Determinants of Healthcare Facilities and Services Utilisation among the Aged: Evidence from Yamoransa in Ghana

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Abstract

The aged are usually infected with chronic diseases and other health problems, but healthcare services/facilities for them are limited particularly in developing countries. Invariably, they encounter many challenges in their search for treatments, but few gerontological studies about healthcare facilities/services utilisation have been conducted in Ghana. This article assesses the socio-economic and demographic variables associated with the use of healthcare facilities/services among the aged, using Yamoransa in Ghana as the study setting. Andersen's Behaviour Model of Health Services Use was applied as theoretical guide. Cross-sectional survey involving interview schedules was conducted for all the aged. The findings show significant preference for government healthcare facilities among the aged, because of their perception that services rendered in such health centres are more effective. Slight variations by sex and age were recorded in the use of healthcare services while ethnicity, formal education, and marriage were the main predisposing factors affecting utilisation of healthcare services. Maltreatment of patients by health service providers and ample time spent in healthcare centres discouraged subsequent use of healthcare services while availability of income based on type of occupation and subscription to health insurance also influenced the use of healthcare services among the aged.

Keywords: Determinants; Health care Facilities; Socio-Economic and Demographic Variables; Utilisation of Healthcare Services; Yamoransa; Ghana.

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1. Introduction

The concept of ageing differs by geographical regions. In many African societies, a person who is 50 years is considered 'aged' while old age begins at 60 years in many developed countries, but the term 'aged' used in this article denotes Ghana's age for retirement which is 60 years and beyond while 'utilisation' refers to the extent to which people approach, use, and receive medical services. Healthcare services imply homeopathic and allopathic medicines and methods used for treatment of diseases in Ghana. Some homeopathic methods include: use of natural herbs, parts of animals, mineral substances, incantations and divinations in the diagnosis and treatment of diseases or infirmities while allopathic methods involve the use of mainstream medical practises in the diagnosis and treatment of diseases or infirmities [11].

Old age is often accompanied with numerous health challenges compared with the other stages of life [6, 21, 1]. Therefore, the aged are expected to utilise healthcare services due to the relatively high incidence of degenerative diseases at that stage, but utilisation of healthcare facilities/services in developing countries is typically affected by socio-economic barriers [19]. In Ghana, the socio-economic situation characterized by: high levels of poverty, small pension allowances, unfavourable social protection for the aged, insufficient geriatrics and breakdown of family support structures affect the use of professional healthcare among the aged [19,14]. A large proportion of the population relies on traditional health care involving the use of herbs, incantations and divination particularly in rural areas. These issues undermine government's efforts to offer universal and quality healthcare for the aged in the country [11, 4].

Despite these challenges, the few studies in Ghana mostly focused on identifying specific diseases of the aged rather than inquiring more into the socio-economic dimensions affecting the use of healthcare services [6, 21, 20]. Knowledge of the socio-economic and demographic factors influencing utilisation of healthcare services among the aged in Ghana will be useful for designing effective approaches to enhancing longevity. This article, therefore, examines the relationship between socio-economic issues in Ghana and utilisation of healthcare services among the aged, using Yamoransa as the study setting.

2. Conceptual model

Numerous frameworks have been developed to determine utilisation of healthcare services, but the Behaviour Model of Health Services Use developed by medical sociologist Andersen in 2007 has been employed in the article. The framework considers utilisation of healthcare services as a function of three factors, namely: perceived and evaluated needs (such as perception of a health problem or an existing health condition); predisposing factors (for example: sex and age); and enabling factors (for instance: availability of insurance, poverty status and actual access to medical care).

