Population ageing and formal support system available for the elderly in Ghana

Bismark Nantomah¹ and Prince Owusu Adoma²*

¹Nalerigu Senior High School, P. O. Box 20, Nalerigu-N/R, Ghana.
²Community Health Nurses’ Training College, Tanoso, P. O. Box 395, Tanoso-B/A, Ghana.

*Corresponding author. E-mail: nanawusu001@yahoo.com

Accepted 25 October, 2014

The challenges of social support systems for the aged are a growing concern in contemporary times due to the teeming proportion of aged population. The traditional family system which served as the main care-providing structure has now dwindled in its core values of providing support to the elderly. The main objective of the study was to assess the formal support systems available for the elderly in Yamoransa. The quantitative research approach and the cross-sectional survey design were employed. A sample size of 153 aged was used for the study. Simple random sampling technique was used to select the respondents. The primary data obtained was entered into a Statistical Product and Service Solutions (SPSS) Version 16 programme for analysis. The results show that the main form of formal support system available to the elderly in the study community is the National Health Insurance Scheme. Though, few of the elderly got support from the Social Security and National Insurance Trust, they indicated that the support was inadequate. The study therefore recommends that members of the family and community should strengthen the traditional family ties of interdependence instead of wholeheartedly embracing the foreign nuclear family system.

Key words: Population aging, formal support system, availability, elderly, Yamoransa, Mfantseman municipality.

INTRODUCTION

The proportion of the aged population has been increasing in all societies of the world (United Nations, 2009). This increase in the number of the aged (60 and older) population around the world is not only ascribable to reductions in fertility but also reductions in mortality which is as a result of improved nutrition, control of infectious and parasitic diseases, improvement in healthcare and public health education (Mba, 2010). In effect, global life expectancy at birth has increased from 46.6 years in 1950-1955 to 67.6 years in 2005-2010 and it is projected to increase by about 8 years to reach 75.5 years in 2045-2050 (United Nations, 2009). This increase in life expectancy correlates positively with the global aged population, for instance, since 1950 the proportion of older persons is on the increase, passing from 8% in 1950 to 11% in 2009, and is expected to reach 22% in 2050 (United Nations, 2009).

Aboderin (2008) argues that contrary to misconceptions, older people in Africa will on average live many years beyond age 60. This is evidenced in the life expectancy at age 60 in sub-Saharan Africa, where men and women have 15 years and 17 years life expectancy respectively, which does not differ markedly from that of other world regions (United Nations Population Division, 2006; Aboderin, 2008).

Although the change in percentage of the elderly population in sub-Saharan Africa from 2000 to 2015 is barely perceptible, the size of the elderly population is projected to increase by 50%, from 19.3 to 28.9 million (Kalasa, 2005). It has been observed that within the overall picture of aged population for sub-Saharan Africa, some clear sub-regional variations exist (Aboderin, 2008). For instance, for the period 2000-2030, the population of older people will be more than double in...
many countries including the Democratic Republic of Congo (2.1 to 4.9 million), Mozambique (0.8 to 2.1 million), Cameroon (0.8 to 1.6 million) and Ghana (1 to 2.8 million) (Kalasa, 2005).

Despite the increasing nature of the aged population, little attention is given by many African governments to providing public-funded social security schemes and this in effect has led to older people still relying on their family for support (Kasala, 2011). Nonetheless, in Ghana the perceived traditional safety net of the extended family has become ineffective and unreliable for the elderly (Tawiah, 2011: Apt, 2007; Apt, 1996). In some time in the past, old age support was a basic function of the family and the community at large but this type of responsibility has dwindled nearly everywhere (Bongaarts, 2004). The availability of formal support systems is therefore very important to the livelihoods of the elderly in Ghana. The attempt by the government of Ghana to initiate and implement a National Policy on Aging so as to address some of the challenges of the elderly have remained in its draft policy status since 1997 and have barely not been ratified by parliament (National Population Council, 2007). The main objective of this study is therefore, to assess the available formal support systems for the elderly in Yamoransa, Ghana.

