

**PRIVATE HOSPITALS IN QUALITY HEALTH CARE DELIVERY IN GHANA:  
PROSPECTS AND CHALLENGES OF SELECTED PRIVATE HOSPITALS IN  
THE KUMASI METROPOLIS**

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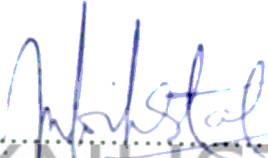
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## DECLARATION

I hereby declare that this submission is my own work towards the Msc. Development Planning and Management and that to the best of my knowledge, it contains no material previously published by another person nor material which has been accepted for the award of any degree of the University, except where due acknowledgement has been made in the text.

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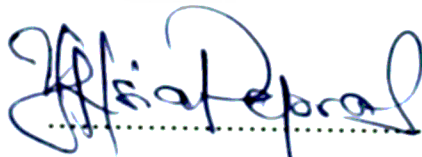
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## ABSTRACT

The Millennium Development Goals (MDG) and the Ghana Growth and Poverty Reduction Strategy (GPRS) II (2006) stress among other things quality healthcare delivery and the elimination of diseases and poverty as a major factor in achieving a middle-income status. Despite efforts made by government to improve the health status of the people, a significant proportion still lack access to quality health care services.

Government alone had not fully succeeded to play the role of solely providing health care services to the people. It has been prudent for government therefore to recognize the participation of private hospitals in the delivery of health services to increase access, improve equity, efficiency and the overall health condition of the people.

Some prospects for the involvement of private hospitals in the delivery of quality services among other things are their ability to provide a range of amenities and suitable facilities that conform to standards of hygienic practices and cleanliness and the introduction of the National Health Insurance Scheme which would increase access and reduce pressure on the public hospitals. Some challenges facing private hospitals in their operations however are, the difficulty in attracting formally trained staff, lack of credit facilities for the acquisition of essential equipment and infrastructure and limited in-service training for their staff.

For private hospitals to succeed in delivering quality health services, it is expected that they are given the necessary support by government. This could be in the form of subsidies and tax reliefs to enable them acquire the necessary inputs. Trained staff of the public service could be loaned to the private hospitals on secondment to support them to provide quality services. These would enable them to help Ghana to achieve its health vision of bridging the equity gap in access to quality health and nutrition services, ensure sustainable financial arrangement that protect the poor and enhance efficiency in service delivery.

## TABLE OF CONTENT

|                                      |      |
|--------------------------------------|------|
| TITLE PAGE .....                     | i    |
| DECLARATION .....                    | ii   |
| ABSTRACT .....                       | iii  |
| TABLE OF CONTENT .....               | iv   |
| LIST OF TABLE .....                  | viii |
| LIST OF FIGURES .....                | ix   |
| LIST OF MAPS .....                   | x    |
| LIST OF ABBREVIATIONS/ACRONYMS ..... | xi   |
| DEFINITION OF TERMS .....            | xiii |
| ACKNOWLEDGEMENT .....                | xiv  |

### CHAPTER ONE

#### GENERAL OVERVIEW

|  |    |
|--|----|
| 1.1 Background to the Study of private hospitals ..... | 1  |
| 1.2 Problem Statement .....                            | 2  |
| 1.3 Research Questions .....                           | 4  |
| 1.4 Objectives of the Investigation .....              | 5  |
| 1.5 Research Methodology .....                         | 5  |
| 1.5.1 Research Approach/Design .....                   | 5  |
| 1.5.2 Unit of Analysis and Key Variables .....         | 6  |
| 1.5.3 Criteria for Selecting the Study Area .....      | 7  |
| 1.5.4 Sampling and Data Collection Approach .....      | 7  |
| 1.5.5 Data Analysis and Presentation .....             | 9  |
| 1.6 Scope .....  | 10 |
| 1.7 Justification .....                                | 10 |
| 1.8 Limitation .....                                   | 11 |
| 1.9 Organization of the Research Report .....          | 11 |



## CHAPTER TWO

### EMERGING ISSUES OF PRIVATE HOSPITALS AND QUALITY HEALTH CARE DELIVERY

|            |   |           |
|------------|---|-----------|
| <b>2.0</b> | <b>Introduction.....</b>  | <b>12</b> |
| <b>2.1</b> | <b>Health Inequalities and Inequities .....</b>   | <b>12</b> |
| <b>2.2</b> | <b>Accessibility to Health Care .....</b>   | <b>14</b> |
| 2.2.1      | <i>Organizational Access .....</i>  | 14        |
| 2.2.2      | <i>Geographical Access .....</i>  | 14        |
| 2.2.3      | <i>Financial Access .....</i>   | 15        |
| 2.1.4      | <i>Socio-Cultural Access .....</i>  | 15        |
| <b>2.3</b> | <b>The Concept of Quality Health Care .....</b>   | <b>16</b> |
| 2.3.1      | <i>Dimensions/Indicators of Quality Health Care .....</i>                               | 17        |
| 2.3.2      | <i>Quality as a System .....</i>  | 19        |
| 2.3.3      | <i>Quality and Its Assessment .....</i>   | 20        |
| 2.3.4      | <i>Quality Health Care and Its Importance .....</i>                                     | 22        |
| 2.3.5      | <i>Barriers to Quality Assurance .....</i>  | 22        |
| 2.3.6      | <i>Improving Service Quality .....</i>  | 23        |
| <b>2.4</b> | <b>Structure of the Health Care System in Ghana .....</b>                               | <b>24</b> |
| <b>2.5</b> | <b>Overview of the Health Care System in Ghana .....</b>                                | <b>25</b> |
| 2.5.1      | <i>Vision, Goal and Objectives .....</i>  | 27        |
| <b>2.6</b> | <b>Private Health Care Provision .....</b>  | <b>27</b> |
| <b>2.7</b> | <b>Analytical Framework for Private Hospitals in Quality Health Care Delivery .....</b> | <b>29</b> |

## CHAPTER THREE

### PROFILE OF THE STUDY AREA

|            |                                     |           |
|------------|-------------------------------------|-----------|
| <b>3.1</b> | <b>Location and size .....</b>      | <b>31</b> |
| <b>3.2</b> | <b>Relief and Drainage .....</b>    | <b>31</b> |
| <b>3.3</b> | <b>Climate and Vegetation .....</b> | <b>33</b> |

|            |  |           |
|------------|--|-----------|
| <b>3.5</b> | <b>Demographic Characteristics .....</b>     | <b>36</b> |
| 3.5.1      | <i>Population .....</i>                      | 36        |
| 3.5.2      | <i>Age and Sex Structure .....</i>           | 37        |
| 3.5.3      | <i>Household Sizes/Characteristics .....</i> | 38        |
| <b>3.6</b> | <b>Economic Characteristics .....</b>        | <b>39</b> |
| <b>3.7</b> | <b>Education .....</b>                       | <b>40</b> |
| <b>3.8</b> | <b>Religion .....</b>                        | <b>41</b> |
| <b>3.8</b> | <b>Health Characteristics .....</b>          | <b>42</b> |
| 3.8.1      | <i>Doctor/Patient ratio .....</i>            | 44        |
| 3.8.2      | <i>Infant Mortality Rate .....</i>           | 45        |
| 3.8.3      | <i>Common Diseases .....</i>                 | 45        |

## CHAPTER FOUR

### RESULTS AND DISCUSSION OF SURVEY DATA

|            |   |           |
|------------|---|-----------|
| <b>4.1</b> | <b>Demographic Characteristics of Respondents .....</b>   | <b>47</b> |
| 4.1.1      | <i>Sex Structure .....</i>                                | 47        |
| 4.1.2      | <i>Religion and Ethnicity .....</i>                       | 48        |
| 4.1.3      | <i>Marital Status .....</i>                               | 49        |
| 4.1.4      | <i>Educational Levels .....</i>                           | 49        |
| <b>4.2</b> | <b>Economic Situation .....</b>                           | <b>51</b> |
| 4.2.1      | <i>Employment Status .....</i>                            | 51        |
| 4.2.2      | <i>Income and Expenditure Levels of Respondents .....</i> | 51        |
| 4.2.3      | <i>Ownership of Durable Goods .....</i>                   | 52        |
| <b>4.3</b> | <b>Sanitation Facilities and Conditions .....</b>         | <b>53</b> |
| 4.3.1      | <i>Types of Toilet Facilities .....</i>                   | 53        |
| 4.3.2      | <i>Places of Garbage Disposal .....</i>                   | 54        |
| 4.3.3      | <i>Sources of Drinking Water .....</i>                    | 55        |
| <b>4.4</b> | <b>Health Seeking Behavior of Clients .....</b>           | <b>56</b> |

|             |  |           |
|-------------|--|-----------|
| <b>4.5</b>  | <b>Client Satisfaction .....</b>   | <b>57</b> |
| <b>4.6</b>  | <b>Services Provided By Private Hospitals .....</b>  | <b>58</b> |
| <b>4.7</b>  | <b>Accessibility Analysis .....</b>  | <b>59</b> |
| <b>4.8</b>  | <b>Health Facilities .....</b>   | <b>61</b> |
| 4.8.1       | <i>Equipment and Infrastructure Facilities .....</i>   | 61        |
| 4.8.2       | <i>Functioning of Equipment and Infrastructural Facilities .....</i>   | 63        |
| 4.8.3       | <i>Medical Examination Facilities .....</i>  | 64        |
| 4.8.4       | <i>Sources of Funds for Maintenance .....</i>  | 64        |
| 4.8.5       | <i>Problems in Quality Health Care Delivery .....</i>  | 65        |
| <b>4.9</b>  | <b>Staffing Situation .....</b>  | <b>65</b> |
| 4.9.1       | <i>Adequacy of Staff .....</i>   | 65        |
| 4.9.2       | <i>Qualification of Staff .....</i>  | 66        |
| <b>4.10</b> | <b>Relationship between Private and Public Hospitals .....</b>   | <b>67</b> |
| <b>4.11</b> | <b>Contribution of the Metropolitan Health Directorate to<br/>Private Hospitals in Ensuring Quality Health Care Delivery .....</b> | <b>67</b> |

**CHAPTER FIVE**  
**PROSPECTS AND CHALLENGES, RECOMMENDATIONS AND  
CONCLUSION**

|                         |                                       |           |
|-------------------------|---------------------------------------|-----------|
| <b>5.1</b>              | <b>Prospects and Challenges .....</b> | <b>69</b> |
| 5.1.1                   | <i>Prospects .....</i>                | 69        |
| 5.1.2                   | <i>Challenges .....</i>               | 71        |
| <b>5.2</b>              | <b>Recommendations .....</b>          | <b>72</b> |
| <b>5.3</b>              | <b>Conclusion .....</b>               | <b>75</b> |
| <b>REFERENCES .....</b> |                                       | <b>77</b> |
| <b>APPENDICES .....</b> |                                       | <b>81</b> |

## LIST OF TABLES

|                    |  |       |
|--------------------|--|-------|
| <b>Table 1.1:</b>  | <b>Questionnaire Distribution in Sub-Metros</b>                        | 8     |
| <b>Table 1.2:</b>  | <b>Selected Private Hospitals</b>                                      | 9     |
| <b>Table 1.3:</b>  | <b>List of Respondents and Method of Data Collection used</b>          | 9     |
| <b>Table 2.1:</b>  | <b>Quality as a System</b>   | 20    |
| <b>Table 2.2:</b>  | <b>Quality Assessment Criteria</b>                                     | 21    |
| <b>Table 3.1:</b>  | <b>Metropolitan Road Conditions</b>                                    | 35    |
| <b>Table 3.2:</b>  | <b>Population of Kumasi (1960-2008)</b>                                | 36    |
| <b>Table 3.3:</b>  | <b>Population Growth Rate in Kumasi (1948 – 2008)</b>                  | 37    |
| <b>Table 3.4:</b>  | <b>Age – Sex Structure of Kumasi Metropolis</b>                        | 37    |
| <b>Table 3.5:</b>  | <b>Household Size Structure</b>  | 39    |
| <b>Table 3.6:</b>  | <b>Distribution of Educational Institutions by Sector (2006)</b>       | 41    |
| <b>Table 3.7:</b>  | <b>Religious Composition</b>   | 41    |
| <b>Table 3.8:</b>  | <b>Health Institutions in the Kumasi Metropolis (2006)</b>             | 43    |
| <b>Table 3.9:</b>  | <b>Doctor/ Patient Ratio in the Metropolis for 2003, 2004 and 2005</b> | 44    |
| <b>Table 3.10:</b> | <b>Infant Mortality Rates in the Metropolis</b>                        | 45    |
| <b>Table 3.11:</b> | <b>Top Ten Diseases</b>  | 46    |
| <b>Table 4.1</b>   | <b>Ethnicity/ Religion</b>   | 48    |
| <b>Table 4.2</b>   | <b>Educational Level Achieved</b>                                      | 49    |
| <b>Table 4.3</b>   | <b>Occupational/Employment Status</b>                                  | 51    |
| <b>Table 4.4</b>   | <b>Source of Drinking Water</b>  | 55    |
| <b>Table 4.5</b>   | <b>Reasons for the Choice of Health Facilities</b>                     | 57    |
| <b>Table 4.6</b>   | <b>Means of Travel to the Private Hospital</b>                         | 59    |
| <b>Table 4.7</b>   | <b>Distances to Access Health Facility</b>                             | 60    |
| <b>Table 4.8</b>   | <b>Health facility and the number of patients per day</b>              | 66    |
| <b>Table B1</b>    | <b>Health Facilities in Kumasi Metropolitan Area</b>                   | 81-87 |
| <b>Table B2</b>    | <b>Selected Private Hospitals</b>                                      | 88    |
| <b>Table B3</b>    | <b>Client Satisfaction Analysis</b>                                    | 89    |



## LIST OF FIGURES

|                    |  |    |
|--------------------|--|----|
| <b>Figure 2.1:</b> | <b>Analytical Framework</b>                      | 30 |
| <b>Figure 3.1:</b> | <b>Conditions of Road Network in Kumasi</b>      | 36 |
| <b>Figure 3.2:</b> | <b>Metropolitan Economic Structure (in %)</b>    | 40 |
| <b>Figure 3.3:</b> | <b>Causes of Death (2005-2007)</b>               | 46 |
| <b>Figure 4.1:</b> | <b>Educational Level Attained</b>                | 50 |
| <b>Figure 4.2:</b> | <b>Type of Toilet Facility Used</b>              | 53 |
| <b>Figure 4.3:</b> | <b>Place of Garbage Disposal</b>                 | 54 |
| <b>Figure 4.4:</b> | <b>Source of Drinking Water</b>                  | 56 |
| <b>Figure 4.5:</b> | <b>Distance Travel to Access Health Facility</b> | 60 |
| <b>Figure 4.6:</b> | <b>A Visible Sign at Asafo Agyei Hospital</b>    | 62 |
| <b>Figure 4.7:</b> | <b>Generating Plant</b>                          | 63 |
| <b>Figure 4.8:</b> | <b>Reservoirs on Building</b>                    | 63 |



## LIST OF MAPS

|               |   |    |
|---------------|---|----|
| <b>Map 1:</b> | <b>Kumasi in Regional and National context</b>                | 32 |
| <b>Map 2:</b> | <b>Sub Metropolitan Areas in Kumasi</b>                       | 33 |
| <b>Map 3:</b> | <b>Sub Metropolitan Areas under Which Health is Organized</b> | 43 |



## LIST OF ABBREVIATIONS/ACRONYMS

|         |   |
|---------|---|
| AM      | Alternative Medicine  |
| CBD     | Central Business District                                     |
| DHD     | District Health Directorate                                   |
| DHMT    | District Health Management Team                               |
| DMHIS   | District Mutual Health Insurance Scheme                       |
| FH      | Faith-based Healers   |
| GDHS    | Ghana Demographic and Health Survey                           |
| GHS     | Ghana Health Service  |
| GMT     | Greenwich Mean Time   |
| GPRS    | Ghana Poverty Reduction Strategy                              |
| GPRS II | Growth and Poverty Reduction Strategy                         |
| IOM     | Institute of Medicine   |
| JCAHO   | Joint Commission on Accreditation of Healthcare Organizations |
| KATH    | Komfo Anokye Teaching Hospital                                |
| KMA     | Kumasi Metropolitan Assembly                                  |
| KVIP    | Kumasi Ventilated Improved Pit                                |
| MDAs    | Ministries Department and Agencies                            |
| MDG     | Millenium Development Goal                                    |
| MHD     | Metropolitan Health Directorate                               |
| MoH     | Ministry Of Health  |
| MTDP    | Medium Term Development Plan                                  |
| NHIS    | National Health Insurance Scheme                              |
| OPD     | Out-Patient Department  |
| QGIH    | Quasi Government Institution Hospitals                        |

|       |  |
|-------|--|
| PHC   | Population and Housing Census              |
| PHMHB | Private Hospitals and Maternity Home Board |
| RHD   | Regional Health Directorate                |
| RHMT  | Regional Health Management Team            |
| SPSS  | Statistical Package for Social Sciences    |
| TBAs  | Traditional Birth Attendants               |
| THB   | Teaching Hospital Board                    |
| TMP   | Traditional Medical Providers              |
| TUC   | Trade Union Congress                       |
| WHO   | World Health Organization                  |





## DEFINITION OF TERMS

**CLIENT:** A person who receives health services or a person dependent on the patronage of private hospitals for health needs.

**HOUSEHOLD:** A person or a group of persons, related or unrelated, who live together in the same household or compound, share the same housekeeping arrangements and are catered for as one unit.

**HOUSEHOLD HEAD:** The head of the household sees to the day to day running of the household and ensures that the needs and well being of members are addressed. The head of a household is defined as the person in the household recognized as such by other members of the household. In his/her absence, any able bodied person of sound mind who took charge of the house was considered "temporary head". All respondents are defined with reference to the head or temporary head.

**PRIVATE HOSPITAL:** The Private Hospitals and Maternity homes Act 1958 (No. 9 of (1958) and amended by the Private Hospital and Maternity Decree 1969 (NLCD 393) defines a "private hospital" 'as any building or other premises where provision is made for medical attention or nursing facilities gratuitously or for reward, and used or intended to be used for the reception of persons suffering from any sickness, infirmity or injury or used or capable of being used for purposes of or incidental to child-birth, but does not include a maternity home, clinic or a government institution'.

**QUALITY HEALTH CARE:** The degree to which the resources for health care or the services included in health care correspond to satisfactory standard and meet the needs of people who patronize it. In a broader sense quality health care is the availability of inputs to deliver health services, the manner in which services are rendered to meet peoples' expectation and the satisfaction people derive from the use of the facility.

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# CHAPTER ONE

## GENERAL OVERVIEW

### 1.1 Background to the Study of private hospitals

The wealth of a nation is in the health of its people and Ghana as a state deserves good, quality and affordable health care for its people to contribute meaningfully to its socio-economic development to achieve national aspirations. According to a WHO executive board study on basic health services, in 1973, before the year 1978, an overwhelming majority of the world's population did not have access to adequate healthcare (WHO 1991). In Ghana, government plays a central role in providing health and establishes the institutional framework for the health sector and provides broad policy directions as well as defining the terms and conditions of public sector employment and the relationship between central and local government and providers of health services. It also legislates and enforces regulations to prevent dangerous practices and to protect the public against negative health practices.

Again the Millennium Development Goals (MDG) and the Ghana Growth and Poverty-Reduction Strategy (GPRS) II (2006) had indicated among other things quality healthcare delivery and the elimination of diseases and poverty as a major factor in achieving a middle-income status. However, a significant proportion of the people lack access to quality health services, especially as manifested in maternal mortality, fertility rates, malaria, guinea worm prevalence and equal access to health care. Besides, the ratio of nurses and doctors to patients as well as hours of waiting to access public health service are major obstacles to efficient health care delivery (GPRS II 2006).

The health service in Ghana is debatably the sector that had received much attention in recent times in a bid to reform it. Some of these improvements have come as a result of the strikes workers in the public sector had embarked on in recent times. The Ghana Registered Nurses Association Newsletter (2005) indicates that each time such a strike occurs hundreds of Ghanaians die painfully. Productivity also suffers and the national budget dislocated because the Government would have to cough out money from



anywhere including sourcing funds from other sectors of the economy to satisfy the nurses to save lives.

It is prudent therefore to advocate the extra participation from private organizations to invest in the health sector in Ghana so as to complement the effort of the public health sector. Until the destitute and the neglected in this country have access to quality healthcare, malaria, HIV/AIDS, tuberculosis, and other pathogenic as well as chronic diseases would continue to be the major headache to the Government and development.

According to Ulrich et al (2005), the privatization that brought competition in Chile's health care delivery brought about efficacy and efficiency, and, thus led to a better health care. Private hospitals in Ghana hardly go on strike and their salaries are paid based on input and output. Already, the Government had recognized the private sector as the engine of growth of which the health sector is no exception. Their operation however is beset with some prospects and challenges which the researcher wants to look into.

## 1.2 Problem Statement

Governments in developing countries are searching for ways to improve equity, efficiency, effectiveness and responsiveness of their health systems. In recent years there has been the acceptance of the important role played by the private hospitals in improving the health status of people. However, there has not been a systematic review of the private hospitals as against the public health delivery system.

According to Kunfaa (1996), in Ghana, the Ministry of Health (MoH) runs a three tier system of managing the health sector. The national head quarters, the regional level and the district level. Efforts have been made by government to restructure the MoH with a view of facilitating decentralized planning and management to improve health care delivery. The MoH delivers health services through a network of publicly owned health facilities such as hospitals, polyclinics, health centres and clinics. The delivery of health



services in Ghana is coordinated by the regional or district health administrations which on behalf of MoH/GHS pursue policies relating to the provision of health care services including the supervision of the private hospitals.

Private sector providers are a mix of the formal such as doctors, pharmacists, chemical sellers and non-governmental organizations and the informal such as herbalists and traditional birth attendants. According to a research conducted by Obuobi et al (1999), over 90% of Ghana's private formal health providers are located in Accra and Tema District as at 1999.

Over the years, heavy infusions of health care resources have been on going in Ghana in terms of infrastructural provision, training and manpower. Even with the increase in health manpower and hospital beds, the public health problems and service inadequacies are continuing. In the Kumasi Metropolitan area, there are only six government hospitals with about forty-four private hospitals (KMA Medium Term Development Plan 2006). Government in most developing countries, including Ghana had not fully succeeded to play the role of solely providing health care. La Fond, cited in Kunfaa (1996) stated that "state dominance in the health sector went unchallenged until the late 1980's".

Attitudes toward private health care providers in developing countries are changing. Growing numbers of policymakers are considering or attempting to incorporate private facilities and practitioners into overall sector policy, using methods such as contracting, training of private practitioners and integration into public referral networks among others. Unfortunately, these efforts are infrequently recorded, making it difficult for policymakers to learn from the experience of others. The ever increasing costs of constructing public health institutions; running and maintaining them, providing and maintaining modern equipment and machinery, staffing and sustaining personnel among other costs, have left the government struggling to run the existing facilities effectively and efficiently.

The existing distribution of healthcare facilities has been very uneven and in many cases expansion of such services go on mainly in urban areas, leaving the majority of the population in the rural areas without such services or with only ineffective and inadequate ones. Who cares about the time it takes for patients to return to work after episodes of sickness? Do the majority of these private institutions concentrated in urban areas have the necessary infrastructure and equipment? Who supervises the ever increasing private institutions in the urban areas? These are questions yet to be answered.

In many of our districts in Ghana, there has been pressure on the main government hospitals located mostly at the district capitals even though several efforts have been put in place to ensure that the PHC system operates. The public sector alone however, is unable therefore to reach out to all communities. The private hospitals are to offer assistance to deliver the service to increase accessibility, efficiency and quality of health care delivery.

### 1.3 Research Questions

The questions the researcher is asking are:

- Do the private hospitals have the basic infrastructure and equipment for providing quality health care?
- Do the private hospitals have the requisite manpower (requisite qualification and training) to ensure quality health care delivery?
- Do people have access to the existing private hospitals?
- What are the prospects and challenges of private hospitals' involvement in the provision of basic health care?
- How best can private hospitals be improved to address the health needs of the people in the Kumasi metropolis?

## 1.4 Objectives of the Investigation

- To find out whether people have access to the existing private hospitals.
- To find out whether the existing private hospitals have the basic infrastructure and equipment for providing quality health cares.
- To assess whether private hospitals have the requisite manpower qualification and training to ensure quality health care delivery.
- To investigate the prospects and challenges of private hospitals' involvement in the provision of basic health care.
- Make policy recommendations on how best private hospitals can be enhanced to promote quality health delivery.

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## 1.5 Research Methodology

### 1.5.1 Research Approach/Design

Choosing a research design or approach depends on a number of factors. Some of these factors include, the objective of the study, the population sample, the control the researcher has on the event being studied, the purpose of the study, be it assessment, descriptive or experimental, the time available for the study and the kind of data to be used among others.

Having considered the above factors, the cross-sectional design was used for the study; specifically the case study approach, which enabled an appreciable level of investigation within the limited time available for the research. The choice of the case study model was also based on the fact that the subject is in a “real life” context and therefore must be investigated in detail to find out the relationships it has with its environment and vice versa. The use of the case study model also allows one to compare similar arrangements in other districts to inform policy decisions for the improvement of private participation in quality health care delivery.

Kumekpor (2002) indicated that even though the case study method involves procedures and techniques of investigation, it does not completely rely on interviewing. The combination of techniques in case study enables the researcher to make inferences from



the issues or situation under investigation and take appropriate decisions and useful solutions. The case study approach also helps the researcher to make careful search as regards to the problem and issues raised in the case and carefully analyze the issues and make suggestions and recommendations. The different techniques in the case study approach helped the researcher to appreciate the uniqueness of each case under investigation.

Again, by using this approach, various units or event can be examined within a limited time frame. The unit under investigation in this research was principally private hospitals and households. Detailed information was obtained using different data collection procedures such as questionnaires and interviews. Data from both secondary and primary sources was also used for the study. Secondary sources of data was collected mainly from library research, publications, health reports, unpublished thesis, text books, news papers, hospital records, and Internet links related to the topic. Primary source of data also involved observations, mail and self administered questionnaires, and the use of unstructured interview guides.

#### *1.5.2 Unit of Analysis and Key Variables*

Selecting the subject matter for inquiry is very important in research because it influences the data collection and data to be analyzed. The unit of analysis is the ultimate subject matter around which the data is gathered. The unit of analysis according to Kumekpor (2002) refers to the actual empirical units, object and occurrences among others which must be observed or measured in order to study a particular phenomenon. Thus the unit of analysis for the study was the operators of private hospitals and households. With regards to households, emphasis was on preferably the head of the household selected within the community. Other key informants were officials of the Metropolitan Assembly, officials of the District Health Directorate (DHD), and Staff of private hospitals.

In research, variables are very important to guide the researcher to be more focused on the event under investigation and progress from a conceptual level to an empirical level.



Choosing the variables depends on the objectives of the event under study. Data collected from the various households were based on variables issues such as sex, educational background, income and expenditure levels, access to health facilities, level of satisfaction and type of health facilities available. With regards to the institutions, data on types of facilities, adequacy of facilities, services they render, sources of funds for maintenance, staffing situation (adequacy and qualification), district influence over the private hospitals, relationship between private and public hospitals, contribution of District Health Directorate to private hospitals and prospects and challenges of private hospitals were looked at.

