countries may not have access to financial support or pensions, making them more economically vulnerable (Albanese *et al*., 2011; Kuo & Lai, 2013). Yumin *et al*. (2011) identified a statistically significant difference in the use of assistive device for walking between frail elderly living in a nursing home and those living in a home environment. This suggests that the role that socio-cultural environment plays in the provision of a quality healthcare for the frail elderly cannot be overlooked.

Another problem confronting the provision of a quality healthcare to the frail elderly is related to the health system or health provider factors. It is argued that health systems around the world address two broad objectives in health: efficiency and equity (Cuyler, 2006). Policymakers share the common concern regarding how to find the right balance between these objectives (Kaplan & Merson, 2002; Victora *et al*., 2003). The challenge related to the provision of a quality healthcare for the frail elderly also sits on the of these two concepts. While the definition of efficiency is that it aims to maximize population health given a certain

budget, equity, or fairness, aims to minimize differences in health among population groups, with special reference to the severely ill, disadvantaged or vulnerable populations (Whitehead, 1991).

The challenges confronting the the desire of policy makers to provide efficient and equitable healthcare are evident in the context of Ghana as well (see Ministry of Health (MOH), 2005). The Ministry of Health (MOH) in Ghana also recognizes the need to consider both efficiency and equity objectives in health (Ministry of Health, Ghana, 2005). This vision was expressed in the second Five Year Programme of Work (POW 2001–2006) which has been revised in the current healthcare strategy was to improve the health status and reduce the inequalities in health outcomes of all people living in Ghana (Ministry of Health, Ghana, 2005).

Furthermore, the problems confronting access to a quality healthcare among the frail elderly could be viewed from the socio-cultural factors as well. The view is that most people aspire to live a long and healthy life, and older people can be valuable economic, social, cultural, and familial resources (Centers for Medicare & Medicaid Services (CMS), 2016). It is noted however, that ageing populations are also likely to be associated with a shrinking workforce and higher demand for healthcare, social care, and social pensions (CMS, 2016). It is estimated that roughly 25% of the marked heterogeneity of health and function in older age is genetically determined (Brooks-Wilson, 2013). The remainder is dominated by the cumulative impact of health behaviours and inequities across the life course (Oxley, 2009). Thus, someone born into a poor family with limited access to education, or in a marginalized cultural group, is also more likely to experience poor health in older age and earlier mortality - there may even be an association between the ability to build financial security in older age and decisions that maintain healthy behaviours (Age Wave, 2011).

Against the background of the above discussed problems (socio-demographic, health system or provider and socio-cultural) influencing the provision of a quality healthcare to the frail elderly, the below discussed gaps in literature served as the justification for the conduct of this study on the perception of quality of healthcare among frail elderly in the Tema Metropolitan Assembly area of the Greater Accra Region.

1.2. Justification of the Study

Studies show the view that in current ages, the common and long-running concern across the world relates to the impact of increasing longevity on healthcare utilization (Rechel *et al*., 2009; Bloom *et al*., 2012). This is a problem, particularly for low-and middle-income countries (LMICs) where 65% of the world's population aged 60 and older currently resides, with this proportion expected to increase to 79% by 2050 (United Nations, 2013). Consequently, there are now strong ethical, political, economic and health arguments being discussed and debated in global forums regarding Universal Health Coverage (UHC) (World Health Organization, 2018). Global interest in UHC may provide an impetus to address these and other major policy challenges faced by governments in LMICs - thus, healthier aging cohorts and risk pooling under UHC may provide a path for a sustainable health service financing and delivery for the frail elderly (Bristol, 2014). The gaps identified in literature on how to provide a quality healthcare to the frail elderly could be summed up from studies, which suggest that assessment of healthcare among older adults in both LMICs and high-income countries is variously influenced by demographic, economic, cultural and health status/system factors (Redondo-Sendino *et al*., 2006; Albanese *et al*., 2011). these gaps have been narrated below.

The analysis showed that there were gaps related to the socio-demographic/economic factors when it comes to the provision of a quality healthcare for the frail elderly (Albanese *et al*.,

2011). For instance, some researchers note that most women who are elderly use primary care and community health services more than men who are elderly, and also older men use inpatient services more often than older women (Redondo-Sendino *et al*., 2006; Roy & Chaudhuri, 2008; Albanese *et al*., 2011). Similarly, studies show that there was a higher inpatient healthcare in urban compared with rural areas in LMICs (Albanese *et al*., 2011). In China, researchers identified rural-urban disparity in health service use with rural respondents using physician's services less than urban respondents and hospitals more (Liu *et al*., 2007). Factors associated with health care assessment among older adults include older age (Wong & Dı´az *et al*., 2007), higher education, living alone, worse self-perceived health (Guerra *et al*., 2001), chronic illness (Paskulin *et al*., 2011), and depressive symptoms (Peytremann-Bridevaux *et al*., 2008). Despite the fact that these issues affect the perception of the provision of a quality healthcare to the frail elderly, it was evident that no particular study had explored these factors in relation to the perception of frail elderly in Ghana in general and the Tema Metropolitan Assembly area in particular. This study sought to address this gap accordingly.

There was a gap in the literature related to the health system/provider factors. Even though earlier studies have suggested that the provision of a quality healthcare for the frail elderly could be viewed from the availability of accessible, and affordable quality health care, it appeared that there were few studies that had examined these in terms of the health system or provider factors (Lloyd-Sherlock, 2000; Fenton *et al*., 2012). It is important to note that quality of healthcare must be made accessible in every age group not just among the elderly. The focus here was on the frail elderly because they have been a much-neglected population in terms of health interventions. Therefore, it is a fundamental right of everybody to be healthy not just the mothers, children and other more widely researched groups (Mba, 2010). Most public health intervention programmes are on maternal and child health, HIV/AIDs,

fertility control to mention but a few - surprisingly very little was known about the elderly specifically, the frail elderly in terms of their access to a quality healthcare (Mba, 2010).

Another limitation identified in literature focused on socio-cultural factors that had not been examined in the few studies on access to a quality healthcare among the frail elderly (Kakwani, & Subbarao, 2005). The argument was that the vast growth of the aged population poses many challenges as chronic diseases and disability are unreasonably high among older people - a growing elderly population increases the demand for healthcare and other social services (United Nations Department of Economic and Social Affairs, 2007). Due to their low economic development, inadequate health infrastructure and limited social security programmes, meeting the needs of older people in the developing world and especially in sub-Saharan Africa is and will be difficult (Kalasa, 2001). This is likely to be compounded by the erosion of the traditional family support systems for older people. Therefore, policies and programmes that address the health and other needs of the growing aged population are urgently needed to ensure successful ageing and functional independence of the aged (Kakwani, & Subbarao, 2005). Yet there appeared to be some gaps in this regard in the literature since no study had accessed the influence of socio-cultural factors on access to a quality healthcare among the elderly in the study area, Tema Metropolitan Assembly area.

Despite the seeming waning of social relationships in contemporary African and Ghanaian societies requires that health research in developing countries, including Ghana has been and continues to be heavily focused on younger population groups - few studies have been done on the aged (Mba, 2007). As such, the extent of ageing, the health needs of the ageing population, as well as the implications of national policies for the health and welfare of the aged are poorly understood and yet to be well appreciated (Mba, 2007). For this reason, some researchers argue that questions about changing health over the life course and compression of morbidity demand an empirical basis for analysis, particularly in the context of planning

and preparing social protection mechanisms, health and pension systems to meet the demands of this growing population group (Rosenberg, 2008).

In summing up, the frail elderly must be on the priority list of quality healthcare assessment in target interventions since they are perceived to be reservoirs of wisdom, knowledge and experience in life and also their vulnerability to so many health conditions as much as HIV infected patients, pregnant women and children (Kakwani, & Subbarao, 2005). Therefore, exploring the perception of quality of healthcare among the frail elderly in Ghana would give an insight into what health provider and social factors affect the health of people as they age. This would pave the way for further research and inform policy makers to target health policy goals that would make healthcare accessible to the frail elderly; and ensure humane conditions under which people grow and live.

Reflexivity: The researcher had experience as a healthcare provider, which helped to contribute to the discussion on the topic of access to healthcare among frail elderly and related matters.

1.3. Objectives of the Study

The objectives of the study have been categorized into general and specific as explained below.

1.3.1. General Objective

The general objective of the study was to explore the perception of the quality of healthcare among the frail elderly in the Tema Metropolitan Assembly area in the Greater Accra Region.

1.3.2. Specific Objectives

The specific objectives were as follows:

1. To explore the frail elderly's perception of the quality of healthcare in the Tema Metropolitan Assembly area.
2. To explore the frail elderly's perception of the influence of health system/provider factors on the quality of healthcare in the Tema Metropolitan Assembly area.
3. To explore the frail elderly's perception of the influence of socio-cultural factors on the quality of healthcare in the Tema Metropolitan Assembly area.

1.3.3. Research Questions

The following questions helped to find answers to address the specific objectives:

1. What is the frail elderly's perception of the quality of healthcare in the Tema Metropolitan Assembly area?
2. What is the frail elderly's perception of the influence of health system/provider factors on the quality of healthcare in the Tema Metropolitan Assembly area?
3. What is the frail elderly's perception of the influence of socio-cultural factors on the quality of healthcare delivery in the Tema Metropolitan Assembly area?

1.4. Outline of the Dissertation

The report of the dissertation is presented according to six chapters. The chapter one is where the introduction is presented. What is shown here include the background, problem statement, justification, objectives, and research questions of the study. In chapter two, there is the review of present literature on the concepts and related studies on the topic under consideration. What is presented in chapter three is the methods that were applied to collect data for subsequent analysis in this study. In chapter four, the results or findings as analysed from the qualitative interviews have been enumerated and presented. The chapter five is where the findings of the study have been explained using the chosen theoretical framework

and related to present literature. In chapter six, the summary of the study, conclusions and recommendations, among others, have been presented.

CHAPTER TWO

LITERATURE REVIEW AND CONCEPTUAL FRAMEWORK

2.0. Introduction

This chapter presents reviews of studies carried out in the area of the quality of health care for the frail elderly. It further explores the socio-demographic and socio-cultural factors that affect the quality of health services among the elderly. The chapter has been grouped according to sections outlining these themes. The chapter ends with a summary which also presents the reader with an idea of what to follow from this chapter.

2.1. Health Sector in Ghana

Ghana's economy is dominated by agriculture, which contributes about 39.3% of the Gross Domestic Product (GDP), trailed by the services sector (32.9%) and lastly, the industrial sector, representing 27.8% (ISSER, 2006). The Ghanaian economy averaged a real GDP growth of 5.3% over the period 2000-2008. It is approximated that about 50% of the population rely on agriculture for their livelihood. Therefore, it is relevant to note that Ghana is the second largest producer of cocoa in the world, only next to Cote D' Ivoire (ISSER, 2006).

It is also the second largest producer of gold and third largest producer of timber in Africa (see ISSER, 2006). In recent times, the economy exports non-traditional commodities such as pineapple, banana, yam and cashew nuts. Moreover, tourism is gaining relevance as a foreign exchange earner. Ever since Ghana gained independence from British colonial administration in 1957, several policy interventions have been employed to basically achieve economic growth and the subsequent trickle-down effect on the other sectors of the economy, including the social sector of which health is prominent (see ISSER, 2006).

In the area of health care, the public and private sectors are important stakeholders with the public sector organized according to national (4 teaching hospitals), regional (10 regional hospitals), district (281 district public and other hospitals), sub-district (622 public health centres) and community (about 1,658 Community Health Planning Service and maternity homes) levels (Ghana Health Service, 2005). Most modern health care is complemented by traditional medicines, which are quite popular among rural dwellers. Out of the 281 districts and other hospitals, over 50% are private or mission hospitals (Ghana Health Service, 2005).

Notwithstanding, the private and mission health facilities are greatly supported by government through staff salary and other facilities (Ghana Health Service, 2005). They provide both outpatient and inpatient services. At the sub-district level where health centres are the highest health facilities and first line of referral to formal health from the community clinics and maternity homes, over 98% of them are public or belong to the government. That is to say, mission or private sector participation in the operation of health centres is very low (Akazali *et al*. 2008). The Ministry of Health (MOH) is the central government institution in charge of sector-wide policy development, financing, regulation, monitoring and evaluation using its agencies, including Ghana Health Service (GHS), which is an executing agency responsible for health service delivery (Ghana Health Service, 2005).

However, despite the strategically dispersed location of health centres in Ghana, the teaching, regional and district hospitals still have to struggle with outpatient and other primary health related cases, which could be handled at the district level creating long queues and congestion (Ghana Health Service, 2007). Ghana faces acute shortage of health personnel. For instance, in the year 2006, 1,180 Ghanaians shared one hospital bed while one medical doctor attended to 14,908 patients as compared with the World Health Organizations' (WHO) norm for sub-Saharan Africa of 1 medical doctor to 7,500 patients (Ghana Health Service, 2007).

The problem of inadequate health personnel is further compounded by frequent industrial action accompanied by poor working conditions and low remuneration (Ghana Health Service, 2005). The health sector is also characterized by persistent movement of health workers and over the period (1993-2002), 3,157 health workers, representing 31% left Ghana for greener pastures (ISSER, 2003). This is against the backdrop that Ghana receives medical aid in the form of medical doctors from Cuba, who are usually posted to the remotest parts of the country. Anecdotal evidence has it that there are more Ghanaian medical doctors in the State of New York of the United States of America alone than the resident doctors of Ghana (see ISSER, 2006).

In the area of healthcare financing, health spending lags behind other equally important sectors such as education and interest payment (Ghana Health Service, 2007). Public spending on healthcare remains one of the less controversial roles of government partly due to its spillover effect on GDP. Although, per capita public health spending has been increasing steadily over the period (2000-2006), it is still below the levels achieved by sub-Saharan African countries such as Mauritius, Botswana and South Africa (Ghana Health Service, 2007).

In 2003, the WHO reported that Ghana's per capita public health expenditure was US$31 while Mauritius had US$105 (WHO, 2003). It is worth mentioning that the boost in public health spending in Ghana has been fueled by donor support. For instance, donor support as a proportion of public health spending amounted to 11.1%, 16.2% and 14% in 2003, 2005 and 2006 respectively (GHS, 2007). The donor support excludes projects directly initiated and implemented by the donor agencies such as Danish International Development Agency (DANIDA), European Union (EU) and United States Agency for International Development (USAID) (see ISSER, 2006; GHS, 2007).

2.2. Frailty and health implications of ageing

Fried *et al*. (2001) proposed a phenotype definition of frailty as a unique clinical syndrome using a set of five physical phenotypic components: unintentional weight loss, exhaustion, weakness, slow walking speed, and low physical activity with an underlying biological basis. As aging is associated with frailty, studies have recommended a policy of universal non- means- tested old age security to provide basic income for persons aged 60 years and above in Ghana (Issahaku, & Neysmith, 2013). It is established that older persons are concentrated in the rural areas of West Africa and a higher proportion of this demographic group is female (Issahaku, & Neysmith, 2013). Issahaku and Neysmith (2013) point out that the majority of older persons in West Africa has low formal literacy, is in the informal economy, and has no income security in old age. These analysts not that, yet, older persons continue to play the significant role of grandparenting. Issahaku and Neysmith (2013) examined Ghana's policy on ageing and revealed inadequacies, which need to be addressed - a policy of universal non- means- tested old age security to provide basic income for persons aged 60 years and above.

The gradual ageing of the global population and the continuous attendant increase in public spending on health and social care are seen as a major threat to worldwide economic stability in the 21st century (Aksoy *et al*., 2015). Global epidemic of chronic disease situations is strongly associated with the ageing population (Prince *et al*., 2015). Prince *et al*. (2015) reported that 23% of the global burden of disease arises in older people and chronic diseases accounting for most of the burden, with leading contributors being cardiovascular diseases, cancers, chronic respiratory diseases, musculoskeletal diseases, and mental and neurological disorders.

A World Health Organisation (WHO) report showed that about 60% of deaths worldwide was caused by chronic conditions and that by 2020, this number is expected to rise to almost 75% (WHO, 2008, 2010). It is noted that chronic disease increases medical expenses and reduces the productivity of labour of caregivers as the economic burden of chronic diseases is immense (see WHO, 2010; Huber *et al*., 2013). Huber *et al*. (2013) reported that in the United States, chronic diseases account for 75% of the total expenditure. A WHO (2010) document further stated that each year, 100 million people are pushed into poverty because they have to pay directly for health services; and in some countries, this may represent 5% of the population forced into poverty each year. The challenge is that Africa bears a significant percentage of the global burden of chronic diseases, along with poor countries of Asia and Latin America (De-Graft Aikins *et al*., 2010). De Graft Aikins *et al*. (2010) observed that, over the next ten years, the African continent would experience the largest increase in death rates from cardiovascular disease, cancer, respiratory disease and diabetes.

