

**AN ASSESSMENT OF HEALTH CARE DELIVERY IN PUBLIC AND PRIVATE  
HOSPITALS IN THE CENTRAL BUSINESS DISTRICT OF KUMASI  
METROPOLIS. A STUDY OF SELECTED HOSPITALS**

**KNUST**

**BY**

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**A Thesis Submitted to the Department of Planning,  
College of Art and Built Environment  
Kwame Nkrumah University of Science and Technology Kumasi, In  
Partial fulfilment of the requirements for the Degree of**

**MASTER OF SCIENCE IN  
DEVELOPMENT POLICY AND PLANNING  
College of Art and Built Environment**

**JULY, 2015**

## DECLARATION

I hereby declare that this submission is my own work towards the award of MSc. Development Policy and Planning 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 other degree of the University except where due acknowledgement has been made in the text.

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## DEDICATION

I dedicate this work to my late husband, Aristotle Ekow Ayensu without whose effort I would not have been where I am now and to my son, Evans Ato Ayensu for his understanding.

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## ACKNOWLEDGEMENT

I wish to express my sincere gratitude first and foremost to the ALMIGHTY GOD who granted me the grace to complete this work successfully to His glorious name.

The next gratitude goes to all those who helped in diverse ways and contributed immensely to the success of this research work, especially Dr. Charles Peprah, Mr. Kwabena Badu Yeboah and Mr. Joseph Korley and colleagues at my workplace without whose help, this work would not have been successful.

I wish to thank the Management and Staff of the selected hospitals for making it possible for me to administer my questionnaire for this dissertation.

I owe a great debt of gratitude to Mrs. Dina Adei of the Department of Planning, KNUST my supervisor for her relentless efforts in giving the necessary assistance and guidance.

God richly bless you.

I also thank my late husband, Mr. Aristotle Ekow Ayensu and Evans Ato Ayensu, my son for the morale support granted me during this research work. God bless you all. AMEN.

## ABSTRACT

The two core functions identified within the health sector in Ghana are: Policy formulation, regulation and coordination of the actions of actors in the sector; and Implementation of policy via service delivery. The performance of these functions still appears to leave healthcare delivery systems ineffective in developing countries. The focus of the study was to assess the challenges that constrain healthcare delivery and to ascertain patients' perception about healthcare delivery in public and private hospitals within the Central Business District of Kumasi Metropolis. The specific objectives were: to assess the perceptions of patients about healthcare delivery in public and private hospitals; to identify the challenges confronting healthcare delivery; to determine challenges common to both sectors and challenges peculiar to each sector and make recommendations to inform policy. The study adopted a case study research design and the data collected were analysed qualitatively and quantitatively. The researcher used multiple sampling techniques to enable her reduce the possibility of research limitations. The analysis of data collected through secondary data and interview and questionnaire from the sampled respondents revealed that the difference in perception of patients about healthcare delivery in public and private hospitals within Central Business District of Kumasi Metropolis was mixed considering the various factors assessed. It was also found that healthcare delivery in both private and public hospitals are undermined by challenges such as frequent power outages and breakdown of equipment, inadequate staff and logistics. Congestion was found unique to have been a major constraint in public hospitals' operations. The study concludes by arguing that the challenges constraining effective healthcare delivery are fundamental to both private and public hospitals and demands concerted efforts not only from the Ministry of Health, the Ghana Health Service but also the very management of the various health institutions. The researcher therefore recommends that patients awaiting consultation should be given periodic updates and doctors should inform patients always about their health conditions because of practical benefit it will be for the patients to manage their lifestyle. The implementation of community sponsorship in admission and training of health students is recommended to reduce unfair distribution and inadequate health workers. Proposals should also be developed by hospitals to seek logistics and equipment support from non-governmental organisations whose focus is to ensure healthy population. Better management of the NHIS to encourage more private hospitals/health facilities to become service providers so as to reduce congestion at public health facilities.



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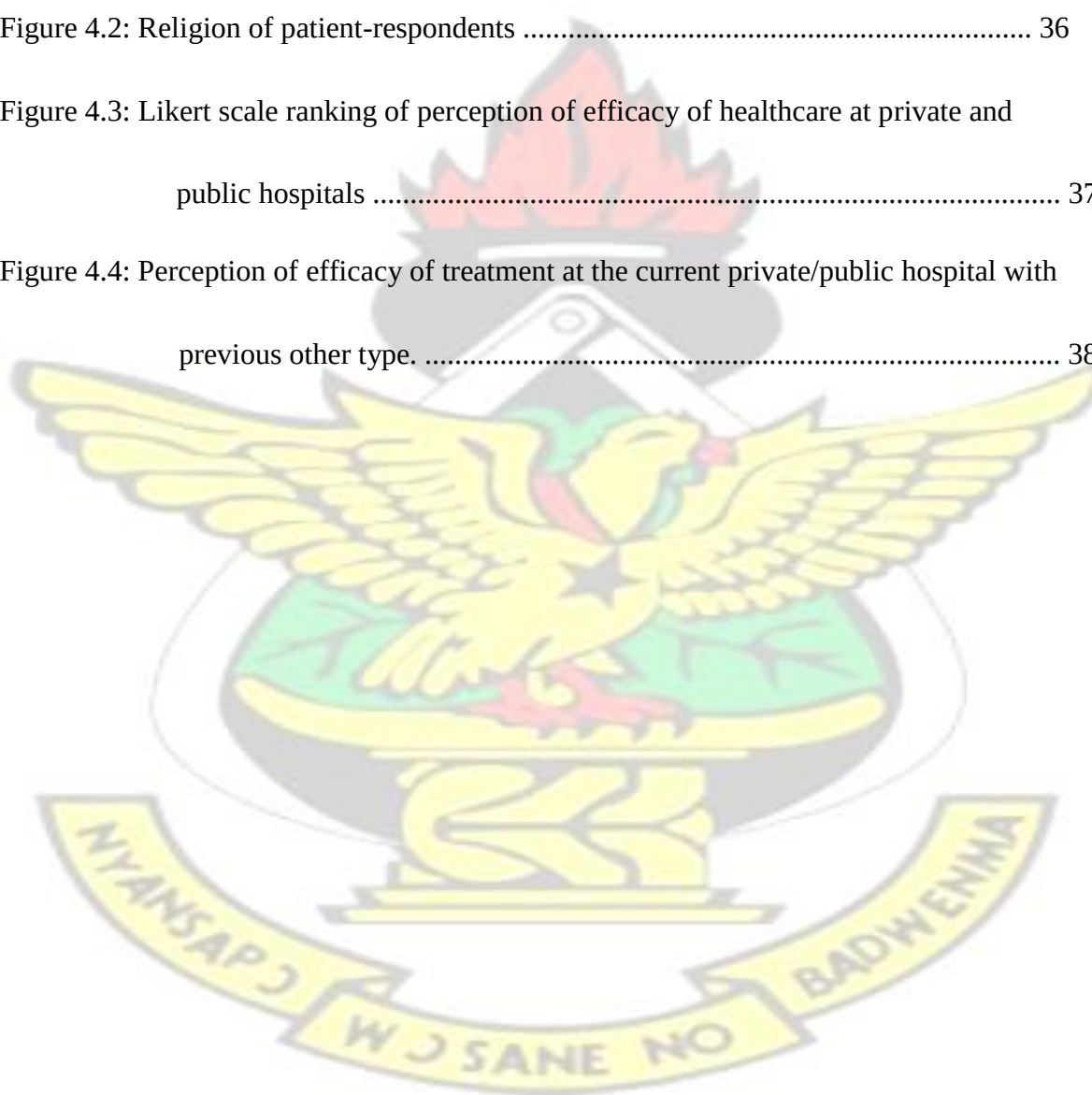
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## LIST OF ABBREVIATIONS

