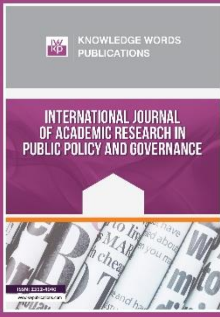

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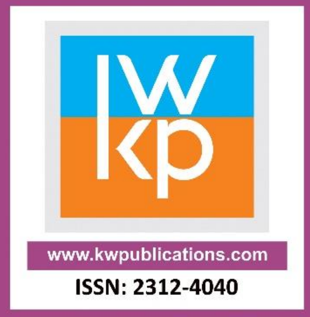

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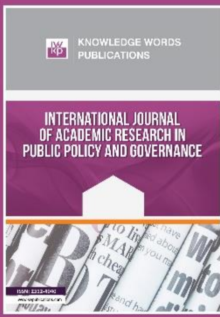
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A Qualitative Review of Ghana's Elderly Care Policy: A Grounded Theory Approach Using EU's "CARMEN" Model

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Abstract

The dramatic demographic change in the population of older persons is occurring in the context of globalization and socio-economic challenges, deterioration of cultural values and morals, spreading of HIV/AIDS pandemic and other diseases. This definitely calls for effective and carefully thought out policy interventions to take advantage of the several opportunities that come with it and reduce its negative impact on the development of our country. Ghana's response to the UNFPA recommendation led to the adoption of the National Ageing Policy for the country in July 2010. The policy has all the elements of the Madrid Plan of Action that qualifies its sub-caption to be rendered as Ageing in Security and Dignity. This study takes a look at the national policy from a grounded theory approach. It adopts qualitative research by interviewing directors of strategic ministries connected to the national ageing policy and other agencies, NGOs and religious organisations that have been assembled as active part of the responsibility of taking care of the elderly by the policy. This study seeks to compare the current policy with other policies currently in operation elsewhere especially the EU to determine the degree of integrated-ness and efficacy of Ghana's national ageing policy. We argue that Ghana's elderly care policy is well crafted and has integrated both domestic and national variables towards effective management of elderly in society. However, the elders are not involved in developing. The elders are not involved in managing the policy, the elders are not involved in reviewing the policy, the elders are not aware of its content and what is due them, there is weak institutional and resource support to implementing the policy and there is no legally binding responsibility on governments to implement the policy. Further it has been noted that there is weak

regulation and inspection of implementation of policy and a weak evaluation and monitoring process of the policy. There is the need to urgently redesign our policy to accommodate the deficit.
Keyword: Ghana, Elderly Care, Policy, Evaluation, Qualitative, Grounded Theory.

Introduction

One of the major concerns of older persons in Ghana is the absence of a comprehensive, coherent and well-articulated policy document on ageing. There is unprecedented increase in the number of older persons globally, continentally and nationally. In fact available statistics show similar trends in all regions and districts of Ghana (Addai-Sundiata, 2006). Population of older persons (60 years and above) is projected to increase from about 600 million in 2000 to almost 2.6 billion in 2050. This increase is phenomenal and yet developing countries are expected to experience even more rapid increases reaching about four times within the same period. Africa will not be spared from this rapid population growth of older persons . In Sub-Saharan Africa, where the struggle with HIV/AIDS pandemic and economic and social hardship continues, the percentage is expected to reach half the level (Obiri-Yeboah, 2010). The 2000 Population and Housing Census Report on Ghana indicate that the proportion of the elderly (65 years and above) formed 5.3 per cent of the population, an increase from 4 per cent in 1984. This dramatic demographic change in the population of older persons is occurring in the context of globalization and socio-economic challenges, deterioration of cultural values and morals, spreading of HIV/AIDS pandemic and other diseases (Apt, 2007). This definitely calls for effective and carefully thought out policy interventions to take advantage of the several opportunities that come with it and reduce its negative impact on the development of our country. Today's generation owe it as a duty to honour and guarantee better living conditions for our older persons. We need to recognize that the society in which we live today has been built thanks to the efforts and toil of previous generations some of whom live with us and defined as older persons. We must make the effort to provide them with efficient health care services and conducive living environment to ensure that they age actively and with adequate security and recognizable dignity (Razavi and Staab, 2008). As a society we have not been able to meet these challenges adequately and satisfactorily. This unsatisfactory performance is partly due to the unsatisfactory treatment we give to older persons because of our own negative perceptions about them including the strange images we use to describe or ascribe to them. Unpardonably, we have sometimes failed to meet their needs even when we have had the capacity to exactly do that (Leichsenring and Alaszewski, 2004).

In 2003, a national policy on ageing was prepared and submitted to Cabinet for approval. The policy sought to address a number of ageing issues at the time but the policy as a comprehensive document was not implemented. The review of the policy is therefore timely if viewed from the perspective of Government's implementation arrangements for the Growth and Poverty Reduction Strategy and the commitment of the Government of Ghana to the Declarations of the Second World Assembly on Ageing and Madrid International Plan of Action on Ageing (Razavi and Staab, 2008). The process for the review is itself commendable as it brought together key stakeholders including older persons themselves, government institutions and policymakers, social partners, private sector, civil society and development partners from national and district levels including representatives of communities. The process adopted for the review was bottom-up, participatory and consultative. It is also consistent with the guidelines recommended by the United Nations for member countries within the framework of the Madrid International Plan of Action (Apt, 2007).

The policy presents a framework that is capable of transforming and improving the lives of older persons in our society. Our shared vision as Ghanaians is to achieve the overall social, economic and cultural re-integration of older persons into mainstream society, and to enable them as far as practicable to participate fully in the national development process (Clark, 2012). It is therefore my hope that the partnership that has led to the development of this policy will continue to be strengthened and deployed in the development of the Action Plan, programs and projects not only to ensure successful implementation of the policy but also to ensure that the quality of life of older persons in Ghana improves significantly and that the goal of ageing actively with adequate security and dignity is achieved. Yet five years of the adoption of the national ageing policy, there are still doubts as to whether Ghana's version has been effective enough (Faye, 2007). The debate ranges between those who believe the current policy has all the essential features to successfully take care of the elderly considering the fact that it is rooted in several international and related policies. The other side of the debate share in the view that the lack of political will and the appropriate resources deployed to service the policy is the bane of the challenge of the national ageing policy (Kholer, et al, 2011). This study takes a look at the national policy from a grounded theory approach. It adopts qualitative research by interviewing directors of strategic ministries connected to the national ageing policy and other agencies, NGOs and religious organisations that have been assembled as active part of the responsibility of taking care of the elderly by the policy. This study seeks to compare the current policy with other policies currently in operation elsewhere especially the EU to determine the degree of integrated-ness and efficacy of Ghana's national ageing policy (Kholer, et al, 2011). The uniqueness in this approach stems from the fact that instead of listing a line by line comparison of policies there is opportunity to hear from both the policy makers and the implementers as well as those who analyse social policy in order to get a more integrated picture of the nature of ageing policy that Ghana currently has. If successful the research will contribute significantly towards the desire expectation of formulating a more rigorous and enforceable national ageing policy.