### *1.5.3 Criteria for Selecting the Study Area*

Considering the time available for the research, the criteria used for the selection of the study area included proximity to enable the researcher to visit an appreciable number of the private hospitals, an area where the researcher can effectively communicate with the people, a district where there are a number of the private hospitals to allow for proper sampling and representation. Also the district has to be one where the private hospitals have been practicing for not less than three years. The Kumasi Metropolitan Assembly met all the above criteria and thus the choice of the area for the study.

### *1.5.4 Sampling and Data Collection Approach*

The resources and size of the study area would not permit a complete survey of the Metropolis within the limited time frame. A sample from selected communities within the Kumasi Metropolis was surveyed. To arrive at a sample size (n), the following formula was used.

$$n = N / [1 + Ne^2]$$

where “N”=Population frame

“e”= Margin of Error

At 90% confidence level; Margin of Error of “e”=0.1 and “N”= 1,782,424

This gives a sample size as  $n = 1,782,424 / [1 + (1,782,424)0.1^2] = 99.99$  which is approximately 100.

The sample size of 100 questionnaires was administered among the five sub-metros under which health is organized within the Kumasi metropolis. The distribution was therefore as follows:

**Table 1.1 Questionnaire Distribution in Sub-Metros**

| Sub- Metro              | No. of Questionnaires |
|-------------------------|-----------------------|
| Manhyia South Sub-metro | 20                    |
| Asokwa Sub-Metro        | 20                    |
| Bantam Sub-Metro        | 20                    |
| Manhyia North Sub-Metro | 20                    |
| Subin Sub-Metro         | 20                    |
| <b>Total</b>            | <b>100</b>            |

Source: Author's Construct, Jan. 2008

The systematic random sampling of five every other house was used to select the household for the administration of the 20 questionnaires within each sub-metro. Where household heads were not available, any able bodied person of sound mind within the household was interviewed.

Kumasi Metropolitan area has 44 private hospitals. The private hospitals are spread under five Sub-metros. The sample frame for the selection of the private hospitals was made available by the Metropolitan Health Directorate. The crude random sampling method was used within the existing Sub-metros to select the private hospitals. A total of ten private hospitals were selected (See table 1.2 below). This method was applied so that each private hospital in the existing Sub-metro was given a fair chance to be selected. However, in the case of the selection of officials of the District Health Directorate, officials of Metropolitan Assembly, Operators of Private Hospitals and Staff of Private Hospitals, the purposive sampling method was used since their numbers were small.



**Table 1.2 Selected Private Hospitals**

| Community               | No. of Private Hospitals | Private Hospitals Selected                         |
|-------------------------|--------------------------|--|
| Manhyia South Sub-metro | 7                        | 1. Sarfo Adu Hospital<br>2. Keffam Health Services |
| Asokwa Sub-Metro        | 14                       | 1. Christ the King Hospital<br>2. City Hospital    |
| Bantam Sub-Metro        | 15                       | 1. Asafo Adjei Hospital<br>2. Siloam Hospital      |
| Manhyia North Sub-Metro | 5                        | 1. Suame Hospital<br>2. Kumasi Medical Centre      |
| Subin Sub-Metro         | 3                        | 1. Gloria Memorial Hospital<br>2. Kuffour Clinic   |
| <b>Total</b>            | <b>44</b>                | <b>10</b>  |

Source: Author's construct, 2007

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**Table 1.3 List of Respondents and Method of Data Collection used**

|  |                                 |                            | Study Communities and no. of Respondents |           |               |               |           |            |
|--|---------------------------------|----------------------------|--|-----------|---------------|---------------|-----------|------------|
| Type of Respondents and data collection tools used |                                 | Sampling technique used    | Asokwa                                   | Bantam    | Manhyia North | Manhyia South | Subin     | Total      |
| Household survey                                   | Questionnaire                   | Systematic Random sampling | 20                                       | 20        | 20            | 20            | 20        | 100        |
| Metro Assembly officials                           | Personal Interview              | Purposive                  | -  | -         | -             | -             | -         | 1          |
| DHD officials                                      | Personal Interview              | Purposive                  | -  | -         | -             | -             | -         | 1          |
| Operators of Private Hospitals                     | Mailed Questionnaire            | Purposive                  | 2  | 2         | 2             | 2             | 2         | 10         |
| Staff of Private Hospitals                         | Self Administered Questionnaire | Purposive                  | 2  | 2         | 2             | 2             | 2         | 10         |
| Total number of sample Private Hospitals           |                                 | Random Sampling            | 2  | 2         | 2             | 2             | 2         | 10*        |
|  |                                 | <b>Total</b>               | <b>24</b>                                | <b>24</b> | <b>24</b>     | <b>24</b>     | <b>24</b> | <b>122</b> |

Source: Author's Construct, Jan. 2008

\* Not part of Respondents

### 1.5.5 Data Analysis and Presentation

Data on respondents was analyzed by using quantitative and qualitative methods of data analysis. Quantitatively, statistical methods used include: tallies, summations, mean among others and particularly the use of Statistical Package for Social Sciences (SPSS). Analyzed data was presented in tables, graphs and charts. This was complemented



qualitatively from information derived from key informant interviews. A careful mix of both qualitative and quantitative research instruments was used.

## 1.6 Scope

Kumasi has a population of about 1,782,424 and about 44 known private hospitals scattered within the five Sub-metros (KMA MTDP 2006-2009). The research is an assessment of the prospects and challenges of the private hospitals in quality health care delivery in the Metropolis in terms of actors, and spatial coverage in line with the research philosophy and resource availability and does not include traditional birth attendants, clinics, maternity homes, private laboratories, traditional medicine, drug stores and chemical sellers. In terms of content, their facilities available, operation and management, services provided and access issues were examined.

## 1.7 Justification

It has become clear that Government alone cannot adequately perform the developmental functions to the citizens of the economy. The participation of non-state actors in development activities is critical now than ever. The Local Government Act (Act 462) and other relevant laws of the country have sections that empower state development practitioners among others to involve the private sector in their developmental activities. Policies have also been formulated to guide collaborative actions between the public and private sectors.

The private hospital involvement in the provision of health services is an attempt to infuse efficient business practices to ensure service satisfaction. The current shift in development paradigm in favour of a reduced role of the state in service provision is a welcome development especially when the District Assemblies have overstretched their limited resources to get these services provided, although with very little success. Phase two of the GPRS, in its human resource development theme stresses the need to improve health care delivery. The study is therefore being undertaken to contribute to the on-going search for realistic strategies to promote better health for the people to enhance development.



The expected output of the study would add to verifiable body of knowledge in the field of development planning and management. This study shall also inform policy makers, planners, administrators, researchers and academicians in the field of private hospitals in development related issues.

### **1.8 Limitation**

The major limitation of the study is the delay in the acquisition of relevant information from some the respondents. Some of the respondents, especially the institutions were not ready to volunteer information for the researcher. Some of them require amounts of money which was not within the means of the researcher.

### **1.9 Organization of the Research Report**

The output of the whole research has been presented in the form of a scientific research paper in five chapters. The first chapter deals with the background to the study, research problem, objectives, methodology, scope, and justification. The second chapter focuses on opinions of other writers about issues raised in the study. Chapter three also provides the platform for description of the selected area (Kumasi Metropolitan Area). The fourth chapter consists of an in-depth analysis and presentation of the data collected from the field while discussion of prospects and challenges of private hospitals in quality health care delivery, recommendations and conclusion are presented in chapter five.

## CHAPTER TWO

### EMERGING ISSUES OF PRIVATE HOSPITALS AND QUALITY HEALTH CARE DELIVERY

#### 2.0 Introduction

This chapter is basically the review of materials on issues concerning private hospitals in quality health care delivery. The chapter looks at issues concerning health inequalities and inequities, access to health care, the concept of quality health care, structures of health care system in Ghana and private health care provision.

#### 2.1 Health Inequalities and Inequities

Achieving equity is a goal pursued by policy makers across the spectrum of nations. The concern of many governments is how to bridge the gap of inequality and inequities in their countries (Acheson, 1998). Leading organizations are championing the course of optimizing the delivery of health care wherever possible to reach all people to bridge the gap of inequalities in health service delivery (<http://www.capgemini.com>).

Access to quality health care for the poor and vulnerable is unresolved in many countries. There are geographically inequitable distribution of facilities and providers together with income-related inequalities of health outcomes. In countries where many of the citizenry are living in poor conditions, it is common that the health status of the people is affected by the issues of inequity and inequality.

Inequities in health are the differences in the levels of health among distinct socio-economic groups that are considered unfair and unjust. Inequality is also the unequal opportunities or treatment based on differences in health determinants or outcomes within or between defined populations such as social, ethnic, racial or economic conditions (Scott-Samuel, 2004).

In many countries, several studies have pointed out the important magnitude health inequalities pose to development. In addition, and more disturbing is that regardless of the knowledge of what inequalities can do the general improvement of the average

population health conditions, an increasing trend of health inequalities still occur in many regions.

Inequities in health systematically put groups of people who are already socially disadvantaged (for example, by virtue of being poor, female, ethnic, or religious group) at further disadvantage with respect to their health. Health inequalities and inequities are not the same or perceived the same way within countries and across countries. Many authors such as Holm (1989) have indicated that countries like Denmark view inequality in terms of access.

Much healthcare reforms the world over have been driven by a set of principles that emphasize efficiency and effectiveness and give little consideration to equity (Gilson 1999). The need to equitably distribute health care to reach the vulnerable and the disadvantaged in society is also very important. Elements that bring about inequalities in the provision of health care must be given the needed consideration than they are at present.

Not all governments recognize inequalities in health care delivery as something the public sector alone can or should address. Nevertheless many governments are interested in improving and achieving economic growth. The World Health Organization (WHO) recognizes the importance of various nations and governments to improve the health status of the citizenry as a means of achieving improved development and reduce poverty. If improving health can have a positive effect on economic growth, then health should become a central priority of every government (WHO 1999 in Egglely 2007).

The afore mentioned issues tell how complex it is in terms of the perceptions and concepts in addressing inequalities and inequities to deliver quality health care. A clear understanding of health inequalities and inequities is paramount for the development of policies and interventions that support all sections of society, as well as directing services, treatment and care in proportion to need.



## 2.2 Accessibility to Health Care

Access to health care is an important component of an overall health system and has a direct impact on the burden of disease that affects many countries in the developing world. Measuring accessibility to health care contributes to a wider understanding of the performance of health systems within and between countries which facilitates the development of evidence based health policies (WHO 2004). According to Bannerman et al (2002), access is the ability of the individual to reach and obtain service. Accessibility is also the ease with which health services are reached (Kelley and Hurst 2006). To Bannerman et al (2002), access to health care service include the following:

### 2.2.1 Organizational Access

Organizational access is the extent to which services are organized for clients such that they can receive care when they need it. Organizational access encompasses issues like hospital hours, waiting time and appointment systems. Supply-side conditions may often be a barrier to access or attract clients. Commonly, health staff may lack skills, or adopt a discouraging attitude towards patients (particularly those who cannot pay). In some cases, diagnostic facilities and drug supplies may be often lacking, the quality of care for patients low, and the ability to diagnose and treat common illnesses often very limited. These barriers may be perceived or real, but in either case they often prevent people from attending facilities. According to Annear (2006), evidence from Phnom Penh in Cambodia (and elsewhere) suggests that it is often the conflict of interest on the part of the health staff, many of whom deny patients quality health care at public facilities in order to attract them into their own private practices.

### 2.2.2 Geographical Access

This is whether people who need to use health service can reach them. Geographical access is determined by factors such as siting of the health facility, distance and means of transport and travel time. For poor communities in remote areas the physical barriers to accessing public health facilities are often prohibitive. The need to travel long distances, or the excessive time taken to travel, often dissuades people from visiting facilities, particularly in conditions where it is thought that the health centre or referral hospital may not be open on arrival. Especially in remote areas, facilities may only open for an



hour or two each morning. This difficulty is compounded when people have no access to transport to assist with travel and must make long journeys on foot, or by boat, which may be the only means of transport in some coastal areas. Users perceive the difficulty in accessing transport and the poor conditions of roads or transport facilities as the barrier to seek medical attention, not simply distance.

### *2.2.3 Financial Access*

Financial access or affordability is whether or not users can pay for the service. Two main factors determine affordability. These are the level of fees, and the ability of the clients to pay no matter the charge levels. The costs of attending health services may be known or unknown, but in either case may prevent people from attending facilities. Even where costs are known they may not be affordable. The dangers of hidden costs could financially ruin a family from even routine services. Costs paid by patients include not only user fees but also drugs, transport and food costs during hospitalization. There are also expensive opportunity costs to be met in terms of forgone income earning opportunities or work-related activities, particularly when long periods of absence are required that would otherwise have benefited the family materially.

### *2.1.4 Socio-Cultural Access*

This deals with social or cultural characteristics, values, beliefs, and attitudes that may serve as a catalyst or barrier to service. If hospitals do not communicate with a client in a language that he understands, they make their services culturally inaccessible to him. When the provider is communicating in a language that the client normally understands, it should be simple, rather than loaded with unfamiliar technical terms and jargon. Even where other barriers can be addressed, often there are still constraints on the use of health facilities arising out of the beliefs and practices commonly evident among communities, especially in rural and remote areas. One barrier is the widespread lack of adequate formal education, illiteracy, and ignorance about disease. Generally, village people prefer to be treated at home, where they are more able to control the episode and draw on resources, and where opportunity costs are low. There is a widespread preference for self medication or for access to traditional healers (whose practices are known and understood and whose costs can often be met in kind rather than in cash).

### 2.3 The Concept of Quality Health Care

Quality Health Care is a term that has been defined severally by different people. According to Feld (2007), Quality Health Care is the degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge. In explaining Quality Health Care, Clancy (2007) also contended that to achieve the best possible results, health care quality is:

- Doing the right thing (getting the medicines, tests, and counseling you need)
- Doing it at the right time (when you need them) and;
- Doing it in the right way (with your health care providers using the appropriate test or procedure).

According to Roemer and Montoya-Aguilar (1988), Quality Health Care concerns the degree to which the resources for health care or the services included in health care correspond to satisfied standard. Those standards, if applied, are generally expected to lead to desired results. Black (1992) identified one fewer in defining a high quality service as one which provides effective care, that meets everyone's needs and that is delivered equitably, humanely and efficiently.

The United State Institute of Medicine (IOM) provided a six-part definition of health care quality that institutions view as the emerging standard (Callender et al 2004). To the IOM, quality involves: *safe* – avoiding injuries to patients from the care that is intended to help them; *effective* – providing services based on scientific knowledge to all who could benefit and refraining from providing services to those not likely to benefit (avoiding underuse and overuse, respectively); *patient-centered* – providing care that is respectful of and responsive to individual patient preferences, needs, and values and ensuring that patient values guide all clinical decisions; *timely* – reducing waits and sometimes harmful delays for both those who received and those who give care; *efficient* – avoiding waste, including waste of equipment, supplies, ideas, and energy; and *equitable* – providing care that does not vary in quality because of personal characteristics such as gender, ethnicity, geographic location, and socio-economic status.



### 2.3.1 Dimensions/Indicators of Quality Health Care

Dimensions of healthcare performance are those definable, preferably measurable and actionable, attributes of the system that are related to its functioning to maintain, restore or improve health (Kelley and Hurst (2006). To them, there are a range of dimensions that can be used to assess the existing quality of health care. Other authors have also come out with different indicators of measuring quality such as Bannerman et al (2002).

The most commonly used dimensions or indicator include *effectiveness* which is the degree of achieving desirable outcomes, given the correct provision of evidence-based healthcare services to all who could benefit, but not to those who would not benefit (Arah et al. 2003). Donabedian (2003) stresses that effectiveness is the extent to which attainable improvements in health are, in fact attained. Juran and Godfrey (2000) also cited effectiveness as the degree to which **processes** result in desired outcomes, free from error.

The dimension of *safety* means the degree to which health care processes avoid, prevent, and ameliorate adverse outcomes or injuries that stem from the processes of health care itself (National Patient Safety Foundation, 2000). Safety is a dimension that is closely related to effectiveness, although distinct from it in its emphasis on the prevention of unintentional adverse events for patients.

*Responsiveness* refers to how a system treats people to meet their legitimate non-health expectations (WHO, 2000). Responsiveness is also the degree to which a system actually functions by placing the patient/user at the center of its delivery of healthcare and is often assessed in terms of patient's experience of their health care. This experience of care refers to the caring, communication and understanding that should characterize the provider-patient relationship. The emphasis here is on the patient's report of her or his experience with specific aspects of care and goes beyond her or his general satisfaction or opinion regarding the adequacy of care.



*Efficiency* is the system's optimal use of available resources to yield maximum benefits or results (JCAHO, 1997). It speaks of a system's ability to function at lower costs without diminishing attainable and desirable results. Efficiency also refers to the overall allocation of public and private expenditures in the health system, which is the overall health spending at the "right" level? In some cases, efficiency is alternately termed "sustainability" or "affordability". Efficiency refers to the value for money realized with available resources, that is, the health system as productive as possible in light of the system inputs and desired outputs. Donabedian (2003) identified the following as other indicators of Quality Health Care:

*Acceptability:* The conformity to the realistic wishes, desires and expectations of healthcare users and their families. Since a person's healthcare experiences have a powerful effect on their future utilization of and response to healthcare, acceptability is fundamental to the quality of care patients receive.

*Appropriateness,* as a performance dimension, is the degree to which provided healthcare is relevant to the clinical needs, given the current best evidence. This dimension is most often presented as part of *effectiveness*.

*Competence or capability:* This dimension assesses the degree to which health system personnel have the training and abilities to assess, treat and communicate with their clients. There are many potential aspects of competence in this context, including technical competence as well as cultural competence.

*Timeliness:* This is also a related concept that is used to refer to the degree to which patients are able to obtain care promptly. It includes both timely access to care and coordination of care once under care, the system facilitating moving people across providers and through the stages of care. There are clinical elements of timeliness, such as the length of time from admission to the administration of therapy for recovery, and there are patient centeredness aspects of timeliness, such as patients' perceptions of their ability to get an appointment for needed urgent care as quickly as they want (Aday and Anderson, 1975).



For private hospitals to perform efficiently to deliver quality health care there is the need to use the indicators as a yardstick to measure standards set by the government, themselves and their clients. This is to ensure that there is sound knowledge base from which appropriate care can be planned and delivered. The ultimate goal should be to ensure that services are not only sensitive but responsive to differences so that individual needs are recognized and addressed.

### 2.3.2 *Quality as a System*

Quality can be looked at from the systems point of view (Bannerman et al 2002). The system is made up of structures, processes, outputs and outcomes and in addition impacts.

*Structure quality* is the availability and quality of inputs needed to carry out an activity or deliver a service. It also refers to how well the service is organized to achieve set objectives. Inputs include physical structure and other materials resources like vehicles, equipments, drugs, furnishing and stationery. Others include human resources such as number and type of personnel, how well trained they are and what system there are to motivate, develop and retrain them. It also includes the management and organizational structures, policies and adequate functioning communication channels.

*Process quality* is also the manner in which services are actually rendered to meet expectations. Some of these process issues in the delivery of quality health care are: waiting time, arrangement of patients, patients flow, information flow and rapport with client, physical examination, receiving patients, privacy, confidentiality of patients' health information, adherence to professional standards and guidelines, appropriate application of technical skills and so on.

*Outcome quality* is measured by the results of care. These also include satisfaction of patients with services, recovery of patients, utilization, re-attendance and re-admission, complications and deaths. Looking at quality as a system, Bannerman et al (2002) further developed a merger of issues for discussion illustrated below.

**Table 2.1 Quality as a System**

|  |   |  |   |
|--|---|--|---|
| <b>Components of The Health System</b> | <b>Quality of Structure</b> <ul style="list-style-type: none"> <li>• Policy</li> <li>• Resources</li> <li>• Organization</li> <li>• Management</li> </ul>   | <b>Quality of Process</b> <ul style="list-style-type: none"> <li>• Service delivery</li> </ul>   | <b>Quality of Outcome</b> <ul style="list-style-type: none"> <li>• Output</li> <li>• Health status</li> </ul>                               |
| <b>Dimensions of Quality</b>           | <ul style="list-style-type: none"> <li>• Accessibility</li> <li>• Availability</li> <li>• Affordability</li> <li>• Relevance to needs</li> <li>• Goodness of amenities</li> <li>• Equity</li> <li>• Sustainability</li> </ul> | <ul style="list-style-type: none"> <li>• Appropriateness</li> <li>• Acceptability</li> <li>• Technical competence</li> <li>• Safety</li> <li>• Good interpersonal relations</li> <li>• Efficiency</li> </ul> | <ul style="list-style-type: none"> <li>• Coverage</li> <li>• Effectiveness</li> <li>• Health impact</li> <li>• User satisfaction</li> </ul> |
| <b>Perspective of Quality</b>          | Client quality <-> professional quality <-> management quality  |  |   |

Source: Ghana Health Service Quality Assurance Manual 2002

2.3.3 Quality and Its Assessment

Over the last few years there has been growing attention to the issue of quality and its measurement across all aspects of health care. In the UK the document, *Working for Patients*, which instituted the major reforms of the National Health Service had an objective to give patients, wherever they live in the UK better health care and greater choice and satisfaction of the service available. The measures which were proposed for achieving the targets included improvement in the quality of service and audit of quality across the health service (Black 1992).

Quality assessment can be described as an evaluative activity in which quality of provision in a service is assessed against standards developed for the structure of that service, the processes within it and its outcome together with efforts to make changes as and when necessary. The initial attention to quality tended to be a concern of health systems in the USA and Europe rather than those in the developing countries. Forsberg et


  
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al (1992) pointed out that attention in the developing world has tended on the extension of services to previously unmet groups. There is now a growing interest in quality assurance in developing countries.

Maxwell (1984) suggested six aspects to assess quality of health care. These aspects include access to service, relevance to need for the whole community, equity, social acceptability, effectiveness, efficiency, and economy. Catford (1993) in Tones and Tilford (1995) has suggested that it may be premature to define rigid criteria for assessing quality even though he agreed that there should be a common set of criteria that can be used to assess performance and quality. At a certain level of generality, there can probably be an agreement on dimensions of quality to be assessed. What will be used as criteria of quality within these dimensions will depend on philosophical approach, whether to address elements of health or the whole of it. Catford therefore offered some vital elements of assessing quality.

**Table 2.2 Quality Assessment Criteria**

| Criterion     | Structure                                | Process                                 | Outcome                                     |
|---------------|--|---|---|
| Acceptability | Designated space meeting agreed criteria | Assessment of staff attitudes           | Uptake of hospitals                         |
| Need          | Practice based hospitals                 | Client participation                    | Reports of needs met                        |
| Effectiveness | Percentage attenders                     | Patient and professional satisfaction   | Health measures e.g BP cholesterol          |
| Efficiency    | Patients seen per hour                   | Ratings on counseling techniques        | Cost in relation to behavior changes        |
| Equity        | Availability of interpreter service      | Written materials in minority languages | Impact on inequalities in health statistics |

Source: Tones and Tilford (1995)



#### 2.3.4 *Quality Health Care and Its Importance*

There is no doubt that provision of quality health care produces enormous benefits to the providers, client and to the nation as a whole. Bannerman et al (2002) in trying to underline some of the benefits of quality assurance also stated that poor quality is very costly. The benefits of good quality to the client include less frustration, optimum use of money, good health outcome and satisfaction.

To the service providers and health care managers, delivering good quality health care results in better understanding of staff and clients, making essential input available, less frustration, good reputation, low complications, low infection rates, limited error in health facility, efficient use of resources, high job satisfaction and most importantly enabling them to meet accreditation criteria. It is therefore imperative for all stakeholders involved in issues of health care to stress on quality.

#### 2.3.5 *Barriers to Quality Assurance*

There are several situations that make it difficult to apply the principle of quality assurance. These barriers threaten the success of quality assurance and must be prevented as much as possible (Bannerman et al 2002). The barriers include:

- Non-commitment of top management to quality
- Wrong attitude of staff
- Lack of team work
- Concept of quality is poorly understood
- Inadequate information about routine practice
- Suspicion about comparison
- Patient views are not given adequate attention
- Lack of facilitative supervision

The tool to overcome these barriers is determination. Donabedian (2003) quoted that “the single most important condition for success in quality assurance is the determination to make it work. If we are truly committed to quality, almost any reasonable method will work. If we are not, the most elegant construction of mechanisms will fail”



### 2.3.6 *Improving Service Quality*

The rich often utilize private providers extensively but undoubtedly, the poor also patronize the services of the private hospitals. More importantly, the poor most often seek care from unqualified and poorly skilled practitioners or pharmacists. Since most attempts to alter these utilization patterns have failed, in some countries policy-makers are exploring methods to improve the quality of care these providers offer as the most direct instrument to improve health care for the poor (Harding (2001). In Ghana, 50 percent of surveyed private clinic patients are from the low-income group and a household survey in Rajasthan also reports that about 80 percent of private sector child health care clients and 75 percent of public sector clients belong to the lower one-half of the income distribution (Sclafani, 1997).

To improve service quality, health administrators require a very specific definition of what is to be assured, for whom, where, when and how the quality should be spelt out. All this should be done in a manner that is relevant and useful for the operation of private hospitals. What should be assured as quality is the delivery of relevant and effective health interventions in line with standards. The objective is to ensure that the simplest effective activities needed are executed in a proper manner (Roemer and Montoya-Aguilar, 1988).

This presupposes that the technologies offered in the field of promotion, prevention, diagnosis, treatment and rehabilitation will be appraised and selected on the basis of their potential for making an impact on the main health problems of the population, with safety as an absolute requirement. Quality care must therefore be based on the use of appropriate technology. For example a simple procedure carried out in the most peripheral unit, such as the sterilization of syringes, should comply strictly with standards of performance if it is not to endanger the health of the people. The same expectations of quality, not more not less, should also be expected from the private hospitals.

Standards of quality should therefore be developed by health systems in a comprehensive manner. In addition, they should not only refer to the technical aspects of effectiveness

and safety. Other related aspects should be included such as compatibility of the service and the environment with human dignity; good communication with communities, with patients, and with their sectors, including a sufficient explanation of health-related events and programmes and the promotion of collective responsibility for health (Roemer and Montoya-Aguilar, 1988).

#### 2.4 Structure of the Health Care System in Ghana

There are four main categories of health care delivery systems in Ghana – the public, private-for-profit, private-not-for-profit, and traditional systems (MOH, 1997). The health system revolves around the Ministry of Health. Administratively, it has a hierarchical organizational structure from the central headquarters in Accra (the capital city) to the regions, districts, and sub-districts. Services are delivered through a network of facilities, with health centres and district hospitals providing primary health care services, regional hospitals providing secondary health care, and two teaching hospitals at the apex providing tertiary services. The two teaching hospitals also play a key role in teaching and research – offering facilities for the training of physicians and other health professionals, and as well for medical and public health research (Govindaraj *et al.*, 1996).