Perceived need points to individuals' perceptions of their need for care while evaluated need refers to perception of a change in one's health evidenced by illnesses and history of previous diagnosis of a disease. Predisposing characteristics are not reasons for accessing healthcare, but rather factors that explain variations among individuals in the use of healthcare services. One's occupation, ability to secure healthcare services, and desire

to secure healthcare services may largely depend on various predisposing characteristics. Predisposing characteristics encompass demographic factors: sex, age, education, and ethnicity, as well as health-related beliefs, such as attitudes, values, and knowledge of the healthcare system and services. Enabling factors include: access to health personnel and facilities, knowledge of how to access health services, and income or health insurance to pay for health services [4].

The model links the use of healthcare services to both individual and structural factors, and in doing so; it addresses criticisms of the Health Belief Model which relates utilisation of healthcare services to individuals' perceptions of their susceptibility to illness, the seriousness of a given illness, the benefits of action weighed against the risks of action, and cues for action. The model considers the point that decisions to utilise healthcare services might not be voluntary or based on individual cost-benefit analyses alone, but rather within the context of social relationships. It reckons the functions played by community networks (proximity, associations, and interactions) on how, when, and if individuals obtain healthcare.

3. Material and methods

The study setting is Yamoransa in the Central Region of Ghana. It has a population of approximately 4,562 comprising 2,036 males (44.7%) and 2,526 females (55.3%) [8]. Those aged 60 years and beyond living in Yamoransa constitute a population of three-hundred and thirty-nine (339). Yamoransa is about 73 miles (118 km) from South-West of Accra, Ghana. It is bordered on the West and Northwest by Abura-Asebu-Kwamankese District, on the East by Gomoa District and on the South by the Atlantic Ocean [16]. It is found within the Mfantseman Municipal Assembly in Ghana.

Descriptive cross-sectional study was conducted for all the residents in Yamoransa who were 60 years and above (339). The population comprised 125 (37%) males and 214 females (63%) [8]. Data for the study were primarily obtained through the administration of interview schedules. The interview schedule focused on the background characteristics of the respondents which were: sex, age, highest level of education attained, marital status, main occupation, ethnic group, religious affiliation, duration of stay in Yamoransa, and number of live children begotten by the aged. Socio-economic factors influencing utilisation of healthcare services such as: attitude of health service providers and availability of income were also considered in the interview schedule. The instrument was reviewed by the University of Cape Coast Ethical Review Board before it was administered. This is a requirement from the university before any fieldwork is conducted.

A total of five students pursuing Master degree programmes in the Social Science Faculty within the University of Cape Coast participated in a 2-day training that started on 28th January, 2014 for the administration of the interview schedules. A pre-test fieldwork was carried out in Sawua in the Ashanti region of Ghana, because the community exhibits similar characteristics as Yamoransa. For instance, Sawua which is known for farming and trading has no hospital within the community and the closest hospital (Jachie-Pramso) is somewhat far from the community just like the situation in Yamoransa. The outcome of the pre-test suggested that the content of the interview schedule was easy to understand. A letter from the Department of Population and Health of the University of Cape Coast was sent to a divisional chief of Yamoransa requesting for permission to conduct the

research. The Assembly Member of Yamoransa was also informed about the research and permission was granted for the commencement of the fieldwork after observing all protocols.

Yamoransa was put into clusters 1, 2, 3, 4, and 5 and the five field workers were assigned to a respective cluster. The clusters comprised the following suburbs: Old Junction, Baako Nyir Akoko, Jerusalem, and Kotokyeraba as first. The second included: Guaekyir, Market area, Kokwaado, Twensukeda and Bye Pass area. The third consisted of Amponsa Kokwaado, Mawemoho, Post Office and Nkwantado. The fourth incorporated Efrikaba; Ahenbrom, Samanadze, Etsifi, Anaafo, Bakaano and Agyepaye; and the last cluster covered Kojokrom, Manntsemannkabi and Mangoase. Since structure numbers existed for the location of the aged within Yamoransa, the field assistants went directly into the structures in which the aged resided, using the structure numbers [8]. The aged were selected using this method until the desired population size was achieved. The fieldwork began on February 19th, 2014 and ended on March 19th, 2014. Three-hundred and eleven respondents instead of the expected 339 participated in the study because 11 aged people were already dead before the time of the data collection. In addition, 17 of them were incapacitated owing to ill-health.