Ghana National Ageing Policy

Following the Second World Assembly on Ageing and the Madrid International Plan of Action on Ageing, the government of Ghana also initiated measures to update and accelerate measures to develop the then ongoing national policy on the elderly or the national ageing policy. As Clark (2012) has indicates, the idea of a national ageing policy has long being rooted in the spirit of the constitution and social policies of successive government but there was no letter to that effect. For this reason the redraft of the national ageing policy in 2009 came as a major step towards taking the responsibility of the aged as a national responsibility albeit a family one as well. Ghana, national policy is divided into nine main chapters with each of them addressing peculiar needs of elderly people sin Ghana (Dsane, 2009; Ministry of Employment and Social Welfare, 2010).

Chapter one of the Ghana national ageing policies reflects on some of the above mentioned background to the national ageing policy, an introduction, implications of ageing and policy imperatives, the rationale for review of the draft national policy on ageing and the policy review process (Obiri-Yeboah, 2010; Ministry of Employment and Social Welfare, 2010). This set the context for the second chapter which provides the legal framework and application of standards. This chapter highlights the international instruments and United Nations Conventions, national laws and development policies that make it mandatory for Ghana to develop a national ageing policy (Faye,

2007; Ministry of Employment and Social Welfare, 2010). In the third chapter of the national ageing policy, the challenges of ageing and national policy is enumerated which entails issues such as the national demographic dynamics, ageing and the development challenge, ageing and fundamental human rights, ageing and poverty, old age and health challenges, ageing and the living environment and ageing and gender (Apt, 2000; Ministry of Employment and Social Welfare, 2010).

With the knowledge of this background information the fourth chapter of the national ageing policy highlights the objectives and principles of the national ageing policy. It stipulates what it calls the overarching goal, the objectives of the policy and principles of the policy while the policies and strategies have been highlighted as well (Odufuwa, 2006; Ministry of Employment and Social Welfare, 2010). This paper evaluates the national ageing policy and discusses the measures adopted to upholding the fundamental human rights of older persons, ensuring active participation of older persons in society and development. It evaluates the degree to which the national policy helps in reducing poverty among older persons, improving health, nutrition and well-being of older persons, improving housing and living environment of older persons and strengthening the family and community to provide support to older persons (Ham-Chande, et al, 2009; Ministry of Employment and Social Welfare, 2010).

The chapter also outlines measures by which the national ageing policy can help to improve income security and enhanced social welfare for older persons, provide adequate attention to gender variations in ageing, strengthen research, information gathering and processing, and coordination and management of data on older persons, enhance capacity to formulate, implement, monitor and evaluate policies on ageing and improve financing strategies to ensure sustainability of implementation of policies and programs of older persons (Ramashala, 2000, Ministry of Employment and Social Welfare 2010) . The institutional framework for policy implementation of the national ageing policy is the subject of analysis of the sixth chapter with clearly delineated roles for government, the family and community, the private sector, employers and organised labour, older persons groups and associations, NGOs and Civil Society, Development Partners and The National Council on Ageing. This is the strength of the integrated nature of the policy in Ghana for the aged where all the institutions that matter are brought together to exchange views and strengths in order to better support the development of the aged (Razavi and Staab, 2008; Ministry of Employment and Social Welfare, 2010).

The seventh chapter examines the financing mechanism that is being deployed for use towards the successful national ageing policy. In the eighth chapter Ghana's national ageing policy outlines its implementation arrangements, the implementation method and approach, monitoring and evaluation and review and revision of the national ageing policy. In all there is evidence that Ghana has a well-documented and well couched national ageing policy which draws on international policies and principles for the management of aged population (Ministry of Employment and Social Welfare, 2010). However as to whether these are well integrated enough to meet the challenges of its current ageing society is what is under review. There are many models which have been developed over the years to help establish the degree of efficacy and integration of the system and the CARMEN model which is the model developed by the European Union for evaluating national ageing policies of its member states is used to evaluate that of Ghana

The Carmen Model

Care and Management of Services for Older People in Europe Network (CARMEN) is a policy framework that offers a checklist for national and regional governments interested in improving services for their elderly and providing them with an integrated care. CARMEN defines integrated care as a well-organized set of services and care processes aimed at different and varying problems and needs peculiar to an individual or a particular category of people (Vaarama, cited in Nies, 2004).The focus of the framework is more geared towards the challenges that come with integrated care processes for elderly people, rather than an attempt to address all policy issues related to the process. It places emphasis on reinforcing policies on active ageing, control by individual older persons and the concept of interdependence. This is very crucial today since many countries are now beginning to search for new ways of dealing with population ageing and members of the public are also growing in their demand for their rights for high quality services. Integrated care is therefore one of the ways to meet the needs of elderly people with complex needs and to reduce the numerous challenges that come with trying to pursue the desired change (Banks, 2002).

Every service provided is aimed at providing the best possible opportunity for people to live normal lives. A lack of co-ordination between the different services however undermines this goal. According to Edwards and Miller (2003), service providers have found that lack of co-ordination leads to lapses such as inefficient use of staff time, generates inter professional conflict and does not make the best use of available resources. Brodsky et al (2003), and Carrier (2002) hold a similar view; the former argues that division, decentralization, and specialization which is typical of the architecture of most complex systems often interfere with efficiency and effectiveness. While the latter adds that fragmentation and unbalanced service systems brings about bottleneck gaps putting pressure on existing services hence frustrating the development of preventive and rehabilitation services that are very crucial to elderly care. It is under this background that integrated care has become very crucial in the discussion of health care and care for the elderly. Hence the European Commission in recent times has put integrated care at the very heart of the three key objectives in national policies on health care and care for older people, namely: accessibility, quality and financial sustainability (European Commission, 2003).

Accessiblity is supposed to ensure that older people receive the best co-ordinated response to their needs as they enter into the service system. Other benefits would also include better integration between health and care services, which includes housing, social care community services, transportation etc. Quality wise, integrated care provides opportunities for better outcomes for older people since services are co-ordinated making room for continuity and a holistic approach. An integrated care approach to elderly care is also a sure way to financial sustainability since it creates the best avenue for cost-effective solutions.

The CARMEN framework has come out with key components for national policy on integrated care for older people and also made recommendations as to the actions that can be taken in implementing a policy. The framework is based on the experiences and expertise of the members of the network. It is worth noting also that, the framework is in line with the central themes of the International Plan of Action on Ageing (United Nations, 2002). The following are the key issues that the CARMEN framework addresses the clarity of vision of ageing policy and evaluates the underpinning principles and values of a national of ageing policy to see if they are consistent with international practices. Further the model evaluates the criteria for operational success and the degree of coherence with

other policies. Finally the CARMEN model evaluates the degree of activeness in the promotion and incentives for integrated care and how the of ageing policy is evaluated and monitored. To enable the model to effectively evaluate the national policies some specific questions are posed to elicit information. It is these questions which have been used for the interview questions in order to draw important and useful lesson from the respondents who are the policy makers of the ageing population in Ghana

Materials and Methods

Data Collection

Given the research purpose of analyzing the essential features of the policy for the elderly in Ghana in relation to current models of elderly care in other parts of the world, senior managers (directors of related institutions- Ministry of Gender, Children and Social Protection and Department of Social Welfare), as well as analysts (NGOs, Religious leaders, trade Union leaders etc, were targeted for interviews. It is important to find the “right person” to be interviewed in a qualitative study, as this determines whether you can obtain relevant and valuable information. Rubin and Rubin (2005) suggest that “interviewees should be experienced and knowledgeable in the area you are interviewing about”. Senior level managers were considered to be those who have broad knowledge about organization’s strategies, policies, and business practices, as well as being involved with different aspects of essential features of the policy for the elderly in Ghana in relation to current models of elderly care in other parts of the world. Thus, it is expected that they may have better ability to understand the research problem than low level management and employees. Similarly, analysts who specialise in the social sector particularly elderly care were chosen to be another set of interviewees on the grounds that they were considered to be the experts who have specialist knowledge and understanding of elderly care.

