

**AN ASSESSMENT OF THE IMPLEMENTATION OF SDG3 IN
ELDERLY HEALTH CARE DELIVERY IN GHANA**

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DECLARATION

This dissertation is the result of research work undertaken by Ewurabena Andoh-Kumi in the Legon Centre for International Affairs and Diplomacy, University of Ghana, under the supervision of Ambassador Dr. Kodzo K. Alabo.

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DEDICATION

I dedicate this work to my father and mother, Prof (Dr) and Mrs K. Andoh-Kumi, and my lovely son, Adomba.

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I would like to acknowledge special individuals who were united in their support and contribution in making this dissertation a success.

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ABBREVIATIONS AND ACRONYMS

| | |
|--------|----------------------------------------------------|
| AIDS | Acquired Immune Deficiency Syndrome |
| BMCs | Budget and Management Committees |
| CHAG | - Christian Health Association Ghana |
| CHPs | Community Home-Based Programme services |
| DHA | District Health Assembly |
| DHMT | District Health Management Team |
| FBH | Faith Based Hospital |
| FDB | Food and Drugs Board |
| GAEC | Ghana Atomic Energy Commission |
| GHS | Ghana Health Service |
| GOG | Government of Ghana |
| GSS | Ghana Statistical Services |
| HFH | Holy Family Hospital |
| HIV | Human Immunodeficiency Virus |
| HMN | Health Metrics Network |
| HRoL | Health Related Quality of Life |
| KATH | Komfo Anokye Teaching Hospital |
| KBTH | Korle-Bu Teaching Hospital |
| LEAP | Livelihood Empowerment against Poverty |
| MIPAA | Madrid International Plan of Action on Ageing |
| MDAs | Ministries, Departments and Agencies |
| MOCGSP | Ministry of Children, Gender and Social Protection |
| MOE | Ministry of Education |
| MOF | Ministry of Finance |

| | |
|-------|----------------------------------------------|
| MOH | Ministry of Health |
| MTHS | Medium Term Health Strategy |
| MDGs | Millennium Development Goals |
| NCDs | Non-Communicable Diseases |
| NDPC | National Development Planning Commission |
| NGOs | Non-Governmental Organisations |
| NHIF | National Health Insurance Fund |
| NHIS | National Health Insurance Scheme |
| OPD | Out-Patient Department |
| PHCs | Primary Health Care services |
| RHA | Regional Health Administration |
| SDGs | Sustainable Development Goals |
| SSNIT | Social Security and National Insurance Trust |
| TH | Teaching Hospital |
| UHC | Universal Health Coverage |
| UN | United Nations |
| UNDP | United Nations Development programme |
| WHA | World Health Assembly |
| WHO | World Health Organisation |
| WMH | Wenchi Methodist Hospital |

ABSTRACT

The elderly go through diverse challenges during their course of life. One of such difficulties affects the health of the elderly and the outcomes of elderly health delivery services. There have been many mechanisms used to enhance elderly health care considering the fact that there has been an increase in the aged population over the years. This study sought to assess the implementation of SDG3 in elderly health care delivery in Ghana. To obtain this objective, qualitative research approach was used to collect primary and secondary data for analysis and discussion. Primary data were obtained using a semi-structured interview guide for officials from GHS, KBTH and GAEC Hospital whiles secondary data sources were from reports, books, journal articles, policy documents, official documents, research papers, internet sources and articles. The SDGs constitute a framework to ensure sustainable development in all spheres of the state, including health. Geriatric care seeks to ensure health care for the elderly in Ghana. Interventions have also been made to ensure the realisation of SDG3 in the elderly health services delivery through UHC, and reduction of NCDs. However, some challenges have been encountered in the implementation of SDG3 in the elderly health care delivery. These include constraints on human resources, challenges associated with NCDs treatment and prevention, shortfalls of NHIS and inadequate funding. So, to curtail these challenges and improve on the others, it is suggested that funds should be set aside for health care delivery for the elderly. GHS and its stakeholders must also implement the framework to ensure easy access for elderly patients with NCDs, and the training needs for health care of the elderly must be reviewed.

CHAPTER ONE

INTRODUCTION

According to Ghana's Population and Housing Report (2010), the concept of ageing is the process by which persons or adults attain chronological ages that are classified with old age (Ghana Statistical Service (GSS), 2013). Globally, health is being recognized and deemed as a determinant of development in a country. It has also been noted that life expectancy is on the rise (Fried & Paccaud, 2010). Ageing comes along with a lot of health complications. A higher proportion of the elderly compared with that of the younger adult suffer from non-communicable diseases (NCDs) such as hypertension and diabetes, which are medically costly and expensive to manage and treat (Hui, 2017). Therefore, states, through their government process, must establish institutions to take care of this situation.

1.0 Background to the Research Problem

One of the trending situations in our world today is demographic ageing. Most people are living into sixty (60) years and beyond (Beard, Officer, & Cassels, 2016). Age distribution is increasingly shifting to older ages. This phenomenon is widespread, though it may be less in some parts of the world, such as Africa (Bloom, 2011).

“Increasing life expectancy and reduced lifetime fertility are the key factors driving demographic transition. At the worldwide level, life expectancy rose from 47 years in 1950-1955 to 65 years in 2000-2005 and is expected to extend to 75 years in 2045-2050” (United Nations Department Economics and Social Affairs(UN DESA), 2007,p (ii))

High fertility and high mortality result in a young population, whereas low birth rate and low death rates yield an older population (Mba, 2010). Also, it has been recorded that Japan holds

the largest, oldest population with 31.6%, followed by Italy with 27.0%, then Germany with 26.7%.

As stated by the World Health Organization (WHO), an increment in the aged population changes the values, needs and health outcomes of elderly people. The health of people specifically the elderly are very significant to society. The elderly contribute to society in diverse ways within the family context, the local community and the society as a whole (Beard et al. 2016). In most cases, ageing is accompanied with accumulated variety of negative health outcomes, which weaken the body and its ability to resist certain diseases. Nonetheless, most country policies do not extensively cater for the health maintenance of elderly people (Steves, Spector, & Jackson, 2012).

Also, an assessment by the WHO, intimates that health systems are deteriorating with regard to satisfying the demands of elderly individuals. The assessment states,

“Current public-health approaches to population ageing have clearly been ineffective. The health of older people is not keeping up with increasing longevity; marked health inequities are apparent in the health status of older people; current health systems are poorly aligned to the care that older populations require even in high-income countries; long-term care models are both inadequate and unsustainable; and physical and social environments present multiple barriers and disincentives to both health participation” (UN, DESA, 2015, p. 91).

Based on the above statement by the UN DESA, it is deemed that elderly health care delivery is inadequate. Hence, it poses an infringement on an elderly person’s right to health. The WHO constitution enshrines *“high attainable standard of health”* as a *“fundamental right of every human being”* (The Constitution of the World Health Organization, 1946, p. 1). It recommends that everyone, the elderly not exempted, to enjoy health rights. According to Baer, Bhushan, Taleb, Vasquez, and Thomas (2016), the right of the elderly includes making

health care and health care services available, accessible, acceptable, and providing quality health care services. Human rights also seek to aid in the realization of health rights. Human rights and other related rights require that health interventions and processes are guided by three core human right principles; stigma and discrimination as a barrier to elderly right to health, informed consent of the elderly in matters of health and wellbeing and accountability of ageing and health. (WHO and Office of the United Nations High Commissioner for Human Rights OHCHR, 2008).

Narrowed down to Africa, many countries have also had defects in the health system which affect health service delivery for the elderly. The special needs of the elderly people are well documented, and the provision of health care for the elderly does not seem to be adequate (WHO African Region, 2013). The insufficient infrastructure and inappropriate education of gerontology and geriatrics poses a threat to elderly health maintenance. It has also been noted that the issues affecting the population are mostly focused on women and children. There is a presumption that the elderly are happily living with their extended families. For instance, it was reported that in South Africa, health personnel are inadequately trained in the care of the elderly. They lack the knowledge, skills and resources to manage health conditions that affect the elderly. (Kalula, 2013)

In effect, there have been assertions that “health is at the heart” of sustainable development. Sustainable Development is defined as, “*development that meets the need of the present without compromising the ability of future generation to meet their needs. It involves the environmental, social and economic concerns in all aspects of decision making*” (Emas, 2015, p. 1). Dora et al. (2015) also advance that health is vital to sustainable development. This stresses the role of elderly people. Healthy people, including the elderly, contribute

immensely to economies and societies because they have the ability to learn. This is an essential reason to uphold the health care delivery of elderly people.

In addressing the health issues of elderly people, United Nations (UN) introduced the Sustainable Development Goals (SDGs), with Goal Three (3): Good health and well-being as a framework to tackle global health issues. The SDGs succeeded the Millennium Development Goals (MDGs) which spearheaded the development front from 2000-2015 through the Millennium Declaration. The SDGs, also known as Global Goals, seek to commit countries into setting targets within their policies and programmes from 2015 to 2030.

At the UN General Assembly 2015, one hundred and thirty-nine (139) member states including Ghana signed up to the Global Goals. With respect to health issues, Universal Health Coverage (UHC) under the SDG3 sought to solve health care delivery pitfall. It, therefore, proposes to ensure that the right to health is enjoyed by everyone as laid down in the WHO Constitution (WHO Constitution, 1946).

1.1 Problem Statement

The adoption of International Plan of Action on Ageing in 1982 by Madrid International Plan of Action on Ageing (MIPAA) at the Second UN General Assembly on Ageing, provides concrete steps to address the needs of the elderly with a globally confronted effort. Efforts must be made by countries to tackle issues concerning the aged population (Fried & Paccaud, 2010). These issues are associated with nutrition, health, housing and a host of others. In effect, Ghana's reaction to the Madrid Plan of Action was the formulation of a National Ageing Policy in 2010.

With regard to health, the National Ageing Policy, 2010, it states that the elderly people are entitled to preventive and curative care such as rehabilitation services by means of retirement homes, but that is not the reality on the ground. Also, the policy indicates that the NHIS seeks to cover medical expenses and basic treatments. However, diseases mostly diagnosed of the elderly are not covered by the scheme. The diseases include diabetes and heart-related problems. A survey of Ghana situation also found out that the elderly are unaware of their rights to health services, for example, they (the elderly) are exempted from “cash and carry system” when accessing health care (Ahenkora, 1999). Biritwum (2013) also confirms that because of poor education and sensitisation, most elderly people are not aware of their entitlements to health care services. The health care of the elderly must go beyond disease treatment (GSS, 2013). Social factors such as the family must be considered to aid health efforts in ensuring primary health care for the elderly.

Ghana’s endorsement to the MDGs in 2000 sets the pace in attaining quality health care. The MDGs report 2015 states that MDG 6 served as a stepping stone in addressing health issues, but it failed to specifically deal with health matters concerning the elderly. The SDGs, on the other hand, encompasses Global Ageing, a “leave no one behind” agenda meaning the vulnerable in society, children, women and the elderly are assured entitlement to globally recognised privileges. Thus, it commits states to address issues concerning the elderly including health related problems(Bluestone, 2016).

With regard to the above, the aim of this research is to assess the implementation of SDG3 in elderly health care provision in Ghana.

1.2 Research Questions

1. What are the health care services for the elderly in Ghana?

2. What are the strategies to ensure SDG3 in elderly health care by Ghana's health care sector?
3. What are the successes and challenges health care providers have encountered in elderly health care delivery in relation to SDG3?

1.3 Research Objectives

1. To identify the health care services for the elderly in Ghana.
2. To assess the strategies and interventions to ensure SDG3 in elderly health care by Ghana's health care sector.
3. To investigate the successes and challenges health care providers have encountered in elderly health care delivery in relation to SDG3.

1.4 Scope of the Study

The successful transition from the MDGs to SDGs deals with the pitfalls of MDGs, and improves upon sustainable development in elderly health care. Thus, the time frame of the study is from 2000 to 2019 which also covers the period of the MDGs, and assesses the SDGs implementation in Ghana so far.

In addition, elderly people are chronologically defined as individuals from the ages of 65 and above. Elderly people are classified as "young-old" who are from 65 to 74 and "old-old" who are from 75 and above. Therefore, the study has a key interest in individuals between the ages of 65 and 85(Park et al, 2019).

Lastly, the study incorporates information from private and public hospitals as well as NGOs, private and public organizations as stakeholders of health care services (Vogel et al, 2013).

1.5 Rationale of the Study

The study sought to contribute to existing knowledge of health care in Ghana. However, it would specifically draw the attention to the conditions of health care for the elderly and the way forward in amending likely challenges since the inception of SDG3. Thus, the study would contribute to policy making, preventive measures and future researches.

1.6 Conceptual Framework

In 1945, the Secretary of State of the United States of America made a declaration on security at the San Francisco Conference,

“The battle of peace has been fought on two fronts. The first is the security front where victory spells freedom of fear. The second is the economic and social front where victory means freedom from want. The only victory on both fronts can assure the world of an enduring peace...” (Alkire, 2003, p. 13)

The concept and enactment of security has been transformed over the years. The change of security from an individualistic point of view as opposed to that of other “referents” such as national security, was first recognized by the UNDP in 1994. This portrays a shift in how the international system views security (Tadjbakhsh & Chenoy, 2007). Human security is divided into two categories; “freedom from want, and freedom from fear”.

“Most people instinctively understand what security means. It means safety from constant threats of hunger, disease, crime, and repression. It also means protection from sudden and hurtful disruption in the pattern of sudden and hurtful disruption in the pattern of our daily lives- whether in our home, in our jobs, in our communities and in our environment” (MacFarlane & Khong, 2006, p. 11)

Human security is arranged in seven elements; “Economic Security, Food Security, Health Security, Environmental Security, Personal/Physical Security, Community Security and Political Security” (Paris, 2001). Some scholars that have contributed to the theory of “human

security” are Poland Paris (Paris, 2001) and King and Murray (King & Murray, 2001). With respect to study, health security sought to be of relevance to the study.

Human security has the following characteristics: the bid to promote security, rights and development. It is people-centred. Human security seeks to position individuals as the focus of analysis. It collectively prioritizes individuals and the community in terms of defining their needs and vulnerabilities and in acting as agents of change. Human security is multi-sectoral. It broadens the understanding of threats and includes causes of insecurity. The framework is also comprehensive. That is, it gives a holistic analysis to its elements, security threats, state actors and sectors. It is context-specific, acknowledging that insecurity varies across different settings. Finally, it is prevention oriented and introduces a dual focus on protection and empowerment. With regards to these, human security seeks to complement state security. (Commission on Human Security, 2003)

Thus, human security has sought to promote development. Former UN Secretary-General, Kofi Annan stated in *“Lager Freedom”*, *“We will not enjoy security without development, development with security, and neither without respect for human rights. Unless all these are advanced, none would be succeeded”* (Holliday and Howe, 2011). Mahbub ul Haq, under the auspices of the UNDP, has contributed a lot to the literature on development. Using a human development approach, human security has sought to shift the attention of development from being economic (CHS, 2003).

Human security features human development which promotes sustainability (Ajdari & Asgharpour, 2011). According to Paris (2001), Human Security could be likened to sustainable development. For instance, through the empowerment of individuals and

respecting human rights (Paris, 2001). Human Security is said to complement state-security (CHS, 2003). UNDP Human Development Report also describes Human Security as security for individuals as well as the nation. Thus, it serves as a platform for sustainable development. In this respect, human security provides a broader vision and strategy as compared to a fundamental rights tactic. It is synchronised with the 2030 SDG agenda which envisages action on multiple fronts of the society including health. It complements the initiatives of businesses and human rights and underpins the fulfilment of the SDGs.

With regard to Health, Human security broadly sets a platform for health security which is recognized in the SDGs. Health security is placed under “freedom from want”. Good health is essential in attaining the security of individuals. This is because security protects human lives not only from external factors. Health security is “*the vital core of human security, and illness, disability and avoidable death are critical pervasive threats*”. Good health is a precondition for social stability. Health security provides peace and development to ensure universal access to basic requirements such as food, clean drinking water, hygiene and sanitation (CHS, 2003).

According to Attuquayefio (2012), one major criticism of human security of individuals is that it is solely the responsibility of the state and no other entities such as the UN. Also, there is an argument that human security only spells out human rights and development studies, so it has nothing new to offer. This argument is based on a realist perspective. With respect to human security and development, it has opposed the assertion that “*a division happens between the individuals who have and the individuals who have not, states which can give Human Security to the populace (Western states) and those which cannot (underdeveloped or powerless states)*” (Duffield and Waddell, 2006).

