International Journal of Social and Administrative Sciences
ISSN(e): 2521-0556
DOI: 10.18488/journal.136.2019.41.14.30
Vol. 4, No. 1, 14-30

URL: www.aessweb.com

INFLUENCE OF JOB RELATED FACTORS ON ENCOURAGING SAVINGS FOR HEALTH CARE TOWARDS OLD AGE AMONG NURSES IN A MUNICIPALITY, GHANA

Felicia Kolekang[1]
Kwasi Awuah-Werekoh[2]
Augustine Adomah-Afari[3+]

[1]*Health Policy, Planning & Management, School of Public Health, College of Health Sciences, University of Ghana, Legon, Ghana*
Email: fkolekang@yahoo.com Tel: 00233(0)541524214
[2]*Lecturer, Business School, Ghana Institute of Management and Public Administration (GIMPA), Accra, Ghana*
Email: kawuah-wereko@gimpa.edu.gh Tel: 00233(0)200318174
[3]*Lecturer, Health Policy, Planning & Management, School of Public Health, College of Health Sciences, University of Ghana, Legon, Ghana*
Email: augustineafari@yahoo.co.uk Tel: 00233(0)265435294

(+ Corresponding author)

Article History
Received: 4 January 2019
Revised: 7 February 2019
Accepted: 11 March 2019
Published: 2 April 2019

Keywords
Credit
Savings account
Hospitals
Nurses
Old age
Savings for health care
Job related factors
Health insurance
Pension scheme
Retirement.

ABSTRACT

In Ghana, the ageing population is projected to increase from 6.7% in 2010, to 11.9% by the year 2050. Meanwhile, the National Health Insurance Scheme (NHIS), does not include most age-related diseases. This makes it necessary for workers to make savings for health care towards their old age. The study determined the influence of job-related factors on savings for health care towards old age among nurses in a municipality in the Greater Accra Region. Data was collected using quantitative methods where 227 nurses from three health facilities responded to a structured questionnaire. Data were analysed using STATA version 15.1. Basic descriptive statistics were run, and the relationship between variables was analysed using simple and multiple logistic regression. A 95% confidence level (α=0.05) was used as a level of statistical significance. The prevalence of saving for health care among nurses was 80%. Job related factors such as a number of years in service, number of years left for retirement, ranks in the nursing, savings account, and incentives were significant in influencing savings for health care towards old age (p=0.002). Policy makers and senior management of health institutions should include; incentive packages, in the form of increased salaries, improved human resources policies; introduce early comprehensive pre-retirement education for all nurses to enable them to save for health care towards old age.

Contribution/ Originality: This study is one of the very few studies which have investigated the need for nurses to make savings for healthcare towards old age in the context of Ghana.

1. INTRODUCTION

In Ghana, the ageing population as of 2010 was 6.7% of the total population and it is projected that by the year 2050, it would have increased to 11.9% (World Health Organization, 2014). This contributes to the global ageing population which is expected to triple from the current estimate of 700 million to 2 billion by the year 2050 (Mba, 2010). WHO (2014) indicated that this growth would even be more rapid in lower and middle-income countries (LMICs) including Ghana. There was, thus, the need to give attention to their health needs since most LMICs are

still fighting communicable diseases; and ageing is associated with non-communicable diseases, hence, the double burden of diseases (WHO, 2014). In Ghana, Nigeria and Cameroon, diseases such as hypertension, stroke, dementia, arthritis, diabetes and cancer, which are common among the aged, account for most adult morbidity and mortality (Aikins *et al.*, 2010). In Ghana, non-communicable diseases are common among the aged due to weakness in their immune system and reduction in their sensory ability which makes it very difficult to function on their own, therefore, depend on other family members for support including health care (Fonta, 2015). Aikins *et al.* (2010) explain that it is unfortunate that such people have limited knowledge of how to manage these conditions and where to seek appropriate help due to poverty, resulting in untimely deaths.

Araujo *et al.* (2014) argue that there will not be enough services available to meet the health needs of the aged and that even the cost of these services will not be affordable to many— Ghana's health system is no exception. Thus, there is the need for policies that will inform health systems on the current and future distribution of morbidity, mortality and dependence to ensure adequate planning to meet the changing dimension of disease occurrence (WHO, 2014). The challenge confronting the social milieu of Ghana is that the strong family system, which provided support for the aged, is gradually breaking down due to the migration of younger people from rural to urban centers for greener pastures. This makes the aged more vulnerable, especially in meeting their health care needs (Aboagye, 2012). WHO (2014) confirms that older people often have unmet expectations, leaving them isolated and at the risk of illnesses because of changes in the Ghanaian traditional norms that ensure respect, support and reciprocity. This indicates the influence of culture on saving for health care towards old age.

In an attempt to provide proactive measures, the Government of Ghana approved the national ageing policy which was to ensure that people age with dignity and security. This policy identified many health challenges of the aged (Ministry of Employment Labour and Social Welfare Ghana, 2010; WHO, 2014). These challenges include dementia, cancers, diabetes, musculoskeletal diseases, respiratory diseases, heart diseases and related conditions, oral health problems among others which require long-term treatment, however, families are not able to bear the financial cost (WHO, 2014). In view of the above, the issue to address is to look at the measures that could be put in place by individuals towards meeting their health needs while awaiting the implementation of the national ageing policy (MELSWG, 2010).

It appears that there is limited preparedness on the part of individuals towards meeting their health care needs in old age even though majority of the population in developing countries will live beyond the age of 60 years (Odeyemi and Nixon, 2013). It is anticipated that if nothing is done to encourage people to make savings for health care towards old age, individuals would be burdened with huge medical bills at the time they are not on salary and their families would be under pressure to provide support which may not be available. This would affect their health outcomes and could lead to avoidable premature deaths, thereby, losing their expertise. That aside, the health indicators of the country would also be affected.

Blakeley and Ribeiro (2008) observed that although nurses make financial preparations for retirement, this process does not begin early in their careers and this affects their comfort and health on retirement. This suggests that senior management should introduce early comprehensive pre-retirement education for all nurses. Despite this suggestion, few studies have investigated factors influencing savings for health care towards old age among nurses, particularly in Ghana (Chowa and Ansong, 2010).

This research aimed to address the gap in knowledge by examining how nurses in Ghana are making savings for their health care towards old age. The argument is that if nothing is done to meet the health care needs of the ageing population in Ghana, the health disparities among the group within this population will continue to widen. The expertise of such professionals will be lost because they will die early and this will affect the health indicators of the country. This research sought to determine the influence of job-related factors on savings for health care towards old age among nurses in a municipality in the Greater Accra Region. This paper suggests that policy makers, especially the Ministry of Health, Ghana Health Service, Ghana Education Service and Ministry of

Employment, Labour and Social Welfare, need to sensitise formal sector employees, especially nurses, on making savings for healthcare outside of the National Health Insurance Scheme (NHIS) towards improving their well-being in retirement as well as the achievements of the overall health sector goals.

