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AN EXPLORATION OF PERCEIVED BARRIERS TO HEALTH SERVICES AMONGST OLDER PEOPLE IN BONGO DISTRICT

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Abstract

Purpose: The research was done to explore perceived barriers to health care services amongst older people in Bongo.

Methodology*:* Using a qualitative methodology, a case study design was employed in the study. A qualitative approach was chosen because of the need to understand the phenomena of healthcare access from a personal perspective. The study was conducted in Bongo District in the Upper East Region of Ghana. Bongo District has six sub-districts with one hundred and forty three (143) communities and a population of 84,545. People aged 60 and above constitute 9.7% of the population. The District has one District Hospital that serves as a referral center for the sub-districts and neighboring communities from Burkina Faso. Central sub-district was randomly selected for the study using folded pieces of paper. A purposive sampling strategy was used and ten elderly people (aged 60 years or above) were recruited by door-to-door. Individual interviews were conducted using an interview guide. Interview material was transcribed verbatim and coded to be presented as results.

Findings: The findings identified poverty, health insurance, long waiting times at hospital, traditional beliefs, health workers attitude, transportation, and lack of drugs at the health facilities as major barriers to health care access. Respondents prefer the hospital as their first choice of contact when sick but do not necessarily patronize the health facilities partly due to traditional beliefs, trust in herbalists, and poverty.

Unique Contribution to Theory, Practice and Policy: From the findings, the researcher recommended that future human resource plan should include training of geriatric nurses and doctors to help address the specific needs of the aged. The health system should strengthen monitoring on quality assurance and quality controls to reduce waiting times and meet minimum pharmacy stock levels. Social support structures especially for the elderly at the community level should be promoted.

Key Words: *Health services, access, perceived barriers, Older People.*

1.0 INTRODUCTION

Ageing is a gradual reduction in physiological reserves and a general decline in an individual's capability (WHO, 2015). With ageing comes a change in social role (eg, change in work patterns, adult status) and a change in capability especially a change in physical characteristics and senility (National Population Council [NPC], 2014). Alternatively, the ageing process may be seen more positively given its contribution to development specifically in sharing rich experiences and knowledge as well as helping nurture future generations (Aboderin & Beard, 2015). Apart from caring for the younger ones, the Aged inculcate in them the cultural practices and social norms, beliefs, and values of society (Aboderin & Beard, 2015) which in a way maintains the identity of the individual or community and may promote good cultural and social practices (such as hand washing, moral values, and respect for elders/authority) which are important in promoting health. Moreover, if an elderly person is ill - apart from losing the roles he/she played, other members of the family will have to spend more time and resources caring for the sick aged which, in turn, may impact negatively upon work and school commitments (WHO, 2015). As the elderly also form a significant part of the agricultural labour force in Ghana so illness due to frailty could have an impact on food production and on the availability of foodstuffs to the wider community.

Globally, there is an increasing concern about the health of the older people (Fitzpatrick, Powe,Cooper, Ives & Robbins, 2004; Aboderin & Beard, 2015; WHO, 2015) particularly considering the rise in the number of older persons (Biritwum, Mensah, Yawson & Minicuci, 2013). Internationally, the elderly population is increasing with the life expectancy rising from 47 years in 1950-1955 to 65 years in 2000-2005 and a 21 per cent increase in the elderly population in developed countries compared with 8 per cent in developing nations/countries as of 2005 (United Nations, 2007). The 2010 Ghana population and housing census showed that there has been a sevenfold increase in the population of the aged (60 years and above) from 215,258 in 1960 to 1,643,978 in 2010 (NPC, 2014). The Aged (60 years and above) constitute 9.2% of total outpatient attendance in Bongo District Hospital in 2015 and 8.9% during 2016 (Ghana Health Service [GHS], 2017). The District also recorded 1,093 deaths in household during 2010 population and housing census (GSS, 2014). Thus, many people fail to utilize the health facilities and end up dying at home. By exploring the personal perspectives of elderly people about healthcare services available to them, the researcher hopes to get a better understanding of what constitutes access barrier to health.