The fieldwork was undertaken between June 2013 and December 2013. At first, interviews with policy makers were arranged and conducted between June 2013 and July 2013, and then directors were approached for interviews from July 2013 to September 2013. It should be noted that, although the work schedule created difficulties in accessing the targeted interviewees, it was helpful to the research because policy makers and analysts could reflect on the essential features of the policy for the elderly in Ghana in relation to current models of elderly care in other parts of the world. This showed variation in core concepts.

There were twelve interviews with social policy analysts and eleven interviews with directors of ministries being conducted. The majority of them were one-to-one interview, with the exception of one interview in which two directors participated. The interviews lasted from fifteen minutes to one-hour and twenty minutes. Six interviews were carried out through telephone, and all others were face- to-face interviews conducted in the location of the case organizations. With the permission of interviewees, eighteen interviews were audio-recorded and were then transcribed carefully in order to provide a basis for reliable data analysis.

The interview questions were designed to be semi-structured in order to encourage participants to talk freely and openly about their opinions and experience. Moreover, semi-structured interviews were more appropriate in terms of ensuring “cross-case comparability” (Bryman, 2004) than unstructured interviews in multiple cases. Interview guides were constructed based on specific CARMEN questions and these have been tabulated as follows:

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Table 1 Themes of Carmen Model

Themes of CARMEN Framework	Key Points Under Each Themes
Clarifying the vision	Clarity of Vision
Principles and values	Older people are treated as individuals and are in control
	Older people's views are central
	Access to integrated care should be equitable and according to need
	Solutions to integrated care must be sustainable
Criteria for operational success	Flexible and innovative integrated services
	Clarity about responsibilities and accountabilities
	Appropriately targeted integrated care
Coherence with other policies	Coherent funding systems
	Promoting independence and well being
	Support to careers
	Integrating information
Active promotion and incentives	Allocating resources
	Resourcing integration
	Awarding responsibilities to integrate services
	Introducing incentives and sanctions
	Supporting shared learning
	Setting standards for integrated approaches
	Providing support to careers
Evaluation and monitoring	Evaluation and Monitoring Scheme
Regulation and inspection	Regulation and Inspection Scheme
Support to implementing policy	Support Services

The interview guides served as a reminder of specifying research focuses and were used flexibly. After each interview, the researcher reviewed the interview process, and revised the interview guides based on gained information. During the interview, different types of questions were asked,

such as main questions, follow-up questions, and probing questions, in order to obtain deep and detailed information and also to ensure the consistent answers were got from interviewees. Notes were taken by the researcher during each interview, regardless of whether it was recorded or not. For non-recorded interviews, notes were the main source for data analysis; while for interviews that were allowed to be recorded, taking notes was also a useful way to capture the main points and to formulate follow-up questions. The transcripts or notes of the interviews were sent back to the participants to get their feedbacks and to check the accuracy of the data.

Data Analysis

The case interview data was processed by adopting a grounded theory data analysis technique. Grounded theory method "uses a systematic set of procedures to develop and inductively derive grounded theory about a phenomenon" (Strauss and Corbin, 1998), and combining this technique with case study has the potential to strengthen case analysis by searching for patterns from cross-case analysis (Parker and Roffey, 1997). Moreover, the clearly specified operational procedures of grounded theory data analysis can enhance construct validity of a qualitative study (Pandit, 1996).

Based on previous works of Beattie et al. (2001); Easterby-Smith et al. (2008); Locke (2001); Parker and Roffey (1997), and Strauss and Corbin (1998), the interview data was analysed through five stages: familiarisation, reflection, open coding, axial coding and selective coding. All the case data was manually analysed due to the consideration that grounded theory is an "interpretive process" (Suddaby, 2006) between the researcher and data, and our theoretical sensitivity tended to be very important in all of these stages. Enhanced theoretical sensitivity helped us to challenge our existing assumptions and knowledge structure and move from description to theoretical analysis. We recognized that we entered the field with various prior theoretical perspectives, such as ideas of social policy and these theoretical constructs were important throughout the data collection, data processing, concept formation and interpretation processes.

As the initial stage of data analysis, familiarization with interview data started in the data collection process. We tried to transcribe the interview immediately after each interview was conducted. Then the case interview transcripts or notes were read and reread. This was to ensure that we were familiar with the details of each case. "Big ideas" or tentative broad concept categories were briefly noted for each interview in this stage, and were recorded in the code notes. These written records served as reminders of what we captured during the reading process, and also acted as data sources for further coding stages.

At the stage of reflection, we tried to do some preliminary cross-case analyses. This process was carried out by comparing and critically evaluating individual case data with other cases and also previous literature. By doing so, similarities and differences among some important issues were grasped, and were recorded in theoretical memos. Memos that recorded our early thoughts, memories and reflections with the case data, such as code notes and theoretical memos, facilitated further systematic coding, and were continuously used throughout the entire process of data analysis.

Subsequent to the stage of reflection, we went through each case interview line-by- line in the open coding stage. The transcripts and notes were read very carefully in order to find key words or phrases, and names or labels were given to them. Then a code card was constructed, and the labelled code was written in it. Once the same concept was identified in other case interviews, it would be

added to the earlier constructed code card, with the case number and page number being indicated. In addition, code notes were written in the right hand margin of the transcripts or notes, which recorded our comments and reflections. During the above stage of line-by-line or paragraph-by-paragraph data processing, a large amount of codes emerged. By applying the technique of constant comparison across case interviews, concepts with similar characteristics were grouped to develop categories and subcategories, which are “higher in level and more abstract than the concepts they represent” (Corbin and Strauss, 1990). Corresponding to the literature on the essential features of the policy for the elderly in Ghana in relation to current models of elderly care in other parts of the world. Axial coding is the process of establishing linkages among categories and subcategories (Strauss and Corbin, 1998). Technique of constant comparison was used in order to test the established relationships against data. Specifically, the linkages among concepts and the main categories were identified, and a new large category was formed, namely “interactions”. This macro category was further developed into three core codes: “intra-category interactions”, “cross-category interactions” and “network interactions”. It should be noted that, although axial coding differs from open coding in terms of purpose and procedure, these two stages are not necessarily sequential analytic steps (Strauss and Corbin, 1998). Specifically, in this study, open coding and axial coding sometimes happened contemporaneously.

In the final step, namely selective coding, the focal core code (or focal category) that is the central category for theory integration (Parker and Roffey, 1997) was selected, and other categories were linked to it. In this case, the core category was the macro category of “interactions” developed in the axial coding process. Surrounding it, other major codes were grouped into two broad conceptual categories: “conditions” and “consequences”. By linking those categories to the central category, a theoretical framework of the Ghana Model was developed and compared with the CARMEN model.