2. LITERATURE AND THEORETICAL PERSPECTIVES

2.1. Saving towards healthcare

Achar (2012) indicates that saving means the act of refraining from spending one's income on consumption; the part of income which is not spent. Available literature indicates that health savings is money put aside for healthcare— usually contributions put into an account that may earn interest even after workers leave their job (Lo *et al.*, 2010). Achar (2012) suggests that income levels, exposure to information on savings, employment status and dependency ratio, stage in life cycle, fiscal policy, pensions, insurance and banking structure are some of the factors that influence savings. From the economist's perspective, people share disposable income between consumption and savings and at various levels of income, there will be a corresponding level of consumption and savings (Issahaku, 2011). Issahaku (2011) uses the classical definition and explains that saving is income minus consumption. This analyst indicates that saving is normally considered in economics as disposable income minus personal consumption expenditure. In other words, it is regarded as income that is not consumed by immediately buying goods and services (Issahaku, 2011). For this study, it must be emphasized that 'health savings' refers to money put in savings accounts which will be used for healthcare in old age (Achar, 2012).

Chowa and Ansong (2010) show that in developing countries, savings are low due to low-income levels, lack of access to banking facilities, lack of education on savings, high dependency ratio and postponement of saving till a well-paid job is gotten. These researchers added that socio-demographic/economic factors such as age, sex, marital status, level of education, income level, employment status and cultural factors influence saving habits among the youth.

A research shows that in Ghana, low-income levels, high dependency ratio, high expenditure and poor financial management are some of the challenges of savings (Addai *et al.*, 2017). They explained that the reasons for savings include children's needs, buying of assets, investment and building a house for retirement and as security.

Even though in Ghana 38% of the population in 2011 had saving accounts, savings in the country has reduced in the past two decades (Afoakwah *et al.*, 2015). (Afoakwah *et al.*, 2015) argue that this has serious financial implications on individuals and the country at large. They suggested that women should be empowered through education as their ability to bargain could increase savings among households.

A research conducted in Kenya indicated that teachers had the ability to save regularly with formal financial institutions but identified age, sex, level of income and dependency ratio as some of the factors influencing their savings (Kibet *et al.*, 2009). Another study revealed that nurses make savings for healthcare in old age. For nurses, their health on retirement and general wellbeing informed their savings (Blakeley and Ribeiro, 2008). Other studies suggest that exposure to information on savings and pension plans are key to ensuring that people take steps early, unlike meeting their health needs in old age. Such studies suggested that people could not make good financial decisions without adequate financial information (Clark *et al.*, 2012). Brown *et al.* (2012) note that in spite of the high costs and major financial risks involved in long-term care, the majority of older Americans do not own long-term care insurance.

2.2. Job- Related Factors and Savings for Healthcare towards Old Age

Working conditions: The working conditions of nurses in most developing countries, including Ghana, are poor. Such make most nurses travel to developed countries in search of better conditions of service (Anarfi *et al.*, 2010). Anarfi *et al.* (2010) suggested that if nothing was done about the poor working conditions of nurses, the majority of the qualified nurses would be lost and this would affect the quality of healthcare delivery in the country.

In a study, nurses mentioned lack of equipment to work with, lack of recognition, housing and transportation and delay in promotion and supplies as some of the challenges that had a negative effect on them and affected the quality of care they provided (Kwansah *et al.*, 2012). A research also suggested that even as health workers (including nurses) form an integral part of the health system, they are oftentimes neglected, leading to the shortage of qualified health workforce as the demand for their services in the developed world is high and at a higher income (Henderson and Tulloch, 2008).

Salary: Kwansah *et al.* (2012) reported of how nurses were not satisfied with their wages and the slow pace at which their salaries were processed, especially for newly qualified nurses. That notwithstanding, nurses in rural areas were willing to remain in rural areas and take care of their clients despite the challenges. These researchers noted that the magnitude of work that nurses undertook did not correspond with the wages and that most of the work they do are not clearly defined in their job description. This seems to suggest that there is a strong correlation between healthcare quality and staff motivation, according to Kwansah *et al.* (2012). According to some researchers, Ghana could not achieve the health-related millennium development goals without instituting a comprehensive motivational package for the health workforce, especially those in government health facilities (Alhassan *et al.*, 2013). Research suggests that there is a relationship between income levels and savings in that lower income limits the ability to save (Chowa and Ansong, 2010).

Incentives: Odoom (2015) indicates that nurses will deliver quality of care if motivational packages are provided. The motivation could be in the form of financial motivation, creating an enabling environment at the workplace, provision of accommodation, transportation and the establishment of welfare policies that could give financial protection to nurses especially during these hard financial times. To train and retain workers, researchers have begun to investigate the factors that are likely to motivate workers in general, especially health workers (Adzei and Atinga, 2012). Adzei and Atinga (2012) found that financial incentives significantly influenced motivation of workers in Ghana. Another research confirms that financial incentives such as higher salaries, salary supplements, benefits and allowance are the best ways of motivating health workers, especially in countries where salaries and wages are low to the extent that they cannot meet the basic needs of health workers and their families, including their health care (Henderson and Tulloch, 2008).

Saving culture: A research suggested that people would be willing to make investments if the benefits on those investments were high compared to low benefits and that higher salaries would lead to higher investment (James, 2009). James (2009) notes that investment policies play a major role in influencing people to invest. He argues that if governments want to encourage investment, the policies should be to ensure higher benefits.

A study in Kenya on household income and savings among teachers, small scale farmers and businessmen found that occupation, gender and educational level of household heads positively influenced the saving behaviour (Kibet *et al.*, 2009). Kibet *et al.* (2009) reported that small scale farmers could not make regular and high savings due to irregular income flow and low income levels whereas businessmen saved regularly and higher due to their high-income level. There is evidence of how various individual attributes, job and organisational factors, family factors and socioeconomic context are related to the retirement process and how one's financial, physical and psychological well-being affect retirement (Wang and Shi, 2014). Wang and Shi (2014) showed that the kind of exposure at work has an influence on the development of disease in later life and could determine the amount of savings for healthcare in old age.

The gaps in literature have to be addressed since the suggestion is that saving for retirement seems to start only in middle-age and is insufficient to prevent a sharp fall in consumption at retirement (Banks *et al.*, 1998). Banks *et al.* (1998) notes that psychological and sociological theories of saving consider further determining factors of saving and asset accumulation including character, incentives, aspirations, expectations and peer and family influences. Other psychological and sociological proposals adopt that saving-related preferences and objectives are not fixed and describe how reasons, goals and potentials are formed (Addai *et al.*, 2017). It was acknowledged by

Addai *et al.* (2017) that the emerging behavioural theory of saving tries to explain people's behaviour about financial matters. According to these analysts, unlike neoclassical economic theory, these models do not assume that people are rational and well-informed since behavioural theory tries to clarify the behaviour of human beings as human and not automatically as rational beings (Addai *et al.*, 2017). The context of this study was that job-related factors would determine whether the individual would make savings for healthcare towards old age. Indeed, job-related factors directly or indirectly influence the chances of an individual making savings for health care towards old age. In a cultural setting like Ghana where children are obliged to take care of their parents in old age, the possibility of not making saving for healthcare towards old age may be high (Aboagye, 2012).

3. METHODS

A quantitative research method was applied to collect empirical data in June 2018 for subsequent analysis in the study.