It is important to note that there is unprecedented increase in the elderly population globally (WHO, 2015). Available statistics show similar trends in all regions and districts of Ghana (Yiranbon *et al*., 2014). The increases in life expectancy from the age of retirement continue to increase, for both men and women in the various regions of about four years and over two decades from 1990 (Ellis & Langhorne, 2005). However, it is indicated that not all these additional years are spent in good health - although the incidence of some disabling conditions is falling, for instance, stroke, it is however, not true for fragility fractures or arthritis (Stuck *et al*., 1993).

A study found that about half the extra time of older people is associated with some disability (Anderson *et al*., 2005). Anderson *et al*. (2005) explain that a disability such as limited mobility or needing help in day-to-day tasks like washing or dressing could be linked to a range of limitations such as breathlessness, weakness, fatigue, forgetfulness or pain, and is

often associated with identified medical conditions. The fact is that many individual diseases produce similar outcomes in terms of functional disability and reduced quality of life for older people (Anderson *et al*., 2005).

Furthermore, many common conditions share risk factors for their causation - it is perhaps not surprising that the severity of individual diseases only contribute to some usually less than half of the variation in functional ability of older people (Age Ageing, 2007). In addition, taking a longitudinal perspective, many older people lose functional ability without there being a clear-cut single diagnosis to explain it (Anderson *et al*., 2005). Anderson *et al*. (2005) provided the explanation for this 'extra' disability, which includes a wide range of age-related changes affecting cell metabolism, organ function, mental health, homeostasis and integration. The challenge is that when individuals lose critical amounts of reserve at any or all of these levels, then they become particularly vulnerable to adverse health states such as functional dependency, hospital admission or even death.

Therefore, this generation has a greater responsibility of honouring and guaranteeing better living conditions for the elderly (Sandberg *et al*., 2014). Sandberg *et al*. (2014) suggest that the society has been built through the efforts and toils of previous generations some of whom still live with us as older persons; and there was the need to make efforts to provide them with efficient healthcare services and favourable living environment to ensure that they advance in age actively and with adequate security and recognizable dignity. This is the reason why the Ghana National Ageing Policy presents a framework that is capable of transforming the lives of the frail elderly, towards achieving the overall social, economic and cultural re-integration of the elderly into mainstream society to enable them participate in the development of the nation (Sandberg *et al*., 2014).

2.3. Quality of Healthcare

The main focus of healthcare delivery, in addition to saving lives and preventing diseases, is to ensure that the care provided is of high quality (World Health Organization (WHO), 2006). However, the definition of the word 'quality of care or healthcare' has been a source of debate among practitioners and academics (Blumenthal, 1996; WHO, 2006). Steffen (1988) stated that the definition of quality is not as consisting of the properties of an object but rather as the capacity of these properties to achieve goals. This researcher defined quality medical care as the capacity of the elements of that care to achieve legitimate medical and nonmedical goals.

In addressing the healthcare needs of the frail elderly, the Donabedian's (1988) healthcare model cannot be overlooked. Donabedian's (1988) conceptual model provides a framework for examining health services and evaluating quality of healthcare (McDonald *et al*., 2007). According to the model, information about quality of care can be drawn from three categories: 'structure, process, and outcomes' (Donabedian, 1988; McDonald *et al*., 2007). Structure describes the context in which care is delivered, including hospital buildings, staff, financing, and equipment. The process denotes transactions between patients and providers throughout the delivery of healthcare. Notwithstanding, outcomes refer to the effects of healthcare on the health status of patients and populations (Donabedian, 1988). Donabedian (1988) stipulated that the outcome measures remain the ultimate validators of the effectiveness and quality of healthcare but can sometimes be difficult to define and have time lags (Frenk, 2000).

While there are other quality of care frameworks, including the World Health Organization's (WHO) - recommended Quality of Care Framework and the Bamako Initiative (Donabedian,

1992; Derose *et al*. 2001), the Donabedian's (1988) Model continues to be the dominant paradigm for assessing the quality of healthcare. This study therefore, was guided by the Donabedian model of healthcare. Hypothetically, the model lookas the description in figure 2.1.

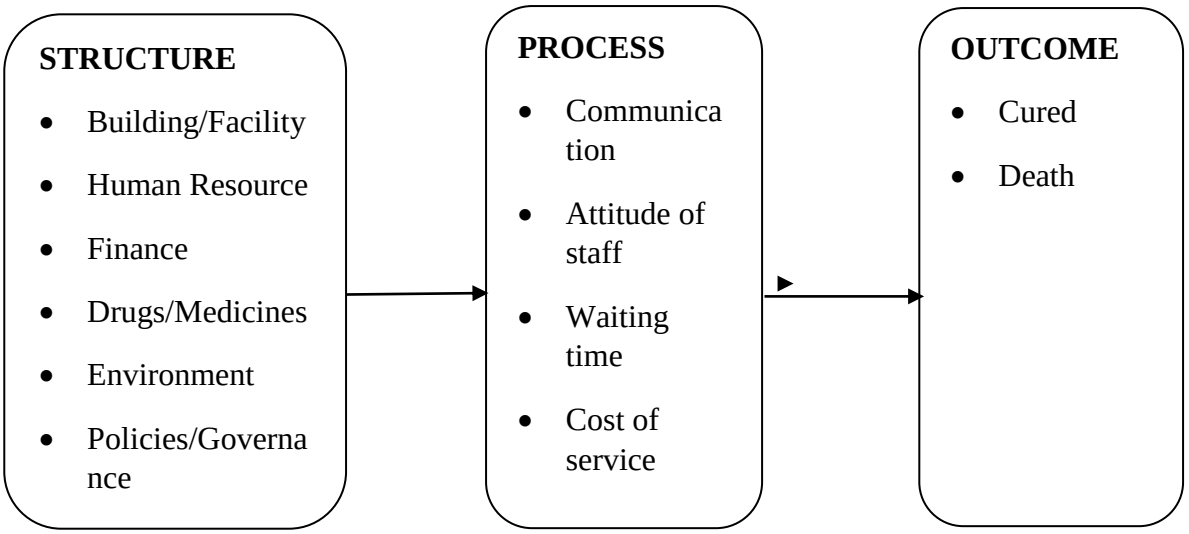

Figure 2.1: Hypothetical quality of care based on Donabedian's (1988) model.

The above conceptual framework was adapted in the development of the quality of care model for this study (see figure 2.4). It would be seen that different factors could influence the perception of quality of care among different people, including the frail elderly (Ng, Hakimi, Byass, Wilopo, & Wall, 2010). For the purposes of this study, the factors presented below were considered as having an influence on the frail elderly's perception of a quality healthcare.

2.4. Factors Influencing a Quality of Healthcare for the Frail Elderly

This section presents analysis of related studies on factors that influence the quality of healthcare for the frail elderly. These may be socio-demographic, health system or socio-

cultural factors influencing the perceptions of a quality of healthcare for the frail elderly in the Tema Metropolitan Assembly area, as presented below.

2.4.1. Structure / Health System Factors

The Donabedian's (1988) quality of care model and the health system framework (see WHO, 2006) have been suggested as models that could be applied in studies on quality of care. In this sense, a combination of the two models provided the basis to look at the structure elements that could influence the frail elderly's perception of quality of healthcare in this study. Therefore, the health system structure looks at the elements or the substances needed to carry out the health services activities, which may include; health facility or equipment, the staffing, policies and the resources (see WHO, 2006). The health system factors in this research were based on health responses in various health domains covering affect, cognition, interpersonal activities and relationships, mobility, pain, self-care, sleep/energy and vision (Salmon *et al*., 2004).

It could be argued that the expected growth in the ageing population in Ghana poses significant challenges to the health system and government (Saeed, Oduro, Ebenezer, & Zhao, 2012). Presently, the health system focuses more on battling infectious diseases such as malaria, cholera, tuberculosis and diarrhea but resources have therefore, not been allocated proportionally to the larger and increasingly threatening burden of chronic non-communicable diseases such as heart diseases, stroke, diabetes, cancer and hypertension (Abikusno, 2007). Abikusno (2007) notes however, that studies on health systems and quality of healthcare among the older population are largely lacking, and very little is known about morbidity among Ghana's older population (Abikusno, 2007).

Although population ageing is mostly associated with industrialised societies such as Europe, America and Japan, the phenomenon is gradually gaining attention in the developing world (World Health Organization (WHO), 2015). Japan amongst other countries in the world has the highest life expectancy and a persistently low birth rate - Japan's population is aging more rapidly than that of any other country (Ministry of Internal Affairs and Communications, Japan, 2016). The proportion of people aged 65 years and older was approximately 10% in 1985 - this proportion doubled to 21% in 2007, making Japan a hyper-aged society (Rockwood *et al*., 2005). In view of this, Japan has started attempts to adapt strategies in order to maximize older people's health and to facilitate healthy aging via maintaining their functional capacity and preventing disability and dependence (Muramatsu & Akiyama, 2011).

Notwithstanding, in Ghana, life expectancy was: Male 62.5, female 64.4 and total life expectancy was 63.4, which gave Ghana a World Life Expectancy ranking of 155 (WHO,2018). The rapid growth of the aged population poses various challenges - chronic diseases and disability are disproportionately high among older people (WHO, 2015). That is, a growing elderly population will increase the demand for healthcare and other social services. Due to their low economic development, inadequate health infrastructure and limited social security programmes, meeting the needs of older people in the developing world and especially in sub-Saharan Africa is and will be difficult (WHO, 2018). Hence, it is suggested that policies and programmes that address the health and other needs of the growing aged population are urgently needed to ensure successful ageing and functional independence of the aged (WHO, 2018).

Saeed *et al*. (2012) suggest that, adjustment for health status (comorbidity) among the ageing Ghanaian population nullified the socio-economic gradients in consulting with orthodox medical services - the outcome points to a potential link with the Ghanaian health policy. Some of the structure elements that could influence the frail elderly's perception of a quality healthcare have been discussed below.

Availability of health facility and equipment

Without the presence of health facilities and equipment, healthcare for the frail elderly would be in shambles. Baum *et al*. (2003) identified the important role facilities and equipment play in the healthcare delivery in a nursing home. A systematic review on the most important ethical considerations in the field of assistive technology (AT) in the care for community-dwelling elderly people, found three main themes (Zwijsen, Niemeijer, & Hertogh, 2011). Zwijsen *et al*. (2011) reported that the first theme was personal living environment, which involved the sub-themes of privacy, autonomy and obtrusiveness; the second theme was the outside world, which involved the sub-themes of stigma and human contact; and the third theme was the design of assistive technology devices, which involved the sub-themes of individual approach, affordability and safety.

Availability of health Professionals

Oeseburg *et al*. (2013) showed that an inter-professional education programme for professionals with different educational backgrounds was feasible and had an added value to the redefining of tasks and responsibilities among general practitioners and practice nurses. However, it is empirical that the human resource base is beefed up for the running of any home for the frail elderly (Oeseburg *et al*., 2013). A study argues that the number and proportion of older persons in the United States is rapidly increasing and significant

deficiencies are projected in the country's capacity to deliver the medical, public health, and support services needed for the future frail and ill older population, and the nation is not investing sufficiently in keeping people healthy late in life (Rowe, Fulmer, & Fried, 2016). Rowe *et al*. (2016) recommend that valuable advances are needed in four vital directions central to the health and well-being of older persons, especially those at greatest risk owing to medical conditions or social disadvantage. It is expected that all these could be realised if there was the availability of the required number of health professionals to deliver their respective roles in ensuring that quality healthcare was provided to the frail elderly.

Health system policy and financing

Some researchers discussed the impact of policies and regulations on achieving the principal aims of healthcare and suggested the need for a strategy to conduct better applied research on environmental interventions (Pynoos *et al*., 2008). Pynoos *et al*. (2008) emphasised on the importance of having policies and guiding principles in achieving quality of care within the healthcare settings. Eklund and Wilhelmson (2009) found that the average cost associated with the use of health resources was 1,922€/year as frail participants had an average total cost of health resources of 2,476€/year, pre-frail 2,056€/year, non-frail 1,217€/year, 67% of the total health cost was associated with hospital admission cost, 29% with specialist visits cost and 4% with emergency visits cost. In view of this, one of the questions that this study sought to answer was: who pays for the costs associated with the frail elderly's access to healthcare?

Availability of resources

A study found that frailty and comorbidity were the most important factors associated with the use of hospital healthcare resources (Eklund & Wilhelmson, 2009). Other researchers observe that be it human, capital or material resources, there is a vast necessity in the nursing

homes for the frail elderly (Baum *et al*., 2003). Baum *et al*. (2003) note that resources are needed in the frail elderly homes to help achieve therapeutic and recreational benefits for the frail elderly. Eklund and Wilhelmson (2009) concluded that frailty and comorbidity were meaningful and complementary associated with increased hospital healthcare resources use, and related costs. Due to the reality that governments may struggle to provide all the needed care to the elderly, countries have occasionally, developed strategies to include other stakeholders (Jacobsen, & Mekki, 2012). Jacobsen and Mekki (2012) confirm that the elderly care sector in Norway is extensive and mainly public, with only a small fraction being run by commercial firms or by voluntary organizations. This is also attributed to the changes in governments' attempt to revise their systems. For instance, as the Norwegian welfare state has been changing quite much during the latest two decades, the same holds true for the elderly care sector (Jacobsen, & Mekki, 2012).

2.4.2. Process

The process segment of the Donabedian's (1988) quality of care model suggests that patients or clients are able to assess the extent of the quality of care accessed based on the interactions between them and the healthcare providers (Birhanu, Assefa, Woldie, & Morankar, 2010). Birhanu *et al*. (2010) suggest that healthcare providers should work towards improving the communication skill of their professionals along with having technically competent workers, which could possibly affect the perception of the patient of the predictors of patient satisfaction. Therefore, understanding the interactions between the healthcare professionals and the frail elderly is a good tool for assessing the quality of healthcare accessed by the frail elderly as a process (Landi *et al*. 2010). There is the need to provide recreational services in the care homes to psychologically treat their changing needs (Alley *et al*., 2008). Some of

the elements identified to have had an influence on the frail elderly's perception of a quality healthcare have been presented below.

Interpersonal relationship between staff and the elderly

Landi *et al*. (2010) concluded that disability exerts important influence on mortality and was common among the frail elderly noting that a good interpersonal relationship between the healthcare professionals and the frail elderly could reduce or delay mortality. The importance of interpersonal relationships towards influencing the frail elderly's perception of a quality healthcare was demonstrated in a study, which showed that interpersonal processes, including perceived empathy, perceived technical competency, non-verbal communication and patient enablement significantly influenced patient satisfaction in central Ethiopia (Birhanu *et al*., 2010).

Health providers' programmes for frail elderly

Alley *et al.* (2008) suggested that there was the need to look at the processes involved in quality healthcare delivery from the perspective of recreational services and creating elderly friendly communities to improve physical and psychosocial health statuses of the frail elderly.

For this reason, a study recommended that nurse- led health promotion and disease prevention (HPDP) interventions should include multiple home visits, multidimensional screening and assessment, multi- component evidence- based health promotion and disease prevention (HPDP) strategies, intensive case management, inter- professional collaboration, providers with geriatric training and experience, referral to and coordination of community services (Markle- Reid, Browne, & Gafni, 2013). Hence, Markle- Reid *et al*. (2013) underscored the need to reinvest in nurse- led health promotion and disease prevention

(HPDP) interventions in home care to optimize health- related quality of life (HRQOL) and promote ageing in place in the target population of frail older adults.

2.4.3. Outcome

The Donabedian's (2005) model shows that, the outcome variable used in assessing the quality of healthcare could be viewed either as when the patient is cured of a disease condition or died of same when accessing healthcare. In other words, this could be measured as a quality of life of the frail elderly (Wright *et al*., 2010). Wright *et al*. (2010) showed the view that patients with cancer who die in a hospital or intensive care unit (ICU) have worse quality of life (QoL) compared with those who die at home. However, in the case of assessing the frail elderly's perception of a quality healthcare in this study, the outcome was conceptualised, which categorized the outcome variable(s) according to 'hope of recovery' and 'feeling of wellness'. These have been presented below.