**Contextual and conceptual issues**

Since independence of Ghana up to 2009, Ghana had undertaken four population censuses. The first population census was carried out in 1960 which reported a population size of 6.7 million. The second census was conducted in 1970 which reported a population size of 8.6 million with an inter-censal growth rate of 2.4%. The third population census was carried out in 1984 and reported 12.3 million population sizes. In 2000, the fourth census was conducted reporting of 18.9 million population size (Ghana Statistical Service, 2009).

The Ghana Demographic and Health Survey in 2008 established that there was a growth rate of 2.7% from 1984 to 2000 population censuses. Since independence, there has been a steady rise in population growth in the country (an example is, it increased from 6.7 million in 1960 to 18.9 million in 2000). The population also doubled from 6.7 million in 1960 to 12.3 million in 1984 (Ghana Statistical Service, 2009).

Though the population is increasing, the proportion of the population under age 15 years decreased from 47% in 1970 to 41% in 2000 (Ghana Statistical Service, 2009). In spite of the fact that Ghana is characteristic of a youthful population, reductions in fertility and mortality rates have resulted in an increase in both the number and proportion of persons aged 60 years and older (Mba, 2007; National Population Council, 2007). Table 1 shows the population trend and ageing in Ghana. Since the first population census in Ghana, the number of aged population increased from 325,178 representing 4.85% of the total population in 1960 to aged population of 1,366,408 making up 7.2% of the total population in 2000 (Ghana Statistical Service, 2009: Mba, 2010). This makes Ghana to have one of the highest proportion of persons aged 60 and older and will continue to be one of the countries with the largest aged (persons aged 60 and older) population of 8.8% by 2030 in sub-Saharan Africa (Kowal and Velkoff, 2007).

Living arrangements of the elderly population are normally considered as the basic indicator of the care and support provided by the family (Beales, 2000; Mohammad, 2010). In Sub-Saharan Africa, the pattern of family support available to the elderly is heavily dependent on their type of living arrangements (Unanka, 2002). Quite a number of research evidence has shown that in the developing world, the family is the key social support system for elderly persons, and their living arrangements are a fundamental determinant of their well-being (Knodel and De Bavalya, 1997; Mba, 2003, 2004, 2005, 2006; Mohammad, 2010).

Zimmer and Dayton (2003) indicate that although co-residence with an adult child is no doubt critical for support of older adults in sub-Saharan Africa, living with grandchildren is also likely to be an important living arrangement. Unlike the tradition in Western families, where parents in nuclear families raise their children, the tradition in Africa is to live with extended families. Zimmer and Dayton (2003) argue that the aged, much like the young, tend to require support for instrumental activities such as cooking and shopping, as well as material and psychological support to ensure their survival, particularly when they no longer work for pay and begin to suffer from ailments that limit their dexterity and ability to carry out tasks necessary for daily survival.

Mba (2007) in a study on gender disparities in living arrangements of older people in Ghana showed that

<table>
<thead>
<tr>
<th>Table 1. Percent of population aged 60 and older.</th>
</tr>
</thead>
<tbody>
<tr>
<td>-----------------------------------------------</td>
</tr>
<tr>
<td>Total population</td>
</tr>
<tr>
<td>Population age 60 and over</td>
</tr>
<tr>
<td>Percent of population age 60 and older (%)</td>
</tr>
</tbody>
</table>

Source: Ghana Statistical Service (2009) and Mba (2010).
among elderly women, almost 72% of them lived in extended households (that is, living with spouse, children, grandchildren, sons-in-law, daughters-in-law, distant relatives and non-relatives) as opposed to about 41% among older men. On the other hand, 37% of elderly men lived in a nuclear household (consisting of spouse and children), compared with about 8% of older women. Mba asserts that although in Ghana, extended household living is still prevalent, there are great variations in living arrangements by sex where more of elderly women live in extended households than their male counterparts.

There are some reasons that Mba (2007) advanced for these variations in living arrangements of the elderly by sex. One reason is that women tend to live longer than men in most populations and may therefore have more grandchildren and children-in-law with whom to live. Another possibility is that when a woman’s husband dies, she may need to join other extended family members for support. Moreover women are the natural choice of individuals due to child care.