The Ministry of Health is charged with the responsibility of regulating the entire health sector through its several policies. The main function of the Ministry is policy formulation, coordination and regulation of the stakeholders in the health sector. In formulating such policies or guidelines for regulation, the ministry collaborates with various Ministries, Departments and Agencies (MDAs) as well as other partners and stakeholders in the health sector (Ackon, 2003; Abekah-Nkrumah, 2005). Policy implementation is carried out through the public, private and traditional sectors. At the public sector end, the Ghana Health Service (GHS), Teaching Hospitals Board (THB) and the Quasi Government Institution Hospitals (QGIH) are the implementing agencies of the ministry.

The Ghana Health Service is responsible for the implementation of government's health policy and regulation of state run health institutions. For the purpose of carrying out its functions, the Ghana Health Service has a secretariat that has been decentralized from the national level to the regions and the districts. At each level there is a team of management that administers the affairs of the service. The districts report to the regions and the regions report to the national level as stipulated in the Ghana Health Service and Teaching Hospitals Act (1996), Act 525. The Teaching Hospital Board (THB) is the institution responsible for the implementation of government's health policy and regulation at the teaching hospital level. This institution was also established by Act 525. The last of the public sector agencies is the Quasi Government Institution. It is responsible for the implementation and regulation of hospitals owned by quasi government institutions (Ackon, 2003; Abekah-Nkrumah, 2005).

The private sector is also a major player in Ghana's health sector, responsible for about 40 per cent of total healthcare delivery (Abekah-Nkrumah, 2006). The main regulatory body for the private sector is the Private Hospitals and Maternity Homes Board (PHMHB), established by Act 1958 (No. 9) as amended. The main providers in the private sector are the mission-based providers; consisting of Christian and Moslem hospitals and the private medical and dental practitioners. Finally, activities of the traditional sector are regulated by a directorate in the Ministry of Health. However, the institutional and legal framework necessary to carry out such work is currently not in place. The main traditional healthcare providers in this sector are the Traditional Medical Providers (TMP), Alternative Medicine (AM) and Faith-based Healers (FH) (Ackon, 2003; Abekah-Nkrumah, 2005).

## **2.5 Overview of the Health Care System in Ghana**

Before the colonial era, the health of the people of Ghana was nurtured and maintained by the traditional health practitioners. These include herbalist, healers, soothsayers, bonesetters, traditional midwives or birth attendants, spiritualists, and so on. According to Kunfaa (1996), the traditional health practitioners were not organized as a group. There was not an organized national health care system. The health of the individual was at



best, the responsibility of the family. However the entire community showed concern for the sick.

The colonial era saw the introduction of a “new” kind of health care. Initially, the “new” health care was restricted to the Europeans alone. After sometime, this health care was extended to the servants and houseboys who worked for the Europeans and later extended to include the indigenous people. Kunfaa (1996) further explained that around 1868, the first hospital was opened in the Cape coast and later in Accra, Kumasi and towns along the coast.

After independence, there was a proliferation of hospitals all over the country by the Nkrumah government which were all own by the government. By the 1980s, it became clear that government had problems maintaining the majority of these hospitals, especially the large ones. Buildings had deteriorated considerably due to lack of maintenance and repair, equipment had gone obsolete or broken down for lack of maintenance and there was brain drain as most health personnel migrated in search of greener pasture (Kunfaa (1996). The brain drain from MoH in search for greener pasture is gradually slowing down because most government doctors now practice privately.

The private sector is involved in all aspects of delivery of health services in developing countries and in Ghana as well. They are most prominent in delivery of primary and curative care, largely due to lower capital requirements, high demand, and willingness to pay on the part of patients. This pattern involves them directly in core “public health” activities such as treating malaria, TB, and other communicable diseases, as well as treating sick children and pregnant women. In many of the poorer countries, the private sector is the dominant provider, with much health care delivered by a mixture of qualified and unqualified or traditional practitioners, as well as drug sellers. Despite widespread concern about clinical quality, patients often bypass public facilities to utilize private providers, often citing reasons of convenience and responsiveness. Many people in developing countries, including the poor, would have no access to health services without such privately provided services (World Bank, 2001).



### 2.5.1 Vision, Goal and Objectives

In recognition of the immense role the private sector plays in national development, government policy objective is to increase private sector participation in health care delivery to 50% by the year 2010. As of 2003, the private health sector was providing 42% of health care services in the country and this has been growing since then. The sector employs over 300 medical and dental practitioners, 400 nurses and midwives, 1200 pharmacists, 10, 000 chemical sellers, and an unknown number of diagnostic facility operators (Ministry of Health 2007).

The GPRS II (2005) identifies access as the major hindrance to quality health care delivery in Ghana. The document has it that in order to accelerate access to quality health services, the health sector will continue to deepen efforts and focus on the three broad policy objectives. These objectives are:

- Bridge equity gap in access to quality health and nutrition services
- Ensure sustainable financing arrangements that protect the poor
- Enhance efficiency in service delivery

Within the Ghanaian environment there are inadequate public health facilities, many hard to reach areas and poor road networks and inadequate health professionals in the public health delivery system. About a third of the all medical and dental practitioners in Ghana and almost 80% of all pharmacists in the country are employed in the private health sector. Building networks of both the public and private health sector actors can provide a strong and reliable framework for the delivery of quality health care even to the remotest area in the country.

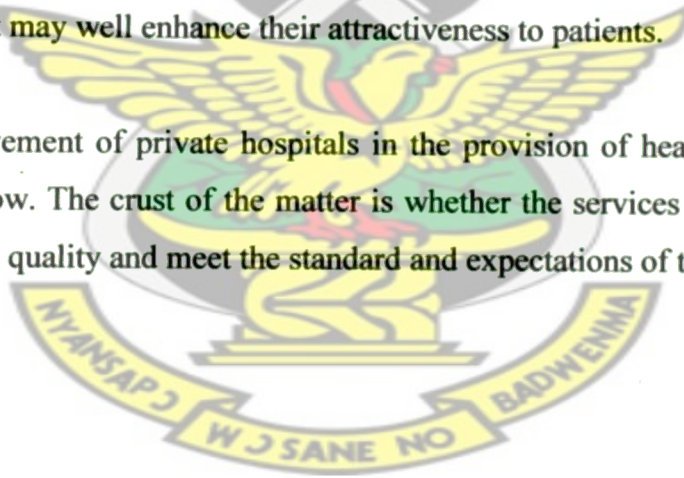
## 2.6 Private Health Care Provision

Public health services are oriented to directly benefit the public, either as individuals, communities or larger populations. Commonly, most private hospitals are excluded from national public health programs, sometimes simply from habit, occasionally from fear that involving unqualified private providers could be seen as formal recognition and encouragement for them to continue their sub-standard practices.

Recently, these providers are coming to be seen as integral part to addressing public health concerns (Uplekar, *et al*, 1991). For instance, private hospitals are now acknowledged to be important source of treatment for diarrhoea, and malaria which combined, account for over half of childhood mortality in developing countries. In many countries, private hospitals treat a large proportion of TB patients, especially in South-East Asia and the Western Pacific where the disease burden is highest (Uplekar, *et al*, 1991). In some cases private hospitals are usually the first, and often the only point of contact with the health system for a wide variety of conditions including maternal and child health (Kafle, *et al*, 1996).

Many people in developing countries see private health care providers for their everyday health needs. Unfortunately, these interactions often leave out critical promotive and preventive care such as vaccinations, and health education. Recently some governments are taking steps to include private providers in implementation of public health efforts to expand utilization of promotive and preventive health care services (World Bank, 2001). This undertaking is challenging. Private hospitals are often interested in participating in these efforts since it may well enhance their attractiveness to patients.

The massive involvement of private hospitals in the provision of health care is not the concern of many now. The crux of the matter is whether the services provided by these private hospitals are quality and meet the standard and expectations of their clients.



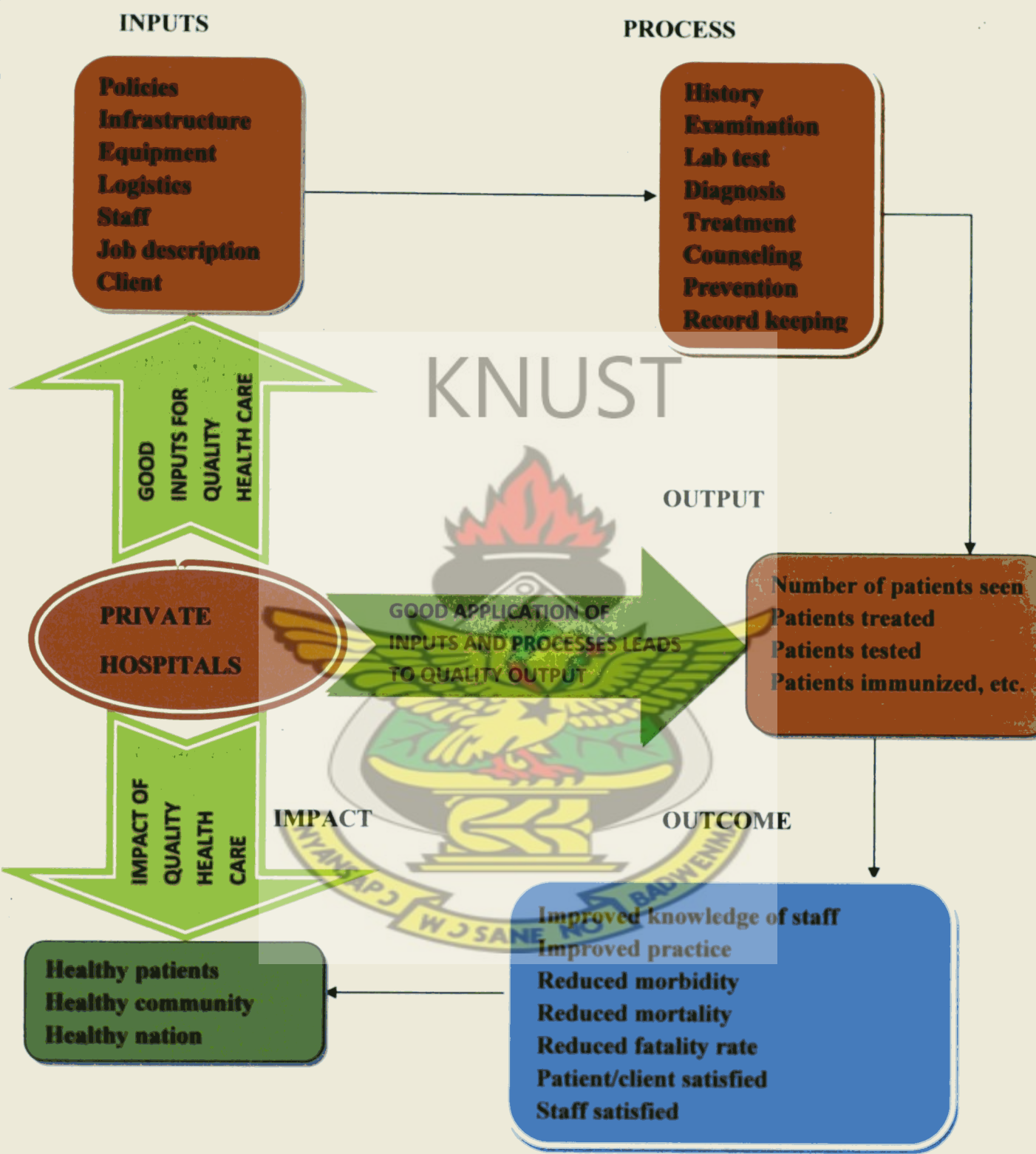
## **2.7 Analytical Framework for Private Hospitals in Quality Health Care Delivery**

The basic priority of the individual is to receive quality health care from the point of call when they are sick. The decision to seek health care and which health care is sought depends on the information available to the individual and the quality of structure put in place.

The conceptual framework shows that for Private Hospitals to provide the necessary quality health care to satisfy the individual there is the need for very good inputs such as infrastructure, equipment, logistics and good staff among others to attract clients. It also tries to show that a good application of the input through very good processes will result in positive outcome and impact such as healthy patients, healthy community and healthy nation.



Figure 2.1 Analytical Framework



Source: Author's construct, April 2008



## CHAPTER THREE

### PROFILE OF THE STUDY AREA

This chapter provides a descriptive summary of the profile of the study area. This information is vital for the drawing of meaningful inferences so as to draw conclusions and make appropriate recommendations. Issues discussed include, location and size, relief, demographic characteristics, education and health.

#### 3.1 Location and size

Kumasi is the capital of Ashanti and the second largest city in Ghana. It is located about 300 kilometres northwest of the national capital, Accra. The metropolitan area covers an area of 254 square kilometres. Generally the metropolitan area is located at more or less the central part of the Ashanti region (see Map 1). It lies within latitudes  $6.35^{\circ}$  North and  $6.40^{\circ}$  North and longitudes  $1.30^{\circ}$  West and  $1.35^{\circ}$  West with an elevation which ranges between 250 – 300 metres above sea level. It is bounded to the north by the Kwabre districts and to the South by Bosomtwe-Kwanwoma district. It is also bounded to the East by Ejisu-Juaben district and the west by the Atwima district (KMA-MTDP 2006-2009).

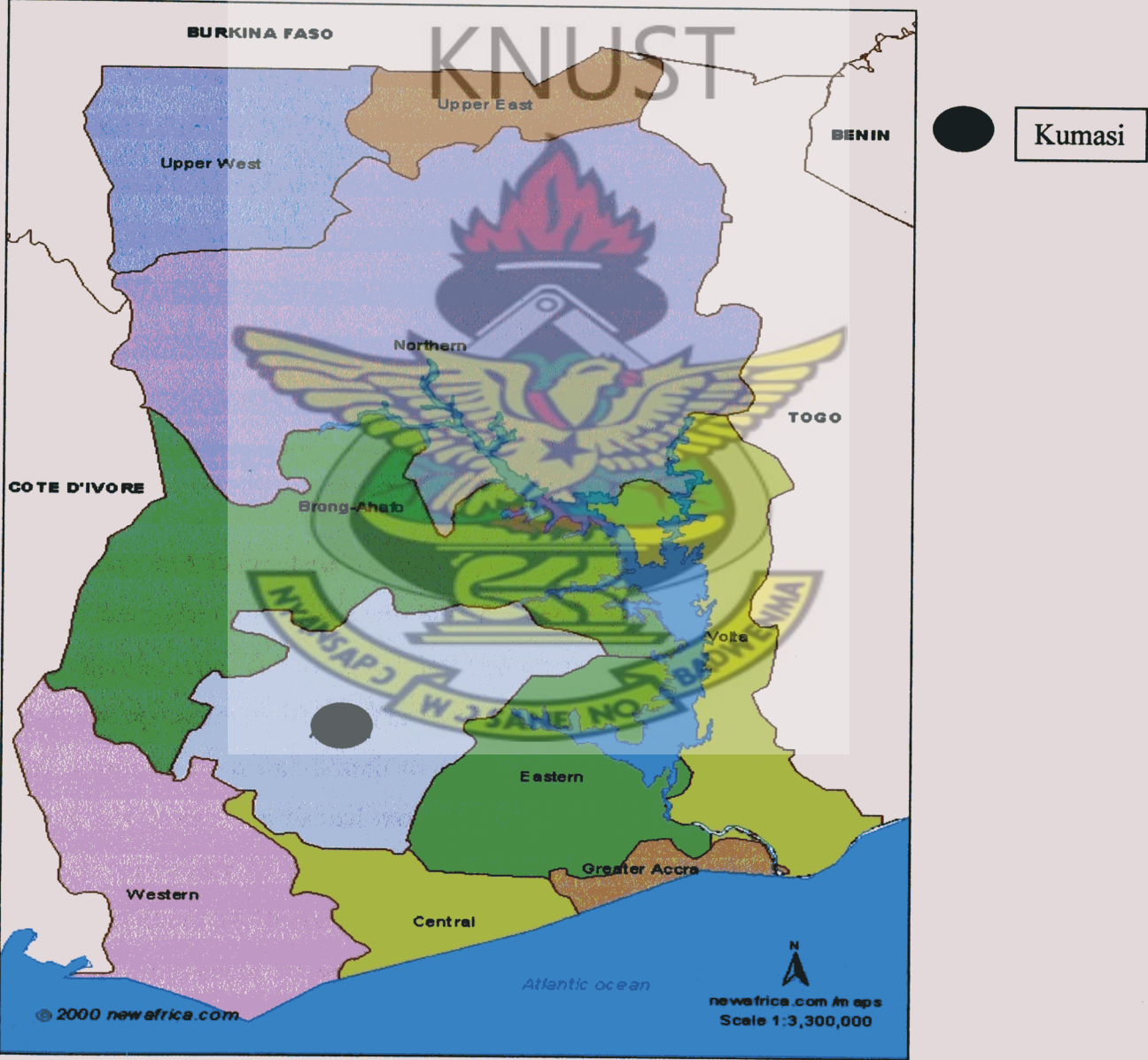
Politically, Kumasi is divided into ten sub metropolitan areas namely: Manhyia, Tafo, Suame, Asokwa, Oforikrom, Asewase, Bantama, Kwadaso, Nhyieso and Subin (refer to Map 2). The city is a rapidly growing one. It encompasses about 90 suburbs, many of which were absorbed into it as a result of the process of growth and physical expansion.

#### 3.2 Relief and Drainage

The Kumasi Metropolis lies within the plateau of the South –West physical region which ranges from 250-300 metres above sea level. The topography is undulating. The city is traversed by rivers and streams, which include the Subin, Wiwi, Sisai, Owabi, Aboabo and Nsuben among others. However, biotic activity in terms of estate development, encroachment and indiscriminate waste disposal practices have impacted negatively on the drainage system and have consequently brought these water bodies to the brink of extinction.

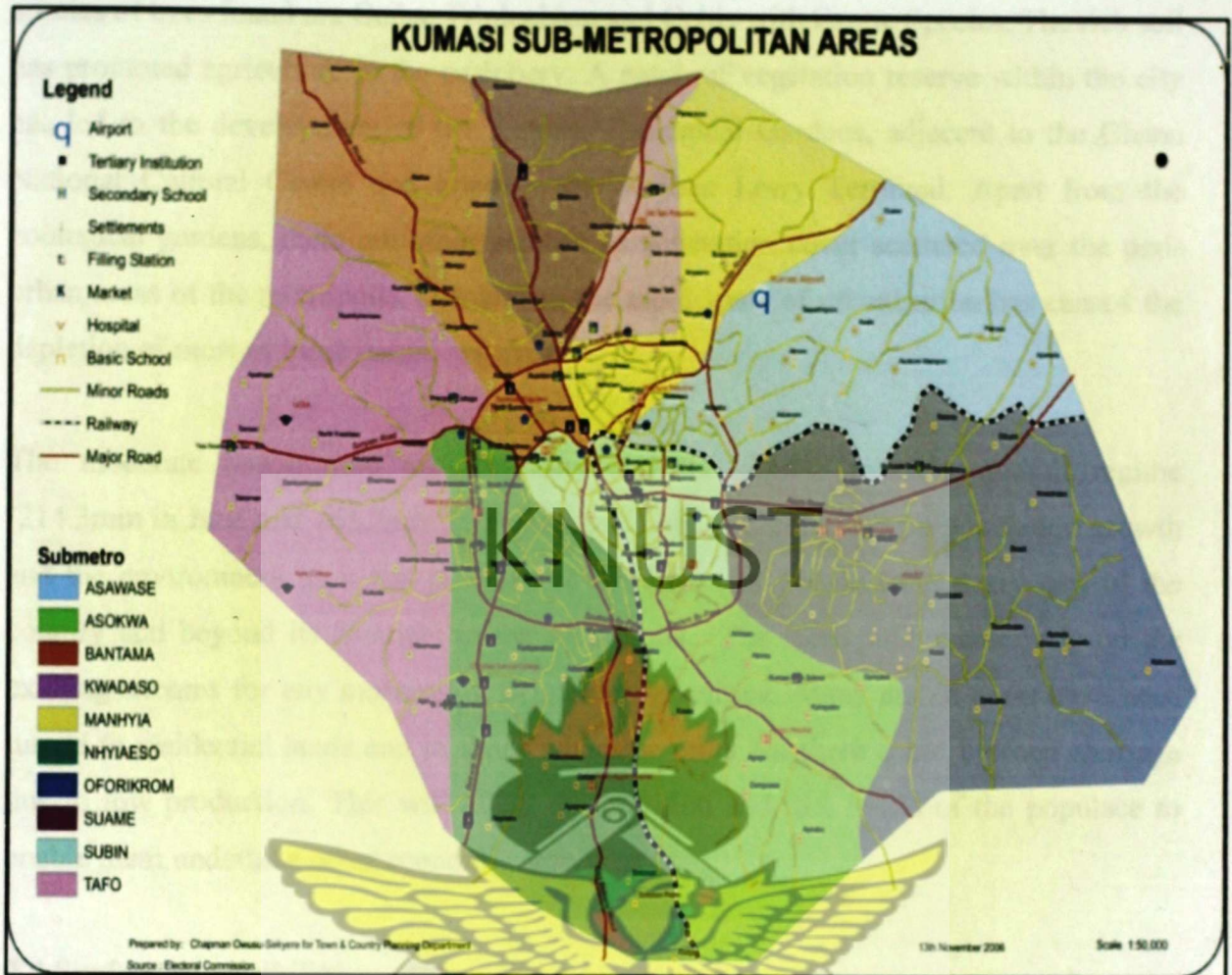
Unlike many districts in Ghana that rely on the water bodies in their area for potable water supply, Kumasi relies on the supply of water from the Ghana Water Company. However, the irregular flow of water compels people living along some of the streams to use the almost contaminated water, making them susceptible to water related diseases. The undulating nature of the metropolis does not make the construction of road difficult as it would be in hilly areas. This may explain why many roads are tarred and that also means that more roads can be constructed with ease to increase access and movement within the metropolis and its periphery to make health services more accessible.

**Map 1: Kumasi in Regional and National context**  
**GHANA ADMINISTRATIVE MAP**



Source: Medium Term Development Plan for Kumasi Metropolitan Area, 2006-2009



**Map 2: Sub Metropolitan Areas in Kumasi**

Source: Medium Term Development Plan for Kumasi Metropolitan Area 2006-2009

### 3.3 Climate and Vegetation

Kumasi lies within the moist semi-humid climatic zone of the country. The climate is the wet equatorial type. The average minimum temperature is about  $21.5^{\circ}\text{C}$  with a maximum average temperature of  $30.7^{\circ}\text{C}$ . The rainfall pattern consists of two rainy seasons; the first rainy season is from mid-March to early July, and the second season begins from late August to October. An annual mean rainfall of about 1345mm is recorded. The period between November to early March is much drier throughout the year. The average humidity is about 84.16 per cent at 0900 GMT and 60 per cent at 1500 GMT. Humidity also varies from about 50 percent in the dry season to about 76 percent at the end of the main wet season.



The city falls within the moist semi-deciduous South-East Ecological Zone. Predominant species of trees found are Ceiba, Triplochlon and Celtis with Exotic Species. The rich soil has promoted agriculture in the periphery. A patch of vegetation reserve within the city has led to the development of the Kumasi Zoological Gardens, adjacent to the Ghana National Cultural Centre and opposite the Kejetia Lorry Terminal. Apart from the zoological gardens, there are other patches of vegetation cover scattered over the peri-urban areas of the metropolis. However, the rapid spate of urbanization has caused the depletion of most of these nature reserves.

The moderate temperature and humidity and the double maxima rainfall regime (214.3mm in June and 165.2mm in September) have a direct effect on population growth and the environment as it has precipitated the influx of people from every part of the country and beyond its frontiers to the metropolis. The metropolis cannot rely on the existing streams for any meaningful irrigation agriculture. Many arable areas have been turned to residential lands and in times when the rains fail there could be food shortage due to low production. This will affect the nutrition and diet levels of the populace to enable them undertake other economic activities.

### 3.4 Surface Accessibility

The predominant means of travel within the metropolis is by use of road which is an important determinant of accessibility of people to services and facilities. The metropolis has been planned with Arterial Roads, consisting of paved and unpaved networks that link residences to the local communities and the periphery. The existing road network provides inter and intra transportation as well as facilitate socio-economic activities within the metropolis. Kumasi is strategically located in the country. The road network is radial with Kejetia and Adum being the hub of the network. All the major arterials such as the Accra road, Mampong road, Sunyani road and Offinso road radiate from the Kejetia/Adum area, which forms the core of the central business district (CBD).

The area has a total inventoried road length of 846km out of which 575km are classified as unpaved while 271km are paved with either asphalt or bitumen. The road and traffic

conditions in most of the areas, especially the new residential areas in such as Atimatim, Buokrom, Odeneho Kwadaso, TUC, and Pankrono Estate and so on are generally poor. The riding surface is usually laterite that had developed potholes, gullies and depressions. The road network outside the CBD is also characterized by missing road links, badly deteriorated paved local roads, lack of interconnecting road links imposed by major streams, intersection capacity restraints and lack of an outer by-pass to take extraneous and through traffic away from the city centre so as to reduce congestion and improve traffic operations within Kumasi.

Most of the local paved roads in the suburbs such as Old Amakom, North and South Suntreso, Asawase, Suame and the like, have badly deteriorated simply because the roads have exceeded their physical and economic life spans and also for reason that there has been a general lack of systematic maintenance of such roads.

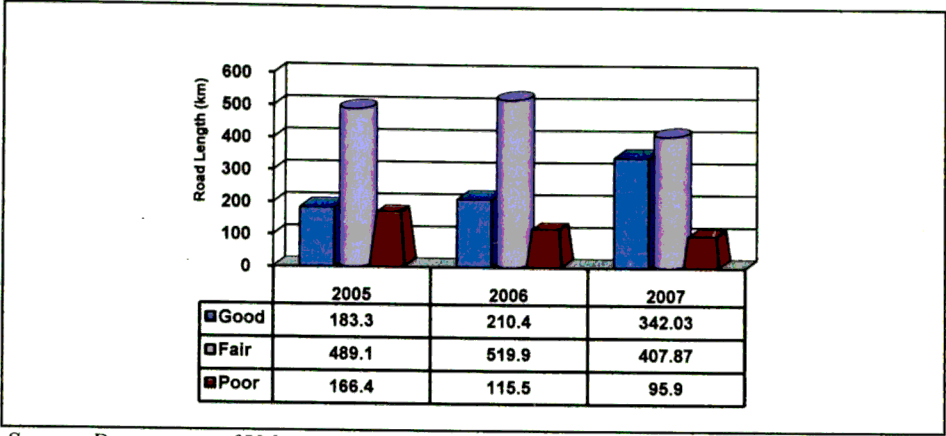
Roads must be developed to enable transport serve new development to help promote economic growth in the local communities. It should help provide affordable and accessible transport that will help people escape the poverty trap. Road development in the local areas must also be made to create easier access for pedestrians and the vulnerable groups. Even though the metropolis has a well spread health facilities, the conditions described above may be a hindrance to some people having access to health facilities, especially during the rainy season when some roads become inaccessible.