Buse and Hawkes (2015) indicate that the concept of Global health is everyone's concern. Human security is of importance to this study because it incorporates sustainable development in policy-making. Therefore, this concept, with respect to health security would aid in the assessment on the implementation of SDG 3: Good Health and Well-being in improving the health care of elderly people in Ghana. The concept also focuses on people and the needed essentials to ensure the health care of the elderly.

1.7 Literature Review

1.7.1 Introduction

This section reviews some of the scholarly works which are aligned with the research objectives and questions. This aided the researcher in identifying the research gap in the topic area to help build a framework for the study.

1.7.2 Ageing and Health Care

First and foremost, Beard, Araujo de Carvalho, Sumi, Officer, and Thiyagarajan (2017) discuss the increase in the aged population recently and begs the question that the elderly are living in good health. The article states that the 2030 agenda for sustainable development commits countries to ensure quality health care for all ages. The WHO, through its "*Global Strategy and action plan on ageing and health*", states that the SDGs includes elderly people. Aside from the absence of diseases, the approach ensures that healthy ageing assures productivity. It also enunciates that global funding for this project is limited and suggest person-centered services should be encouraged to promote universal health coverage. Also, families could aid in long term care. Systems must also be created to complement caregivers. The physical and social environment are also important factors in achieving health and well-being.

Also, Aboderin (2010) discusses the international debates on health public challenges having a trend in Sub-Saharan Africa. The enforcement of the UN MIPAA (2002) and “*Plan of Action on Age (AU Plan)*” has committed countries in the region to develop policies concerning health care services. These include health challenges on health with morbidity and NCDs. However, states are not able to efficiently attain this goal. It also argues that systematic research is the most appropriate means to address this gap. The definite arrangements must be accounted for; acute resource constraints, focus on the MDGs and equity in health care. The paper also outlines that capacities could strengthen strategies concerning the elderly. They include, “*the magnitude of the problem, its impacts on progress towards the MDGs, the possible existence of age-related inequities in healthcare access, determinants of access to healthcare, and social determinants of health and function at older ages*”.(Aboderin , 2010, p. 369)

1.7.3 Universal Health Coverage (UHC)

According to Franz and Ghebreyesus (2019), UHC has been a central theme for all countries. It seeks to extend health care to more of their citizens to avoid issues of out-of-pocket payment, ensure equitable health outcomes and use resources efficiently. UHC has been adopted by the UN to capture the degree to which different societies are realizing the need to ensure “health for all”. Glassman, Giedion and Smith (2017) also affirm that UHC seeks to assure less financial risks for health care services.

To attain a high standard of health, UHC is a means to the target. O'Connell, Rasanathan, and Chopra (2014) give a clear definition of what UHC is. UHC seeks to provide equal health services and protect individuals from financial barriers. This concept has been construed and addressed. The UN describes UHC as “*access to key promotion, preventive, curative and rehabilitative health interventions for all at an affordable cost, thereby achieving equity in*

access” (O’Connell et al., 2014, p. 1). This implies that parity is the goal of UHC policies. However, it is rather the conditions surrounding the policies that determine the extent by which UHC policies promote equity.

The study also elucidates that the MDGs constructed inaccurate aims into strategies. The MDGs emphasizes on national imbalances, gave UHC policies worsened conditions, rather than reduce differences. Thus, UHC required to be discharged into measurable targets that can be indicated to stakeholders. UHC is also reducing disparities in health outcomes. The advantages UHC gave needed to be properly explained to encourage stakeholders to participate in the shaping of national goals(O’Connell et al., 2014).

It adds that there should be a creation of pro-equity UHC indicators under the post-2015 global development agenda. An effective strategy would make UHC achievement a more inclusive and country-led process, rather than simply one controlled by intellectuals. The framework would change the course of UHC and encourage suitable interventions and build on lessons learnt during the movement of the MDGs, and contribute to the SDGs. Thus, providing a framework for the implementation of UHC by countries.(O’Connell et al., 2014)

However, the contestation here is the maintenance of UHC in health care systems of states (Borgonovi & Compagni, 2013). The sustainability of health systems is of great concern to all countries. The article reviews the concerns pertaining to health care with respect to financial stability. It also examines the dimensions of social and political sustainability with respect to health. Finally, it recommends that decisions pertaining to must reflect on matters of societal, governmental, and financial sustainability, their interaction, and often their inherent trade-offs.

Lastly, the article sought to widen the debate surrounding UHC by structuring sustainability into various facets. In developing UHC strategies, there is the need for “*various parts and tiers of government, the main political forces in a country, health care managers, professionals, technology producers, and citizens*” (Borgonovi & Compagni, 2013, p. S38) Framing UHC as a matter of social and political sustainability of health care systems has the potential to focus the efforts of these actors as part of an interrelated socio-political system, the development and viability of which should be assured to future generations.

One strategy used in attaining UHC in developing countries was proposed through health literacy (Amoah & Phillips, 2018). It affirms that UHC is not only attained through the SDG3 but also with other underpinning goals. The study sought to investigate the obstacles that dread the achievement of UHC in developing countries and how health literacy is used as a means of attaining UHC. It states that Ghana has a promising health care system in Sub-Saharan Africa but lacks the efficient implementation of UHC.

The article provided a methodology in attaining and implementing SDG3 and gives an in-depth knowledge of UHC. The findings suggest that with low Health Literacy, even favourable policies for UHC are not able to attain its set goals. Hence, Health Literacy, as a central strategy for policies could solve challenges of health disparity in Ghana and other similar developing countries. Nevertheless, it is advisable to recognize the diverse social and cultural trends when pursuing the Health Literacy agenda. This is because Health Literacy and the other determinants of Health Related Quality of Life are imprinted in local and historical features. Accordingly, improving Health Literacy in places such as Ghana, scientific studies are limited, would require a multifaceted action towards a healthy and well-informed population (Amoah & Phillips, 2018).

1.7.4 Financial Health Protection

Quality universal health is attained through financial health protection. Alhassan, Nketiah-Amponsah, and Arhinful (2016) contend that Ghana's effort to acquire financial health protection was through the NHIS in 2003. The scheme was first enshrined in ACT 650, 2003 and currently endorsed in ACT 852, 2012 which spells out that everyone should enrol in the NHIS. The NHIS is funded by the NHIF. Active members of the NHIS are individuals under 18 years, 70 years and above, pregnant women and indigents. The scheme provides financial assistance which, in the long run, tackles health care issues. For instance, subscription to the NHIS by pregnant women has decreased the mortality rate. However, the introduction of the NHIS has put pressure on health infrastructure and staff.

The above challenge is reaffirmed by Agyepong et al. (2016) by saying that the challenges Ghana faces with NHIS implementation are policy and program related. Resource availability and affordable package of essentials require effective policies and programs that make NHIS more mandatory than optional. Each health stakeholder at each level, either national or regional requires careful attention and responsiveness. With these in mind, renewals and new enrolment would increase and not somewhat be stagnant.

With regard to NHIS enrolment, the NHIS was to end the "cash and carry system". Asante, Arhinful, Fenny and Kusi (2014) indicate that many households are making "out-of-pocket payment" for health. The percentage of "out-of-pocket payment" for health was "47% in 2000 and 39% in 2009". The study issues that this is due to the misinterpretation of the NHIS. Many understood the Scheme was for the sick and poor, and not for everyone as the NHIS Act stipulated (Act 650 and revised to Act 852). The study also states that extending the NHIS to the marginalized in society is a major challenge.

1.7.4 Research Gaps

The reviewed literature acknowledges the need to address elderly health issues, through the MDGs and the SDGs. However, the gap identified is the appropriate implementation of frameworks and law binding the elderly. Most literature refer to countries connoting political will rather than being specific to health systems. Also, limited information is given on geriatric care in Ghana.

1.8 Research Methodology

Research is a way of thinking. It explores the various aspects of your day-to-day professional work, understanding and formulating guiding principles that govern a particular procedure, and developing and testing new theories that contribute to the advancement of your practice and profession. It involves various approaches in sieving the right information for the study. This is the philosophy or the general principle which will guide your research(Dawson, 2002).The research approaches are namely; quantitative, qualitative and mixed research approaches (Kumar, 2019).

Qualitative research explores attitudes, behavior and experiences through such methods as interviews or focus groups. It attempts to get an in-depth opinion from participants. Quantitative research generates statistics through the use of large-scale survey research, using methods such as questionnaires or structured interviews. Mixed research synthesis is the latest addition to the repertoires of mixed methods research and systematic review. Mixed research synthesis is our name for the type of systematic review aimed at the integration of results from both qualitative and quantitative studies in a shared domain of empirical research (Sandelowski, Voils, & Barroso, 2006).

The research used the qualitative research approach with the aim of addressing its research questions and objectives. It sought to provide in depth information from participants and give descriptive findings in the bid to assess the implementation of SDG3 in elderly health care delivery in Ghana (Dawson, 2002). This approach was adopted by making use of semi-structured interviews. Semi-structured interviews are conversations by the researcher set questions based on prior knowledge. This form of interview is appropriate because it also creates room for follow up questions. This is to ascertain a particular form of data. Officials from Ghana Health Service (GHS), Korle-Bu Teaching Hospital (KBTH) and Ghana Atomic Energy (GAEC) Hospital were interviewed based on their experiences and expertise on the topic (Fylan, 2005, p. 65).

1.8.1 Sampling Techniques

Institutions were selected based on their appositeness. One primary importance of qualitative research is to be provided with in-depth data on a phenomenon. In doing so there was the need for study to use purposive sampling to help gain precise and concise information. The purposive sampling technique, also called judgment sampling is the deliberate choice of a participant due to the qualities the participant possesses (Etikan, Musa, & Alkassim, 2016).

The following states the reason for choosing these institutions as the sample size:

- The GHS had extensive knowledge on the overview of Ghana's Health Care delivery services.
- The GHS and the KBTH had record and reports on elderly health care delivery.
- Personnel from the GAEC Hospital shared challenges of elderly health care based experiences and expertise.

1.9 Sources of Data

The study employed the use of primary and secondary data. The Ghana Health Services (GHS), Korle-Bu Teaching Hospital (KBTH) and Ghana Atomic Energy Commission (GAEC) Hospital provided unmediated information. Official documents, annual reports and policy documents from the WHO and GHS were used to ascertain information. Other secondary sources data include published books, reports, journal articles and the internet.

1.9.1 Data Collection

An interview schedule which comprises of a list of questions was used to collect data from respondents. Semi-structured interview was most preferred with open-ended questions. This gave room for respondents to elaborate on salient issues relevant to the topic (Dawson, 2002).

1.10 Data Analysis

An interview summary form was produced after each interview. This includes the time, duration and venue of the interview. Interviews were also transcribed and attached to the interview summary form. Data is put under themes that emerged from data collection. Background readings also formed part of the analysis process to help explain emerging themes (Dawson, 2002).

1.11 Ethical Consideration

In a qualitative study, ethical considerations have a particular resonance due to the in-depth nature of the study process. The concern of ethical issues becomes more salient when conducting face to face interview with vulnerable group of participants. They may potentially become stressed while expressing their feelings during the interview session (Arifin, 2018).

Informed Consent

The process of obtaining Consent consists of the following: consent should be given freely (voluntary), subjects should understand what is being asked of them, and involved persons must be competent to consent. This means, to participate in a research study, participants need to be adequately informed about the research, comprehend the information and have a power of freedom of choice to allow them to decide whether to participate or decline. Participant's agreement to participation in this study was obtained only after a thorough explanation of the research process (Arifin, 2018).

The study generally reflects a true and fair representation of data, acknowledgement of sources and attains consent from interviewees prior to the interview.

1.12 Limitations

There was a constraint on the availability of health professionals to be interviewed. This is because interviews were held in medical facilities where their duties are being discharged. Also, there was difficulty having appointments with persons from the Family Health Division of the Ghana Health Service.

1.13 Arrangement of Chapters

This dissertation is in four chapters. Chapter One is an Introduction to the study. Chapter Two is an Overview of Health Service Delivery in Ghana. Chapter Three is an assessment of the SDG 3 in elderly health care delivery in Ghana. Chapter Four provides a summary, conclusions and recommendations.

REFERENCES

- Aboderin, I. (2010). Understanding and advancing the health of older populations in sub-Saharan Africa: policy perspectives and evidence needs. *Public Health Reviews*, 32(2), 357
- Agyepong, I. A., Abankwah, D. N. Y., Abroso, A., Chun, C., Dodoo, J. N. O., Lee, S., Asenso-Boadi, F. (2016). The “Universal” in UHC and Ghana’s National Health Insurance Scheme: policy and implementation challenges and dilemmas of a lower middle income country. *BMC Health Services Research*, 16 (1), 504 doi: 10.1186/s12913-016-1758-y
- Ajdari, B., & Asgharpour, S. E. (2011). Human security and development, emphasizing on sustainable development. *Procedia - Social and Behavioural Sciences*, 19, 41-46. doi:<https://doi.org/10.1016/j.sbspro.2011.05.105>.
- Alhassan, R. K., Nketiah-Amponsah, E., & Arhinful, D. K. (2016). A Review of the National Health Insurance Scheme in Ghana: What Are the Sustainability Threats and Prospects? *PLoS One*, 11 (11), e0165151 doi:10.1371/journal.pone.0165151
- Ahenkora (1999). The Contribution of Older People to Development. The Ghana Study, *Unpublished Paper Help Age International and Help Age Ghana*
- Alkire, S. (2003). A Conceptual Framework for Human Security, p. 9-17

Amoah, P. A., & Phillips, D. R. (2018). Health literacy and health: rethinking the strategies for universal health coverage in Ghana. *Public Health*, 159, 40-49. doi:10.1016/j.puhe.2018.03.002

Asante, A. F., Arhinful, D.K., Fenny, P.A., & Kusi,A. (2014). Who is excluded in Ghana's National Health Insurance Scheme and why: a social, political, economic and cultural (SPEC) analysis

Attuquayefio, P.K. (2012). Co-opting human security and deduction for security policy-making in Ghana, *Ghana Journal of development Studies*, p. 93-95

Baer, B., Bhushan, A., Taleb, H. A., Vasquez, J., & Thomas, R. (2016). The Right to Health of Older People. *Gerontologist*, 56 Suppl. 2, S206-217 doi:10.1093/geront/gnw039, p. S206-S213

Beard, J. R., Araujo de Carvalho, I., Sumi, Y., Officer, A., & Thiyagarajan, J. A. (2017). Healthy ageing: moving forward. *Bull World Health Organ*, 95(11), 730-730a. doi:10.2471/blt.17.203745

Beard, J. R., Officer, A. M., & Cassels, A. K. (2016). The World Report on Ageing and Health. *Gerontologist*, 56 Suppl. 2, S163-166 doi:10.1093/geront/gnw037

Arifin, S. R. M. (2018). Ethical Considerations in Qualitative Study.

- Biritwum, R. B., Mensah, G., Minicuci, N., Yawson, A. E., Naidoo, N., Chatterji, S., & Kowal, P. (2013). Household characteristics for older adults and study background from SAGE Ghana Wave 1. *Global health action*, 6 (1), 20096
- Bloom, D. E. (2011). 7 billion and counting. *Science*, 333 (6042), 562-569. doi:10.1126/science.1209290
- Bluestone, K. (2016). The future of development is ageing.
- Borgonovi, E., & Compagni, A. (2013). Sustaining universal health coverage: the interaction of social, political, and economic sustainability. *Value Health*, 16 (1 Suppl) S34-38 doi:10.1016/j.jval.2012.10.006
- Buse, K., & Hawkes, S. (2015). Health in the sustainable development goals: ready for a paradigm shift? *Globalization and health*, 11 (1), 13.
- Commision on Human Security. (2003). *Human security now*, United Nations Publications, p. 8-103
- Dora, C., Haines, A., Balbus, J., Fletcher, E., Adair-Rohani, H., Alabaster, G., Neira, M. (2015). Indicators linking health and sustainability in the post-2015 development agenda. *Lancet*, 385(9965), 380-391. doi:10.1016/s0140-6736(14)60605-x
- Duffield, W., & Waddell, N., (2006). Securing Humans in a Dangerous World, *International Politics* 43(1):1-23. DOI: 10.1057/palgrave.ip.8800129

Emas, R., (2015). The Concept of Sustainable Development: Definition and defining principles, p.1

Etikan, I., Musa, S. A., & Alkassim, R. S. (2016). Comparison of convenience sampling and purposive sampling. *American journal of theoretical and applied statistics*, 5(1), 1-4.

