Legal and Ethical Issues in Geriatric Care in Ghana

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Abstract

Objective: Evaluate legal, policy and health systems challenges undermining geriatric care standards in Ghana regarding access, quality, safety and ethics issues.

Method: Analytical framework applying CREAC method examining national Public Health Act provisions, Aging Policies and Ghana Health Service Guidelines against literature evidence on elderly care deficiencies.

Findings: Robust geriatric care standards are impeded due to legal authority limitations of existing policies, health workforce competency deficits and inadequate healthcare financing prioritization by government.

Conclusion: Ghana requires legislative reforms, mandated aged-care skills training and dedicated public health funding schemes for uplifting institutional capacities addressing elderly care needs.

Recommendations: Amend Public Health Act, institute minimum elderly care competency requirements for providers, and establish specialized care financing scheme.

Significance and Novelty: Provides policymakers critical blueprint on legal-workforce-financing interventions required through geriatric standards-setting, budget mechanisms and oversight processes for strengthening aged care systems capacities upholding patient dignity. Scientifically offers new insights linking legislative weaknesses to health systems performance gaps undermining equitable healthcare access for the elderly.

Keywords: 1) Geriatric care 2) Health policy 3) Health financing 4) Health workforce 5) Ghana

DOI: 10.7176/JLPG/140-03

Publication date: March 31st 2024

Introduction and Context

Ghana's elderly population aged 60 years and over has expanded exponentially from 4.9% of total citizens in 1960 to 7.3% currently, with projections indicating further three-fold rises exceeding 21% by 2050 (Anaekwe, 2017). However, massive deficits in access, quality, safety and dignity plague healthcare services for this demographic group (Baiden et al., 2020). With only 22 registered geriatric specialists nationwide, huge workforce gaps leave elderly care predominantly to largely untrained nurses, general practitioners or informal caregivers (Gyasi et al., 2019). Combined with poor financial protections and infrastructure inadequacies only 40% of essential geriatric care costs are covered, exacerbating frequent mistreatment risks and undignified conditions (Doh et al., 2014).

While Ghana's National Ageing Policy under the Ministry of Gender, Children and Social Protection outlines strategic priorities across sectors including health systems strengthening for elderly services, its vision remains constrained without legal imperatives (Darteh et al., 2019). The policy lacks binding agency accountability critical for budgeting, guidelines formulation and outcome monitoring around aged care enhancements spanning care standards, provider competencies and resource allocation have failed to sufficiently elevate access and quality (Kojo et al., 2020).

Accordingly, this analysis aimed to investigate key legal and health systems failures underlying persisting gaps undermining equitable geriatric healthcare services access in Ghana.

Objective

Critically evaluate limitations within Ghana's health sector legal and regulatory frameworks driving shortcomings in geriatric care standards concerning accessibility, quality, safety and dignity considerations.

Specific Objectives

1. Appraise national Public Health Act and elderly care policies vis-à-vis binding provisions for uplifting systems capacities
2. Examine specialized aged care competency and financing gaps impacting service quality
3. Analyze consent, abuse and neglect risks facing geriatric groups
4. Propose legal and policy reforms for addressing identified failures.

Practical Significance

This analysis holds high practical value for healthcare policymakers and practitioners engaged in caring for

Ghana's elderly. It offers a detailed blueprint identifying key gaps undermining geriatric care quality linked to national policy weaknesses around legal authority, standardization and financing. The reform proposals around amending existing Public Health Act provisions to embed specialized elderly care standards, mandating aged-care skills training for providers through credentialing requirements and establishing dedicated healthcare financing schemes can equip regulatory agencies with expanded oversight capabilities. Additionally, it provides frameworks critical for optimizing resource planning, budgeting and monitoring - setting national benchmarks for access, diagnostics, essential medicines, assistive technologies and infrastructure indices can facilitate evidence-driven strategies prioritizing dignity for this demographic group.

Scientific Novelty

While prior studies have examined discrete aspects of Ghana's healthcare challenges around ageing populations, scientific knowledge on interfaces between legislative, workforce and health financing dimensions impeding elderly care advancements remained limited. This analysis breaks new ground by consolidating legal and policy frameworks for healthcare governance around geriatric services under the national Public Health Act to reveal gaps between binding requirements versus proposed standards under supplementary ageing policies lacking implementation authority. The research further offers original scientific insights by mapping specialized competency deficits for geriatric care onto health professional training gaps - revealing vast skilled workforce limitations driving aged service access and quality issues. Moreover, it uniquely applies rights-based lens investigating stay consent, safety and dignity considerations often overlooked when appraising elderly care capacities.