**Table 3.1                      Metropolitan Road Conditions**

| Road Type               | Length of Road |
|-------------------------|----------------|
| Inventoried Road Length | 846km          |
| Unpaved Road Length     | 575km          |
| Paved Road Length       | 271km          |
| Asphalted Surface       | 100km          |
| Bitumen                 | 171km          |

*Source: Department of Urban Roads, 2007*

**Figure 3.1      Conditions of Road Network in Kumasi**



Source: Department of Urban Roads 2007

**3.5 Demographic Characteristics**

**3.5.1 Population**

Kumasi metropolis is the most populous district in the Ashanti Region. During the 2000 Population Census, it recorded a figure of 1,170, 270. The current population is estimated to be 1,782,424 based on its annual growth rate of 5.4% and this account for just under a third of the regions population. The population figure is applicable during the night since day time population is above 2,000,000. There are about 213 communities in Kumasi.

Kumasi has attracted such a large population partly because it is the Regional Capital and also the most commercialised centre in the region. Other reasons include the centrality of Kumasi as a nodal city with major arterial routes linking it to other parts of the country and also the fact that it is an educational centre with two state universities.

**Table 3.2      Population of Kumasi (1960-2008)**

| Area/Year | 1960      | 1970      | 1984       | 2000       | 2008       |
|-----------|-----------|-----------|------------|------------|------------|
| Kumasi    | 218,172   | 346,336   | 487,504    | 1,170,270  | 1,782,424  |
| Ashanti   | 1,481,698 | 2,090,100 | 2,948,161  | 3,612,950  | 4,720,916  |
| Nation    | 6,700,000 | 8,632,000 | 12,296,081 | 18,912,079 | 23,404,686 |

Source: Medium Term Development Plan for Kumasi Metropolitan Area 2006-2009



**Table 3.3**                      **Population Growth Rate in Kumasi (1948 – 2008)**

| Area/year | 1948 – 1960 | 1960 – 1970 | 1970 – 1984 | 1984 – 2000 | *2000 – 2008 |
|-----------|-------------|-------------|-------------|-------------|--------------|
| Kumasi    | 7.9         | 4.5         | 2.5         | 5.2         | 5.4          |
| Ashanti   | 2.0         | 3.8         | 3.8         | 3.4         | 3.4          |
| Nation    | -           | 2.4         | 2.6         | 2.7         | 2.7          |

Source: Population Census Reports (1948, 1960, 1970, 1984 and 2000)

\* Projected

### 3.5.2 Age and Sex Structure

The age structure of the population in the metropolis is skewed towards the youth (2000 Population census). The highest proportions of the population are in the age cohorts 0 – 4 years (13.2%) and 5 – 9 years (12.4%). Cumulatively, 39.9 per cent of the population is below 15 years, in contrast to other districts, which range from 40 to 47 per cent. This may be an indication of a slow, incipient decline in fertility. There are more males (50.2%) than females (48.8%) in the metropolis.

**Table 3.4**                      **Ages – Sex Structure of Kumasi Metropolis**

| DISTRICT             |              |              |              |
|----------------------|--------------|--------------|--------------|
| AGE GROUP<br>(Years) | KUMASI       |              |              |
|                      | MALE         | FEMALE       | TOTAL        |
| 0-4                  | 13.2         | 13.2         | 13.2         |
| 5-9                  | 12.2         | 12.6         | 12.4         |
| 10-14                | 10.6         | 12.3         | 11.4         |
| 15-19                | 10.5         | 12.1         | 11.3         |
| 20-24                | 10.8         | 10.9         | 10.9         |
| 25-29                | 9.1          | 9.4          | 9.3          |
| 30-34                | 7.0          | 7.2          | 7.1          |
| 35-39                | 5.4          | 5.7          | 5.5          |
| 40-44                | 4.5          | 4.4          | 4.5          |
| 45-49                | 3.8          | 3.0          | 3.4          |
| 50-49                | 2.6          | 2.4          | 2.5          |
| 55-59                | 2.0          | 1.5          | 1.8          |
| 60-64                | 1.7          | 1.4          | 1.6          |
| 65-69                | 1.5          | 1.0          | 1.2          |
| 70-74                | 1.1          | 0.8          | 0.9          |
| 75 +                 | 4.0          | 2.1          | 3.0          |
| <b>TOTAL</b>         | <b>100.0</b> | <b>100.0</b> | <b>100.0</b> |

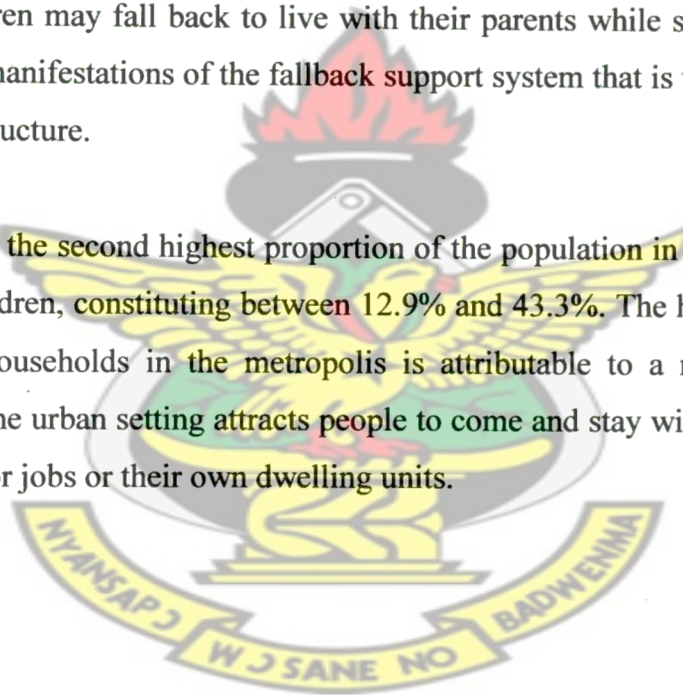
Source: Medium Term Development Plan for Kumasi Metropolitan Area, 2006-2009

### 3.5.3 Household Sizes/Characteristics

The average household size in Ashanti is 5.3 persons, the same as the Brong Ahafo. However, the average household size in the metropolis is 5.1. The average number of households per house is 3.4. This relatively large number of households per house is due largely to the large population in the metropolis (KMA MTDP 2006-2009).

Children constitute 34.0%, the highest proportion of household members in the metropolis. Several factors may account for this high proportion of children of household. In addition to minors who may still be living with their parents, there could also be children, particularly females, who might move to stay with their parents in accordance with tradition, during the latter part of pregnancy, well into the post natal leaning period, before returning to their spouses. Divorced, widowed, unemployed or even destitute children may fall back to live with their parents while sorting themselves out. All these are manifestations of the fallback support system that is the bedrock of the traditional family structure.

Other relatives form the second highest proportion of the population in households in the metropolis after children, constituting between 12.9% and 43.3%. The high proportion of other relatives in households in the metropolis is attributable to a number of socio-economic factors. The urban setting attracts people to come and stay with relatives whilst actively searching for jobs or their own dwelling units.



**Table 3.5            Household Size Structure**

| Household Size | 1984 | 2000 |
|----------------|------|------|
| 1              | 21.1 | 23.3 |
| 2              | 13.7 | 14.8 |
| 3              | 12.7 | 12.9 |
| 4              | 11.9 | 12.1 |
| 5              | 10.5 | 10.5 |
| 6              | 8.7  | 8.5  |
| 7              | 6.5  | 6.8  |
| 8              | 4.7  | 5.1  |
| 9              | 3.2  | 3.3  |
| 10             | 5.7  | 1.9  |
| 15+            | 1.3  | 0.8  |

*Source: Population Census Reports (1984, and 2000)*

The demographic characteristics show a vibrant city with possible increase in health needs. The increased number of children and the youth and the influx of other people into the metropolis mean that the city needs a lot of health facilities to take care of the medical needs of the people. Without the expansion of the existing ones and the establishment of new ones, there is the likelihood and possibility of pressure on the major health institutions, be it private or public.

**3.6 Economic Characteristics**

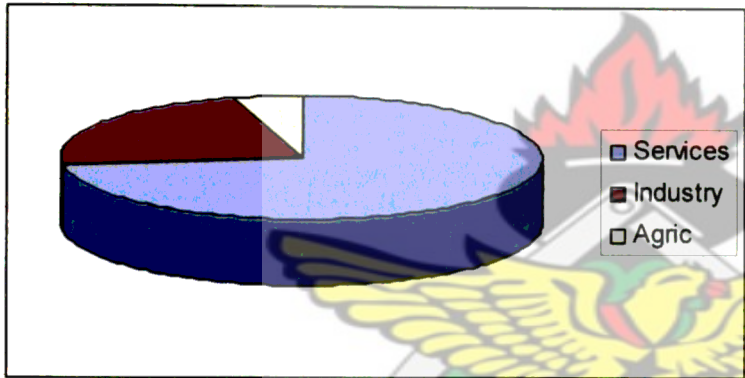
The KMA is made up of the formal and the informal sectors. The Formal sector is characterized by businesses with corporate ownership, large-scale operation, capital-intensive and the use of sophisticated technology. The informal sector structure of Kumasi is “a confusing maze of thousands of tiny workshops and enterprises producing everything under the sun, with a complicated distribution and communication network at their disposal”. Kumasi’s informal sector contributes so much to the total city economy (KMA MTDP 2006-2009).



About 89% of the labour force is employed, while eleven 11% is unemployed. The major sector of the metro economy is the Trade/ Commerce/Services which accounts for about 71%. This is followed by the industrial/Manufacturing sector with about 24% and the agricultural sector being 5%.

The primary production sector of the metropolis is made up of urban agriculture and quarrying/sand winning. The agricultural sector, which is made up of farming, aquaculture, horticulture etc is limited to production of staple crops including maize, plantain, cocoyam, cassava, vegetables and nursery of industrial crops mainly oil palm and citrus fruits. There is also specialization in the distribution of food crops which are brought in from other parts of the country.

**Figure 3.2 Metropolitan Economic Structure (in %)**



Source: Medium Term Development Plan for Kumasi Metropolitan Area 2006-2009

**3.7 Education**

Educational facilities in the city are provided by the public and private (individual and religious bodies) sectors. The private sector provides the bulk of these institutions at the pre-school, first and second cycle levels, whereas the public sector is the leader at teacher training colleges and tertiary levels. These are evenly distributed in space.

Kumasi is endowed with a lot of educational opportunities. About 48% of the population have acquired up to Middle School Leaving Certificate and Junior High School level and below, 28% have been to Senior High School, with 4% having been to the tertiary institutions. In spite of the above, over 20% are illiterates (KMA MTDP 2006-2009).

**Table 3.6      Distribution of Educational Institutions by Sector    (2006)**

| Level                    | Public Sector |     | Private Sector |    | Total |
|--------------------------|---------------|-----|----------------|----|-------|
|                          | Absolute      | %   | Absolute       | %  |       |
| <b>Tertiary</b>          |               |     |                |    |       |
| University               | 2             | 67  | 1              | 33 | 3     |
| Polytechnic              | 1             | 100 | 0              | -  | 1     |
| Nursing Training         | 1             | 100 | 1              | -  | 1     |
| Teacher Training College | 2             | 100 | -              | -  | 2     |
| <b>Second Cycle</b>      |               |     |                |    |       |
| SHS                      | 18            | 37  | 31             | 63 | 49    |
| Technical/Vocational     | 1             | 6   | 31             | 93 | 32    |
| <b>First Cycle</b>       |               |     |                |    |       |
| Primary                  | 204           | 31  | 448            | 69 | 652   |
| JSS                      | 169           | 46  | 197            | 54 | 366   |
| Pre-School               | 159           | 26  | 443            | 74 | 602   |

*Source: Metropolitan Education Directorate,*

The level of education of the individual can have effect on his condition of health. This is because education can change the perception of how people relate to the environment and issues about health. Even though there are a lot educational facilities in the metropolis, the level of illiteracy suggest that health facilities should be available to take care of the expected health needs.

### 3.8 Religion

Christianity is the dominant religion in the metropolis. The proportions of the population in the metropolis in terms of religion are 78.8%, 16.0%, 0.3% and 0.7% for Christianity, Islam and Traditional and Others respectively. Apart from these four groupings, there is this other group with “No Religion” which constitutes about 4.2% but could vary.

**Table 3.7      Religious Composition**

| Religious Group | % Composition |
|-----------------|---------------|
| Christianity    | 78.8          |
| Islam           | 16.0          |
| Traditional     | 0.3           |
| Others          | 0.7           |
| No Religion     | 4.2           |
| Total           | 100           |

*Source: Medium Term Development Plan for Kumasi Metropolitan Area, 2006-2009*

Religion usually can affect the health of the people. Often, there are constraints on the use of health facilities arising out of the beliefs and practices among people, especially in relation with their religion. Among the various religions, there are different conceptions about diseases. Generally, traditionalists prefer to be treated at home, and prefer self medication. This means that in communities that have dominant traditionalists, patronage to hospitals will be very low. On the other hand Christians and Moslems may access hospitals because of the beliefs and practices.

### 3.8 Health Characteristics

The Metropolitan Health Services are organized around five (5) Sub Metro Health Teams; namely, Bantama, Asokwa, Manhyia North, Manhyia South and Subin, even though Kumasi now has a total of ten (10) sub metros. The Metro Health Team is led by its Director of Health Services who has the overall responsibility for planning, monitoring and evaluating the performance of the Health Sector in the metropolis.

The city has a number of health facilities in both the public and private sectors. Notable among them are the Komfo Anokye Teaching Hospital (KATH), which is one of the two (2) national autonomous hospitals, four (4) quasi health institutions, five (5) health Care Centres owned by the Church of Christ and the Seventh-Day Adventist Church. In addition, there are over two hundred (200) known private health institutions and 13 Industrial Clinics in the metropolis. There are also 54 trained Traditional Birth Attendants (TBAs), nine (9) Maternal and Child Health (MCH) points and 119-outreach sites. These facilities are evenly distributed in space.

Table 3.8 shows categories of Health Facilities and the spatial distribution of health delivery institutions in Kumasi. One can infer from map 3 that the facilities are evenly distributed in space.

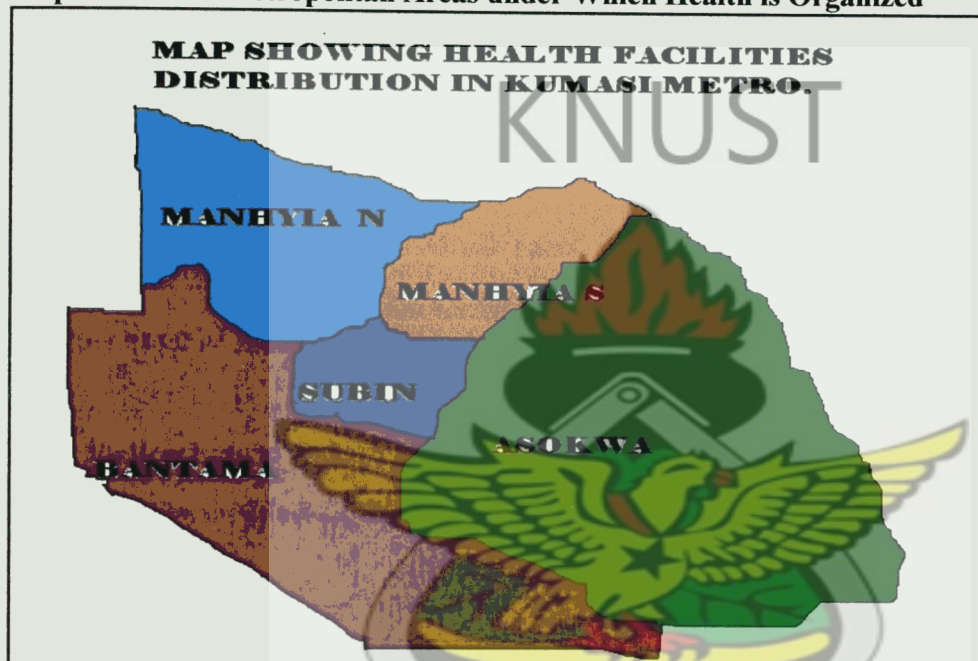


**Table 3.8 Health Institutions in the Kumasi Metropolis (2006)**

| Sub-Metro     | Gov't Hospital | Quasi Gov't Hospital | Mission Hospital/ Clinic | Private Hospital | Private Clinics | Mat. Home | Homeo-Pathic Clinic | Private Labs | Outreach Stations |
|---------------|----------------|----------------------|--------------------------|------------------|-----------------|-----------|---------------------|--------------|-------------------|
| Asokwa        | 1              | 1                    | 1                        | 14               | 22              | 18        | 4                   | 1            | 47                |
| Bantama       | 1              | 0                    | 1                        | 15               | 22              | 30        | 0                   | 7            | 39                |
| Manhyia North | 1              | 0                    | 1                        | 5                | 10              | 16        | 13                  | -            | 14                |
| Manhyia South | 1              | 0                    | 1                        | 7                | 14              | 4         | 3                   | 2            | 15                |
| Subin         | 2              | 3                    | 1                        | 3                | 11              | 3         | 1                   | 3            | 7                 |
| <b>Total</b>  | <b>6</b>       | <b>4</b>             | <b>5</b>                 | <b>44</b>        | <b>79</b>       | <b>54</b> | <b>21</b>           | <b>13</b>    | <b>122</b>        |

Source: Metropolitan Health Directorate, 2006

**Map 3: Sub Metropolitan Areas under Which Health is Organized**



Source: Metropolitan Health Directorate, 2006

Accessibility in terms of cost is a thorny issue as the cost of procuring medicare is high. To enhance financial accessibility to health delivery the government in 1997 came out with an exemption policy for some vulnerable groups. This policy gives free medical treatment including certain laboratory services to all pregnant women, the aged (above 65 years of age) and children less than 5 years of age. There was also the refund of medical bills incurred in public hospitals to civil servants under the control of the Kumasi Metropolitan Assembly (KMA) in consultation of with the Metropolitan Health Directorate. With the passage of the National Health Insurance Bill in 2005, the Kumasi Metropolis had four District Mutual Health Insurance Schemes in operation (DMHIS) in

four Sub Metropolitan District Councils, namely; Subin, Bantama, Manhyia and Asokwa. This is expected to improve the financial accessibility to health care delivery in the Kumasi Metropolis.

The health institutions in the metropolis face the following problems such as:

- Lack of office and residential accommodation for the Metro health staff
- Inadequate staff (doctors, professional nurses and other paramedical personnel)
- Inadequate budgetary allocation to the health sector and late release of funds for programmes.
- Lack of transport for the institutions. Available vehicles are old and break down often.
- Poor sanitation and lack of good environmental practices leading to Cholera outbreaks in 1998 and 1999.
- High doctor-patient ratio
- Poor state of health infrastructure and obsolete equipment (KMA MTDP 2006-2009).

3.8.1 Doctor/Patient ratio

**Table 3.9 Doctor/ Patient Ratio in the Metropolis for 2003, 2004 and 2005**

| Year | Indicator |
|------|-----------|
| 2003 | 1: 56,250 |
| 2004 | 1: 66,886 |
| 2005 | 1: 70,552 |

Source: Metropolitan Health Directorate, 2006

Table 3.9 shows that from the year 2003 to 2005 the Doctor/Patient Ratio has been increasing over the years. The implication is that more patients are chasing few doctors. It also reveals a situation of a not too good health delivery system. The rippling effects are lost of time resulting from chasing fewer doctors, a lethargic society and low productivity.

3.8.2 Infant Mortality Rate

A cursory glance at the table below reveals that the number of infants who die per 1,000 live births each year continues to grow. It increased from 21 in 2003 to 29 in 2004 and 36 in 2005 representing an increase in percentage of 27.6 and 19.4 respectively.

**Table 3.10     Infant Mortality Rates in the Metropolis**

| Year | Indicator            |
|------|----------------------|
| 2003 | 21/1,000 live births |
| 2004 | 29/1,000 live births |
| 2005 | 36/1,000 live births |

Source: Metropolitan Health Directorate, 2006

The implication for development is that the population will not be replacing itself and the result will be an ageing population with a low human resource base. It will also impinge on productivity and the overall development of the metropolis.

3.8.3 Common Diseases

By virtue of the area’s location (moist semi-deciduous ecological zone), malaria remains the number one disease. This calls for a more concerted effort at reducing the incidence of malaria by promoting environmental cleanliness and the use of treated bed nets, especially for pregnant women and children. The increase in in-patient admissions is associated with the deteriorating environmental conditions in the Metropolis and the filth created by the unchanging attitude of the population.

Malaria and diarrhoea remains the two common diseases for admission over the past years. This is also largely due to non- observance of certain healthy practices and unsanitary conditions in some of the communities. During the rainy season, the incidence of these diseases reaches its peak when water gets trapped in gutters and stagnant in other areas to serve as breeding grounds for mosquitoes. Most fruits are also brought to market during the raining season. These are normally not properly washed before eating, leading to worm infestation, stomach upsets and diarrhoea.



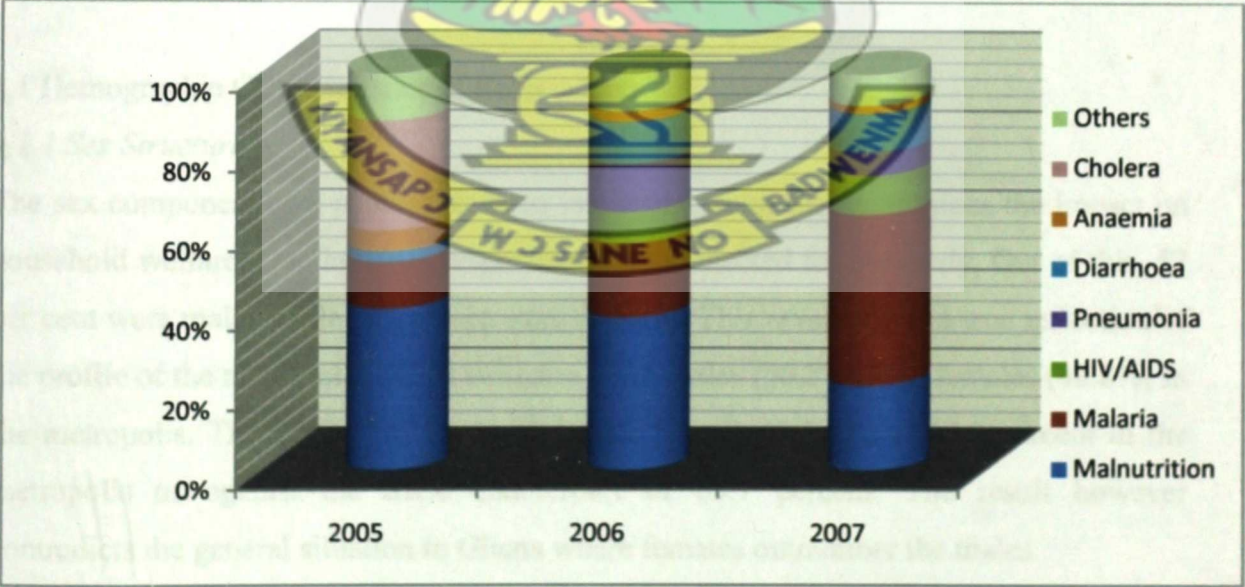
Table 3.11: Top Ten Diseases

| Top Ten OPD Diseases               |         |      | Top Ten Causes of Admissions  |        |      |
|------------------------------------|---------|------|-------------------------------|--------|------|
| Disease                            | Number  | %    | Disease                       | Number | %    |
| Uncomplicated Malaria              | 316,721 | 56.7 | Uncomplicated Malaria         | 7,451  | 60.5 |
| Cough or Cold                      | 73,229  | 13.1 | Diarrhoea with Blood          | 1,450  | 11.8 |
| Skin diseases & ulcer              | 40,417  | 7.2  | Hypertension                  | 780    | 6.3  |
| Hypertension                       | 33,050  | 5.9  | Severe Malaria                | 594    | 4.8  |
| Occupation/Home injury             | 29,757  | 5.3  | Acute Urinary Tract Infection | 407    | 3.3  |
| Diarrhoea with no hydration        | 20,667  | 3.7  | Typhoid Fever                 | 394    | 3.2  |
| Lab. Confirmed Malaria             | 17,934  | 3.2  | Pneumonia                     | 334    | 2.7  |
| Acute Urinary Tract Infection      | 11,411  | 2.0  | Lab. Confirmed Malaria        | 324    | 2.6  |
| Rheumatic & other Joint Conditions | 9,394   | 1.7  | Anaemia                       | 310    | 2.5  |
| Severe Malaria                     | 6,122   | 1.1  | Asthma                        | 275    | 2.2  |

Source: Annual Report 2007- Metro Health Directorate

Even though HIV/AIDS remains one of the scary diseases and causes of death in the metropolis, there is no doubt that malnutrition and malaria remains the prevalent causes of death. Malnutrition accounted for 39.7 per cent, 38.7 per cent and 21.6 per cent in 2005, 2006 and 2007, respectively. Malaria also accounted for 14.1 per cent, 21.3 per cent and 43.1 per cent in 2005, 2006 and 2007, respectively. This calls for a concerted effort to reduce both malnutrition and malaria

Figure 3.3: Causes of Death (2005-2007)



Source: Adopted from Annual Report 2007- Metro Health Directorate

## CHAPTER FOUR

### RESULTS AND DISCUSSION OF SURVEY DATA

This chapter provides a descriptive summary of the findings of the demographic, social and economic characteristics of households sampled in the survey with a focus on some basic background characteristics such as sex, education and socio-economic conditions of the sampled households. This information is vital for the drawing of meaningful inferences so as to draw conclusions and make appropriate recommendations. Findings from the operators of private hospitals, their staff and the metropolitan health directorate are also discussed.

The Millennium Development Goals (MDG) and the Ghana Growth and Poverty Reduction Strategy (GPRS) II (2006) had indicated among other things quality healthcare delivery and the elimination of diseases and poverty as a major factor in achieving a middle-income status. Again the GPRS II indicated that even though the health status of Ghanaians has generally improved over the years, a significant proportion of the people lack access to quality health service. The document recognizes partnership and collaboration between government sector and private sector in improving health care delivery. The study is to find out whether the private hospitals have the necessary manpower and facilities to deliver the needed quality health care.

#### 4.1 Demographic Characteristics of Respondents

##### 4.1.1 Sex Structure

The sex component of a population is an important factor that determines the impact on household welfare. One hundred respondents were selected for the study. Out of this, 57 per cent were males while 43 percent were females. This revelation is a true reflection of the profile of the metropolis which indicates more males (50.2%) than females (48.8%) in the metropolis. The 2000 PHC also put female household heads at 34.3 percent in the metropolis as against the male counterpart of 65.7 percent. The result however contradicts the general situation in Ghana where females outnumber the males.



This situation can partly be explained by the fact that traditionally, Kumasi has a male dominated population. Unlike many of the adjoining districts where agriculture is the main occupation, the metropolis is more involved in sales and manufacturing activities which also attract more men. The sex ratio in the metropolis however stands at 100.8 males to 99.3 females.