Data were edited and analysed using the Statistical Product for Service Solutions (SPSS) version 16 software. Frequency distribution tables, cross tabulations and chi-square were used to report outcomes of the data collected. Research participants were informed about the purpose and objectives of the study before they gave their consent and data have been kept confidential. Anonymity was ensured by not affiliating personal information of the respondents such as name to the data.

4. Results

4.1 Preferred healthcare facilities among the aged

To set the context for the study, it is vital to acknowledge the self-reported health problems of the aged. Six health problems were reported by the aged; namely: arthritis (32%), injury (8%), stomach problems (14%), high blood pressure/heart problems (30%), malaria (18%) and diabetes (10%). It is therefore expected that they visit healthcare facilities for treatment, but people obtain medical services from various sources and for other reasons apart from their ill-health. Table 1 indicate that more than half (63%) of the aged opted for public hospitals/clinics for treatments in their last visit while less than a quarter preferred private hospitals/clinics (22%), Traditional Healthcare Centres (8%) and pharmaceutical shops (7%). Focusing on their background characteristics, there was no difference in their preferred sources of healthcare facilities compared to the general pattern, but more males than females preferred public hospitals/clinics, Traditional Healthcare Centres and pharmacy shops while more females than males preferred private hospitals/clinics. For the various age groups, the results were quite similar to the general pattern, but more than a quarter (30%) of those who were aged between 60-64 (years) opted for private hospitals/clinics. Marital status, educational attainment, religious affiliation, ethnicity, occupation, duration of stay in their present location, and the number of live children begotten by the aged corroborate the general pattern (Table 1). Chi-square test was used to compute the significant relationships between the background characteristics and the preferred healthcare centres. Generally, age (x^2=32.537; p=0.001), marital status (x^2=25.031; p=0.000), religious affiliation (x^2=20.198; p=0.003),

occupation (x^2=27.194; p=0.001), duration of stay in present location (x^2=24.539; 0.004), and number of children begotten by aged (x^2=26.757; 0.002) showed significant relationships with the preferred healthcare centres, meaning that, the aforementioned background variables played a significant function on their preferences (Table 1). Therefore, the likelihood for an aged person to opt for any healthcare facility is largely influenced by their age, marital status, religious affiliation, occupation, duration of stay in present location and their number of live children.

Table 1: Preferred healthcare facilities by socio-demographic and economic variables

	Healthcare facilities (N=311)					
	Private hospitals/	Government	Traditional healthcare	Pharmacy	X^2	Sig. ≤ 0.05
Total	21.9	63.0	7.7	7.4	5.577	0.134
Sex			0.326	0.568		
Male	16.4	64.7	11.2	7.8		
Female	25.1	62.1	5.6	7.2		
Age**					32.537	0.001
60-64	30.4	61.7	3.5	4.3		
65-69	26.6	57.4	7.4	8.5		
70-74	12.5	65.0	17.5	5.0		
75-79	0.0	76.0	16.0	8.0		
80+	8.1	70.3	5.4	16.2		
Marital Status**					25.031	0.000
Married	26.5	59.2	13.3	1.0		
Divorced	26.9	53.8	10.3	9.0		
Widowed	15.6	71.1	2.2	11.1		
Highest level of education					20.475	0.059
No formal education	18.1	64.5	7.1	10.3		
Primary	29.2	56.2	14.6	0.0		
Middle/Junior High	23.5	61.2	7.1	8.2		
Senior High	40.0	60.0	0.0	0.0		
Tertiary	0.0	100.0	0.0	0.0		
Religious affiliation**					20.198	0.003
Christianity	21.9	64.0	8.1	6.0		
Islam	33.3	50.0	5.6	11.1		
Traditional	0.0	60.0	0.0	40.0		
Ethnic group					5.516	0.138
Akan	22.6	62.5	7.3	7.6		
Mole-Dagbani	0.0	80.0	20.0	0.0		
Main occupation**					27.194	0.001
Retired	0.0	92.0	8.0	0.0		
Trader	27.0	62.2	7.2	3.6		
Farmer	11.2	66.2	10.0	12.5		