Franz, C., & Ghebreyesus, T. A. (2019). *The Road to Universal Health Coverage: Innovation, Equity, and the New Health Economy*: JHU Press.

Fried, L. P., & Paccaud, F. (2010). Editorial: The Public Health Needs for an Ageing Society. *Public Health Reviews*, 32(2), 351-355. doi:10.1007/bf03391606

Fylan, F. (2005). Semi-structured interviewing. *A handbook of research methods for clinical and health psychology*, 5(2), 65-78.

Ghana Statistical Service (2013). *2010 Population & Housing Census. Millennium Development Goals in Ghana*, p. 1-3

Ghana Statistical Service (2013). *2010 Population and Housing Census Report: The Elderly in Ghana*, p.1-12

Glassman, A., Giedion, U., & Smith, P.C. (2017). *What's in, What's out: designing benefits for universal health coverage*, Washington DC: Center for Global Development, LCCN 2017021073, p. 1&2

Government of Ghana (2010). National Ageing Policy, " Ageing with security and dignity"

Holliday, I., & Howe, B.M., (2011). Human Security: A Global Responsibility to Protect and Provide, *Korean Journal of Defense Analysis* 23(1) p.74-79

Hui, L. (2017). Assessment of the role of ageing and non-ageing factors in death from non-communicable diseases based on a cumulative frequency model. *Sci. Rep*, 7(1), 8159. doi:10.1038/s41598-017-08539-0

Kalula, S. (2013). Medicine in the elderly: Unique Challenges and management. *Continuing Medical Education*, [S.I], v. 31,n. 10,p.352, ISSN 2078-5143. Available at: <http://cmej.org.za/index.php.cmej/article/view/2878/3234>>. Date accessed: 27th July 2019.

King, G., & Murray, C. J. (2001). Rethinking human security. *Political science quarterly*, 116(4), 585-610

Kumar, R. (2019). *Research methodology: A step-by-step guide for beginners*: Sage Publications Limited.

MacFarlane, S. N., & Khong, Y. F. (2006). *Human security and the UN: A critical history*: Indiana University Press.

- Mba, C. J. (2010). Population ageing in Ghana: research gaps and the way forward. *J Aging Res*, 2010, 672157 doi:10.4061/2010/672157, p. 1&2
- O'Connell, T., Rasanathan, K., & Chopra, M. (2014). What does universal health coverage mean? *Lancet*, 383(9913), 277-279. doi:10.1016/s0140-6736(13)60955-1
- Paris, R. (2001). Human security: paradigm shift or hot air? *International security*, 26 (2): 87-102.
- Park, C. H. K., Lee, J. W., Lee, S. Y., Shim, S. H., Kim, S. G., Lee, J., Ahn, Y. M. (2019). Characteristics of the "young-old" and "old-old" community-dwelling suicidal Ideators: A longitudinal 6-month follow-up study. *Compr Psychiatry*, 89, 67-77. doi:10.1016/j.comppsy.2018.12.002
- Sandelowski, M., Voils, C. I., & Barroso, J. (2006). Defining and Designing Mixed Research Synthesis Studies. *Research in the schools : a nationally refereed journal sponsored by the Mid-South Educational Research Association and the University of Alabama*, 13(1), 29-29.
- Steves, C. J., Spector, T. D., & Jackson, S. H. (2012). Ageing, genes, environment and epigenetics: what twin studies tell us now, and in the future. *Age Ageing*, 41(5), 581-586. doi:10.1093/ageing/afs097
- Tadjbakhsh, S., & Chenoy, A. (2007). *Human security: Concepts and implications*: Routledge.

World Health organisation (1946). *The constitution of the world health organization*, 1 C.F.R. (1947)

United Nations. Department of Economics and Social Affairs (2007). *Development in Ageing World*, E/2007/50/Rev.1 ST/ESA/314 ,ISBN 978-92-1-109154-0, p. (ii)

United Nations Department of Economics and Social Affairs, Population Division (2015). *World Population Ageing* (ST/ESA/SER.A/390), p. 91

Vogel, J. P., Oxman, A. D., Glenton, C., Rosenbaum, S., Lewin, S., Gülmezoglu, A. M., & Souza, J. P. (2013). Policymakers' and other stakeholders' perceptions of key considerations for health system decisions and the presentation of evidence to inform those considerations: an international survey. *Health Research Policy and Systems*, 11(1) 19 doi:10.1186/1478-4505-11-19

World Health Organization, Regional Office for Africa (2013). *Healthy Ageing in the African Region; Situation Analysis and Way Forward* The African Regional Health report, p. 2

CHAPTER TWO

AN OVERVIEW OF THE HEALTH CARE DELIVERY SERVICES IN GHANA

2.0 Introduction

WHO underscores six parameters for universal health. The ideal stipulates that, “*strong health systems must have robust governance structures, financing mechanisms, human resources, health information and medicines and technological supply structures that work hand in hand to provide accessible, equitable, responsive and quality health services to the populace*” (WHO, 2007 p. 3; WHO 2010 p.vi&vii).

Ghana is one of the developing countries in West Africa with a population of about twenty-six (26) million in 2013. Although the country has some economical deprivations, it has a proud history. For instance, it is one of the first African countries to gain independence from European colonization in 1957, provide basic education, has a comparatively high literacy rate for developing countries, increase in life expectancy at birth, and is gifted with lucrative natural resources including gold, timber, and cocoa (Alagidede, Baah-Boateng, & Nketiah-Amponsah, 2013). Ghana has a much higher per capita economic output than most West African countries but remains partially dependent on international financial and technical assistance (Drislane, Akpalu, & Wegdam, 2014).

In the 1970s, global discussions were put forth to improve equity and health care. This concluded with the 1978 Alma-Ata Declaration. It allied global health benchmark of providing ‘Health for All’ by 2000. Therefore, the Ghanaian government, specifically the Ministry of Health signed up to the agreement and expounded a ten-year plan for establishing and implementing PHCs. Currently, Article 190 Section (1) subsection (a) of the 1992 Constitution of the Republic of Ghana sought to provide a mandate for the formation of the

Health Service to primarily address the wellness demands of the nation(de-Graft Aikins & Koram, 2017) (Constitution, 1992).

2.1 Health Sector Reforms

2.1.1 What are health sector reforms?

Reforms symbolize changes, more or less characterized by the central, multifaceted, and widespread in nature. Reform infers, “*change in what is done, how it is done, and who does it*”. Health reforms could be defined in many ways. However, simply put, health sector reforms refers “*to the totality of policies, programs, institutions, and actors that provide health care - organized efforts to treat and prevent disease*”. It could also be referred to as managing efficiency, equity and effectiveness of the health sector (Berman, 1995).

Health reforms are very necessary particularly in developing countries such as Ghana. Governments are to guarantee that allotted share of public revenue is given to the health sector when the need be. This is to foster proper health care delivery services and avoid citizens from spending highly on service expenses as a result of an accident or illness (Christopher J Murray, Lopez, & Jamison, 1994). It has been identified that the need for reforms is given due to many problems associated with the health system. This is mostly triggered by political and economic changes, shifts in the role of governments or demographic transformation. Taking a case as South Africa, radical political change has revealed the potency for reforms in the apartheid (Cassels, 1995).

2.1.2 Health Sector Reforms in Ghana

Looking at the basis of health reforms, Ghana has also had some adjustments with respect to health. The health sector has seen many transformations since the mid-‘80s. It aims at improving the management of health, that is, efficiency, equity, and effectiveness of the

health sector. The commencement of the health reforms had the Ministry of Health (MOH) as the sole provider of services collaborating with the assignments and the para-government bodies. Health service provision was more or less towards curative care (GSS, 2003). This brings out that the MOH was to implement policies and programmes as well as take charge of health in the country.

The development of Vision 2020 in 1996, which is a deep-rooted vision for the country by 2020 was enforced. Hence, the MoH released a document, *“a five year programme of work that is to guide health development in Ghana from 1997 to 2001”* known as Medium Term Health Strategy (MTHS). The MTHS sought to give overall guidelines on how the health sector should function within that period. Its mission statement stipulates that;

“As one of the critical sectors in the growth and development of the Ghanaian economy, the mission of the health Ministries, Departments and Agencies is to improve the health status of all people living in Ghana through the development and promotion of proactive policies for good health and longevity; the provision of universal access to basic health service, and provision of quality health services which are affordable and accessible. These services will be delivered in a humane, efficient, and effective manner by well-trained friendly, highly motivated, and client-oriented personnel.” (GSS, 2003, p.14 & 15).

The country’s health reforms are known to confront health care problems in developing countries as well. With the quest to achieve utmost health care status, the government, foreboded by the MOH in collaboration with foreign aid, financial institutions and the Ministry of Finance (MOF), private sectors, and Non-Governmental Organisations sought to achieve MTHS for Ghana for the period 1997 to 2001. The programme sought to address the difficulties associated with dispensing health services and obtain good health care delivery

through the regeneration of good health infrastructure and care inputs (Verhage, van de Gronden, Awanyo, & Boateng, 2002).

According to Saleh (2012), Ghana established an extensive authorized and supervisory agenda for delegation, under the auspices of a devolution model due to the Medium Term Health Strategy. As part of a lengthy procedure of decentralization from independence, the country mostly delegated power to the districts which is stipulated in the Local Government Act 452, 1993.

Until then, the Health Ministry executed its administrative work on its own. It later factored in, delegation of roles and responsibilities to different agencies as part of its reform strategy. Hence, GHS was established in 2003 forerun public sector health services due to the passage of Act 525 in 1996 (de-Graft Aikins & Koram, 2017).

The administration of GHS is more flexible though it is an organ of MOH. This allows for more flexible administrative options. MOH identified the pluralistic make up of health care delivery in the country in the process of establishing GHS (GSS, 2003). The Ministry's strategies aimed at advancing communal health services as well strengthening individual significant contributions to health service delivery. Act 525 also provided a module for public health in terms of policies, service delivery and administration of the MOH. The Act enabled the establishment of the regulatory bodies, such as "*the FDB, the Nurses and Midwives' Council, the Medical and Dental Council, the Traditional Medicine Board, the Funeral Homes Board, and the Private and Maternity Homes Board.*" (GSS, 2003) The reform also led to the establishment of teaching hospitals.

Nonetheless, Act 525 of 1996 did not agree to the said changes. There was decrease in concentration within GHS which conflicted with Act 425. The later Local Government Service Act (Act 656, 2003) circumvented the decentralization of the personnel of the social sector to local government authorities (GSS, 2003). This in effect has not made the decentralization clear in Ghana health delivery system and poses possible challenges to the division.

However, the health sector has made some advances despite the challenges it has encountered. The decentralization in the health sector has reinforced information systems and supportive services in terms of obtaining drugs and equipment and maintenance of funds. The efforts were also evident in the health workforce. Although remunerations are still merged; finances are fairly decentralized. Monetary subsidiarity in Ghana is more apparent than real. Most of the funds are given to districts. Nevertheless, the major of these assets are managed by the central government. The local authorities have little or no say with regard to allocation of resources. Considerable suspensions and changeable transfers and release of assets contributes to the diminishing of the districts' authority which was a challenge (GSS, 2003).

This situation lessened the strength of governance and decentralization of the health sector. It also had an effect on the local health authorities. There is interferences and unaccountability within the sector. Allocation and management of assets were not properly executed. A survey of regional and district officers concluded that many lack understanding of the objectives, prerequisites, and implications of the health sector (Couttolenc, 2012). Thus, the building of consensus and support became a challenge to the health modifications.

This was to increase decentralization of health care provision by expanding of district-based health care consisting of health centres and referral hospitals; and develop organization of essential efforts to health care such as pharmaceuticals, health sector personnel, infrastructure, and equipment have rendered most of the populace to be marginalized. For instance, GSS reports have focused more on child health, maternal health and recently mental health (de-Graft Aikins & Koram, 2017).

2.2 The Structure of Ghana's Health Sector

There is a need to understand the components and framework of the health system in order to have a better understanding of their objectives and responsibilities (Cassels, 1995). The constitution of Ghana gives an elaborate illustration of the health sector and its relationship with other public sectors (Abdallah & Prinz, 2009). The laws of the country declare that, *“the state shall safeguard the health, safety, and welfare of all persons in employment, and shall establish the basis for the full deployment of the creative potential of all Ghanaians”* (The Constitution of Ghana, 1992, p. 34).

The health system is basically structured into private and public sectors and further categorised into public, private-for-profit, private-not-for-profit and traditional systems. Though it may seem unlikely, efforts are being made since 1995 to integrate traditional medicine into the orthodox mainstream. Ghana's health administration in Ghana is divided into three administrative levels: the national, regional and districts levels with additional functional levels known as national, regional, district, sub-district and community levels. All the levels of administration are organized as Budget Monetary Committees or cost center for the purpose of administering funds by the Government and other stakeholders (Abor, Abekah-Nkrumah, & Abor, 2008).

Furthermore, corporate governance has been widely studied and has been identified as an important determinant of organizational performance (Adjasi & Abor, 2007). Corporate governance is “concerned with the relationship between the internal governance mechanisms of corporations and society’s conception of the scope of corporate accountability” (Deakin and Hughes, 1997). It can also be defined as “structures, processes, cultures, and systems that engender the successful operation of the organizations” (Keasey, Thompson, & Wright, 1997). This is a mechanism the Ghanaian government used to make the public service, such as health service, more transparent and accountable to the citizens (Corporate Governance Manual for Governing Boards/Council of the Ghana Public Services, 2015). These actions are currently played out by the various ministries, departments, and agencies through their roles.

The Ghanaian health sector is diverse in nature due to its decentralized governance (de-Graft Aikins & Koram, 2017). Thus, the following paragraphs discuss the role of the various health care organs in the country.

2.2.1 Public Sector

Ministry of Health

The Ghanaian Ministry of Health falls under the Civil Service Act of Ghana (ACT 327). It stipulates the establishment of the service and the functions to perform under the 1992 constitution. The vision of the health sector is to “have a healthy population for national development”. The mission is to “contribute to socio-economic development and the development of a local health industry by promoting health and vitality through access to quality health for all people living in Ghana using motivated personnel” (Akazili, Adjuik, Jehu-Appiah, & Zere, 2008, p. 2).

Most health policy objectives are to ensure equal access to health care and nutrition services, sustainable financing protect that secure the poor and heightens governance and improve the efficiency and effectiveness of the health system. The goals of the ministry are to improve the health status of all people living in Ghana through effective and efficient policy formulation, resource mobilization, monitoring and regulation of the delivery of health care by different health agencies, improve quality of health services (GSS, 2003). Its core functions are as follows:

- Formulation of overall sectoral policy.
- Determining national health priorities.
- Resource mobilization and allocation.
- Performance and policy monitoring.

The Key Implementing Agencies of Health Service

Policy enactment is done by the various divisions of the sector. At the public sector end, the GHS and TH are the implementing agencies of the ministry under Act 525 (Abor et al., 2008).

Ghana Health Service

Under Act 525 (GHS and TH Act), the MOH gives authority GHS manage and control almost all public facilities. The GHS is a semi-autonomous agency with the mandate to “ensure access to health services at the community, sub-district, district, and regional levels” (Couttolenc, 2012).

The GHS is liable for the transportation, equipment and infrastructural provisions, delivery of information and structures policies and strategies for the Ghana Health Service Council. The

duties of the divisions under the GHS are organized and directed by the Ghana Health Service Council supervised by the MOH. Its central goals are to, “*implement approved national policies for health delivery, increase access to improved health services and manage prudently resources available for the provision of health services. Other contributors outside the health service such as the National Health Insurance secretariat and the auditing offices and controlling services work directly with the council. MOH is particularly in charge of policy making and information management in areas such as human resource and infrastructure*” (Abdallah & Prinz, 2009). There have been attempt to restructure GHS as an executive body of MOH, on lines broadly similar to United Kingdom’s National Health Scheme. The legal framework for the GHS is provided by Act 525 of 1996. In effect GHS is not separate from Ghana’s civil service, to ensure optimum of administrative resilience to carry out its responsibilities (Larbi, 1998).