4.1.2 Religion and Ethnicity

Religion can usually affect the health of the people. Often, there are constraints on the use of health facilities arising out of the beliefs and practices among people, especially in relation with their religion. The surveyed population showed different religious groups in the metropolis. This representation is similar to what is represented in the 2000 Population and Housing Census (PHC) report. Akans constitute majority of the population captured with Christianity as the dominant religion practised. The reason is not far from the fact that the metropolis is the capital of the Ashantis who are Akans.

Table 4.1 Ethnicity/ Religion

| Ethnicity      | Religion  |        |             | Total |
|----------------|-----------|--------|-------------|-------|
|                | Christian | Moslem | Traditional |       |
| Akan           | 82        | 1      | 0           | 83    |
| Ga             | 4         | 0      | 1           | 5     |
| Ewe            | 2         | 0      | 0           | 2     |
| Guan           | 0         | 4      | 0           | 4     |
| Northern Group | 1         | 5      | 0           | 6     |
| Total          | 89        | 10     | 1           | 100   |

Source: Author's field survey, April 2008

About 17 per cent of the respondents captured are non-Akans. There are also more Christians than any other religion. The mixture of the different ethnic groups and religion without reports of conflict suggest peaceful co-existence and religious tolerance which is a good social atmosphere to propel development.



4.1.3 Marital Status

Majority of the respondents are married. About 69 per cent of them are in monogamous marriage. About 12 per cent of the respondents who are not married are also in relationships. This is an indication of the importance people in the communities attached to marriage as an institution and family life. The average household in the metropolis is 5.1 which is lower than the regional household of 5.3 persons per household. However, considering the size of the household, there will be the need for childcare, motherhood care, household welfare, protection and security which will be a toll on the household income.

4.1.4 Educational Levels

The level of education of an individual and a household make an impact on the level of information and choices they make regarding their health and well-being. According to the 2000 PHC report, over 65 per cent of the population in the region are literate. The survey revealed that 56 percent of male respondents and 37 per cent of female respondents had attended one form of school or the other. Only about 7 per cent of the respondents have no formal education. With the high level of education, marriage among women may be delayed and so will be child birth. This will help to reduce fertility rate in the metropolis.

Table 4.2            Educational Level Achieved

| Educational Level/Sex | Sex  |        | Total |       |
|-----------------------|------|--------|-------|-------|
|                       | Male | Female | No.   | %     |
| Primary               | 6    | 2      | 8     | 8.0   |
| JSS/Middle            | 14   | 22     | 36    | 36.0  |
| SHS/Secondary         | 22   | 10     | 32    | 32.0  |
| Post Sec              | 3    | 1      | 4     | 4.0   |
| Tertiary              | 11   | 2      | 13    | 13.0  |
| None                  | 1    | 6      | 7     | 7.0   |
| Total                 | 57   | 43     | 100   | 100.0 |

Source: Author's field survey, April 2008

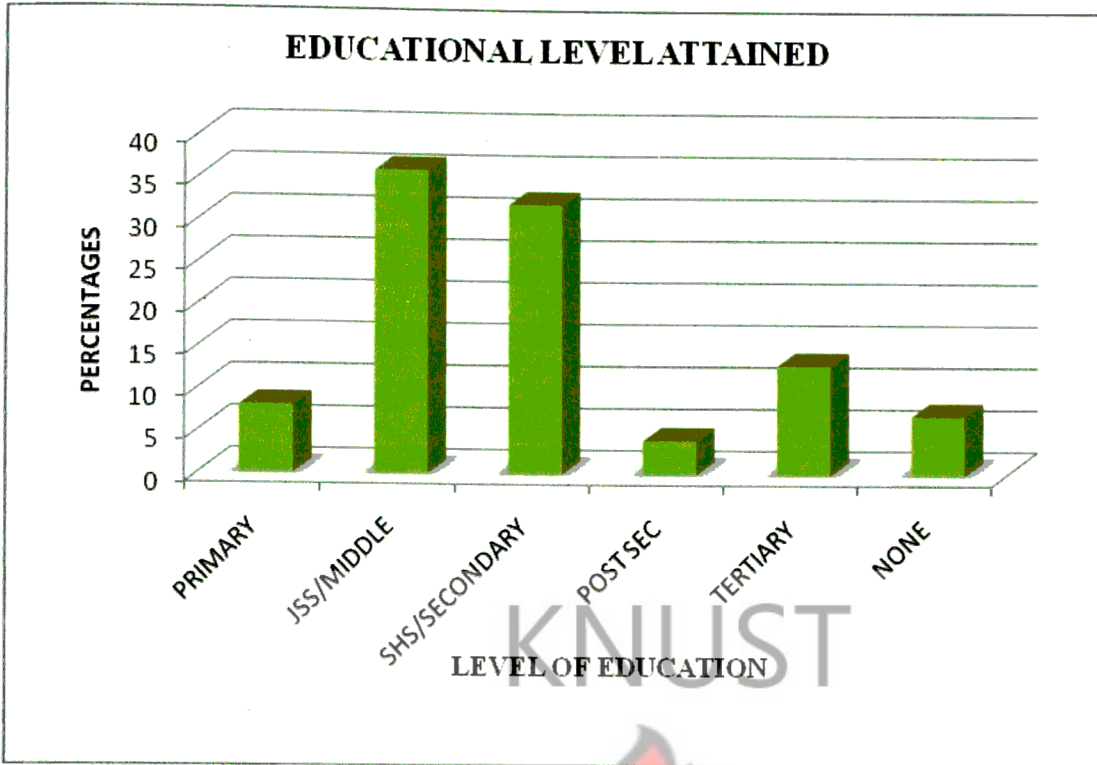


Figure 4.1 Educational Level Attained

Source: Author's field survey, April 2008

Grossman (1995) noted that education has a positive relation with the utilization of health services. Education tend to influence the type of services used; for instance Green (1992) noted that the level of education among mothers are generally related to the level of infant mortality, effective feeding and good use of health services. The implication is that higher education result in higher and effective utilization of health services. The assertion is supported by the 2003 GDHS report which observed that women with higher level of education had a greater likelihood of using a modern family planning method and were likely to have a small family size.

The contribution of education is critical in accessing the utilization of health services in both rural and urban areas. Many people in the urban area are highly exposed to the mass media. With their level of education, their information on the availability and utilization of health facilities is positively improved. Many of these people also show interest in their health and ways to improve it and this can affect the choice of health facility they prefer to use.

4.2 Economic Situation

4.2.1 Employment Status

The economic situation of the respondents is similar to that of the metropolis where commerce, service and industry continue to be the major occupation. According to the 2000 population and housing census, 87.1% of Kumasi population is employed in the informal sub sector while the formal sector employs between 2.7 and 9.0 %. About 86 percent of the respondents are employed with predominant proportion (52%) engaged in commerce, a situation that is confirmed by the 2000 PHC report and the metropolitan profile which put employment level at 89 percent.

Table 4.3 Occupational/Employment Status

| Occupational Status | Employment Status |              | Total |
|---------------------|-------------------|--------------|-------|
|                     | Employment        | Unemployment |       |
| Agriculture         | 3                 | 0            | 3     |
| Commerce            | 52                | 0            | 52    |
| Service             | 19                | 0            | 19    |
| Industry            | 12                | 0            | 12    |
| Student             | 0                 | 4            | 4     |
| None                | 0                 | 10           | 10    |
| Total               | 86                | 14           | 100   |

Source: Author's field survey, April 2008

Majority of those in the commercial sector are self employed and require only a small space to operate their businesses. Twelve per cent of the respondents are engaged in industrial activities producing everything under the sun, with a complicated distribution and communication network at their disposal. About 4 per cent of those unemployed respondents in the metropolis are students.

4.2.2 Income and Expenditure Levels of Respondents

A cursory inspection of the word health picture suggests that the single most important factor determining survival and health is income. Income is prominent in having an effect on the utilization and accessibility of services. Even though life expectancy in some low income countries are improving and some people in high per capita income countries have relatively low health status, there are all indications that the health of a nation is dependent to a large extent on economic growth and development.



The availability of health facilities and services in a country is mostly determined by the wealth on the nation. Very low incomes would render some household members who have to spend on other utilities financially inaccessible to their health needs. According to Green (1992), as a rule direct medical charges in many Third World Countries are comparably cheaper than some developed countries.

Commerce, service and industry were the main source of income for respondents accounting for 55per cent, 28 per cent and 10 per cent, respectively. The mean income of respondents was estimated at Gh¢ 151 per month. Green (1992) noted that the price paid for health services and medication is an inhibiting factor for some people due to their low income. Respondents spend an average of Gh¢ 19.75Gp on health services. The private hospitals also indicated that they charge an average of Gh¢ 12 for treatment. All things held constant and if respondents are ready to spend the same amount on health all the time, it would be said that the charges by the private hospitals are within the means of the respondents, and hence their continual use of their facility.

#### *4.2.3 Ownership of Durable Goods*

According to the 2000 PHC report, assets ownership is a measure of the well-being and living standard of a household or an individual. These include both movable (durable goods) and immovable assets (land, houses). Household durable goods include cars, bicycle, television sets, refrigerators and radio sets. The acquisition and ownership of these durable amenities by individuals and households is very vital for the determination of their socio-economic status. Respondents were asked about the ownership of particular amenities such as radio, television and cell phone for accessing information, bicycle, car, motor and others as a means of transport.

From the survey conducted, majority of the respondents owes durable goods. About 92 per cent of the respondents owe radio set, 86 per cent have access to television and 80 per cent have cell phones. The percentage with car, bicycle and motor bikes were 8 per cent 7 per cent and 3 per cent respectively. With easy access to news paper and the presence of electricity to power the gadget and coupled with the numerous FM stations in the

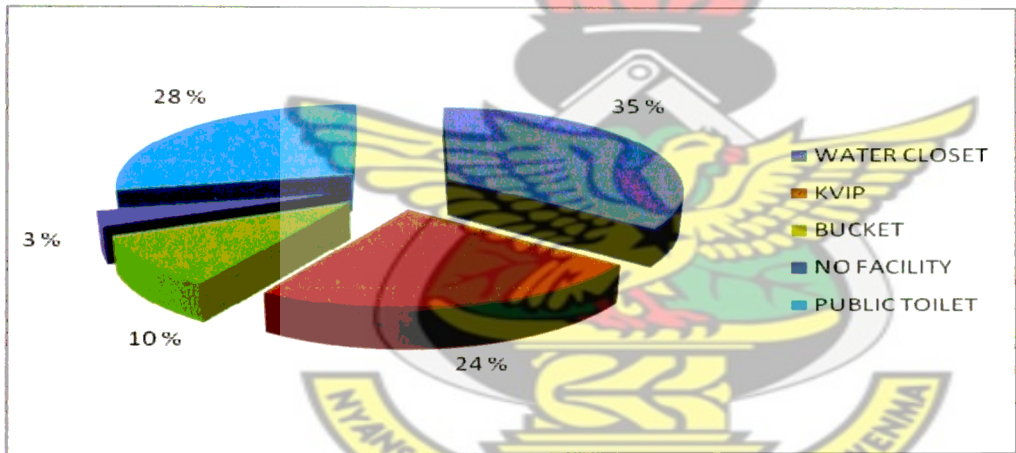
metropolis it is likely that majority of the population will be well informed about the availability of health services in the metropolis. Those who have means of transport would also find it easy to access the health facility of their choice no matter the distance.

4.3 Sanitation Facilities and Conditions

4.3.1 Types of Toilet Facilities

Toilet facilities within the household and the community is a means of ensuring a more efficient and hygienic way of human waste disposal. According to the 2000 population and housing census, about 32 percent of households in urban areas use public toilet, 12.7 per cent of households have no toilet facility or use other means while in rural areas 28.5 per cent of households do not have a toilet facilities. The 2000 PHC report also indicated that in the Kumasi Metropolis, 27.8 per cent use water closet while 36.8 per cent use public toilet.

Figure 4.2                      Type of Toilet Facility Used



Source: Author’s field survey, April 2008

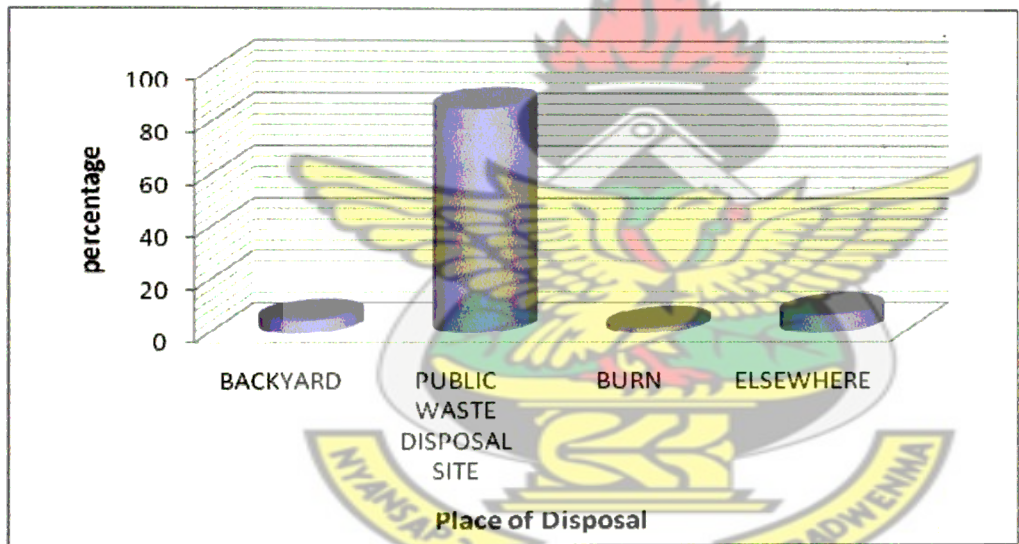
In the Kumasi Metropolis, only a small proportion of the respondents (3 per cent) have no access to toilet facilities. About 35 per cent of the respondents use water closet while 24 per cent use KVIP. The 2000 PHC report indicated that 27.8 per cent of the population in Kumasi use public toilet. The survey also indicated that 28 per cent of the respondents use public toilet. Despite the ban on the use of bucket/pan latrines in 1998, 10 per cent of the respondents still use this facility.

It is a good sign that majority of the population sampled in the metropolis (97 per cent) have access to one form of toilet facility or the other. Concerning the respondents who do not have toilet facilities, it is expected that they will defecate anywhere (bush, drains, and other places), leading to the spread of diseases, such as typhoid fever, diarrhea and cholera.

4.3.2 Places of Garbage Disposal

From the 2000 PHC report more than two-thirds of households in all districts in the Ashanti Region use the public dump to dispose of solid waste. The survey indicated that about 86 per cent of the respondents use the public waste disposal site while about 5 per cent, 2 percent and 7 per cent dispose of their garbage at their backyard, burn or elsewhere respectively.

Figure 4.3 Place of Garbage Disposal



Source: Author's field survey, April 2008

Indiscriminate disposal of waste tends to create filthy environments leading to the breeding of mosquitoes and may increase malaria cases as well as other diseases such as typhoid fever, diarrhoea, and cholera. It may also lead to flooding since most of the gutters will be choked during rainy seasons. The proportion of households throwing solid waste elsewhere in the Kumasi metropolis (7 per cent) has very serious financial and health implications. The Metropolitan Assembly may have to use large sums of money



for the cleaning of gutters, which could have been used for other development needs of the Assembly.

4.3.3 Sources of Drinking Water

The source of drinking water to a community is of concern to every one. This is because adequate supply of potable water to its members is a catalyst to achieve a good quality of life. Water is an important requirement in all spheres of human endeavour. The 2003 World Environmental Day was commemorated under the theme “Water: Vital Resource For Life”, indicating that the importance of water is widely acknowledged. It is important therefore that the distribution of water is undertaken in such a way that people are not denied water.

The improvements in hygiene and sanitation are dependent on water availability. Accessibility to potable water also minimizes the occurrence of water related diseases such as guinea worm, bilharzia, dysentery, typhoid and cholera among others. The 2000 PHC report shows that about 82.5 per cent of the population in the Kumasi metropolis use pipe borne water, 11.5 per cent use wells and 1.5 per cent use streams and rivers.

Table 4.4                      Source of Drinking Water

| Source Of Water | Frequency | Percent |
|-----------------|-----------|---------|
| Pipe Borne      | 84        | 84.0    |
| Stream          | 2         | 2.0     |
| Borehole        | 6         | 6.0     |
| Well Water      | 5         | 5.0     |
| Other           | 3         | 3.0     |
| Total           | 100       | 100.0   |

Source: Author’s field survey, April 2008

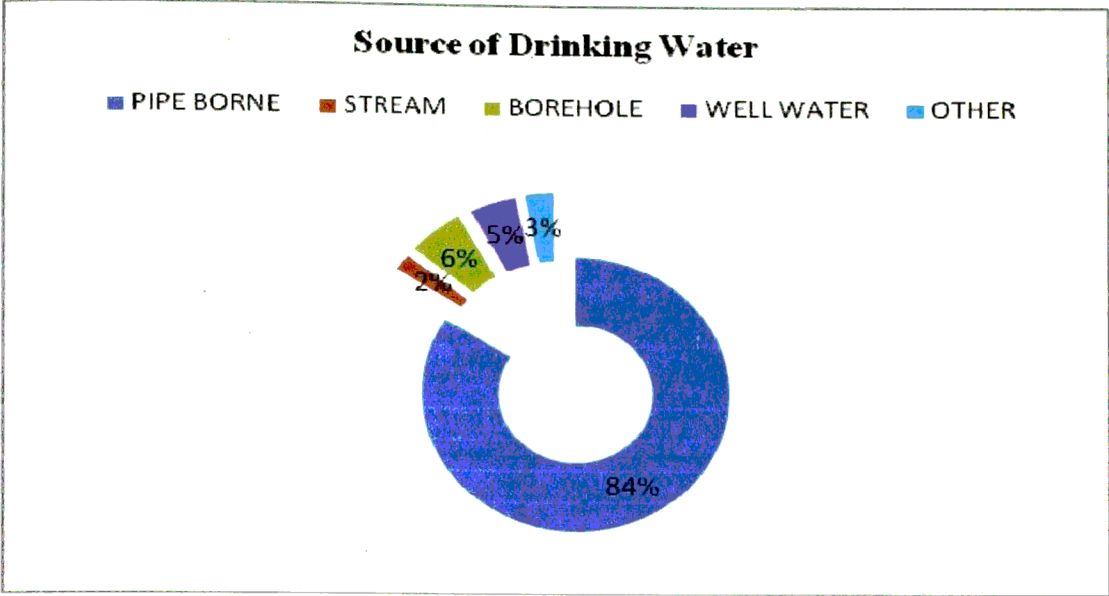


Figure 4.4 Source of Drinking Water

Source: Author's field survey, April 2008

From the household sampled, 84 per cent of the respondents have their source of drinking water from pipe borne and about 3 per cent have their source from others which include tanker supply. Water from the taps does not flow all the time in the metropolis. Out of the total respondents, about 94 per cent do not treat their water before drinking. Transporting the water from source to the point of use could create some health problems. This is dependent on the medium of transport. Very old pipe line can be contaminated and buckets and tankers if not well washed can also be a source of pollution. Water from the various sources should be treated in the form of boiling, sieving or adding aluminium before they are used.

4.4 Health Seeking Behavior of Clients

The metropolis has a number of health facilities in both the public and private sectors which is well distributed over the five sub-metros under which health delivery is organized. Notable among them is the Komfo Anokye Teaching Hospital (KATH), which is one of the two (2) national autonomous hospitals. Respondents however, make their decision to choose one of the health facilities over the other based on the factors which Kunfaa (1996) noted as the knowledge the client has so as to press for and participate in their service needs.

More than half of the sampled respondents (54%) made their choice of health facility from which to access health services based on proximity to a health facility. About 26 per cent of the surveyed population chooses their preferred health facility based on the fact that the facility has all the needed facility they would want.

Table 4.5        Reasons for the Choice of Health Facilities

| Indicator                    | Frequency | Percentage |
|------------------------------|-----------|------------|
| Proximity                    | 54        | 54         |
| Better alternative           | 8         | 8          |
| Have all the needed facility | 26        | 26         |
| Don't know                   | 4         | 4          |
| Only type available          | 8         | 8          |
| Total                        | 100       | 100        |

Source: Author’s field survey, April 2008

4.5 Client Satisfaction

Respondents’ level of satisfaction over the use of private hospitals was analyzed based on the indicators Bannerman et al (2002) stated as a means of measuring quality health care delivery such as the goodness of the amenities used, safety measures put in place in service delivery, interpersonal relationship between staff of private hospitals and clients, affordability of services delivered among others.

A Likert scale between -1 and 2 was used to assess respondents satisfaction with services such that -1 meant not satisfied, 0 meant fairly satisfied, 1 meant satisfied and 2 meant very satisfied. Another Likert scale (less than 0 – not satisfied, 0.1 to 0.49 – satisfied and 0.5 to 1 –very satisfied) was used to interpret the overall satisfaction level of the clients. The result was 0.78(78 per cent satisfaction) indicating that respondents were very satisfied with the services they receive from the private hospitals they attend (refer to Appendix 3 for calculations and details).

Only about 2.5 per cent of the respondents were not satisfied with the services they receive from the private hospitals. Some of the reasons they gave among others for non-satisfaction of the services they receive was the fact that private hospitals charge high and exorbitant prices. Other reasons they gave include the non acceptance of the National



Health Insurance card in some private hospitals because they do not meet the required standard, incompetence of some nurses and non availability of some facilities.

#### 4.6 Services Provided By Private Hospitals

Depending on the type of institution, a private hospital may provide one or a combination of services outlined in Appendix 5. Apart from stating the operational hours, health services become truly available if the services are provided at the said time. With the exception of two of the facilities, all the private hospitals surveyed stated their operational hours. The various private hospitals start OPD and general services from 8.00 o'clock till all the patients for the day are seen. In the case of emergencies other than OPD, a 24 hour service is run by all the private hospitals.

All the private hospitals surveyed also provide general medical services which include outpatient in the form of prevention and management of specific non communicable diseases and prevention and management of injuries and common emergencies such as malaria treatment which remains the highest on top of the diseases in the metropolis, hypertension and diabetes, burns, cuts, snake and dog bite, among others. Other general services include laboratory and dispensary services.

Two out of the ten hospitals do not operate in-patient services which gives a question to whether proper inspection was done before certification was given. Four of the hospitals surveyed provide additional services such as surgical and gynecological services. In addition to these, one of the private hospitals performs special function in ring haemorrhoidectomy and receives referrals from various hospitals.

The private hospitals are therefore providing health care services that are in line with the service requirements in appendix 5. From the survey, all the ten private hospitals selected (see appendix 2), in some cases refer patients to the Komfo Anokye Teaching hospital when management finds out that the case is beyond their control.

4.7 Accessibility Analysis

Physical accessibility refers to the ease with which an individual moved from one place to another to obtain or enjoy a service. According to Bannerman et al (2002), access is measured in terms of the ease and ability of the individual to reach and obtain a service. It is assumed that the further the location of a facility, the less accessible that facility become to the consumer. On the contrary, Rondinelli (1995) in Eggley (2007) states that proximity to a health facility does not necessarily mean utilization of the facility. Sometimes, improved means of transport may make people travel long distances to access a facility.

Again, Bannerman et al (2002) stated that factors to consider in analyzing accessibility include distance and means of transport and travel time, the level of fees and the ability of the clients to pay no matter the charge levels, hospital hours, waiting time, appointment systems and the level of knowledge about existing facility among others. The three conditions underlying the accessibility analysis were distance covered to use the health facility, means of reaching the facility and time spent in obtaining the service.

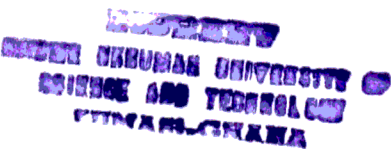
In the Kumasi metropolis, roads are the main mode of transport. The private hospitals are also well spread within the various sub-metros. About 66 per cent of the respondents who use private hospitals walk to the facility.

Table 4.6 Means of Travel to the Private Hospital

| Means Of Travel                | Frequency | Percent |
|--------------------------------|-----------|---------|
| Walking                        | 47        | 66.0    |
| Commercial Vehicle             | 20        | 28.0    |
| Private Vehicle                | 4         | 6.0     |
| Do Not Access Private Hospital | 29        | -       |
| Total                          | 100       | 100.0   |

Source: Author's field survey, April 2008

The survey revealed that physical distance to the private hospitals did not act as a barrier. Even where there are bad roads, most of the private hospitals are within walking



distances and so the nature of the roads does not serve a necessary hindrance to people who want one facility or the other.

Based on the speed of travel, waiting time, spread of health facility and the mode of travel, an assumption was made that the means of transport to the various private hospitals is walking and that an average of five kilometers is covered within 60 minutes. For a client to be within the high access zone of enjoying private hospital, the person should not spend more than 20 minutes while a client within a medium access zone and a low access zones should not spend more than 40 minutes and 60 minutes respectively.

Table 4.7 Distances to Access Health Facility

| Distance       | Frequency | Percent |
|----------------|-----------|---------|
| Between 1-2km  | 78        | 78.0    |
| Between 2-5km  | 21        | 21.0    |
| Between 5-10km | 1         | 1.0     |
| Total          | 100       | 100.0   |

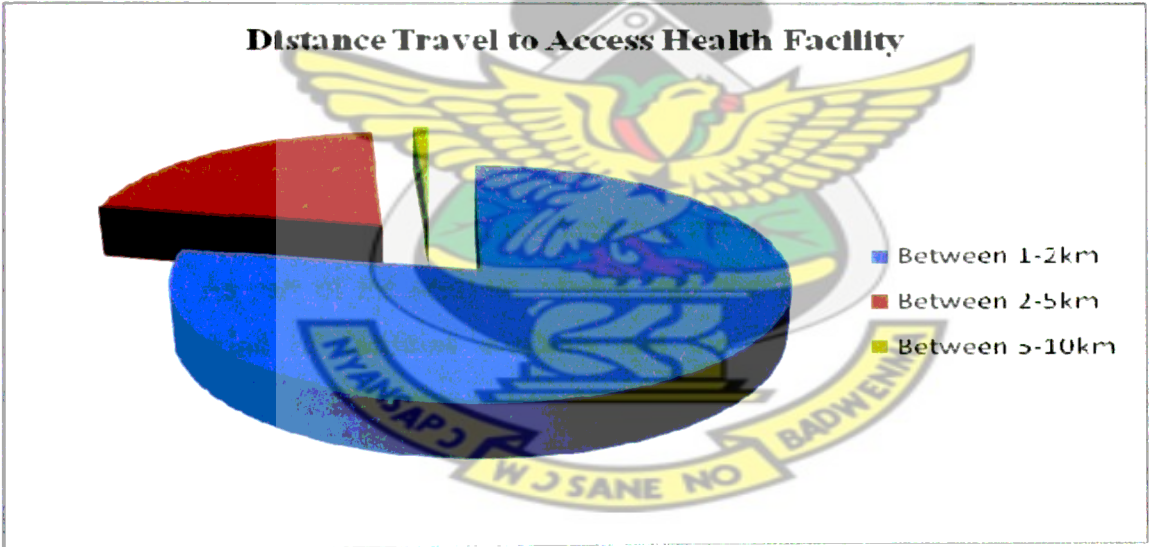


Figure 4.5 Distance Travel to Access Health Facility  
Source: Author's field survey, April 2008

The survey showed that, about 78 per cent of the respondents are in the high access zone and 21 per cent in the medium access zone which means that 99 per cent travel less than 40 minutes to access a health facility. The high access to the private hospitals is due to the fact that there are a lot of these private hospitals and the metropolis has been planned



with Arterial Roads, consisting of paved and unpaved networks that link residences to the local communities and the periphery.