Hope of recovery

The common thinking is that people would be cured or recovery when they access healthcare (see Sager *et al*., 1996; Ali, Vitulano, Lee, Weiss, & Colson, 2014). Sager *et al*. (1996) concluded that there was the need to reexamine current inpatient and post discharge practices that might influence the functioning of older adults because that gives them the hope of recovery. Wright *et al*. (2010) found that hospital deaths were associated with a heightened risk for prolonged grief disorder compared with home hospice deaths; and suggest that interventions aimed at decreasing terminal hospitalizations or increasing hospice utilization may enhance patients' quality of life (QoL) at the end of life (EOL) and minimize bereavement-related distress. A study on the experiences of patients who carry a diagnosis of chronic Lyme disease in the United States healthcare system, found four major themes, which

emerged from participants' descriptions of their experiences and perceptions: changes in health status and the social impact of chronic Lyme disease; doubts about recovery and the future; contrasting doctor-patient relationships, and the use of unconventional therapies to treat chronic Lyme disease (Ali *et al*., 2014).

Feeling of wellness

While it may be difficult to measure actual wellness of a sick person, it was still necessary to use it as a measure of the quality of healthcare accessed by the frail elderly (Diener, & Chan, 2011). Diener and Chan (2011) identified seven types of evidence, which indicated that high subjective well- being (such as life satisfaction, absence of negative emotions, optimism, and positive emotions) could cause better health and longevity. McBee (2012) describes that mindfulness practices of the healthcare system can be tailored to individuals with different needs and this help the frail elderly to achieve improved quality of life. Bernstein and Munoz (2012) suggest that access and availability of wholesome, nutritious food is essential to ensure successful aging and well-being for the rapidly growing, heterogeneous, multiracial, and ethnic population of older adults.

2.5. Patients' socio-demographic and socio-cultural factors

The other factors, which could have an influence on the frail elderly's perception of a quality healthcare are their socio-demographic characteristics and socio-cultural issues (Jacobsen & Mekki, 2012; Kong *et al*., 2014). Jacobsen and Mekki (2012) suggest that the health care system could be viewed in a social, cultural and material context, with a main focus on the elderly care sector as part of a changing welfare state in Norway. The socio-demographic status is a combination of educational attainment, income status, wealth, employment and occupational status, which is generally representative of the social standing or social class of

an individual or a group of people (Kong *et al*., 2014). These socio-demographic characteristics and socio-cultural issues have been presented below.

Socio-demographic characteristics

Literature shows that socio-demographic factors that could have an influence on the adults' assessment of a quality of healthcare include age, sex, education, marital status, socio-economic status and household information, such as the household size (Yawson *et al*., 2013).

Ng *et al*. (2010) concluded that being female, old, unmarried and having low educational and socio-economic levels were significantly associated with poor self-reported QoL, health status and disability among older people in Purworejo District of Indonesia.

In some countries such as the United States of America, socioeconomic status varies markedly by ethnicity and race (American Sociological Association, 2003). Asians and whites are disproportionately represented among the higher socioeconomic groups whereas Blacks and Hispanics are disproportionately represented among the lower socioeconomic status groups (Malone *et al*., 2000; US Census Bureau, 2003). Studies showed that while education and income in many cases are comparable as socioeconomic indicators in the context of healthcare utilization, equity in one socioeconomic dimension does not rule out inequity in the other (Vikum, Krokstad & Westin, 2012).

Khan *et al*. (2006) indicated that both the poor and non-poor families living in areas of low poverty concentration had quality healthcare rates as compared with persons living in higher poverty areas in Tanzania. Besides, it has long been demonstrated by social scientists that wealthy people tend to be healthier and live longer than poor individuals in a society

(Maskileyson, 2014). The positive association that exists between economic resources and health could be attributable to two main reasons. Firstly, economic resources could be used to purchase quality healthcare services (Van Doorslaer, Masseria, & Koolman, 2006). Secondly, poor health status of the population may lead to a depletion of economic resource (Maskileyson, 2014). Though both methods are logical and quite undoubted, they are by no means conflicting.

Economists usually regard detailed data on household income and/or expenditure as the gold-standard measure of current socioeconomic status (Morris *et al*., 2000). Nevertheless, health researchers seldom have the means or expertise necessary to carry out such assessments (Hargreaves *et al*., 2007). Hargreaves *et al*. (2007) also indicated that total wealth, reflecting the balance between income and expenditure over a longer period, may be a more appropriate marker of socioeconomic position when health outcomes are considered. Therefore, rapid techniques for assessing household wealth are required. It is of this view that a number of measures of socioeconomic position have been developed, including shortened income or expenditure questionnaires and measures of healthcare quality, education, nutritional status and so on. Hargreaves *et al*. (2007) indicated that another alternative technique, which uses Participatory Wealth Ranking (PWR), in which community members rank the wealth of households in their community, is widely used in development practice but rarely used in health research.

Wealth inequality measure is based on an index that operationalizes wealth as ownership of household assets and household structural components (Zimmer, 2008; Khan *et al*., 2006). Khan *et al*. (2006) note that because the wealth scores are usually based on patterns of asset ownership among households rather than the monetary value of assets owned, the scores

obtained could be used to define relative socioeconomic position and relative poverty. Results from a research in rural Cambodia confirmed difficult economic conditions, which are similar to those in Ghana and other African countries (Zimmer, 2008). Zimmer (2008) reported that the lowest wealth quintile lived in households that owned nothing, while the next quintiles were only slightly better off. Zimmer (2008) suggested that the ability to generalise the relationship between wealth inequality and health to extremely poor people as a very minor difference in wealth makes a relatively large difference with respect to health associations among those in meagre surroundings. A study observed that income quintile was a major determinant of healthcare services, therefore, those in the highest income quintile needed care and also received more care compared with those in the lowest income quintile; nearly half of the respondents in the lowest quintile did not receive care, compared with only 22% of respondents in the highest income quintile in Ghana (Biritwum & Mensah, 2013).

Socio-cultural factors

The socio-cultural issues that were identified to have had an influence on the frail elderly's perception of a quality healthcare included family involvement, family health seeking behaviour, and expectation from society (see De Graft Aikins *et al*., 2010). It would be recalled that the low economic development, inadequate health infrastructure and limited social security programmes in counties such as Ghana are likely to be compounded by the erosion of the traditional family support systems for older people. Most Ghanaian older people play very important roles in their families and their society (Kaseke, 2013).

In traditional Japanese society, older parents typically co-reside with one of their youngest children, usually a daughter (extended family), who accepts responsibility to take care of

them until they die (Kaseke, 2013). In addition, wealthy older persons who provide key inter-generational support for families, have high social status and are respected in their communities (Schroder-Butterfill, 2004). For instance, Japanese people highly respect older people because of the value placed on lineage. However, it appears that many of the older people in Ghana, particularly those who are widowed, live in poverty (IFAD, 2014).

It is reported that most of them, particularly women, have low education - older people who are still working are less economically dependent on their next-of-kin (Keasberry, 2001). Elderly care and inter-generational relationships have become an emerging issue, particularly for those who live in urban areas, as societal values change from extended family to nuclear family structures, and younger generations become more mobile in search of better career opportunities (Keasberry, 2001). A significant amount of research and literature on older people in Indonesia focus on the socio-cultural aspects of ageing, inter-generational relationships and changes in family structure and support for older people (Keasberry, 2001; Kreager & Schroder-Butterfill 2008).

2.6. Theoretical and conceptual framework

The findings of the study were explained by the theoretical perspective of the health belief model (Laurenhan, 2013) and the health systems building blocks or the health systems framework on quality of care (WHO, 2005). These theoretical frameworks have been explained below.

2.6.1. The Health Belief Model

The health belief model (HBM) is a psychological health behaviour change model developed to explain and predict health-related behaviours, particularly in regard to the uptake of health

services (Laurenhan, 2013). The health belief model was developed in the 1950 (Laurenhan, 2013). Laurenhan (2013) explains that the health belief model suggests that people's beliefs about health problems, perceived benefits of action and barriers to action, and self-efficacy explain engagement (or lack of engagement) in health-promoting behavior. A stimulus, or cue to action, must also be present in order to trigger the health-promoting behaviour. That is, for an individual to engage in a health-promoting programme, one or more of these beliefs must be fulfilled. One of the beliefs is that the person must perceive the benefits or gains he/she would attain and that would be motivating enough to petronise healthcare. Another perspective is that there could be barriers that would hinder one from accessing healthcare. These barriers could be physical accessibility, cultural norms and geographical locations of the health facilities (Laurenhan, 2013). The key concepts of the health belief model have been shown in figure 2.2.

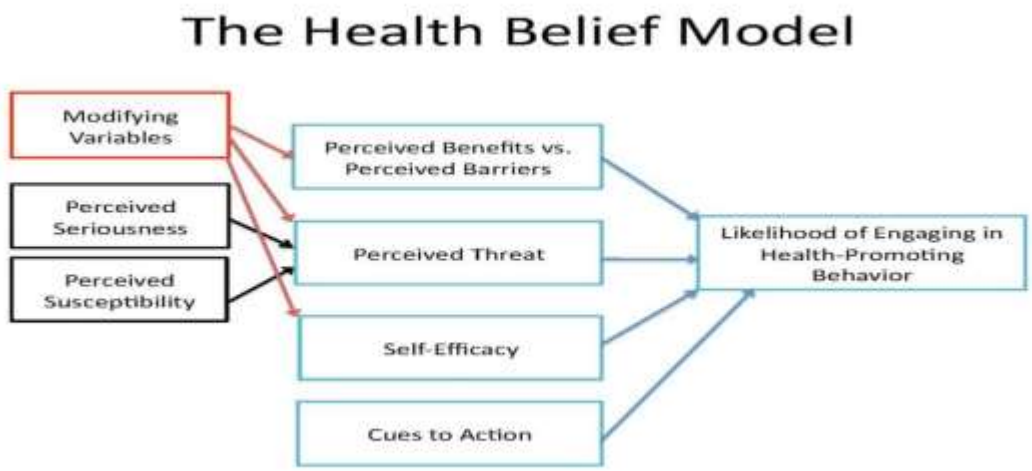

Figure 2.2: The Health Belief Model.

Source: Laurenhan (2013)

2.6.2. Building blocks of the health system

For a comprehensive and effective health service delivery, the six building blocks identified by the World Health Organisation must be in place (WHO, 2005). Managing essential resources to deliver health services is crucial to healthcare delivery. The six building blocks encompasses all the components of resources; human resources, capital, medications, and medical equipment (WHO, 2005). To carry out effective healthcare, there must be service delivery. Service delivery requires provision of services in diverse ways to achieve equity. Additionally, the concept of the health system building blocks talks about the health service workforce, which entails the human resources capacity needed to carry out all forms of activities within the healthcare system (WHO, 2005).

The next component of the building block is information, which discusses how data is transmitted and feedback is received within the health system. Another component deals with the supply of vaccine, medicines and medical products, which throws more light on the essential drugs, which is an inevitable part of the health system (WHO, 2005). One crucial part of the building blocks is the financial aspect, which deals with the capital resources required to effectively carry out all health activities. The leadership and governance of the health system is one of the crucial components of the building blocks as effective governance and leadership results in a good healthcare system (WHO, 2005). The key elements of the health system building blocks/systems framework have been outlined in figure 2.3.

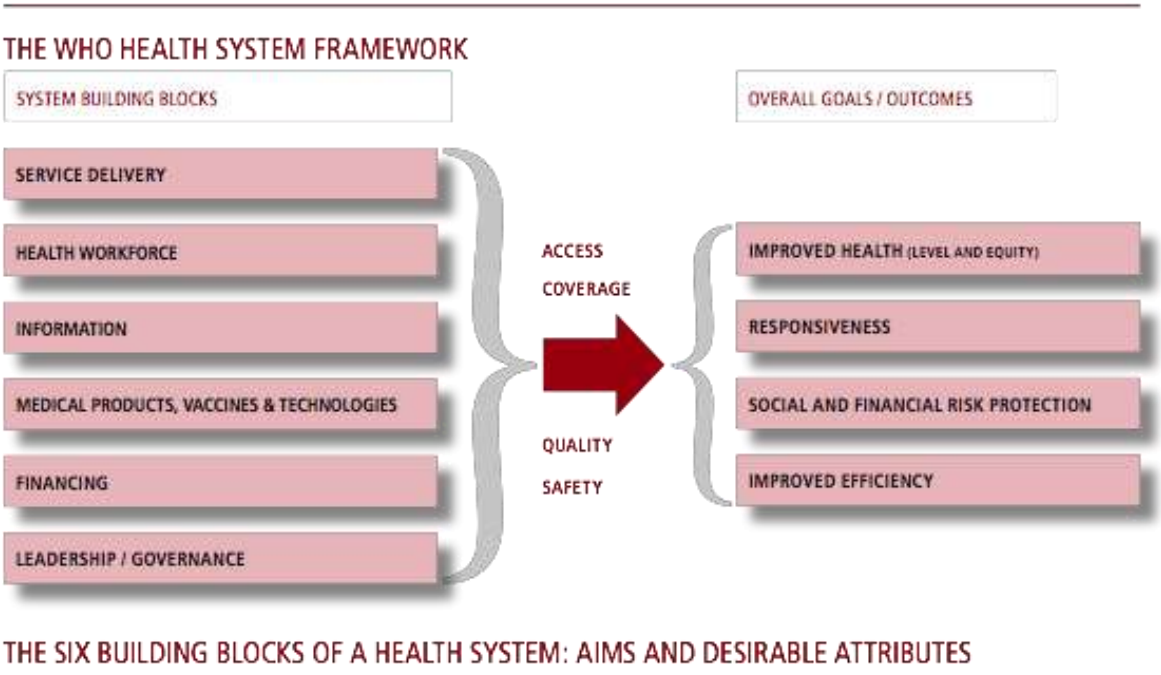

Figure: 2.3: The six building blocks /health systems framework.

Source: (WHO, 2017)

2.7. Conceptual framework of frail elderly's perception of quality healthcare

Based on the hypothetical conceptual framework in figure 2.1, the conceptual framework in figure 2.4 was developed based on the analysis of literature and theoretical framework to demonstrate how the frail elderly's perception of quality of care was influenced by the structure/health system, process and outcome measures of quality of healthcare as proposed by Donabedian (1988, 2005). That is, based on the understanding of the Donabedian model and deducing from the health system building blocks/framework, the Donabedian model was adapted for this study where the themes that emerged from the interview data were used for the analysis as depicted in figure 2.4.

It would be recalled that quality measures are intended to quantify healthcare processes, systems, and patient outcomes associated with high-quality health care - They drive improvements by determining areas in need of better quality, identifying differences in care

or outcomes among populations, and improving care coordination (Centers for Medicare & Medicaid Services (CMS), 2016). It is observed that quality of health services is gaining grounds in healthcare literature as healthcare stakeholders such as governments, health authorities and consumers are attaching much importance to healthcare quality (Lapsley, 2000; Smith *et al*., 2006). Other studies also documented that the quality of care, especially perceived quality is based on patients' evaluations and opinions of the healthcare provider or facility and is an important deciding factor in choosing a health facility (Karkee & Kadariya, 2013).

The argument is that the perception of a quality of care could be assessed based on the structure, process and outcome variables. Since the structure factors are related to the health system/provider, and the process is where there is the interaction between the health provider and the patient, the frail elderly could assess the influence of structure when they utilised healthcare service and measured the influence of the process factors by how the health providers/professionals related to them. The outcome was measured on the basis of the improvement in their quality of life since the study was not based on a cause-effect relationship. Underlying these were the factors outside the parameters of the healthcare system or environment such as the patients' socio-demographic characteristics and socio-cultural intuitions. Some of these factors spelt out in the conceptual framework, especially the socio-cultural factors were analysed in the study.

That means that health determinants (patient socio-demographic and socio-cultural factors, and health system/provider factors and) as shown in the conceptual framework, contribute to an individual 's perception of access to a quality healthcare. Each of these health determinants acts through intermediates that directly affect quality of healthcare for the frail

elderly. However, there are demographic and epidemiological transitions that may not have as large an impact on overall healthcare use and costs as once predicted, therefore, there is an expectation that policy-makers would ensure that health and social systems are adequately equipped to support the aging population (Suhrcke *et al*., 2010).