|        |   |                                                               |
|--------|---|---------------------------------------------------------------|
| AM     | - | Alternative Medicine                                          |
| AIDS   | - | Acquire Immune Deficiency Syndrome                            |
| BITAP  | - | Brookings Institution Transparency and Accountability Project |
| BMCs   | - | Budget and Management Centres                                 |
| CBC    | - | Canadian Broadcasting Corporation                             |
| CBD    | - | Central Business District                                     |
| CHAG   | - | Christian Health Association of Ghana                         |
| CHPS   | - | Community-based Health Planning and Services                  |
| DHAs   | - | District Health Administrations                               |
| DHMT   | - | District Health Management Team                               |
| DTAM   | - | Department of Traditional and Alternate Medicine              |
| EPN    | - | Ecumenical Pharmaceutical Network                             |
| FH     | - | Faith Healers                                                 |
| GHS    | - | Ghana Health Service                                          |
| GHSP   | - | Government Hospitals                                          |
| GII    | - | Ghana Integrity Initiative                                    |
| GMA    | - | Ghana Medical Association                                     |
| GNA    | - | Ghana News Agency                                             |
| GNI    | - | Gross National Income                                         |
| GoG    | - | Ghana of Government                                           |
| GPRS   | - | Ghana Poverty Reduction Strategy                              |
| HC     | - | Health Centres                                                |
| HIPC   | - | Heavily Indebted Poor Countries                               |
| HIV    | - | Human Immune Virus                                            |
| HND    | - | Higher National Diploma                                       |
| ILO    | - | International Labour Organisation                             |
| ISODEC | - | Integrated Social Development Centre                          |
| KNUST  | - | Kwame Nkrumah University of Science and Technology            |
| MBP    | - | Mission Based Providers                                       |
| MDBS   | - | Multi-Donor Budgetary Support                                 |
| MDGs   | - | Millennium Development Goals                                  |
| MOH    | - | Ministry of Health                                            |



|       |   |                                              |
|-------|---|----------------------------------------------|
| MTHS  | - | Medium Term Health Safety                    |
| NHIC  | - | National Health Insurance Council            |
| NHIS  | - | National Health Insurance Scheme             |
| PC    | - | Poly Clinics                                 |
| PHMHB | - | Private Hospitals and Maternity Homes Board  |
| PMDP  | - | Private Medical and Dental Practitioners     |
| PHR   | - | Physicians for Human Rights                  |
| QGIH  | - | Quasi Government Institution Hospitals       |
| SSA   | - | Sub-Sahara Africa                            |
| SSNIT | - | Social Security and National Insurance Trust |
| SPSS  | - | Statistical Package Social Scientist         |
| SWAp  | - | Sector Wide Approach                         |
| TI    | - | Transparency International                   |
| THOSP | - | Teaching Hospitals                           |
| TMP   | - | Traditional Medical Providers                |
| UDHR  | - | Universal Declaration of Human Rights        |
| WB    | - | World Bank                                   |
| WHO   | - | World Health Organisation                    |



## CHAPTER ONE

### INTRODUCTION

#### 1.1 Background to the Study

Healthcare means the treatment and management of ailment and the maintenance of health through services provided by the medical, pharmaceutical, dental, clinical laboratory sciences (in vitro diagnostics), nursing, and related health workers (Langwick, 2006). According to Dermer and Montgomery (1997: 80), healthcare involves all the goods and services intended to enhance health, comprising preventive, curative and palliative interventions, whether focused on individuals or populations. Good health is important for human happiness and comfort. It also makes a significant impact to economic advancement, as healthy people live longer, produce more and make more savings. Article 25 of the Universal Declaration of Human Rights (UDHR) goes on to indicate that; Everyone has the right to a standard of living suitable for the health and comfort of himself and of his family, including food, clothing, housing and medical care and necessary social services, and the right to safety in times of redundancy, illness, incapacity, widowhood, old age or lack of livelihood in situations he has no control of (UDHR, 1948). Hence, the right to better healthcare is not only important, but also a key concern of the government (Constitution of Ghana, 1992).

Loewenson and Whiteside (1997) contend that, healthcare in developing countries is a complex and multi-faceted issue. Most developing countries including Ghana, is doing all it can to offer a complete healthcare scheme to the citizenry. Abekah-Nkrumah (2005) states that two main functions recognised with Ghana's health sector are; formulation of policies, directing and monitoring of the activities of players in the sector; and the execution of policies through the delivery of service.

