Southern African Journal of Gerontology (1999), 8(1): 19-22

Viewpoint

The elderly in rural Ghana: health-care needs and challenges

O.K. Darkwa*
Jane Addams College of Social Work, University of Illinois at Chicago, USA

Abstract

The health-care needs of elderly persons who live in rural areas of Ghana are considered. Brief socio-demographic information on the population is given. Barriers and challenges to the provision of health care to the population are examined. The Ghanaian pluralistic health system is described briefly. Finally, measures are proposed to meet the challenges of providing health care to the elderly rural population.

Even though the Ghanaian population may be regarded as "youthful" (US Bureau of the Census, 1998), the percentage of older persons in the total population has increased dramatically over recent years (Adlakha, 1996). In 1996, persons aged 60 and over constituted less than 5% of the Ghanaian population (US Bureau of the Census, 1996a,b). It is projected that by 2025 the population aged 60 and over will increase to 12.4% of the total population (US Bureau of the Census, 1996b). While the size of the older population in percentage terms is expected to remain small, the absolute number of persons aged 65 years and over is expected to increase from 514 985 in 1994 to over a million in 2020 (Adlakha, 1996). Persons aged 60 years and over will number 1.7 million in 2020 (Apt, 1997).

The growth in the older population is due in part to an increase in life expectancy. In 1998 in Ghana, life expectancy at birth was 56.8 years. This figure is projected to increase to 60.6 years by 2010 (US Bureau of the Census, 1999).

The majority of older Ghanaians (persons aged 60 and over), about 72%, live in the rural areas of the country, although there has been a large increase in the number who live in urban areas (Apt, 1995). As in other parts of Africa, rural-urban migration in Ghana has been dominated by the youth (15-34 years), who move to the urban areas for education and employment opportunities (Nabila, 1986). Given this migration trend, it may be expected that the rural population will age more rapidly than the urban population. About 69% of the total Ghanaian population lives in small isolated rural communities (Nukunya, 1992).

As in other parts of the world, the elderly Ghanaian population is predominantly female – about 52% (Apt, 1994). Elderly Ghanaians generally have lower incomes than persons in all other age groups, excluding children. The majority of older persons engage in informal labour, as peasant farmers, artisans, masons, craftsmen and traders (Apt, 1994). Incomes in the informal sector tend to be low and unstable. Although no recent data are available on yearly income differentials of rural and urban older persons, a sizeable percentage of the urban dwellers presumably were previously employed in the formal sector and enjoyed a higher income than their rural counterparts. (A survey conducted on poverty and income differentials in rural and urban areas classified 27% of urban dwellers and 44% of rural dwellers as poor (Rimmer, 1992).)

The vast majority of older Ghanaians (99%) live in the community and share a home with family members – i.e. they do not live in an institution. Traditionally, family members cared for their older relatives. However, the traditional family structure in Ghana is changing, which has impacted on the provision of care and support to older persons.

Although research on elderly Africans has expanded significantly over the past few years, little is known about the health-care needs of the older population in the rural areas. Indeed, only a few programmes exist to address the health-care of this rural population (Rosenmayr, 1991).

This paper focusses on the health-care needs of elderly persons who live in rural areas of Ghana. First, the country's pluralistic health-care system and how it functions to meet the needs of older Ghanaians are briefly examined. Thereafter, measures are proposed to meet the health-care needs of the rural-based older population.

The Ghanaian health-care system

In pre-colonial times, the health-care systems in most African countries were primarily in the domain of traditional healers. With the advent of colonial administrations, a Western biomedical system was introduced in the countries. Nonetheless, a sizeable percentage of the Ghanaian population still relies on traditional medicine.

The Ghanaian ethnomedical system encompasses various types of healers and healing practices. Among the subdisciplines are herbalists (practitioners who use herbs in their practice); fetish priests/priestesses (those who combine herbs and divination); faith healers (usually leaders of syncretic churches who use prayer and religious rituals in their practice); traditional birth attendants (usually elderly women

* *Address correspondence to*
Prof. Osei K. Darkwa, Jane Addams College of Social Work, University of Illinois at Chicago, 1040 West Harrington Street, Chicago, IL 60607-7134, United States of America. E-mail: darkwa@tigger.cc.uic.edu

who assist mothers with deliveries); bone-setters (those skilled in the ability to treat bone fractures); and spiritual healers (those who use mediums and occults) (cf. Twumasi, 1975; Warren, Bova, Tregoning & Kliewer, 1982).