There are few formal and quasi - formal support systems for the elderly in Ghana. The existing old age pension system which is the Social Security and National Insurance Trust (SSNIT) is a contributory old age pension scheme. It is therefore mandatory that formal sector employees contribute to the scheme so as to benefit whilst on retirement (SSNIT, 2009). Ghana did not have formal social security scheme until 1946 when the colonial government of the then Gold Coast introduced a non-contributory pension scheme (“CAP 30”) to cover senior civil servants (Tibuahson, 2003). The “CAP 30” was extended to cover certified teachers in 1955 but in 1960 a compulsory savings scheme was introduced to cover all formal sector workers (Boon, 2007). Many decrees were passed in the reformation of the Social Security Scheme from 1965 until 1991 when the Social Security Law (P.N.D.C.L. 247) was promulgated which called for the establishment of a Trustee (called SSNIT), with the responsibility to administer the state pension scheme (Tibuahson, 2003).

Boon (2007) elaborates that the SSNIT pension scheme provides three main benefits which include old age pension, invalidity pension and survivors’ lump sum benefit. In the category of old age pension, certain conditions prevail for potential beneficiaries. First, a member is entitled to full old age pension provided the member is at least 60 years and at least 55 years for females and second if he or she has made contribution for at least 240 months. Kumado and Gockel (2003) discovered that the minimum pension payable to a beneficiary is 50% of an average of his or her three (3) best years’ salary for a minimum contribution period of 240 months. Kumado and Gockel further revealed that for any additional month served after the 240 months, a worker earns a pension right of 1.5% for every 12 months in addition to the 50% start off.

According to the Social Security and National Insurance Trust (2009), SSNIT pension scheme has further been reformed into a 3-tier pension by a new law in 2008, Act 766:

1. A first tier mandatory basic national social security scheme which will incorporate an improved system of SSNIT benefits, mandatory for all employees in both the private and public sectors.
2. A second tier occupational (or work-based) pension scheme, mandatory for all employees but privately managed, and designed primarily to give contributors higher lump sum benefits than presently available under the “CAP 30” and SSNIT pension scheme.
3. A third tier voluntary provident fund and personal pension schemes, supported by tax benefit incentives to provide additional funds for workers who want to make voluntary contributions to enhance their pension benefits and also for workers in the informal sector.

One of the main features of Act 766 is that an employer is required to make a monthly contribution of thirteen percent (13%) of a worker’s salary whilst the worker makes a contribution of five and a half percent (5.5%) making a total of eighteen point five percent (18.5%) as mandatory contribution to the scheme (SSNIT, 2009). The act also reduced the minimum contribution from 240 months to 180 months. Despite these reforms, “CAP 30” has remained a non-contributory plan for the armed forces, the police, and the prisons service (Boon, 2007).

Regardless of the benefits of SSNIT to its contributors, the National Population Council (2007) highlights the following characteristic about pension schemes in Ghana:

(a) Older people recognize the importance of the pension schemes regarding their standards of living and that of their families.
(b) Poverty is still the older person’s trap because the schemes cover only a small percentage of the working population in Ghana.
(c) The amount offered to majority of pensioners is too meager to serve them adequately.
(d) There are a lot of bureaucracies associated with accessing the schemes on retirement and when increments are offered in the course of the year.
(e) Collecting pension from the banks is too burdensome to many older people in terms of distance and time spent in the banks.
(f) Pension is not adjusted regularly to meet the effects of inflation and therefore does not sustain the intended level of consumption of the elderly at the time of retirement.

In contrary to Botswana, Mauritius, and Namibia, it is clear that in Ghana much concern is not placed on how to incorporate the elderly who are not employees of the formal sector into the Social Security and National Insurance Trust. This is evident in the new national pension law of 2008 Act 766, which emphasizes on a
mandatory contribution by both employers and employees towards the end of service benefit of the employee.