The Ministry of Health (MOH) is the policy making body whiles execution of policies is the duty of service providers in the public and private sectors. The Ghana Health Service (GHS) is the key service provider in the public sector; with a national secretariat and healthcare facilities at the regional through to the community level. Two main bodies operate in the private sector; the mission providers, whose activities are mainly in rural areas as private non-profit making organizations, and the private for-profit making organizations (Abekah-

Nkrumah, 2005). Just like the public sector, the contribution of the private sector in healthcare delivery in Ghana cannot be overemphasized. According to Ann and Miloud (2011), the private sector owns over 50 percent of health facilities in Ghana. Notwithstanding the enterprise of the public and private sectors in the healthcare delivery system of most developing countries, strong challenges still bedevil the industry.

In a study of six study sites in South Africa in the cities and countryside on the assessment of the eminence of primary healthcare provision, comparison of opinions on healthcare service attributes between general practitioner users and clinic practitioner users were described and rated. The two groups of users, rated services precisely the same order as follows: health workers attitudes, type of treatment, the waiting time, continuousness of treatment by the same person and proximity to the service. A study by Aniansson et al., (1994) on the effectiveness of various models of primary healthcare delivery in Southern Africa is backed by the evidence given by Bachmann (2004), Chamuka (2007) and Chang (2002). Her study established that healthcare provision by the state leads to extensive delays, less interaction with physicians and hence low acceptability of care to users.

An earlier project on the assessment of the quality of care of primary healthcare provision in six study locations in the metropolitan and remote areas of South Africa was performed Kiiza and Ninsiima (2006) between 1992 and 1993 and results were published in 1996. On the recommendations of this study, a project was embarked on to improve quality of care in public hospitals in Northwest province from August 1996 to March 1998. The main successes of this project were enhancements in supply of medicine; proper combination of service delivery; improvement in technical performance and good behaviour towards patients and the public as a whole. This project established that there is the need for continuous quality assessments. Sustainability of the successes gained, was, nonetheless, a main concern at the end of the project. Lindelöw and Svensson (2003) examined the impact of user fees policy changes on clinic turnout patterns in Hlabisa health district in rural South Africa. While there was an increase in attendance at curative services, attendance for preventative services declined. This was worrying because “if vaccine coverage is low due to poor attendance, outbreaks of vaccine preventable diseases may occur.”

## **1.2 Statement of the problem**

Due to poor economic performance and declining resources many countries in SubSaharan Africa lack the ability to provide adequate quality and coverage of healthcare services. This has prompted many countries to promote the implementation of health sector reforms with a view to making the optimum use of resources available in improving access, efficiency and quality of healthcare services provided. Healthcare delivery systems are met with vital problems posed by the fast growth of communication and biomedical technology, the need for cost-containment and the focus on effectiveness and efficiency, the increasing need for services and changes in demographic and epidemiological factors. Marek (2003) contend that the introduction of free healthcare for all at health provision points in most developing countries brought overcrowding in hospitals and a reduced meeting session. Health staff therefore felt pressurized into reducing the consultation time and as a therefore found their jobs annoying and tiring (Ministry of Health (MOH), 2009). In a developing country like Ghana, such problem and many others are said to be hampering the smooth delivery of healthcare but lack of credible research on the issue has ensured that these challenges remain unspoken about and untackled effectively. Furthermore, the differences in operation between public and private hospitals in Ghana gives rise to the conception that both institutions could not be hampered by the same set of challenges. Since there has been little or no research into this area, there appears to be a research gap which this thesis aims to fill by examining what the case is regarding healthcare delivery by private and public hospitals in Kumasi Metropolis.

### **1.3 Research Questions**

The study sought to answer the question regarding what has been patients' perception about and challenges confronting the healthcare delivery by public and private hospitals within the Central Business District of Kumasi Metropolis. These specific questions are posed: In order to assist the analysis, the under-listed research questions were designed to guide the study.

- i. What are the perceptions of patients about healthcare delivery in public and private hospitals?
- ii. What are the challenges confronting healthcare delivery in public and private hospitals in the Central Business District (CBD) of Kumasi metropolis?



- iii. What are the challenges common to both (public and private hospitals) and peculiar to each sector?
- iv. What possible measures can be taken to address the identified challenges to improve healthcare delivery within the Central Business District of Kumasi Metropolis

#### **1.4 Research Objectives**

This study focuses on assessing the perceptions of patients and challenges in healthcare delivery in public and private hospitals within the Central Business Districts of Kumasi metropolis and make recommendations to inform policy. Under this broad objective, the specific objectives of the study are to:

- i. assess the perceptions of patients about healthcare delivery in public and private hospitals;
- ii. identify the challenges confronting healthcare delivery in public and private hospitals in the Central Business District of Kumasi metropolis;
- iii. determine challenges common to both sectors (public and private hospitals) and challenges peculiar to each sector;
- iv. make recommendations to inform policy.

#### **1.5 Significance of the Study**

This study is intended to provide immense benefit to health service delivery in Ghana.

Most problems of Ghana's health system stem from poor delivery of healthcare. This study therefore comes as a solution to improve the healthcare delivery process. It provides insight into the challenges that confront both public and private hospitals and how these challenges affect healthcare delivery and identified measures to resolve these challenges.

Furthermore, investigating into the challenges confronting healthcare delivery in public and private hospitals in the Central Business District of Kumasi metropolis provides important data that serves as a good base of information and reference to policy makers in their pursuit to design policies and guidelines that would enhance the healthcare delivery system in particular and the health service in general. This study gives new focus to academics' struggles to appreciate the relationship between challenges that confront public hospitals and



private hospitals and how these challenges affect healthcare delivery in general. The study further serves as a source of knowledge to future researchers.

## **1.6 Scope**

The study is limited to health workers and patients in six selected hospitals in the CBD in the Kumasi metropolis. Three of these selected hospitals are publicly managed whilst the other three are privately managed. A specific time period was considered and therefore the analysis and conclusions based on this time period.

## **1.7 Limitations**

The following limitations inhibited the progress of the research study. The uniqueness of the study area, the CBD of Kumasi being different from other areas in terms of geography and culture, it may be difficult to replicate the findings of this study in other places. The study is also limited to only six hospitals due to time constraints, reducing the study's ability to gather more views. Resource constraint was also a major barrier to the study. There is the likelihood for partial responses from hospital employees, for fear of revealing important information about the operation of their hospitals. Yet, these impending hindrances did not significantly affect the validity of the findings of the study.

In addressing these limitations, permission was sought from the managers of the hospitals. It was also explained to the respondents that the exercise was purely an academic one and that their responses and revelations would be treated with the utmost confidentiality that it deserves. Respondents were therefore encouraged to eschew all manner of fear and reluctance and contribute freely to an exercise which was purely academic.