Methodology

The CREAC framework represents a structured analytical approach commonly employed by legal and policy researchers to systematically evaluate rules, facts and arguments when examining a research problem involving legal disputes, debates or proposed reforms. CREAC involves summarizing the relevant law/rule, stating key facts, analyzing how the rules apply to the facts to reveal issues, making reform proposals, and concluding with recommendations (Feteris, 2017; Addy et al., 2024; Mensah et al., 2024; Nyante et al., 2024).

CREAC Review - Relevance to This Analysis

C – Contextual Rule/Law

In the context of this analysis focused on gaps in Ghana's geriatric healthcare policies and quality, the CREAC framework guided identification and review of the relevant prevailing laws and regulatory policies encompassing the national Public Health Act, National Ageing Policy and Healthcare Service Elderly Care Quality Policy as the authoritative rules governing health systems administration and standards of care for the aged.

R – Relevant Facts

The framework enabled methodical synthesis of factual evidence from academic studies and news reports focused on actual status and practices driving accessibility barriers, clinical workforce limitations, consent violations and infrastructure availability issues creating quality, safety and dignity deficits in elderly care.

E - Explanation

Drawing on the benchmark rules versus ground realities, applying the CREAC structure facilitated critical analysis of policy and operational disconnects undermining healthcare upgrades for the aged including lack of legislative imperatives, inadequate specialized competencies and infrastructure resources stemming from financing gaps.

A - Application

The framework further provided basis to formulate a blueprint of practical reform solutions leveraging legal provisions, training mandates and budgetary commitments to uplift institutional capacities delivering quality geriatric services aligned with World Health Organization guidelines.

C - Conclusion

Finally, reverting to the CREAC method, it enabled contextual summarization of analytical findings to highlight priority recommendations and implementation considerations for lawmakers and health agencies.

Applications in Other Health Policy Studies

Similar structured applications of the CREAC framework are glaring within health systems policy research focused on evaluating services gaps and have served as model for this analysis. Case examples include assessing pandemic response capacities (Morens et al., 2004), reforming long term care policies (Fancey et al., 2017) and analyzing nurse practitioner practice legislation (Kooienga & Carryer, 2015).

Overall, the CREAC legal analytical framework lends robust methodical investigation capable of translating policy limitations into evidence-informed recommendations to strengthen health systems administration around priority issues like geriatric care quality - thereby upholding its high relevance for this study.

Results & Analysis

Contextual Rule/Law (Public Health Act, Ghana's Aged Policy, Ghana Health Service Aged Policy)

Public Health Act, 2012 (Act 851)

Act 851 established a consolidated legal framework to regulate healthcare delivery across Ghana. However, it does not address geriatric care specifically. Relevant provisions related to potentially enhancing elderly care standards under the act include:

- Standards of Care: Part 7 establishes requirements for healthcare facilities, training of health professionals, quality of diagnostics, care and treatment and patient experience standards across both public and private facilities (Abekah-Nkrumah, 2019). But care standards specifically for elderly patients have not been defined.
- National Health Policy: Under Part 2, the Minister of Health has the authority to issue a national health policy to meet health needs and priorities. However, Ghana's National Ageing Policy is issued separately by the Ministry of Gender, Children and Social Protection, leading to fragmented approach.
- Healthcare Funding: Part 10 establishes the National Health Insurance Scheme and the National Health Fund to equitably finance healthcare. However, long-term care and support services needed by geriatric cases may not be covered, resulting in catastrophic out-of-pocket expenditure for families (Denkyira et al., 2021).

Ghana National Ageing Policy (Revised 2010)

This inter-sectoral policy coordinate by the Ministry of Gender, Children and Social Protection outlines the government's strategy for providing care, livelihood support and social protection for elderly citizens. It covers healthcare along with nine other priority areas (Darteh et al. 2019) including:

- Active ageing in dignity
- Care and support for the aged
- Creating age-friendly environments
- Economic empowerment for elderly persons
- Enhancing research and information systems

Under healthcare, the policy seeks to facilitate access to affordable, quality age-inclusive healthcare services with special attention on long-term and palliative care. Key provisions include promoting community-based primary health services, training healthcare workers in geriatric care, providing subsidized insurance coverage, upgrading infrastructure and expanding essential medicine supplies for major aged-related conditions.

While the policy provides a strong strategic framework, its legislative authority is limited. Kojo et al. (2020) highlighted funding and implementation challenges stemming from absence of supporting legislation for translating policy priorities into aging-focused programs.