The health of Ghanaians has also been one of the priority areas to succeeding governments (Ghana Statistical Service, 2009). Before Ghana attained independence from colonial rule, the colonial government financed the healthcare of civil servants through general taxation whilst non-civil servants received health care through the “cash-and-carry” system. This “cash-and-carry” system required that patients pay up-front for health services at government clinics and hospitals. After Ghana’s independence in 1957, healthcare was provided freely to all citizens who subscribed to public health facilities in the country. This free medical care system was not sustained because the country experienced economic crises in the 1970s and 1980s. In order to mitigate the effect of the economic challenges, in 1985 the government had to reintroduce the cost-recovery health delivery system known as the “cash-and-carry” system. Since 1985, Ghana has operated a cost-recovery health delivery system known as the “cash-and-carry” system which has resulted in many poor people unable to pay for their health services (Nketiah-Amponsah, 2009).

Mensah et al. (2010) describe that with the introduction of the cash-and-carry system in the 1980s, many patients of the Nkoranza St. Theresa’s Hospital, like many of their counterparts across the country, found it difficult to pay their hospital bills. The situation worsened to the point of undermining the sustainability of the hospital’s Poor and Sick Fund, created by the Catholic Diocese to assist those who could not pay for their health care at the hospital. They added that in 1989, the idea of establishing a health insurance scheme was discussed at a Catholic Church Hospitals Administrators’ meeting at Sunyani, the Brong Ahafo regional capital.

In order to respond to the health financing need of patients, a pilot health insurance scheme commenced at the St. Theresa’s Hospital in 1990/91, under the leadership of Dr. Ineke Bossman, the Nkoranza District Medical Officer of Health. In the later year thus 1992, the Nkoranza District Health Financing Scheme was officially launched, with financial support from MEMISA - a Dutch NGO. The success of the Nkoranza Scheme laid a sound foundation for the establishment of the West Gonja District Health Insurance Scheme in the Northern Region in 1995 and of several others across the country in subsequent years (Mensah et al., 2010).

In recent time, in an effort by the government to enable Ghanaians have access to universal, equitable and acceptable quality health care, the National Health Insurance Act (Act 650) was passed into law in 2003; however, the law became effective in 2005 (Nketiah-Amponsah, 2009; Witter and Garshong, 2009). It has been observed that before the introduction of the National Health Insurance Scheme (NHIS), the government of Ghana instituted exemption policy in 1998 to address the health needs of the elderly. By this policy, persons aged 70 years and older were exempted from paying for medical services at the public health facilities in the country (National Population Council, 2007).

This exemption policy for the elderly in 1998 did not cover certain types of diseases such as diabetes and hypertension among others. However, the introduction of the NHIS has brought a relief to the elderly because it incorporated all these diseases (National Population Council, 2007). Also, the extreme poor, children under 18 years whose parents are enrolled, indigenes, pensioners under the social security scheme, and pregnant women are exempted from paying the premium (Durairaj et al., 2010). The benefit package of NHIS for the elderly covers in-patient care; emergency and transfer services; and out-patient care at primary and secondary levels (National Population Council, 2007).

The National Health Insurance Scheme is cashless and the insured are not required to make any payment at the time of health-care delivery. Payments for referrals (under the gatekeeper system) up to teaching hospital are covered. However, HIV retroviral drugs, hormone and organ replacement therapy, heart and brain surgery other than the ones caused by accidents, diagnosis and treatment abroad, dialysis for chronic renal failure and cancers are excluded from the insurance package (Durairaj et al., 2010).

Another important system of support is the Livelihood Empowerment Against Poverty (LEAP). The idea of the LEAP social grants originated from the National Social Protection Strategy, which brought to light that there was a gap in existing government policies on social interventions. There was no formal social support scheme in Ghana which provided basic livelihood security to some of the most vulnerable groups such as the elderly, children, and the disabled. These vulnerable groups did not necessarily benefit from existing development interventions and needed extra support to meet even their basic needs, such as food, education and healthcare. Because of this, Ghana’s Ministry of Manpower, Youth and Employment (MMYE) launched the LEAP in March 2008 which was based on the Growth and Poverty Reduction Strategy II (GPRS II) of the country (Sultan and Schrofer, 2008).