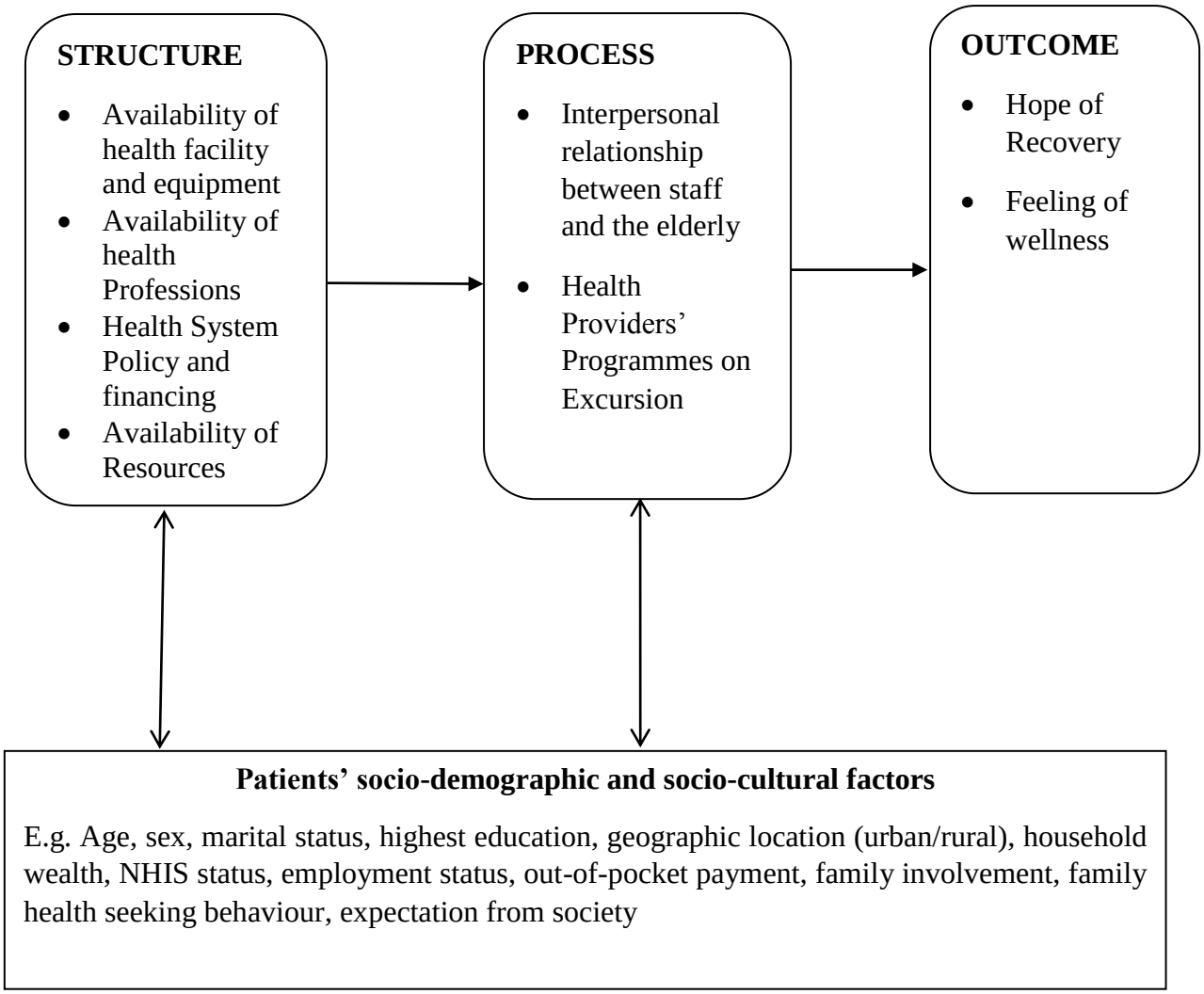

Figure 2.4: Conceptual framework of frail elderly's perception of quality healthcare. Source: Adaption of Donabedian's (1988) quality of care model

2.7. Gaps in literature

Generally, in Ghana, not much research has been done on how patient and socio-cultural factors and health system/provider factors influence the frail elderly's perception of access to

a quality healthcare, especially in the Tema Metropolitan Assembly area. This study attempted to fill this gap in knowledge by conducting this study in the Tema Metropolitan Assembly area.

2.8. Chapter summary

This chapter has presented analysis of the key concepts and related studies on the topic under consideration. The subsequent chapter presents the methods applied to collect data for analysis.

CHAPTER THREE

METHODS

3.1 Introduction

This chapter specifies the materials and methods that were used in the collecting data on the quality of healthcare for the frail elderly in the Tema metropolis, greater Accra. The chapter is divided into sections.

3.2. Study Design

The study is a qualitative study design, focusing on exploring the quality of healthcare for the frail elderly in the Tema metropolis.

3.3. Study location/Area

The population of the elderly in Ghana was 1,643,381 according to the population and housing census of 2010 (Ghana Statistical Service, 2010). The proportion of the female elderly population was 56% as compared with 44% male elderly. A higher proportion (54%) resides in the rural areas whilst 47% of the females and 44% of the males are resident in urban areas. This study was carried out in the Tema Metropolis in Ghana. The Tema Metropolitan Assembly is made up of four districts (Tema East, Tema South, Tema West and Tema North) and it is one of the ten (16) districts in the Greater Accra Region of Ghana. The metropolis is further grouped into twenty-six communities. The most popular and busiest communities are Communities are 1,2,4,7,8,9,13 (Sakumono), 18,19 and 20 (GSS, 2010).

Demography

Sakumono is a small town before Nungua from Ashaiman. It is in the Tema Metropolitan district, a district in the Greater Accra Region of Ghana. It was originally a small fishing village on a lagoon, but by 2008 is being swallowed up as the twin cities of Nungua and Tema merge. Elevation is 71m. Sakumono is one of the interesting towns, also known as Community 13. It

has the main township which is close to the beach and lagoon. Has a lot of sects of Estate buildings and jurisdiction?

Economy

The Tema Metropolis has a number of tourist attractions, such as, the Meridian Stone, Greenwich Meridian and the Sakumono beach. Tourism has the potential of diversifying the Metropolitan economy if the sector is given the needed attention, as well as, generating employment and revenue for TMA. Furthermore, there are 350 hotels and guest houses in the Metropolis. The Sakumono beach is one of the investment areas which have not been tapped into, and TMA, foreign and local investors need to channel resources to this sector for development (GSS, 2010).

Health care provision

Sakumono has both public and private health facilities that are spread across the entire Metropolis and their classification by type of facility is based on their functions and the range of services they provide. The total number of health facilities in the public sector is 46 (54.2 %), is higher than that of private health facilities16 (38.9%). This means that in terms of accessibility to health facilities in the Metropolis, the public sector has a wider coverage in the provision of healthcare. However, due to rapid increase in the population of the Metropolis, expansion of health facilities both public and private has become necessary to meet the needs of the population

Figure 3.1: Map of Sakumono.

Source: TDC, 2019

Study site: Mercy Home Care Centre

The study was carried out at the Mercy Home Care Centre at Sakumono. It is a 50 bed capacity facility in a two story-building which was established in 2010 by Mrs. Mercy Adarkwa

3.4. Study Population

The study comprised of 15 participants both men and women inclusive aged 60-100 years. The participants constituted the frail elderly in the study area.

3.4.1. Inclusion Criteria

Inclusion criteria for the older persons were described. Firstly, participants should be aged at least 60 years. Secondly, participants should be resident in the Mercy Home Care Center. Thirdly, participants should be in need for help with two or more activities of daily living, meaning that the participant cannot perform daily activities by themselves. For example, cleaning, transportation, and or managing medications. Lastly, participants should have been on admission at a hospital at least twice or four visits to an outpatient care/department, in the

last 12 months prior to the study. In addition, participants should have been cognitively adequate and feel well enough to give their consent to participate in the interview.

3.4.2. Exclusion Criteria

The following were used to exclude participants. Firstly, participants should be aged at least 60 years old. Secondly, participants should not be resident in an ordinary home. Thirdly, participants should not be in need for help with two or more activities of daily living, meaning that the participant cannot perform daily activities by themselves. For example, cleaning, transportation, and or managing medications. Lastly, participants should not have been on admission at a hospital at least twice or four visits to an outpatient care/department, in the last 12 months prior to the study. In addition, participants should not have been cognitively adequate and feel well enough to participate in the interview.

3.5. Sampling method

Purposive sampling technique was used to select research participants and the facility for data collection. Thus, data was collected using a purposive sampling technique, which focused on particular characteristics of a population of interest, which enabled the researcher to get answers to the research questions (Creswell, 2013).

3.6. Data Collection and analysis

Data was collected by means of personal or face to face interviews between April and May, 2019. The interviews were semi-structured, which means that they were neither fully structured nor fully unstructured. The participants were allowed to talk freely about any subject, but the interviewer guided the interviewees. Care takers or providers were permitted to assist in situations where interviewees or elderly were unable to communicate appropriately. The semi-structured interview guide was divided into sections.

Section A collected information on socio-demographic/economic characteristics. However, these were not analysed statistically. The questions covered issues such as the type of health facility and homes used by the respondent during the last reported illness, appointment or checkup. These were private health facilities, which would include homes for the aged and public health facilities which include hospitals. The other information was on participants' age, sex, marital status, employment status, household wealth, highest educational level, health insurance status, geographic location, gender of provider, and out-of-pocket payments. Section B however collected information on health system or provider factors, including health service satisfaction, chronic condition and self-reported health. Section C collected information on socio-cultural factors such as family and friends' support, beliefs, myths, and traditions, among others.

Furthermore, the interviews were conducted in health facilities or places chosen by the researcher. Each interview lasted between 10 and 40 minutes depending on the contribution of the interviewees. The interviews were recorded with the voice recorder on a mobile phone. Notes were also being taken of the non-verbal clues of the participants to support the analysis. Efforts were made to minimise the interference of other elements that had no relationship with the frail elderly as well as noise. The semi-structured interview guide is shown in appendix B.

The interviews were analysed by content analysis. Berg (2004) suggests that content analysis comprises a combination of both manifest and latent analysis. The manifest part concerns what was said and were visible in the text, while the latent part included finding an interpretable structure, a deeper underlying meaning. The recorded interviews were played back to the participants before they were transcribed using a Microsoft word application in rich text format. This allowed for the patterns and themes to emerge and were supported with

Nvivo application. Codes were used to describe participants wherever they are quoted in the analysis. FE = means frail elderly.

3.7. Ethical Considerations

The ethical issues that were adhered to in the conduct of the study have been presented below.

Ethical Clearance

Ethical approval was granted by the Ghana Health Service (GHS) Ethics Review Committee before commencement of the study. The certificate number is: GHS-ERC 048/04/19

Approval from Study Area

Approval was sorted from the management of the Mercy Home Care Centre. That is, a letter of introduction was sent from the Department of Health Policy, Planning and Management, School of Public Health, University of Ghana to the management of the Centre.

Description of Subjects in the Study

Participants of this study were above the age 60 years and had been admitted to the facility (Mercy Home Care Centre) for receiving one care or the other.

Potential Risk/Benefit

Though the participants did not have any immediate or direct benefits from the study, their responses would be helpful in policy planning and formulation of recommendations to appropriate authorities concerning care for the elderly. There was no anticipated risk or harm from the study. The only inconvenience was the time spent in the interview. In view of this, the design of the interview guide was well structured to facilitate the discourse. The

respondents were informed about the general nature of the study and assured of no potential harm during the study.

Privacy and Confidentiality

The researcher ensured that the interviews were conducted in a secure place free from interaction of other on-going activities. The name and identity of the participants were kept safe and highly confidential in this study. However, the information they provided were coded and were treated strictly confidential. They were assured of total confidentiality to the information they provided. Apart from the researcher and supervisor of this research, no one else had/will have access to information provided whether in part or whole. Data files would be kept for six months after which they will be destroyed or discarded.

Data Storage and Usage

All files, papers and data obtained from the study have been locked in a cabinet and on computers protected by passwords. Electronic data files have been stored on an external drive with a secured password with access limited to only the researcher and supervisor. Research assistants would not have access to these documents except when granted permission by either the researcher and /or supervisor. Data files would be kept for six months after which they will be destroyed or discarded.

Description of Consenting Process

Consent of participants were obtained before data was collected. An information sheet was read out to participants or respondents. In this sheet, the potential benefit of the study to participants and the country were outlined. This was done through thumb printing or signing of a consent form. The purpose of the study, the benefits and rights of the subjects and the

procedure involved were explained to all participants prior to the interviews (see appendix A for the participant's consent form).

Voluntary Participation and Withdrawal

The participation in the interviews was voluntary. Participants were informed of their right to stop and opt out of the interview at any point during the process. There were no consequences, like loss of benefit or care to them if they choose to withdraw from the study. Participants were informed that the information already obtained before they chose to withdraw from the study were not be used in the analysis.

Compensation

There was no compensation for participating in this study.

Protocol amendments

In the event that there was any change to the study site, participants and other relevant issues involved in the study, these would be communicated in writing to the ethical review committee.

Declaration of Conflict of Interest

The researcher had no conflict of interest in this study.

Funding Information

The researcher self-funded this study.

3.10. Study Limitation

A limited sample size of 15 was used because the number of clients in the facility were twenty-seven. Meaning, 15 respondents were more than half the total number of clients in the facility. Moreover, this study only used one municipality however, more than one municipalities would have given a more accurate insight into the research objective.

3.11. Chapter summary

This chapter has enumerated the various methods that were applied to conduct the study within the Mercy Home Care Centre in the Tema Metropolis. The philosophical assumption of the researcher as an interpretivist, which encouraged the application of qualitative methods has been declared. Moreover, the ethical considerations involved in the study since it involved human subjects, have also been explained. The next chapter presents the results of the analysis.

CHAPTER FOUR

RESULTS

4.0. Introduction

This chapter presents the findings of the study under the themes and sub themes that emerged as a result of triangulation of analyses of data collected. This chapter has three main sections. Whereas the first section presents the personal and the demographic profile of the participants, the second section presents the key findings under varying themes and sub-themes. Thus, several themes and sub-themes identified in the interviews conducted have been presented within the second part of this chapter. Section three presents the summary of the chapter.

4.1. Demographic profile of interviewees

The personal and the demographic profile of interviewees consisted of the age ranges that the interviewees fell within. Their religious affiliations were also taken and recorded. Their level or the stage of the educational ladder they attained was also inquired and recorded. Their marital statuses were requested and documented as well. The interviewees gave their tribes they belong to when asked and were recorded as such. Within the first part, the frailty history of the interviewees was also propped to gather a few more information. The number of years they have been frail and the number of facilities they have visited since being frail and their preferred facility to visit, be it private or public were also queried to gather enough information about the interviewees.

The fifteen frail elderly who were interviewed were based in a care home at Sakumono in the Tema Metropolis. They were there because they were aged (above 60 years) and needed one form of assistance or the other and that they could not take care of themselves because of their frailty. Some of these elderly was retired government workers, some did their own

businesses, others lived and work abroad and the rest were unemployed housewives. Table 4.1 presents the demographic profile of the interviewees.

Table 4.1: Demographic profile of interviewees

Personal Profile			Frailty Profile	
Age in years	Number of participants		Duration of frailty	Number of participants
60 – 69	5		0 – 5 Years	5
70 – 79	6		6 – 10 years	4
80 – 89	4		Above 10 years	6
Sex			Number of facilities visited	
Male	5		1-3	6
Female	10		4-6	5
Religion			More than 6	4
Christians	13		Preferred Facility	
Muslims	2		Public	9
Education			Private	2
Tertiary	5		Both	4
Secondary	3			
Basic	7			
Marital Status				
Married	5			
Divorced	5			
Widowed	5			
Tribe				
Akans	7			
Ewes	3			
Gas	3			
Hausa	2			

Out of the fifteen (15) interviewees, 5 were between the ages of 60 -69 years old, thus 33.3%. Six (6) were between the ages 70 – 79 years old, making 40% and the remaining 4 were between the ages of 80 – 89 years old, representing 26.7%. The average age of the interviewees was 73 years old. Ten of the respondents were females, representing 67% whiles 5 of the respondents were male, also representing 33.3%. Five (5) of the respondents, representing 33.3% were married. Five (5), thus 33.3% of the respondents had married but divorce and the remaining 5 (33.3%) were either widows or widowers. All the respondents at

one point in their live at least had been married. Of the fifteen (15) respondents, 5 had completed tertiary education representing 33.3%, 3 has completed secondary education that is 20% and seven (7) had only completed the basic education or started but could not finish, that represents 47% of the total number of interviewees. Thirteen (13) of the respondents were Christians. That denotes 87% of the total number of respondents. Two (2) of the respondents were Muslims. That represents 13%. The tribes of the respondents were as follows: seven (7) Akan, three (3) Ewe, three (3) Gas and two (2) Hausas (refer to table 4.1).