Analysis of Results

Does Ghana’ Elder Care Policy Has A Clear Vision

According to the CARMEN model the first requirement of an integrated elderly care management system is that there should be a clear vision. Experience and theory in the field of complex adaptive systems (Chapman, 2002) highlights the importance of a clear vision and direction of travel set by national policy. This is particularly important in integrated care, where a range of organisations and sectors-statutory, voluntary or non-governmental, private, independent, professional and community-need to work together to deliver integrated care, each with very different perspectives, agendas and values.

An analyst interview indicated that governments can play a crucial role in legitimising the creation of networks and collaborative and integrated working. Integrated care is a means to an end-the vision needs to clarify the goal and rationale. The desired outcome is to make sure that older people’s quality of life is maximised, and that they and their carers are properly listened to, have a say in the services they use, and are in control of their situation, in the setting of their choice. In order to achieve this goal, services need to be well co-ordinated, to address older people’s needs and aspirations and to work in ways that meet their complex, and often inter-related, needs (Banks et al, 1998).

As one of the directors of the Ministry of Employment and Social Welfare in Ghana appropriately explained:

“a pre-condition for integrated care is to have a full range of services available, across health, social

care, housing, transport, education, leisure and other sectors, and to ensure that they are accessible to local populations. Services need to be delivered across organisational boundaries, with clear access points and pathways, and with ways of assessing and guiding older people through them".

In essence, services need to work together as a single, comprehensive, integrated whole system: 'A whole system approach which places the older person at the centre will benefit older people by providing the right support, at the right time and by addressing the entire range of their needs' (Carrier, 2002).Integration thus takes place at the level of the individual, at service networks level and in the wider system of services for the local population (Edwards and Miller, 2003; Nies, 2004). Another respondent from a non-Governmental organisation (HelpAge Ghana) said that at the individual level, services must be tailored to support the older person's way of life, weaving together the support from professionals, carers and volunteers and providing full information to enable people to make decisions. At the organisational and networks level, collaboration and co-ordination takes place within and across teams and different service providers and organisations. At the strategic level, agencies and service organisations plan together for the needs of a whole population. Integration is important within sectors at each of these levels, as well as between sectors. Lack of integration within one sector may make it more difficult to integrate activities between sectors (van Raak et al, 2003).
So there is no one model of integrated care -particularly where 'integration' has a number of dimensions. Integration may be described along a spectrum ranging from tolerance to co-operation, joint ventures, partnerships and mergers. There will be horizontal and vertical forms of integration within and across different organisations and professional groups. The degree and type of integration will depend upon the outcome sought rather than any aspiration towards merger (Vaarama et al, 2001). Processes rather than structures will be all-important in achieving integrated care and clarity about where 'integration' is, or is not, an appropriate means to achieve better outcomes for older people. Based on the review of the national ageing policy and the interview responses, it is obvious that the respondents agree to the fact that Ghana's national policy for the aged has a strong and clear vision because it is adopted based on the experiences of developed countries such as Japan and the EU. In its vision and objectives for national policy for older people, the Ghana policy specifies that older people must be able to:

- *be able to live an active life and have influence over their everyday lives*
- *be able to grow old in security and retain their independence*
- *be treated with respect and*
- *have access to good healthcare and social services.*

Again the National Ageing policy in Ghana includes proposals for making sure that older people get proper care through better collaboration. A director interviewee from the Ministry of Gender, Children and Social Protection averred in her submission that Ghana's national ageing policy has a clear vision in that it advises local decision-makers to develop a general old-age strategy to improve the wellbeing and health of their older citizens in collaboration with all local and regional players. As part of this strategy, local authorities are advised to prepare local and regional action plans for developing and integrating social and health care services for older people (United Nations, 2002).

What are The Principles and Values of Ghana's Ageing Policy

Given the potential range of models and approaches to achieve the vision, a number of core principles will need to underpin policy on integrated care, and against which policy and innovations can be assessed. In models such as CARMEN which is the dominant model in the EU, it encourages, older people to be treated as individuals and are in control of the system, older people's views must be central, access to integrated care must be equitable and according to need and solutions to integrated care must be sustainable (Tester, 1996). Faced with this recommendation the respondents were asked to indicate based on their knowledge and experience whether older people are treated as individuals and are in control of Ghana National Ageing Policy. This is where one of the weaknesses of Ghana's policy comes to play.

Instead of Older people themselves being encouraged to participate in the strategy-making process, as well as in setting the goals and evaluating the results, the policy is more concentrated among civil and public servant most of whom are far from achieving elderly age (National Population Commission, 2004). An interviewee from the National Catholic Secretariat indicated his response that the National Ageing policy is not promoting integrated services that are person-centred and tailored to people's needs, where people have control over their own lives, where there is no age discrimination in accessing services and where active ageing is an underpinning philosophy (Obiri-Yeboah, 1991). Ghana's situation in this context is a sharp departure from those fellow Commonwealth member such as England where the National Service Framework for Older People in England sets out national evidence-based standards and service models which focus on rooting out age discrimination, providing person-centred care, promoting older people's health and independence and fitting services around people's needs. Further a director at the Ministry of Employment and Social Welfare was also agreed with the views that:

"*Through its own policy development process, the Ghana National ageing policy does not support and model the involvement of older people in planning developing, evaluating and using integrated services so that older people and their carers are always central to services*"

This acknowledgement by major stakeholders is contrary to what pertains in most European countries such as Sweden where there are pensioners' councils at national level and in the majority of municipalities and county councils. The councils act as advisory bodies and the pensioners' organisations (of which there are five nationwide) are represented on them (Odufuwa, 2006). Nearly half of all older people in Sweden belong to a pensioners' organisation. In essence even though Ghana is picking after those of developed countries it is yet to embrace all the good things of the elderly care policies in the West.

These weaknesses as far as the principles and values of Ghana's Ageing Policy notwithstanding, the policy shows a greater sign of improving equitable access to integrated care and according to need. Even this opportunity if constrained with weaknesses in terms of implementation (Tamsma, 2004). As a respondent from the Ministry of Gender, Children and Social Protection did indicate "*the national ageing policy of Ghana, gives ample support for fair and equitable access to integrated care so that older people and carers from the different socio-cultural groups, all segments of the population, and of all ages, including those with disabilities, can access appropriate integrated care".*

He posited that "*per the policy, the local service systems must offer an adequate mix of services*

that meet the various needs of older people from all communities, with suitable care pathways and co-ordinating processes. However these services are not well integrated in ways that offer streamlined and easier access to information and support for older people from all communities"
. This is also a departure from what pertains in the European countries such as Italy where in the Belluno province, Italy, more than 70 voluntary organisations are co-ordinated through a joint committee (*comitato d'intesa*), which acts as a unique reference point for activity relating to health and social care, and fights against the segregation of disadvantaged groups and socially excluded people, including older people. In its 27 years of activity, the committee has worked to develop co-operation and synergy between public, private and not-for-profit services, and to develop new service models. The committee manages the Voluntary Service Centre of Belluno-one of more than 50 such centres in Italy supporting the voluntary sector and meeting citizens' needs through a range of professional and voluntary services (Mba, 2010). At the heart of its work are providing advocacy, acting as an ombudsman to support the legal rights of individuals and voluntary organisations, and publicising and lobbying on the problems of citizens and organisations. In the case of Ghana eventhough HelpAge Ghana an offshoot of an international agency appears to be leading the way, their collaboration with other agencies appears to be limited (Karlberg, 2003, Ghana Statistical Service 2005). Even though the national policy itself states a list of institutions which must be empaneled and integrated for action including the family, churches, NGOs, Government Agencies, Para-statal institutions and other, the spinal cord that draws all of these actions together is very weak hence hardly noticed except the individual effort of each of them. Finally with respect to the principles of elderly care management, another area of interest which the respondents agreed to be a weakness in Ghana's current policy is the extent to which solutions to integrated care are sustainable.
In their responses and reviewing the current policy as it stands now, it is possible to agree that the national ageing policy is weak in terms of policy supporting sustainable change but rather advocates for short-term projects or developments, particularly through the provision of integrated funding systems and encouragement of whole system planning and networking. Again if Ghana is attempting to learn from the EU then it is still far from the reality because in the ideal Dutch case which the EU proposes, the Dutch government has sought to establish a better co-ordinated system of care to achieve tailor-made care in the community through an integrated funding system for home care and district nursing, as well as for care in residential and nursing homes (Paganin, 2003*).* The development of integral regional policies on care, housing and welfare and integrated assessment procedures for residential and community care to determine eligibility for long-term care All of these appear to be key missing link in Ghana's quest to promote and integrated elderly care management practices and policy towards the achievement of Ghana's Vision 2020