The LEAP Design Mission (2007) points that the LEAP program provides conditional cash transfers to extremely poor households who have either no alternative means of meeting their subsistence needs or limited in productive capacity. Besides, the cash transfers to beneficiaries as opposed to in-kind grants give households the freedom to spend the money on their own priority needs. The beneficiaries are selected by using a combination of a ‘means test’ and other targeting criteria (Osei, 2010). Households with one eligible beneficiary receive GH¢8, those with two receive GH¢10, those with three receive GH¢12, and those with four or more beneficiaries get GH¢14 as monthly allowances through Ghana Postal
Company. However, as the situation of the households as well as of household members changes over time, households need to be reassessed after a certain time period to verify whether they still qualify for the scheme. This appraisal will allow many households to benefit from the grants (LEAP Design Mission, 2007).

A study by Amuzu et al. (2010) in Northern Ghana revealed that the LEAP program is helping households to meet many of their needs, including covering the costs of essential food items, school supplies and the national health insurance card. They also show that the cash transfers guarantee beneficiary households the opportunity to receive and repay loans from members of their families and friends. Despite this, the transfer amount is low and does not provide especially women with any significant financial independence or start-up capital for petty income generation projects (Amuzu et al., 2010).

One other major quasi-formal support system is Non-Governmental Organizations (NGOs). In Ghana, there are both international and local Non-Governmental Organizations (NGOs) which are concerned about the plight of older people and are making efforts in supporting them. Such NGOs include HelpAge International, HelpAge Ghana and Akrowa Aged-Life Foundation (AALF).

Beer (1994) establishes that in Ghana, HelpAge International began with a concern for older refugees and this has since remained high in their agenda. Besides its initial agenda, HelpAge International has in diverse ways through its agencies provided housing and accommodation for older people. In order to cement the need to care for the elderly, HelpAge Ghana was formed in 1987 by a group of concerned Ghanaian citizens who realized the growing problems of the aged and the need to support them. This local NGO got affiliated to HelpAge International in order to get more assistance to support the aged. HelpAge Ghana operates in ten sub-zones in Accra with each zone being responsible in bringing up the needs of the aged for discussion and action at the headquarters in Osu, Accra. HelpAge Ghana has continually been supportive to the aged by providing financial, material and moral support, either directly or by affiliated associations in Accra (Banga, 1993).

According to the Akrowa Aged-Life Foundation (AALF) (2011a), the AALF is a local non-governmental organization which was established by Collins-Woode, who is a Ghanaian musician and currently a trained social and health-care officer. He originally went to Denmark in connection with his music; however, besides his music industry, his understanding of the Danish health-care system for older people led him to establish Akrowa Aged-Life Foundation (AALF) in Ghana to support the elderly.

Akrowa Aged-Life Foundation (2011b) points that the organization supports over 400 vulnerable older people in six communities around Accra, the capital city of Ghana. This organization offers older adults home care assistance including the following:

1. Door to door medical assistance.
2. Cooking and light housekeeping.
3. Companionship and social activities.
4. Bathing, dressing and grooming assistance.
5. Transportation to doctor’s appointments.
6. Shopping from market, pharmacy, etc.
7. Assisting with walking and transfer from bed to wheelchair.

In addition, women accused as witches are supported in restoring their rights to dignity, recognition, self-esteem and social status which they are deprived of for reasons based on outmoded socio-cultural practices which expose them to various forms of isolation (AALF, 2011a). Currently, the organization is building a Social and Health-care College to train volunteers to take care of the elderly professionally and to create job openings for the uneducated and unemployed youth in this profession (AALF, 2011b).

In order to have a sound premise to better explain the variables pertaining to the study, the conceptual framework adopted was the hierarchical compensatory model of social care developed by Cantor in 1979, which was equally adopted by Asharaf (2007) in a study of perceived ageing and its bearing on informal care in Kerala, India. Figure 1 shows the hierarchical compensatory model of social care.

The focus of the study is on the principle of the hierarchical compensatory model of social care which provides a comprehensive illustration of the various support systems consisting of informal, quasi-formal and formal systems for the elderly. The family system forms the informal support system which provides the immediate support needs. The next support system for the elderly is the quasi-formal support system which embodies all forms of religious organizations. The third category of support system for the elderly is the formal system which comprises of governmental and non-governmental institutions. For the purpose of this study, the quasi-formal support system forms part of the formal support system.