Five of the respondents had been frail between one (1) to five (5) years (33%), four of them had been frail between six (6) to ten (10) years (27%) and six had been frail for more than ten (10) years thus 40%. Six (6) of the respondents had visited one (1) to three (3) different health facilities before coming to the nursing home. Five (5) of them had visited four (4) to six (6) facilities while the remaining four (4) had visited more than six (6) facilities. Nine (9) of the respondents preferred public/government health facilities. This represents 60% while only two (2), thus 13% preferred a private health facility. Four (4), thus 27% of them preferred any or both (government & private) depending on proximity and other issues (refer to table 4.1).

4.2. Frail elderly's perception of quality of care

The respondents described the hardware and software in healthcare systems, the physical structures as well as their current health status as factors making up the quality of healthcare. Five sub-themes emerged from their perception of the quality of health care: Hope of recovering, feeling of wellness, interpersonal relationship with staff, the availability of a facility, and healthcare staff professional approach. These sub-themes have been analysed below.

4.2.4. Availability of health facilities and Equipment

To better understand and assess the quality of health care, the structural component cannot be left out. Structure means the features of the settings in which care occurs. The facilities and the equipment forms an integral part of the structures to ascertain quality healthcare. It was important to inquire about the perception of the frail elderly in respect of the facility and equipment available to them to judge the quality of care they received/accessed. The analysis revealed that interviewees had experienced similar nursing home settings before and this informed the elderly's person's perception of the contribution of health facilities and equipment to quality of care:

> *I studied medicine in Germany and I have lived in the UK and the USA.In the western world, non like Ghana, there are facility like, Care home, assisted living, Nursing homes and the continuing care retirement communities. There are not much of such facilities in Ghana here. It is my brother who informed me about this place and apart from here, I've been asking my brother and other people to know if there is any other place but the answer I get is 'no' or 'none that I have heard of'…From my observations too, it seems that the facility does not have sufficient quipment…Anytime I need a wheelchair, the nurse tells me 'wait, someone is using it'…The walkers are not enough and sometimes no hand sanitizers, among other things. …There is no oxygen station here for emergency situations…If I say these things, it appears that I talk too much so I don't bring them up. All the same, we are still coping (IDI with Participant 2, 77 years old, 3 years of frailty).*

It was brought to light from the analysis that the nursing home lacks some of the basic equipment that were needed to assist in their rehabilitation while in residence:

My problem is my inability to walk…I wish there are enough assistive devices here for walking but unfortunately, they are not enough…That is why I am still in bed though it is day break…I wish I can move around and even go to sit outside and watch what is going on but unfortunately, I don't have that opportunity…We need equipment or assistive devices as elderly people (IDI with Participant 3, 69 years old, 3 years of frailty).

Invariably, some of the conditions that affect the elderly most are arthritis, rheumatism or stroke, which may require the application of physiotherapy. However, it appeared that such a care was non-existent at the nursing home:

I have been having severe pains in my hand…It is one Nurse who has been massaging it for me but it's still paining…Anytime I take medicine, the pain reduces just for a short while but recurs... I think if there was any specialized equipment I could use to exercise to help alleviate the pains in my hand, I would be glad (IDI with Participant 5, 75 years old, 3 years of frailty).

I think if there was a physiotherapy unit here to help those of us with stroke, it would really help…First, I used to attend physio at 37 Military Hospital but when I was discharged I was asked to try and visit a nearby facility…I could not get any…I was hoping there would be one here to help me but here too, there is none (IDI with Participant 7, 65 years old, 5 years of frailty).

I cannot stand - my problem is my inability to walk and therefore, I am always in the wheelchair…The other clients complain a lot that I am the only one using the wheelchair…How I wish agencies and individuals were donating wheelchairs and other equipment to this facility… Frankly speaking, there is scarcity of equipment and

does not make us feel we are being catered for very well (IDI with Participant 9, 70 years old 1 year of frailty).

Deducing from the responses above, it could be appreciated that the frail elderly acknowledged the role that availability of facilities and equipment play in health care delivery. It was revealed that many of the frail elderly were specific with the type of equipment that would help their specific needs. This explains why it has been suggested that to ensure quality of healthcare, the physical environment must be designed to accommodate disabilities and to ensure that care could be provided or arranged to meet varying levels of need.

4.2.3. Interpersonal relationship between the staff and the elderly

The frail elderly, like any other client have autonomy and therefore, would like to be treated with all the dignity and respect they deserve. The respondents exhibited that they paid particular attention to the ways they were handled verbally, physically or circuitously. The interactions between the healthcare staff and the elderly play an important role in the perception of the quality of healthcare among the frail elderly. Healthcare staff are to communicate and help the frail elderly and their family make informed choices with respect to their healthcare. The healthcare staff's expressions should empower the elderly and increase their confidence in the care they receive/accessed. Healthcare staff are required to inform, encourage and to provide the necessary enabling environments for positive health outcomes. When questioned about the interpersonal relationship between the health professionals and the frail elderly to bring about confidence, the interviewees expressed their views appropriately:

The Nurses and Doctors do their best to help anyway but sometimes when you call them, they don't even show up…The Nurses are not always around, especially when you need them most…When they come around, they are always in a hurry to leave…They don't have time for me let alone to talk about quality time to explain my feelings to them…I remember yesterday for instance, I asked one Nurse to get me water to bath, she shouted 'you "koraaa" why! Why do you like worrying like that?'...I became very worried…I asked myself whether that was the services I was paying for but I am only trusting God to take care of me here… (IDI with Participant 1, 84 years old, 5 years of frailty).

Other interviewees also looked at their relationships with the healthcare providers from the perspective of effective communication that was supposed to ensue between them on the need to explain their conditions to them:

The Nurses here are always in their room watching television…I never get to have an effective communication with them…I don't have any believe in the Doctors and Nurse because they don't explain things better for me to understand…I remember one day when I asked the Doctor why I had so much weakness in my legs, he said 'what else do you expect once you are growing old'. I mean how? How can a Doctor answer me this way? In fact, all my trust is in God (IDI with Participant 8, 65 years, 2 years of frailty).

I don't know much about my health condition…I only know that I cannot stand on my feet…I don't get any of the Doctors or Nurses to explain to me exactly what is wrong with me...My only problem is the inability to walk…Even though I follow all the

instructions given to me by the Doctors and Nurses I doubt their capabilities (IDI with participant 9, 70 years old, 1 year of frailty).

Nevertheless, other interviewees also perceived a good relationship between them and the healthcare providers due to the drastic change in their conditions accordingly:

I was a serious alcoholic…I don't remember when I started drinking because it is a very long time ago…Since I was brought here, I have been taking through a lot of behavioral therapies which has really changed me now…The Doctors and Nurses are very good…They highly communicate with me…I have completely stopped drinking alcohol…Thanks to the Doctors and Nurses for their expert care... (IDI with Participant 10, 66 years old, 1 year of frailty).

The analysis also showed that the relationship between the healthcare providers and frail elderly at the home was based on the positive attitude portrayed by the elderly as well - reciprocity was needed:

I think the Nurses and Doctors will do their very best for any client who treat them with much respect and dignity…I treat them well so they also do their best for me...They are good to me... They communicate, educate me on my disease condition and explain every procedure to me before they carry them out (IDI Participant 12, 66 years old, 2 years of frailty).

However, this reciprocity was based on the financial status of a particular elderly - perceived discrimination on the basis of social status:

> *One thing I have realized with the Nurses here is that, if a client has money they do take good care of them…There are some of the clients, you will always see a Nurse or two Nurses with them…This shows clearly that there are disparities among the choice of clients…The patient I am talking about does not have any serious condition to be receiving that preferential treatment…I don't have much confidence in the Nurses and Doctors…They only give their best when you influence them with money (IDI with Participant 13, 80 years old, 6 years of frailty).*

It was evident from the above submissions that good interpersonal relationship between the healthcare professionals and the client fosters a good and therapeutic environment. This confirms the admonition that in assessing the quality of healthcare, the processes, which denote the transactions between patients and providers throughout the delivery of healthcare can never be overlooked.

Another revelation that arose from the interviews was the perception that those who had money were being given level of care, higher than the others of lower socioeconomic status, so to say.

4.2.5. Availability of Healthcare Professionals

The availability of the required number of human resources, their qualifications, capability and their expert delivery of care is a key determinant in the assessment of quality of care. Personnel who have the requisite knowledge and experience to understand and appreciate the specific needs of the elderly are able to offer professional care. The interviewees in their submissions, were able to appreciate the quality of care they received/accessed when they come into contact with the healthcare professionals. The frail elderly was questioned on their personal judgement of the professional care they received from the healthcare professional:

I cannot tell whether the Doctors and Nurses have good knowledge medically about my condition…I am saying this because they keep doing the same thing over and over…In the morning, they will get me water to bath and only take my temperature…As at now, I don't know exactly what is wrong with me…I only know I am so weak…I think there should be more professional Doctors who come here every day so that I can tell them my problems for them to help me (IDI with Participant 3, 69 years old, 3 years of frailty).

I am suffering from Parkinson's disease and with this, it cannot be cured but I am only hoping for the best. I am very sure the Doctors understand my needs but I am not sure about the Nurses… I am saying this because I once asked a Nurse 'Do you know what Parkinson's disease is?' to my surprise, she responded, 'Yes, we learnt that in school but me, I've forgotten, don't really remember' (IDI with Participant 4, 70 years old, 10 years of frailty).

I was expecting to see a structure and a system for caring for us here…There are no protocols, I feel things happen for you only when you request for them…I don't understand the system working here (IDI with Participant 8, 65 years of age, 2 years of frailty).

The discussions also brought the ability of the entire healthcare or home care system to identify and manage some health conditions in the Ghanaian society. The apparent lack of ideas about first aid procedure among the public was highlighted:

When I had an epileptic attack, the treatment I received made me develop the blindness. I ask myself where lie the competencies of our healthcare professions?

> *What does our health system say about clients who develop epilepsy? I know the Doctors and Nurses may be good at managing such a situation…Another question I have is 'whose responsibility is it to educate the general public in handling such a situation?…When I had the seizure, I learnt bystanders used different substances to rub my face. I had a blurred vision after the episode…It was my believe that Doctors could help restore my sight but I'm still unable to see…I think our health system and the expertise of our Doctors still needs improvement (IDI with Participant 12, 66 years old, 2 years of frailty).*

From the above submissions, it could be deduced that they expected some level of experience, proficiency and perfection from the healthcare professionals - an expertise that the ordinary person would have no idea of and that which achieves something out of the ordinary. Nonetheless, the elderly frail did not appear to have enough confidence in the professional competencies of the available health professionals.

4.2.1. Hope of recovering

The elderly described their experiences in life and many things they had seen, read or heard over the years. These informed them a lot about the possible outcome of their health conditions. Thus, these multiple situations put them in a position to anticipate the possible outcome of their health conditions. To some, once they anticipate no room for recovery, then, there was no quality of care whereas hope of recovery constituted their perceived quality of care. Participants were asked about their perception of the quality of care at the nursing home and the interviews revealed different perspectives. Some interviewees discussed the genesis of their current health condition and how they perceived a possible recovery and the quality of care so far:

> *At the age of 66, thus 3 years ago, I realized that I needed a special care… I felt so weak generally though there was a complete weakness at my right side, affecting my upper and lower limbs…I could not walk at all…The Doctors told me that I had stroke… At that time, it was so strange to me... I thought the end of my life was so near…Now, before God and man, there has been great improvement…I am able to talk better and walk well with the aid of this Zimmer frame…There is so much believe in my heart that I am going to recover and walk normally as I used to do…Since my speech is okay now, I know very soon, there would be a full recovery (IDI with Participant 3, 69 years old, 3 years of frailty).*

Other interviewees explained their perception of quality of health care based on their professional experience and knowledge, which also created doubts about their possible hope of recovery:

> *I was a pharmacist by profession so you should know I have read a lot about my condition…I know that I am suffering from Parkinson's disease and with this, it cannot be cured but I am only hoping for the best… I know the Doctors and Nurses and other healthcare professionals are just doing their best but my condition is irreversible or cannot be cured…Because of that, sometimes I do take the Doctors and Nurses instructions but at times I don't (IDI with Participant 4, 70 years old, 10 years of frailty).*

The analysis revealed that attempts to work very hard and refusal to adhere to prescribed medications by individuals in society could contribute to sudden ill-health. When this happens, people repose their trust in the supreme being while undergoing orthodox treatment:

Sometime past, I used to work hard to take care of my family until I was diagnosed of Hypertension…I used to default in the medications I was given, which subsequently led to the stroke…Since I developed the stroke, I have been taking my drugs judiciously and every day, the nurses tell me that my BP is good…I am just left to start walking, which I believe I will by God's grace (IDI with Participant 7, 65 years old, 5 years of frailty).

My physical disability has prevented me from doing some activities I used to do without assistance…What I know is that, my blindness resulted from an epileptic attack and through the treatment of the epileptic attack that I got blind… I believe that with the reviews I have been attending at the eye clinic, I will be able to see again… However, everything is in the hands of God (IDI with Participant 12, 66 years old, 2 years of frailty).

However, other interviewees had given up any hope of recovering from their current health condition due to the underlying causes:

The main health issue I have is my sight; my inability to see…I don't have much confidence in the Nurses and Doctors therefore, I don't always follow their directives. I know they are doing their best but for them to make me have a restoration of my sight, I doubt their capabilities… I have no hope of recovering (IDI with Participant 13, 80 years old, 6 years of frailty).

The interviewees believed that so far as there was hope in the healthcare system or supreme being, their health status would improve and lead to their recovery to enable them resume their normal health and activities. This showed their perception of quality of care. Though

others did not perceive this hope of recovery mainly due to their vast knowledge or experience, they appreciated the efforts of the health care professionals. However, it was important to assess how the elderly population perceive the quality of healthcare in respect of health outcomes in order to improve care coordination as indicated by the Centers for Medicare & Medicaid Services (CMS), (2016). The health expectations of each client differs from the other. However, from the responses above, it indicates that, they have not fully recovered, once they believe they will recover, they have the satisfaction they needed.

4.2.2. Feeling of wellness

The analysis showed that clients' expression of wellbeing was a good determinant of the quality of health care they had received. Most of them showed gratitude and wished that they were in their own homes but for the fact that they might not have anybody to keep them company. In effect, they appreciated the quality of healthcare they had received because they were feeling a bit well. The aim of every health institutions is to have their clients have optimum health and wellbeing. In questioning how they were feeling now in respect of their health and whether that related to a quality healthcare accessed, the interviewees explained their perspectives of wellness and wellbeing in diverse ways. Some understood that their present condition was not much of an ill-heath related but a process of aging:

> *Initially, I wasn't able to cope with the changes I was encountering as a result of the aging but now I understand that this is aging…Although I am very confident in the Doctors and Nurses here, I am not sick…I am not sure they (Doctors and Nurses) need any knowledge about my condition because I'm not sick…Besides, since I am not sick, I have nothing to recover from Personally, I know I am enjoying life.. I am completely well (IDI with Participant 2, 77 years old, 3 years of frailty).*

The results showed that other interviewees perceived that they were on the road to wellness and wellbeing as their conditions were more of behavioural than a serious incurable health condition:

> *My only problem was alcoholism…I started drinking a very long time ago. I was brought here because anytime I drank, I created a lot of problems at home…I have been taking through a lot of behavioral therapies, which has really changed me now…Now, I can do without alcohol…I have completely stopped and I make a lot of meaning with life now…thus, I used to spend unnecessarily when I was drinking but now, I am able to save some money… Thanks to the Doctors and Nurses for their expert care (IDI with Participant 10, 66 years old, 1 year of frailty).*

It was also revealed that the nursing home provided a place of solace for elderly frail who had recovered/feeling well but faced seemingly lack family relationships due to the current trends and family reforms taking place in the Ghanaian society:

> *I am well…I have no issues anymore though first, I had pains in my waist and knee and a burning sensation in my fingers, they are all gone…I'll feel bored when I leave and go home…I am able to interact with my peers while I am here, which gives me my joy (IDI with Participant 15, 76 years old, 6 years of frailty).*

Deducing from the responses above, it was observed that though it is believed that frailty is a permanent condition among the elderly, it was not always so. The interviewees expressed high levels of wellness and managed to carry out activities of daily living in their own way. It was also noticed from the responses that once the elderly were able to cope with the changes associated with aging, they felt they were completely well. This confirms view that the

outcome measures remain the ultimate validators of the effectiveness and quality of healthcare.