Both traditional and modern medical systems are therefore operated in Ghana but they are independent of each other. The Ghanaian Ministry of Health is responsible for the administration of formal health services, which are planned and delivered through regional and district offices. Under its primary health care (PHC) policy, community health centres were established in some rural areas – but few communities actually benefit from the implementation of the policy.

An emphasis in public hospitals is on cost recovery by charging user fees, a practice known locally as "cash and carry." Due to this system, the poorest Ghanaians (the majority of whom live in the rural areas) suffer the greatest burden. The 1997 United Nations' Ghana Human Development Report notes that public spending on health tends to favour the more affluent section of the population, which is also urban based. According to the report, over 90% of the urban population has access to the formal health-care system, compared to 45% of the rural population. Part and parcel of an urban/rural differential in this regard is the fact that more older people live in the rural areas than in the urban areas.

Health care for rural elderly Ghanaians

In general, resource constraints have prevented health policy makers in various developing countries from extending health-care services to rural areas equivalent to those in urban areas. Thus, access to health care is likely to be even more problematic for rural dwellers than for urban dwellers. Studies in Ghana (Apt, 1995; Banga, 1992, 1993) and others have shown that rural dwellers have poorer health status and poorer access to health-care services, and may face cultural, socio-economic and environmental barriers which prevent them from utilizing services, compared to urban dwellers. Despite efforts to expand medical services in the rural areas of Ghana, disparities continue in the distribution of national health resources.

A major challenge is thus to develop policies, programmes and services to meet emerging and current health-care needs of this population and suggestions in this regard are made below.

Meeting the health-care needs of rural elderly Ghanaians

Community involvement in rural health care

In Ghana, the central government, through the Ministry of Health, has come to be viewed as the sole provider of health services, which has limited the involvement of local people in their health care. However, the District Assemblies (DAs) have been charged with the responsibility of addressing health and socio-economic needs at the district level. It is suggested that the DAs should provide incentives to local people to support the establishment of community health posts in villages. Community involvement and responsibility for the facilities could be shared between the DAs and local communities.

Public health insurance for the elderly

Although in 1996 the government pledged free health care for the elderly, very little has been done to translate the pledge into reality. The institutionalization of some form of free health-care services for the older population is essential. The creation of a state-subsidized national health-care insurance scheme to provide basic and preventive health services, regardless of income level, ability to pay, or prior labour force history, is proposed (Darkwa, 1997). Optional health services could be provided at a fee to cover selected advanced surgical procedures. A portion of the funding for a programme of this nature could come from the accumulated surpluses of the government's state-controlled monopsonies, such as the Cocoa Marketing Board. The initial goal of the government's dual pricing policy regarding its marketing boards was to use the surplus to subsidize the incomes of farmers. However, the fund has never been used for this purpose; instead, the funds are invested in long-term foreign securities. Funding universal health care for the elderly from this source will be more consistent with the intended objective of the fund.

Incentives to health workers to practise in rural settings

The majority of health workers in Ghana are trained in urban areas and prefer to remain in an urban area on completion of their training. This preference is partly because of a lack of social amenities in the rural areas. There is also very little in their training which prepares them for practice in a frequently under-resourced and isolated rural environment. The encouragement and preparation of health workers to work in rural communities are essential, and the workers need to be supported in their work. To address the scarcity of health personnel in the rural areas, it is proposed that the government enacts a Rural Incentive Act, which offers incentives to practitioners to relocate to rural areas. Incentives could include higher remuneration, free accommodation, a car loan, and other facilities which will enable the practitioners to have a comparable level of comfort enjoyed by their urban counterparts.

Preventative community health

As with health-care systems in some other parts of Africa, the Ghanaian system is more reactive than proactive. Its focus is on curative medicine, as opposed to preventive medicine. It is proposed that the Ministry of Health develops new approaches to health promotion, health education, health empowerment and disease prevention, and proactively addresses the health-care needs of the population, as well as those of the elderly rural population. Health maintenance in the elderly will reduce their need for health-care services and scarce resources will be available to meet other needs. Thus, what is broadly needed is a re-direction of health expenditure from a curative approach to a health promotion and disease prevention approach, and the expansion of preventative health services generally.

Establishing geriatric services at community health centres

Ghana has no precedent of establishing age-specific facilities for its citizens. Given the expected increase in the number of older persons, population policy makers should begin to explore the establishment of geriatric services within existing health-care facilities. Such services should also offer education in nutrition, healthy living and disease prevention. To date, these areas have been under-emphasized in most community health programmes. Duodo (1998) has outlined suggestions for the provision of geriatric services in Ghana.