**METHODOLOGY**

**Study area**

Yamoransa is located in the Mfantseman Municipality of the Central region of Ghana. The municipality covers an area of about 612 square kilometers with 168 settlements. About 50.2% of the municipality is rural and 49.8% is urban. The Mfantseman Municipality is located within latitudes 5°7’ to 5°20’ north of the Equator and longitudes 0°44’ to 1°11’ west of the Greenwich Meridian.
This municipality is bounded by many districts and an ocean; to the North by Ajumako Enyan Essiam District and Assin South District, to the West and Northwest by Abura-Asebu-Kwamankese District, to the East by Gomoa West District and to the south by the Atlantic Ocean (Mfantseman District Assembly, 2006). Figure 2 shows a map of Mfantseman municipality showing Yamoransa.
Cross-sectional survey design was used for this study. The study targeted all aged people (age 60 and older) in Yamoransa of the Mfantsiman Municipality in Central Region, Ghana. A recent study conducted by the Department of Population and Health of the University of Cape Coast (2010) in Yamoransa showed that the community had a population size of 5,283 with 407 aged population consisting of 171 and 236 males and females respectively. The age for pension in Ghana thus age sixty was used as the chronological marker for old age (National Population Council, 2007). The age categorization of the elderly included; the “Young old” (Age 60 to 69), the “Old old” (Age 70 to 79), and the “Oldest old” (Age 80 and older) (Giddens et al., 2005).

In order to get a sample size for the survey, the Fisher et al. (1998) formula for determining sample size was employed to get a sample size of 153. Probability sampling method was applied with specific emphasis on simple random sampling technique. The sample was obtained through the lottery method (Sarantakos, 2005).

Data for the study was collected from the aged through an interview schedule. Research assistants were carefully selected and trained to assist in the data collection which lasted for two weeks. The interviewer verbally presented structured questions to respondents and at the same time recorded their responses on the interview schedule. Interviewers made follow-ups to respondents who were not readily available to be interviewed.

Interview schedules that were returned from the field were examined for consistency in order to serve as a quality control measure. The data obtained was entered into Statistical Product and Service Solutions (SPSS) Version 16 software for analysis. Descriptive statistics such as frequencies, percentages, proportions, tables and figures were used to present the results.

RESULTS AND DISCUSSION

Socio-demographic characteristics of respondents

Table 2 shows percentage distribution of the background characteristics of respondents by sex. The sample of 153 elderly populations for the study was made up of about 42% males and about 58% females. Among the respondents, the young old (60-69) constituted 58% of males and about 48% of females; the old old (70-79) formed 35.9% of males and 42.7% of females, and the oldest old (80 and older) consisted of 6.3% males and 9.0% females. Females dominated after the young old age cohort, for instance, there were more females (42.7%) than males (35.9%) within the cohort of the old old. This result is in line with Apt (2007) assertion that the aging society is a female society because the life expectancy of women is greater than that of men.
The results in Table 2 show that more than 67% of the respondents have never had any formal education. About 21% of those who had acquired some level of education ended at the secondary school level. Besides, very few of the respondents (0.6%) had some form of tertiary education. This result is in line with Brown (1992) who found that majority (73.6%) of the elderly population in Ghana had not had any formal education.

More than 90% of the respondents were Christians, 4.6% were traditionalists and 3.9% were atheists. This supports the findings of the Ghana Statistical Service (2002) that nationally, Christianity is dominant, with over two-thirds (68.8%) of the population claiming affiliation with the Christian faith.

Table 2 further shows that about 66% of males and 33% of their female counterparts were married. Widowhood was disproportional among respondents with about 56% widows and about 24% widowers. This affirms the results of the Ghana Demographic and Health Survey in 2008 that women are more likely than men to be widowed (Ghana Statistical Service, 2009). One of the reasons that account for this is that whereas women tend to be without spouses in their older years due to divorce and widowhood, men tend to keep marrying younger and younger wives over the life course (Oppong, 2006).