#### 4.8 Health Facilities

To be able to assess quality health care delivery by private hospitals, it is important to look at their infrastructural services, medical examination facilities, sources of funds and find out whether these services are adequate and also functioning. Ten out of forty-four (44) private hospitals in the metropolis were selected for the survey. Their selection was based on the simple random sampling such that each of the facility was given an equal chance of being selected (see Appendix 1 and 2).

##### *4.8.1 Equipment and Infrastructure Facilities*

Basic infrastructural facilities and other basic equipment are pre-requisite for the delivery of quality health care services. According to Mensah and Saka (1999), infrastructure and equipment requirement for the delivery of services by private hospitals depends on the hospital involved (Appendix 5). The various hospitals however require examination room, treatment room, dispensary, laboratory, male and female ward and sanitary facilities which include toilet, urinal and place of waste disposal.

Another important factor to consider is whether or not the private hospitals are accessible to the public. As part of the analysis, visible sign boards to show the presence of the hospitals, the kind of facilities available and the adequacy of infrastructural and equipment were used as indicators.

All the private hospitals surveyed have visibly displayed sign posts to show their location except one. This is an advantage for the population to choose a facility of their choice. About 93 per cent of respondents are educated and this means that majority of the people will be pre-informed before they come into contact with the facility of they choose.



Figure 4.6 A Visible Sign at Asafo Agyei Hospital

Source: Author's Field survey, May 2008

All the private hospitals sampled have OPD, consulting room, treatment/injection room, laboratory and sanitary facilities which include places of convenience and bath. Four of the private hospitals, which represent 40 per cent of the sample, have additional infrastructural facilities including theatre, side ward and car park.

Equipments used by the private hospitals also include sphygmomanometer, stethoscope, thermometer, microscope, examination couch and screen. Others include dryer, scanner, chemical analyzer, centrifuge, theatre equipment and computer.

Asked whether the facilities and equipment they are operating are adequate, and taking adequacy to mean whether there is no shortage in supply, all the private hospitals surveyed said their facilities and equipments are adequate. This was mostly so because a facility normally depends on the size and services provided by the hospital. With their current practices and services, they explained that in their current state they are capable of satisfying the clients that visit. The nurses also attested to the fact that they have the requisite equipment needed for the operation of their duties. They therefore believe that without pressure on their facilities their facilities are adequate.

#### 4.8.2 Functioning of Equipment and Infrastructural Facilities

One aspect of quality health care delivery is whether or not the infrastructural facilities operated by these private hospitals are functioning. Most hospital equipment and facilities require efficient electricity supply. Other facilities that are essential for quality health care delivery and need to be functioning include proper running water and good sanitary facilities.

All the private hospitals visited have electricity supply even though they complain that there are sometimes power outages. They also have running water and sanitary facilities. Five of them have generating plant to propel their facilities and equipment in time of power outages. The private hospitals also have reservoirs to keep water to avoid water shortages in their premises.

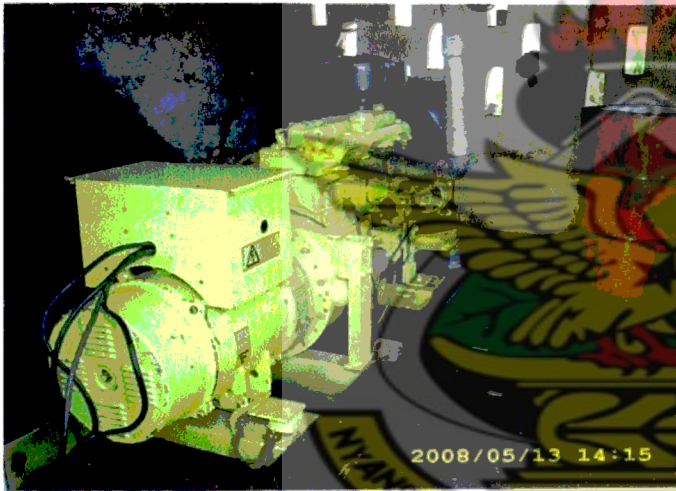


Figure 4.7 Generating Plant at Asafo Agyei hospital

Source: Author's Field survey, May 2008



Figure 4.8 Reservoirs on top of Building

Source: Author's Field survey, May 2008

The other equipment and facilities operated by the various private hospitals are functioning very well. From the survey conducted, those that are not functioning, for example, thermometers, microscopes, scanners, theatre equipment and computers are promptly replaced. The situation enables the private hospitals to provide services without interruptions.



#### *4.8.3 Medical Examination Facilities*

To be sure and recommend an appropriate diagnosis for patients to overcome their ailment, it is important that the patient is examined for any physiological problem which will need attention. Such an examination should be conducted in a manner not to inconvenience the patient. It is therefore required that the correct equipment should be used in a well lit and clean environment. In such a situation the patient will not only explain what is wrong but will be confident that his/her privacy is assured.

All the private hospitals surveyed satisfy the above requirements. Their services are provided for individuals in a closed door examination room with well lit environment. The floors of the various hospitals are cleaned with chemicals and the seats well arranged to accommodate as many patients that visit their facilities.

The private hospitals visited also use vital clinical equipment which are well functioning to conduct their medical examination. The basic equipment used include the sphygmomanometer (BP apparatus), thermometer stethoscope, microscope, examination couch and screen. These equipment are necessary to get first hand information on the condition of the patients.

#### *4.8.4 Sources of Funds for Maintenance*

Funding is an important component to achieve quality health care. For every entity to achieve its objective there is the need for that entity to solicit enough funds to run its day to day activities. The 2000 PHC report indicated that in Ghana, the health sector has received relatively adequate attention in terms of the share of the national budget and donor support. This support is however limited to the public health sector. Private hospitals also need funding either in kind or in cash to keep them functioning.

All the private hospitals visited are self funded. Money is generated internally from the charges and fees paid by the client. Only two of the private hospitals are listed on the NHIS. Even then, the scheme is not yet in operation in those hospitals and clients have to pay for the services they receive to enable them run.

The Metropolitan Assembly has no influence on the activities of the private hospitals. According to the private hospitals, nothing is received from the Metropolitan Assembly as assistance. The Metropolitan Assembly however maintain that even though their assistance is given through the Metropolitan Health Directorate (MHD) they also directly and indirectly offer assistance to the private hospitals in the form of developing general infrastructure such as roads, water and electricity in their areas of operation.

#### *4.8.5 Problems in Quality Health Care Delivery*

There is no doubt that in an attempt to provide quality health care for all your clients, there may be some problems which of course need to be addressed to achieve efficiency. Some of the problems the private hospitals encounter in their quest to deliver their services include:

- ☐ The intolerant and impatient behaviour of some patients. Some patients want to be treated specially and faster than the others.
- ☐ Long delays of reported cases which result in complications and sometimes leading to the loss of life
- ☐ Frequent power outages during operational hours
- ☐ Difficulty in obtaining state registered nurses
- ☐ Lack of credit facilities for the purchase of vital equipments

### **4.9 Staffing Situation**

#### *4.9.1 Adequacy of Staff*

According to the Ministry of Health criteria for the registration of private health institutions, the basic requirement for private hospital is one doctor who should possess a minimum of five years post qualification experience, a professional nurse and four auxiliaries all of whom should be in full time employment. Seven of the sampled private hospitals have one doctor each to attend to their patients. Two of the private hospitals have two doctors each and one other hospital has three doctors.

From the survey, one hospital has fourteen (14) nurses while the remaining nine hospitals have between four to eight nurses. Supporting staff include cleaners, accountants and

watchmen, among others. All the private hospitals have watchmen and other supporting staff ranging between two and eight.

Going by the criteria for registering the private hospitals (see appendix 5.1), it can be said that the staffing situation of private hospitals is adequate since all the private hospitals have the required doctors and nurses.

**Table 4.8 Health facility and the number of patients per day**

| Health Facility          | Average no. of patients per clinic per day |
|--------------------------|--|
| Keffam Health Services   | 18   |
| Sarfo Adu Hospital       | 22   |
| Christ the King Hospital | 15   |
| City Hospital            | 50   |
| Siloam Hospital          | 30   |
| Suame Hospital           | 34   |
| Kumasi Medical Centre    | 17   |
| Gloria Memorial Hospital | 12   |
| Kuffour Clinic           | 45   |
| Asafo Adjei Hospital     | 80   |

*Source: Author's field survey, April 2008*

Considering the patients that visit the various private hospitals average between twenty-five and forty-two and with the current doctor patient ratio of 1:7,982 and nurse patient ratio of 1:1,606 in the metropolis, it can also be said that there are enough staff in the private hospitals to take care of the clients that visit.

#### 4.9.2 Qualification of Staff

Bannerman et al (2002) explained that if health staff lack skills, or adopt a discouraging attitude towards patients, it may often be a barrier to provide and access quality health care. Donabedian (2003) also indicated that the degree to which health system personnel have the training and abilities to assess, treat and communicate with their clients should be a vital indicator for quality health care delivery. This is because the life of an individual lies in the hands of the health personnel once he/she chooses the facility. A little mistake can cause someone to loose his/her life.

All the doctors in the sampled private hospitals were trained and have the requisite qualification to examine, diagnose and treat patients. Out of the total of fifty-nine (59)



nurses in the surveyed hospitals, only nine (9) were formally trained. The rest (50) were given on the job and in-service training by the private hospitals through the MHD.

The nursing situation described above is not good for the achievement of the desired quality health care objectives. The time spent in formal training and the reality of learning both the theory and practical aspect of nursing grooms a nurse to be able to perform creditably. However, even though all of them do not have the requisite qualification, the long service engagements coupled with the occasional in-service training they receive from the MHD have made them quite experienced.

#### 4.10 Relationship between Private and Public Hospitals

All the private hospitals surveyed maintained that they rely on the public hospitals for some of their services especially referral cases. On the issue of whether the public hospitals also rely on the services of the private hospitals, all the private hospitals responded that there are no clear instances that the public hospitals directly rely on them except one of the private hospitals that receive indirect referral for pile cases. On the whole, the relationship between the private and public hospitals is on association bases and occasionally attending courses together.

#### 4.11 Contribution of the Metropolitan Health Directorate to Private Hospitals in Ensuring Quality Health Care Delivery

According to the official at the metropolitan health directorate, there are about 44 private hospitals in the metropolitan area. The private hospitals according to him have gone through the normal process involved in the registration of private hospitals (Appendix 4). However, the private hospitals in the metropolis do not directly register with the metropolitan health directorate. What the directorate does is to help in the registration process by teaming up with the regional health directorate to inspect the initial facility to be used for the operation of the hospital and send recommendation to Accra for approval.

The staff requirements of private hospitals are dependent and determined by the size of the facility (Appendix 5). It is mandatory for private hospitals to have a doctor, medical assistant, midwife, nurses, laboratory technicians/assistants, X-ray technician, health care assistants, pharmacists/dispensary technicians, record keepers, accounts and laundry staff and kitchen staff.

As part of their service requirement, private hospitals should have OPD, Inpatient, surgical department where applicable, family planning unit where applicable, laboratory, X-ray department, laundry, dispensary, parking bay and very good sanitary facilities. The metropolitan health official explained that even though most private hospitals are trying to maintain the required standard, some of them do not have the minimum facility and staff requirement. The metropolitan health directorate does not go on regular inspection according to laid down guidelines. This is mostly due to the fact that the private hospitals are tied to the Ministry of Health in Accra rather than the regional and metropolitan directorates. The metropolitan health directorate has very minimal influence over the private hospitals. The directorate is however mandated to ensure quality health care in both public and private hospitals. What they do is the use of interaction and dialogue to get the private hospitals to provide these quality health services. As part of their effort to ensure quality service delivery, the MHD provides the following assistance to the private hospitals;

- ☐ In-service training for the staff of private hospitals
- ☐ Provision of essential drugs for the prevention of malaria in pregnancy
- ☐ Supply of mosquito nets
- ☐ Money to support TB treatment
- ☐ Logistics to support TB treatment
- ☐ Information sharing
- ☐ Support for immunization

To ensure quality health care delivery in various private hospitals, it is necessary for the metropolitan health directorate to promptly supply them with the above and monitor their activities regularly.

## CHAPTER FIVE

### PROSPECTS AND CHALLENGES, RECOMMENDATIONS AND CONCLUSION

This chapter deals with the findings, recommendations and conclusions. The recommendations are discussed under various thematic areas such as sanitation conditions, service provision, infrastructure, sources of funds and staffing. It is hoped that if these recommendations are implemented within the next five years, it would go a long way to improve quality health care delivery in Ghana.

#### 5.1 Prospects and Challenges

According to the Republic of Ghana Medium Term Health Strategy (1995), Ghana's official health strategy calls for active partnership between public and private health care providers to improve the coverage and quality of the health care system. It is expected that the involvement of the private hospitals will help to offer a comprehensive package of basic services to cover the whole country. In this chapter, the prospects as well as the challenges that confront the private hospitals in their quest to help deliver quality basic health care are discussed.

##### 5.1.1 Prospects

- In the first place, private hospitals play a substantial role in the delivery of health care in Ghana. They provide a range of preventive and curative services for both the upper and lower groups and generally perform creditably. Their services serve as an alternative to people who would not prefer to be in long queues in the public hospitals.
- Secondly, most of the private hospitals maintain set standard of health care. They provide a range of amenities and suitable facilities that conform to the standards of hygienic practices and cleanliness. Most of their facilities have pipe borne water supply, water closet toilet facility, injection/treatment rooms, bathrooms attached or detached from the facility, screening rooms, emergency ward, among others. Some of them also have laundry and catering facilities as well as stores for their supplies.



- Most patients are often very confident and assured of their privacy and safety and would continue to access the services of the private hospitals. The relationships between the staff and client are very cordial and regular inspection is conducted by their operators to ensure that the level of operation satisfies their clients.
- Again, private hospitals desire to expand their scope in terms of facilities and the services they render. Some of them are putting up extra facilities to enable them expand their services. The desire for some of them to have international affiliation also means that they have to improve their services to reach international standards.
- The National Health Insurance is beginning to be operative in the private hospitals. Some of the private hospitals have been listed on the National Health Insurance Scheme. When the insurance becomes fully operative, most people who hitherto would have used the public hospitals would be attracted to some of the private hospitals. This will certainly reduce some of the pressure on the public hospitals as a result of the insurance.
- Through the various district health directorates, some of the private hospitals are involved in national programmes such as immunization, in-service training and information sharing. The district health directorates also supply private hospitals with essential drugs for the prevention of malaria, mosquito nets and some money to support tuberculosis treatment. This is a good sign of the commitment of government to involve and give them support in the delivery of health services.
- Generally, private hospitals operate daily and 24 hour service. Most of the facilities are within walking distance of the communities. With the availability of electricity and stand-by generator for some of them, patients can walk in any time for treatment to avert any calamity.
- The research shows that most people make their decision to choose one health facility or the other based on such factors as proximity, better alternative, having all the needed facilities and the only type available. Since most of the private hospitals are within the reach in the various communities and the only type available, they would continue to attract the attention of patients to patronize them.

### 5.1.2 Challenges

- The establishment and running of private hospitals require substantial financial inputs. The results of the study into their operations show that private hospitals rely on their personal sources of funds that they internally generate. Purchasing of inputs and equipment for the delivery of quality services would require that the private hospitals get access to credit facilities.
- A substantial proportion of private hospitals encounter difficulty in employing qualified staff. Research from the Environment and Health Sector of the Council for Scientific and Industrial Research shows that about 40 per cent of the providers have difficulty in attracting trained specialists, nurses, midwives, accounting officers and administrators. The study also showed that 50 out of the 59 nurses interviewed were not formally trained. Many of the private hospitals are not able to afford the high cost of trained staff and many others are not able to hire them because such trained staffs are in short supply.
- In-service training is necessary to keep the worker up to date and improve the quality of service provided. Through such in-service training and long service, some of the nurses in the private hospitals have become experienced and are working to achieve quality but the fact still remains that some of the nurses interviewed could not explain to the researcher the concept of quality health care.
- To qualify for a private hospital, the facility should operate in-patient services. Some of the private hospitals however do not operate such services. This would certainly call for continued referral of in-patient cases to mostly the public hospitals.
- Doctors in public health care institutions are not officially allowed to make referrals to private hospitals. Referrals from private hospitals to public health care institutions are accepted but most of them are resented or passively accepted. It is worth noting that some of the doctors in the private hospitals are also practitioners in the public hospitals.
- Government policy on the private hospitals has sought to regulate the growth of the ever increasing private hospitals to ensure the effective and efficient functioning of these private hospitals. However, some government policies seem



to discriminate against those who want to go into private practice. For instance the establishment of private hospitals requires a doctor to have not less than five years post- qualification experience. Hospital bills of most government employees are not officially recognized when they are from private hospitals.

- The introduction of the National Health Insurance Scheme is supposed to increase patronage of health services by the populace. Some of the private hospitals have been listed on the scheme but most of the private hospitals that are not listed are beginning to have dwindling number of patients patronizing their facilities.

## 5.2 Recommendations

### *Economic situation*

- There are still some people in the metropolis who are not employed. This could lead to social vices such as arm robbery and its attended problems. It is important for the Metropolitan Assembly to make frantic efforts to create more jobs to absorb such people. This could be in the form of giving them short term (preferably six months) training to be self employed so that when such people are sick, they can afford to go to the hospital.

### *Sanitation conditions*

- Malaria continues to be on top of the diseases in the metropolis. There is evidence of choked gutters as a result of indiscriminate disposal of waste which creates filthy environments leading to the breeding of mosquitoes. The Metropolitan Assembly must step up efforts to clean the gutters periodically to avoid the breeding of mosquitoes. People should also change their attitudes towards creating filthy environment to bring about healthy living. This is because healthy living will reduce pressure on the health systems.
- Landlords must be encouraged to provide toilet facilities in their homes to help control the possibility of diseases outbreak. The Metropolitan Assembly must ensure that people who are putting up buildings make adequate provision for toilet facilities not only on their plans but execute them.



- There should be regular flow of water from the Ghana Water Company in the metropolis to prevent people from resorting to the use of contaminated water to reduce water borne diseases. Also, there is the need to treat water from various sources before consumption. This could be in the form of sieving or boiling before consumption.
- Since majority of the people in the metropolis rely on pipe borne water as their only source of water, very old pipe lines that are used by the Ghana Water Company for the transportation of water to the various homes in the metropolis need to be changed within the shortest possible time.

### *Service Provision*

- The National Health Insurance Scheme should be expanded to include majority of the private hospitals. Very few of the private hospitals are listed on the scheme. It is hoped that if government involve all the private hospitals in the National health Insurance Scheme, it would increase the intake of patients who visit their facilities and ease the burden on the public hospitals as well as improving the quality of service of private hospitals.
- According to the operators of private hospitals, very little support is received from government for their activities. For example, provision of essential drugs for the prevention of malaria, logistics to support TB, available ambulance service, among others has not received attention. The government can encourage the private hospitals to expand their services by making available to them credit facilities. This could be in the form of loans to purchase essential inputs.
- The various private hospitals should be well scrutinized before they are given the licence to operate. To qualify for a private hospital, the facility should operate in-patient services. Some of the private hospitals however do not operate such services.
- The Metropolitan Health Directorate should be given the power to monitor and inspect the private hospitals periodically to ensure quality health care delivery. The MHD should also supervise the private hospitals to make sure that they do not go beyond their bounds. A further research would be necessary to look into

why the metropolitan directorate has no direct influence on the private hospitals and why facilities that do not operate in-patient are given the hospital status.

- Some of the laws that do not allow government employees to patronize private hospitals must be relaxed. Private hospitals should be recognized by organizations as entities that are capable of delivering quality service. Bills from private hospitals should be promptly paid to encourage employees to patronize their services.

### *Infrastructure*

- There is the need for all the private hospitals to have in-patient facilities, theatres and car parks to be able to absorb emergencies and increase access to their facility. Some of the existing facilities like toilets even though present, there is the need for operators of private hospitals to improve them.
- It is also recommended for the private hospitals to acquire stand by generators to prevent sudden power outages by the electricity company that affect their operations.

### *Sources of funds*

- The objective of Ghana's Medium Term Health Strategy to integrate or establish partnerships with private health providers should be supported by the government through incentives such as equipment and logistics as a means of improving the overall coverage and quality of health care. To enable private hospitals to reach out to patients in all communities at low cost, the government could assist them with subsidies and tax relief.

### *Staffing situation*

- It is necessary for the nurses of private hospitals to go through the three year formal training given by the Ghana Health Service to equip them with the requisite skills to deliver quality health care. Private hospitals should employ qualified doctors, nurses and other supporting staff to provide quality services.

- Through the collaboration of the operators of private hospitals and the Ghana Health Service, staff that are already trained could be given periodic in-service training to help them to adjust to the changes of time.

### 5.3 Conclusion

The health sector in Ghana has made and continues to make several efforts in improving the quality of services and coverage to people. The last effort is the introduction of the National Health Insurance Scheme. The private hospitals have not received the necessary attention from government as stated in the country's policy objective. It is expected that the private hospitals would also be given the necessary support to participate and improve the quality of health services in the country.

An analysis of selected issues namely: client satisfaction, health seeking behaviour of clients, services provided by the private hospitals, accessibility, equipment and infrastructural facilities, medical examination facilities staffing situation and the contribution of the Metropolitan Health Directorate to the private hospitals among others was undertaken. Various strategies put in place to ensure quality health care by the private hospitals were looked at to see how they have impacted on the above indicators.

Lapses and gaps were identified such as large number of untrained staff, frequent power outages, absence of in-patient facilities for some of the private hospitals, inadequate supervision by the Metropolitan Health Directorate and over reliance on internally generated funds for their operations. It was realized that all these lapses could one way or the other affect the delivery of quality health care in the metropolis. Considering the role private hospitals play in reaching out to the health needs of people to promote development, it is important for government to give them the needed support to help them deliver.

Bank loans, if available could greatly influence the expansion of the private hospitals in terms of their equipment and infrastructure. The government could also assist them to obtain loan facilities from the banks on liberal terms.



In-service training facilities in the public sector are not readily available to the private hospitals and referrals from public facilities to private hospitals are limited by government directives. The Ministry of Health could promote cooperation and partnership between the public and private hospitals by assisting private hospitals with specialized staff.

There should be effective collaboration between public and private hospitals, Ministry of Health, Regional and Metropolitan Health Directorates and in fact, the involvement of all stake holders. This would enable the private hospitals to help Ghana to achieve its health vision of bridging the equity gap in access to quality health and nutrition services, ensure sustainable financial arrangement that protect the poor and enhance efficiency in service delivery.