## **1.8 Organization**

The study is organized into five major chapters. Chapter one deals with the background to the study, problem statement, research questions and objectives, significance of the study, scope, limitations and organization of the study. Chapter two is a review of literature on what other researchers and authorities have written in the subject area. Chapter three also takes

care of the study area and research methodology. In chapter four data collected was analysed and discussed. Chapter five summarizes the major findings, implications of findings, recommendations and conclusion.

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## **CHAPTER TWO**

### **A REVIEW OF THE SYSTEM OF HEALTHCARE DELIVERY**

#### **2.1 Introduction**

This chapter discusses the outcomes of the analysis of secondary sources of data in relation to the research topic. Materials for the literature review was collated from important sources like related articles, textbooks, journals, speeches, web sites and other sources. This chapter also deals with the studies that have been done by other researchers which were deemed significant for the subject of study: Overview of Ghana's Health Sector, Organization of the Ghana Health Service and Political/Administrative Structure of Health. The Health Delivery Structure, Public and Private Health Care System were also considered in this chapter.

The chapter further looked at Challenges in Healthcare Delivery in the public healthcare system, Challenges in Healthcare Delivery in the Private Sector, Overall Healthcare System: Challenges and Planned Reforms, Health Expenditure Data and Trends, Insurance and Coverage, Out-of-Pocket Payments, External Sources of Finance, Provider Payment Mechanisms and Human Resources.

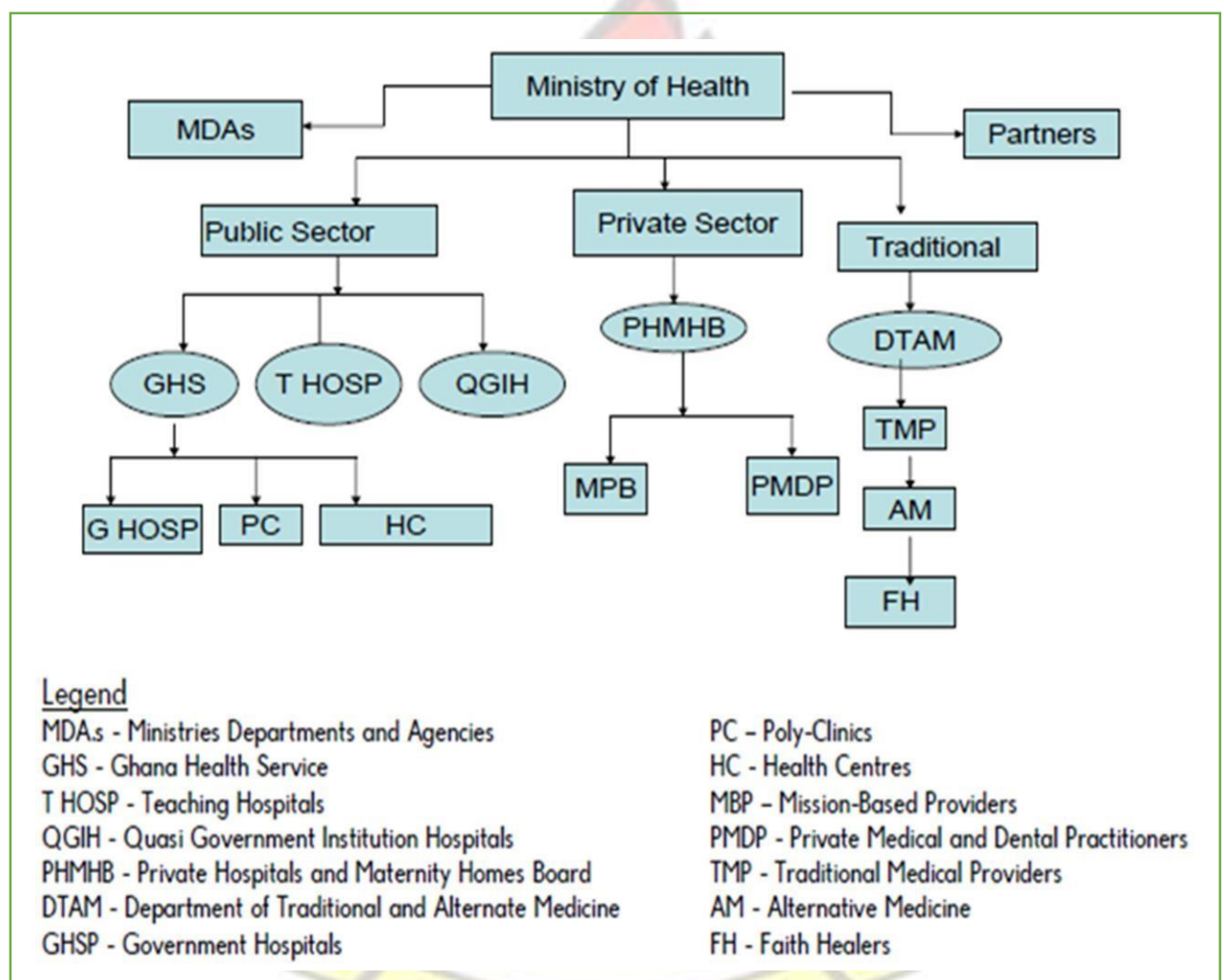
#### **2.2 Overview of Ghana's Health Sector**

The historical background of Ghana's healthcare system is influenced by the British. Before the year 1957, Ghana remained a colony of the government of Britain; consequently, the system of healthcare delivery was modeled by the British, possibly after their own system back home (Abekah-Nkrumah, 2005). The healthcare delivery system at that time centred on the provision of basic healthcare services and the demands of the missionaries and the civil servants. Hence, many healthcare centres were sited in the district capitals with a centralized form of administration. In 1972, the government at the time tried to spread out healthcare services to the districts while policy formulation remained at the center. Since then, a number of changes have followed this effort in 1977, 1997 and 2002 which has risen to a complete decentralised system of healthcare delivery, from national right down to the communities (Abekah-Nkrumah, 2005).