What is the Criteria for Operational Success of Ghana' Elder Care Policy

The next element of an integrated elderly care management used as benchmark in evaluating Ghana's elderly care policy is the Criteria for operational success. From the experience and evidence shared within CARMEN, a well-operating system of integrated care would offer flexible and innovative integrated services for older people, clarity about responsibilities and accountabilities and appropriately targeted integrated care (Nies et al, 1993). Policy on integrated care will also need to

assess how far it is assisting the delivery of these benefits. From the analysis of interview responses and the national ageing policy one can conclude that Ghana ageing policy is not in want in this respect.
A director at the ministry of employments and social welfare who was a respondent in this study indicated that the current policy has been designed to support the development of services that offer choice and control to older people and are flexible to meet individual needs (Nies, 2002). These services may include extra care, housing, outreach support and rehabilitation teams that are not building-based, direct payments for older people to buy in their own care, and assistive technology to enable people to stay in their own homes. The director indicated that this view was incorporated into the current national policy based on the experiences of Belgium. The Flemish Government in Belgium emphasises the concept of inclusive policy as a basic principle. Inclusive policy refers to a shift away from categorical ideas about living and caring and instead emphasises a tailor-made supply of integrated services where the personal choice of the older person is guaranteed. This does, however, include a responsibility of older people to make timely decisions about their future 'living career (Nies, 2004)'.
Another respondent also indicated that Ghana's national policy for the Aged is clear about the responsibilities and accountabilities where services are integrated, so that decisions are taken in a clear and appropriate way and there is proper accountability to service users, stakeholders and the wider community. The policy clear gives outlines the responsibilities of the state as against those of older people and those of family carers such that carers have rights to support in their caring role (Leichsenring, 2004). Another area which also comes up for discussion is appropriately targeted integrated care. Even though integration is not the solution to all problems, the Ghana national policy on the aged tries to support differentiated responses to complex and simple needs to ensure the most cost- effective and appropriate responses. An analyst on social policy indicated that that currently targeted responses are consistent with policy on equitable access and non-discrimination eventhough implementation appears to be constrained in one way or the other (Henwood and Waddington, 2002)..

Is Ghana' Elder Care Policy Coherent with other Policies

This section relates to joined-up policy-making. Given the current problems and barriers experienced in every country to achieve effective integrated care (Nies, 2004b), policy to support integrated care needs to ensure its coherence with policies in a number of areas, including coherent funding systems, promoting independence and wellbeing support to carers and integrating information. Asked whether Ghana's policy has a coherent funding system, most of the respondents gave a negative response. A respondent from an NGO did indicate in clearer terms that:
"*there is no element in the policy that talks about resource allocation and long-term care funding support for the integrated solutions*".
Another respondent also indicated that there are no well laid down measures to allocate lead management responsibilities, enable pooled funding and facilitate other joint arrangements overcome these barriers. This means that there is a strong deficit in terms of promoting independence and wellbeing (European Commission, 2003). Even though there is some measure to ensure that policies on pensions and benefits, employment and education support people to live well in later life and empower older people and their carers to access and co-ordinate their own services, where appropriate, these are not backed by appropriate and strong measures of implementation hence often leaving people wanting as to what is really due to them (Department of Health and

Children, 2001). A typical example is found in the response of an interviewee who said that

"If you visit the Pensions House you will see how Pensioners are treated before they get their own hard earned money"

If Ghana is to fully integrate its current policy of aged, then it must follow best practices in terms of policy supporting structural solidarity as it pertains in Belgium. Flanders, policy pays special attention to the concept of 'structural solidarity', which in essence concerns the integration of income, living and care (Department of Health, 2001). Financial and other mechanisms are to be developed to combine these three elements into one basic system of security. Even though Ghana's elderly care policy has a component that on prevention (to keep people well at home) and policy to promote health and wellbeing (to enable local populations to live well in their later years) these are not actively supported as major components of a well-functioning system of services and an integrated approach. Again a respondent from the Ministry of Gender, Children and Social Protection was spot on when he said that compared to the case in Sweden where Ghana has learnt a lot of its policy implication, there are still gaps in prevention policy (Brodsky et al, 2003).

One of the most important principles of Swedish policy for older people is that society's initiatives are to be framed in such a way that older people can continue living in their own homes for as long as possible, even when they are in need of extensive care and social services. An accessible society, good housing, transport services and home-help services are examples of important measures to realise that principle. In Sweden the National Action Plan on Policy for the Elderly, adopted in 1998, has laid the foundations of a wider perspective on policy work for older persons. It contains about 20 measures aimed at achieving the national objectives for policy for the elderly. Most of these measures are missing In Ghana's version of the policy (Banks et al, 1998).

According to the respondent from HelpAge Ghana (an NGO), the excuse of the state has always being the lack of funding for such a project but this excuse is gradually becoming untenable. This is because equally constrained countries are bringing up new measures to make their elderly care practices better, A typical example is the case of Greece which has been at the receiving end of the Euro debt crisis. In the Greek system of elderly care policy, there is a basic policy principle for older people which is to guarantee for the elderly decent living conditions, the fact they remain in their family environment as well as their support by means of specific programs so that they continue to be equal and active members of (our) society' (Banks, 2002)

In line with this policy, Open Care Centres for the Elderly (KAPI) have been financed by the Ministry of Health and Welfare and are being implemented by the municipalities. These centres offer psycho-social support, health education and prevention activities to older people, thus improving their wellbeing while they continue to live in their own personal and social environment. There are more than 320 KAPIs, staffed by teams of social workers, health visitors, occupational and physiotherapists and family assistants (Edwards and Miller, 2003).