Community-centred mobile rural health banks

Another way to address the health-care needs of the rural elderly is through the establishment of community-centred mobile rural health banks. Hospitals located in urban areas

should establish a mobile division which is responsible for making periodic visits to surrounding rural areas. The mobile vans will have trained medical staff, such as doctors and nurses, and basic medical and surgical equipment capable of providing basic health services. The vans will ply rural routes, making scheduled stops at designated rural locations. The system will be comparable to geriatric units on wheels. Rural mobile health units could operate under the umbrella of district and regional medical facilities which will co-ordinate their schedule.

Health databank electronic health information infrastructure

The need for and the use of information technology by health providers in rural and remote areas of Ghana will be vital to the future delivery of health services to these communities. Access to these technologies may overcome barriers of distance, cost, poor distribution of services, and a lack of support to health providers that at present restrict rural communities' access to the level of health services enjoyed by urban communities. Health authorities and policy makers need to maximize the opportunities provided by health information technologies, to access and share support, to provide long-distance education, training and consultation, and to access a wide range of on-line health resources. Currently, there is an acute lack of health information in Ghana which restricts health workers in their work.

Computer-based telecommunications systems, such as the Healthnet services already established by SatelLife in a number of African countries, are a way to address the paucity of information in the health sector. The SatelLife service comprises a system of Low Earth Orbit (LEO) satellites, simple ground stations, and radio and telephone based computer networks which link individual users to the network via HealthNet "nodes" in countries where HealthNet operates (SatelLife, 1996). Currently, SatelLife has established a HealthNet service in two locations in Ghana – in Accra, the capital, and in Navrongo, in the North. The service provides access to the latest medical information, e-mail connectivity, electronic conferencing, and other services tailored to meet the current demands of its users This service could be expanded to provide health information to health workers operating in rural areas of Ghana.

In addition, a wide range of interactive technology systems exists, such as Telehealth, which promises to improve access to health care in rural areas (Sherps, 1996). Telehealth could also enable health providers in rural and remote areas to access distant education and training programmes. However, the success of any telehealth service is dependent on the availability of communication services. An immediate and urgent need is to ensure that rural health-care providers have access to the basic information technology infrastructure needed for launching telemedicine. This is going to be one of the greatest challenges in the area of health care in Ghana – since Ghana, like most African countries, lacks electronic connectivity in the rural areas. Richardson (1997) has noted that rural communities represent the "last mile of connectivity." The African continent as a whole, with about 12% of the world's population, has only 2% of the global telephone network.

Fortunately, there is a growing realisation in the country of the potential of information technology for development, thanks to efforts on the part of the government and international donor agencies which are working to develop telecommunication structures in selected rural areas. For example, the USAID Leland initiative aims to provide 20 African countries, including Ghana, with connections up to 128 kilobits. In addition, the programme will provide assistance with materials, expertise, training and free internet access for a limited period. Similar efforts are being made by the United Nations' Economic Commission for Pan-African Development Information Systems (PADIS) initiative, which aims to establish low-cost and self-sustained nodes to provide access to electronic mail in 24 African countries. In addition, the African Information Society initiative, with its primary goal of building information and communication infrastructure in Africa, and the Acacia Project initiative, an international effort led by the Canadian-based International Development Research Council (IDRC) to empower Sub-Saharan African countries with the ability to apply information technology to health and socio-economic development, will enhance telemedicine in the country. The development of such infrastructure will not only enhance rural health-care delivery, but will also facilitate the establishment of a medical emergency response system in the rural areas.

A comprehensive rural health research agenda

There is a need to develop a comprehensive research agenda to study health-care issues in the rural areas. Health resources available to the older population in the rural areas as well as the unmet health-care needs of this population need to be documented. The recruitment, retention and training of health manpower in the rural areas need to be investigated, as does the health-seeking behaviour of older persons in these areas – both biomedical and ethnomedical help-seeking behaviour.

Political will

Ultimately, the distribution of health resources in Ghana, as in other countries world-wide, is based on political decisions. It is time that the Ghanaian authorities restructure the distribution of the resources to proportionately benefit the rural areas. Thus, a commitment is required of political leaders to address the imbalances in health care in the country.