##### **2.2.1 Organisations of the Ghana Health Service**

The healthcare system is run under four main kinds of delivery systems: public, private which operate for profit, private which operate as nonprofit making business and the traditional systems. Though the first three are mostly identified with healthcare delivery in Ghana, stakeholders in the sector have been making the plans since 1995 to incorporate traditional medicine into the conventional mainstream (Abor, et al., 2008). This is evident with the introduction of a programme in Herbal Medicine at KNUST.

**Figure 2.1 Structure of the Ghana Health Sector**



Source: Abor, et al, 2008

Despite this structure, healthcare delivery in Ghana lives much to be desired as collaboration between private and public healthcare sector is non-existent or very low. According to Centre



for Global Development (CGD), 2009 officials in the public health sector usually give minimal support and advice on private sector engagement in developing countries.

### 2.2.2 Political and Administrative Structure of Health

The 1992 constitution of Ghana states; the state shall protect the health, security and welfare of all citizens in employment, and shall provide the means for the full deployment of the innovative skills of every Ghanaian (Constitution of Ghana, 1992, Article 36/10). The present health insurance scheme of Ghana is centred on the parliamentary bill “ACT 852 and LI 1809” (National Health Insurance Act), which became law in 2012. The National Health Insurance Scheme (NHIS) was officially showcased in December 2004 (Hepnet, 2007).

Three administrative levels have been identified with the Health Administration of Ghana. These are: the national, regional and districts levels. It has been further divided into five operating levels at the nation’s capital, regions, districts, sub-districts and communities; all of which are managed as Budget and Management Cost Centres (BMCs) or cost centres for the administration of financial resources by stakeholders and the government (Ghartey, 2000). There exist a sum of 223 operational BMCs and 110 Sub-Districts BMCs (MOH, 2002). The head office of the Ghana Health Service (GHS) is also run as a BMC, including the ten Regional Health Administration, eight Regional Hospitals, 110 District Health Administrations and ninety five 95 District Health Centres. All of which are run as Budget Management Centres (MOH, 2002).

The Ghana Health Service (GHS) has the mandate for the provision of equipment, transport, infrastructure, dissemination of information as well as support and guidance for the formulation of policies and strategies to the Ghana Health Service Council (MOH, 2008). The Ghana Health Service Council is in charge of the activities of the number of bodies under the Ghana Health Service with the supervision of the Health Minister. Its main tasks are to execute approved state plans for healthcare delivery in the country, increase coverage to enhance health services and manage discretely available resources to provide quality healthcare services (MOH, 2008). External contributors of the healthcare including the National Health Insurance administration and the auditing offices and regulatory services work directly with the council (MOH, 2002). The Health Ministry has the responsibility of

policy development procedures and information handling in terms of funding, health professional/development and infrastructure (MOH, 2008).

### 2.2.3 Health Delivery Structure

According to Van den Boom et al., 2004 currently, the government of Ghana provides the largest healthcare services in the country, the mission is the second largest provider of healthcare; followed by the private practitioners (van den Boom et al., 2004). The state health services facilities can be grouped in four levels according to the services rendered at the facility: village or community health posts, district clinics, regional hospitals and the three autonomous teaching hospitals (MOH, 2012).

**Table 2.1 Treatment levels of Healthcare delivery**

| Treatment levels           | Role                                 | Type of institution     | Main personnel in charge  | Basis of treatment                             | Reimbursements                        | Operators                                   | Demo-graphics covered                |
|----------------------------|--------------------------------------|-------------------------|---------------------------|------------------------------------------------|---------------------------------------|---------------------------------------------|--------------------------------------|
| Primary                    | Preventive, information and curative | Community health centre | Community health officers | First point of contact                         | NHIS, "Cash-and-carry" and gratuitous | Government, mission and others <sup>6</sup> | Towns and surrounding areas          |
|                            | Prevention and information           | Rural health centre     | Rural health worker       |                                                |                                       |                                             | Rural areas                          |
| Reproductive health care   | Birth attendance                     | Maternity home          | Midwives                  | First point of contact                         | "Cash-and-carry"                      | Government, mission and others              | Rural, towns, urban and metropolitan |
| Secondary                  | Curative                             | District hospital       | General medical personnel | First and second point of contact on referral  | NHIS, "Cash-and-carry"                | Government and mission                      |                                      |
| -                          | Training of Health workers           | Training Centre         | Public health trainers    | -                                              | -                                     | Government and Mission                      | Rural areas and towns                |
| Secondary and tertiary     | Curative                             | Regional Hospital       | General medical personnel | Second and third point of contact              | NHIS, "Cash-and-carry"                | Government and Mission                      | Towns Urban and rural areas          |
| Primary and secondary      | Curative, training and preventative  | Polyclinic              | General medical personnel | First and second point of contact              | NHIS, "Cash-and-carry"                | Government                                  | Urban and Metropolitan Centres       |
| First, second and tertiary |                                      | Teaching Hospital       |                           | First, and Second point of contact or referral |                                       |                                             |                                      |

Source: Ghana Health Service, 2008.

The provision of preventive and primary healthcare services is offered mainly by the community health posts; they do not, however, give extensive curative treatment. This is because they are traditionally not operated by physicians but nurses and other health staff. At these posts health workers give first aid services and refer cases to district hospitals, polyclinics, regional or tertiary hospitals, depending on the institution's closeness and the care needed. Curative services are provided at the Hospitals and polyclinics since they are the key providers of curative, secondary and tertiary healthcare services. In the cities/urban centres the polyclinics also serve as first point of call of primary healthcare services; thus provide a combination of preventive and curative care and with the regional hospitals serving as referrals facilities. The regional and the teaching hospitals are usually known to be providers of high quality of healthcare services. The community health posts are managed by nurses and midwives (Van den Boom et al., 2004;4).

The Ghana Health Service responsible of the operation of healthcare delivery in the country. As a result of a government decentralized restructuring of the health sector, the healthcare provision is generally operated at the 10 regional levels (MOH, 2008). At the regional levels curative services are rendered at the regional hospitals and public health centres by the District Health Management Teams (DHMT). At the district level, hospital offer curative services. A number of these district health facilities are faith based hospitals working with the public health institutions for healthcare delivery. Traditional birth attendants and healers are also acknowledged at the district and community levels. Public health services are provided by the DHMT and the Public Health unit of the district hospitals. The sub-district health facilities provide preventive and curative services as well as out-reach services to the towns/villages within their environs. Basic preventive and curative services for minor sicknesses are taken care of at the community and household level with the introduction of the Community-based Health Planning and Services (CHPS)" (Ghana CHPS, 2009).