GHS was publically established in 2003 (GSS, 2003). The GHS is also responsible for the execution of the government’s health strategy and directive of state-owned health organizations. In carrying out its functions, the GHS has a secretariat that has been decentralized from the national level to the regions and the districts. Each level has a management team that administers the affairs of the service. The districts report to the regions and the regions report to the national level as stipulated in the GHS and TH Act (1996), Act 525 (Abor et al., 2008).

Also, regional and district administration assimilated as one goes down the hierarchy of health structure from the national to the sub-district. This undermines the overseeing of services, whereby one technical person down the line may supervise several technical areas of service delivery. At the regional level, curative services are ensured at regional hospitals

and public services are done by the District Health Management Team (DHMT). There is a body known as the Regional Health Administration (RHA) that supervises and manages health services in the districts and sub-districts. District hospitals are responsible for curative services at the district level. These hospitals are mostly mission based. Public health services are delivered by the DHMT and the public health unit of the district hospitals. The District Health Assembly (DHA) provides supervision and management support to the sub-districts. At the sub-district level, both preventive and health-giving services are provided by the health centres, as well as outreach services to the communities within their catchment areas. Basic preventive and curative services for minor ailments are being addressed at the community and household level with the introduction of the Community Home-Based Programme services CHPs (GSS, 2003).

Teaching Hospitals

The complexity of THs is a major characteristic. It is an epitome of excellence in the health sector (GSS, 2003). Governance of Teaching Hospitals (THs) is atypical. It encompasses multi-fold players including the MOH, the Ministry of Education, universities such as the University of Ghana and political influences in the community. The panel members of the THs are selected by the MOH. Such appointments are often seen as an appointment by the government since both the GHS and the MOH are accountable to the government. This situation restricts the board in playing an independent role contributing to its complexity (Chawla, Govindaraj, Berman, & Needleman, 1996).

THs demand well trained personnel, complex technology as well as adequate funds. They also support the training of health personnel both preservice and in-service. This keeps them abreast with modern intervention health care requirements (GSS, 2003).

From 1970, management teams were provided for hospitals at all levels due to decentralization and Health Sector Reforms. As part of the reforms, two teaching hospitals were set up; KBTH and Komfo Anokye Teaching Hospital (KATH). These hospitals have been granted autonomy through Law 209 in 1990 (Govindaraj, Obuobi, Enyimayew, Antwi, & Ofosu-Amaah, 1996).

The autonomy of the THs is guarded by standing authorized frameworks and institutionalized practices. Autonomy in defining user charges, contracts for goods and services, and personnel management are controlled. The need to refer to a number of external bodies for evaluations and consents for the running of the institution is a major source of operational inefficiency. Until 1996, the government appointees were in the majority on the boards, with the risk of politicizing the boards. Also, the boards' ability to determine policies and plan for the hospitals has been undermined by formal and informal controls retained by the central MOH. The senior managers of the THs are inclined to have divided loyalty as they look to the centre and to the boards for direction at the same time. The recently enacted GHS and THs Act attempt to address some of these problems, but it is too early to say what its impact will be (Larbi, 1998).

Core Functions of Teaching Hospitals

THs serve as health care providers. The agency provides complex curative tertiary care, preventive care, participate in public health programmes and total primary health care. Basically, referrals from districts and regional hospitals are sent to teaching hospitals. Teaching Hospitals provide information on various health problems and disease due to their research advancement. Thus, they provide solutions to local and national health problems

through research. Alternative treatments such as day surgery, home care, and home hospitalization and outreach services are also done by teaching hospitals. The structuring of quality-standardized treatment protocols is one of their primary roles as well as the provision of both basic and graduate courses for health personnel (GSS, 2003).

2.2.2 Private Sector

The GHS supports health care from private sectors; Non-Governmental Organisations (NGOs) and Faith Based Hospitals (FBHs). In 2002, the GHS began affiliations with NGOs to take up health responsibilities on the basis of relative benefit. Government coffers monies for the contracts of NGOs services. The GHS also offers support to Mission health facilities by supporting personnel and giving out important equipment (GSS, 2003).

The NGOs and the private sector are to work with communities in collaboration with the DHMT and provide a trimestral progress report. Their activities are guided by the GHS standards and protocols. However, the private sector's health services are more of curative than preventive. There is not much supervision and monitoring of services of NGOs and the private sector. (GSS, 2003)

Faith-based Organizations are rather significant in the service of health care. They are known as Quasi-Government Institutions. The bigger religious bodies sometimes offer medical services and organize awareness programmes. Predominantly, Christian organizations own health facilities mostly in rural areas. Christian healthcare delivery organizations are accepted by the government under the leadership of the Christian Health Association of Ghana (CHAG). More than fifty (50) percent of the total operating proceeds of the Christian FBH sector come from subsidies from the government. According to CHAG, a requirement for

access to this insurance scheme is the Christian faith, the scheme is as a result, open to Christian Ghanaians only. Islamic institutions also offer minimal health services through organizations such as the Ahmediyyah Muslim Mission of Ghana (Abdallah & Prinz, 2009).

The Methodist Church has a hospital in Wenchi (WMH). Correspondingly, the two key health institutions in Techiman are both faith-based institutions: the Holy Family Hospital (HFH) is operated by the Roman Catholic Mission and the Ahmadiyya Moslem Mission owns the Ahmadiyya Hospital. There are also three private clinics in Wenchi and five hospitals and clinics in Techiman. The WMH and HFH are members of the CHAG.

2.2.3 Traditional Health Services

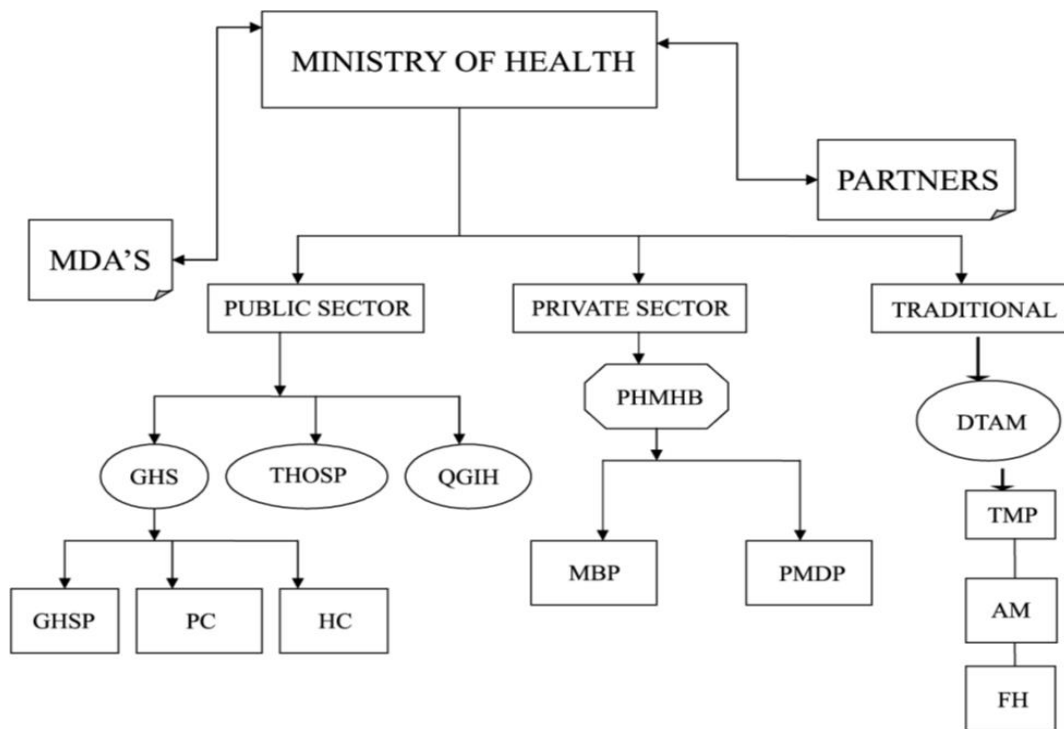
Traditional medicines serve as auxiliary to conventional forms of medicines in Western countries. It surprisingly outshines conventional medicine in many developing countries. “Traditional medicine”, is defined as, the *“health practices, approaches, knowledge, and beliefs incorporating plant, animal and mineral based medicines, spiritual therapies, manual techniques and exercises, applied singularly or in combination to treat, diagnose and prevent illnesses or maintain well-being”*. The WHO stated that, *“Africa had up to 80% of the population uses traditional medicine for primary health care”*. Furthermore, traditional practices such as homeopathy, naturopathy, and osteopathy are already better integrated into Ghana's health system than in other African countries (Abdallah & Prinz, 2009, p. 14).

With the regular unaffordable cost of treatment, traditional medicine therefore still remains important in Ghana (van den Boom, Nsowah-Nuamah, & Overbosch, 2007). The incorporation of this type of treatment into health care in Ghana done by the WHO and central government. Researches have shown that, in more than twenty years since the

introduction of out-of- pocket health delivery, more than half of the country's patients have turned to traditional and self-medication (Boom, Nuamah, & Overbosch, 2004).

Though the traditional medical practices supplement the national health care service, they also create problems to the government's determinations in offering universal healthcare in the country. A challenge is the mixing of orthodox and traditional medicine which is known for herbal treatment and religious prayers. They are known in the country as "healing churches". Many of these groups, claim to have spiritual powers for healing physical and mental illnesses (Abdallah & Prinz, 2009).

Fig 1: The Structure of Ghana Health System



Key:

- MDA's – Ministries Departments and Agencies
- GHS – Ghana Health Service
- THOSP – Teaching Hospitals
- QGIH – Quasi Government Institution Hospitals
- PHMHB – Private Hospitals and Maternity Homes Board
- DTAM – Department of Traditional and Alternate Medicine
- GHSP – Government Hospitals
- PC – Poly Clinics
- HC – Health Centres
- MBP – Mission Based Providers
- PMDP – Private Medical and Dental Practitioners
- TMP – Traditional Medical Providers
- AM – Alternative Medicine
- FH – Faith Healers

Source: Second Five Year Programme of Work (2002-2006, p. 48)

(Abor et al., 2008)

2.3 A Brief on the Health Status of Ghanaians

Health care in Ghana has experienced considerable reforms since independence in 1957. In the late 1950s, disabilities and death were largely caused by infectious diseases and negative maternal and child health conditions. Now, there has been the dual load of infectious and chronic non-contagious diseases, such as high blood pressure and diabetes, causing high rates

of impairment and premature death in adult populations (de-Graft Aikins & Koram, 2017). Ghana's independence awakened the government to the challenge of ensuring equity and sustenance of the health system (Arhiful, 2003). That is to say, records have shown that the government, since Nkrumah's era has strived to achieve a commendable health care system.

To achieve the above, research shows that the predominant health problems of Ghanaians were communicable, maternal, perinatal, and nutritional diseases at the time. However, from 1990 to 2010, the highest causes of premature deaths were NCDs, with some conditions. The disease patterns have over time varied athwart age, gender, location, and socioeconomic status. Thus, the central focus of Ghana's health care was devoted to these conditions.

Also, maternal health had problems which have brought about disparities between the Southern and Northern Regions. Pregnant women face certain risks which could lead to death (MOH, 2013). Maternal mortality rates, like child mortality rates, have almost halved over the last twenty years. For instance, *"in 1990 the maternal mortality ratio was 600 per 100,000 live births, in 2010, 350 per 100,000"* (de-Graft Aikins & Koram, 2017).

Akin to the point above, Ghana is categorized as being in the malaria control stage with regard to child mortality rate, It is noted that malaria occurs more in children below the ages of five .Over the years, *"there has been a decline in childhood mortality by the aid of policy development and control, from 14.4% in 2000 to 0.6% in 2012. However, the same level of success has not been achieved with malaria morbidity"* (Awine, Malm, Bart-Plange, & Silal, 2017, pp. 2).

In addition, NCDs such as hypertension, strokes, cancers, and diabetes affect adults (de-Graft Aikins, Addo, Ofei, Bosu, & Agyemang, 2012). Therefore, there is the need to put in place structures to cater for the health of the elderly (Ayernor, 2012). Mostly, the frequency of chronic NCDs increases rapidly with advancement in age (Murray & Lopez, 2013). In the county's capital, medical conditions that are associated with old age are hypertension, diabetes and stroke. Also, while diabetes prevalence is higher among men, obesity, a major risk factor for diabetes, is higher among women (Agyemang et al., 2016). There are also conditions which affect the elderly. These include musculoskeletal disorders arthritis, lower back pain, neck pain, and neuro-degenerative disorders dementia. There are conditions such as cancers, diabetes, and hypertension that affect both the elderly and younger populations, compared to the global average age of onset (de-Graft Aikins & Koram, 2017).

There has also been a historical neglect for mental health disorders although there is an insurrection burden. The estimated prevalence rate of common mental disorders, such as depression and anxiety, is ten (10) percent (Roberts, Mogan & Asare, 2014). These conditions are experienced as psychosocial outcomes of difficult life circumstances among the rural and urban poor, among women and older adults (Aikins, 2015). Crucially, they often co-occur with the major chronic physical illnesses such as diabetes, cancers, and strokes, as well as with recurring infectious diseases.

There are also complex interactions between diseases, such as tuberculosis and diabetes, which display the double burden of infectious and chronic diseases. In poor communities, diseases such as diabetes, cancers, and strokes, are most likely to recur with infectious diseases (Young, Critchley, Johnstone, & Unwin, 2009).

Finally, in 2005 an independent body known as the Health Metrics Network reviewed Ghana's health system. (HMN, 2005). It deduced that *“44 percent of the population is below the age of 15 while only 5 percent is above the age of 65. There are slightly more women (53 percent) than men (47 percent) in the overall population. Life expectancy at birth for a Ghanaian was estimated at 57.7 years: 55 years for males and 59.2 years for females. Infant mortality worsened from 64 per 1000 live births in 2003 to 71 in 2006. Ghana recorded an under-five mortality rate of 111 per 1,000 live births in 2006”* (Abdallah & Prinz, 2009, p. 5).

The WHO gave a statistical review in 2006 and noted that sanitation-related diseases are becoming a problem in Ghana's health system (Abdallah & Prinz, 2009). The Ghanaian Chronicle also stated in 2008, eighty-two (82) percent of the entire population lack proper toilet facilities which is to the detriment of environmental health (Saeed, Oduro, Ebenezer, & Zhao, 2012). Malaria has also be comprehended as continuously being rampant in the Ghanaian community (Saeed & Abdul-Aziz, 2013).

2.4 Conclusion

This Chapter sought to give a summary of the health care delivery services in Ghana. Taking into consideration the health of Ghanaians, it further elaborates on the health reforms, structures and agencies of Ghana's health care delivery. This is concrete in understanding the framework through which Ghana acts out health services.

REFERENCES

- Arhinful, D. K. (2003). *The solidarity of self-interest: Social and cultural feasibility of rural health insurance in Ghana*. African Studies Centre, Leiden, p. 3-6.
- Abdallah, S., & Prinz, V. (2009). Health care in Ghana. *Research and Documentation Österreichisches Rotes Kreuz Wiedner Hauptstraße 32 1040 Wien Austrian Centre for Country of Origin & Asylum*. Accra. Ghana, p. 4-26.
- Abor, P., Abekah-Nkrumah, G., & Abor, J. (2008). An examination of Hospital Governance in Ghana (Vol. 21), p. 49-51.
- Adjasi, C. K. D., & Abor, J. (2007). Corporate governance and the small and medium enterprises sector: theory and implications. *Corporate Governance: The international journal of business in society*, 7(2), 111-122. doi:10.1108/14720700710739769, p 113.
- Agyemang, C., Meeks, K., Beune, E., Owusu-Dabo, E., Mockenhaupt, F. P., Addo, J, Stronks, K. (2016). Obesity and type 2 diabetes in sub-Saharan Africans – Is the burden in today's Africa similar to African migrants in Europe? *The RODAM study. BMC Medicine*, 14 (1) 166. doi:10.1186/s12916-016-0709-0
- Aikins, A. (2015). Mental illness and destitution in Ghana: A Social-psychological perspective: *The Culture of Mental Illness and Psychiatric Practice in Africa*.