Unemployed	30.5	53.7	6.3	9.5		
Duration of stay in present location (years)**					24.539	0.004
Less than 1	8.3	70.8	8.3	12.5		
1-5	44.4	27.8	27.8	0.0		
6-10	14.3	71.4	0.0	14.3		
10	22.0	64.3	6.7	7.1		
Number of live children**					26.757	0.002
0	0.0	76.5	0.0	23.5		
1-3	25.7	66.2	1.4	6.8		
4-6	24.5	56.8	9.7	9.0		
More than 6	16.9	70.8	12.3	0.0		

Source: Fieldwork, 2014; **=significant

4.2 Rationale for the preferred healthcare facilities

Understanding the underlying reasons why the aged opt for a particular healthcare facility is the core of the discussion. Overall, 43 percent made their choices because of supposed effective services, followed by 32 percent who chose a health facility because of its proximity to their residence. Less than a quarter made their choices because the chosen facilities accept National Health Insurance [NHI] (11%) while about one out of ten (10%) visited a particular healthcare centre because services were sponsored by foreign medical professionals who seldom visit the people of Yamoransa. Approximately, 40 percent of those who preferred private clinics/hospitals to any other healthcare centre made their choices because of effective services.

Table 2: Rationale for Preferred Healthcare Facility

Type of healthcare centre	Reasons for opting for a particular healthcare facility				
	Convenient location	Acceptance of NHIS`	Effective services	Free community outreach programme	Inadequate income
Total	31.5	10.9	42.8	9.6	5.2
Private clinic/ hospital	27.9	2.9	39.8	29.4	0.0
Public clinic/hospital	28.6	16.3	48.5	5.1	1.5
Traditional Healthcare Centre	50.0	0.0	45.8	0.0	4.2
Pharmacy shops	47.8	0.0	0.0	0.0	52.2

Source: Fieldwork, 2014

Nearly half (49%) of those who preferred a public clinics/hospitals also gave effective services as the reason for their choices while exactly half (50%) of those who preferred Traditional Healthcare Centres opted for it

because of proximity of the healthcare centre to their residence. Slightly more than half (52%) also chose Pharmacy shops as their most preferred healthcare centres and cited inadequate finances as the main reason for their choices (Table 2).

4.3 Socio-demographic and economic factors influencing utilisation of healthcare services among the aged

In line with the Behaviour Model of Health Services Use, socio-demographic and economic factors affect utilisation of healthcare services among the aged [15, 18, 3, 22]. Sex, age, marital status, educational level, religious affiliation, ethnic group, duration of stay in Yamoransa and number of live children begotten by the aged were the main background variables considered in the analyses. Socio-economic issues, specifically: time spent in healthcare centre, nature of treatments given by health service providers, payment for medical expenses, subscription to health insurance scheme, cost of transport to healthcare centre, support from family and friends, distance to healthcare centre, and autonomy in visiting healthcare centre were other variables included in the analyses. Utilisation of healthcare services was measured based on their last visits to healthcare centres within 12 months preceding the survey.

Generally, it was revealed that majority (92%) of the aged utilise healthcare services, but more males (93%) than females (91%) utilise healthcare services (Table 3). This confirms proposition of [22] that males are more likely to utilise healthcare services than females. However, the margin of difference in the use of healthcare services by sex was minute indicating an insignificant relationship (x^2= 0.326; p=0.568) between sex and utilisation of healthcare services among the aged (Table 3).