### **2.3 Public Health Care System**

Ghana's healthcare system is run via the National Health Insurance Scheme (NHIS) which allows the running of three kinds of health insurance schemes; namely: District-Wide (Public) Mutual Health Insurance schemes which operates in all the 216 administrative districts of the country, private mutual health insurance schemes and private commercial



health insurance schemes. These notwithstanding, it is the District-Wide (Public) Mutual Health Insurance schemes alone that have financial backing of the NHIS (Hepnet, 2007).

## **2.4 Private Health Care Systems**

As observed by (Van den Boom et al, 2004; 8) healthcare services on private basis attracts a fee of almost 10 US Dollars per consultation, although the minimum wage of Ghanaians was about 1.5 US Dollars daily. A 1995 report indicates that, while the missionaries (Christian and Muslim health services) attend to the deprived for no fee, many private medical physicians like the herbalists, fetish priests and several conventional private practitioners allocate charges for services offered, the sum of which “vary widely” (Asenso, 1995).

The NHIS permits the functioning of private mutual health insurance and private commercial health insurance schemes simultaneously with the District-Wide (Public) Mutual Health Insurance schemes to provide Ghanaians a variety to choose from (IRIN, 2004).

A study undertaken between August and October 2005 by the Ecumenical Pharmaceutical Network (EPN), it was revealed that faith-based health services in Ghana offer about 40 percent of the available healthcare. In one of its quotations, the Christian Health Association of Ghana (CHAG) the Christian healthcare services providers own 56 hospitals and 83 clinics during the period of research (CHAG, 2006).

The Catholic and the Presbyterian churches that form the larger religious organizations provide their own conventional medical insurance schemes, upon which public screening, vaccination, treatment and awareness programmes are organized. Generally, Christian organizations run larger hospitals and clinics, mainly in the remote communities, small towns and rarely, in regional capitals and metropolitan areas. Christian healthcare delivery establishment which are recognized as such by the government comes under the management of CHAG; The government of Ghana subsidizes 45 percent to 60 percent of the entire operating incomes of the Christian faith based health sector (CHAG, 2006, 9). According to CHAG, one has to be a member of the Christian faith before one can access the Christian health insurance scheme.



Islamic organizations are not too much involved in terms of healthcare provision in the private sector of the country. Apart from the Islamic Republic of Iran which operates a clinic in the country (ICRO, 2007), the Ahmadiyyah Muslims Mission of Ghana and other organizations of Muslim background organize medical aid programmes and implement healthcare provision programmes like free medical care once a while (WHO, 2009).

## **2.5 Challenges in Healthcare Delivery in the Public Healthcare System**

The public healthcare is faced with a number of challenges: among them inadequate personnel and under funding, including an unfair allocation of health professions in the country's regions (Van den Boom et al., 2004). The Western Region which is the most heavily populated, absorbs 10 percent of Ghana's population but have only 99 physicians. The Volta Region has 91 doctors whiles and the Northern Region has 33 in relation to 1238 public and private medical including dental practitioners in the Greater Accra Region alone (ACCORD, 2009).

There exist wide spread corruption which appears to be another key challenge in Ghana's public healthcare structure: In its 2006 Global Corruption report, Transparency International (TI) declared the health sector of Ghana is faced with dishonesty which stems from bribery and deceit across the breadth of healthcare services. This is said to have ranged from pilfering and extortion, to extensive falsification of health policy and under-funding/over-funding, fed by payoffs to officials in the sector (Abenorku, 2012).

In a study conducted in some rural communities, it was discovered that other reasons such as traditional believes, social stigma, poverty and illiteracy continue to impede the standard healthcare provision. For instance, in a study carried on payment of health insurance in the Kassena Nankana District in Northern part of Ghana, some of the respondents said that; paying money in anticipation of ailment was not right as that in itself could call for more diseases (HRU, 2005a,7). Another survey in a district hospital identified that people with leprosy and tuberculosis evade medical consultation because of social stigma, poverty and/or the need to fend for themselves or others (HRU, 2005, 8).

## **2.6 Challenges in Healthcare Delivery in the Private Sector**

The key function of the private sector in healthcare continues to be a much-debated and controversial matter. Critics of private sector involvement maintain that healthcare given by the private sector is below the required standard (Nkya, 2000). Nonetheless, poor quality of healthcare is not peculiar to the private sector and might be prevalent to health systems in the developing countries. For instance, proof from a recent multi-country studies advocates that quality of healthcare and provider know-how is virtually the same in the public and private health sector (Reinikka and Svensson, 2003). Others are worried about user fees charged by the private healthcare providers, indicating that such fees undermine access to healthcare amongst the poor, which therefore leads to increasing discrepancies in health care utilization (World Health Organisation (WHO), 2004). The evidence here is also mixed since in some countries fees are charged for services offered in public facilities and there is no convincing proof that user fees in the private sector are higher than it is in the public sector (Kiiza, et al., 2006).

Alternatively, given that health systems are often under resourced, another way to increase access to healthcare is to recognise and build upon the prospects and resources of a prevailing private health sector (Marek, 2003). A recent work using information from 34 countries finds that more private sector involvement corresponds with enhanced access and reduced differences in healthcare between rich and poor as well as urban and rural populations (Chang, 2007). The result remains after controlling for per capita GDP and maternal education, two confounding factors that could be interrelated with appropriate private sector contribution and better healthcare access.

While the debate about actual function of the private health sector remains unanswered, the demand to solve difficulties of poor health results and access to care in Sub-Sahara Africa (SSA) is paramount. Considering the great part played by the private health sector in most countries, a measure of commitment by the state is needed (Chamuka, 2007). Appropriate involvement with the private sector will need to solve the setbacks private healthcare providers encounter both as businesses and as healthcare providers. Stated differently, policies should aim at not only improving the quality of care in the private sector but also ensure that these providers can become and remain viable and independent while delivering

the healthcare needs of the people. However, policies that lead to growth of the private sector may have an unclear effect on equity and access (Dermer and Montgomery 1997).