Akazili, J., Adjuik, M., Jehu-Appiah, C., & Zere, E. (2008). Using data envelopment analysis to measure the extent of technical efficiency of public health centres in Ghana. *BMC International Health and Human Rights*, 8(1), 11, p. 2& 4.

Alagidede, P., Baah-Boateng, W., & Nketiah-Amponsah, E. (2013). *The Ghanaian Economy: An Overview* (Vol. 1), p. 4-7.

Awine, T., Malm, K., Bart-Plange, C., & Silal, S. P. (2017). Towards malaria control and elimination in Ghana: challenges and decision-making tools to guide planning. *Global health action*, 10(1), 1381471-1381471 doi:10.1080/16549716.2017.1381471, p. 2.

Ayernor, P. K. (2012). Diseases of ageing in Ghana. *Ghana medical journal*, 46 (2 Suppl), 18-22, p. 21.

Berman, P. (1995). Health sector reform: making health development sustainable. *Health Policy*, 32 (1), 13-28. doi:[https://doi.org/10.1016/0168-8510\(95\)00726-9](https://doi.org/10.1016/0168-8510(95)00726-9)

Boom, V., Nuamah, N., & Overbosch, G. (2004). *Curative health care utilization in Ghana: a multinomial analysis of equitable access opportunities*.

Cassels, A. (1995). Health sector reform: Key issues in less developed countries. *Journal of International Development*, 7(3), 329-347. doi:10.1002/jid.3380070303, p. 1-3.

Chawla, M., Govindaraj, R., Berman, P., & Needleman, J. (1996). *Improving hospital performance through policies to increase hospital autonomy: methodological guidelines*. Boston, MA. Data for Decision Making Project, Harvard School of Public Health

Constitution, G. (1992). The 1992 constitution of the Republic of Ghana, 1992.

Couttolenc, B. F. (2012). *Decentralization and governance in the Ghana health sector*: The World Bank, p. 1-20.

de-Graft Aikins, A., Addo, J., Ofei, F., Bosu, W., & Agyemang, C. (2012). Ghana's burden of chronic non-communicable diseases: future directions in research, practice and policy. *Ghana Medical Journal*, 46 (2 Supplement), p. 1-3.

de-Graft Aikins, A., & Koram, K. (2017). Health and Healthcare in Ghana, 1957-2017, p. 365-373.

Ghana Statistical Service (GSS), Health Research Unit, Ministry of Health, and ORC Macro. (2003). *Ghana Service Provision Assessment Survey 2002*. Calverton, Maryland: Ghana Statistical Service and ORC Macro, p. 13-24

Govindaraj, R., Obuobi, A., Enyimayew, N., Antwi, P., & Ofosu-Amaah, S. (1996). Hospital autonomy in Ghana: the experience of Korle Bu and Komfo Anokye Teaching hospitals. Boston, MA, *Data for Decision Making Project, Harvard School of Public Health*.

Keasey, K., Thompson, S., & Wright, M. (1997). *Corporate governance: Economic and financial issues*: OUP Oxford.

Larbi, G. A. (1998). Institutional constraints and capacity issues in decentralizing management in public services: the case of health in Ghana. *Journal of International Development: The Journal of the Development Studies Association*, 10(3), 377-386, p. 377-384.

Murray, C. J., & Lopez, A. D. (2013). Measuring the global burden of disease. *N Engl J Med*, 369 (5), 448-457. doi:10.1056/NEJMra1201534

Murray, C. J., Lopez, A. D., & Jamison, D. T. (1994). The global burden of disease in 1990: summary results, sensitivity analysis and future directions. *Bull World Health Organ*, 72(3), 495.

Roberts, M., Mogan, C., & Asare, J. B. (2014). An overview of Ghana's mental health system: results from an assessment using the World Health Organization's Assessment Instrument for Mental Health Systems (WHO-AIMS). *International Journal of Mental Health Systems* 8(1), 16.

Saeed, B. I., & Abdul-Aziz, A. (2013). Assessing the influential factors on the use of healthcare: Evidence from Ghana. *International Journal of Business and Social Science* 4(1).

Saeed, B. I., Oduro, S. D., Ebenezer, A. M. F., & Zhao, X. (2012). Determinants of healthcare utilization among the ageing population in Ghana. *International Journal of Business and Social Science* 3(24), p. 64.

Saleh, K. (2012). *The health sector in Ghana: a comprehensive assessment*: The World Bank, p. 31-37.

van den Boom, G., Nsowah-Nuamah, N., & Overbosch, G. (2007). Healthcare provision and self-medication in Ghana, 2004. *Accessed 10th October*.

Verhage, R., van de Gronden, J., Awanyo, K., & Boateng, S. (2002). Procurement reform in the Ghana health sector. *Journal of Public Procurement*, 2(2), 261-268.

W Drislane, F., Akpalu, A., & H J Wegdam, H. (2014). *The Medical System in Ghana* (Vol. 87), p. 322.

World Health Organization (2007). Everybody's business--strengthening health systems to improve health outcomes: WHO's framework for action.

World Health Organization (2010). *Monitoring the building blocks of health systems: a handbook of indicators and their measurement strategies*: World Health Organization.

Young, F., Critchley, J. A., Johnstone, L. K., & Unwin, N. C. (2009). A review of co-morbidity between infectious and chronic disease in Sub Saharan Africa: TB and Diabetes Mellitus, HIV and Metabolic Syndrome, and the impact of globalization. *Globalization and Health* 5 (1) 9. doi:10.1186/1744-8603-5

CHAPTER THREE

THE IMPLEMENTATION OF SDG3 IN ELDERLY HEALTHCARE DELIVERY IN GHANA

3.0 Introduction

This part of the study reviews the health care services for the elderly, the sustainable development goals and its health-related goals. It further gives an assessment of the implementation of SDG3 in elderly health care delivery in Ghana.

3.1 Sustainable Development Goals

A universal call for action to end poverty, protect the planet and ensure that people enjoy peace and prosperity is the core mandate of the SDGs. After succeeding the MDGs in 2016, the SDGs sought to expand the goals of its predecessor as well as tackling its shortcomings. Thus, SDGs claims to be much higher and ambitious in terms of its goals and targets (Tangcharoensathien, Mills & Palu, 2015).

3.1.1 Emergence of the SDGs

The MDGs (2000-2015) marked a historical method of global partnership to tackle social issues and design goals to structure the behaviour of states. It was endorsed on the premises of the Millennium Declaration of Action. It had eight (8) goals with its *“three health-related goals to be met by 2015: reduction in child (under 5 years) mortality (Goal 4); reduction in maternal mortality and access to reproductive health care (Goal 5); and reversing the spread of HIV/AIDS, tuberculosis and malaria (Goal 6)”* (Buse & Hawkes, 2015). The achievements recognized by states, such as the eradication of poverty and a widespread understanding of

environmental objectives such as tackling the effects of climate change, caused states to vouch for a new agenda to extend the successes of the MDGs into future years (Sachs, 2012).

On the other hand, critics of the MDGs also deemed it poised to develop another framework of global partnership. First, the MDGs could not achieve the North-South aid agenda which were promises of development assistance made by developed countries to developing countries (Fukuda-Parr, 2016). Also, the MDGs incorporated a “piecemeal approach” that is “choosing to engage with some but not all of the MDGs”. That is MDGs could only work for countries in the Global South (Woodbridge, 2015).

Furthermore, developmental consequences such as the Anthropocene, which is termed as the *“human imprint on the global environment has now become so large and active which rivals some of the great forces of Nature in its impact on the functioning of the Earth system”*. This drew the attention for a need for an effective plan of action for people and the planet (Bonneuil & Fressoz, 2016, p. 16; Griggs et al., 2013).

The Rio+20 Summit in June, 2012 marked the effort prior to the establishment of the SDGs. It issued a report recommending that the world adopt a set of SDGs (Woodbridge, 2015). The negotiation process began with an Open Working Group of the UN General Assembly in 2013. Ghana played a significant role by holding one of the seven seats apportioned for the African Region. Thus, Ghana took part in discussions and negotiations on poverty, gender, climate change, financing for development and other pressing issues on the table (NDPC, GSS, 2018).

Seventeen goals were set and adopted by world leaders in September 2015. The goals reflect their main intended outcomes. The health goals, SDG3, are people-centred. It aims to deliver individual and collective wellbeing through improved health and education, ensuring equitable distribution within and between individuals and countries. SDG3 is supported by goals that relate to the production, distribution, and delivery of goods and services including food, energy, clean water, and waste and sanitation services in cities and human settlements. These infrastructural goals, address essential functions of societies and the state as a whole. Environmental goals also play a vital role. They relate to the governance of natural resources and public goods on land, in ocean, and in air, including biodiversity and climate change. The biophysical systems that underpin sustainable development are all here (Waage et al., 2015).

3.2 A Global Overview of Geriatric Care

Health care is a series of separated but related services. These include laboratory test, physician office visits, consultation and a host of others. They are the multiple services that seek to achieve optimum care for a particular medical condition over time. These service seek to sustain and ensure the good health and well-being of people (Hornbrook, Hurtado, & Johnson, 1985).

The global population is ageing and the last few years have witnessed an upsurge in the total and the comparative numbers of the elderly in both developing and developed countries. This demographic transition presents many opportunities as well as challenges for population ageing. Elderly people are found to have particular prerequisites and most health systems are poorly equipped to meet them. For example, the elderly with time are more likely to have manifold comorbidities, a variety of conditions or diseases that co-occur (Valderas, Starfield, Sibbald, Salisbury, & Roland, 2009). Most health facilities see the need to provide extensive health care to the elderly. Therefore, it is important that health personnel are trained adequately to cover the specific needs of the elderly. Researchers have also suggested that

gerontological training, the comprehensive multidisciplinary study of ageing and the elderly, is also necessary in this field (Novielli & Arenson, 2003; Valderas et al., 2009).

3.2.1 Geriatric Care in Ghana

In Ghana, the needs of the elderly were given due acknowledgement of MIPAA. MIPAA was agreed by the Second World Assembly on Ageing in April, 2002. It provides a bold agenda dealing with matters of concern when it comes to age advancement. The MIPAA pays central attention to the elderly and the means to have quality healthcare and ensuring a conducive environment. Governments and other actors within the international system are obliged under the framework of MIPAA to orient their policies and frameworks in a way that would help society perceive, interact with and care for their older citizens (UN, 2002).

In order to place MIPAA into Ghana's cultural setting, a National Ageing Policy was drafted to address ageing issues in the country. The drafted policy identified health issues associated with elderly health care delivery. First, though elderly persons are fully entitled to have access to preventive and curative care, including rehabilitation and sexual health care, they are often denied them, in addition to other essential health care services. Also, the training of health personnel gives little attention to older people and very few specialist services for the elderly exist. Most health care services were ran through the "*out-patient department*" (GAEC 1&2 Interview, July 2019) in both private and public health facilities. Thus, the elderly patients went through "*lumped services*" (Korle-Bu Interview, April, 2019) such as the hospital consultations, laboratory tests and a host of others to attain health care delivery with other categories of the population; children and pregnant women. There were also no additional packages for health workers and students in the field of geriatrics and gerontology (Apt, 1997; GOG, 2010).

Nevertheless, the re-occurrence of health reforms within Ghana's health care delivery system has led to the establishment of Geriatric care within the health sector to man health care services for the elderly. *"The Family Health Division at the Korle-Bu polyclinic trains geriatricians under the auspices of the KBTH. Private health care delivery facilities have also began to provide geriatric services. Although geriatricians are specially trained in the care of the elderly, most of them are generalist or family physicians"* (Korle Bu Interview, April 2019). Their services are done in a continuum with careful attention given by the physician for the purposes of care transition which is very important to the navigation of the continuum of elderly care (Durso, Bowker, Price & Smith, 2010).

3.3 Assessing the Interventions to Ensure SDG3 in Elderly Health Care (Geriatric Care) by Ghana's Health Sector

The SDG3 has nine targets. These cover aspects that were already present in the MDGs, such as the reduction of the global maternal and child mortality ratios and an end to epidemics of AIDS, tuberculosis, malaria and neglected tropical diseases. They also address other specific global health problems: substance abuse, road traffic accidents, and sexual and reproductive healthcare. Moreover, considerable attention is paid to the improvement of worldwide health coverage, with one of the most ambitious SDG3 targets seeking to achieve UHC by 2030.

Although the SDG3 does not exclusively merit the structure of elderly health care delivery, it is still incorporated in its execution. *"There is awareness of the SDG3 especially UHC"* (GAEC1&2, July 2019). Therefore, with regard to elderly health care delivery target four (4) and eight (8) would be of central focus:

"3.4: By 2030, reduce by one-third premature mortality from non-communicable diseases through prevention and treatment and promote mental health and well-being"

3.8: *Achieve universal health coverage, including financial risk protection, access to quality essential health-care services and access to safe, effective, quality and affordable essential medicines and vaccines for all”*

3.3.1 Universal Health Coverage

According to the WHO, UHC connotes that, “all people and communities can use promotive, preventive, curative, rehabilitative and palliative health services they need, of sufficient quality to be effective while also ensuring that the use of these services does not expose the user to financial hardship”. The WHO further represents UHC into three goals:

- Health care should be access by every individual.
- The quality of health services should be efficient.
- People should be protected against financial risk (WHO, 2019).

To advance towards UHC, policymakers must address rival priorities for different population groups, services, and financing mechanism (Acharya, 2015). The elderly require diverse approaches to health care and are frequently incapable to pay for these services. Therefore, health systems must to be readjusted pointedly to meet these targets. The WHO Global strategy and action plan on ageing and health also provides an administrative directive for action to enable this change (Sadana, Soucat, & Beard, 2018).

This would aid elderly people to be included in health care delivery through the sustainable development goals. To achieve UHC, countries must advance in at least three dimensions. Countries must open more facilities, increase the number of health beneficiaries and personnel, and reduce “out-of-pocket” payments. Ghana has accepted and adopted the concept of UHC. Thus, the MOH through its main implementation agency GHS, have put in

efforts to ensure equitable access to quality health services which includes geriatric care and specialized out-patient clinic and services for the elderly (WHO, 2014; MoH 2018).

Universal health coverage is classified in terms of health facilities, health personnel and financial protection.

Access In Terms Of Health Facilities

Ghana has a wide-ranging health service delivery system. It includes community-based programs, such as the CHPS initiative (GHS 2002); sub district health centres and clinics; district general hospitals; regional general hospitals; and specialized tertiary hospitals. It is reported that, *“the public sector has the largest share health facilities where as the private sector complements the public health agencies. At least 34 percent of hospital beds belong to the private. The CHAG represents a significant proportion of beds in the non– public sector with equal representation in urban and rural areas. For profit facilities are concentrated in urban areas.”* (Saleh, 2012, p. 43).

Consequently, health facilities run either by public or private entities, have made efforts to make health care available to the elderly. This also applies to all the health administrative levels; national, regional, district, sub-district and community levels (Abor, Abekah-Nkrumah, & Abor, 2008; Akande, 2004).

Prior to the implementation of the SDGs, the elderly had access to health care delivery from OPD. However, *“the establishment of a geriatric centre at Korle-Bu Polyclinic in September 2018 assured a health facility specifically for the elderly”* (Korle BU Interview, April, 2019). Although most public and private health care delivery agencies do not have geriatric centres,

they have special services for the elderly. For instance, “*the GAEC Hospital has a diabetic and hypertension clinic. The clinic educates the elderly on their conditions, management of the disease, diet and lifestyle patterns*” (GAEC 1 Interview, July 2019). Likewise, new polyclinics, health centres and CHPS compounds have assisted in attaining quality healthcare to the doorsteps of people including the elderly (Parliamentary Hansard, 31st May 2016; 5th Jan 2017).

Also, in terms of access to health facilities, the geriatric centre in Korle-Bu has partners such as the Centre for Ageing Studies, University of Ghana, Legon. The geriatric centre has outreaches with its partners on Senior Citizens Day. The geriatric centre and some private health agencies that offer geriatric services handle referrals from their partnered hospitals and clinics (Korle-Bu Interview, April 2019).

In addition, most private services in the country are somewhat vigorous in the delivery of health care for elderly people. For instance, HelpAge Ghana is one of such institutions that encourage the welfare of the elderly in Ghana regardless of their sex, creed and colour; provide leadership in ageing policy development and implementation; and promote the rights and well-being of older people (WHO, 2014).