With the exception of some peculiar situations, demand for healthcare services often increases with age [18]. Contrarily, Table 3 shows that apart from those aged 75-79 years (100%), the use of healthcare services declines while age increases [65-69 years (94%), 60-64 years (91%), 70-74 years (90%) and 80 years+ (87%)]. Possible explanation to this result is that among the aged, age alone does not always engender utilisation of healthcare services; since they are all at risk of chronic ailments [1].

It has not been fully confirmed by health researchers whether marital status has direct effects on the use of healthcare services among the aged [15]. In our findings, the chi-square test in Table 3 displays a significant relationship (x^2=6.028; p=0.049) between marital status and utilisation of healthcare services, with those married (96%) using healthcare services more than those widowed (93%) and divorced (86%). This means being married, widowed or divorced largely influenced variations in the use of healthcare services among the aged.

All those who had attained Tertiary (100%) and Senior High School Education (100%) utilized healthcare services compared with the other levels of education (Table 1), purporting that higher education has a positive influence on utilisation of healthcare services. This echoes the contention of [10] that education promotes utilisation of healthcare services by providing both economic and psycho-social resources including knowledge about healthcare and higher income for accessing healthcare services.

Table 3: Utilization of healthcare services by socio-demographic and economic variables

	Utilisation of healthcare services (N=311)			
	Yes (%)	No (%)	X^2	Sig. ≤ 0.05
Total	92.0	8.0		
Sex			0.326	0.568
Male	93.1	6.9		
Female	91.3	8.7		
Age			4.309	0.366
60-64	91.3	8.7		
65-69	93.6	6.4		
70-74	90.0	10.0		
75-79	100.0	0.0		
80+	86.5	13.5		
Marital Status**			6.028	0.049
Married	95.9	4.1		
Divorced	85.9	14.1		
Widowed	92.6	7.4		
Highest level of education			5.766	0.217
No formal education	92.3	7.7		
Primary	95.8	4.2		
Middle/Junior High	87.1	12.9		
Senior High	100.0	0.0		
Tertiary	100.0	0.0		
Religious affiliation			1.099	0.577
Christianity	91.5	8.5		
Islam	94.4	5.6		
Traditional	100.0	0.0		
Ethnic group**			14.278	0.000
Akan	93.0	7.0		
Mole-Dagbani	60.0	40.0		
Main occupation**			10.905	0.012
Retired, but receives pension funds	100.0	0.0		
Trader	94.6	5.4		
Farmer	83.8	16.2		
Unemployed	93.7	6.3		
Duration of stay in present location (years)**			34.014	0.000
Less than1	70.8	29.2		
1-5	88.9	11.1		
6-10	64.3	35.7		
10	95.7	4.3		

Table 3 continued.

Number of live children			5.164	0.160
None	100.0	0.0		
1-3	94.6	5.4		
4-6	92.3	7.7		
More than 6	86.2	13.8		
Spent much time in health centre more than expected**	85.0	15.0	12.809	0.000
Maltreated by a health service provider**	68.0	32.0	21.114	0.000
Difficulty in paying for medical expenses	92.9	7.1	0.152	0.697
Subscription to National Health Insurance**	97.6	2.4	16.910	0.000
Problem paying for transport cost	86.5	13.5	3.258	0.196
Neglect by family	8.3	91.7	0.903	0.342
Neglect by friends	8.1	91.9	0.002	0.963
Autonomy in visiting healthcare centre	91.9	8.1	4.460	0.108
Health service provider explain things clearly to the aged	90.5	9.5	2.190	0.335

Source: Fieldwork, 2014; **=significant

The aged hold health beliefs which are sometimes associated with their religious dispensations [2]. Our findings show that all the Traditionalists (100%) utilized healthcare services while about nine out of ten Muslims (94%) and Christians (92%) utilized healthcare services (Table 1). This somewhat deviates from the findings of [2] which argue that Traditionalists and Muslims are less likely to utilize healthcare services compared to Christians. Furthermore, the results indicate a significant relationship (x^2=10.905; p=0.012) between occupation and the use of healthcare services.