### Living arrangements of the elderly

Table 3 presents information on the living arrangements of the elderly. About 12% of the respondents lived alone. This is more than the findings by Mba (2007) that about 11% of older adults in Ghana live alone. Also, Table 3 indicates that 23% of the elderly lived in nuclear households consisting of spouse only; spouse and children only; and children only. Table 3 reveals that more males (28.1%) than females (19.1%) lived in nuclear households. In the context of extended households, more than half of the elderly (61.4%) both sexes lived in extended households (spouse and grandchildren only; spouse, children, grandchildren, son and/or daughter-in-law; children, grandchildren, son and/or daughter-in-laws; distant relatives). This supports the Ghana Statistical Service (2002) findings that unlike the typical nuclear household which is characteristic of the developed countries, the household in Ghana is predominantly extended in structure despite the modernization of the traditional household composition.

Table 3 further shows that more females (62.9%) than males (59%) lived in extended households. This is consistent with Mba’s (2007) assertion that more females are likely to live in extended households than males. Mba further gave some reasons to buttress the variation in living arrangements of males and females. One of the reasons is that women outlive men and are likely to have more grandchildren and children-in-laws with whom to live. The second reason is that grandmothers rather than grandfathers are the natural choice for children due to their care for grandchildren.

### Support from the Social Security and National Insurance Trust

Table 4 presents pensioners by sex. Very few of the elderly (12.5% of males and 5.6% of females) benefitted from the Social Security and National Insurance Trust (SSNIT) pension. This reflects Ajomale (2007) assertion that in the African circumstances where the proportion of the population employed in the formal sector is very
small; the numbers of elderly who benefit from the social security scheme are very few.

To ascertain whether the SSNIT pension was adequate or not to the pensioners, a specific question was asked for pensioners to rate the SSNIT pension they received. More than two-thirds of the pensioners (92%) indicated that the SSNIT pension they received was inadequate (Figure 3). This supports the National Population Council (2007) of Ghana claim that the amount offered to majority of pensioners is too meager to serve them adequately. Also, it explains why extreme poverty and hunger are major challenges of the elderly across the world (HelpAge International, 2008a). Another reason could be that the elderly did not earn sufficient income to enable them accumulate sufficient savings or they might have underestimated their retirement consumption (Gerrarr, 1998).

Support from the National Health Insurance Scheme (NHIS)

Table 5 shows NHIS subscription of the respondents by sex. Overall, more than half of the respondents (52.3%) did not subscribe to the scheme. There were many reasons accounting for respondents’ low patronage of the NHIS program. Table 6 shows reasons why respondents did not subscribe to the NHIS programme. The most pressing reason was that they preferred cash payment at health facilities and pharmacy shops (41.2% of males and 60.9% of females).

In an effort to further identify subscribers with valid NHIS cards, the study found that out of the 73 elderly who subscribed to NHIS, about 78% (both sexes) possessed valid cards (Table 7). Among those with the valid NHIS cards, more females (79.1%) than males...
(76.7%) had valid cards.

**Comparison of support for the elderly from the SSNIT and the NHIS**

Figure 4 presents a comparison of respondents received support from the formal support systems. The findings show that the elderly received minimal support from formal support systems. This is evidenced in Figure 4, because very few of the elderly (8.5%) received SSNIT pension. However, more than one third of the elderly (47.7%) benefitted from the NHIS programme. Even though, about 48% of the elderly benefitted from the NHIS programme, Tawiah (2011) indicates that elderly people who are employed in agriculture and other informal activities may not have adequate financial resources to cater for their needs in old age let alone to pay for “high” annual health insurance premium.

**Religious organizations material support for the elderly**

Table 8 shows religious organization support received by sex of the elderly. Material support included foodstuff, money and clothing. The vast majority of the respondents (100% of males and 88.8% of females) did not get

---

**Table 7. Subscribers with valid National Health Insurance Scheme cards by sex.**

<table>
<thead>
<tr>
<th>Valid cards</th>
<th>Male (n = 30)</th>
<th>Female (n = 43)</th>
<th>Total (n = 73)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>76.7</td>
<td>79.1</td>
<td>78.1</td>
</tr>
<tr>
<td>No</td>
<td>23.3</td>
<td>20.9</td>
<td>21.9</td>
</tr>
<tr>
<td>Total</td>
<td>100.0</td>
<td>100.0</td>
<td>100.0</td>
</tr>
</tbody>
</table>

Source: Fieldwork, 2011.