With respect to the question as to how far housing policy allow for integration with health and social care services, Ghana's policy is completely silent and falls short of what the CARMEN model expects to be in a policy., Borrowing from the example in Ireland, one respondents said that a team from Ghana was commissioned to learn the policy of the Irish government and found a great deal of information that could help but these were not incorporated for lack of what the authorities will

later call the potential; burden that the policy will have on public demands. The team noted that the Irish government has adopted as national policy a new health strategy entitled 'Quality and Fairness'. This includes the objective of 'an integrated approach to meeting the needs of ageing and older people will be taken'. The Department of Health and Children, in conjunction with the Departments of the Environment, Social, Community and Family Affairs and Public Enterprise, have agreed as a priority to develop a co-ordinated action plan to meet the needs of older people (Department of Health and Children, 2001)

In the same regard the respondents on the issue about support to carers indicated that currently Ghana's elderly care policy has a provision to support carers coherent with policy on integrated care for older people, so that the vital role of family carers is recognised, However carers' own needs are not taken into account and carers are not automatically seen as a substitute for professional care. The policies currently support carers including employment policies that address the needs of staff who have caring responsibilities outside of their employment

A related area where there is additional deficit in Ghana's ageing policy is more related to integrating information. The national policy does policy not have any specific provisions for privacy and data protection support service integration and does not allow for integrated information and communication systems. All the respondents were unanimous in agreeing that Ghana policy on elderly care is limited in terms of active promotion and incentives. The analysts respondents indicated that:

"*In addition to setting the direction of change and clarifying the boundaries to work within, governments will need to provide incentives and actively promote integrated care by allocating sufficient resources, resourcing integration, awarding responsibilities to integrate services, introducing incentives and sanctions, supporting shared learning, setting standards for joint working and integrated approaches and providing support to carers*"

The directors of the Ministry of Employment and Social Welfare and Gender, Children and Social Protection agreed with the views of the analyst when it comes to deficit in resource allocation. Two of the directors explained that resource allocation is a key factor in ensuring a good balance of services and a well-functioning integrated system. While every country will be working within resource constraints, effective integration of services around the individual older person will depend on an adequate 'menu' of local services (Edwards and Miller, 2003). Lack of capacity in one sector is likely to cause problems in another. For example, poorly funded home care services may delay hospital discharges and lead to unnecessary admission of older people to residential care; poorly resourced primary and community care services may lead to unnecessary admissions to acute care. In the case of Ghana respondents agreed that there is very limited resources for integration and managing co-ordination available. There is limited consideration for making plans about costs of planning and promoting service networks, staff with responsibilities to co-ordinate services for older people, related IT and other infrastructure costs. Further there are also deficiencies in allocation of authority and responsibilities to different levels of government, organisations and individuals to implement integrated care? This may be through a range of measures-legal, regulatory, financial and advisory (Henwood and Waddington, 2002).

Ghana can learn best from countries in the Scandinavia such as Sweden. As far as 1992, the municipalities took over the collective responsibility for health care in special residences and in

outpatient activities from the regional level (but not doctor care). The responsibility for home care remained with the county councils, but the municipalities were given the right to offer the same medical care in the older person's own home and, if the county council agreed, to take over responsibility for home care (Karlberg, 2003). Today, approximately half the municipalities provide health care for older people living at home, and in the other half home care falls under the aegis of the county council's primary care organisation. The Swedish government is currently reviewing this organisation of health care and welfare for older people (Swedish Association of Local Authorities/Federation of Swedish County Councils, 2003)

Again Ghana can learn from the Netherlands in terms of measures to integrate home nursing and home care in the mid-1990s, the Netherlands government took measures to improve the integration of home nursing and home help. These services had been delivered by separate organisations, funded separately. From 1997, the entitlements to both services have been combined, and funding brought together into one framework (the public and universal national long-term care insurance, known as AWBZ). New organisations were admitted only if they were able to deliver the complete continuum of home care. This policy led to a number of mergers, integration of home care, and care better tailored to needs. However, it has meant that new competitive home care organisations that did not receive funding directly from AWBZ were allowed to have only a partial package of services (Tester, 1996)

Another area where lessons can be learnt by Ghana is in respect of promoting new integrated care providers as it happens in Spain. In Spain, the Catalan Adding Life to Years programme has promoted the development of care at an intermediate level between acute hospitals and nursing homes, introducing new providers that offered health and social care simultaneously. Socio-sanitary centres provide long-stay, convalescence and palliative care, while day hospitals provide a broad spectrum of services, and different multi-disciplinary teams support older people with complex needs. The programme is financed by the Catalonian Health Service and the Social Welfare Department. Private agencies are also involved, usually receiving funds from the regions. Sometimes these private agencies take responsibility for health and social care for the large health areas (Raak *et al,* 2003)

Introducing Incentives and Sanctions

When it comes to whether incentives and sanctions, the responses suggest that different levers and sanctions not been used to actively promote integrated care-for example, removing legal barriers to pooling budgets, awarding ring-fenced funding for integration, or cross-charging for delayed discharges. Even in the few cases where sanctions have been introduced to only one part of the system, there have been knock-on effects on other parts of the system which were unanticipated (Karlberg, 2003). For example, paying attention to delayed discharges from hospital also calls for action to prevent unnecessary admissions to acute care and development of a good mix of community services. Ghana can learn from England where a range of measures has been introduced to support partnership working (Henwood and Waddington, 2002). These include removing legal barriers to enable budgets to be pooled between health and social services making partnership working mandatory for the NHS and awarding funding for integrated services, specifically intermediate care. It also includes reimbursement scheme that levies charges on local authorities where there are delayed hospital discharges because of inadequate community services (Banks, 2002). *In Sweden there is* strong legislation to support collaboration which is missing in the Ghana system. In Sweden,

municipalities and county councils have expanded authority to work together based on local conditions in a joint political commission. A new law took effect from 2003 to allow extensive collaboration in the field of health care and welfare. The joint task of this commission is to provide access to both doctors and municipal efforts for the care and welfare of older people (Swedish Association of Local Authorities/Federation of Swedish County Councils, 2003) Ghana. Currently the system have no incentives for collaborative approaches to drive change in systems with a mix of public and private provision neither is there a mechanism to supporting shared learning. A Social Policy Analyst respondent in this study said that:

"National programs can play a key role in offering opportunities for shared learning and exchange of innovatory services and integrated approaches yet demonstrating the benefits of integrated care and sharing learning have not been a key part of promoting and achieving change"

In England Ghana can learn a better approach to supporting shared learning. In England, the Department of Health has set up and funded the Integrated Care Network, to support those wishing to integrate working between local authorities and the NHS. Resources include an interactive website, national meetings to share information, action learning sets to develop skills and knowledge and support to organizational development programs.

When it comes to Setting standards for integrated approaches, the analyzed responses suggest that both in policy and in practice Ghana, lacks designed standards set for joint working and evidence-based care pathways and guidelines to support the development of effective integrated processes. The Dutch have better example for Ghana to emulate because in the Netherlands, national multi-disciplinary guidelines for rehabilitation have been developed, based on experts' consensus and evidence-based practice. The guidelines include the organization of stroke care into care pathways or stroke units, a number of which have been established

On another hand Finland provides Ghana with more accurate way of promoting integrated care which is often limited in Ghana's policy and actual practice. In addition to its National Framework for High Quality Care of Older Persons (Ministry of Social Affairs and Health/Association of Local and Regional Authorities 2001), the Finnish Ministry of Social Affairs and Health has provided a set of performance indicators (Vaarama *et al* 2001) addressing integration, quality and outputs of care and guidebooks on quality improvement in multi-professional teams. The government has also earmarked some finances for local authorities to help implement its recommendations – particularly regarding staff ratios. The most significant effort to promote integrated care is through a major national project called the Macro Pilot, which involves the development and testing of seamless service chains for elderly care with the aid of information and communication technology (Raak *et al,* 2003)

Finally the responses also give an impression of a relatively weak policy of taking care of the elderly population in Ghana when it comes to providing support to carers. Proactive support to carers will be an important component of policy to ensure proper integration between formal and informal systems of care. Family carers, including spouses and partners of similar age, play a key role in integrating care for older people. Different strategies to address their needs, both as care givers and as individuals in their own right, can support the prevention of breakdown in the home and unnecessary admission of older people to acute health or residential care (Banks *et al* 1998). A director respondent from the Gender and Social Protection ministry could not have agreed more than to say that:

"*In our policy, carer support strategies do not address the well-researched needs of carers for proper recognition and assessment of their needs, information, quality services to give them peace of mind, a*

break from caring, emotional support, training to care, financial security and opportunities to have a voice in services".