A significant relationship (x^2=34.014; p=0.000) was found between respondents' duration of stay in Yamoransa and utilisation of healthcare services. Majority (96%) of those who had lived in Yamoransa for a period of 10 years and above utilized healthcare services compared with those who had lived in Yamoransa for less than a year (71%) (Table 3). Results in Table 3 further indicate that majority of Akans (93%) utilized healthcare services, compared with Mole Dagbanis (60%). Also, a significant relationship (x^2= 14.278; p=0.000) was seen between ethnicity and utilisation of healthcare services. The implication is that the ethnic group of an aged person substantially plays a function on the use of healthcare services. This discrepancy in utilisation by ethnicity might have originated from the unique health beliefs of the ethnic groups. The findings further illustrate an inverse relationship between high fertility and the use of healthcare services. Thus utilisation of healthcare services declines as children begotten by the aged increases (Table 3).

More than three-quarters (85%) of the aged reported that they spent much time than they expected in their last visit to a healthcare centre, highlighting a significant relationship (x^2=12.809; p=0.000) between time spent in a

healthcare centre and utilisation of healthcare services. This suggests that the more the aged are delayed in healthcare centres, the less likely they seek for future healthcare services (Table 1). Individuals who had experienced negative attitudes such as rude and uncaring treatment from a medical professional are less likely to seek for help from a medical professional in future [17]. In consonance with the proposition of Moore et al. (2004), the result indicates a significant relationship (x^2=21.114; p=0.000) between maltreatment from a health service provider and utilisation of healthcare services.

Unless provided with a subsidised healthcare plan, the aged can have difficulty affording for the costs associated with healthcare services, making utilisation less likely [23]. Ninety-three percent of the aged complained of difficulty in paying for medical expenses while 87 percent also lamented on difficulty paying for cost of transport (Table 1). As a result, not having health insurance is probably the major barrier to receiving healthcare among the aged. Subscription to health insurance shows a significant relationship (x^2=16.910; p=0.000) with utilisation of healthcare services among the aged.

Owing to high incidence of fragility among the aged, they are suppose to be escorted to healthcare centres when they are ill. Therefore, social support is necessary in the utilisation of healthcare services among the aged [5]. We found that 8 percent of the aged were neglected by their families in their last visit to a healthcare centre while another 8 percent also reported neglect by their friends (Table 1). This to some extent corresponds with the findings of [12] which revealed that in many cultures, some illnesses/diseases among elderly people are regarded as a normal process of ageing which did not require much attention.

There are two main conceptions of self, one that is autonomous and one that is heteronomous [9]. Heteronomous networks such as friendships can provide an impetus for the use of healthcare services, but may also stimulate an individual to abstain from utilising healthcare services. This affects decisions to visit a healthcare centre when in need of healthcare services. Our findings show that 92 percent of the aged said the decision to visit a healthcare centre largely depends on them indicating autonomy in the decision to visit a healthcare centre. Ninety-one percent also mentioned that the health service providers explained things clearly to them during medical treatment. In support, [24] hold that healthcare providers need to give patients the needed information about healthcare whenever they are seeking for help.

5. Discussion

The aged in Ghana are expected to utilise the available healthcare facilities/services, but they have various perceptions about the healthcare facilities/services which underlie utilisation. More than half of the aged prefer government health facilities which have relatively affordable healthcare services. Others opt for private hospitals, traditional healthcare centres and pharmacy shops which are contingent upon various factors. To a large extent, they opt for these facilities because of effective services. Owing to the fragility of most of them, the issue of distance to health centres evoked their choices. Most of them prefer health facilities with shorter proximities while others opted for some health facilities because they welcome health insurance. Yamoransa has no modern hospital or clinic and people living there usually travel to neighbouring communities to seek for professional healthcare. Increasing distance increases the likelihood of a household opting for self-treatment

rather than utilising formal healthcare services. An increase in distance implies paying some cost to travel to the source of treatment as opposed to seeking self-treatment [18]. However, their choices varied tremendously by their marital status, occupation and their number of live children.