3.1. Study Design and Population

A cross-sectional study, which is a snapshot of the outcome situation at a point in time, was applied to collect data because it enabled the researchers to focus on a section of the health workforce (Hall and Lavrakas, 2008) while the quantitative research method, which involved the collection of data that could be quantified and subjected to statistical treatment, was applied since the variables of interest in this study could be quantified and analysed statistically (Williams, 2007). The study participants involved 227 nurses of all categories who were on the government payroll and were between the ages of 18 and 60 years. The idea was that since the nurses were working permanently and receiving regular income and given their knowledge of health and related matters, they would be more inclined to save for healthcare towards old age. The use of nurses who constitute the largest of the health sector workforce was also to assist the researchers to extrapolate or generalise the findings to the nurses/nursing population/profession. The evidence could be used to design appropriate policies for other healthcare workers and professionals as well.

3.2. Study Area and Sampling

This study was conducted in a municipality in the Greater Accra Region. This municipality was selected because the majority of the inhabitants were migrants with different cultural and social backgrounds. It was also because they had different health facilities with nurses of different categories. The municipality has 22 health facilities and various categories of health staff that provide healthcare to the people. Out of the twenty-two (22) health facilities, seventeen (17) are private, four (4) are government-owned and one (1) under the Christian Health Association of Ghana (CHAG). For this study, three (3) health facilities were selected; a public psychiatry hospital, a public polyclinic and a private hospital. Stratified and simple random sampling techniques were used to select the participants for the study. Since there was no available prevalence rate specifically related to the municipality, the study adopted the prevalence rate used in a study in Pakistan (see Rehman *et al.* (2011)). That is, a sample size of 206 was generated using the prevalence of 84% at 95% confidence interval and 0.05 margin of error using the Fisher's formula. Additionally, 10% of non-response was added to make up a total sample of 227 participants.

3.3. Data Collection

Using the approach by earlier researchers, a structured questionnaire with closed-ended questions was designed and self-administered by the study participants answerable within 30 minutes at their various workplaces (see Adler and Stead (2015)). That is, the questionnaire was designed by the researchers based on variables identified in the literature and supported by theoretical evidence (see (Modigliani and Brumberg, 1954; Friedman, 1957; Pollak, 1998; Rehman *et al.*, 2011)). The questionnaire was divided into sections covering the socio-

demographic/economic characteristics and social factors of the participants. The questionnaires were distributed to participants with the help of two research assistants.

3.4. Data Quality Assurance, Validity and Reliability

The two research assistants were trained for two days for them to understand how to use data collection tools and how to collect adequate data, make corrections and ensure completeness. In conducting a study that applied quantitative methods, it was necessary that efforts were made to ensure the validity and reliability of the data and results. Validity refers to the degree to which empirical evidences and theoretical rationales support the adequacy and appropriateness of interpretations and actions based on test scores while a test is seen as being reliable when it can be used by several different researchers under stable conditions, with consistent results and the results not varying (see (Wahyuni, 2012; McCusker and Gunaydin, 2015)). To ensure validity and reliability, the data collection instruments were pretested at a different polyclinic with nurses, which provided the opportunity for the researchers to reframe the questions to suit the requirements for the conduction of the main study and appropriate analytical strategies were applied in the analysis of the data. Relevant theories that exist on savings were also reviewed and factored into the development of the questionnaire. It was anticipated that the results would be valid and reliable. Thus, the strategy could be replicated by other researchers in other settings.

3.5. Data Management and Analysis

The data collected was edited manually to correct any duplications and wrong entries. The edited data was then coded and entered and analysed statistically using Stata software version 15.1. Basic descriptive statistics were run and the results presented using tables depicting frequencies, percentages and proportions. The relationships between variables were further analysed using simple and multiple logistic regressions. This data analysis strategy was earlier applied by some researchers and was adapted due to the fact that it was relevant to this study (Rehman *et al*., 2011). The level of significance of this study was 95% ($p<0.05$).

3.6. Ethical Consideration

Ethical approval was granted by the Ghana Health Service Ethics Review Committee before the commencement of the study with the clearance reference number: GHS-ERC: 045/01/18. Permission was also obtained from the Greater Accra Regional Health Directorate, Municipal Health Directorate and management of the three selected health facilities. Consent of the participants was sought before inclusion in the study. Confidentiality of data collected was ensured by using identifiers rather than names of participants. Participation in the study was voluntary. The study involved no risk to the participants and there was no compensation package provided to the participants. There was no conflict of interest in this study because the researchers had nothing to do with the facilities where the study was conducted. This study was funded by the researchers and there was no third-party funding.

4. RESULTS

4.1. Socio-Demographic/Economic Characteristics of Respondents

Out of the 227 questionnaires distributed, about 214 were retrieved with a return rate of 94.3%. The ages of the respondents were classified into four groups as: <30 years, 76 (36.9%); 30-39 years, 101 (49.0%); 40-49 years, 18 (9.0%); 50+, 11 (5.1%), and there rest (3.7%) did not disclose their ages with the mean age of 32.16 and standard deviation 8.06. About 44 (20.6%) respondents were males and 169 (79.3%) were females. In classifying the respondents by marital status, 78 (36.6%) were single, 132 (61.9%) were married and, 2 (0.9%) were divorced. About 42 (19.6%) were certificate holders, 108 (50.4%) were diploma holders, 44 (20.5%) were undergraduates, 1 (0.4%) was a graduate and 19 (8.8%) were post-graduates. Dependents of respondents ranged between 1 and 11

which included siblings, 88 (60.7%), parents, 108 (74.5%), in-laws, 12 (8.28%), and children ranged between 1 and 6. The results showed that 193 (91.0%) of the respondents did not report any known chronic health condition while 19 (8.96%) had a known existing chronic condition. More than half [195 (93.3%)] of the nurses were insured while 14 (6.7%) were not insured with 184 (87.6%) having their insurance cards active. About 201 (94.3%) were Christians compared with 12 (5.6%) Muslims. The major ethnic groups in the study were Akan, 63 (36.0%), Ewe, 46 (26.2%), Ga, 24 (13.7%), Dagomba, 6 (3.4%) and Fanti, 12 (6.8%). About 176 (85.0%) lived in the urban areas, 16 (7.7%) lived in the peri-urban areas and 15 (7.25%) lived in rural areas. A summary of the socio-demographic/economic characteristics of the study respondents is shown in Table 1.

Table-1. Socio-demographic/economic characteristics of respondents.

Variable	Frequency (N)	Percentages (%)
Age		
<30	76	36.9
30-39	101	49.0
40-49	18	9.0
50+	11	5.1
Sex		
Male	44	20.66
Female	169	79.34
Marital status		
Single	78	36.62
Co-habiting	1	0.47
Married	132	61.97
Divorced	2	0.94
Widowed	0	0
Level of education		
Certificate	42	19.62
Diploma	108	50.47
Under-graduate	44	20.56
Post-graduate	20	9.35
Number of Dependents		
1	18	12.6
2	54	37.7
3	39	27.3
4	19	13.3
5+	13	9.1
Existing known chronic condition		
Not known	193	91.04
Known	19	8.96
Health insurance status		
Non-insured	14	6.70
Insured	195	93.30
Religion		
Christian	201	94.37
Muslim	15	5.63
Tribe		
Ewe	46	26.29
Akan	63	36.00
Ga	24	13.71
Fante	12	6.86
Dagomba	6	3.48
Others	23	13.66
Place of residence		
Urban	176	85.02
Peri-urban	16	7.73
Rural	15	7.25

Source: Field Data (2018).