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# APPENDICES

# KNUST





## Appendix 1: Health Facilities in Kumasi Metropolitan Area

**Table B1 Health Facilities in Kumasi Metropolitan Area**

|          | HEALTH FACILITY                       | DISTRICT            | LOCATION         | TYPE     | OWNER |
|----------|---------------------------------------|---------------------|------------------|----------|-------|
| <b>1</b> | <b>MANHYIA SOUTH SUBMETRO</b>         |                     |                  |          |       |
| 1        | MANHYIA GOVERNMENT HOSPITAL           | KUMASI METROPOLITAN | MANHYIA          | HOSPITAL | G     |
| 2        | NAKA HOSPITAL                         | KUMASI METROPOLITAN | BUOKROM ESTATE   | HOSPITAL | P     |
| 3        | BUOKROM ESTATE KEFFAM HEALTH SERVICES | KUMASI METROPOLITAN | BUOKROM ESTATE   | HOSPITAL | P     |
| 4        | MANHYIA SARFO ADU HOSPITAL            | KUMASI METROPOLITAN | ASHANTI NEW TOWN | HOSPITAL | P     |
| 5        | ASAWASI BOAKYE DANKWA HOSPITAL        | KUMASI METROPOLITAN | DICHEMSO         | HOSPITAL | P     |
| 6        | BOATEMAA MATERNITY HOME               | KUMASI METROPOLITAN | ASAWASI          | CLINIC   | P     |
| 7        | BUOKROM ESTATE EFFAH HOSPITAL         | KUMASI METROPOLITAN | BUOKROM ESTATE   | HOSPITAL | P     |
| 8        | BUOKROM BABY PEARL MATERNITY HOME     | KUMASI METROPOLITAN | BUOKROM          | CLINIC   | P     |
| 9        | BUOKROM ESTATE PIMA CLINIC            | KUMASI METROPOLITAN | BUOKROM ESTATE   | CLINIC   | P     |
| 10       | MOSHIE ZONGO RUSSIA CLINIC            | KUMASI METROPOLITAN | MOSHIE ZONGO     | CLINIC   | P     |
| 11       | MOSHIE ZONGO CLINIC                   | KUMASI METROPOLITAN | MOSHIE ZONGO     | CLINIC   | P     |
| 12       | VICTORY MATERNITY HOME                | KUMASI METROPOLITAN | MOSHIE ZONGO     | CLINIC   | P     |
| 13       | MATTY MATERNITY HOME                  | KUMASI METROPOLITAN | MOSHIE ZONGO     | CLINIC   | P     |
| 14       | ASH TOWN BRAINOK SALVATION CLINIC     | KUMASI METROPOLITAN | ASHANTI NEW TOWN | CLINIC   | P     |
| 15       | KAMA CLINIC                           | KUMASI METROPOLITAN | ASHANTI NEW TOWN | CLINIC   | P     |
| 16       | NEW TOWN CLINIC                       | KUMASI METROPOLITAN | ASHANTI NEW TOWN | CLINIC   | P     |
| 17       | ASH TOWN ENEC DENTAL CLINIC           | KUMASI METROPOLITAN | ASHANTI NEW TOWN | CLINIC   | P     |
| 18       | AGYENKWA NADOM CLINIC                 | KUMASI METROPOLITAN | SEPE BUOKROM     | CLINIC   | P     |
| 19       | ABRAFI MEMORIAL HOSPITAL              | KUMASI METROPOLITAN | DICHEMSO         | CLINIC   | P     |
| 20       | ASH TOWN CLINIC                       | KUMASI METROPOLITAN | ASHANTI NEW TOWN | CLINIC   | P     |
| 21       | ASAWASI NYAME YE MATERNITY HOME       | KUMASI METROPOLITAN | ASAWASI          | CLINIC   | P     |

|          |  |                     |                |          |    |
|----------|--|---------------------|----------------|----------|----|
| 22       | MAMMIE MATERNITY HOME                  | KUMASI METROPOLITAN | BUOKROM ESTATE | CLINIC   | P  |
| 23       | DICHEMSO WISDOM HOSPITAL               | KUMASI METROPOLITAN | DICHEMSO       | HOSPITAL | P  |
| 24       | DICHEMSO ALLEN HOSPITAL                | KUMASI METROPOLITAN | DICHEMSO       | HOSPITAL | P  |
| 25       | NEW ZONGO GHANA LEGION CLINIC          | KUMASI METROPOLITAN | NEW ZONGO      | CLINIC   | P  |
| 26       | NEW ASAWASI CLINIC                     | KUMASI METROPOLITAN | ASAWASI        | CLINIC   | P  |
| 27       | PIMA CLINIC                            | KUMASI METROPOLITAN |                | CLINIC   | P  |
| <b>2</b> | <b>ASOKWA SUBMETRO</b>                 |                     |                |          |    |
| 1        | KUMASI SOUTH GOVERNMENT HOSPITAL       | KUMASI METROPOLITAN | CHIRAPATRE     | HOSPITAL | G  |
| 2        | BOMSO CHURCH OF CHRIST CLINIC          | KUMASI METROPOLITAN | BOMSO          | HOSPITAL | M  |
| 3        | BOMSO CLINIC                           | KUMASI METROPOLITAN | BOMSO          | CLINIC   | P  |
| 4        | KNUST HOSPITAL                         | KUMASI METROPOLITAN | KNUST CAMPUS   | HOSPITAL | QG |
| 5        | EMINAA ANIMWAA MEDICAL CENTRE          | KUMASI METROPOLITAN | EMINAA         | HOSPITAL | P  |
| 6        | PRINCE OF PEACE CLINIC                 | KUMASI METROPOLITAN | ABOABO NO 2    | CLINIC   | P  |
| 7        | COMFORT MATERNITY HOME                 | KUMASI METROPOLITAN | ODUOM          | CLINIC   | P  |
| 8        | SEPE DOTE CLINIC                       | KUMASI METROPOLITAN | SEPE           | CLINIC   | P  |
| 9        | ATONSU ADABIE HOSPITAL                 | KUMASI METROPOLITAN | ATONSU         | HOSPITAL | P  |
| 10       | VICTORY MATERNITY HOME                 | KUMASI METROPOLITAN | AYIGYA         | CLINIC   | P  |
| 11       | AKOREM DR OSEI HOSPITAL                | KUMASI METROPOLITAN | AKOREM         | HOSPITAL | P  |
| 12       | AMAAMATA MATERNITY HOME                | KUMASI METROPOLITAN | ADEYANSE       | CLINIC   | P  |
| 13       | AHENSAN CHRIST THE KING                | KUMASI METROPOLITAN | AHENSAN        | HOSPITAL | P  |
| 14       | AYEDUASE MCH CENTRE                    | KUMASI METROPOLITAN | AYEDUASE       | CLINIC   | G  |
| 15       | ATONSU LAKE ROAD HOSPITAL              | KUMASI METROPOLITAN | ATONSU         | HOSPITAL | P  |
| 16       | ATONSU ST ANNE'S HOSPITAL              | KUMASI METROPOLITAN | ATONSU         | HOSPITAL | P  |
| 17       | BOADI MUSLIM HOMEOPATHIC CLINIC        | KUMASI METROPOLITAN | BOADI          | CLINIC   | M  |
| 18       | ASOKWA ST MARKU'S HOSPITAL (AIDS ALLY) | KUMASI METROPOLITAN | ASOKWA         | HOSPITAL | P  |
| 19       | ASOKWA CITY HOSPITAL                   | KUMASI METROPOLITAN | ASOKWA         | HOSPITAL | P  |
| 20       | ASOKWA POKU TRANSPORT HOSPITAL         | KUMASI METROPOLITAN | ASOKWA         | HOSPITAL | P  |
| 21       | OFORIKROM HOSPITAL                     | KUMASI METROPOLITAN | OFORIKROM      | HOSPITAL | P  |
| 22       | ALLEN'S CLINIC                         | KUMASI METROPOLITAN | AHENSAN        | CLINIC   | P  |
| 23       | ASOKWA TWUMASI MEMORIAL HOSPITAL       | KUMASI METROPOLITAN | ASOKWA         | HOSPITAL | P  |

|    |                                     |                     |                 |          |   |
|----|-------------------------------------|---------------------|-----------------|----------|---|
| 24 | QUEEN'S HOSPITAL                    | KUMASI METROPOLITAN | DOMPOASE KUWAIT | HOSPITAL | P |
| 25 | AYIGYA CLINIC                       | KUMASI METROPOLITAN | AYIGYA          | CLINIC   | P |
| 26 | COMPLIMENTARY CLINIC                | KUMASI METROPOLITAN | GYINYASE        | CLINIC   | P |
| 27 | SIR GIBRINNES CLINIC                | KUMASI METROPOLITAN | SEPE TIMPOM     | CLINIC   | P |
| 28 | PPAG TEENS CENTRE                   | KUMASI METROPOLITAN | SEPE TIMPOM     | CLINIC   | P |
| 29 | BORN AGAIN HOMEOPATHIC              | KUMASI METROPOLITAN | ADUKROM         | CLINIC   | P |
| 30 | HOMEOPATHIC CLINIC                  | KUMASI METROPOLITAN | NSENIE          | CLINIC   | P |
| 31 | MAAME SERWAA MATERNITY HOME         | KUMASI METROPOLITAN | BOKRO LAST STOP | CLINIC   | P |
| 32 | MAUD MATERNITY HOME                 | KUMASI METROPOLITAN | AHENSAN         | CLINIC   | P |
| 33 | ST HELENA MATERNITY HOME            | KUMASI METROPOLITAN | ANWIAM          | CLINIC   | P |
| 34 | OWUSUWAA MATERNITY HOME             | KUMASI METROPOLITAN | ADUKROM         | CLINIC   | P |
| 35 | KAASE MATERNITY HOME                | KUMASI METROPOLITAN | KAASE           | CLINIC   | P |
| 36 | MARY'S MATERNITY HOME               | KUMASI METROPOLITAN | NEW ASOKWA      | CLINIC   | P |
| 37 | QUEEN'S VICTORY MATERNITY HOME      | KUMASI METROPOLITAN | ANLOGA          | CLINIC   | P |
| 38 | PARADISE MATERNITY HOME             | KUMASI METROPOLITAN | ANLOGA          | CLINIC   | P |
| 39 | AHENSAN COCA COLA BOTTLING CLINIC   | KUMASI METROPOLITAN | AHENSAN         | CLINIC   | P |
| 40 | AHENSAN GHANA BREWERY CLINIC        | KUMASI METROPOLITAN | AHENSAN         | CLINIC   | P |
| 41 | A. G. TIMBERS CLINIC                | KUMASI METROPOLITAN |                 | CLINIC   | P |
| 42 | HABITAT SAWMILL CLINIC              | KUMASI METROPOLITAN |                 | CLINIC   | P |
| 43 | KAASE GUINNESS GHANA LIMITED CLINIC | KUMASI METROPOLITAN | KAASE           | CLINIC   | P |
| 44 | AMANSIE ENTERPRISE CLINIC           | KUMASI METROPOLITAN |                 | CLINIC   | P |
| 45 | PAUL SAGOE SAWMILL CLINIC           | KUMASI METROPOLITAN |                 | CLINIC   | P |
| 46 | OMEGA SAWMILL CLINIC                | KUMASI METROPOLITAN |                 | CLINIC   | P |
| 47 | BIBIANI LOGGING & LUMBER CLINIC     | KUMASI METROPOLITAN |                 | CLINIC   | P |
| 48 | LOGS LOGGING & LUMBER CLINIC        | KUMASI METROPOLITAN |                 | CLINIC   | P |
| 49 | JOHN BITAR COMPANY CLINIC           | KUMASI METROPOLITAN |                 | CLINIC   | P |
| 50 | JCM COMPANY CLINIC                  | KUMASI METROPOLITAN |                 | CLINIC   | P |
| 51 | ATWIMA TIMBER CLINIC                | KUMASI METROPOLITAN |                 | CLINIC   | P |
| 52 | ACADEMY CLINIC                      | KUMASI METROPOLITAN | ASOKORE MAMPONG | CLINIC   | P |
| 53 | BOSOMTWE CLINIC                     | KUMASI METROPOLITAN | ABOABO AKOREM   | CLINIC   | P |



|    |                                      |                     |                 |               |   |
|----|--------------------------------------|---------------------|-----------------|---------------|---|
| 54 | EBENEZER CLINIC                      | KUMASI METROPOLITAN | ANLOGA          | CLINIC        | P |
| 55 | ATONSU-AGOGO CLINIC                  | KUMASI METROPOLITAN | ANLOGA          | CLINIC        | P |
| 56 | VIBRO MATERNITY CLINIC               | KUMASI METROPOLITAN |                 | CLINIC        | P |
| 3  | <b>BANTAMA SUBMETRO</b>              |                     |                 |               |   |
| 1  | SUNTRESO GOVERNMENT HOSPITAL         | KUMASI METROPOLITAN | SUNTRESO        | HOSPITAL      | G |
| 2  | APATRAPA HEALTH CENTRE               | KUMASI METROPOLITAN | APATRAPA        | HEALTH CENTRE | G |
| 3  | ABREPO COUNTY HOSPITAL               | KUMASI METROPOLITAN | ABREPO          | HOSPITAL      | P |
| 4  | QUEEN OF PEACE                       | KUMASI METROPOLITAN | ADOATO          | CLINIC        | P |
| 5  | PATASI WEST END CLINIC               | KUMASI METROPOLITAN | PATASI          | CLINIC        | P |
| 6  | EBENEZER MATERNITY CLINIC            | KUMASI METROPOLITAN | ADOATO          | CLINIC        | P |
| 7  | KWADASO SDA HOSPITAL                 | KUMASI METROPOLITAN | KWADASO         | HOSPITAL      | M |
| 8  | ATASEMANSO CLINIC                    | KUMASI METROPOLITAN | ATASEMANSO      | CLINIC        | P |
| 9  | PREMPEH COLLEGE CLINIC               | KUMASI METROPOLITAN | PREMPEH CAMPUS  | CLINIC        | G |
| 10 | PATASE SUAME NKWANTA HOSPITAL        | KUMASI METROPOLITAN | PATASI          | HOSPITAL      | P |
| 11 | AMPABAME CLINIC                      | KUMASI METROPOLITAN | AMPABAME        | CLINIC        | P |
| 12 | DAABAN ASAFO AGYEI HOSPITAL          | KUMASI METROPOLITAN | DAABAN          | HOSPITAL      | P |
| 13 | DANYAME MAGAZINE CLINIC              | KUMASI METROPOLITAN | DANYAME         | CLINIC        | P |
| 14 | ASUOYEBOA MARANATHA CLINIC           | KUMASI METROPOLITAN | ASUOYEBOA       | CLINIC        | P |
| 15 | ADIEMBRA TOGBE CLINIC                | KUMASI METROPOLITAN | ADIEMBRA        | CLINIC        | P |
| 16 | ODENEHO KWADASO MARY POMAA MEMORIAL  | KUMASI METROPOLITAN | ODENEHO KWADASO | CLINIC        | P |
| 17 | BANTAMA ROBERT KHOCK HEALTH SERVICES | KUMASI METROPOLITAN | BANTAMA         | CLINIC        | P |
| 18 | ADIEBEBA HOSPITAL                    | KUMASI METROPOLITAN | ADIEBEBA        | HOSPITAL      | P |
| 19 | AHODWO CLINIC                        | KUMASI METROPOLITAN | AHODWO          | CLINIC        | P |
| 20 | AHODWO WASHIE HOSPITAL               | KUMASI METROPOLITAN | AHODWO          | HOSPITAL      | P |
| 21 | TANOSO PHILIPO MATERNITY HOME        | KUMASI METROPOLITAN | TANOSO          | CLINIC        | P |
| 22 | KWADASO SILOAM HOSPITAL              | KUMASI METROPOLITAN | KWADASO         | HOSPITAL      | P |
| 23 | SOKOBAN HEBRONA HOSPITAL             | KUMASI METROPOLITAN | SOKOBAN         | HOSPITAL      | P |
| 24 | SOKOBAN AGYEI ELI HOSPITAL           | KUMASI METROPOLITAN | SOKOBAN         | HOSPITAL      | P |
| 25 | DAKODWOM AURORA CLINIC               | KUMASI METROPOLITAN | DAKODWOM        | HOSPITAL      | P |
| 26 | BOHYEN ST ANTHONY HOMEOPATHIC CLINIC | KUMASI METROPOLITAN | BOHYEN          | CLINIC        | P |

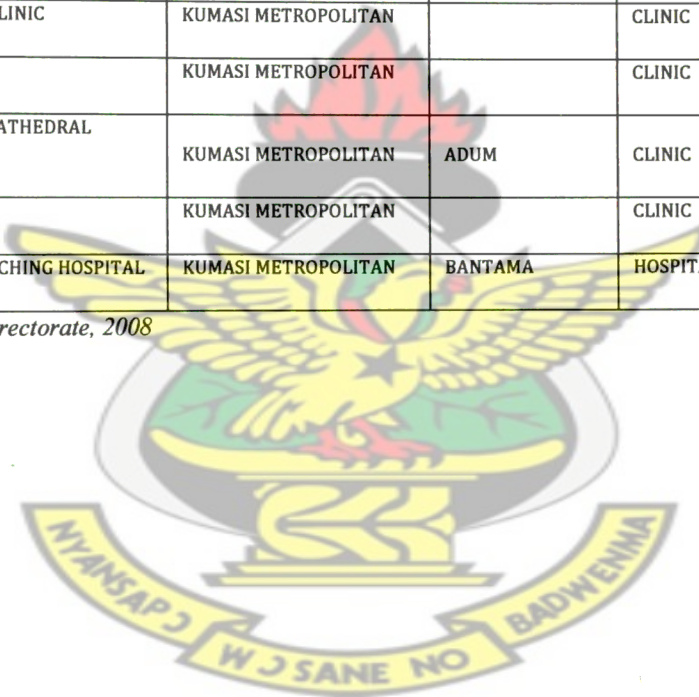
|    |   |                     |                 |          |   |
|----|---|---------------------|-----------------|----------|---|
| 27 | AMPABAME ST MONICA MATERNITY HOME         | KUMASI METROPOLITAN | AMPABAME        | CLINIC   | P |
| 28 | AMANFROM CLINIC                           | KUMASI METROPOLITAN | AMANFROM        | CLINIC   | P |
| 29 | SANTASI CLINIC                            | KUMASI METROPOLITAN | SANTASI         | CLINIC   | P |
| 30 | SANTASI BOAMPONG HOSPITAL                 | KUMASI METROPOLITAN | SANTASI         | HOSPITAL | P |
| 31 | SOKOBAN ASADU MATERNITY HOME              | KUMASI METROPOLITAN | SOKOBAN         | CLINIC   | P |
| 32 | ODENEHO KWADASO LIVING WATERS M/HOME      | KUMASI METROPOLITAN | ODENEHO KWADASO | CLINIC   | P |
| 33 | SOUTH SUNTRESO YONKODO M/HOME             | KUMASI METROPOLITAN | SOUTH SUNTRESO  | CLINIC   | P |
| 34 | TANOSO UEWK SICK BAY                      | KUMASI METROPOLITAN | TANOSO          | CLINIC   | P |
| 35 | RESTORATION CLINIC                        | KUMASI METROPOLITAN |                 | CLINIC   | P |
| 36 | CALVARY MATERNITY HOME                    | KUMASI METROPOLITAN | NWAMASI         | CLINIC   | P |
| 37 | DIVINE MATERNITY HOME                     | KUMASI METROPOLITAN | KWADASO ESTATE  | CLINIC   | P |
| 38 | KROPO CHARITY HOME                        | KUMASI METROPOLITAN | KROPO           | CLINIC   | P |
| 39 | SHALOM MATERNITY HOME                     | KUMASI METROPOLITAN |                 | CLINIC   | P |
| 40 | MEJERO MATERNITY HOME                     | KUMASI METROPOLITAN | BOHYEN          | CLINIC   | P |
| 41 | TIWAA ACUPUNCTURE                         | KUMASI METROPOLITAN | OHWIMASE        | CLINIC   | P |
| 4  | <b>MANHYIA NORTH SUBMETRO</b>             |                     |                 |          |   |
| 1  | TAFO GOVERNMENT HOSPITAL                  | KUMASI METROPOLITAN | OLD TAFO        | HOSPITAL | G |
| 2  | DR BROWNE CLINIC                          | KUMASI METROPOLITAN |                 | CLINIC   | P |
| 3  | SOS HOME CLINIC                           | KUMASI METROPOLITAN | AIRPORT R/ABOUT | CLINIC   | G |
| 4  | OLD TAFO SIAW LARBI CLINIC                | KUMASI METROPOLITAN | OLD TAFO        | CLINIC   | P |
| 5  | PANKRONO SHALOM MATERNITY CLINIC          | KUMASI METROPOLITAN | PANKRONO        | CLINIC   | P |
| 6  | JOY MATERNITY CLINIC                      | KUMASI METROPOLITAN |                 | CLINIC   | P |
| 7  | MAAKRO HISTORIC ADVENTIST CLINIC          | KUMASI METROPOLITAN | MAAKRO          | CLINIC   | M |
| 8  | KWAPRA COSMOS MEDICAL                     | KUMASI METROPOLITAN | KWAPRA          | CLINIC   | P |
| 9  | PANKRONO CENTRAL MATERNITY CLINIC         | KUMASI METROPOLITAN | PANKRONO        | CLINIC   | P |
| 10 | BREMANG CLINIC                            | KUMASI METROPOLITAN | BREMANG         | CLINIC   | P |
| 11 | MAGIES MATERNITY CLINIC                   | KUMASI METROPOLITAN |                 | CLINIC   | P |
| 12 | NEW SUAME AYIWA MEMORIAL MATERNITY CLINIC | KUMASI METROPOLITAN | NEW SUAME       | CLINIC   | P |
| 13 | BREMANG MINTA CLINIC                      | KUMASI METROPOLITAN | BREMANG         | CLINIC   | P |

|    |                                    |                     |                   |          |    |
|----|------------------------------------|---------------------|-------------------|----------|----|
| 14 | NEW TAFO ASIHENES CLINIC           | KUMASI METROPOLITAN | NEW TAFO          | CLINIC   | P  |
| 15 | TAFO NHYIAESO BETHEL CLINIC        | KUMASI METROPOLITAN | TAFO NHYIAESO     | CLINIC   | P  |
| 16 | OLD TAFO ABU CLINIC HOME           | KUMASI METROPOLITAN | OLD TAFO          | CLINIC   | P  |
| 17 | NEW TAFO FAITH MATERNITY CLINIC    | KUMASI METROPOLITAN | NEW TAFO          | CLINIC   | P  |
| 18 | MANHYIA EXTENTION ST JOHNS CLINIC  | KUMASI METROPOLITAN | MANHYIA EXTENSION | CLINIC   | P  |
| 19 | PANKRONO VINCENT CLINIC            | KUMASI METROPOLITAN | PANKRONO          | CLINIC   | P  |
| 20 | PANKRONO AMOAH MEMORIAL CLINIC     | KUMASI METROPOLITAN | PANKRONO          | CLINIC   | P  |
| 21 | GOD'S GLORY MATERNITY CLINIC       | KUMASI METROPOLITAN |                   | CLINIC   | P  |
| 22 | HAPPY DAY MATERNITY CLINIC         | KUMASI METROPOLITAN |                   | CLINIC   | P  |
| 23 | OLD TAFO NEW BIRTH MATERNITY HOME  | KUMASI METROPOLITAN | OLD TAFO          | CLINIC   | P  |
| 24 | KUMASI MEDICAL CENTRE              | KUMASI METROPOLITAN | MMBROM            | HOSPITAL | P  |
| 25 | OLD TAFO ST PAUL'S CLINIC          | KUMASI METROPOLITAN | OLD TAFO          | CLINIC   | P  |
| 26 | GRACELAND CLINIC                   | KUMASI METROPOLITAN |                   | CLINIC   | P  |
| 27 | HOLY ROSARY MATERNITY HOME         | KUMASI METROPOLITAN |                   | CLINIC   | P  |
| 28 | OLD TAFO THE WORD MATERNITY HOME   | KUMASI METROPOLITAN | OLD TAFO          | CLINIC   | P  |
| 29 | HUMBLE MATERNITY HOME              | KUMASI METROPOLITAN |                   | CLINIC   | P  |
| 30 | OLD TAFO WASHINGTON CLINIC         | KUMASI METROPOLITAN | OLD TAFO          | CLINIC   | P  |
| 31 | OLD TAFO SUAME HOSPITAL            | KUMASI METROPOLITAN | OLD TAFO          | HOSPITAL | P  |
| 32 | PANKRONO NEURO-PSYCH. HOSPITAL     | KUMASI METROPOLITAN | PANKRONO          | HOSPITAL | P  |
| 33 | OLD SUAME TURKSON'S MATERNITY HOME | KUMASI METROPOLITAN | OLD SUAME         | CLINIC   | P  |
| 34 | ADAB - SAB MATERNITY HOME          | KUMASI METROPOLITAN |                   | CLINIC   | P  |
| 35 | NKONTWIMA CLINIC                   | KUMASI METROPOLITAN |                   | CLINIC   | P  |
| 5  | SUBIN SUBMETRO                     |                     |                   |          |    |
| 1  | MATERNAL AND CHILD HEALTH HOSPITAL | KUMASI METROPOLITAN | KEJETIA           | HOSPITAL | G  |
| 2  | KMA CLINIC                         | KUMASI METROPOLITAN | KMA               | CLINIC   | G  |
| 3  | 4 MEDICAL RESEARCH STATION         | KUMASI METROPOLITAN | MILITARY BARRACKS | HOSPITAL | QG |
| 4  | POLICE CLINIC                      | KUMASI METROPOLITAN | POLICE BARRACKS   | CLINIC   | QG |
| 5  | PRISONS CLINIC                     | KUMASI METROPOLITAN | PRISONS YARD      | CLINIC   | QG |
| 6  | AMAKOM BIMPEH HILL HOSPITAL        | KUMASI METROPOLITAN | AMAKOM            | CLINIC   | P  |



|    |  |                     |             |          |   |
|----|--|---------------------|-------------|----------|---|
| 7  | AMAKOM STADIUM CLINIC                  | KUMASI METROPOLITAN | AMAKOM      | CLINIC   | P |
| 8  | ADUM AGYEMANG MEMORIAL CLINIC          | KUMASI METROPOLITAN | ADUM        | CLINIC   | P |
| 9  | ADUM KUFFOUR CLINIC                    | KUMASI METROPOLITAN | ADUM        | CLINIC   | P |
| 10 | BOMPATA DUNKIRK CLINIC                 | KUMASI METROPOLITAN | BOMPATA/FNT | CLINIC   | P |
| 11 | ADUM CLINIC                            | KUMASI METROPOLITAN | ADUM        | CLINIC   | P |
| 12 | AMAKOM ST EDWARD'S CLINIC              | KUMASI METROPOLITAN | AMAKOM      | CLINIC   | P |
| 13 | AMAKOM CLINIC                          | KUMASI METROPOLITAN | AMAKOM      | CLINIC   | P |
| 14 | AKWATIALINE KYEI MEMORIAL CLINIC       | KUMASI METROPOLITAN | AKWATIALINE | CLINIC   | P |
| 15 | AKWATIALINE GLORIA MEMORIAL HOSPITAL   | KUMASI METROPOLITAN | AKWATIALINE | HOSPITAL | P |
| 16 | BOMPATA MINTA AFARI MATERNITY HOME     | KUMASI METROPOLITAN | BOMPATA/FNT | CLINIC   | P |
| 17 | AKWATIALINE ELIZA MATERNITY HOME       | KUMASI METROPOLITAN | AKWATIALINE | CLINIC   | P |
| 18 | ROPHI MATERNITY CLINIC                 | KUMASI METROPOLITAN |             | CLINIC   | P |
| 19 | RABITO CLINIC                          | KUMASI METROPOLITAN |             | CLINIC   | P |
| 20 | ADUM METHODIST CATHEDRAL CHURCH CLINIC | KUMASI METROPOLITAN | ADUM        | CLINIC   | P |
| 21 | ANWIAM CLINIC                          | KUMASI METROPOLITAN |             | CLINIC   | P |
| 22 | KOMFO ANOKYE TEACHING HOSPITAL         | KUMASI METROPOLITAN | BANTAMA     | HOSPITAL | G |

Source: Regional Health Directorate, 2008



**Appendix 2: Selected Private Hospitals**

**Table B2      Selected Private Hospitals**

| <b>Community</b>        | <b>No. of Private Hospitals</b> | <b>Private Hospitals Selected</b>                  |
|-------------------------|---------------------------------|--|
| Manhyia South Sub-metro | 7                               | 1. Sarfo Adu Hospital<br>2. Keffam Health Services |
| Asokwa Sub-Metro        | 14                              | 1. Christ the King Hospital<br>2.City Hospital     |
| Bantam Sub-Metro        | 15                              | 1. Asafo Adjei Hospital<br>2. Siloam Hospital      |
| Manhyia North Sub-Metro | 5                               | 1. Suame Hospital<br>2. Kumasi Medical Centre      |
| Subin Sub-Metro         | 3                               | 1. Gloria Memorial Hospital<br>2. Kuffour Clinic   |
| <b>Total</b>            | <b>44</b>                       | <b>10</b>  |

*Source: Author's construct, 2007*

### Appendix 3: Client Satisfaction Analysis

#### Likert scale:

|                  |    |
|------------------|----|
| Very Satisfied   | 2  |
| Satisfied        | 1  |
| Fairly Satisfied | 0  |
| Not Satisfied    | -1 |

**Table B3**

**Client Satisfaction Analysis**

| Indicator  | Very Satisfied |                    | Satisfied  |                    | Not Satisfied |                    | Total       |
|--|----------------|--------------------|------------|--------------------|---------------|--------------------|-------------|
|  | Freq           | Weighted Frequency | Freq       | Weighted Frequency | Freq          | Weighted Frequency |             |
| Goodness of amenities available                      | 37             | 74                 | 33         | 33                 | 1             | -1                 | 106         |
| Equipments used in delivering service                | 34             | 68                 | 37         | 37                 |               |                    | 105         |
| Safety measures put in place in delivering service   | 40             | 80                 | 31         | 31                 |               |                    | 111         |
| Having enough time during consultation               | 62             | 124                | 8          | 8                  | 1             | -1                 | 131         |
| Having enough privacy during consultation            | 57             | 114                | 4          | 4                  |               |                    | 118         |
| Interpersonal relationship between staff and clients | 60             | 120                | 11         | 11                 |               |                    | 131         |
| Technical competence of staff                        | 49             | 98                 | 22         | 22                 |               |                    | 120         |
| Relevance of services delivered                      | 42             | 84                 | 29         | 29                 |               |                    | 113         |
| Affordability of services delivered                  | 23             | 46                 | 32         | 32                 | 16            | -16                | 62          |
| Efficiency of the health institution                 | 39             | 78                 | 32         | 32                 |               |                    | 110         |
| <b>Total</b>   | <b>443</b>     | <b>886</b>         | <b>239</b> | <b>239</b>         | <b>18</b>     | <b>-18</b>         | <b>1107</b> |

Source: Author's construct, 2007

Using the Likert scale helps to get the clear picture of the situation. In an ideal situation, a very satisfied health service will be the total of those who receive service from the private hospital by the weight of 2; ( $710 \times 2 = 1420$ ) divided by itself ( $1420/1420 = 1$ ), giving an ideal situation of one. However, this is not the existing situation and so a scale for interpreting the result was defined. Less than 0 or negative was defined as not satisfied, 0.1 to 0.49 as satisfied and 0.5 to 1 as very satisfied. The overall satisfaction level was ( $1107/1420 = 0.78$ ) which signifies a very high level of satisfaction among clients.