4.3. Influence of health system factors on quality of care

The population in Ghana is ageing and this poses substantial challenges to the health system and government. Presently, the health system focuses more on battling infectious diseases such as malaria, cholera, tuberculosis and diarrhea. Chronic non-communicable diseases such as heart diseases, stroke, diabetes, cancer and hypertension, which are common with aging does not receive proportionate allocation of resources. The World Health Organisation's (WHO) six building blocks: service delivery, health workforce, information, medical products, vaccines and technologies, financing and leadership or governance, all require resources to achieve the maximum effect. Resources are considered under three main classifications namely: Human, Capital and Material. All aspects of the health system would function effectively with the employment of any or all of these resources be it human, capital or material. It was therefore, spot-on to assess the extent to which health system factors influence the quality of healthcare delivered to the frail elderly. In assessing their perception of the influence of healthcare system on the quality of health care, three sub-themes emerged: health system policies, health system programmes and frail elderly facilities/resources as presented below.

4.3.1. Health system policies and financing

Policies can be in the form of laws, documents, procedures, guiding principles, statements of intent or working frameworks to achieve certain objectives. Policies could also be viewed a rules or regulations. The responses of the elderly highlighted key aspects of their lives that they wished operational policies in the care of the frail elderly in the country would help to

enhance. These key areas included, monitory, healthcare and security. The frail elderly were probed on their knowledge of health system factors affecting the quality of healthcare. Different responses were provided:

> *I think I have heard that there are such policies but just that I don't know the details...Policies to concentrate on our wellbeing would be very good for us…For example, the elderly person should be seen first in the hospital or any other institution but this is not so...We have to compete with the youth in almost everything (IDI with Participant 1, 84 years old, 5 years of frailty).*

> *I am not aware of any policy that the government has instituted to help the elderly or people of my age…However, if the government were to institute such a policy, I am very sure it would have gone a long way to make our living conditions better (IDI with Participant 3, 69 years old, 3 years of frailty).*

> *Whether or not there are government policies, I don't know...As for me, I am not so concerned about government policies because I am able to do things own my own - I fetch my own water to bath (IDI with Participant 5, 75 years old, 3 years of frailty).*

While interviewees showed their apparent lack of knowledge of the existence, they also discussed the need for specific government policies on the elderly that would assist in revamping the overall care of the aged in the Ghanaian society:

> *If there are any policies for the elderly, as for me, I am not aware of…If there are such policies, please tell me so that I know and become a beneficiary…In my own opinion, they should give us some money for our upkeep (IDI with Participant 6, 70 years old, 11 years of frailty).*

I wish the government had policies to help us the elderly, especially in the field of healthcare…Honestly speaking, I am not aware of any policy for the elderly (IDI with Participant 7, 65 years old, 5 years of frailty).

Policies that would provide for us all our needs as elderly people would be most appreciated…If there were programmes that would provide us with some monies for our personal needs, or provision of food stuffs, or constant education on what to expect as elderly people, that would be a great idea (IDI with Participant 7, 65 years old, 5 years of frailty).

I don't know of any health policy for the aged…However, I think an increment in the retirees' salary would be good (IDI with Participant 10, 63 years old, 1 year of frailty).

I think an insurance policy for the aged would help us a lot…Since non-communicable diseases like hypertension and diabetes are common among the elderly, an insurance package to cater for our healthcare needs would help greatly (IDI with Participant 11, 82 years old 15 years of frailty).

I don't know of any programme that is currently ongoing for the frail elderly…I want the government to provide money for the aged for feeding and other up keep (IDI with Participant 8, 65 years old, 2 years of frailty).

What was common among the responses of the interviewees was their unawareness of any social policy regarding their age category. However, they suggested policies that would provide them with money or just to cater for their needs. Though this is an unfortunate

situation, it should however, be noted that attention for the elderly is gradually becoming a societal concern as compared with industrialised societies such as Europe, America and Japan who have established policies. These policies are well known to the general public and are guiding their bahaviour towards quality care for the elderly.

4.3.2. Health systems programmes

Health system programmes for the elderly could be said to be a set of health and safety related activities or measures for the elderly with a particular long-term aim. To better appreciate the perception of the elderly of the quality of healthcare, their knowledge on ongoing activities or programmes were assessed. The interviewees while providing their understanding of such programmes after the meaning of a health system programme was explained to them, most of them appeared not to be aware of existence of any such programmes:

> *There are no such programmes for the elderly…The government should have some programmes that are running – that provide food and other essential commodities for the frail elderly…I have not travelled outside Ghana before but I am sure this is what exactly happens in the developed world (IDI with Participant 3, 69 years old, 3 years of frailty).*

> *I wish there were programmes that could provide food that would be beneficial to the elder… Though I always want to be served food that I have appetite for, I ask myself whether they are good for my health or not…If there was a programme that would provide us food of quality nutrition specifically for the elderly, I am sure I would be*

very much happy…I have been thinking about it (IDI with Participant 4, 70 years old, 10 years of frailty).

There should be a programmes for those of us who had technical and vocational jobs but are now weak so that we could feed ourselves and our family…Even by so doing, we will impact our knowledge and skill to the upcoming generation (IDI with Participant 13, 80 years old 6 years of frailty).

The frail elderly in their submissions exhibited grossly that they had been left in the dark in the discourse of programmes geared towards their wellbeing. Indeed, some programmes they would wish were in place to help their specific needs such as income, foods, healthcare, and psychological empowerment among other essential commodities.

4.3.3. Availability of Resources

To better understand a comprehensive quality of care given under health system factors, resources availability play an important role. Resources need to be allocated to meet the increasingly threatening burden of chronic non-communicable diseases such as heart diseases, stroke and diabetes, which are common among the older population. The interviewees gave their perceived ways of how the health systems could be resourced to achieve the quality of healthcare they hoped for. Inquiring about what the elderly had to say about resources needed in the healthcare system, the following were disclosed, among others:

At this stage, I am so weak and cannot do anything...If I had enough money, I would have personally employed nurses to take care of me at home or as I am here, I would pay for one Nurse to sit by me all the time to assist me… I am so weak and I think the government must provide facilities that will help us cope with the environment (IDI with Participant 1, 84 years old, 5 years of frailty).

Some of the discussions centred on the availability of nursing homes in the country to take care of the frail elderly in times of healthcare need outside of their homes:

> *Before coming to Ghana, I visited six different facilities in the USA... In the States, there are well-resourced institutions like the care homes, Nursing homes and even hospice…There are a remarkable number of facilities, personnel and equipment to aid the aged and persons with disabilities…There are such in Ghana but not enough…It appears as if the onus lie with the private institutions…I expect the government to build such institutions, well-resourced to deliver quality healthcare to the frail elderly (IDI with Participant 4, 70 years old, 10 years of frailty).*

> *Some of my children are working and others have traveled and schooling so I did not have anyone to take care of me…I hoped to know a facility or institution that could help my situation but no one in my family knew of such.…We searched on the internet till we found here…There should be such facilities across the length and breadth of the country and not only in Accra (IDI with Participant 9, 70 years old, 1 year of frailty).*

It could be noted that resources allocation to the specific needs of the frail elderly was required to deliver the quality of healthcare.

4.4. Influence of socio-cultural factors on the quality of care

It could be argued that the Ghanaian traditional extended family system is gradually breaking off and many people are now living in the nuclear family structure. Even within the nuclear family system, the members, especially the younger generations at a stage in their life would

migrate in search of better career opportunities. The out-migration of young people is mainly from rural areas, that results in older people being left behind without children to look after them. With the above understanding that people migrate and will therefore, have the need for the care of their aged relatives leads to the choice of the setting. There are different ways family members can contribute to the care of their elderly though they may be far off engaged in different activities.

Thus, there was the need to explore the involvement of the family members though they pursue career opportunities or greener pastures elsewhere and what the frail elderly expected from society to appreciate the quality of healthcare they received/accessed. In accessing the socio-cultural factors influencing the quality of healthcare delivery, three main sub-themes emerged: family involvement in the healthcare, family health seeking behaviour and expectation from society as analysed below.

4.4.1. Family involvement in the healthcare

In the Ghanaian context, the family is the first institution one is born into, grow up in the mist of their parents, siblings and other key members like aunties, cousins, uncles and others. The analysis revealed how some of the frail elderly expressed the pain they were bearing because they were detached from their family, especially their children who should have been so close to them. However, some were glad to mention that though they felt the pain for losing the presence of their family, especially their children, they appreciated that it was generally due to the current economic situation of the state/country. The frail elderly were asked about how family involvement could influence their perception of the quality of healthcare. The explanations provided were mixed - widowhood and divorce were the issues. For the elderly frail who had children, their healthcare needs were been paid for even though the children could not have time to be with them:

My husband is late and my parents too died so many years ago…My children stay in Accra here so they brought me all the way from Sandema…It is my children who do pay for all my medical bills and my stay here…My children have been supportive…If I didn't have children, I am sure I would be dead by now (IDI with Participant 1, 84 years old, 5 years of frailty).

My children are doing well in taking care of me, especially the one in the United Kingdom... He sends money for my upkeep and other needs (IDI with Participant 7, 65 years old, 5 years of frailty).

On the other hand, for the elderly frail who had no children, their healthcare needs were been paid for by siblings, where they were able to afford:

My wife is late and I have no children too…I have no friends in Ghana too, all my friends are in the United States…My friends are those I have come to meet here…I am being catered for by my brother who is a deacon in the Church of Pentecost (IDI with Participant 2, 77 years old, 3 years of frailty).

For the frail elderly who retired from the formal sector and made pension savings, paying for the cost of their healthcare was their own responsibility where they did not have immediate family members or had but were not interested in their healthcare:

I am the one taking care of myself with my pension money…No one else takes care of me…My wife and I are divorced and we had only one child who is in the USA with my formal wife (IDI with Participant 4, 70 years old, 10 years of frailty).

> *None of my parents are alive - I have lost them both…None of my extended family members come to visit me apart from my wife and kids who do visit from time to time…They take of all my expenses…In fact, that make me feel so good: I don't have any problem because I have come to meet my peers here and we are able to discuss things at our level (IDI with Participant 6, 70 years old, 11 years of frailty).*

However, there were others whose immediate family members were taking care of their cost of healthcare although they did not have the time to keep them at home:

> *I am a widow but my other family members are doing very well to take care of me…I have a supportive family…My children, my nieces and nephews put their heads together to pay for my expenses and also provide me some money for my upkeep...They are really doing well for me... (IDI with Participant 14, 82 years old, 5 years of frailty).*

It was evident that strong family attachments made the frail elderly fulfilled and felt healthier. That is the participants who expressed their family's strong involvement in their healthcare appeared much healthier and stronger.

4.4.2. Health seeking behaviour

The health seeking behaviour of every individual influences their perception of how much quality healthcare receive/access. Usually, the society the individual finds him/herself in also influences their choices of healthcare facility or healthcare providers. Sometimes too, it depends on the type of facilities available in a given community. In probing about the health seeking behaviour of the frail elderly, the responses were not different from what has been mentioned earlier. The choice of a nursing home facility for healthcare depended on the

health condition, proximity to, availability of facilities, expertise of health professionals and other considerations:

> *I started feeling weak about 5 years ago since then, I have visited three facilities in Kumasi, one hospital in Sandema and another one at Tamale before finally coming here…In all, I have visited 6 different facilities…Three of the facilities were public, two private and one herbal…I usually report to facilities that are recommended to me by my family members or friends (IDI with Participant 1, 84 years old, 5 years of frailty).*

> *My family and I all visit Mamobi or Kaneshie Polyclinic when we need to seek healthcare…We go to these facilities because of proximity…They are closer to where we stay (IDI with Participant 6, 70 years old, 11 years of frailty).*

> *We live at Anyaa about 20 kilometers from Odorkor…My family and I have to move to Odorkor or Mallam to seek medical care in a private facility because that is the closest facility to us...We don't have a health facility within my vicinity (IDI with Participant 7, 65 years old, 5 years of frailty).*

> *I prefer going to a Government hospital to seek healthcare…In fact, each and every member of my family have their own health seeking behaviour. My dad is late but mum who is 96 years old is still alive – she prefers visiting the government hospitals as well (IDI with Participant 8, 65 years old, 2 years of frailty).*

It is either Pantang or Korle-Bu Teaching Hospital that my family and I visit anytime we need to...For me, the experienced Doctors and Nurses are there so they can take care of us better… (IDI with Participant 12, 66 years old, 2 years of frailty).

Considering the opinions shown by the frail elderly, most of them preferred to visit the public hospital to seek healthcare. Some do so by reason of proximity but clearly, most of them understand their venerability at this stage and would not do a try-an-error with their health. Apparently, none of the interviewees mentioned that self-medication was the preferred health seeking behavior.

4.4.3. Expectations from society

Aside from economic situations, infrastructure adequacy, policies and programmes, interconnectedness between the frail elderly and the society play a major role in acquiring a complete and holistic quality healthcare. The religious affiliations, social groups or organizations, friends as well as societal norms and values play a significant role in the healthcare of any individual. The frail elderly's connection with the society put them in a safer situation to recover from ailments and acquire improved health status. There is the sense of belongingness within the society once there is the association with the social groupings. The respondents expressed that this sense of belongingness had positive incursions on their physical, psychological and emotional wellbeing. The interviewees gave their views when questioned about their perception of the society's influence on the quality of healthcare accessed:

Because I lived all my life in the state, I don't have friends in Ghana…I have not also joined any groups as of now - don't go to church too…Trust me, I feel lonely…It

makes me feel very down and weak sometimes (IDI with Participant 2, 77 years old, 3 years of frailty).

I am a Methodist and a member of the women's fellowship…Almost every Sunday, members of my church come to visit me…Anytime they come, they sing for me, give me food stuffs, pray for me and also share the word of God with me…This gives me so much joy and happiness…I am able to express myself in their mist and some also encourage me (IDI with Participant 11. 82 years old, 15 years of frailty).

Sometimes, different groups and societies that I don't even know of come to visit us and donate to us…It is refreshing to meet such people…They talk to us, listen to our concerns and try to help us in diverse ways (IDI with Participant 14, 82 years old, 5 years of frailty)

It was revealed from the responses that the involvement of the society gave the elderly frail a high sense of belongingness. The interviewees expressed gross satisfaction when churches and other social groups paid a courtesy call on them. On the other hand, those who did not get this privilege, did express how much they needed such opportunities.

4.5. Chapter summary

This chapter dealt with the analysis of the results under the themes and sub themes that emerged from the analyses of data collected. The next chapter presents the discussion of the findings of the study in relation to theoretical concept and literature.

CHAPTER FIVE

DISCUSSION OF EMPIRICAL FINDINGS

5.0. Introduction

This chapter presents the discussion of the findings of the study and their relationship with available theoretical concepts of quality of care, health systems building blocks, and literature. This chapter has four main sections. Section one presents a discussion of frail elderly's perception of quality of healthcare. Here, the sub-themes presented include: availability of a facility, interpersonal relationship with staff, healthcare staff professional approach, hope of recovering and their feeling of wellness. Section two also presents discussion of the influence of the health system factors on the quality of healthcare. Sub-themes that were discussed here also include: health system policies and financing, health system programmes and availability of resources. The third section of this chapter further presents a discussion of the findings on the sub-themes that emerged from the influence of socio-cultural factors on the quality of healthcare for the frail elderly, which include: family involvement in the healthcare, health seeking behaviour and expectation from society. The final section presents the chapter summary.

5.1. Frail elderly's perceptions of quality of care

One of the theoretical models underlying the conduct of this study was quality of care, which has key components as structure, process and outcome as proposed by Donabedian (2005). Finding in this section of the chapter have been related to this theoretical model and literature accordingly. Literature shows that care receivers or patients, generally measure quality of care on outcome criteria such as feeling comfort, happy, informed and satisfied (Wheatley, *et al.,* 2008). In this study, the interviewees made known their perceptions of the quality of healthcare. They described the availability of a facility, interpersonal relationship with staff,

healthcare staff professional approach, their hope of recovering and their feeling of wellness. These findings are in line with Donabedian's (2005) model of the assessment of quality of healthcare, which is classified under three categories: structure, process and outcome. The inference can be made as; the availability of a facility (structural), interpersonal relationship with staff and healthcare staff professional approach (process) and their hope of recovering and their feeling of wellness (outcome).

5.1.1. Availability of facilities and equipment (Structure)

A quality healthcare delivery requires institutionalization and furnishing the establishment with the required equipment. Donabedian (2005) emphasises the role facilities and equipment play as a structural component for a quality healthcare delivery. The study discovered that the frail elderly acknowledged the imperative role that availability of facilities and equipment play in healthcare delivery. It was revealed that many of the frail elderly were specific with the type of equipment that would help their specific needs. This explains why Robert and Rosalie (2001) concluded in their study that to ensure quality of healthcare, the physical environment must be designed to accommodate disabilities and to ensure that care could be provided or arranged to meet varying levels of need.