4.2. Overall Savings for Healthcare towards Old Age

Deposits made into saving accounts were used to measure savings for healthcare towards old age. Overall, out of 214 respondents, 41 (19.9%) reported that they would not save money for healthcare towards old age while 165 (80.1%) would make savings for healthcare towards old age. The results are represented in Figure 1.

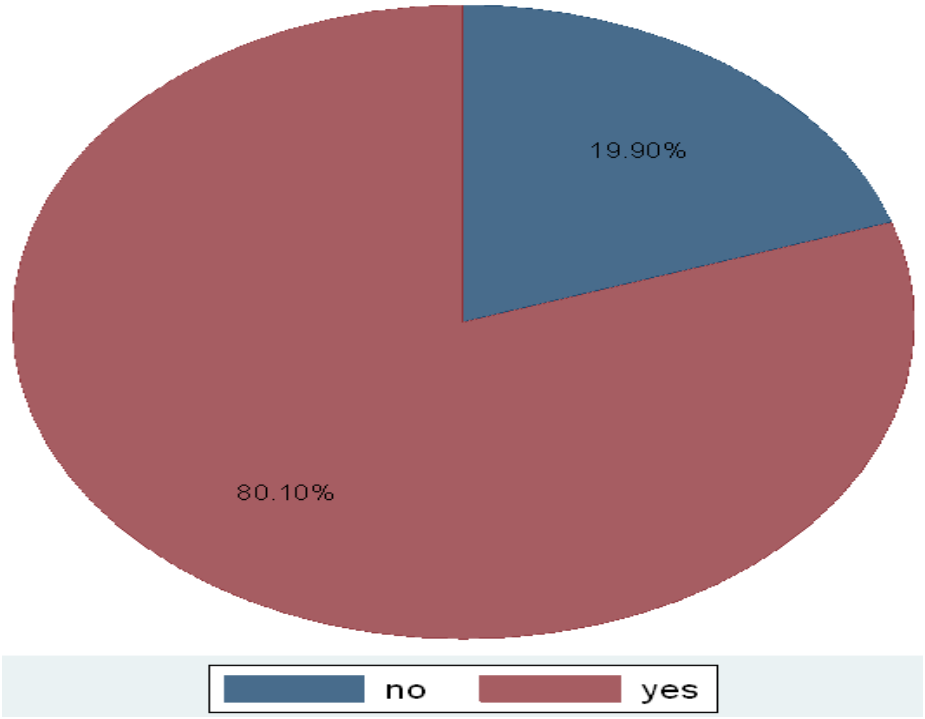

Figure-1. Overall savings for health care towards old age.

Source: Field Data (2018).

4.3. Relationship between Job-Related Factors and Savings for Health Care

The results of the univariate analysis showed that out of the highest number of 145 (67.8%) respondents who had worked for less than 10 years, 115 (82.1%) were saving for healthcare. However, years in service was not statically significant in the bivariate analysis (p=0.742). Out of the highest number of 102 (47.7%) respondents who had worked for 21-30 years, 79 (80.6%) were saving for healthcare but this was not statistically significant (p=0.352). Salaries of respondents ranged between GHS559 and GHS3863 with 205 (97.6%) on regular salary and only 78 (36.9%) out of 214 (63.0%) respondents disclosed their salaries in the questionnaire. Out of the highest number of 205 (97.6%) respondents who received regular salary, 161 (80.5%) were saving for healthcare yet this was not statistically significant (p=0.784). A question was posed regarding how the salary (amount) earned was encouraging respondents to save towards health care. Out of the 35 (44.3%) respondents who received salary in the range of GHS1500 – GHS1999, 31 (88.6%) were saving for healthcare. Nonetheless, this was not statistically significant (p=0.088).

In response to how the nursing rank could motivate the respondents to save, the results revealed that out of the 48 (30.8%) in the Nursing Officer rank, 41 (91.1%) were saving. That notwithstanding, the nursing rank had no statistically significant relationship with savings for healthcare (p=0.091). Over 172 (83%) of respondents said they did not have job incentives and 138 (65.4%) had taken a loan out of which 60 (69.7%) said it was affecting their savings for healthcare towards old age. Nevertheless, job incentives were not statistically related to saving for healthcare (p=0.099).

Table-2. Relationship between job-related factors and savings for healthcare.

Variable	Frequency N(%)	Saving for health care Yes- n(%)	No n(%)	Chi-square $=X^2$	P-value
Year in service				**1.245**	**0.742**
<10	145(67.76)	115(82.14)	25(17.86)		
11-20	53(24.77)	39(75.00)	13(25)		
21-30	5(2.34)	1(20.00)	2(80.00)		
31+	11(5.14)	77(77.78)	2(22.22)		
Years left for retirement				**3.273**	**0.352**
<10	15(7.01)	11(73.33)	4(26.67)		
11-20	22(10.28)	15(68.18)	7(31.82)		
21-30	102(47.66)	79(80.61)	19(19.39)		
31+	75(35.05)	60(84.51)	11(15.49)		
Salary				**0.075**	**0.784**
Regular	205(97.62)	161(80.50)	39(19.50)		
Not regular	5(2.38)	3(75.00)	1(25.00)		
Salary (amount)					
<1000(low)	6(7.59)	5(83.33)	1(16.67)	**6.552**	**0.088**
1000-1499(middle)	24(30.38)	15(65.22)	8(34.78)		
1500-1999(high)	35(44.30)	31(88.57)	4(11.43)		
2000+(highest)	14(17.72)	13(92.86)	1(7.14)		
Nursing rank					**0.091**
Staff nurses	43(27.56)	27(67.50)	13(32.50)		
Senior staff nurse	54(34.62)	43(79.63)	11(20.73)		
Nursing officer	48(30.77)	41(91.11)	4(8.89)		
Principal nursing officer	10(6.41)	7(70.00)	3(30.00)		
Deputy director of nursing services	1(0.64)	1(100)	0(0.00)		
Others					
Do you have other job incentives				**2.728**	**0.099**
Incentives	35(16.91)	30(90.91)	3(9.09)		
No incentives	172(83.09)	134(78.44)	36(21.56)		
Do you have any insurance policy				**1.194**	**0.275**
Insurance policy	117(56.52)	94(83.19)	19(16.81)		
No insurance policy	90(43.48)	67(77.01)	20(22.99)		
Do you have other sources of income				**0.331**	**0.565**
Have other sources of income	65(31.10)	48(78.69)	13(21.31)		
No other sources of income	144(68.90)	115(82.14)	25(17.86)		
Savings account				**7.573**	**0.006****
Account	188(88.68)	152(83.52)	30(16.48)		
No account	24(11.32)	13(59.09)	9(40.91)		
Frequency of savings				**3.372**	**0.338**
Weekly	8(4.12)	6(75.00)	2(25.00)		
Monthly	168(86.60)	134(83.23)	27(16.77)		
Quarterly	14(7.22)	12(85.710	2(4.29)		
Yearly	4(2.06)	2(50)	2(50)		
% of savings for healthcare				**0.791**	**0.853**
10%	86(46.49)	66(80.49)	16(19.51)		
20%	56(30.27)	45(84.91)	8(15.09)		
30%	29(15.68)	25(86.21)	4(13.79)		
40%	14(7.57)	12(85.71)	2(14.29)		
Savings enough to meet health needs on retirement				**0.141**	**0.707**
Enough	58(28.57)	45(81.82)	10(18.18)		
Not enough	144(70.94)	112(79.43)	29(20.57)		
Do you belong to credit union				**1.401**	**0.237**
Credit union	40(18.87)	33(86.84)	5(13.16)		
No credit union	172(81.13)	130(78.31)	36(21.69)		
Do you belong to a welfare club				**2.331**	**0.126**
Welfare club	84(39.62)	69(85.19)	12(14.81)		
No welfare club	128(60.38)	94(76.42)	29(23.58)		
Have you taken a loan				**0.058**	**0.809**
Loan	73(34.60)	56(78.87)	15(21.13)		
No loan	138(65.40)	106(80.30)	26(19.70)		
Loan affecting savings for health care				**0.061**	**0.805**
Affecting	60(69.77)	46(79.31)	12(20.69)		
Not affecting	26(30.32)	20(76.93)	6(23.08)		