## Appendix 4: Process of Accreditation and Registration

### A. PRACTITIONER TO PRESENT THE FOLLOWING TO THE RHMT/DHMT

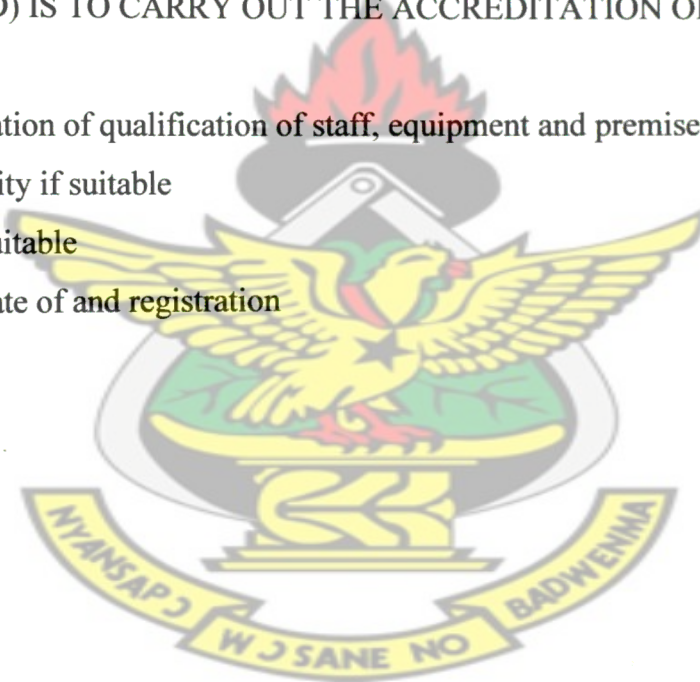
1. 3 copies of approved plan of premises.
2. Equipment list with their technical specifications.
3. Staff list and copies of certification of qualification and accreditation from relevant professional bodies.
4. Clearance from the Environmental Protection Agency.
5. List of type of service.
6. Proof of at least 5 years-post qualification experience in a recognized institution of relevance to his/her profession.
7. Copy of registration certificate from the relevant statutory professional regulating authority (Medical and Dental Council).
8. Properly completed application form.
9. An arrangement to submit monthly statistical returns to RHMT/DHMT
10. An arrangement to conform to standards set by MOH/ Board for Health Care Service.
11. Non-Ghanaians are in addition to the above required to provide evidence of:
  - a. Valid work permit issued by Ministry of Interior.
  - b. Registration with appropriate statutory professional body.
  - c. Has practiced in his/her professional capacity in Ghana for at least one year prior to application.
  - d. Has passed
    - English language proficiency test where English was not the language he/she was trained in
    - a professional test set by the appropriate professional body in Ghana, where applicable.
    - has registered with the Register Generals Department and
    - has fulfilled any other condition set by the board.

**B. RHMT/DHMT TO CHARGE A COMBINED REGIONAL AND DISTRICT TEAM TO:**

1. Vet application and reject if attachments are incomplete or conditions for registration are not met.
2. Carry out inspection i.e. fill checklist and carry out physical verification of facilities, staff and equipment.
3. Report and make recommendations to the Board as to the suitability of the facility or otherwise.
4. Comment on location in relation to other similar facility (e.g. number/type of other health facilities in the same locality within 8 kilometres radius in rural areas and 200 metres in urban areas)

**C. PRIVATE HEALTH CARE BOARD (PRIVATE HOSPITALS AND MATERNITY HOMES BOARD) IS TO CARRY OUT THE ACCREDITATION OF THE FACILITY:**

1. Cross verification of qualification of staff, equipment and premises
2. Register facility if suitable
3. Reject if unsuitable
4. Issue certificate of and registration



## **Appendix 5: Infrastructure, Equipment, Manpower and Service Requirements of Private Hospitals**

### **CLASSIFICATION/CATEGORISATION OF PRIVATE HEALTH FACILITY**

Based on available basic infrastructure, manpower, equipment and service rendered private health facilities may be classified into hospitals, clinics and maternity homes.

### **HOSPITALS**

A hospital offers a mixture of services and shall necessarily have in-patient's facilities. The facility may also be set up along general or specialist line. A hospital shall serve as a referral point for clinics and maternity homes.

#### **1. MANPOWER REQUIREMENTS**

The basic requirement for private hospital is one Doctor, a professional nurse and four auxiliaries for a ten-bed hospital, all of whom should be in full time employment. There should be a professional nurse auxiliary ratio of 1:4:10 beds. Meaning that as the number of beds increases the number of auxiliary nurses should also increase. For each day shift there should be one auxiliary attending to ten beds. Private hospitals with theatres should have a minimum of one anaesthetist on duty at any time. Should the hospital offer Maternity Services, the hospital should have an additional staff representative of what has been prescribed for Maternity Homes.

#### **2. HOSPITAL LAYOUT AND BUILDING**

The hospital layout should be based on smooth air circulation, adequate ventilation and separation of outpatients from inpatients.

A hospital unit should include:

##### **2.1 Out Patient Department (OPD) which includes;**

- i. Treatment room
- ii. Pharmacy/dispensary
- iii. Laboratory
- iv. Administration



v. Parking bay

## 2.2 Inpatient Department

- i. Male, Female, Children and isolation wards, (with arrangements to separate medical from surgical cases)
- ii. Maternity wing with delivery room where applicable
- iii. Operating suite with anaesthesia and recovery room where a hospital has facility for surgery
- iv. Kitchen and laundry facility

The OPD should be the first unit encountered near the main entrance from which there should be easy flow to the laboratory, operating theatre, maternity and other wings of the hospital.

## 3. PHYSICAL FACILITY AND INFRASTRUCTURE

### A. WATER SUPPLY

Apart from the buildings, water supply is the first priority and should be potable, adequate and free as possible from particulate matter. Where a town water supply is not available, an adequate supply (boreholes, or otherwise) must be established prior to any further investment in a facility. Adequate water supply should be available on the premises all the time.

### B. SEWAGE AND SEWAGE DISPOSAL SYSTEM

Sanitation measures must include proper disposal of human waste and hospital garbage. Toilet should be operational throughout the hospital.

### C. LIGHTING

The whole hospital should be well lit.

### D. STERILIZATION

Facility for sterilization must be available.

## E. EQUIPMENT

Equipment for the various hospitals depends on the services to be delivered.

## 4. SERVICE DELIVERY

Depending on the type of institution, a private hospital may provide one or a combination of services outlined below.

### A. Maternal health services

1. Provide antenatal care
2. Identify/ refer at risk antenatal cases
3. Perform normal delivery
4. Refer and evacuate emergency obstetric cases
5. Provide postnatal care
6. Counsel mother on infant and child nutrition
7. Counsel/ prescribe/ distribute contraceptives and provide follow-up services
8. Treat minor ailment

### B. Expanded programme of immunization

1. Organize/provide systematic immunization at the hospital
2. Maintain cold chain

### C. Prevention control and management of specific endemic diseases

1. Diagnose and manage cases of malaria
2. Promote the use of bed net
3. Diagnose and manage diarrhea diseases
4. Recognize and manage cases of dehydration
5. Manage acute respiratory infection
6. Identify and treat sexually transmitted diseases including HIV
7. Provide counseling/trace partners of persons treated for STD
8. Recognize and manage cases of tuberculosis
9. Recognize and manage simple skin, eye, ear and oral infection
10. Recognize and treat cases of measles, whooping cough, tetanus, poliomyelitis

11. Identify and manage cases of onchocerciasis, schistosomiasis, buruli ulcer and yaws

D. REVENTION/MANAGEMENT OF SPECIFIC NON COMMUNICABLE DISEASES

1. Screen, identify and manage hypertension and diabetes
2. Screen, identify and manage cases of sickle cell diseases

E. PREVENTION AND MANAGEMENT OF INJURIES AND COMMON EMMERGENCIES

1. Management of emergencies/trauma (burns, cuts, kerosene poisoning, snake and dog bite)
2. Manage operative surgical cases

F. DENTAL SERVICE

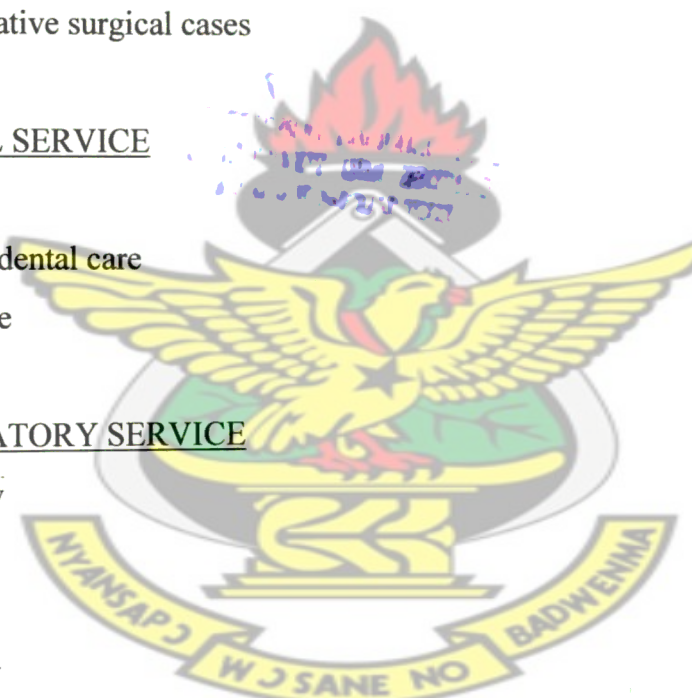
1. Extraction
2. Prophylactic dental care
3. Filling service

G. LABORATORY SERVICE

1. Microbiology
2. Culture
3. Serology
4. Biochemistry
5. Haematology
6. Embryology

H. PHARMACY SERVICE

1. Drug information including patient counselling
2. Drug formulation
3. Drug dispensing





- 4. Drug storage
- 5. Drug procurement

# KNUST



Appendix 6: Household Questionnaires

DEPARTMENT OF PLANNING  
Faculty of Planning and Land Economy  
College Of Architecture and Planning  
Kwame Nkrumah University of Science and Technology, Kumasi

KUMASI METROPOLITAN ASSEMBLY

PRIVATE HOSPITALS IN QUALITY HEALTH CARE DELIVERY:  
PROSPECTS AND CHALLENGES OF SELECTED PRIVATE HOSPITALS IN  
KUMASI METROPOLIS

Household Questionnaires

- I. Name of Interviewer.....II. Date of Interview.....  
III. Name of Community..... IV. Health Zone.....  
V. Name of Respondent.....

Household Composition

1. Sex  
( ) Male 1 ( ) Female 2  
2. Ethnicity  
( ) Akan 1 ( ) Ga 2 ( ) Ewe 3 ( ) Guan 4 ( ) Northern group 5 ( ) Other (Specify) 6  
3. Religion  
( ) Christian 1 ( ) Moslem 2 ( ) Traditional 3 ( ) Other (specify) 4  
4. Educational level attained  
( ) Primary 1 ( ) JSS/Middle school 2 ( ) SHS/Secondary 3 ( ) Post Sec 4 ( ) Tertiary 5  
( ) None 6  
5. Employment status  
( ) Employed 1 ( ) Unemployed 2





16. On what do you spend the household income and how much?

| Item                             |    | Amount/ week | Amount/month | Amount/annum |
|----------------------------------|----|--------------|--------------|--------------|
| Food                             | 1  |              |              |              |
| Clothing                         | 2  |              |              |              |
| Toiletries                       | 3  |              |              |              |
| Rent                             | 4  |              |              |              |
| Utilities                        | 5  |              |              |              |
| Fuel                             | 6  |              |              |              |
| Health care                      | 7  |              |              |              |
| Transportation                   | 8  |              |              |              |
| Education                        | 9  |              |              |              |
| Communication                    | 10 |              |              |              |
| Household durables               | 11 |              |              |              |
| Donations, gifts and remittances | 12 |              |              |              |
| Savings                          | 13 |              |              |              |
| Levies                           | 14 |              |              |              |
| Credit payment                   | 15 |              |              |              |
| Other (specify)                  | 16 |              |              |              |

#### Availability and use of Health Facilities

17. What are some of the health facilities you have around?

( ) Public Hospital 1 ( ) Clinic 2 ( ) Private Hospital 3 ( ) Other (specify) 4.....

18. How far is the nearest health facility from your house?

( ) Between 1- 2km away 1 ( ) Between 2 - 5km away 2 ( ) Between 5- 10km away 3

19. Where is the first point of call for treatment when someone in your household gets sick?

( ) Public Hospital 1 ( ) Private Hospital 2 ( ) Clinic 3 ( ) Other (specify) 4.....

20. How often do you visit the nearest private hospital?

( ) Weekly 1 ( ) Monthly 2 ( ) Quarterly 3 ( ) Annually 4 ( ) Other (specify) 5.....

21. By what means do you get to the private hospital?

( ) Walking 2 ( ) Commercial Vehicle 3 ( ) Private vehicle 4 ( ) Other (specify) 5.....

22. Why do you prefer the private hospital to other health institutions?

( ) Proximity 1 ( ) Better alternative ( ) Have all the facilities ( ) Don't know 4  
( ) only type available

23. In your own estimation, are the health personnel at the private hospital you have been visiting adequate?

( ) Yes 1 ( ) No 2

24. How long do you spend at the private hospital when you visit? ( ) 1-2 hours 1( ) 2-3 hours 2  
( ) 3-4 hours 3 ( ) Other (specify) 4.....

25. What are some of the problems you encounter when you attend the private hospitals?  
.....  
.....  
.....

26. Are you aware of the National Health Insurance Scheme?  
  
( ) Yes 1            ( ) No 2

27. Have you registered? ( ) Yes 1            ( ) No 2

28. If no, why?  
.....  
.....

29. If you have not registered with the NHIS, how do you pay at the private hospital?  
.....  
.....

30. What is the maximum amount you pay?.....

31. What is the minimum amount you pay?.....

32. How satisfied are you with the services of the private hospital you access in terms of the following:

| Indicator  | Very Satisfied<br>1 | Satisfied 2 | Not Satisfied 3 |
|--|---------------------|-------------|-----------------|
| Goodness of amenities available                      |                     |             |                 |
| Equipments used in delivering service                |                     |             |                 |
| Safety measures put in place in delivering service   |                     |             |                 |
| Having enough time during consultation               |                     |             |                 |
| Having enough privacy during consultation            |                     |             |                 |
| Interpersonal relationship between staff and clients |                     |             |                 |
| Technical competence of staff                        |                     |             |                 |
| Relevance of services delivered to your needs        |                     |             |                 |
| Affordability of services delivered                  |                     |             |                 |
| Efficiency of the health institution                 |                     |             |                 |

**Appendix 7: Interview Guide for Metropolitan Assembly Official's**

**DEPARTMENT OF PLANNING**  
**Faculty of Planning and Land Economy**  
**College Of Architecture and Planning**  
Kwame Nkrumah University of Science and Technology, Kumasi

**KUMASI METROPOLITAN ASSEMBLY**

**PRIVATE HOSPIALS IN QUALITY HALTH CARE DELIVERY:  
PROSPECTS AND CHALLENGES OF SELECTED PRIVATE HOSPITALS IN  
KUMASI METROPOLIS**

**Metropolitan Assembly Official's Interview Guide**

- I. Name of interviewer:.....
  - II. Name of respondent:.....
  - III. Position of respondent:.....
  - IV. Date of interview:.....
- 
- 1. Bye-laws for the operation of private hospitals
  - 2. Processes involved in establishing private hospitals
  - 3. Registration of private hospitals with Metropolitan Assembly
  - 4. Insistence on quality health care delivery by Metropolitan Assembly
  - 5. Regular inspection of services provided by the private hospitals
  - 6. Collaboration with private hospitals
  - 7. Influence of Metropolitan Assembly over private hospitals
  - 8. Contributions of the private hospitals to the Metropolitan Assembly
  - 9. Contributions of the Metropolitan Assembly to private hospitals
  - 10. Problems private hospitals pose to the Metropolitan Assembly



Appendix 8: Questionnaire for Operators of Private Hospitals

DEPARTMENT OF PLANNING  
Faculty of Planning and Land Economy  
College Of Architecture and Planning  
Kwame Nkrumah University of Science and Technology, Kumasi

KUMASI METROPOLITAN ASSEMBLY

PRIVATE HOSPITALS IN QUALITY HALTH CARE DELIVERY:  
PROSPECTS AND CHALLENGES OF SELECTED PRIVATE HOSPITALS IN  
KUMASI METROPOLIS

Questionnaire for Operators of Private Hospitals

I. Name of Health Institution:.....

II. Name of Locality:.....

III. Name of respondent:.....

IIIV. Position of respondent:.....

V. Date of interview:.....

1. What are the infrastructural facilities available in your hospital.....  
.....  
.....

2. Are these facilities adequate? ( ) Yes 1      ( ) No 2

3. If no, what measures are put in place to ensure their adequacy?.....  
.....  
.....

4. What equipment are available in your hospital?.....  
.....  
.....

5. Are the equipment in your hospital adequate? ( ) Yes 1 ( ) No 2

6. Are all the equipment available in your hospital functioning? ( ) Yes 1 ( ) No 2

7. How many doctors are available in your hospital?.....

| Number | Category |
|--------|----------|
|        |          |
|        |          |
|        |          |

8. How many nurses are in your hospital?

9. How many supporting staff are available in your hospital?.....

10. Are all your staff trained? ( ) Yes 1 ( ) No 2

11. Is the staff strength available adequate? ( ) Yes 1 ( ) No 2

12. If no how many more are needed?.....

13. What are the services you render in your hospital?.....  
.....  
.....

14. How are the services you render funded?.....  
.....  
.....

15. Is your facility enlisted on the National Health Insurance Scheme? ( ) Yes 1 ( ) No 2

16. How do you obtain funds for the running and maintenance of your facilities?.....  
.....  
.....

17. Does the Metropolitan Assembly have any influence over your activities? ( ) Yes 1 ( ) No 2

18. Do you receive any assistance from the Metropolitan Assembly? ( ) Yes 1 ( ) No 2

19. If yes, what kind of assistance do you receive?.....  
.....  
.....

20. Do you sometimes rely on the public hospitals for your services? ( ) Yes 1 ( ) No 2
21. If yes, in which areas do you rely on them?.....  
.....  
.....
22. Do the public hospitals sometimes rely on your outfit for their operations? ( ) Yes 1 ( )No 2
23. If yes, in which areas do they rely on you?.....  
.....  
.....
24. What relationship exists between your hospital and other private hospitals?.....  
.....  
.....
25. How do you ensure Quality Health Care Delivery in terms of the following?

| Indicator                                  | Ways of Ensuring Quality Health Care Delivery |
|--|---|
| Access to your facility                    |   |
| Waiting time                               |   |
| Safety of services delivered               |   |
| Affordability of service                   |   |
| Interpersonal relation of staff and client |   |
| Technical competence of staff              |   |
| Ensuring equity                            |   |
| Level of satisfaction of clients           |   |
| Adequacy of staff                          |   |
| Adequacy of infrastructure and equipment   |   |
| Others                                     |   |



26. How many patients are attended to/treated in a day/week?.....  
.....
27. What are the common diseases that are reported in your hospital?.....  
.....
28. Do you undertake any counseling?      ( ) Yes 1   ( ) No 2
29. What are the challenges you face in your institution?.....  
.....  
.....  
.....
30. What are the prospects of your hospital?.....  
.....  
.....  
.....



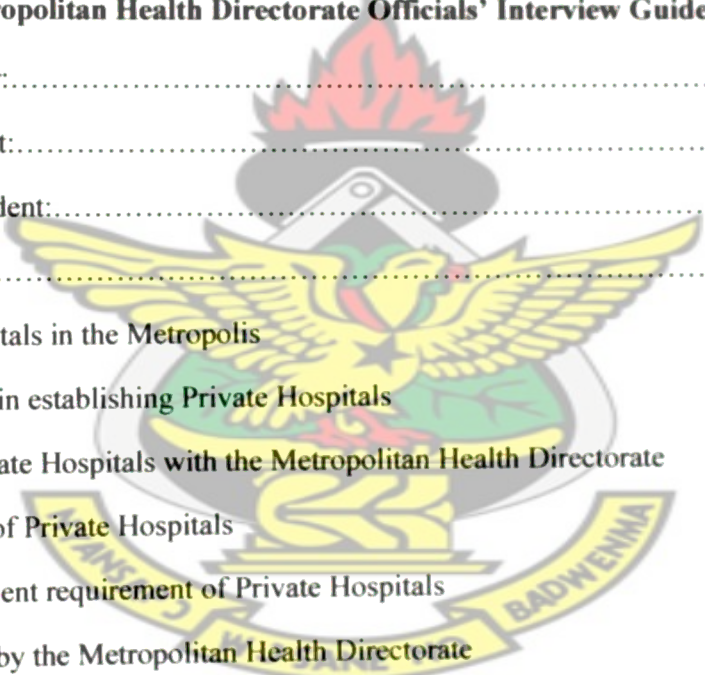
**Appendix 9: Interview Guide for Metropolitan Health Directorate Officials'**

**DEPARTMENT OF PLANNING**  
**Faculty of Planning and Land Economy**  
**College Of Architecture and Planning**  
Kwame Nkrumah University of Science and Technology, Kumasi

**KUMASI METROPOLITAN ASSEMBLY**

**PRIVATE HOSPIALS IN QUALITY HALTH CARE DELIVERY:  
PROSPECTS AND CHALLENGES OF SELECTED PRIVATE HOSPITALS IN  
KUMASI METROPOLIS**

**Metropolitan Health Directorate Officials' Interview Guide**

- 
- I. Name of interviewer:.....
- II. Name of respondent:.....
- III. Position of respondent:.....
- IV. Date of interview:.....
1. No of Private Hospitals in the Metropolis
2. Processes involved in establishing Private Hospitals
3. Registration of Private Hospitals with the Metropolitan Health Directorate
4. Staff requirements of Private Hospitals
5. Facility and equipment requirement of Private Hospitals
6. Regular inspection by the Metropolitan Health Directorate
7. Top ten diseases
8. Assistance of the Metropolitan Health Directorate to Private Hospitals
9. Influence of Metropolitan Health Directorate over private hospitals
10. Ensuring quality health care delivery
11. Challenges of Private Hospitals
12. Prospects of Private Hospitals

**Appendix 10: Questionnaire for Staff of Private Hospitals**

**DEPARTMENT OF PLANNING**  
**Faculty of Planning and Land Economy**  
**College Of Architecture and Planning**  
Kwame Nkrumah University of Science and Technology, Kumasi

**KUMASI METROPOLITAN ASSEMBLY**

**PRIVATE HOSPITALS IN QUALITY HALTH CARE DELIVERY:  
PROSPECTS AND CHALLENGES OF SELECTED PRIVATE HOSPITALS IN  
KUMASI METROPOLIS**

**Questionnaire for Staff of Private Hospitals**

I. Name of Health Institution:.....

II. Name of Locality:.....

III. Name of respondent:.....

IIV. Position of respondent:.....

V. Date of interview:.....

1. How long have you been working in this hospital?.....

2. Do you have the requisite qualification to work in a hospital? ( ) Yes 1 ( ) No 2

3. How long have you been trained?.....

4. Have you attended in-service training and other courses after your initial training?

( ) Yes 1 ( ) No 2

5. If yes, what was the training about?.....

.....

.....



4. Do you have the necessary equipment you need to undertake your daily activities?

( ) Yes 1      ( ) No 2

5. If yes, what are they?.....  
.....  
.....  
.....

6. How would you describe your relationship with the patients?.....  
.....

7. How would you describe your relationship with other staff?.....  
.....

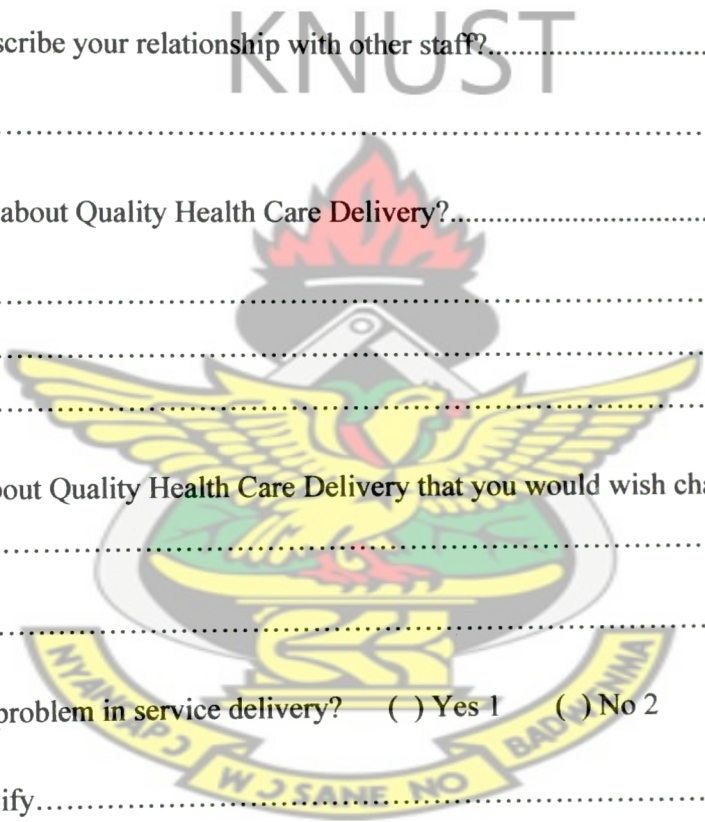
8. What do you know about Quality Health Care Delivery?.....  
.....  
.....

9. Is there anything about Quality Health Care Delivery that you would wish changed? (added or deducted) .....  
.....

10. Do you have any problem in service delivery?      ( ) Yes 1      ( ) No 2

11. If yes, please specify.....  
.....  
.....

12. What are the challenge you face in this institution?.....  
.....  
.....



13. What are the prospects of this hospital?.....

.....

.....

.....

14. How do you ensure Quality Health Care Delivery in terms of the following?

| Indicator                                  | Ways of Ensuring Quality Health Care Delivery |
|--|---|
| Access to your facility                    |   |
| Waiting time                               |   |
| Safety of services delivered               |   |
| Affordability of service                   |   |
| Interpersonal relation of staff and client |   |
| Technical competence of staff              |   |
| Ensuring equity                            |   |
| Level of satisfaction of clients           |   |
| Others                                     |   |