5.1.2. Interpersonal relationship between the staff and the elderly (Process)

Interpersonal relationship between the healthcare professionals and clients in general leads to a good therapeutic atmosphere for desired health outcomes (Yümin *et al*., 2011). The study found nothing apart from the assertion that a good interpersonal relationship between the healthcare professionals and the frail elderly could foster a good and therapeutic environment. This confirms Donabedian's (2005) admonishing that in assessing the quality of

healthcare, the processes, which denote the transactions between patients and providers throughout the delivery of healthcare could never be overlooked.

Another revelation that arose from the interviews was the perception that elderly persons who had money were being given level of care, higher than those of lower socioeconomic status, so to say. This turns to be in agreement with a study, which found that income quintile was a key factor of health care services, hence, those in the highest income quintile needed care and also received more care compared with those in the lowest income quintile (Biritwum & Mensah, 2013). Biritwum and Mensah (2013) reported in their study that almost half of the respondents in the lowest quintile did not receive care, compared with only 22% of respondents in the highest income quintile in Ghana. This was confirmed in this study since those who were affluent received special treatment from healthcare staff than those with lower socioeconomic status.

5.1.3. Availability of healthcare professionals (Process)

The availability of the needed personnel, their qualifications, ability and their expert delivery of care is a key determining factor in the assessment of quality of healthcare (Donabedian, 2005). Donabedian (2005) observe that, personnel who have the requisite knowledge and experience to understand and appreciate the specific needs of the elderly are able to offer professional care and that form part of the process determinant of quality of care. The study brought to light the perception of the frail elderly of the quality of care they received/accessed when they came into contact with the healthcare professionals.

Other studies have also documented that the quality of care, especially perceived quality was based on patients' evaluations and opinions of the healthcare provider and was an important deciding factor in choosing a health facility (Karkee & Kadariya, 2013). Some of the frail

elderly appreciated that some of the healthcare professionals exhibited some level of experience, proficiency and perfection in the discharge of their duties. This confirms the findings of a study by Mannava *et al*. (2015) that an ordinary person appreciates the expertise of a professional health worker. Nonetheless, some of the elderly frail did not appear to have enough confidence in the professional competencies of the available health professionals because they did not display any sign of professionalism. This was corroborated by findings of other studies (see Whitburn, Jones, Davey, & Small, 2017; Bohren *et al*., 2015; Mohammad *et al*., 2014).

5.1.4. Hope or recovery (Outcome)

This study revealed that the interviewees believed that so far as there was hope in the healthcare system or supreme being, their health status would improve and lead to their recovery to enable them resume their normal health and activities. The Centers for Medicare & Medicaid Services [(CMS), 2016)] documented that, it was important to assess how the elderly population perceive the quality of healthcare in respect of health outcomes in order to improve care coordination. The study found that to some of the frail elderly, hope of recovery was an outcome indicator as postulated by Donabedian (2005). Though others did not perceive this hope of recovery mainly due to their vast knowledge or experience, they appreciated the efforts of the healthcare professionals. It must therefore, be noted that the health expectations of each client differs from the other (Fishbein, 2008).

5.1.5. Feeling of wellness (Outcome)

Another outcome criteria in assessing the quality of healthcare delivery to the frail elderly was the feeling of wellness. Deducing from the responses of the interviewees, it was observed that though it was believed that frailty was a permanent condition among the elderly

as argued by some researchers, it was not always so (Paskulin *et al*. 2011). The interviewees expressed high levels of wellness and managed to carry out activities of daily living in their own way. It was also noticed from the responses that once the elderly were able to cope with the changes associated with aging, they felt they were completely well. This confirms Donabedian's (2005) view that the outcome measures remain the ultimate validators of the effectiveness and quality of healthcare.

5.2. Influence of health system factors on the quality of healthcare

Another theoretical model underlying the conduct of this study was the six health system building blocks that could be applied to measure access to a quality of care (WHO, 2018). Thus, it was very important to assess the extent to which health system factors influence the quality of healthcare delivered to the frail elderly. The argument is that the population of Ghana is ageing and this poses substantial challenges to the health system (Abikusno, 2007). Abikusno (2007) contends that government therefore, instead of focusing more on battling infectious diseases such as malaria, cholera, tuberculosis and diarrhea, chronic non-communicable diseases such as heart diseases, stroke, diabetes, cancer and hypertension, which are common with aging must have a fair attention from policy makers. The study identified the influence of health system factors on the perception of the frail elderly of the quality of healthcare under three sub-themes: health system policies, health system programmes and frail elderly's access to available facilities/resources as presented below.

5.2.1. Health system policy and financing (Health Financing)

Health financing is one of the six health system building block suggested by the World Health Organisation (WHO, 2018). This study revealed that there was no known social policy existing to make the lives of the elderly better or to improve their healthcare

considering their susceptibility to chronic and non-communicable diseases. This is quite different from some developed countries like Europe, America and Japan where there are established policies. For instance, Japan amongst other countries with the highest life expectancy and persistently low birth rates, have policies that improve the functional capacities and preventing disabilities among the elderly (Ministry of Internal Affairs and Communications, Japan, 2016). These policies are well known to the general public and are guiding their bahaviour towards quality care for the elderly.

Another important exposé of the study was that most of the interviewees suggested that they would be much happier if there were policies that would provide them with money or just to cater for their needs. This assertion is in line with the acclamation of Khan *et al*. (2006) and Zimmer (2008) that persons living in difficult economic conditions need policies that are not aimed at making them wealthy but to cater for their healthcare and other basic needs. Other studies also observe that older adults in lower income countries may not have access to financial support or pensions, making them more economically vulnerable (Albanese *et al*., 2011; Kuo & Lai, 2013).

5.2.2. Health system programmes (Health Service Delivery)

Health service delivery is one of the six health system building blocks that could help enhance access to quality healthcare (WHO, 2018). The frail elderly in their submissions exhibited obviously that they had been left in the dark in the discourse of programmes geared towards their wellbeing. They wished there were programmes in place to help their specific needs such as income, foods, healthcare, and psychological empowerment among other essential services. The wishes of the elderly in their state, was not different from findings from a study that Japan had started to adapt society and institute programmes in order to

maximize older people's health and to facilitate healthy aging via maintaining their functional capacity and preventing disability and dependence (Muramatsu & Akiyama, 2011).

5.2.3. Availability of Resources (Health Workforce)

The World Health Organisation's (WHO, 2015) six building blocks: service delivery, health workforce, information, medical products, vaccines and technologies, financing and leadership or governance, all require resources to achieve the maximum effect. Resources are considered under three main classifications namely: human, capital and material. All aspects of the health system would function effectively with the employment of any or all of these resources be it human, capital or material. Some of the frail elderly in expressing their perception of quality of healthcare they received/accessed with respect to the availability of resources, were dissatisfied with the scarcity of resources. This was however, in line with the conclusion of a study that, not much resources had been allocated proportionally to the larger and increasingly threatening burden of chronic non-communicable diseases such as heart diseases, stroke and diabetes (Abikusno, 2007). However, the findings of this study are timely as studies on health systems and quality of healthcare among the older population are largely lacking, and very little was known about morbidity among Ghana's older population.

5.3. Influence of socio-cultural factors on the quality of healthcare

The theoretical perspective of the health belief model was used to explain the healthcare seeking behaviour of the frail elderly as well (Bookman, Kimbrel, Bookman, & Kimbrel, 2018). Arguably, the Ghanaian traditional extended family system is gradually breaking off and many people are now living in the nuclear family structure. The nuclear family system, however, faces challenges like migration, especially among the younger generations at a stage in their lives (Van der Geest *et al*., 2004). The out-migration of young people is mainly

from rural areas, that results in older people being left behind without children to look after them. The frail elderly therefore outlined their perception of quality health with respect to the socio-cultural factors under three different themes: family involvement in the healthcare, family health seeking behaviour and expectation from society.

5.3.1. Family involvement in the health care of the elderly (Perceived Benefits)

It was loudly highlighted in the submissions of the frail elderly in this study that the involvement of their family members in their healthcare was very significant. It was evident that strong family attachments made the frail elderly fulfilled and felt healthier. This confirms the findings that good relationships and family tidings keep people healthier and happier and in effect, live longer (Waldinger, 2008).

5.3.2. Health seeking behaviour (Perceived Benefits and Barriers)

Health seeking behaviours differ from person to person, society to society and community to community. The usual determinants are the availability of a facility, assess to the appropriate facilities and the cultural norms and believes of the individuals (Pang, Jordan-marsh, Silverstein, & Cody, 2003). The health belief model developed to explain and predict health related behaviours, particularly in regard to the uptake of health services has it that perceived severity, susceptibility and benefits cause the behavioral change in seeking health services.

According to the findings of this study, most the frail elderly, preferred to visit the public hospital to seek healthcare. Some did so by reason of proximity but clearly, most of them understood their venerability at this stage and would prefer a facility where there was assurance of professionalism. Van der Geest *et al*. (2004) looked at the causes necessitating the decision to adopt a particular setting for the delivery or access to healthcare for the frail

elderly and concluded that older people migrate to societies where there are systems and resources in caring for the aged. However, the findings of Van der Geest *et al*. (2004) did not correspond with the findings of this study.

5.3.3. Expectations from society (Cues to Action)

It was revealed from the responses that the involvement of the society gave the frail elderly a high sense of belongingness. This sense of belongingness is what is stated as the third most important need of mankind in the hierarchy of need as 'the need of love and belongingness' (Maslow, 1943). Some of the interviewees expressed gross satisfaction when churches and other social groups paid a courtesy call on or visited them. On the other hand, those who did not get this privilege, did express how much they needed such opportunity.

5.4. Chapter summary

This chapter has presented a discussion of the findings of the study with respect to how they were related to available theories and literature. The next chapter will be discussing the conclusions and the recommendations of the study.

CHAPTER SIX

SUMMARY, CONCLUSIONS AND RECOMMENDATIONS

6.0. Introduction

This chapter presents the summary, conclusions and recommendations of the study. The chapter is made up of six sections. Section one presents the summary of the study. Section two presents the conclusions based on the objectives of the study. Section three presents contribution to knowledge in terms of policy and practice, methodology and theory. Section four presents the recommendations based on the findings of the study. Section five presents limitations to the study. Section six presents future research.

6.1. Summary of the Study

This study was conducted to assess the perception of the frail elderly of the quality of healthcare they received/accessed. Generally, the study explored the challenges confronting the elderly in their frailty and extracts of how they wished to receive quality healthcare. This was achieved by implementing a qualitative research methodology, where in-depth interviews were conducted with 15 frail elderly who were more than 60 years old and needed assistance to carry out some activities of daily living. Those who had cognitive adequacy were used in order to provide the responses that would be most appropriate for analysis. Their perceptions of the quality healthcare were unraveled to identify how they would like to receive quality healthcare. The findings of the study were analyzed using suitable frameworks and related to earlier studies conducted on the elderly. The perception of the quality of healthcare among the frail elderly was explored in the Tema Metropolis in the Greater Accra Region and the main conclusion is that, there are so many lapses with regards to quality healthcare provision to the frail elderly. The study was able to address the objectives of the study and the main conclusions have been outlined as below.

6.2. Conclusions of the study

The main conclusions of the study in this section are presented on the basis of the specific objectives of the study.

6.2.1. Frail elderly's perception of quality of care

This study concludes that there were lapses in the quality of healthcare provided to the frail elderly in terms of the availability of a facility, interpersonal relationship with staff and healthcare staff /professional approach. They suggested ways or the manner they wished to receive healthcare. The sub-themes that emerged under this them have been presented below.

6.2.1.1. Availability of facilities and equipment

The study concludes that though there were some nursing homes for the aged, these were not enough and not well known to the general public. Some homes had folded up and added their clients up to the Mercy Home Care at Sakumono. These homes folded up because they did not have the equipment and other resources to cater for the frail elderly. At the Mercy Home Care at Sakumono, the study found that they lacked some of the basic equipment like wheelchairs, assistive device for walking, air mattresses and oxygen points for emergency situations. These equipment are needed in frail elderly's nursing home to ensure their safety, healthcare and quality of life (Robert & Rosalie., 2001)

6.2.1.2. Interpersonal relationship between the staff and the elderly

The study found and concludes that interpersonal relationship between the healthcare professionals and the frail elderly was not very cordial. The elderly claimed that the healthcare professionals preferred to stay away from them and only came to their aid when they had actually called for assistance. It was found that the healthcare givers preferred

watching television or playing with their phones at their station other than spending quality time with them to explain some issues concerning their condition to allay their anxiety. Thus, it could be argued that at their age, the frail elderly needed effective provider-patient relationship to enable them get through their conditions. A similar suggestion has been documented in the literature (Yümin *et al*., 2011).

6.2.1.3. Availability of healthcare professionals

The study concludes and argues that the frail elderly's perception of the competency of the healthcare professionals was mixed. This study found that some of the frail elderly appreciated that some of the healthcare professionals exhibited some level of experience, proficiency and perfection in the discharge of their duties. However, some of the elderly frail did not appear to have enough confidence in the professional competencies of the available health professionals because they did not display any sign of professionalism. The study concludes that the frail elderly perceived that most of the available healthcare professionals did not have the requisite knowledge of caring for their specific needs. That is, they perceived that the nurses did not even under the conditions they were suffering from. Previous studies have noted similar observations (Mannava *et al*., 2015).

6.2.2. Influence of health system factors on the quality of healthcare

The extent to which health system factors influence the quality of healthcare delivery to the frail elderly were assessed. The argument is that the population of Ghana is ageing and this poses substantial challenges to the health system considering the high vulnerability of the aged to chronic non-communicable diseases. The sub-themes that emerged under this them have been presented below.

6.2.2.1. Health system policy and financing (Health Financing)

This study revealed that there was no known social policy existing to make the lives of the elderly better or to improve their healthcare considering their susceptibility to chronic conditions like hypertension, diabetes, cancers and frailty. Another important exposé of the study was that most of the interviewees elderly suggested that they would be much happier if there were policies that would provide them with money or just to cater for their fundamental needs. This conclusion contrasts with evidence of social policy for the elderly in other developed economies (Ministry of Internal Affairs and Communications, Japan, 2016).

6.2.2.2. Health system programmes (Health Service Delivery)

The study also concludes that the frail elderly had apparently been left in the dark in the discourse of programmes geared towards their wellbeing. They wished there were programmes in place to help their specific needs such as income, foods, healthcare, and psychological empowerment among other essential needs. This conclusion may be prevalent in most countries in Sub-Saharan Africa, however, the story is different in other developed countries (Muramatsu & Akiyama, 2011).

6.2.2.3. Availability of Resources

The study found and concludes that some of the frail elderly in expressing their perception of quality of healthcare they received/accessed with respect to the availability of resources indicated that they were dissatisfied with the scarcity of resources. Therefore, the study concludes that not much resources have been allocated proportionally to care for the larger and increasingly threatening burden of non-communicable diseases such as heart diseases, stroke and diabetes affecting the frail elderly. Similar arguments have been registered by some researchers (Abikusno, 2007).

6.2.3. Influence of socio-cultural factors on the quality of healthcare

The study argues that many people in Ghana, are currently, living in the nuclear family structure and even with that, there is a challenge of out-migration of the younger generation. This could lead to the older people being left behind without people or children to look after them. Therefore, the frail elderly outlined their perception of quality health with respect to the socio-cultural factors under three different themes: family involvement in the healthcare, family health seeking behaviour and expectation from society as presented below.

6.2.3.1. Family involvement in the healthcare

It was loudly highlighted in the submissions of the frail elderly in this study that the involvement of their family members in their healthcare was very significant. It was evident that strong family attachments made the frail elderly fulfilled and felt healthier. Therefore, the study concludes that the involvement of the family and significant others was very important in the delivery of quality healthcare to the frail elderly. This feeling of family support shows the foundation stone of the African and Ghanaian society, which is gradually waning (Waldinger, 2008).

6.2.3.2. Family health seeking behaviour

The findings of this study revealed that, the frail elderly, preferred to visit the public hospital to seek healthcare. While the reason could be due to proximity but clearly, the elderly were assumed to understand their venerability at this stage and would prefer a facility where there was assurance of professionalism. The frail elderly's quest for quality healthcare was based on where they could encounter experienced personnel. The study concludes that, though the frail elderly were admitted into a nursing home, they would prefer to a public hospital when they feel really ill. Studies have made similar observations (Pang et al., 2003).