Problem Statement

The rate of population ageing is increasing faster in developing countries and Ghana is no exception. According to the Ghana Statistical Service (GSS), life expectancy of Ghanaians is 60.7 years for males and 61.8 years for females as of 2010 (GSS, 2013). This is a marked increment from the year 2000 when it was 55 years for males and 60 years for females; and in the year 1984 when life expectancy was 52.7 years (NPC, 2014). Based on the above figures, 'aged', 'elderly', or 'older' used in this study refers to anybody with a chronological age of 60 years or above. With increasing age comes an increase in co-morbidities and an increasing need for medical care (Boutayeb & Boutayeb, 2005; Steyn, 2006; WHO, 2015). A Ghana study on

global AGEing and adult health (SAGE, 2013) showed that, in addition to communicable diseases there was a rising trend of non-communicable diseases (NCD) (Biritwum, et al., 2013). Hypertension, joint diseases, skin infections, diarrhea, acute eye and ear infections are among the top twenty diseases affecting the aged in Ghana as enumerated by Ghana Health Service (2010). The burden of disease is greater in low and middle income countries like Ghana and may be higher in low resource settings (WHO, 2015) like Bongo (a rural district) yet available data indicates a disparity between health-care needs and health-care utilization in these settings and the less privileged subgroups of the elderly in high income settings (WHO, 2015). This indicates unmet medical needs as a result of poor utilization of health services which can be linked to numerous barriers of access to healthcare (Fitzpatrick, et al, 2004; WHO, 2015; Agyemang-Duah et al., 2019).

These barriers are grouped as either supply problems or demand (O'Donnell, 2007). Supply problems for example, quality and effective healthcare services are not readily available as in the case of Ghana where older peoples's homes are lacking and the health facilities are not friendly to the elderly as they have to stay in long queues with other age groups to access healthcare (Larbi, Ottie-Boakye & Appiah, 2015). On the demand side, people fail to utilize services they could potentially benefit because of numerous barriers such as cost, transportation, health insurance status, poor attitude of healthcare providers, and lack of information among others (Fitzpatrick et al., 2004; Agyemang-Duah et al., 2019). Ensor and Cooper (2004) found that waiting times and direct expenses for service are both supply-side and demand-side barriers to access health care.

Alongside these problems is an increasing demand for the elderly to be active in their community responsibilities as they play a critical role counseling the youth, caring for children in their families and the community at large (mostly their grandchildren) especially those whose parents have either died or emigrated (Aboderin, 2008). Despite the contributions of the Aged in caring for younger generations and the major contribution they make to the agricultural workforce, health services for the elderly are a low priority in comparison to healthcare services for infants, children, and pregnant women (Lordos, et al., 2008).

The evidence base is largely drawn from other countries with little on Ghana especially the Northern part of the country. The studies are also mainly quantitative with little focus on qualitative studies which has the opportunity to explore more barriers to access especially allowing the elderly to have a voice to explain on their experiences. This study therefore made a qualitative contribution and explored the perceived barriers to health care services amongst older people in the Bongo District of Upper East Region of Ghana.

2.0 LITERATURE REVIEW

Theoretical Framework

One's perception about health determines the need to access and utilize healthcare. It was found in a cross-sectional survey by Exavery et al., (2011) that healthcare utilization was significantly associated with self-rated poor health and the presence of a medical history of chronic diseases. Anderson's healthcare utilization model (Anderson, 1995) states that one's access to and use of health services is dependent on three characteristics:

Predisposing factors: the socio-cultural characteristics that prevail prior to the sickness (social structure [education, social networks, occupation, and ethnicity], health beliefs, and age/gender).

Enabling factors such as family (how to access health service), community (available health personal, facility, and reception), and genetic factors or psychological characteristics.

Need factor: actual or perceived general health and functional state. The study therefore adopted this model and sort to find out if these characteristics are barriers to access healthcare service by the elderly.

Empirical Literature

It has been established that old age has association with ill-health (Steyn, 2006; WHO, 2006) and an increased healthcare demand (Fitzpatrick, et al, 2004; Aboderin and Beard, 2015; WHO, 2015) making them the largest consumers of healthcare services (Cuc et al., 2010). Other studies affirm the increase in ill-health amongst the elderly and the increasing need for healthcare but disclaim the elderly as being the largest consumers of healthcare service as they often don't seek for healthcare due to some barriers (Fitzpatrick et al., 2004; WHO, 2015; Agyemang-Duah et al., 2019).