Source: Field Data (2018).

In a multiple response question on what could be done by their employer to increase their ability to make savings for healthcare towards old age, 179 (86.5%) of respondents asked for an increase in salary, 120 (59.9%) accommodation, 118 (57.0%) reduced taxes on salary, 125 (60.4%) transportation allowance, 105 (50.7%) rent allowance, 90 (43.5%) immediate promotion with salary increment, 83 (40.1%) risk allowance and 80 (38.7%) reduction in cost of further training. About 90 (43.4%) of the respondents did not have insurance policies while 117 (56.5%) had a form of insurance. The results showed that insurance policy was not statistically significant (p=0.275). On other sources of income, 144 (68.9%) said they did not have other sources of income compared with 65 (31.10%). Other sources of income was not statistically significant (p=0.565).

The results revealed that 24 (11.3%) respondents did not have saving accounts compared with 188 (88.6%). There was a statistical relationship between saving accounts and saving for health care towards old age (p=0.006). Classifying under frequency of saving, 8 (4.1%) respondents saved weekly, 168 (86.6%) saved monthly, 14 (7.2%) saved quarterly, 4 (2.0%) saved yearly, some saved when they had surplus while others could not save at all because their salary was not enough to meet immediate needs. The frequency of saving had no statistical significance with saving for healthcare towards old age (p=0.338).

Table-3. Logistic Regression: Job related factors and savings for health care.

Variable	COR (95%CI)	P-value	AOR(95%CI)	P-value
Number of years in service				
Ref				
11-20	0.7(0.30, 1.40)	0.272	0.1(0.01, 0.37)	0.002**
21-30	0.7(0.1, 8.11)	0.902	0.1(0.00, 15.35)	0.322
31+	0.8(0.1, 3.9)	0.742	0.5(0.07, 4.14)	0.553
Number of years left for retirement				
Ref				
11-20	0.8(0.18, 3.34)	0.737	19.1(0.66, 555)	0.086
21-30	1.5(0.43, 5.27)	0.517	10.3(0.56, 189	0.116
30+	1.9(0.53, 7.37)	0.306	22.9(1.20, 436)	0.037**
Job incentives				
Ref				
Have incentives	2.7(0.79, 9.52)	0.111	2.1(0.34, 12.90)	0.428
Nursing rank				
Ref				
Senior staff nurse	1.88(0.74, 4.79)	0.185	10.0(1.70, 59.21)	0.011**
Nursing officer	4.94(1.45, 16.74)	0.010**	51.32(5.43, 484)	0.001**
Principal nursing officer	1.12(0.24, 5.06)	0.880	72.1(4.01, 1295)	0.004**
Deputy director of nursing services				
Insurance policy				
Ref				
With policy	1.47(0.73, 2.98)	0.276	2.1(0.58, 7.76)	0.255
Savings account				
Ref				
With accounts	3.51(1.38, 8.94)	0.009**	9.3(1.57, 55.51)	0.014**
Other sources of income				
Ref				
Have other income sources	0.8(0.38, 1.70)	0.566	0.6(0.16, 2.21)	0.445

Source: Field Data (2018).

4.4. Logistic Regression: Job-Related Factors and Savings for Health Care

At the logistic regression level, the study further explored the extent of the influence of job-related factors on savings for healthcare towards old age. The results revealed that the odds of saving for healthcare among senior staff nurses was 1.88 times compared with staff nurses (p =0.185, CI= 0.74-4.79). After adjusting all other job-related factors, the odds of saving for healthcare towards old age among senior nursing officers increased 10 times more than that of staff nurses p=0.011, CI=1.7-59.22). Furthermore, the odds of saving for healthcare among

nursing officers was 4.9 times compared with staff nurses (p=0.010, CI=1.45-16.74). When all other job factors were held constant, the odds of saving for healthcare among nursing officers increased 51 times more than that of the staff nurses (p=0.001, CI=5.43 – 484). Moreover, the odds of saving for healthcare among those with saving accounts was 3.51 times compared with those without saving accounts (p=0.012, CI= 1.38-8.94). The overall module comparing job-related factors and saving for healthcare towards old age was p=0.0002 (p<0.05). The details of the results are shown in Table 3. About 86 (46.5%) of the respondents saved 10% of their income. Relating this to savings for healthcare, it was seen that 66 (80.5%) were doing so towards old age. This was not statistically significant (p=0. 0.853). The results showed that 144 (70.9%) acknowledged that their savings would not be able to meet their health needs compared with 58 (28.6%). This was not statistically significant (p=0.707). The results showed that 172 (81%) did not belong to a credit union while 128 (69%) did not belong to a welfare club. There was no statistical relationship between a credit union (p=0.237), a welfare club (p=0.126) and savings for healthcare. When responding to a question whether they had taken a loan, out of 138 (65.4%) who said 'no', 106 (80.3%) were also willing to save or saving for healthcare towards old age. However, the association was not statistically significant (p=0.809). The results showed that out of the 60 (69.8%) who answered that the loan was affecting savings for healthcare, 46 (79.3%) noted that they were saving for healthcare. There was no statistically significant association (p=0.805). The results are shown in the Table 2.