6.2.3.3. Expectation from society

One key conclusion of this study is that the frail elderly just expect so much from society in order to categorise healthcare as a quality. It was revealed that the involvement of the society gave the elderly frail a high sense of belongingness. This was adduced from the findings that the frail elderly expressed gross satisfaction with the visit by churches and other social groups. On the other hand, other frail elderly who did not get this privilege, did express how much they needed such an opportunity.

6.3. Contribution to knowledge

The study makes prospective contribution to knowledge, which has been categorized under policy and practice, theory and methodology. These have been expanded below.

6.3.1. Implications for policy and practice

The Government of Ghana provides in the national aging policy document, "aging with security and dignity," (2010), a framework that is intended to transform and improve the lives of older persons in the country. The document is aimed at providing an action plan, programmes and projects not only to ensure successful implementation of the policy but also to ensure that the quality of life of older persons in Ghana improves significantly and that the goal of ageing actively with adequate security and dignity is achieved.

However, one startling revelation of this study was that there seemed to be no defined policy framework for healthcare management among the frail elderly within the country's health care system. Thus, changes in the provision of quality healthcare for frail elderly may involve changes in policy direction, organizational structures as well as clinical interventions to ensure satisfactory, continuous and consistent delivery of care. The following have been

suggested for consideration by health policy makers in their efforts at improving quality of healthcare for the frail elderly.

The nation, endowed with the enormous natural resources with huge state capital should build facilities aimed at caring for the elderly. However, there appeared to be no known facility as indicated in this study that the participants had to do a thorough search through the internet and asking family and friends until they heard of the Mercy Home Care Centre. Even apart from that, they did not know of any other facility of similar nature. Having facilities across the length and breadth of the country would help cater for the increasing older population. Such homes could even serve as a centre to acquire knowledge and experience. The youth could visit such centre and have a chat with these personalities who have accomplished so much in life so that they could also better shape their lives in the right direction.

It was highlighted that money was so much a needed commodity for the frail elderly. In view of that, a policy direction that would look at earmarking taxes for caring for the aged in their frailty, would give them satisfaction and better lives. These funds would not be meant for putting monies in their pockets, but to resource them with essential drugs and medicines as well as relevant gadgets that support their specific needs.

The interviewees who were retired public servants were so bitter about the amount of money they were receiving as their monthly retirement packages. This implies that if the laws regarding payment into SSNIT be reviewed so that the elderly could have enough money to cater for themselves in their frailty. Some of these frail elderly had younger generations who still depend on them for a living. Therefore, an increase in their monthly earnings would help them so much that they could provide for their personal need and other responsibilities.

In the meantime, since there are some private institutions that have started these aging home services, the government could support them or probably adopt such institutions as quasi-government to help in the effective management of the healthcare of the frail elderly. Since Public Private Partnership (PPP) is proven to be one of the most effective means of achieving high standards of productivity of good and services, this study suggests such for the frail elderly in Ghana (Tang, Shen, & Cheng, 2010).

This study found that specific training is required to take care of the frail elderly in a more professional manner. Therefore, it would be necessary for the health training institutions (the universities, nursing training colleges) to inculcate care for the elderly in their curriculum/curricula. It would be most appreciated to have a health training institution solely for the training of professions/professionals to provide healthcare to the frail elderly.

The study suggests that individuals, institutions, NGO's and the government should support the frail elderly by providing them with food, medicines and other essential materials needed for healthy living. Communities, religious groups and other social organizations should be encouraged to visit the frail elderly and engage them in conversations, offer them gifts to allay their anxiety and provide them with some form of diversional therapy. All these would psychologically improve the health of the elderly preventing morbidities and mortalities among the frail elderly.

6.4.2. Contribution to methodology

This qualitative study addressed a gap in the literature by exploring the perceived quality of healthcare among the frail elderly. Different studies have applied quantitative methods to arrive at a results (Yümin et al., 2011). This study rather delved deeper into knowing their experiences, their perception, their feelings and how they would like quality healthcare to be

provided to them. Key findings of this study would be useful and important in effecting changes in the provision of healthcare to the elderly, especially the frail and providing the most conducive environment for their care. The argument here is that the application of a quantitative method would just have been able to quantify the responses without showing the reasons behind them.

6.4.3. Contribution to theory

This study makes significant contribution to knowledge with respect to the application of research theories by triangulating different theories to interpret the findings of the study. That is, the researcher successfully applied the health belief model, the health system building blocks and the Donabedian's model of assessing the quality of healthcare. The adaptation of the theoretical triangulation of these three theoretical frameworks gave a deeper understanding to the findings of the study (Creswell, 2013). Thus, an exploration of the frail elderly's perceptions the quality of healthcare accessed at the nursing home.

6.4.4. Recommendations

This part draws on findings of the study and provides recommendations, which would contribute to the quality of healthcare to the frail elderly. Health policy makers and the general public could take useful lessons from them.

1. There is the need to review the laws regarding payment into SSNIT pension fund. This could be achieved by increasing the premiums so that the elderly could have enough money to cater for themselves in their frailty.

2. There is the need to support private institutions that care for the elderly. Government could adopt such institutions as quasi-government to help in the effective management of the healthcare of the frail elderly.

3. There should be special training for healthcare professionals in the healthcare and management of the frail elderly.

4. There is the need for individuals, institutions, NGO's and the government to support the frail elderly by visiting and providing them with food, medicines and other essential materials needed for healthy living. They should also engage them in conversations, offer them gifts to allay their anxiety and provide them with some form of diversional therapy.

6.5. Limitations to the Study

The study may possibly have some element of biases since it was conducted in a private healthcare or nursing home. The interviewees may want to withhold some vital information pertaining to their healthcare within the nursing home. Another limitation of the study would possibly be that only one facility was used. Probably, if more facilities where used, there might be a different perspective but for how uncommon these facilities were. Again, a sample size of 15 was used because the number of clients in the facility were twenty seven. Meaning, 15 respondents were more than half the total number of clients in the facility. Moreover, this study only used one municipality but more than one municipalities would have given a more accurate insight into the research objective. Lastly, the involvement of the researcher may have affected the quality of care offered by the health providers. A similar remark has been made (Rowe et al., 2006).

6.6. Further research

Further qualitative studies should be conducted to generate more information on the perspective of quality of care of both health providers and the frail elderly in the whole country. Again, further studies should include more facilities to probably achieve a different perspective to the findings of this study. Furthermore, a study that would have an increased sample size could provide a more precise outcome. Moreover, using more than one municipality in a further research would give a more accurate insight to the research objective.

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APPENDICES

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APPENDIX A: PARTICIPANTS INFORMATION SHEET

This information sheet provides information about the research for the elderly at Mercy Home Care at Sakumono to make an informed decision of whether to participate in the study or not. It outlines the nature of the research, what the research involves, risks, benefits and compensation.

Title of Study: "Assessment of the quality of healthcare to the frail elderly in the Tema Metropolis"

Introduction: I am Samuel Donkor a Master of Public Health (MPH) student at the School of Public Health of the University of Ghana, Legon. My email address is samdonkor56@gmail.com and my telephone number is 0201784314. I am conducting a research on the topic: Assessment of the quality of health care to the frail elderly in the Tema Metropolis

Background and Purpose of research: The World Health Organisation (WHO) statistics reveal that people worldwide are living longer; and today, for the first time in history, most people can expect to live into their sixties and beyond (WHO, 2018). The WHO (2018), document continues that by 2050, the world's population aged 60 years and older will total 2 billion, up from 900 million in 2015, as currently, 125 million people are aged 80 years or older. However, many older adults develop chronic diseases and disability as they age, and have poor quality of life in their later years (Fried *et al*., 2004; Abellan *et al*., 2008). In view

of the above evidence that the aged population is growing and that there will be the need to ensure that health systems are improved to be able to address their needs, one fact that remained to be examined was the issue of provision of a quality of healthcare for the frail elderly in the Ghanaian communities. It was in this direction that this study was set out to explore the quality of care for frail elderly persons in the Tema Metropolis of the Greater Accra Region.

Nature of research: This study is qualitative study, focusing on exploring the quality of healthcare for the frail elderly in the Tema metropolis. I am interested in finding the influence of health system factors and socio-cultural factors on the quality of healthcare among the frail elderly. Fifteen frail elderly who are at least 60 years old, need assistance with one or two activities of daily living and are cognitively adequate will be used for the study. The study will take place right here at the Mercy Home Care Centre.

Participants involvement: I would like to invite you to participate in this study because you are an elderly who is at least 60 years old, need assistance with one or two activities of daily living and cognitively adequate in the Tema Metropolis. I believe that you can help me by providing the appropriate responses.

Duration /what is involved: I am going to interview you; ask you some question. If you are interested in participating in this study, your responses will be recorded after which I will play back your voice for you to listen and agree to the information given. I will be asking you questions about your perception of the quality of healthcare. The interview will last between 20 – 30 minutes. I will go and write down all your responses to do analysis.

Potential Risks: There would be no anticipated risk or harm from the study. The only inconvenience would be the time spent in the interview. In view of this, the design of the interview guide is well structured to facilitate the discourse. The respondents would be

informed about the general nature of the study and assured of no potential harm during the study.

Benefits: Though you may not have any immediate or direct benefits from the study, your responses would be helpful in policy planning and formulation of recommendations to appropriate authorities concerning care for the elderly.

Costs: Participation in this study will not cost you any money. You will also not receive any money/incentives for participating in this research.

Compensation: You will not be compensated for your participation and loss of time

Declaration of Conflict of Interest: The researcher has no conflict of interest in this study.

Confidentiality: Your name and identity will be kept safe and highly confidential in this study. However, the information you are going to provide will be coded and will be treated strictly confidential. You are assured of total confidentiality to the information you will give. Apart from the researcher and supervisor of this research, no one else will have access to information provided whether in part or whole. Data files would be kept for six months after which they will be destroyed or discarded.

Voluntary participation/withdrawal: Participation is voluntary. You are free to choose if you want to take part in this study. Also, you can withdraw your consent at any time without further explanation, and without any adverse consequences.

Outcome and Feedback: Data gathered will help to improve policy formulation for the frail elderly in Ghana.

Feedback to participant: No feedback will be given to you as an individual but a report will be given to the various stakeholders involved in formulating policies for the frail elderly in Ghana (GHS, MoH just to mention a few).

Funding information: The principal investigator if funding this study.

Sharing of participants Information/Data: Data gathered will be kept in my possession and will not be shared with any other organization(s) or individuals. It will be solely mine.

Storage of samples: Data files would be kept for six months after which they will be destroyed or discarded. Clearance will be sought from the ERC before it would be used for any other purpose.

Provision of Information and Consent for participants: You will be given copy of the Information sheet and Consent after it has been signed or thumb-printed to keep.

Voice Recording: The voices will be recorded with mobile phone voice recorder and later transcribed to be analysed.

Who to Contact for Further Clarification/Questions: If you have a concern about any aspect of this research, please contact Samuel Donkor at The School of Public Health, Legon or speak to me on tel. no 0201784314/0248337663. For further clarification on ethical issues please contact Madam Hannah Frimpong, the administrator at the Ghana Health Service Ethics Review Committee on Tel 0507041223.

APPENDIX B: CONSENT FORM

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CONSENT FORM FOR INTERVIEWEES AT MERCY HOME CARE CENTER

PARTICIPANTS' STATEMENT

I acknowledge I have read or have had the purpose and the content of the Participants' Information Sheet read and all questions have been satisfactory explained to me in the language I understand (English [ ] Twi [ ] Ga [ ]). I fully understand the content and any potential implications as well as my right to change my mind. (ie withdraw from the research) even after I have signed this form. I voluntary agree to be part of this research.

Name or Initial of Participant……ID Code…….

Participants' signature……..OR Thumb Print……

I agree that my voice be recorded for this study: YES ☐ NO ☐

INTERPRETERS' STATEMENT

I interpreted the purpose and content of the Participants' Information sheet to the afore mentioned participant to the best of my ability in the (Twi [ ] Ga [ ]) language to his or her proper understanding. All questions, appropriate clarifications sort by the participant and answers were also duly interpreted to his/her satisfaction.

Name of Interpreter…….signature of interpreter……..

Date ……. Contact Details……

STATEMENT OF WITNESS

I was present when purpose and content of the Participants' Information sheet was read and explained satisfactorily to the participant in the language he/she understood (Twi [ ] Ga [ ]). I confirm that he/she was given the opportunity to ask questions/ seek clarifications and same were duly answered to his/her satisfaction before voluntarily agreeing to be part of the research.

Name …….Signature…….OR Thumb Print……..

Date……..

INVESTIGATOR STATEMENT AND SIGNATURE

I certify that the participant has been given ample time to read and learn about the study. All questions and clarifications raised by the participant has been addressed.

Researcher's name…….. Signature…….

Date ……Participant's ID Code……..

Place……

APPENDIX C: SEMI-STRUCTURED INTERVIEW GUIDE ON ASSESSMENT OF THE QUALITY OF HEALTHCARE FOR FRAIL ELDERLY IN THE TEMA METROPOLIS, GHANA

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Introduction

I am a student of the University of Ghana, Legon, carrying out a research on the topic: "Assessment of the Quality of Healthcare for Frail Elderly in the Tema Metropolis, Ghana". I would be grateful if you could provide answers to the following questions. Whatever information provided will be given utmost confidentiality. Thank you.

Section A: Socio-Demographic Characteristics

1. How old are you?
2. Current marital status?
3. Where are you currently living?
4. Which type of house do you live in?
5. What is your religious affiliation?
6. Ethnicity
7. Employment status.

Section B: Health System Factors Associated with Quality of Care

8. Are you aware of any programme that the Government has instituted to help your health care?

9. Mention any health policy for the elderly you are aware of.
10. What do you think should be done in our health care system to improve care for the elderly?
11. At what age did you realize you were becoming weak and needed constant care?
12. How many different facilities do you visit?
13. Are you assisted in carrying out activities of daily living and who assists you if there is any?
14. Which type of health facility is within the vicinity where you live?

Section C: Socio-Cultural Factors Influencing the Quality of Healthcare Delivery

15. Which type of health facility do you and your family members usually visit?
16. How old were your parents when they died?
17. How are you being catered for by your family members?
18. Do you know where those persons of your age are and what they are doing now?

Section D: Perception of Quality of Health Care

19. Are you very concerned about your current general health?
20. How much understanding do you have about your current health problems?
21. Thinking about the doctors and nurses you usually see, how confident are you that they will understand your need?
22. How confident are you that, they will do their best to help if you need it
23. Do you think they have good medical knowledge about your condition?

24. Do you have any hope of recovering?
25. Thinking about your doctors and nurses, how much of their advice are you following on your medication or treatment?
26. Thinking about your doctors and nurses, how much of their advice are you following on Leading a healthy lifestyle and why?
27. Do you at times feel that when it comes to quality healthcare you are been sidelined?
28. Does your physical or mental health prevent you from enjoying life or doing your normal activities?

Thank you.

APPENDIX: D ETHICAL CLEARANCE

GHANA HEALTH SERVICE ETHICS REVIEW COMMITTEE

In case of reply the number and date of this Letter should be quoted.

Research & Development Division
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MyRef. GHS/RDD/ERC/Admin/App/19/226
Your Ref. No.

15th July, 2019

Samuel Donkor
37 Military Hospital
Trauma and Surgical Emergency Unit

The Ghana Health Service Ethics Review Committee has reviewed and given approval for the implementation of your Study Protocol.

GHS-ERC Number	**GHS-ERC 048/04/19**
Project Title	Assessment of the Quality of Health Care Delivery to the Frail Elderly in the Tema Metropolis
Approval Date	15th July, 2019
Expiry Date	14th July, 2020
GHS-ERC Decision	**Approved**

This approval requires the following from the Principal Investigator

- Submission of yearly progress report of the study to the Ethics Review Committee (ERC)
- Renewal of ethical approval if the study lasts for more than 12 months,
- Reporting of all serious adverse events related to this study to the ERC within three days verbally and seven days in writing.
- Submission of a final report after completion of the study
- Informing ERC if study cannot be implemented or is discontinued and reasons why
- Informing the ERC and your sponsor (where applicable) before any publication of the research findings.
- Please note that any modification of the study without ERC approval of the amendment is invalid.

The ERC may observe or cause to be observed procedures and records of the study during and after implementation.

Kindly quote the protocol identification number in all future correspondence in relation to this approved protocol

SIGNED.....
DR. CYNTHIA BANNERMAN
(GHS-ERC CHAIRPERSON)

Cc: The Director, Research & Development Division, Ghana Health Service, Accra