A study conducted in USA revealed that 20% of the working age adults have unmet medical needs (Bloom et al., 1997) and a similar study in Africa shows that many people in developing countries fail to access health care they could have profited importantly (O'Donnell, 2007). O'Donnell is of the view that this is due either to supply problems (quality and effective health care not presented) or demand (people fail to utilize services they could benefit). The demand-side refers to influencing factors that determine health service use at the individual, family, or community level (eg cost, transport, stigma, and lack of health awareness) whereas the supply-side refers to factors integral to the health system that hamper service usage by the individual, family, or community (eg. service location, waiting time, staff interpersonal skills, and price of services) (Jacobs et al., 2011). For example, unlike developed countries, Ghana does not have residential homes for the elderly and Ghana lacks health facilities that are friendly to the elderly (Larbi et al., 2015) hence the elderly have to stay in long queues with other age groups to access healthcare. Ensor and Cooper (2004) found that waiting times and direct expenses for service are both supply-side and demand-side barriers to access health care.

Blanchet et al. (2012) reported that individuals enrolled in the national health insurance scheme (NHIS) are more likely to visit clinics, obtain prescriptions and seek formal health care when sick. However, DeVoe et al (2007) found that barriers to health care can be overwhelming for some families even with those covered by health insurance. This is partly due to payment for transport; care givers feeding and/or accommodation; opportunity cost for treatment-since treatment takes time; and informal payment to staff or the facility (Ensor and Cooper, 2004). Ensor and Cooper (2004) also found cost of access, cultural factors, and lack of information as barriers militating against access to healthcare especially the poor and vulnerable groups. Studies in Vietnam, Zimbabwe, Uganda, and Namibia have shown that location and distance greatly impede access to health service among older people (Amooti-Kaguna and Nuwaha, 2000; Ensor and Cooper, 2004; Van Roy et al., 2015). A study conducted in Tanzania revealed that the absence of specific consulting rooms and Doctors for older people and insufficient drugs as well as medical equipment in most public health care facilities are major hinders in accessing health services (Frumence, et al., 2017). Another study in Johannesburg (South Africa) on access to oral

Global Journal of Health Sciences
ISSN 2519-0210 (Online)
Vol 5, Issue 1, No.3, pp 26 - 36, 2020

health revealed that the obstacles experienced prohibited 72% of the participants from using oral health services (Molete et al., 2014). The obstacles most repeatedly reported included the conviction that they were not able to pay for treatment and lack of transportation. Available literature on access barriers in Ghana is not different from those discussed: A study conducted in Northern Ghana revealed that cost and healthcare navigation, social marginalization, poor medical understanding, and distance to health facility are the main barriers to accessing surgical care (Steward et al, 2015). Also, a study in rural communities in Ghana revealed that rural dwellers are highly deprived in terms of physical accessibility to healthcare facilities partly due to unavailability of healthcare facilities in the rural communities, poor transportation systems, long travel distances, and low income levels (Sulemana & Dinye, 2014; Agyemang-Duah et al., 2019). These studies however have little attention to "lay epidemiology" regarding the Aged's health. The Aged beliefs about the nature of sickness and values about the place of health as well as health risks are important determinants to seeking care and choice of treatment (Allmark and Tod, 2006).

The evidence base is largely drawn from other countries with little on Ghana especially the Northern part of the country. The studies are also mainly quantitative with little focus on qualitative studies which has the opportunity to explore more barriers to access especially allowing the elderly to have a voice to explain on their experiences. This study therefore seeks to make a qualitative contribution and to explore the perceived barriers to health care services amongst older people in a rural town of Upper East Region of Ghana.