**Figure 4. Comparison of support from formal support systems. Source: Fieldwork, 2011.**

**Table 8. Religious organizations support by sex.**

<table>
<thead>
<tr>
<th>Religious support</th>
<th>Male (n = 64)</th>
<th>Female (n = 89)</th>
<th>Total (n = 153)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>0.0</td>
<td>11.2</td>
<td>6.5</td>
</tr>
<tr>
<td>No</td>
<td>100.0</td>
<td>88.8</td>
<td>93.5</td>
</tr>
<tr>
<td>Total</td>
<td>100.0</td>
<td>100.0</td>
<td>100.0</td>
</tr>
</tbody>
</table>

Source: Fieldwork, 2011.
assistance from any religious organizations, implying that very few of the respondents (11.2%) particularly females had the opportunity to benefit from religious organizations. This is in line with Ajomale (2007) findings that few faith-based organizations such as the Catholic Church in Nigeria make some contributions of the service provision to older people.

Figure 5 further shows that the Methodist and Catholic religious bodies provided material support to the elderly. Majority of the support in the form of money and clothing (83.3%) was provided by the Methodist church. Half of the support in the form of food and money (50.0%) was also provided by the Catholic Church.

The need for Non-Governmental Organizations support for the elderly

Among the formal support systems, a specific question was posed on whether there was the need for some Non-Governmental Organizations (NGOs) to support the elderly. More than half of the respondents (85.9% of males and 66.3% of females) affirmed that there was really the need for NGOs to assist them (Table 9). The respondents gave some reasons in order to justify why they needed NGOs to assist them. Nearly half of the elderly (48.2%) indicated that the NGOs will provide their basic needs, about 33% of the respondents indicated that their families did not provide them with all their needs, and less than a quarter of the respondents (13.2%) indicated that they needed money to support their business (Table 10). The results in Table 10 support Cantor (1979) cited in Asharaf (2007) position in the hierarchical compensatory model of social care that the elderly substitute formal support for informal care if their support needs are not met at the level of the informal support system.

**Table 9.** Need for Non-Governmental Organizations’ support by sex.

<table>
<thead>
<tr>
<th>Need for NGO support</th>
<th>Male (n = 64)</th>
<th>Female (n = 89)</th>
<th>Total (n= 153)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>85.9</td>
<td>66.3</td>
<td>74.5</td>
</tr>
<tr>
<td>No</td>
<td>14.1</td>
<td>33.7</td>
<td>25.5</td>
</tr>
<tr>
<td>Total</td>
<td>100.0</td>
<td>100.0</td>
<td>100.0</td>
</tr>
</tbody>
</table>

Source: Fieldwork, 2011.

**Table 10.** Reasons for need of Non-Governmental Organizations’ support.

<table>
<thead>
<tr>
<th>Reason</th>
<th>(n = 114)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provide our basic needs</td>
<td>48.2</td>
</tr>
<tr>
<td>Need money to support our work</td>
<td>13.2</td>
</tr>
<tr>
<td>Family does not provide all our needs</td>
<td>32.5</td>
</tr>
<tr>
<td>Government does not help us</td>
<td>6.1</td>
</tr>
<tr>
<td>Total</td>
<td>100.0</td>
</tr>
</tbody>
</table>

Source: Fieldwork, 2011.
Conclusion and Recommendations

Very few of the elderly benefitted from the SSNIT and they clearly indicated that the SSNIT pension they received was woefully inadequate. Less than half of the respondents subscribed to the NHIS. Majority of the elderly did not also get assistance from any religious organization. Only very few of the respondents particularly females had the opportunity to benefit from the Methodist and Catholic churches.

Drawing from the above conclusions, the government should make it a priority by collaborating with corporate organizations so as to establish old age homes or centers in each region or possibly each district in Ghana to provide assistance to the elderly. Religious institutions should establish elderly welfare fund that will help provide support to the elderly.

REFERENCES

Cartographic Unit, Department of Geography and Regional Planning (2011). Map of Mfantseman municipality showing Yamoransa. University of Cape Coast (Unpublished).