Conclusion

African countries are faced with an enormous need to provide health-care services to older persons who live in rural areas. In Ghana, efforts should be made to bridge the rural-urban health gap and to provide appropriate health care through a well-planned investment programme, whereby more health-care facilities are provided and infrastructure is expanded in the rural areas. These projects may be supported through the District Assemblies with donor funds. Ghana is seeking to reform its national health system. A need for a prevention-oriented approach to health care for older persons may be a partial solution to the problem of health-service delivery in the rural areas. Policy makers should thus invest more heavily in preventive medicine and less so in curative medicine. The effectiveness of a rural health-care delivery system for the elderly is contingent upon a co-ordinated national rural health-care plan and health-care infrastructure which will allow access to a national network of health resources.

Multi-pronged and complementary health-care programmes and strategies are thus needed to address the problem of poor health-care service provision to the older rural population. These efforts will require a political commitment, fundamental restructuring in the distribution of health resources, community action to influence policy, and some tough political decisions and choices.

References

Adlakha, A. 1996. *Population trends: Ghana.* International Brief. Washington, DC: US Department of Commerce, Bureau of the Census.

Apt, N.A. 1992. Family support to elderly people in Ghana. In: Kendig, H., Hashimoto, A. & Coppard, L.C. (Eds) *Family support for the elderly.* Oxford: Oxford University Press, pp. 203-212.

Apt, N.A. 1994. An approach to health care of the elderly in Africa. Paper read at the WOCHH Conference on Home Health Care, Chicago.

Apt, N.A. 1995. Ageing in Ghana. In: Apt, N.A., Bester, F.C.J. & Insley, M.L. (Eds) *Effective response to ageing in Africa by the year 2000.* Accra: African Gerontological Society Workshop Report, pp. 47-61.

Apt, N.A. 1997. *Ageing in Africa.* Geneva: World Health Organization, Ageing and Health Programme.

Banga, E.H. 1992. Social changes and the emerging images of the elderly in Ghana: health and nursing implications. In: Akiwumi, A. (Ed.) *Nursing education for the 21st century.* Legon: University of Ghana, Department of Nursing, pp. 58-76.

Banga, E.H. 1993. The emerging image of the aged in Accra, capital of Ghana. *BOLD,* 3(4): 11-15.

Darkwa, O.K. 1997. Retirement policies and economic security for older people in Africa. *Southern African Journal of Gerontology,* 6(2): 32-36.

Duodo, Y. 1998. The need for geriatric services in Ghana. *Southern African Journal of Gerontology,* 7(2): 33-34.

Nabila, J.S. 1986. Rural urban migration and its implications for rural development in rural Ghana. In: Brown, C.K. (Ed.) *Rural development in Ghana.* Accra: Ghana Universities Press, pp. 75-89.

Nukunya, G.K. 1992. *Tradition and change in Ghana: an introduction to sociology.* Accra: Ghana Universities Press.

Richardson, D. 1997. The internet and rural and agricultural development: an integrated approach. Rome: Food and Agricultural Organization.

Rimmer, D. 1992. *Staying poor: Ghana's political economy 1950-1990.* Accra: Pergamon Press.

Rosenmayr, L. 1991. Improving the health status of the rural elderly in Mali. *Journal of Cross-Cultural Gerontology,* 6: 301-318.

SatelLife HealthNet. 1996. *Information services guide.* Http://www.healthnet.org

Sherps, C. G. 1996. The diffusion of telemedicine and hospital information systems in the southeastern United States: a rural-urban perspective. *The Rural Gazette,* 5(1): 1-6.

Twumasi, P.A. 1975. *Medical systems in Ghana.* Accra: Ghana Publishing Corporation.

United Nations Development Program. 1997. *Ghana Human Development Report.* Accra, Ghana: UNDP.

US Bureau of the Census. 1996a. *Current population reports, Special Studies, P 23-190, 65+ in the United States.* Washington, DC: US Government Printing Office.

US Bureau of the Census. 1996b. *Global aging in the 21st century.* Washington, DC: US Department of Commerce, Economics and Statistics Administration.

US Bureau of the Census. 1998. *Population pyramid summary for Ghana. International data base.* Washington, DC: International Programs Center. Http:www.census.gov/cgi-bin/ipc/idbpyrs.pl

US Bureau of the Census. 1999. *International data base.* Washington, DC: International Programs Center. Http://www.census.gov/cgi-bin/ipc/idbsum

Warren, D.M., Bova, G.S., Tregoning, M.A. & Kliewer, M. 1982. Ghanaian national policy toward indigenous healers: the case of the primary health training for indigenous healers (PRHETIH) program. *Social Science and Medicine,* 16: 1873-1881.