3.0 METHODOLOGY

Using a qualitative methodology, a case study design was employed in the study. A qualitative approach was chosen because of the need to understand the phenomena of healthcare access from a personal perspective. The study was conducted in Bongo District in the Upper East Region of Ghana. Bongo District has six sub-districts with one hundred and forty three (143) communities and a population of 84,545 (GSS, 2013). People aged 60 and above constitute 9.7% of the population. The study population comprised of men and women who were 60 years old or above. The working age group in Ghana ranges from 15 to 60 years and the compulsory retirement age is 60 years (GSS, 2013). The District has one District Hospital that serves as a referral center for the sub-districts and neighboring communities from Burkina Faso. Central sub-district was randomly selected for the study using folded pieces of paper. By purposive sampling, ten elderly people (aged 60 years or above) were recruited by door-to-door. Individual interviews were conducted using an interview guide. Thematic analysis was used to analyze the data after transcribing it verbatim. Interview material was transcribed verbatim, coded and presented as results. The six phases of thematic analysis as described by Braun and Clarke (2006) were used to identify important ideas, perceptions and classifications in the interview transcript.

3.1 Ethics

The main principles of research were strongly observed during the study; the right to consent and withdraw from study, the principle of not doing harm, benefice, justice, confidentiality and anonymity (Leeds Beckett University, 2016). Ethical approval for the study was granted by the

Global Journal of Health Sciences
ISSN 2519-0210 (Online)
Vol 5, Issue 1, No.3, pp 26 - 36, 2020

ethical review committee of University of Health and Allied Sciences, Ho (Ghana) and Leeds Beckets University, UK respectively.

4.0 FINDINGS OF THE STUDY

4.1 Introduction

This section presents the findings to the study which explored perceived barriers to health services amongst older people in Bongo District. From the findings the following themes were identified.

1. Service utilization (choice of treatment)
2. Barriers to health care

The research cohort was made of ten participants; eight men and two women all aged above 60years and one is said to be above 100years. Almost all the participants are practicing African traditional religion and have low or no education. Their main activities are farming and animal rearing.

4.2 Service Utilization (choice of treatment):

Data from the interview revealed that majority of the respondents prefer the hospital as their first choice of contact when sick. The following quotes affirms that.

> *"Those days when you were sick, like our parents days, you would go to a soothsayer (paused) but nowadays when you are sick you run to hospital for treatment. Currently we don't have any place apart from hospital"* (6th respondent).
> *"I go to the doctor for treatment… I have to send a child to call the nearest relative with a motorbike to send me to hospital"* (1st respondent). *"….go to hospital….This is because the sicknesses are many and the hospital can do test and treat you well"* (2nd respondent). *"Eeh! the smaller gods are no more there we have to go to hospital. But if you don't go to hospital where will you be?"* (9th respondent). *"…when I'm sick I have some people's numbers that I can call and they will wake up at night to send me to hospital… I have to first go there for diagnosis and if they can't then I will come back for local treatment"* (8th respondent).

However, they alluded to the fact that they also resort to the traditional medicine or herbs when sick for reasons of traditional beliefs, trust in herbalists, and failure to cure some sicknesses at hospital.

> *9th respondent: "Our strength is in the hospital but also, there are sicknesses that are not for hospital treatment (paused) we have to struggle with traditional medicine"*
> *8th respondent: "There are other sicknesses that you must not take injection so if you know it's that sickness you have to treat at home"*
> *7th respondent: "Do you know some went to hospital and they returned them home to do local treatment? ... so why should people abandoned herbs and now on hospital every day … go to the right herbalist for treatment…. if you're sick you have to first identify the sickness, there are many herbalists for different types of sickness"*
> *6th respondent: "I can't say we go to hospital only, no!! We have herbalists some go there for treatment".*

4.3 Barriers to health care

When asked about barriers to healthcare access, majority of the respondents mentioned money or poverty as the main barrier. Others included long waiting times (in queues), expired health insurance cards, health workers' attitude, and a lack of drugs at the health facilities.

> *"I have the health insurance card but I fear going to hospital so I rely on buying…My son if you go there you won't get your treatment on time. I ever went with my elder sister very early in the morning till about 3pm and we didn't even eat. My child has to follow up after waiting for hours, he then bought food for us to eat and then collected our cards to continue the processes". "I as an old lady will go and spend the whole day standing there whiles those who come after me but know people in the hospital will be served before you. And I have to wait till my child comes to help me… I think its favoritism, they attend to those they know first"* (3rd respondent).
> *"… you can send your relative to hospital and it is serious… eer but when you get there hmm so you were not supposed to join a queue you see but they will say join a queue because you came last but the sickness is serious, soo that one too is against the hospital"* (8th respondent).