Beyond their choices of healthcare facilities, the use of healthcare services was measured taking into consideration socio-demographic and economic variables. Specific background characteristics, such as: marital status, occupation, and their duration of stay in their present location predispose them to using healthcare services. People who are married usually have positive attitudes toward seeking for healthcare services compared with the unmarried because a legal partner might provide the socio-economic support to the other spouse in the form of encouragement and income which can propel the use of healthcare services. [13] affirm that marital status of the aged is a determinant of the use of healthcare services. The propensity of using healthcare services is vastly influenced by whether an aged person is employed (type of occupation) or unemployed. In a similar way, a study in Ghana revealed that the primary cause of poor accessibility to healthcare services is functional to financial constraints grossly emanating from unemployment [7]. The likelihood of utilising healthcare services is considerably influenced by a person's duration of stay in his/her present location. Expounding this result, people who have lived in a place for sometime have knowledge of where and how to go for healthcare services compared with new entrants who might not even have access to health insurance in their present location. In part, children are usually regarded as assets to providing social and financial support for the elderly in seeking for healthcare services, but the results portrays otherwise. Probable reasons for this is the cultural belief that health problems associated with ageing is natural and cannot be treated, which sometimes develops into neglect of aged persons particularly when they are ill [12].

From an economic viewpoint, subscription to health insurance scheme largely influenced the use of healthcare services among the aged. Those who were assigned to the National Health Insurance Scheme mostly utilized healthcare services compared with those who did not possess health insurance. In confirmation to literature, the findings back studies conducted by [15] who posited that, the aged who are financially supported by a healthcare plan do not face difficulties in affording for medical services which makes them more likely to utilise healthcare services.

Ample time spent at the healthcare centres coupled with maltreatment by health service providers discouraged subsequent use of healthcare services among the aged. [18] likewise suggested that long waiting time and the nature of treatment of patients by healthcare service providers are significant determinants of the use of healthcare services. The inference is that the aged are likely to visit a different healthcare centre for treatment after previous maltreatment from a health service provider. Others may never go for healthcare services from facilities similar to those they had had their experiences while others may resort to self-medication.

6. Conclusions

Our study suggests variations in the use of healthcare services among the aged, taking into consideration the socio-economic and demographic variables identified in the Behaviour Model of Health Services Use and some other empirical studies. Based on the findings, the aged prefer government hospitals/clinics to other healthcare

facilities in Ghana largely because of their perceptions of effective services. Demographically, aged males are more likely to utilise healthcare services than aged females. Those aged between 75-79 years mostly utilise healthcare services than any other age group beyond 60 years. The aged who had attained higher levels of education (Tertiary and Senior High levels) utilise healthcare services more than those with no formal education while those married utilise healthcare services more than those divorced and widowed. Occupational status of the aged, ethnicity and marital status are significantly affiliated to the utilisation of healthcare services.

Maltreatment of the aged by healthcare providers and ample time spent in healthcare centres discourage future use of healthcare services. A major factor enabling utilisation of healthcare services among the aged is subscription to health insurance scheme. Other variables that induce utilisation of healthcare services are mainly availability of income and the type of occupation of the aged which reflects their ability to pay for health expenses including transportation bills. Retirees receiving pension funds utilise healthcare services more than farmers and those unemployed.

The findings provide useful knowledge about socio-economic and demographic factors affecting the use of healthcare services among the aged. However, one limitation to the study is that some of the aged could not precisely remember previous visits to healthcare centres which would have been beneficial in measuring the specific medical costs associated with the use of healthcare services. Hence, utilisation of healthcare services was limited to their last visits preceding the survey. Further studies can look at the challenges associated with subscription to health insurance plan and its implications on utilisation of healthcare services. Future approaches to ensuring utilisation of healthcare services among the aged could consider the establishment of health departments/centres solely for aged care and training of geriatricians as recommended by some respondents.

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