5. DISCUSSION

The findings of the study could be viewed from the perspective of Moos' work on environment scale which suggests that a supportive work environment enables nurses to provide quality patient care, enhance their own self-esteem, increase job satisfaction and provide cost savings to their employers (Moos, 1994; Hayhurst *et al.*, 2005). Hayhurst *et al.* (2005) note that such an environment promotes retention of skilled, caring, knowledgeable and experienced nurses who provide better patient care with fewer complications and reduces the economic and social costs of healthcare for both providers and consumers. Spear (2005) argues that by improving their work while they are actually doing it, healthcare practitioners could deliver extraordinary savings – in lives and dollars. The results indicated that senior staff nurses had 1.8 times higher ability to save for healthcare than that of staff nurses (p=0.185) but when all other job-related factors were controlled, the odds among senior nurses increased 10 times more than that of staff nurses (p=0.011). Moreover, the odds of saving for healthcare towards old age among nursing officers was 5 times more than that of staff nurses (p=0.010). This means that nursing officers had the highest chance of saving for healthcare towards old age among the nursing ranks. Nurses who had other job incentives were more likely to save for healthcare than those without job incentives, meaning that incentives had a positive influence on savings for healthcare towards old age even though not statistically significant (p=0.111). In contrast, a study found no significant differences between the staff nurse and manager groups (Blakeley and Ribeiro, 2008). In addition, nurses who had savings accounts were more likely to save for healthcare compared with those without such, which was statistically significant (p=0.009). This finding is similar to a study which suggests that motivational packages in the form of financial motivation gave financial protection to nurses (Odoom, 2015).

A study found that individual nurse characteristics were indirectly related to retention through intent to stay while the individual characteristic of tenure was indirectly related to retention through autonomy as an intrinsic characteristic of job satisfaction and intent to stay (Ellenbecker, 2004). Relatedly, the results also indicated that there was an association between number of years in service and savings for healthcare. Nurses who had worked between 11 and 20 years were about 30% less likely to save for healthcare towards old age compared with those who had worked for less than 10 years (p=0.272). When all other factors were adjusted for, they were 90% less likely to save for healthcare towards old age (p=0.002). Hayhurst *et al.* (2005) explored the perceptions of the work environment among acute care nurses working in a large county hospital who left their units during an 18-month

period compared with those who stayed. This suggested that the nurses who remained in their units perceived less work pressure and had greater perception of peer cohesion, supervisor support and autonomy than nurses who left.

Skinner (2007) observes that retirement encompasses both age 66, when healthy households can easily substitute home cooking for more expensive prepared food, and age 86, when few can substitute home production for purchased health care arguing that growth rates for out-of-pocket health care spending have kept pace with overall healthcare cost growth and, thus, continue to outstrip GDP growth and they may accelerate as firms jettison retiree health benefits. Juxtaposing this with the findings of this study, the results also revealed that there was an association between number of years left for retirement and saving for healthcare towards old age as nurses who were left with more than 30 years to retire were twice more likely to make savings for healthcare compared with those who have less than 10 years to go on retirement (p=0.306). The above findings could be viewed against the suggestion that older people often have little money and would not be able to access quality healthcare which has negative impact on their health-seeking behaviour, hence, the quality of their health (Tawiah, 2011).

Literature shows the view that the nursing shortage, downsizing and long working hours create challenges for nurses trying to deliver quality client care; nurses are experiencing high levels of physical injury in their work environments which have led them to leave the workplace (Geiger-Brown *et al.*, 2004). The findings of this study showed that majority of nurses were making savings for health which could be attributed to their awareness of the health risks associated with their job and old age as against the reality that the NHIS was yet to cover most of the health conditions associated with old age and the SSNIT pension scheme would not be enough to meet their needs, including healthcare (p=0.0002) (Jehu-Appiah *et al.*, 2011). The above findings are similar to the suggestion that nurses would always put their health first and would make savings for healthcare (Blakeley and Ribeiro, 2008). It was found that since they had regular form of income and their salaries were paid through financial institutions (the banks) that manage these savings, it enables them to make savings for healthcare towards old age. The above is similar to a study which suggests that when income is regular, it increases the ability to make savings; and the higher the income, the higher the savings (Kibet *et al.*, 2009).

A study examined the role of wages in the migration decision and the likely effect of wage increases on source countries in slowing migration flows (Vujicic *et al.*, 2004). Vujicic *et al.* (2004) noted that at current levels, wage differentials between source and destination country were so large that small increases in healthcare wages in source countries were unlikely to affect significantly the supply of healthcare migrants. Consequently, the findings of this study revealed that the nurses would need an increased salary to enable them to make savings for healthcare towards old age. This was evident in a response to a multiple response questions when the majority (86.5%) of the nurses asked for an increase in salary, 57% asked for reduced taxation on salaries, 60% asked for transportation allowance and 51%, rent allowance, as some of the ways or incentives that their employers could provide to assist them in making savings for healthcare. This finding confirms the suggestion that low levels of income would make it difficult for savings (Addai *et al.*, 2017) as improved salaries and benefits are major financial incentives for workers to remain in the health sector (Henderson and Tulloch, 2008).

6. CONCLUSION

This research aimed to determine the influence of job-related factors on savings for healthcare towards old age among nurses in Ghana. A cross-sectional study using quantitative methods was conducted among nurses in a municipality in the Greater Accra Region of Ghana. Generally, the study concludes that nurses were making savings for healthcare towards old age with a prevalence of 80%. Even though the prevalence was below WHO standards, there was evidence of the relationship between the savings for healthcare towards old age and job-related factors in the study. The low prevalence could be due to limited knowledge of planning for the future as far as healthcare was concerned as suggested in earlier studies (Clark *et al.*, 2012). There was also an association between some job-related factors and savings for healthcare towards old age. The findings showed that the number of years

in service, the number of years left for retirement, ranks in nursing and saving accounts were factors associated with savings for healthcare towards old age at the univariate level; and incentive packages in the form of financial motivation had the ability to increase savings for healthcare towards old age, similar to findings in a previous study (Odoom, 2015).

6.1. Contribution to Policy and Practice and Management of Healthcare Institutions

This finding of the study contributes to policy and practice and management of healthcare institutions. There is the need for policymakers at the Ministry of Health / Ghana Health Service and Ministry of Employment, Labour and Social Welfare to consider the factors identified in this study for inclusion in the formation and reformulation of the national ageing policy (MELSWG, 2010; WHO, 2014). There is the need for the introduction of early pension healthcare plan education preferably at the point of appointment to enable nurses to start early and save adequately for healthcare towards old age since older age has a negative influence on savings (see Marmot (2013)). The key point to consider is that job demands and job control were found to be independent predictors of early retirement thoughts even when adjusted for age, gender, educational level and self-rated health (Elovainio *et al.*, 2005).

The management of health institutions should organise periodic sensitisation workshops on pensions and insurance as a way of encouraging their workers to start planning for retirement early to be able to save enough for healthcare towards old age. There is the need for the management of health institutions to provide incentive packages for nurses, especially financial incentives, which will increase their disposable income and, hence, their ability to make savings for healthcare towards old age.

Nurses should be encouraged to engage in other income-generating activities that would increase their sources of income since their salary alone is not enough to enable them make savings for health care. A clue could be deduced from the findings of a study which explored various factors and income sources that registered nurses believed were important in retirement planning and suggested that all nurses may need to focus more on financial preparation and begin the process early in their careers if they are to have a comfortable and healthy retirement (Blakeley and Ribeiro, 2008). Blakeley and Ribeiro (2008) found that while 71% of nurses had planned to retire by age 60, only 24% had done a large amount of planning. The crucial variables that could be considered by management of healthcare institutions in Ghana and elsewhere are the top four planning strategies identified including the need to keep healthy and active, both physically and mentally, and a major financial planning strategy which ranked fifth. Work pensions, a government pension and a personal savings plan were ranked as the top three retirement income sources (Blakeley and Ribeiro, 2008).