Furthermore, initiatives have been undertaken by the Ministry of Children, Gender and Social Protection (MOCGSP) to implement the Ageing Bill. The Ministry has moved away from institutional care, placing emphasis on day care facilities and safe places for the aged. This may seem outside the health sector but it affirms that the implementation of UHC is a collaborative effort from the health sector with other ministerial departments (Parliament Hansard, 28th Jan 2018).

Lastly, the proportion of regional and district health facilities offering traditional medicine has remained the same for the past three years. Currently, there are 19 hospitals (District and Regional) offering herbal medicine services. Earlier in 2013, a decision was made to pilot the provision of traditional (herbal) medicine alongside allopathic medicine in some of our public health facilities. These services are not exclusive to the elderly but have added up to the capacity of health facilities in the country (MOH, 2018).

Access in terms of human resource

In 2010, the National Ageing Policy stated, *“The training of health personnel gives little attention to older people and very few specialist services exist. Currently, there are no special incentives to attract medical and health students to offer courses in geriatrics and gerontology”*. Human resource is a key component in achieving UHC. The policy proposed that the production of the adequate and appropriate health workforce is desirable. Adequate training and incentives will be institutionalized to attract students of medical and health training institutions to receive education and training including specialized training in geriatrics and gerontology. Arrangements will be made to enable health and social service care professionals to counsel and guide persons reaching old age on healthy lifestyles. In addition to this Government will develop and implement programs to educate older persons and the general public including informal caregivers about specific nutritional needs of older persons (GOG, 2010, p.32-33).

There was only one geriatric specialist in 2004 and the country had intentions for a national policy on the aged. Therefore, equal distribution of health personnel had to be wrongly given per the right number and skills mix in measuring the geographical access to medical practitioners and health service delivery (MOH, 2018).

In 2016, a team of general geriatric doctors were trained to handle the health care needs of the elderly. Unlike most poly clinics, the geriatric doctors were trained at the Korle-Bu polyclinic. Currently, there are four geriatric doctors stationed at the Korle-Bu Polyclinic. The doctor to population ratio is also satisfactory which is determined by the number of patients a doctor serves in a day to its efficient output. Also, private health care facilities also have geriatricians who handled referral cases from hospitals or clinics without geriatricians (Korle-Bu Interview, July 2019).

Access in terms of Financial Protection

The abstraction of financial protection in health has established increasing consideration as international organizations and governments have focused on the risk that high health expenses pose to the financial security of poor and vulnerable populations (Waters, Anderson, & Mays, 2004). African countries including Ghana have taken initiatives to safeguard financing in their health systems, and provide universal coverage with financial protection for their citizens if they are to achieve the health-related by 2030 (Akazili, Gyapong, & McIntyre, 2011).

Ghana's present-day UHC journey began in 2003 when the National Health Insurance Act 650 was passed by parliament. The policy sought to *"to assure equitable and universal access for all residents of Ghana to an acceptable quality package of essential healthcare"* (Agyepong et al., 2016). It was reported in 2011 that:

"The premium exemption policy under the NHIS catered for categories of persons by virtue of their ages, types of care needed, being indigent, or being SSNIT pensioners or SSNIT contributors. The exemption policy of the NHIS provides exemptions on premium payment for children younger than 18 years who are SSNIT contributors, SSNIT pensioners, people aged 70 years and older, indigents, pregnant women, and LEAP beneficiaries" (Akazili et al., 2011, p.4).

In addition, elderly persons above the ages of 60, who are legally working are exempted from paying for public health care. Once an initial one-off payment for registration is made, all health-care services are free of as a minimum benefit package offering health care services (WHO, 2014).

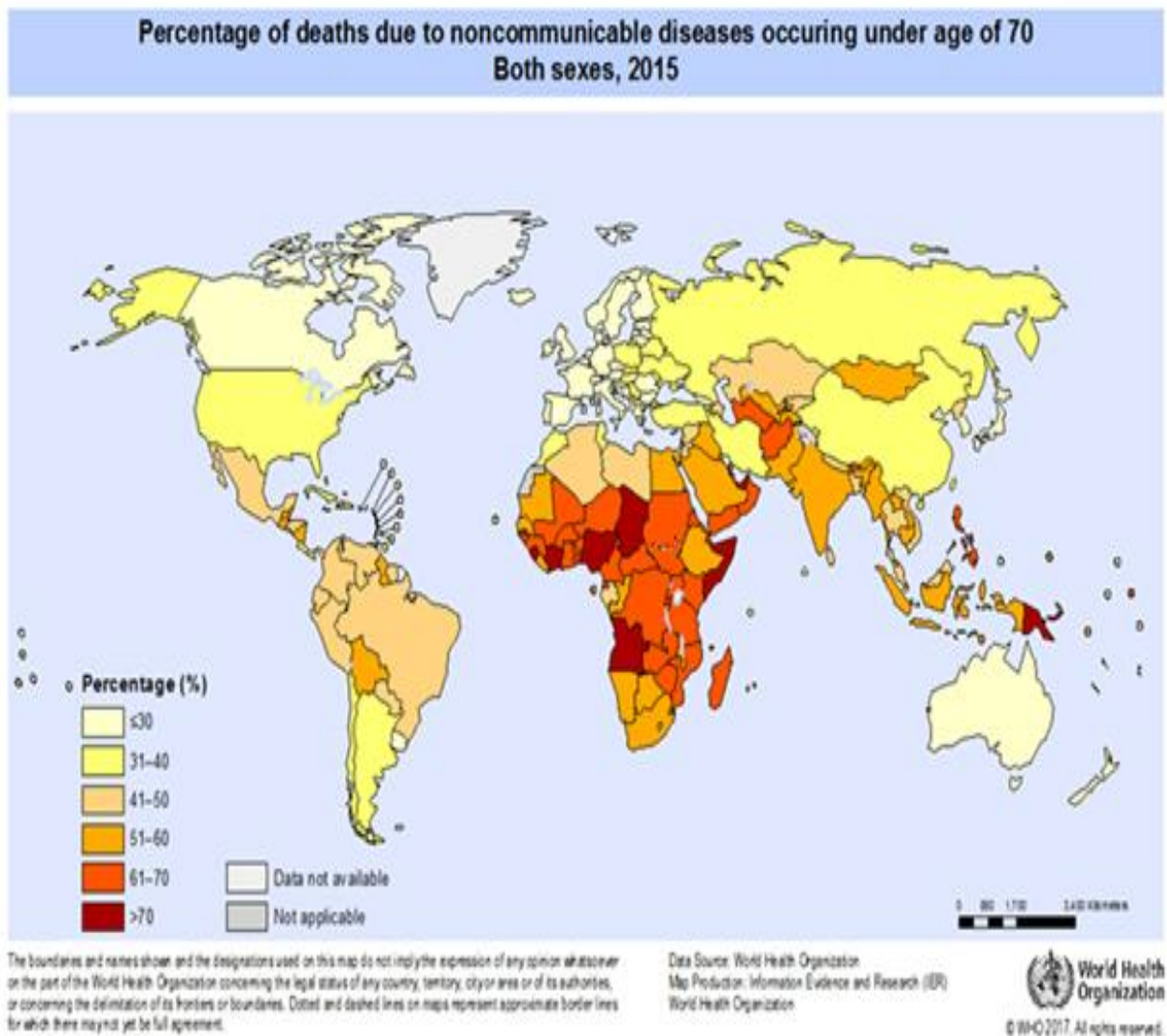
The MOGCSP have made significant initiatives that facilitate access to social services such as the NHIS by the elderly. This is done through activities and commemorations such Senior Citizens' Day. This initiative suggests that some determinants of health are outside the health sector (Parliamentary Hansard, 28th Jan 2018).

Currently, the NHIS is still being accepted by all health facilities. Once a patient is a beneficiary of the health insurance package, the patient is given a subsidized health service. Also, patients aged seventy years (70) and above still enjoy the benefit from the premium exemption policy (Korle-Bu interview, April 2019; GAEC 1 Interview, July 2019).

3.3.2 Non-communicable diseases (NCDs)

In low- and middle-income countries, about 46% of deaths occurred before the age of 70 in 2016.

Fig 2: Percentage of death caused by NCDs in 2015



Source: WHO, 2017

From the map, individuals from sixty-one years and above die from non-communicable diseases in Ghana.

Most causes of death has shifted primarily from communicable disease to the amalgamation of both communicable and chronic non-communicable diseases in the last few years. Hypertension, diabetes and stroke are reportedly part of the topmost causes of death in the country. Ageing populations and weak health systems are implicated in the prevalence of NCDs, morbidity and mortality (de Graft Aikins, Addo, Ofei, Bosu & Agyemang, 2012).

Akin to the submission above, a research conducted in 2007 calculated the frequency of a number of chronic conditions by self-report and also by symptom reporting. “The list of conditions includes stroke, angina pectoris, diabetes mellitus, osteoarthritis, chronic lung disease, asthma, depression, and hypertension. A number of conditions (angina, asthma, arthritis, and depression) have symptoms with sufficient specificity and sensitivity to also consider prevalence/incidence rates estimates generated with established diagnostic algorithms. For these conditions, the rates were reported both ways” (Biritwum et al., 2013).

The burden of NCDs in Ghana is projected to increase due to ageing, rapid urbanization and unhealthy lifestyles. Scholars deemed it fit for Ghana to have a policy to man the prevalence of NCDs (de Graft Aikins et al., 2012). In the year 2012, a National Policy for the Prevention and Control of Chronic Non-Communicable Diseases in Ghana was introduced by the MOH. The policy states:

“A National Multi-sectoral Board will be recognized to recommend to the Minister of Health on activities to be taken to avoid and regulate the occurrence of NCDs and monitor their progress. This Committee will ensure that NCDs are given high priority in the national development agenda. Members will be drawn from relevant institutions which influence the development and outcome of NCDs such as the Ministries Departments and Agencies, Universities, professional bodies, and NGOs.

The NCDs policy recognizes that favorable sector-wide public policies in areas such as trade, urban planning, transport, agriculture, education, finance, and social services are essential. Hence, the whole of government approach across all sectors would be adopted for the implementation of this policy” (MOH, 2012, p. 13).

Also, the collaborative efforts made by the GHS and Novo Nordisk in achieving the SDGs, by fighting against diabetes and NCDs. Novo Nordisk is a global leader in diabetic care. Their key contribution is to discover, development and manufacture better biological medicines and make them accessible to people all over the world. Thus, NCDs are advanced on the health and political frameworks of the country (GHS, 2017).

Lastly, health facilities have become more responsive to non-communicable diseases affecting the elderly. Medical practitioners attend carefully to the elderly with non-communicable diseases through geriatric care or the OPD. Health facilities have taken the initiative by creating awareness of diseases and how to manage the condition (GAEC 1 & Korle Bu interview, 2019).

3.4 Some successes and challenges Ghana have encountered in elderly health care services in relation to SDG3

3.4.1 Successes

Collaborative networks to reduce Non-Communicable Diseases

The MOH and Novo Nordisk recognized the need for refining the health of individuals with diabetes in Ghana along with preventing and detecting early signs of diabetes in the country. The MOH is currently focused on decreasing morbidity, mortality, and disability and improve the health status of the Ghanaian by providing a complete package of promotive, preventive,

curative, rehabilitative and regulating health services which fall under UHC. This is done in partnership with major stakeholders.

The two organizations are dedicated to contributing to the attainments of the SDGs particularly, the goal of reducing by one third the mortality due to NCDs. The MOH seeks to use its capability in the field of healthcare management and policies, and Novo Nordisk’s expertise in the field of diabetes care to provide medicines and devices, capacity-building, supply chain management, innovative projects to improve diabetes care and treatment such as The Buddy Doctor Initiative (BDI) and the Base of the Pyramid (BoP) project (GHS, 2017).

The GHS has also introduced a number of programs to improve access to and appropriately manage non-communicable diseases (MOH, 2017).

Increase in the number of Health Facilities

The fact sheets from the 2017 to 2018 GHS reports have shown a significant number of health facilities by type. These facilities may not be exclusive to the elderly but increase the accessibility to good health.

Tab 1. National Health Infrastructure in 2017 and 2018

| Health Facilities | 2017 | 2018 |
|--------------------------|-------------|-------------|
| CHPs | 4185 | 5421 |
| Clinics | 1003 | 998 |
| District Hospitals | 137 | 140 |
| Health Centers | 855 | 1004 |
| Hospitals | 267 | 357 |
| Maternity Homes | 328 | 346 |

| | | |
|-----------------------|----|----|
| Mines | 3 | 11 |
| Polyclinics | 34 | 38 |
| Psychiatric Hospitals | 3 | 3 |

(GHS Facts and Figures, 2017; 2018)

The table shows an increase in the number of health facilities for citizens. Thus, this increases the health structures available in the country from which the elderly can benefit from.

3.4.2 Challenges

Constraints on Human Resources

Nationwide, poor accessibility to health is further compounded by the unequal geographic distribution of limited health workforce where urban centers have greater access to the health labor force. The WHO stated that Ghana had just over 11 health personnel per 100,000 which is less than half the number needed to achieve the MDG health goals. Also, rural areas are poorly served in terms of health care delivery as compared to the urban centres (ACCA, 2013).

Furthermore, there is also a disparity between the doctor–population ratios in the Greater Accra Region and in the Northern Regions. Highly skilled health professionals remain in urban southern areas and there is great disparity in service provision in the Northern regions. The country has offered some solutions by operationalizing the task-shifting approach through the community-based health programme, but there are major implementation and logistical challenges (de-Graft Aikins & Koram, 2017).

Currently, with regard to the “*doctor per population ratio of geriatricians*”, there is a limited number of geriatricians in the country to cater for the elderly population. Also, hospitals who

have made the efforts to have specialized clinics for the elderly also have a limited number of staff to provide for such services (Korle Bu Interview, July 2019).

Challenges associated with Non Communicable Diseases (NCDs) prevention and treatment

Although there has been an increase in awareness of NCDs, through the initiatives put by Ghana's health sector, elderly people still seem to have a bit of a challenge with regard to NCDs (GAEC 1 Interview, July 2019).

Ghana is undergoing an epidemiological transition where by NCDs have become an increasing concern. NCDs are increasingly becoming more widespread in Ghana. Among the elderly, 67 percent of deaths were caused by NCDs, predominately cardiovascular and infectious diseases are leading causes of death (Saleh, 2012).

There are also prevalence of hypertension and diabetes as causes of death .For instance, 2016 and 2017 recorded the cause of death due to hypertension as 747 and 2024 respectively. Also, death caused by diabetes was recorded as 332 and 556 in 2016 and 2017 respectively. Thus, the challenge here is the correlation between NCDs awareness and its treatment (GHS facts and figures; 2017, 2018). Also, there is poor data collection for non-communicable diseases (MOH, 2018).

Lastly, the emergence and recognition of NCDs, health structures are typically intended to recognize and manage acute communicable diseases. Consequently, parity in terms of access to health care facilities is inhibited by elderly with NCDs. This is mainly acute for elderly with other barriers relating to their age, such as dementia, functional decline and socioeconomic circumstances (WHO, 2014).

Shortfalls of National Health Insurance Scheme

Medications of NCDs are not covered or partly covered by the NHIS such as diabetic medications. As stated in the National Ageing Policy, 2010, most medications given for NCDs are not covered by the NHIS. Thus, there is financial protection for services delivery in Ghana but not its treatment. Some medications covered by the NHIS cannot supply the full doses to patients. This is deemed as a challenge because most elderly people categorized in the premium exception policy are retirees or have not had any formal working experience (GAEC 1&2 Interview, July 2019; GOG, 2010).

Inadequate Funding

The provision of efficient elderly health care delivery has not been adequately funded. This is because of the rivalry for uncommon assets which generally target children, teen-agers, pregnant women and mothers. The health goals of the MDGs and SDGs mostly focus on child care and maternal health (WHO, 2014).

3.5 Conclusion

The Ghana health system has acknowledged the need to ensure the elderly right to health care. This was first introduced through the National Ageing Policy in 2010. The SDGs period has also witnessed the introduction of geriatric medicine and specialized health services for the elderly. This Chapter, therefore, sought to assess elderly health care delivery through the SDG3 target of UHC and reduction of NCDs. It also identified some successes and challenges in implementing SDG3 in elderly health care delivery.