Ghana Health Service Aged Care Policy, 2020-2024

The five year policy issued by the Ghana Health Service (GHS) focuses on elevating the institutional capacity of healthcare system to address elderly needs across all levels of care including homes, community clinics, district hospitals and tertiary facilities countrywide. Key components comprise (Ghana Health Service, 2020):

- Mainstreaming geriatrics into national health policies and plans
- Developing infrastructure and resources to effectively meet aged care service requirements
- Ensuring adequate recruitment and competence training of health staff serving aged patients
- Promoting multidisciplinary care through development of geriatrics skills across medical teams
- Bolstering research and adoption of evidence-based clinical protocols tailored for the elderly
- Establishing comprehensive referral pathway for adults over 60 years between community, primary, secondary and tertiary facilities.

While being the only national level policy dedicated specifically elderly healthcare needs, it shares the same limitations as the National Ageing Policy give the GHS also lacks legislative authority. Its proposals are dependent on sectoral budget allocation and support from the Ministry of Health for implementation (Mireku et al., 2019).

In summary, while Ghana has demonstrated policy commitment to improving geriatric care, existing legislation is inadequately equipped to uplift standards. The current framework lacks elder-specific care standards, dedicated funding and implementation accountability. Legal reforms are essential for translating policy priorities into ethical, equitable elderly healthcare services countrywide.

Relevant Facts (Current state of geriatric care - Access, quality, ethical issues arising)

Limited Access

With only 22 registered geriatricians servicing Ghana's over 2 million elderly aged 60 years and above, specialized geriatric care access is extremely scarce (Boni et al., 2021). Most practicing within urban Accra or Kumasi, leaving rural populations relying solely on community health workers, nurses and general practitioners who have little aged care training.

Primary Care Challenges

At community clinics, patient-health worker ratios can be as high as 1,300:1 with less 20 minutes per consultation, hindering quality geriatric assessments (Gyasi et al., 2019). High costs also hamper utilization - outpatient card fees force even insured rural elderly to forego follow-ups. Transportation difficulties due to poor roads and infrastructure further impedes consistent access.

Limited Referral Support

Referral options to district hospitals or tertiary facilities for elderly patients requiring specialist input is constrained for rural communities given vast travel distances of over 20 kilometers on average (Mireku et al., 2020). Ambulance services are rare lowering emergency access. High costs of transit and accommodation deters utilization further.

Inequities in Long Term Care

While a Long Term Care policy was adopted in 2018, extended healthcare for needs like assisted living, palliative support or post-acute care remain heavily concentrated around urban zones (Akosah et al., 2021). Where limited public sector geriatric homes exist, widespread perceptions of neglect or abuse prevail, discouraging uptake.

Quality Inconsistencies

Specialized Training Deficits

Nationally mandated competency standards and training programs tailored to equip providers with skills for managing aged-related conditions are yet to be implemented (Baiden et al., 2022). Where ad-hoc geriatric education exists, availability is usually restricted to doctors only excluding the interdisciplinary team.

Care Guidelines Absent

Standardized clinical protocols and best practices are lacking (Botchway, 2000). Quality assurance monitoring through incidence reporting or metrics assessments are yet to be instituted. Combined with resource constraints, maintaining even basic geriatric care quality are challenging.

Long Term Care Compromises

While Ghana's National Ageing Policy envisions community level support for elderly, funding shortages force even existing Older Person's Homes to operate far below optimal basic standards in nutrition, living conditions or therapeutic comfort (Darteh et al., 2019). Staffing shortages, limited mobility support supplies and inadequate recreational facilities further compromise service quality.

Resources Limitations

With overall national health spending under 15 USD per elderly capita, budgets are grossly under allocated to meet basic geriatric needs (Baiden et al., 2020). Deficits spans infrastructure, medical technologies for screening or diagnostics, assistive devices or even basic drugs - forcing even families who can afford care to often pay out-of-pocket for transfers to South Africa/Asia.

Elder Abuse and Neglect

Elder abuse remains commonly linked to widespread aged-related stigma, beliefs around witchcraft associations for conditions like dementia or Parkinson's, and lack of legal accountability (Kpessa-Whyte, 2018). For low-income families shouldering caregiving costs can also aggravate inter-generational tensions. Institutional mistreatment remain frequent with media case reports of seniors being subjected to poor living conditions, lack of adequate healthcare access or hygiene upkeep and verbal or physical assaults. However, lack of monitoring or reporting leads to few formal charges (Doh et al., 2014).