It is important for Ghana to learn from England in this context. A National Strategy for Carers in England emphasises that all organisations involved in caring must now not only focus on the client, but must also include carers. The aim is to enable 'those who choose to care, and where care is wanted by another person, to do so without detriment to the carer's inclusion in society and to their health'. To support the strategy, special funding from government has been awarded to local authorities to provide additional breaks from caring (HM Government, 1999)

Again Ghana can learn from Finland hat has a long tradition of carer-support policy. Benefits to carers in Finland include home care allowance, support services and respite care. However, in response to evidence of an uneven distribution of benefits and scarce supply of services, the government has set up a committee to reform its policy to support carers. The new initiative aims to introduce the same eligibility criteria in all municipalities, three classes of payment to be paid according to the dependence of the person being supported, more multi-faceted respite care services, and additional services to support the carer's own health and wellbeing.

Finally Belgium also offers Ghana a great lesson in carer-support policy. The regional government in Flanders issues strategic policy advice emphasising five different aspects for supporting carers: A respondent was clear on this when he said that choosing to be a carer should be a freely taken choice.

- *To optimise the quality of care, the carer must be acknowledged and respected as the first and most important partner during the whole care trajectory.*
- *The carer must have access to emotional support to increase their strengths and capacities.*
- *A seamless home-care service system must be available when needed.*
- *Appropriate legal and funding mechanisms must be in place so as not to financially penalise carers.*

Evaluation and Monitoring

According to Zimmer and Dayton (2003) if policy is to support innovations within parameters set by core principles, it will also be important to specify core evaluation requirements. There is still much to be learned about integrated care and how the impact of whole-system approaches can best be evaluated and monitored. In that respect international exchange is important in order to learn from failures and success. The question as to whether the current national ageing policy in Ghana does policy specify core evaluation requirements was met with weak agreement by all the respondents., This suggest that it is one of the areas of the current policy than need substantial revision. The respondents indicated that the range of stakeholders and the variety of processes and structures involved in different forms of integrated care call for multi-faceted evaluation. A social analyst interview indicated that the following key areas have not been addressed:

- *The impact on the lives of older people and their carers?*
- *Changes in services and care outcomes?*
- *cost effectiveness of whole system approaches and integrated services?*
- *Changes in processes and protocols to improve the integration of services?*

Ghana has in Ireland and example of how they can involve older people in evaluation. In Ireland, the

Eastern Health Board (now Northern Area Health Board, East Coast Area Health Board, South Western Area Health Board) adopted a ten-year action plan aiming to co-ordinate existing services to provide 'the best and most comprehensive range of care for older people'. As a result of this plan, community area co-ordinators or managers of services for older people were created to cover the health board region, each catering for a population of 130,000, with approximately 13,000 over 65 years old. Each manager leads a multi-disciplinary team that works in partnership with voluntary organisations, older people, acute hospitals and psychiatric services. Services are delivered, planned and evaluated for local older people in co-operation with local older people (Eastern Health Board, 1999). According to the respondents it is important for resource inputs, service outputs and welfare outcomes need to be monitored.

Ghana has to learn from examples of high level performance indicators to demonstrate change-for instance, those that may relate to shifts away from residential care to care in people's own homes (for example, the proportion of total people aged over 75 receiving long- term intensive support who are receiving this at home), or indicators relating to delayed discharges from hospital. However, in Ghana feedback from people's individual experiences as they use services across the system, which is obtained on a regular and systematic basis, are not available to provide a more informative way of monitoring progress in integration. In general as observed by a respondent and existing literature, there are challenges to evaluate social care outcomes as against measuring health care effectiveness which focuses on baseline and post-intervention measurement.

These approaches are often less applicable to social care where there may be no equivalent baseline. 'Outcomes' may include both quality of life outcomes as well as intermediate or service process outcomes – ways in which services are delivered. Outcomes might be considered at the individual or aggregated level and comparisons made between different groups of users or different service models. In the analysis of the views of the respondents viz-a-viz, the extant literature and the models of elderly care being practiced in Europe, four different dimensions have been identified for defining social care outcomes: intermediate and final; short-term and long-term, subjective and objective, individual and aggregated. The dimensions are not polar opposites, but points on a continuum (Henwood and Waddington, 2002).

This brings to another weakness but which is a requirement in the new CARMEN Model for managing the care of the elderly. In Ghana older people and their carers are not involved in developing methodologies to evaluate outcomes because there are no evaluation mechanisms at all. Without this engagement, there is a danger of overlooking factors that are of particular importance to service users. There is an example Ghana can learn from the Netherlands where evaluation results lead to new policies. In the early 1990s, the Government in the Netherlands initiated a number of experiments to determine the feasibility of substituting community care for institutional care. These experiments were evaluated, including those on case management, cash payments for care and integrated planning, funding and delivery of services through network organisations. One outcome was the introduction of a new national policy on cash payments for care, implemented in 2003 (Tester, 1996)

Regulation and Inspection

The next issue of concern in evaluating the care of the elderly policy of a country is the degree of regulation and inspection. Ordinarily a good policy need to be coherence between any regulatory and

inspection systems for health, social care, housing and other services to prevent separate inspection processes that may duplicate one another, and to ensure integrated practices and service models are promoted. A respondent summarised the views of all the other respondents when she said that:
"Ghana's elderly care policy has no inspection and regulatory processes that hence these are not co-ordinated to avoid duplication and to support integrated care".
There is a better example that Ghana can learn from England with the National service framework review. In England, the Healthcare Commission, Audit Commission and Commission for Social Care Inspection are carrying out a review of the national service framework (NSF) for older people. The NSF for older people sets out the standards to improve the experiences of older people and their carers using health, social care and other services. Progress by NHS and social care organisations on implementing these standards will be assessed across England in the form of a wide-scale review. This will involve measuring progress against the NSF standards so that good practice is shared and action can be taken where necessary to further improve services.