REFERENCES

- Association of Chartered Accountants ACCA (2013) *Key health challenges in Ghana* p. 5-25
- Abor, P., Abekah-Nkrumah, G., & Abor, J. (2008). An examination of Hospital Governance in Ghana (Vol. 21). p. 49
- Acharya, M. (2015). Universal health coverage as a distinct sustainable development goals target: dispelling doubts and underlining implications. *Frontiers in public health* 3, 238, p. 1&2.
- Agyepong, I. A., Abankwah, D. N. Y., Abroso, A., Chun, C., Dodoo, J. N. O., Lee, S., Oh, J. (2016). The “Universal” in UHC and Ghana’s National Health Insurance Scheme: policy and implementation challenges and dilemmas of a lower middle-income country. *BMC Health Services Research*, 16 (1), 504, p.2-12.
- Akande, T. (2004). *Referral system in Nigeria: study of a tertiary health facility*.
- Akazili, J., Gyapong, J., & McIntyre, D. (2011). Who pays for health care in Ghana? *International journal for equity in health* 10(1), 26 , p. 2-4.
- Apt, N., A. (1999) Ageing in Africa, *Southern African journal on Gerontology*. p 24
- Biritwum, R. B., Mensah, G., Minicuci, N., Yawson, A. E., Naidoo, N., Chatterji, S., & Kowal, P. (2013). Household characteristics for older adults and study background from SAGE Ghana Wave 1. *Global health action*, 6 (1), 20096, p. 70-104.

Bonneuil, C., & Fressoz, J.-B. (2016). *The Shock of the Anthropocene: The earth, history and us*: Verso Books, p. 16.

Buse, K., & Hawkes, S. (2015). Health in the sustainable development goals: ready for a paradigm shift? *Globalization and health*, 11 (1), 13, p. 1&2.

de Graft Aikins, A., Addo, J., Ofei, F., Bosu, W. K., & Agyemang, C. (2012). Ghana's burden of chronic non-communicable diseases: future directions in research, practice and policy. *Ghana medical journal*, 46 (2), 1-3

de-Graft Aikins, A., & Koram, K. (2017). *Health and Healthcare in Ghana, 1957-2017*. p 373

Durso S, Bowker L., Price J. & Smith S., (2010) *Oxford American Handbook of Geriatric Medicine*. Oxford University Press, p. 14

Fukuda-Parr, S. (2016). From the Millennium Development Goals to the Sustainable Development Goals: shifts in purpose, concept, and politics of global goal setting for development. *Gender & Development*, 24 (1), 43-52.

Ghana Health Service (2016) *Ghana Health Service Annual Report*

Ghana Health Service (2017) *Facts and Figures*

Ghana Health Service (2018) *Facts and Figures*

Government of Ghana (2010) *National Ageing Policy "Ageing with security and dignity"*

Griggs, D., Nilsson, M., Stevance, A., & McCollum, D. (2017). *A guide to SDG interactions: from science to implementation*: International Council for Science, Paris, p.1-3.

Griggs, D., Stafford-Smith, M., Gaffney, O., Rockström, J., Öhman, M. C., Shyamsundar, P., Noble, I. (2013). Policy: Sustainable development goals for people and planet. *Nature*, 495 (7441), 305, p.1-3.

Hornbrook, M. C., Hurtado, A. V., & Johnson, R. E. (1985). Health Care Episodes: Definition, Measurement and Use. *Medical Care Review*, 42 (2), 163-218. doi: 10.1177/107755878504200202

Lobmann, R. (2015). Geriatrics in Practice and Research-Worldwide. *Geriatrics* (Basel Switzerland), 1 (1), 1. doi:10.3390/geriatrics1010001

Ministry of Health (2012) *National Policy for the Prevention and Control of Chronic Non-Communicable Diseases*

Ministry of Health (2018) *Holistic Assessment of 2017 Health Sector Programme of Work*

National Development Planning Commission & Ghana Statistical Service (2018) *Ghana Sustainable Development Goals (SDGs): Indicator Baseline report*

Novielli, K. D., & Arenson, C. A. (2003). Overview of geriatrics. *Clinics in Podiatric Medicine and Surgery*, 20(3), 373-381. doi:[https://doi.org/10.1016/S0891-8422\(03\)00030-2](https://doi.org/10.1016/S0891-8422(03)00030-2)

World Health Organization (2014). *Making fair choices on the path to universal health coverage*. Final report of the WHO Consultative Group on Equity and Universal Health Coverage

Parliamentary Hansard, Ghana, 31st May 2016

Parliamentary Hansard, Ghana, 5th Jan 2017

Parliamentary Hansard, Ghana, 28th Jan 2018

Sachs, J. D. (2012). From millennium development goals to sustainable development goals. *The Lancet*, 379(9832), 2206-2211, p. 2206-2208.

Sadana, R., Soucat, A., & Beard, J. (2018). Universal health coverage must include older people. *Bulletin of the World Health Organization*, 96 (1), 2, p. 2.

Saleh, K. (2012). *The health sector in Ghana: a comprehensive assessment*: The World Bank, p. 43-87.

Tangcharoensathien, V., Mills, A., & Palu, T. (2015). Accelerating health equity: the key role of universal health coverage in the Sustainable Development Goals. *BMC medicine*, 13 (1), 101, p. 1-5.

Valderas, J. M., Starfield, B., Sibbald, B., Salisbury, C., & Roland, M. (2009). Defining comorbidity: implications for understanding health and health services. *The Annals of Family Medicine*, 7(4), 357-363, p. 358.

Waage, J., Yap, C., Bell, S., Levy, C., Mace, G., Pegram, T., Kock, R. (2015). Governing the UN Sustainable Development Goals: interactions, infrastructures, and institutions. *The Lancet Global Health* 3 (5), e251-e252

Waters, H. R., Anderson, G. F., & Mays, J. (2004). Measuring financial protection in health in the United States. *Health policy*, 69(3), 339-349

Woodbridge M. (2015) From MDGs to SDGs: What are the Sustainable Development Goals? *ICLEI Brief Sheet- Urban Issues*

World Health Organization (2014) *Ghana country assessment report on ageing and health*, p. 19-30.

UN General Assembly, (2015) *Transforming our world the 2030 Agenda for Sustainable Development*. A/RES/70/1, available at: <https://www.refworld.org/docid/57b6e3e44.html> [accessed 8 July 2019]

United Nations (2002) *Political Declaration and Madrid International Plan of Action on Ageing*, New York

United Nations, (2018) *Sustainable Development Goals* Available at: <https://www.un.org/sustainabledevelopment/sustainable-development-goals/> [accessed 11 July 2019]

CHAPTER FOUR

SUMMARY OF FINDINGS, CONCLUSIONS AND RECOMMENDATIONS

4.0 Introduction

This chapter summarizes the findings of the research, draws conclusions and gives applicable recommendations. The research sought to assess the implementation of SDG3 in elderly health care delivery in Ghana.

4.1 Summary of Findings

This section summarizes the entire study based on the objectives stated in Chapter One. Resource persons were interviewed to obtain relevant data on the research. The interviews conducted revealed that health care providers are aware of the SDG3 (Good Health and Well-being) targets in relation to elderly health care delivery. The study focused on “*reduction by one-third premature mortality from non-communicable diseases through prevention and treatment*”, and achieving universal health coverage.

The first objective exposed elderly health care delivery in Ghana as geriatric care. Prior to the introduction of geriatric care in Ghana, a National Ageing Policy which was influenced by the objectives of the MIPAA was drafted in 2010. The drafted policy identified issues with elderly health care delivery in Ghana. These included growth in the number of expert services for the elderly, training of health personnel to provide elderly care and the availability of elderly care services. The introduction of geriatric care in Ghana, set a tone to tackling the issues identified in the National Ageing Policy. Thus, geriatric care seeks to assure that special care and careful attention is given to the elderly for the purpose of care transition. It was also identified that health facilities without geriatric centers have specialized services to cater for the health prerequisites of the elderly.

Also, the second objective sought to assess the interventions to ensure SDG3 in elderly health care delivery in Ghana's health system. The assessment handled two aspects of the SDG3 targets; UHC and NCDs. Under UHC, three themes emerged from the data collection. These include access in terms of health facilities, access in terms of health personnel and access in terms of financial protection.

The third objective sought to investigate the successes and challenges Ghana has encountered in elderly health care delivery in relation to SDG3. The successes included the collaborative networks in the prevention and treatment of non-communicable disease and increase in number of health care facilities. The challenges identified were constraints on human resources, issues associated with elderly care and NCDs, the shortfalls of the Scheme NHIS and inadequate funding.

4.2 Conclusion

The global demographic transitions have realized and increase in the elderly population. Though it may be of lesser growth rate in Africa, there is the need to implement policies and programmes which would care for the needs of the elderly. Health outcomes are one of the changes identified with this global phenomenon. In Ghana, the health care delivery system is in charge of dispensing health services in the country. The implementation of policies and programmes is done by the GHS and the THs. With regard to the implementation of SDG3 in elderly health care services, efforts have been through geriatric and other specialized services. Though, Ghana's health care delivery system has encountered some challenges, there are a few successes identified within the SDG3 framework. Thus, the assessment suggests that much effort has been made but the health sector must consider the challenges so as ensure optimum health benefits by the elderly in Ghana.

4.3 Recommendations

The recommendations given are centered on the conclusions and findings and must be enacted by Ghana's Health Sector;

- First and foremost, the Ministry of Health and its implementing agencies must set aside funds exclusively for elderly health care delivery. One of the challenges identified in the findings was inadequate funding for elderly health care. This is due to the fact that most funds are channelled into child care and maternal health. These funds could mostly preferably gotten from foreign assistance. The MOH and GHS must be in charge of the execution of this initiative. The funds raised could be used to subsidize the cost of medication and health care services that the NHIS cannot cover. Also, funds could be used to build more geriatric centres in the country.
- In addition, the GHS must implement a framework that seeks to cater for the care of patients with NCDs. These diseases are mostly chronic conditions and strategies must be put in place to make life easier for elderly. The framework must provide easy access to health facilities as well as health personnel. Patients who are unable to convey themselves to the health care center must be provide with home care services once the condition has been reported to the health care provider. The home care services must have satisfactory geriatric doctor to population ratio as well as nurse to population ration to ensure the efficiency of the services. Also, a “whole life course approach” to non-communicable diseases that is comprehensive should be implemented.
- Lastly, the training needs for the health care of elderly must be reviewed. This should lead to the development of an inclusive strategy for Ghana. It must include primary

prevention, as well as screening and treatment programmes that include the elderly.

Also, the training requirements of community health officers should be revised to maintain efficient geriatric care for the elderly in their communities and own homes.

BIBLIOGRAPHY

Books

- Alagidede, P., Baah-Boateng, W., & Nketiah-Amponsah, E. (2013). *The Ghanaian Economy: An Overview* (Vol. 1).
- Arhinful, D. K. (2003). *The solidarity of self-interest: Social and cultural feasibility of rural health insurance in Ghana*. African Studies Centre, Leiden.
- Bonneuil, C., & Fressoz, J.-B. (2016). *The shock of the Anthropocene: The earth, history and us*: Verso Books.
- Couttolenc, B. F. (2012). *Decentralization and governance in the Ghana health sector*: The World Bank
- Dawson, C. (2002). *Practical research methods: A user-friendly guide to mastering research techniques and projects*: How to books Ltd.
- Durso, S., Bowker, L., Price, J., & Smith, S. (2010). *Oxford American Handbook of Geriatric Medicine*. Oxford University Press.
- Franz, C., & Ghebreyesus, T. A. (2019). *The Road to Universal Health Coverage: Innovation, Equity, and the New Health Economy*: JHU Press
- Ghana Statistical Service., Unit, G. M. o. H. H. R., & Macro, O. (2003). *Ghana Service Provision Assessment Survey 2002*: Ghana Statistical Service.
- Glassman, A., Giedion, U. & Smith, P.C., *What's in, What's out: designing benefits for universal health coverage*, Washington DC: Center for Global Development, LCCN 2017021073
- Griggs, D., Nilsson, M., Stevance, A., & McCollum, D. (2017). *A guide to SDG interactions: from science to implementation*: International Council for Science, Paris.

Keasey, K., Thompson, S., & Wright, M. (1997). *Corporate governance: Economic and financial issues*: OUP Oxford.

Kumar, R. (2019). *Research methodology: A step-by-step guide for beginners*: Sage Publications Limited.

MacFarlane, S. N., & Khong, Y. F. (2006). *Human security and the UN: A critical history*: Indiana University Press.

Saleh, K. (2012). *The health sector in Ghana: a comprehensive assessment*: The World Bank.

Tadjbakhsh, S., & Chenoy, A. (2007). *Human security: Concepts and implications*: Routledge.

W Drislane, F., Akpalu, A., & H J Wegdam, H. (2014). *The Medical System in Ghana* (Vol. 87).

World Health Organization (WHO). (2010). *Monitoring the building blocks of health systems: a handbook of indicators and their measurement strategies*: World Health Organization.

Book Section

Aikins, A. (2015). Mental illness and destitution in Ghana: A Social-psychological perspective: *The Culture of Mental Illness and Psychiatric Practice in Africa*.

de-Graft Aikins, A., & Koram, K. (2017). *Health and Healthcare in Ghana, 1957-2017*.

Conference Proceedings

Boom, V., Nuamah, N., & Overbosch, G. (2004). Curative health care utilization in Ghana: a multinomial analysis of equitable access opportunities

Journal Articles

- Abdallah, S., & Prinz, V. (2009). Health care in Ghana. Austrian Centre for Country of Origin & Asylum Research and Documentation. *Österreichisches Rotes Kreuz/Wiedner Hauptstraße 32 1040 Wien*. Accra, Ghana
- Aboderin, I. (2010). Understanding and advancing the health of older populations in sub-Saharan Africa: policy perspectives and evidence needs. *Public Health Reviews*, 32(2), 357
- Abor, P., Abekah-Nkrumah, G., & Abor, J. (2008). An examination of Hospital Governance in Ghana (Vol. 21)
- Acharya, M. (2015). Universal health coverage as a distinct sustainable development goals target: dispelling doubts and underlining implications. *Frontiers in Public Health*, 3, 238
- Adjasi, C. K. D., & Abor, J. (2007). Corporate governance and the small and medium enterprises sector: theory and implications. *Corporate Governance: The international journal of business in society*, 7(2), 111-122. doi:10.1108/14720700710739769
- Agyemang, C., Meeks, K., Beune, E., Owusu-Dabo, E., Mockenhaupt, F. P., Addo, J., Stronks, K. (2016). Obesity and type 2 diabetes in sub-Saharan Africans – Is the burden in today's Africa similar to African migrants in Europe? *The RODAM study. BMC Medicine*, 14(1), 166. doi:10.1186/s12916-016-0709-0
- Agyepong, I. A., Abankwah, D. N. Y., Abroso, A., Chun, C., Dodoo, J. N. O., Lee, S., Asenso-Boadi, F. (2016). The “Universal” in UHC and Ghana's National Health Insurance Scheme: policy and implementation challenges and dilemmas of a lower middle income country. *BMC Health Services Research*, 16(1), 504. doi:10.1186/s12913-016-1758-y
- Ajdari, B., & Asgharpour, S. E. (2011). Human security and development, emphasizing on sustainable development. *Procedia - Social and Behavioral Sciences*, 19, 41-46. doi:<https://doi.org/10.1016/j.sbspro.2011.05.105>