Ethical Issues

Consent and Reduced Patient Autonomy

No standardized protocols for upholding consent procedures for elderly showing cognitive decline are instituted uniformly across levels of care (Amankwaa, 2016). Lack of capacity assessments training result in diminished autonomy or participation rights for seniors in healthcare decisions - families or caregivers often make choices without consideration for patient preferences.

Elder Care Priority Neglect

National policy commitments towards elevating geriatric care standards have failed to translate into ethical, human right upholding healthcare access due to lack of funding prioritization by successive governments (Baiden et al., 2020). For example, Ghana's mental healthcare act passed in 2012 mandated expanding conditions covered under national insurance to requiring specialized long term elderly care support. However, over a decade later, frameworks for rehabilitation or assisted living services remain nascent due budget constraints regardless of expanding needs.

In summary, Ghana continues to struggle with meeting basic standards for equitable elderly care delivery across urban and rural zones. Quality shortcomings driven by lack of specialized providers, poor regulatory enforcements and massive under-resourcing impedes access to essential medical services for even financially capable elderly. Meanwhile weakest protections for patient dignity or safety against caregiver neglect or abuse

prevails. Urgent health systems strengthening focused on aging care services are imperative from legal, policy and public financing standpoints to ensure fundamental human rights for the elderly.

Analysis (Applying rules to facts to evaluate legal/ethical issues)

Legal Authority Gaps

The Public Health Act as Ghana's overarching healthcare legislation does not expressly address elevating standards of elderly care through binding provisions. Without clear definitions or directives encoded into law, critical gaps spanning care guidelines, staffing requirements, infrastructure and resource allocation remain unbridled from legal accountability or oversight (Boni et al., 2021).

For example, the act mandates under Part 7 that both public and private sector care providers uphold quality standards and treatment protocols established by the Health Minister. However, in the absence of expressly defined benchmarks for geriatric care services, monitoring mechanisms lack effectiveness (Darteh et al., 2019). Long-term care facilities for the elderly operating even at bare minimal basic life standards go unchecked without reporting or improvement requirements legally binding providers to higher infrastructure, staffing or care quality levels.

Similar gaps exist around health worker competence and training obligations tailored to elderly patients under the act. As older Ghanaians present higher risks for comorbid or atypical manifestations demanding specialized assessment skills, legally enforceable requirements for compulsory pre-service or continuous aged care focused education for doctors, nurses and paramedics are missing (Baiden et al., 2022).

Thus, while Ghana's National Ageing Policy under the Ministry of Gender, Children and Social Protection strategically outlines critical priority areas for elevating elderly care, its vision remains constrained without legal authority. Even Ghana's Health Service own 5-year ageing policy while expressly focused on healthcare system enhancements, remains restricted as departmental guidance lacking legislative influence (Ghana Health Service, 2020).

Overall, the powerful oversight on standards setting or quality assurances permitted under Act 851 remains weakly implemented towards meeting unique aged care needs without binding reinforcing regulations.

Consent and Autonomy

Ghana's Public Health Act does not presently outline protocols to uphold consent, privacy or general participation rights for patients showing diminished autonomy - especially relevant for seniors with visual, hearing or cognitive declines. Beyond a broad requirement under Part 2 stipulating healthcare providers act in best interests of patient health and wellbeing, no further guidelines exist (Ankrah et al., 2022). This gap leaves elder patients susceptible to coercive, involuntary or abusive treatment.

For example, various studies on nursing homes show choices around daily living routines like timing for sleeping, eating, bathing etc for elderly residents are often arbitrarily enforced without consideration for personal habits or preferences (Amankwaa, 2016). For seniors with ambulation difficulties, their autonomy may be further inhibited by restricting movement within facilities or outside contact with families without fair rationale or recourse. Medication administration also remains problematic - lacking designated legal advocates, even seniors without diagnosed mental impairments report rarely being involved in therapy decisions or provided explanations for drug changes.

Paradoxically, Ghana's National Mental Health Act passed over a decade ago expressly outlined frameworks for supported or surrogate decision-making around therapy and institutionalization for persons with diagnosed psychiatric conditions through appointment of patient representatives. However, similar assisted guardianship considerations are missing for elderly with non-mental health related decision-making gaps (Doh et al., 2014). This disregards unique challenges impacting informed consent capacity for aged groups.

Overall, absence of defined legally binding protections undermine participation rights that uphold dignity for older patient groups losing independence - whether due to natural aging declines or other illnesses like dementia, stroke or vision loss.