Poverty or lack of money is said to be the major barrier to accessing healthcare. The following quotes affirms that:

> *"The problem I get is money, immediately you reach the hospital you have to remove money. If you don't have money you can't get everything free… and if you don't have money you can't go to hospital. It's all about poverty"* (6th respondent).
> *"I will go to the doctor but if I don't have resources there are other people who will attend to you using their skill, and I will become well. You understand?"* (4th respondent).
> *"…now there is no money what can I do… Do I trade? Or is the sickness selective? …you can see these blocks are molded by people who are not around. And these blocks does not mean you have resources or money* (1st respondent).

The following views by respondents depict that expired insurance cards are barriers to accessing healthcare:

> *"Some sickness can worry you and when you arrive ooh you have insurance but it is expired. They will say this is your debt, this is your debt, which is why some poor people who are sick will not go to hospital…. Your insurance can expire for only one month and they can't consider you small but they will say this is your debt"* (8th respondent). *"when they checked my insurance card it was expired …the bigger thing is medicine, money to buy medicine"* (6th respondent).

When asked if any barriers exist in accessing healthcare, a respondent said "No, it's only that my insurance is expired I'm yet to renew it" (5th respondent).

Lack of drugs at health facilities was also observed as a barrier.

> *"if you arrive and they say go and buy medicine… you have to look for a different treatment (herbalist)"* (1st respondent). *"When we go to hospital they say go to store for medicine, go to hospital go to store, do we have money and they are directing us to stores? That is why at times we sit back at home but we all fall sick… there are no*

Global Journal of Health Sciences
ISSN 2519-0210 (Online)
Vol 5, Issue 1, No.3, pp 26 - 36, 2020

barriers apart from asking me to go to drug store for some medicine" (9th respondent).

Health worker attitude is another obstacle to some respondents in accessing healthcare from health facilities.

> *"…, these days people are looking for money and don't have sympathy for human beings. You see, if somebody is sick and you want to charge for your money whether the person survives or not you don't care. You should only charge for your money, it's all about searching for money that is why some don't want the hospital"* (8th respondent). *"I think its favoritism, they attend to those they know first. That is what I think"* (2nd respondent).

A majority of the respondents have challenges with transportation but did not see it as a major barrier to access healthcare.

> *"I stand by the road site to board a car but if it is serious a child will charter a car to come for me because I am not capable of walking to the hospital"* (9th respondent). *"I will stand by the road side and look for a car to send me but if it's late and I can't get a car my child has to go to Bolga [15km drive] to look for a car"* (10th respondent). *"…if you are unwell and can't sleep I have to send a child to call the nearest relative with a motorbike to send me to hospital"* (1st respondent). *"Others have cars, I can beg them to send me to hospital or look for anybody with a motorbike to carry me"* (4th respondent). *"One of my children will send me using motor or bicycle"* (2nd respondent).

DISCUSSIONS, CONCLUSIONS AND RECOMMENDATIONS

5.1 Discussions

5.1.1 Service Utilization

The study revealed that respondents prefer the hospital as their first choice of contact when sick but do not necessarily patronize the health facilities due to traditional beliefs, trust in herbalists, and poverty. These findings are similar to that of O'Donnell (2007) and Anderson (1995). Anderson's healthcare utilization model states that one's access to and use of health services is dependent on the socio-cultural characteristics that prevail prior to the sickness, health beliefs, among others. The study results also shows that the lay belief, for instance "*there are other sicknesses that you must not take injection so if you know it's that sickness you have to treat at home (8th respondent),* is a hinder to service utilization. This finding is in conformity with that of Allmark and Tod (2006) which states that the Aged beliefs about the nature of sickness and values about the place of health as well as health risks are important determinants to seeking care and choice of treatment. The Aged have rich experience in herbal treatment coupled with their values and beliefs which inform them to rely on herbalists thereby failing to appraise hospital treatment. Their experiences at the health facilities as against their values or beliefs also inform their choice to utilize a health facility (Exavery et al., 2010). These beliefs and values need an improved communication links between healthcare providers and the stakeholders of the community to help people make informed choice regarding healthcare. The researcher upon interactions with the participants has observed that participants have poor understanding of health and disease patterns.