There is the need for the management of health institutions to provide a conducive working environment for nurses – a similar suggestion has been recorded (Hayhurst *et al.*, 2005). This will help them to be free from stress and reduce the risk of infections which lead to reduced spending on current health to save for healthcare towards old age similar to what has been documented (Geiger-Brown *et al.*, 2004). Compulsory regular medical checkup should be instituted as part of the conditions of service of all employees, especially nurses, at least, once every year. This will aid early identification of health problems for proper management before old age, hence, helping to reduce the costs of healthcare. Management of health institutions should not wait until they encounter a situation where during labor shortage, employment-based benefits may be used to recruit and retain workers (Spetz and Adams, 2006).

It is recommended that policy makers, especially the Ministry of Health, Ghana Health Service, Ghana Education Service and Ministry of Employment, Labour and Social Welfare consider these key findings to ensure that appropriate actions are taken to address the deficiencies while improving on the achievements of the overall health sector goals. Firstly, there is the need for the Government of Ghana to sensitise nurses on the need to buy private health insurance since the NHIS is not well-resourced to meet the health needs of all its citizenry and

regulate the activities of private insurance companies to ensure that they provide the needed financial protection. Secondly, the SSNIT pension plan should be revised by the Ministry of Employment, Labour and Social Welfare to meet the current financial needs of its contributors. Thirdly, the management of healthcare institutions that supervise and manage nurses should ensure that nurses are sensitised on savings, pensions and insurance policies early to ensure adequate preparation towards healthcare in old age; incentives in the form of financial motivation such as increase in salaries, benefits and allowances should be introduced to increase their ability to make savings for healthcare towards old age (see Meltzer and Huckabay (2004)).

6.2. Contribution to Methodology

The use of quantitative methods in data collection and analysis enabled the researchers to quantify the data that was collected and interpreted the results with figures which gave a clear picture of the findings compared with qualitative data that is not able to quantify the findings (see McCusker and Gunaydin (2015)). It also enabled the researchers to measure and quantify the association between the dependent and independent variables which could not have been possible using qualitative methods (Wahyuni, 2012). Consequently, the findings of this study could be generalised to the population of interest.

6.3. Limitations to the Study

The target population of the study by the nature of their work is busy and this could be seen in the incompletion of some of the questionnaires; administering the questionnaires at the hospital environment influenced the responses as the nurses were busy attending to their clients. In addition, most of the respondents considered information about salary and saving culture as personal. This was evident while checking for completeness and accuracy of the responses to the questionnaires and during analysis where it was found that out of the 214 respondents, only 78 of them indicated their salary level. This might have affected the quality of the information that was given. Another limitation was the fact that the questionnaires were self-administered and the researchers did not have control over the responses to the questions. This could have affected the results. The study population that consisted of all categories of nurses might have had similar characteristics and this could also have affected the study results. Another limitation was the fact that deposits made into saving accounts were used to measure savings for healthcare towards old age. However, there could be other ways nurses were making savings for healthcare.

6.4. Future Research

In view of the limitations encountered in the conduct of this study, it is recommended that more studies should be conducted to identify the investment opportunities available for nurses in Ghana and other developing countries. The sample size and the study sites should be increased in future studies by considering people from different professional backgrounds to improve on the findings and ensure comparative analysis.

Funding: This study received no specific financial support.
Competing Interests: The authors declare that they have no competing interests.
Contributors/Acknowledgement: All authors contributed equally to the conception and design of the study.

REFERENCES

Aboagye, E., 2012. Old age dependence on family support: The effect of health insurance intervention. Master's Thesis, University of Oslo.

Achar, A., 2012. Saving and investment behaviour of teachers, an empirical study. International Journal of Physical and Social Sciences, 2(8): 263-286.

Addai, B., A.G. Gyimah and W.K.B. Owusu, 2017. Savings habit among individuals in the informal sector: A case study of gbegbeyishie fishing community in Ghana. International Journal of Economics and Finance, 9(4): 262-272.Available at: https://doi.org/10.5539/ijef.v9n4p262.

Adler, N.E. and W.W. Stead, 2015. Patients in context-EHR capture of social and behavioral determinants of health. New England Journal of Medicine, 372(8): 698-701.Available at: https://doi.org/10.1056/nejmp1413945.

Adzei, F.A. and R.A. Atinga, 2012. Motivation and retention of health workers in Ghana's district hospitals: Addressing the critical issues. Journal of Health Organization and Management, 26(4): 467-485.Available at: https://doi.org/10.1108/14777261211251535.

Afoakwah, C., S. Annim and J. Peprah, 2015. Household savings and women's bargaining power in Ghana. Journal of Global Economics, 3(2): 1-6.

Aikins, A.d.-G., P. Boynton and L.L. Atanga, 2010. Developing effective chronic disease interventions in Africa: Insights from Ghana and Cameroon. Globalization and Health, 6(1): 1-15.Available at: https://doi.org/10.1186/1744-8603-6-6.

Alhassan, R.K., N. Spieker, P. van Ostenberg, A. Ogink, E. Nketiah-Amponsah and T.F.R. de Wit, 2013. Association between health worker motivation and healthcare quality efforts in Ghana. Human Resources for Health, 11(1): 1-11.Available at: https://doi.org/10.1186/1478-4491-11-37.

Anarfi, J., P. Quartey and J. Agyei, 2010. Key determinants of migration among health professionals in Ghana. Development Research Centre on Migration, Globalisation and Poverty.

Araujo, D.C.I., J. Byles, C. Aquah, G. Amofah, R. Biritwum, U. Panisset, J. Goodwin and J. Beard, 2014. Informing evidence-based policies for ageing and health in Ghana. Bulletin of the World Health Organization, 93: 47-51.Available at: https://doi.org/10.2471/blt.14.136242.

Banks, J., R. Blundell and S. Tanner, 1998. Is there a retirement-savings puzzle? American Economic Review, 88(4): 769-788.

Blakeley, J. and V. Ribeiro, 2008. Are nurses prepared for retirement? Journal of Nursing Management, 16(6): 744-752.Available at: https://doi.org/10.1111/j.1365-2834.2008.00916.x.

Brown, J.R., G.S. Goda and K. McGarry, 2012. Long-term care insurance demand limited by beliefs about needs, concerns about insurers, and care available from family. Health Affairs, 31(6): 1294-1302.Available at: https://doi.org/10.1377/hlthaff.2011.1307.

Chowa, G. and D. Ansong, 2010. Youth and savings in assets Africa. Children and Youth Services Review, 32(11): 1591-1596.

Clark, R.L., M.S. Morrill and S.G. Allen, 2012. The role of financial literacy in determining retirement plans. Economic Inquiry, 50(4): 851-866.Available at: https://doi.org/10.1111/j.1465-7295.2011.00390.x.