## **2.7 Overall Health Care System: Challenges and Planned Reforms**

Health is one of the socio-economic topics at the centre of the Millennium Development Goals (MDGs), which Ghana hopes to accomplish in 2015. The government therefore prioritise"s health issues within the MDGs, three of which deal with health issues. The fourth goal of the MDGs is to reduce under-five mortality rate to two-thirds by 2015; the fifth goal is to reduce the maternal mortality ratio by three-quarters by 2015 and the sixth is to try and to combat infection rates of HIV/AIDS, malaria, and other infectious diseases related to sanitation and environment by 2015. All of these have been made primary healthcare goals, which the government has sought to fix into community level healthcare (MOH, 2008). The major difficulty in achieving the health-related MDGs, according to the Ministry of Health is the general low coverage and failure to get to the poor more successfully. According to WHO, 2008 as countries pursue to reinforce their health systems, they are progressively considering primary healthcare (PHC) to provide a clear and complete sense of direction.

The Public Agenda newspaper reports that in spite of the general upward expenditure in health sector, a 2006 sector review mentioned the continuous low success in terms of goals. It refers to a November 2007 report based on a combined input by the Brookings Institution Transparency and Accountability Project (BITAP) and the Integrated Social Development Centre (ISODEC), said that the health budget decreased from 70.5 percent in 2001 to 63.9 percent in 2006. The report further stated that it is about time for the state commit itself to allotting additional funds to investment spending in the health sector. This is to guarantee some steadiness in development project execution even when there is donor bias (Public Agenda, February 6, 2008).

On the whole, in the face of great determination by the state, the healthcare system is still challenged with insufficient funds and inadequate staff: The Ghana Health Service is aware that there is a crucial need for supplementary health amenities and additional competent health professionals, especially in the countryside (IRIN, 2008).



There exists enough evidence that some of the key hitches in the healthcare system of Ghana are caused by simple hygiene related ailment such as malaria, cholera (Compah et al., 2013). Other significant issues contributing to differences between the healthcare delivery structure and its application in the health industry of Ghana stems from nepotism, favoritism and corruption to occasionally tribalism. There exist widespread corruption which appears to be another key issue in Ghana's public healthcare system: In its 2006 Global Corruption report, Transparency International (TI) declared the health sector of Ghana as a corruption prone area which stems from bribery and deceit across the scope of medical services. This is said to have ranged from pilfering and extortion, to massive falsification of health policy and under-funding/over-funding, fed by payoffs to officials in the sector (Abenorku, 2012:12).

The regular problems of Ghana's health sector are resolved by the 1995 Medium Term Health Strategy (MTHS) and the ensuing Sector Wide Approach (SWAp), which tried to reform the health financing system. One unique area the reform put emphasizes on is to "strengthen the district health capabilities and their financial management systems" (Asante et al., 2006; 10). A financial management reform followed SWAp and transferred management functions to the district level and gave greater control of funds to local managers. District Health Administrations (DHAs) constantly receive and directly manage monies for non-salary recurrent expenditure under the concept of Budget Management and Cost Centres. Asante et al. noted that; while this has been welcomed as an improvement in district healthcare delivery, flow of funds to districts has been untimely and irregular. First quarter provisions to be paid in January are often received in the second quarter, usually as late as June. Fourth quarter allotment may not be paid at all. This unreliable flow of funds to district health services threatens to offset any possible benefits from the reforms (Asante et al., 2006; 9).

In 2005, the government adjusted the salaries of health professionals upwards; the payment, nonetheless, did not match domestic income desires of the workers (Witter et al., 2007). Typically, when it comes to payment systems for health sector workers it attracts diverse feelings: In 2005, a survey was conducted in two regions of Ghana on health workers' earnings and its effects on their enthusiasm. The result depicted an overall improvement in



attitude towards patients since the institution of the scheme. Health workers became obliged and stayed on duty for more hours (Witter et al., 2007). Their workloads had increased but this did not affect their morale, since the increase in workload for public sector health workers had been matched by a distinct pay rise (Witter, 2008; 14). The study found out that health workers have experienced a salary increment higher than those of other public sector workers. When asked about the NHIS, the health workers expressed mixed feeling about the scheme. Though they valued their wage increase, they insisted that the processes of provider payment were unpredictable. They cautioned that unreliable government payments are impeding sustainability (Witter, 2008).

A 2005 study indicated health information and data management as a basic part of healthcare delivery and hinted that the single most often quoted limitation to improved health information is human resources availability and capability at all levels, national through to community levels. From the study, people with specialised skills in health information and data management were required urgently in the system. The study also said the Ghana Bureau of Statistics which manages these data is overcrowded with unqualified staff who lacked the proper skills for the management of health information (HMN, 2005, p. 3).

#### 2.7.1 Health Expenditure Data and Trends

Published in 2006, Augustine Asante described the method of budget allotment as follows:

“The pattern of allocation of the previous year is used as a guide for the current year's allocation. This has little link considering the health demands of the population. Regardless policy obligation to enhance the resource allocation formula to include health needs, gender and poverty issues, only trivial changes have been made (Asante et al., 2006; 10). Nonetheless, the Government of Ghana has lately changed its policy in resource allocation by prioritizing a “pro-poor and needs-based resource allocation in the health sector”. The MOH sends part of the health budget and lodges it with specific Budget and Management Centres (BMCs) to protect dire service areas from the risk of inadequate funding. The ring-fencing is also used to ensure that resource allocation patterns reflect national poverty eradication and equity obligations (Asante et al., 2006;12). A significant share of the pro-poor finance strategy goes into ensuring that exemptions are paid for among other things, “maternal deliveries and Guinea Worm eradication in northern

Ghana”. Meanwhile, Asante states that much of these efforts in “resource allocation in the Ghanaian health sector remains insufficiently reflected on the health needs of the population, and to date, only few indicators of need are included in the resource allocation criteria” (Asante et al., 2006;12).

The funding of the insurance scheme is based on a system called “cross-subsidization.” In this payment system, the rich subsidize the poor, the healthy subsidizes the sick and the economically active adults pay for children, natives and the old (70 years and above) (Hepnet, 2007). Through the Social Security and National Insurance Trust (SSNIT), workers pay 2.5 percent of their salaries with extra funding coming from a 2.5 per cent value added levy on selected goods and a minimum premium of 72,000 Cedis (US\$ 7.74) yearly from informal workers. Apart from these payments, other consolidated funds are used to finance the scheme. These are donations, grants, gifts and other charitable assistance are also added to fund the scheme.(Salusi and Prinz, 2009).