- Akande, T. (2004). Referral system in Nigeria: study of a tertiary health facility.
- Akazili, J., Adjuik, M., Jehu-Appiah, C., & Zere, E. (2008). Using data envelopment analysis to measure the extent of technical efficiency of public health centres in Ghana. *BMC International Health and Human Rights*, 8(1), 11
- Akazili, J., Gyapong, J., & McIntyre, D. (2011). Who pays for health care in Ghana? *International journal for equity in health*, 10(1), 26
- Alhassan, R. K., Nketiah-Amponsah, E., & Arhinful, D. K. (2016). A Review of the National Health Insurance Scheme in Ghana: What Are the Sustainability Threats and Prospects? *PLoS One*, 11(11), e0165151. doi:10.1371/journal.pone.0165151
- Alkire, S. (2003). A Conceptual Framework for Human Security
- Amoah, P. A., & Phillips, D. R. (2018). Health literacy and health: rethinking the strategies for universal health coverage in Ghana. *Public Health*, 159, 40-49. doi:10.1016/j.puhe.2018.03.002
- Apt, N., A. (1999) Ageing in Africa, *Southern African Journal on Gerontology*.
- Arifin, S. R. M. (2018). Ethical Considerations in Qualitative Study.
- Asante, A. F., Arhinful, D.K., Fenny, P.A., & Kusi,A. (2014) Who is excluded in Ghana's National Health Insurance Scheme and why: a social, political, economic and cultural(SPEC) analysis
- Attuquayefio, P.K. (2012) Co-opting human security and deduction for security policy-making in Ghana, *Ghana Journal of Development Studies*
- Awine, T., Malm, K., Bart-Plange, C., & Silal, S. P. (2017). Towards malaria control and elimination in Ghana: challenges and decision making tools to guide planning. *Global health action*, 10(1), 1381471-1381471 doi:10.1080/16549716.2017.1381471

- Ayernor, P. K. (2012). Diseases of ageing in Ghana. *Ghana medical journal*, 46(2 Suppl.), 18-22
- Baer, B., Bhushan, A., Taleb, H. A., Vasquez, J., & Thomas, R. (2016). The Right to Health of Older People. *Gerontologist* 56 Suppl. 2, S206-217 doi:10.1093/geront/gnw039
- Beard, J. R., Araujo de Carvalho, I., Sumi, Y., Officer, A., & Thiyagarajan, J. A. (2017). Healthy ageing: moving forward. *Bull World Health Organ*, 95(11), 730-730a. doi:10.2471/blt.17.203745
- Beard, J. R., Officer, A. M., & Cassels, A. K. (2016). The World Report on Ageing and Health. *Gerontologist*, 56 Suppl. 2, S163-166 doi:10.1093/geront/gnw037
- Berman, P. (1995). Health sector reform: making health development sustainable. *Health Policy*, 32(1), 13-28. doi:[https://doi.org/10.1016/0168-8510\(95\)00726-9](https://doi.org/10.1016/0168-8510(95)00726-9)
- Biritwum, R. B., Mensah, G., Minicuci, N., Yawson, A. E., Naidoo, N., Chatterji, S., & Kowal, P. (2013). Household characteristics for older adults and study background from SAGE Ghana Wave 1. *Global health action*, 6 (1), 20096
- Bloom, D. E. (2011). 7 billion and counting. *Science*, 333(6042), 562-569. doi:10.1126/science.1209290
- Bluestone, K. (2016). The future of development is ageing.
- Borgonovi, E., & Compagni, A. (2013). Sustaining universal health coverage: the interaction of social, political, and economic sustainability. *Value Health*, 16(1 Suppl.), S34-38. doi:10.1016/j.jval.2012.10.006
- Buse, K., & Hawkes, S. (2015). Health in the sustainable development goals: ready for a paradigm shift? *Globalization and health*, 11(1), 13
- Cassels, A. (1995). Health sector reform: Key issues in less developed countries. *Journal of International Development*, 7(3), 329-347. doi:10.1002/jid.3380070303

- Chawla, M., Govindaraj, R., Berman, P., & Needleman, J. (1996). Improving hospital performance through policies to increase hospital autonomy: methodological guidelines. *Data for Decision Making Project*, Harvard School of Public Health, Boston, MA
- de Graft Aikins, A., Addo, J., Ofei, F., Bosu, W. K., & Agyemang, C. (2012). Ghana's burden of chronic non-communicable diseases: future directions in research, practice and policy. *Ghana medical journal*, 46(2), 1-3
- Dora, C., Haines, A., Balbus, J., Fletcher, E., Adair-Rohani, H., Alabaster, G., Neira, M. (2015). Indicators linking health and sustainability in the post-2015 development agenda. *Lancet*, 385(9965), 380-391. doi:10.1016/s0140-6736(14)60605-x
- Duffield, W., & Waddell, N., (2006) Securing Humans in a Dangerous World, *International Politics* 43(1):1-23. DOI: 10.1057/palgrave.ip.8800129
- Emas, R.,(2015) The Concept of Sustainable Development : Definition and defining principles
- Etikan, I., Musa, S. A., & Alkassim, R. S. (2016). Comparison of convenience sampling and purposive sampling. *American journal of theoretical and applied statistics*, 5(1), 1-4.
- Fried, L. P., & Paccaud, F. (2010). Editorial: The Public Health Needs for an Ageing Society. *Public Health Reviews*, 32(2), 351-355. doi:10.1007/bf03391606
- Fukuda-Parr, S. (2016). From the Millennium Development Goals to the Sustainable Development Goals: shifts in purpose, concept, and politics of global goal setting for development. *Gender & Development*, 24(1), 43-52.
- Fylan, F. (2005). Semi-structured interviewing. *A handbook of research methods for clinical and health psychology*, 5(2), 65-78.
- Govindaraj, R., Obuobi, A., Enyimayew, N., Antwi, P., & Ofosu-Amaah, S. (1996). Hospital autonomy in Ghana: the experience of Korle Bu and Komfo Anokye Teaching hospitals., *Data for Decision Making Project*, Harvard School of Public Health Boston, MA

- Griggs, D., Stafford-Smith, M., Gaffney, O., Rockström, J., Öhman, M. C., Shyamsundar, P., Noble, I. (2013). Policy: Sustainable development goals for people and planet. *Nature*, 495 (7441), 305
- Holliday, I., & Howe, B.M., (2011), Human Security: A Global Responsibility to Protect and Provide, *Korean Journal of Defense Analysis* 23(1)
- Hornbrook, M. C., Hurtado, A. V., & Johnson, R. E. (1985). Health Care Episodes: Definition, Measurement and Use. *Medical Care Review*, 42(2), 163-218. doi:10.1177/107755878504200202
- Hui, L. (2017). Assessment of the role of ageing and non-ageing factors in death from non-communicable diseases based on a cumulative frequency model. *Sci Rep*, 7(1), 8159. doi:10.1038/s41598-017-08539-0
- King, G., & Murray, C. J. (2001). Rethinking human security. *Political science quarterly*, 116(4), 585-610
- Larbi, G. A. (1998). Institutional constraints and capacity issues in decentralizing management in public services: the case of health in Ghana. *Journal of International Development: The Journal of the Development Studies Association*, 10(3), 377-386.
- Lobmann, R. (2015). Geriatrics in Practice and Research-Worldwide. *Geriatrics* (Basel, Switzerland), 1(1), 1. doi:10.3390/geriatrics1010001
- Murray, C. J., & Lopez, A. D. (2013). Measuring the global burden of disease. *N Engl J Med*, 369(5), 448-457. doi:10.1056/NEJMra1201534
- Murray, C. J., Lopez, A. D., & Jamison, D. T. (1994). The global burden of disease in 1990: summary results, sensitivity analysis and future directions. *Bull World Health Organ*, 72(3), 495

- Novielli, K. D., & Arenson, C. A. (2003). Overview of geriatrics. *Clinics in Podiatric Medicine and Surgery*, 20(3), 373-381. doi:[https://doi.org/10.1016/S0891-8422\(03\)00030-2](https://doi.org/10.1016/S0891-8422(03)00030-2)
- O'Connell, T., Rasanathan, K., & Chopra, M. (2014). What does universal health coverage mean? *Lancet*, 383(9913), 277-279. doi:10.1016/s0140-6736(13)60955-1
- Paris, R. (2001). Human security: paradigm shift or hot air? *International security*, 26(2), 87-102
- Park, C. H. K., Lee, J. W., Lee, S. Y., Shim, S. H., Kim, S. G., Lee, J., Ahn, Y. M. (2019). Characteristics of the "young-old" and "old-old" community-dwelling suicidal Ideators: A longitudinal 6-month follow-up study. *Compr Psychiatry*, 89, 67-77. doi:10.1016/j.comppsy.2018.12.002
- Roberts, M., Mogan, C., & Asare, J. B. (2014). An overview of Ghana's mental health system: results from an assessment using the World Health Organization's Assessment Instrument for Mental Health Systems (WHO-AIMS). *International Journal of Mental Health Systems*, 8(1), 16
- Sachs, J. D. (2012). From millennium development goals to sustainable development goals. *The Lancet*, 379(9832), 2206-2211.
- Sadana, R., Soucat, A., & Beard, J. (2018). Universal health coverage must include older people. *Bulletin of the World Health Organization*, 96(1), 2
- Saeed, B. I., & Abdul-Aziz, A. (2013). Assessing the influential factors on the use of healthcare: Evidence from Ghana. *International Journal of Business and Social Science*, 4(1)
- Saeed, B. I., Oduro, S. D., Ebenezer, A. M. F., & Zhao, X. (2012). Determinants of healthcare utilization among the ageing population in Ghana. *International Journal of Business and Social Science*, 3(24)

- Sandelowski, M., Voils, C. I., & Barroso, J. (2006). Defining and Designing Mixed Research Synthesis Studies. *Research in the schools : a nationally refereed journal sponsored by the Mid-South Educational Research Association and the University of Alabama*, 13(1), 29-29.
- Steves, C. J., Spector, T. D., & Jackson, S. H. (2012). Ageing, genes, environment and epigenetics: what twin studies tell us now, and in the future. *Age Ageing*, 41(5), 581-586. doi:10.1093/ageing/afs097
- Valderas, J. M., Starfield, B., Sibbald, B., Salisbury, C., & Roland, M. (2009). Defining comorbidity: implications for understanding health and health services. *The Annals of Family Medicine*, 7(4), 357-363.
- van den Boom, G., Nsowah-Nuamah, N., & Overbosch, G. (2007). Healthcare provision and self-medication in Ghana, 2004. Accessed 10th October.
- Verhage, R., van de Gronden, J., Awanyo, K., & Boateng, S. (2002). Procurement reform in the Ghana health sector. *Journal of Public Procurement*, 2(2), 261-268.
- Vogel, J. P., Oxman, A. D., Glenton, C., Rosenbaum, S., Lewin, S., Gülmezoglu, A. M., & Souza, J. P. (2013). Policymakers' and other stakeholders' perceptions of key considerations for health system decisions and the presentation of evidence to inform those considerations: an international survey. *Health Research Policy and Systems*, 11(1), 19. doi:10.1186/1478-4505-11-19
- Waage, J., Yap, C., Bell, S., Levy, C., Mace, G., Pegram, T., . Kock, R. (2015). Governing the UN Sustainable Development Goals: interactions, infrastructures, and institutions. *The Lancet Global Health*, 3(5), e251-e252
- Waters, H. R., Anderson, G. F., & Mays, J. (2004). Measuring financial protection in health in the United States. *Health policy*, 69 (3), 339-349
- Woodbridge M. (2015) From MDGs to SDGs: What are the Sustainable Development Goals? *ICLEI Brief Sheet- Urban Issues*

World Health Organization (WHO). (2007). Everybody's business--strengthening health systems to improve health outcomes: WHO's framework for action.

Young, F., Critchley, J. A., Johnstone, L. K., & Unwin, N. C. (2009). A review of co-morbidity between infectious and chronic disease in Sub Saharan Africa: TB and Diabetes Mellitus, HIV and Metabolic Syndrome, and the impact of globalization. *Globalization and Health*, 5(1), 9. doi:10.1186/1744-8603-5

Official Documents/Reports/Unpublished Papers

ACCA (2013) *Key health challenges in Ghana*

Ahenkora (1999) The Contribution of Older People to Development. The Ghana Study, Unpublished Paper *Help Age International and Help Age Ghana*

Commission on Human Security. (2003). *Human security now*: United Nations Publications.

Constitution of Ghana. (1992). The 1992 constitution of the Republic of Ghana, 1992.

Ghana Health Service (2016) *Ghana Health Service Annual Report*

Ghana Health Service (2017) *Facts and Figures*

Ghana Health Service (2018) *Facts and Figures*

Ghana Statistical, S., & Macro, O. R. C. (2004). *Ghana Service Provision Assessment Survey 2002*. Retrieved from Calverton, Maryland, USA: <http://dhsprogram.com/pubs/pdf/SPA6/SPA6.pdf>

Government of Ghana (2010) *National Ageing Policy, "Ageing with security and dignity"*

Ministry of Health (2012) *National Policy for the Prevention and Control of Chronic Non-Communicable Diseases*

Ministry of Health (2018) *Holistic Assessment of 2017 Health Sector Programme of Work*

National Development Planning Commission, Ghana Statistical Service. (2018) *Ghana Sustainable Development Goals(SDGs): Indicator Baseline report*

Parliamentary Hansard, Ghana, 31st May 2016

Parliamentary Hansard, Ghana, 5th Jan 2017

Parliamentary Hansard, Ghana, 28th Jan 2018

The constitution of the world health organization, 1 C.F.R. (1947).

United Nations. Department of Economics and Social Affairs (2007) *Development in Ageing World*, E/2007/50/Rev.1 ST/ESA/314 ,ISBN 978-92-1-109154-0.

United Nations. Department of Economics and Social Affairs, Population Division (2015) *World Population Ageing* (ST/ESA/SER.A/390)

United Nations (2002) *Political Declaration and Madrid International Plan of Action on Ageing*, New York

World Health Organization (2014) *Ghana country assessment report on ageing and health*

World Health Organization (WHO) (2014). Making fair choices on the path to universal health coverage: final report of the WHO Consultative Group on Equity and Universal Health Coverage

World Health Organization, Regional Office for Africa (2013) *The Health of the people, What works. The African Regional Health report*

Interviews/ Resource Persons

Brobbey Y., University of Ghana, Legon (Business School)- 15th March, 2019

Agyekum C., and Ansah Dankwah P., GAEC Hospital,- 5th July, 2019

Dr. Lenusia Ahlijah, Korle-Bu Poly Clinic – 24th April and 11th July, 2019

Internet sources

GNA (2004) Ghana has only one geriatric specialist. Available at: <https://www.ghanaweb.com/GhanaHomePage/NewsArchive/Ghana-has-only-one-geriatric-specialist-63974#> [accessed 28 July 2019]

Kalula, S.,(2013) Medicine in the elderly: Unique Challenges and management. *Continuing Medical Education*, [S.I], v. 31,n. 10,p.352, ISSN 2078-5143. Available at: <http://cmej.org.za/index.php.cmej/article/view/2878/3234>>. Date accessed: 27th July 2019.

UN General Assembly, Transforming our world : the 2030 Agenda for Sustainable Development, 21 October 2015, A/RES/70/1, available at: <https://www.refworld.org/docid/57b6e3e44.html> [accessed 8 July 2019]

United Nations, (2018) Sustainable Development Goals. available at: <https://www.un.org/sustainabledevelopment/sustainable-development-goals/> [accessed 11 July 2019]

APPENDICES

Appendix I

INTERVIEW QUESTION FOR KORLE-BU POLYCLINIC

1. What is the mission statement of the institution?
2. What are the health care delivery services for the elderly in Ghana?
3. When was the geriatric center established?
4. How has the institution implemented SDG3-universal health coverage in elderly health care delivery?
5. Does the hospital accept health insurance?
6. How do the elderly gain access to the facility?
7. Is the doctor to population ratio satisfactory?

Appendix II

**INTERVIEW QUESTIONS FOR GHANA ATOMIC ENERGY COMMISSION
HOSPITAL**

1. What are the health care delivery services for the elderly in this hospital?
2. Is the hospital aware of SDG3-universal health coverage?
3. Are there sufficient staff to provide elderly health care delivery services?
4. Does the hospital conform to the Health insurance policy exemption for the elderly?
5. Do the elderly patients have access to your facilities?
6. How are elderly made aware of the specialized services in the hospital?

Appendix III

INTERVIEW SUMMARY

| Name | Venue | Duration | Date |
|----------------------------------|------------------------------------------|-------------------------------------------------|-------------------------------------------------------------|
| Dr Lenusia Ahlijah (KORLE BU) | Geriatric Centre, Korle-Bu Polyclinic | 9 mins,7 secs 3mins (telephone interview) | 24 th April, 2019 11 th July, 2019 |
| Peace Ansah Dankwah (GAEC 1) | GAEC Hospital | 10mins, 48secs | 5 th July, 2019 |
| Cecelia Agyekum (GAEC 2) | GAEC Hospital | 4mins | 5 th July, 2019 |