Barriers to health care

Findings from the study has revealed that poverty is a major barrier in accessing health care by the Aged. The finding are similar to earlier studies in Ghana which found cost and healthcare navigation (Steward et al, 2015; WHO, 2015), and low income levels (Sulemana & Dinye, 2014; Agyemang-Duah, 2019) as barriers to accessing healthcare services in Ghana.

Long waiting times as a barrier in accessing care as exposed by this study adds to available literature that many people in developing countries fail to access healthcare that would benefit them as a result of supply problems (O'Donnell, 2007; Jacobs et al., 2011). This is partly due to lack of residential homes for the elderly in Ghana and insufficient health facilities that are friendly to the elderly (Larbi et al., 2015). Unlike developed countries, Ghana lack specific consulting rooms for the elderly (Frumence et al., 2017), hence the Aged have to stay in long queues with other age groups to access healthcare. The study also found expired health insurance cards as a barrier to accessing healthcare by the Aged. An earlier study found that barriers to health care can be devastating for some families even with those covered by health insurance (DeVoe, et al., 2007).

In addition, the study revealed that transportation, health workers attitude, and lack of drugs at the health facilities are barriers to accessing healthcare by the Aged. The study is in agreement with earlier studies (Ensor & Cooper, 2004; Molete et al., 2014; WHO, 2015; Agyemang-Duah, 2019). Lack of drugs at health facilities as revealed in this study is a current health issue in Ghana partly due to delays in reimbursement of funds by National Health Insurance Scheme to accredited health institutions. One respondent expressed his dissatisfaction on the issue of lack of drugs; "*When we go to hospital they say go to store for medicine, go to hospital go to store, do we have money and they are directing us to stores?* (9th respondent).

5.2 Conclusions

Based on the findings from the study, the research has the following conclusions:

Barriers to healthcare access by the Aged do exist and has a direct effect on service utilization. These barriers include traditional beliefs, poverty, and transportation, long waiting times at hospital, expired health insurance cards, health workers attitude, and lack of drugs at the health facilities (Fitzpatrick et al., 2004; WHO, 2015; Agyemang-Duah, 2019). The Aged fail to utilize health facilities due to these barriers thereby resorting to traditional herbal treatment or self-medication (purchase from chemical sellers). As espoused in Anderson's Health Care Utilization model, the predisposing factors (traditional beliefs, age, and educational level), enabling factors (poverty, transportation, long waiting, and lack of drugs) and the need factor (traditional beliefs) greatly determined the Elderly healthcare access in Bongo. Even though this qualitative study did not seek to generalize, the finding has insinuations on health systems equity and its policy framework in Ghana at large.

5.3 Recommendations

Based on the findings from the study, the researcher has therefore made the following recommendations: A quantitative study will help to establish if these findings can be applied on a broader scope beyond the sample population. Future human resource plan should include training of geriatric nurses and doctors. Currently there is no geriatric specialty course in Ghana for Nurses and Medical Doctors. The health system should strengthen monitoring on quality

assurance and quality controls. Following the health care utilization model, social support structures especially for the elderly at the community level should be promoted.

REFERENCES

Aboderin, A. & Beard, R. (2015). Older people's health in Sub-Saharan Africa. *Lancet,* 385(9968), 9-11.

Aboderin I. (2008). Advancing health service provision for age-related non communicable disease and older persons in Africa: Identifying key information and training needs. *African Research on Ageing Network (AFRAN), Policy-Research Dialogue*, July, 3-18.

Agyemang-Duah, W., Peprah, C., & Peprah, P. (2019). Barriers to formal healthcare utilisation among poor older people under the livelihood empowerment against poverty programme in the Atwima Nwabiagya District of Ghana. *BMC Public Health*, *19*(1), 1–12. https://doi.org/10.1186/s12889-019-7437-2

Allmark, P. and Tod, A. (2006). How should public health professionals engage with lay epidemiology? *J Med Ethics*, 32, 460-463.