Support to Implementing Policy
The last element of the CARMEN Model of elderly care management with which Ghana policy can be compared is support to implementation. Policy can set the direction for change but it needs to allow for experimentation, innovation and learning. Particularly in the absence of one model, various different methods and mechanisms can achieve integrated care. This is another area of Ghana's policy deficit which came to the fore from the interview and analysis of the policy. Ghana policy hardly provides support for innovation even though it does not obstruct change in itself. Indeed the fact that the policy has undergone series of review gives ample testimony of this fact.
However, this is not enough. On the contrary Ghana can learn from major countries in the EU as to how they are making things work for them and the current approach of the Dutch to supporting the implementation of the elderly policy can be a strong area that Ghana can learn few lessons to better the system. In the Netherlands, the improvement of stroke services has required the effective collaboration between all the players at national and local level. National government has supported the work of the National Heart Foundation to improve the prevention and treatment of strokes, and has established a research fund. Local networks of collaborating services – usually hospitals, nursing homes, rehabilitation centres, residential homes, home care organisations and GPs-have submitted proposals.
Evaluation of selected experimental regions has led to a 'breakthrough improvement' programme aimed at up to 30 regional stroke chains of various care providers. Work is progressing to develop benchmarks and performance indicators. Ghana current policies will benefits from such an endeavour because of the absence of a range of specific support been provided. Ghana's current policy is yet to introduce measures to support the infrastructure needed to empower older people and ensure their effective involvement. A director at the Department of Social Welfare was unequivocal in agreement with the deficit when he said that: "currently our policy does not support cultural change through exchange of good practices, dissemination of learning, involvement of older people, shared learning networks, encouragement of 'bottom-up' approaches and other developmental work. There is no space to allow time to introduce changes so necessary cultural shifts can take place. Another weakness which was confirmed in the analysis of the responses also shows that in Ghana there is deficit in policy of the elderly regarding workforce development to train people in new approaches.

For example, working in networks and partnerships as well as to introduce new integrated posts? This includes integrated education and training and promotion of integrated approaches by professional training institutes as well as encouraging secondment opportunities to work in partner agencies, job shadowing and exchanges. It will also include strategies for raising the status of staff working within services to older people and skilling those staff without any kind of recognised qualification.
Ghana’s current policy lacks a mechanism for leadership development to ensure senior and middle managers are equipped to reinforce the vision, lead by example, work across boundaries and focus on outcomes for older people and their carers. It also lack the mechanism for developing effective shared IT and information systems as part of the infrastructure to integrated care and developing technological solutions to support older people to remain in the setting of their own choice and under their control. Again as it pertains in other countries Ghana can enhance the current policy on the Aged by learning from Finland where technology solutions have been developed to support integrated services. In Finland, legislation has encouraged experiments with seamless service chains in social welfare and health care services and general social protection, and related services involving personal advisers, plans for service chains, electronic client’s cards and reference databases. One aim of the Act on Experiments with Seamless Service Chains in Social Welfare and Health Care Services and with a Social Security Card is to find new ways to optimise the use of information technology so that it answers the client’s needs regardless of which operating unit provides or implements the services. Considerable research funding has also been allocated to decrease the implementation threshold of health care applications software by developing more efficient and open standard solutions to improve their integration in practice (Government of Finland, 2000). Finally Ghana national policy is also weak in terms of having a research strategy been developed and supported to evaluate innovative approaches, develop evidence about best practice in integrated care and assess cost effectiveness of integrated solutions.

Conclusions and Recommendations

The 1992 Constitution makes it categorically clear in Article 37(6b) that the "State provides social assistance to the aged...to enable them to maintain a decent standard of living". However, there is no policy that protects the rights of the ageing currently. It is heart-warming to note that Ghana’s National Ageing Policy acknowledges that today’s generation owe it as a duty to honour and guarantee better living conditions for our older persons. Specifically the policy claims that:
“We need to recognize that the society in which we live today has been built thanks to the efforts and toil of previous generations some of whom live with us and defined as older persons. We must make the effort to provide them with efficient health care services and conducive living environment to ensure that they aged actively and with adequate security and recognizable dignity” (Ministry of Employment and Social Welfare, 2010)

It is also heart-warming to note that the Ghana National Policy on the Aged agrees to the fact that as a society Ghana has not been able to meet these challenges adequately and satisfactorily. This unsatisfactory performance is partly due to the unsatisfactory treatment given to older persons because of the negative perceptions about them including the strange images used to describe or ascribe to them. By so doing unpardonably, Ghanaians have sometimes failed to meet their needs even when they have had the capacity to exactly do that (Ministry of Employment and Social Welfare,

2010). With this concession it thought that any National Policy to be developed must be tough and resilient despite the social pressures that Ghana is faced with. It is often said that in the kingdom of the blind one eyed man is the king. There is an equivalent Hindi proverb which states, among the blind a squint-eyed is the king or probably, Gulliver in the land of the pygmies (Lilliputians). It means that if everyone else around you is worse than you at something, you have an advantage, even if you are not very good at the skill. The above proverb summarises the current state of the Ghana elderly care policy. In 2010, Mr Enoch Teye Mensah, the then Minister of Employment and Social Welfare in addressing the National Executive Council Meeting of the National Pensioners Association (SSNIT) in Accra, indicated that Cabinet has approved the National Ageing Policy and Action Plan to be captured in the 2011 fiscal year. He said the policy would serve as a co-ordinating machine to address issues facing the aged, including pensioners and Ghana was one of the few countries in Africa to have taken an initiative to provide a policy framework for managing the elderly in the society. However based on the evaluation of Ghana's elderly care policy with best practices in the world especially the EU's CARMEN model, it is evident that Ghana's current model even though provides what it calls "dignity for the elderly" is in need of substantial revision. Despite the weak economic base of Ghana, when it comes to elderly policy it should be above economic capabilities to developing strong institutional and policy framework. A typical example is the case of Bolivia. Despite its economic challenges, in October 2010, the Global AgeWatch Index issued a report on the quality of life of older people in 91 nations. The report included several factors such as income security, health and well-being, employment and education. African nations did not fare well. South Africa was the highest ranked African nation at number 65 while Ghana, Morocco, Nigeria, Malawi, Rwanda and Tanzania came in at numbers 69, 81, 85, 86, 87 and 90 respectively. Although South Africa rich as it is was ranked at number 65, Bolivia, one of the poorest countries on the list was ranked at number 46. This shows that higher-income does not always correlate with better quality of life for the elderly. In fact, some lower-income countries that invested in aging saw positive impacts. Bolivia, for instance, implemented a national plan on aging and free health care for older people, which vastly improved quality of life (Zimmer and Dayton, 2013). The rankings illustrate that limited resources need not be a barrier to countries providing for their older citizens, that a history of progressive social welfare policies makes a difference, and that it is never too soon to prepare for population aging. This is important for other African nations because the elderly are a significant boon. As African nations, we can do better by learning from each other as well as other non-African nations. Our collective goal is to improve the elderly's quality of life for present and future generations.

The bare facts as far as Ghana is concerned is that population ageing is a global issue and of global concern and Ghana's Population is ageing. The Ageing population has impact on many aspects of national life both economic and socio-economic and globally there is a call on countries to develop policies to manage the ageing population and the aged. Ghana has developed a national ageing policy by the Ministry of Employment and Social Welfare. Ghana's elderly care policy is well crafted and has integrated both domestic and national variables towards effective management of elderly in society. However, the elders are not involved in developing (Ham-Chande, et al, 2010). The elders are not involved in managing the policy, the elders are not involved in reviewing the policy, the elders are not aware of its content and what is due them, there is weak institutional and resource support to implementing the policy and there is no legally binding responsibility on governments to implement the policy. Further it has been noted that there is weak regulation and inspection of implementation

of policy and a weak evaluation and monitoring process of the policy. There is the need to urgently redesign our policy to accommodate the deficit. The Rational Model by Kato et al (2012) can help redesign the national policy. It must start from knowing the needs of the elderly from the elders themselves

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