Ellenbecker, C.H., 2004. A theoretical model of job retention for home health care nurses. Journal of Advanced Nursing, 47(3): 303-310.Available at: https://doi.org/10.1111/j.1365-2648.2004.03094.x.

Elovainio, M., P. Forma, M. Kivimäki, T. Sinervo, R. Sutinen and M. Laine, 2005. Job demands and job control as correlates of early retirement thoughts in finnish social and health care employees. Work & Stress, 19(1): 84-92.Available at: https://doi.org/10.1080/02678370500084623.

Fonta, L.C., 2015. Assessing health inequality among the elderly in Ghana. Doctoral Dissertation, University of Ghana.

Friedman, M., 1957. A theory of the consumption function. National bureau of economic research. NJ, USA: Princeton University Press.

Geiger-Brown, J., A.M. Trinkoff, K. Nielsen, S. Lirtmunlikaporn, B. Brady and E.I. Vasquez, 2004. Nurses' perception of their work environment, health, and well-being: A qualitative perspective. Aaohn Journal, 52(1): 16-22.Available at: https://doi.org/10.1177/216507990405200108.

Hall, J. and P. Lavrakas, 2008. Cross-sectional survey design. Encyclopedia of Survey Research Methods: 173-174.Available at: http://dx.doi.org/10.4135/9781412963947.n120.

Hayhurst, A., C. Saylor and D. Stuenkel, 2005. Work environmental factors and retention of nurses. Journal of Nursing Care Quality, 20(3): 283-288.Available at: https://doi.org/10.1097/00001786-200507000-00015.

Henderson, L.N. and J. Tulloch, 2008. Incentives for retaining and motivating health workers in pacific and Asian countries. Human Resources for Health, 6(1): 18.Available at: https://doi.org/10.1186/1478-4491-6-18.

Issahaku, H., 2011. Determinants of saving and investment in deprived district capitals in Ghana - a case study of Nadowli in the Upper West Region of Ghana. Continental Journal of Social Sciences, 4(1): 1-12.

James, S., 2009. Incentives and investments: Evidence and policy implications. Investment Climate Advisory Services, 58816. The World Bank, Washington, DC: USA. Available from http://documents.worldbank.org/curated/en/945061468326374478/pdf/588160WP0Incen10BOX353820B01PUBLIC1.pdf [Accessed 11 November, 2017].

Jehu-Appiah, C., G. Aryeetey, E. Spaan, T. De Hoop, I. Agyepong and R. Baltussen, 2011. Equity aspects of the national Health insurance scheme in Ghana: Who is enrolling, who is not and why? Social Science & Medicine, 72(2): 157-165.Available at: https://doi.org/10.1016/j.socscimed.2010.10.025.

Kibet, L.K., B.K. Mutai, D.E. Ouma, S.A. Ouma and G. Owuor, 2009. Determinants of household saving: Case study of smallholder farmers, entrepreneurs and teachers in rural areas of Kenya. Journal of Development and Agricultural Economics, 1(7): 137-143.

Kwansah, J., M. Dzodzomenyo, M. Mutumba, K. Asabir, E. Koomson, M. Gyakobo, P. Agyei-Baffour, M.E. Kruk and R.C. Snow, 2012. Policy talk: Incentives for rural service among nurses in Ghana. Health Policy and Planning, 27(8): 669-676.Available at: https://doi.org/10.1093/heapol/czs016.

Lo, S.A.T., M. Shah and B.K. Frogner, 2010. Health savings accounts and health care spending. Health Services Research, 45(4): 1041-1060.Available at: https://doi.org/10.1111/j.1475-6773.2010.01124.x.

Marmot, M., 2013. Fair society, healthy lives. European Forum Alpbach. Available from http://www.alpbach.org/wp-content/uploads/2013/04/Marmot-Michael.pdf [Accessed 15 November, 2017].

Mba, C.J., 2010. Population ageing in Ghana: Research gaps and the way forward. Journal of Aging Research, 2010: 1-8.Available at: https://doi.org/10.4061/2010/672157.

McCusker, K. and S. Gunaydin, 2015. Research using qualitative, quantitative or mixed methods and choice based on the research. Perfusion, 30(7): 537-542.

Meltzer, L.S. and L.M. Huckabay, 2004. Critical care nurses' perceptions of futile care and its effect on burnout. American Journal of Critical Care, 13(3): 202-208.Available at: https://doi.org/10.1016/s1036-7314(06)80020-2.

Ministry of Employment Labour and Social Welfare Ghana, 2010. National ageing policy: Ageing with security and dignity. Accra, Ghana: Ministry of Employment, Labour and Social Welfare.

Modigliani, F. and R. Brumberg, 1954. Utility analysis and aggregate consumption functions: An attempt at integration. Post Keynesian economics. New Brunswick: Rutgers University Press.

Moos, R.H., 1994. Work environment scale manual. Palo Alto, CA, USA: Consulting Psychologists Press.

Odeyemi, I. and J. Nixon, 2013. Assessing equity in health care through the national health insurance schemes of Nigeria and Ghana: A review-based comparative analysis. International Journal for Equity in Health, 12(1): 9.Available at: https://doi.org/10.1186/1475-9276-12-9.

Odoom, E., . , 2015. Assessing the impact of motivation on the work performance of nurses at the Amasaman Municipal Hospital. Doctoral dissertation, University of Ghana.

Pollak, R., 1998. Notes on how economists think. Working Paper No. 3. Joint Centre for Poverty Alleviation. Chicago, USA.

Rehman, H.-u., F. Bashir and M.Z. Faridi, 2011. Saving behavior among different income groups in Pakistan: A micro study. International Journal of Humanities and Social Science, 1(10): 268-277.

Skinner, J., 2007. Are you sure you're saving enough for retirement? Journal of Economic Perspectives, 21(3): 59-80.Available at: https://doi.org/10.1257/jep.21.3.59.

Spear, S.J., 2005. Fixing health care from the inside, today. Harvard Business Review, 83(9): 78.

Spetz, J. and S. Adams, 2006. How can employment-based benefits help the nurse shortage? Health Affairs, 25(1): 212-218.Available at: https://doi.org/10.1377/hlthaff.25.1.212.

Tawiah, E., 2011. Population ageing in Ghana: A profile and emerging issues. African Population Studies, 25(2): 623-645.Available at: https://doi.org/10.11564/25-2-249.

Vujicic, M., P. Zurn, K. Diallo, O. Adams and M.R. Dal Poz, 2004. The role of wages in the migration of health care professionals from developing countries. Human Resources for Health, 2(1): 3.Available at: https://doi.org/10.1186/1478-4491-2-3.

Wahyuni, D., 2012. The research design maze: Understanding paradigms, cases, methods and methodologies. Journal of Applied Management Accounting Research, 10(1): 69-80.

Wang, M. and J. Shi, 2014. Psychological research on retirement. Annual Review of Psychology, 65(1): 209-233.Available at: https://doi.org/10.1146/annurev-psych-010213-115131.

Williams, C., 2007. Research methods. Journal of Business & Economic Research, 5(3): 65-72.

World Health Organization, 2014. Ghana country assessment report on ageing and health. Geneva, Switzerland: World Health Organisation.