Andersen, R. (1995). Revisiting the behavioral model and access to medical care: does it matter**?** *Journal of Health and Social Behavior*, *36* (1), 1–10.

Ensor, T. and Cooper, S. (2004) Overcoming barriers to health service access: influencing the Demand side. *Health Policy and Planning.* 19(2), 69-79. https://doi: 10.1093/heapol/czh009

Biritwum, R., Mensah,G., Yawson, A. & Minicuci, N. (2013*). Study on global AGEing and adult health (SAGE), Wave 1: The Ghana National Report.* July, 2-103.

Boutayeb, A, & Boutayeb, S. (2005). The burden of non-communicable diseases in developing countries. *International Journal of Equity Health*, *4*(2).

DeVoe, J., Baez, A., Angier, H., Krois, L., Edlund, C. & Carney, P. (2007) Insurance + Access≠ Health Care: Typology of Barriers to Health Care Access for Low-Income Families. *Annals of family medicine*. 5(6), 511-518.

Exavery, C., Klipstein-Grobusch & Debpuur, C. (2010). *Self-Rated health and healthcare utilization among rural elderly Ghanaians in Kassena-Nankana District*. http://uaps2011.princeton.edu/papers/110332

Fitzpatrick, A.L, Powe N.R, Cooper, L.S, Ives, D.G, & Robbins, J.A (2004). Barriers to health care access among the elderly and who perceives them. *American Journal of Public Health, 94*(10), October, 1788-1793.

Frumence, G., Nyamhanga, T., and Anaeli A. (2017). Facilitators and Barriers to Health care Access among the Elderly in Tanzania: A Health System Perspective from Managers and Service Providers. *Journal of ageing research and healthcare.* June, 1(3), 1-9.

Ghana Health Service (2017). *Center for Health Information Management. Ghana Health Service Systems.* Accra, Ghana.

Ghana Statistical Service (2013). *2010 Population and Housing Census Report: The Elderly in Ghana.* Accra, Ghana.

Jacobs, B., Ir, P., Bigdeli, M., Annear, P., and Van Damme, W. (2011). Addressing access barriers to health services: an analytical framework for selecting appropriate interventions in low-income Asian countries. *Health Policy and Planning*. May 3, 1–13.

Larbi, R., Ottie-Boakye, D. & Appiah, M. (2015*). Access and payment of inpatient healthcare among the aged in Ghana: evidence from the WHO multi-country study.* 7th African population conference. Johannesburg, South Africa.

Leeds Beckett University (2016). *Research ethics procedures,* December, 6-12

Lordos, E., Herrmann, F., Robine, J., Balahoczky, M, Giannelli, S., … Gold, G., et al. (2008). Comparative value of medical diagnosis versus physical functioning in predicting the 6-year survival of 1951 hospitalized old patients. *Rejuvenation Res*, *11*(4), 36-829.

Molete, M., Yengopal, V., and Moorman, J. (2014) Oral health needs and barriers to accessing care among the elderly in Johannesburg. *SADJ.* September, 68 (8), 352-357.

O'Donnell, O. (2007). Access to health care in developing countries: breaking down demand side barriers. *Cad. Saúde Pública, Rio de Janeiro, 23*(12), 2820-2834.

Stewart, B., Gyedu, A., Abantanga, F., Abdulai, A., Boakye, G., and Kushner, A. (2015) Barriers to Essential Surgical Care in Low- and Middle-Income Countries: A Pilot Study of a Comprehensive Assessment Tool in Ghana. *World Journal of Surgery,* August. Springer.

Steyn, K., (2006). Hypertension in South African adults: Results from the Demographic and Health Survey 1998. *Journal of Hypertension, 19*, 1717-1725

Sulemana, A. and Dinye, R. (2014) Access to Healthcare in Rural Communities in Ghana: A Study of Some Selected Communities in the Pru District. *European Journal of Research in Social Sciences,* 2 (4). 122-131.

United Nations (2007). *World Economic and Social Survey 2007: Development in an Ageing World.* New York: United Nations publication, V-15.

World Health Organization (2015). *World Report on Ageing and Health.* Luxemburg, 1-224.