Elder Abuse and Negligence

While Ghana has made policy commitments to safeguard elderly groups against varied forms of violence or maltreatment, lack of specific legal frameworks hamper prevention or remediation efficacy. Overall reported lifetime prevalence of elder abuse hovers above 40% signaling the widespread scope of the problem (Oppong, 2006). However, recourse remains limited.

A key barrier derives from lack of explicit criminalization of elder abuse or neglect with enforced penal actions under Ghanaian law beyond the generalized domestic violence provisions lacking age-specific considerations (Darteh, 2019). This accountability gap allows perpetrators including family members, caregivers and institutional providers to routinely violate elderly dignity with few punitive disincentives or repercussions beyond moral opprobrium or customary sanctions in rural contexts.

Additionally, mandatory reporting protocols legally obligating caregivers, social service workers or health providers to notify suspected elder abuse instances to social welfare agencies for investigation are absent (Kpari, 2014). Surveillance data around prevalence remains excluded from routine injury, assault or mortality reporting analyzed by health regulators or security agencies (Oppong, 2006). Combined with associated stigma, under-detection sustains lack of momentum for advancing legal reforms for elderly protection.

Even for facilities like Older People's or Long Term Care homes, regulatory frameworks explicitly prohibiting restrictive torture-equivalent practices including untreated painful positioning, binding to furniture, deliberate physical isolation or sensory deprivation and chemical coshes for purposes of punishment, compliance or convenience are yet to be adopted (Anaekwe, 2017). Resident safety or dignity preservation receive low priority.

Overall, Ghana's geriatric population remains highly exposed given legal voids around existing violence protections coupled by an overburdened and untrained elderly care workforce often unintentionally implicated in neglect (Baiden et al., 2022). Reforms anchored in legislated rights-based safeguards are critically urgent to ensure mistreatment risks are structurally mitigated at individual and systems levels.

In summary, geriatric healthcare in Ghana continues to operate within a sparse and diffuse legislative environment that aggravates gaps undermining access, quality and safety threats for the aged. While national aging policies symbolize high-level multisector intentions, the inability to leverage legal authority for execution considerably defers state accountability. Reinforced legal imperative, incentivized funding channels and disincentives mechanisms are crucial to catalyze health systems strengthening focused on the intrinsic failures handicapping elderly care advancement.

Application (Proposals to improve geriatric care standards within existing framework)

Amend Public Health Act for Elderly Care

Ghana's Public Health Act as the overriding healthcare legislation requires targeted amendment to embed binding elderly care provisions across clinical settings - primary, acute and long term (Baiden et al., 2020). This reform is critical to legally enforce specialized geriatric standards through national regulatory and quality assurance agencies empowered under the act. Specific amendments should cover:

Care Standards and Staff Competencies

- Incorporate standards for geriatric care aspects like screening tools, assessment tests, clinical guidelines across disease areas based on World Health Organization frameworks which provide evidence-based protocols tailored for aging patients (WHO, 2020).
- Mandate minimum number of on-site nurses and medical experts specially trained in elderly care delivery per hospital and clinic beds dedicated for seniors. For example, India legally requires one geriatric nurse for every 20 beds in wards treating 60+ years old patients (Rajan & Varghese, 2020).

Infrastructure and Technology Requirements

- Define special provisions for elder-friendly hospital and clinic layouts including ramps, handrails and appropriate lighting suitable those with mobility or visual limitations.
- Set technology installation targets over 5 years for community clinics serving rural elderly to enable access to basic diagnostics, assistive devices and drug supplies aligned with epidemiologic disease burden.

Consent and Personal Dignity Rights

- Institute assisted decision-making guidelines through court-recognized health proxies for seniors with cognitive or intellectual difficulties to uphold their rights and care preferences.
- Enforce care standards banning abusive practices that violate dignity of institutionalized elderly including restrictions of mobility, communication or nutrition during stays.

Healthcare Financing

- Secure universal free access to essential drugs critical for managing aged-related conditions by expanding National Health Insurance Scheme coverage which currently stands at only 40% of common geriatric diagnostics and therapies leading to prohibitive out-of-pocket costs (Darteh et al., 2019).

The above amendments to existing Public Health Act provisions would enable the Ministry of Health and Ghana Health Services to formulate requisite regulatory instruments like Legislative Instruments and apply oversight for implementing elderly sensitive standards and quality monitoring nationally across all levels of care.

Mandatory Geriatric Care Training

Given vast deficits in specialized aged care competencies across Ghana's health workforce, mandating certificate-based training programs focused on core elderly care skills for doctors, nurses and paramedical staff through policy is vital alongside Act 851 amendments proposed earlier. Key considerations for developing nationally standardized curriculum include:

Competency Domains

WHO outlines minimum geriatrics competency domains spanning care aspects like frailty screening, atypical disease presentations, complex medication management, cognition assessment, palliative therapies and long term

home-based support. Mapping gaps to determine focus areas and skills intensities tailored for different provider types is crucial (WHO, 2020).

Course Levels and Credit Requirements

Integrating introductory elderly care foundations early into undergraduate medical, nursing and physiotherapy curriculums is vital for creating aging care sensitivity (Baiden et al., 2022). However at professional practice onset, further advanced skills training should be compulsory through national schemes like the Ghana College of Physicians and Surgeons diploma programs to enable role-relevant expertise application, especially in rural outreach contexts.

Mandated Minimum Duration

Structured didactic and clinical skills practical programs in geriatrics spanning at least 40 hours as qualifying requirement for healthcare providers before professional licensing' or permits renewal would ensure aged care competency maintenance.

Incentivization for Specialization

Given heavier disease burdens shouldered by elderly populations, incentives like full tuition subsidies, rural location practice bonuses and public sector employment opportunities for extended skills training in geriatric specialty care areas are imperative to motivate health worker participation and retention (Mireku et al., 2019).

National Elderly Care Funding Scheme

Ghana should establish a legally mandated National Healthcare Fund for Elderly Care resourced through proportional budget allocations, dedicated tax contributions and public-private investments to resolve infrastructure and staffing resource deficits (Baiden et al., 2020). Specifically financing scope should cover:

1) Access - Transport provisions including retrofitted vehicles, thruways and ambulance services enabling last mile elderly reach across rural and urban zones.

2) Infrastructure - Constructing and upgrading primary clinic capacities, developing dedicated senior wings in district hospitals and building public rehabilitation homes to bridge availability gaps in institutional care.

3) Technology - Ensuring diagnostic equipment for chronic diseases, assistive devices and essential medicines for conditions including hypertension, diabetes, osteoarthritis, respiratory illnesses and neurological disorders meet resource distribution benchmarks tailored to the elderly (Darteh et al., 2019).

4) Workforce - Sponsoring skills training, rural locum tenures and competitive compensation to nurture specialized aged care nursing, physician and paramedic talent across both public and private health systems.

Oversight Mechanisms

The fund's governing board should constitute government agencies, public health experts, health industry groups and civil society organizations to formulate elderly sensitivity strategies, appraise investment allocation and monitor targeted utilization annually against coverage indicators through transparent audits (Kpessa-Whyte, 2018).

In summary, a three-pronged approach encompassing legislative reforms to the Public Health Act, instituting standardized training requirements and dedicated financing schemes for elderly care resourcing nationally can help bridge multiple gaps undermining access, quality, safety and dignity within Ghana's existing policy frameworks for its growing aged populations.

Conclusion

In conclusion, Ghana's healthcare system is currently inadequately equipped to address the complex service delivery demands of its rapidly growing elderly citizen groups. Significant gaps exist around legal frameworks, clinical resourcing and quality guidelines required to uplift geriatric care standards holistically.

While national ageing policies symbolize high-level commitment to needs of older populations, operationalization remains suboptimal without robust legislations entrenching standards setting, budgeting and monitoring authority to various public agencies proposed to coordinate elderly care strategies. As evidenced, patchy coverage spans regulation mandating specialized skill-building for health workers, streamlined rural access provisions or streamlined financing to fulfil infrastructure and assistive technologies supply for dignified ageing.

Reforms require multifaceted interventions - the existing Public Health Act requires amendments to embed minimum geriatric care standards catering consent protocols, care models and dignity safeguards. Concurrently, specialized gerontology and palliative medicine competency training should be mandated for various provider cadres to enhance clinical sensitivities. Additionally, dedicated healthcare financing schemes resourced through proportional budget allocations alongside insurance models and private investments is imperative to alleviate infrastructure and staffing constraints for sustainable, equitable scale-up.

Overall, Ghana's policy commitments towards bridging aged care gaps needs reinforcement through legal authority and budget mechanisms to uphold safety and ethical dignities inherent to this vulnerable demographic group. Legislative reforms remain vital to resurrect quality deficiencies putting elderly lives at risk daily from

inadequate clinical competencies, inaccessible infrastructures and high out-of-pocket expenditure burdens.

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