#### 2.7.2 Insurance and Coverage

Three kind of insurance schemes operates under the National Health Insurance Scheme of Ghana: They are; District-Wide (Public) Mutual Health Insurance scheme in which public sector workers directly make their contribution of their incomes into the health insurance scheme; a Private Mutual Health Insurance scheme through which small-scale farmers and informal sector workers and the jobless (not formerly employed in the public sector) are to make their contribution; and lastly Private Commercial Health Insurance Scheme through which those employed by bigger companies and multi-national companies such as Barclays bank pay their donations (William C. Hsiao and R. Paul Shaw 2006).

Within the schemes mentioned, the health insurance programme offers the under-listed assistance and package:

- i. Full Out Patient Department and treatment on admission (medical and surgery) cost including feeding;
- ii. Full payment of approved drugs
- iii. Payments for referrals (gatekeeper system) are borne by the scheme if in the approved list. The treatment not paid for by the scheme, include:

- iv. Prostheses, appliances, rehabilitation, dentures, organs aids, plastic surgery and aided reproduction;
- v. HIV retroviral drugs, hormone and organ replacement therapy;
- vi. Heart and brain surgery other than accidents;
- vii. Diagnosis and treatment abroad, as well as
- viii. Dialysis for chronic renal failure and cancers (Hepnet, 2007).

The scheme is faced by challenges such as governance, organisational and management point of view include the exclusion of sizeable number of people, a weak monitoring system, delays in respect of payment to providers and distrust between providers and scheme staff. Management hitches and delays in the production of ID cards and circulation are also known to be causing problems (Hepnet, 2007).

The NHIS has also managed so far to fully bring on board the poor and weak. Most poor people do not fall in the category as being extremely poor, but they, however, cannot afford to pay the registration fees and premiums (Normand and Weber, 2009)

Other problems of the system include patients inability to seek medical attention from one facility and multiple prescriptions (poly pharmacy) by patients, non-conformity to approved healthcare provision procedures and the NHIS agreed list on treatment and medications, concerns on accreditations (few Drug stores, Private Providers and Maternity Homes accredited) resulting in stress on state providers, insufficient and mal-distribution of providers, as well as unequal supply of health professionals to the merit of city settlers to the disadvantage of the rural population (Hepnet, 2007).

### 2.7.3 Out of Pocket Payments

In 2005, the portion of payment made out of pocket in Ghana amounted to 79.1 percent of the entire private spending on health, which forms 65.9 percent of the nation's total expenditure on health (WHO, 2008). As can be deduced from these figures, on the spot payments make up nearly 50 percent of the overall public and private expenditures on health.



The Health system of Ghana is still in a transformation process – it is being changed from the former “cash-and-carry” to the newly effected health insurance system. The system prior to the current one was based on a full cost recovery on the spot payment. The reason for charging service fees was to recuperate 15 percent of the public sector running cost. Though this objective was realised, there were always problems as costs of ailment differ and many people could not pay for treatment received. “Financial access and equity” for poor people was always a problem. Though some exemptions were introduced, increasing public displeasure called for its abolition (Hepnet, 2007).

#### 2.7.4 Provider Payment Mechanisms

All providers of healthcare services are registered businesses that operate on both private and public basis. Hospitals and pharmacies wanting to operate as providers within the scheme undergo basic procedures controlled by the National Health Insurance Act (No. 852, 2012).

A 2007 review of the performance of the National Health Insurance Scheme revealed healthcare provider payment methods as one area among many that must be reconsidered to be able reshape the scheme. The report, which was the outcome of a study undertaken with sponsorship from the World Bank and the International Labour Organisation, says that it was to ensure stabilising the NHIS’s monetary sustainability within a medium-term time prospect. This was to be done by reinforcing the policy formulation and execution capability of the National Health Insurance System in resolving essential ongoing policy issues in relation to contribution, collection, risk equalization and the overall provider payment method, [...] enhancing the purchasing tasks of the NHIC and District Mutual Insurance Health Organizations and improving the billing function of the provider network. Health Economics and Policy Network in Africa (Hepnet), also uncovered that unequal distribution of delivery facilities and insufficient provision facilities continue to affect the scheme (Hepnet, 2007).

#### 2.7.5 Human Resources



One of the protracted difficulties in the country's health sector is the issue of inadequate health personnel. While the government is putting in efforts to reshape the health organisation, it is losing the little that the nation has to the western economies. Mensah K. et al, 2005 reveal that there exist continuous evidence of high migration of Ghanaian health profession into western countries. The organization, Physicians for Human Rights (PHR) noted that in Africa, inadequate health professionals are the most crucial, by far, in rural and other poor communities (PHR, 2004, p. 2). With about 400 additional doctors employed by MOH in 2014, the doctor to population ratio improved from one doctor to 10,170 persons in 2013 to one doctor to 9,043 in 2014. For the first time, the doctor to population ratio has passed the mark of 1 doctor to 10,000 persons. The nurse to population rate continued previous years' improvements and met the target of less than 1,000 persons per 1 nurse. This computation includes community health nurses (MOH, 2014). Although this appears to be an improvement over the previous year, there is still much to be done. The Ministry of Health has to collaborate with the Universities to admit more students to close the gap between health workers and patients.

The Physicians for Human Rights states that the Ghana Medical Service estimates that 1,200 Ghanaian medical doctors have migrated to the United States. Presently, Ghana has only about half the number of nurses it used to have the mid-1980s, when its population was almost half of what it was in 2008. In 1999 alone, 328 nurses emigrated from Ghana, almost equivalent to the number of nurses Ghana produces yearly. In 2002, along with 70 physicians and 214 nurses, Ghana lost 77 pharmacists to other high income earning countries. The retail giant Wal-Mart is said to be recruiting pharmacists from sub-Saharan Africa and India to work in their Canadian stores (PHR, 2004 p. 19-21).

To avert this situation, the government has taken several steps in improving the salaries of health professions in the country since 2006. Results of assessments in many districts in the eastern part of the nation indicated that since the increases were made, "the lowest paid public health worker now receives around ten times more of average gross national income (GNI) per capita, while the doctors earn 38.5 times GNI per capita" (Witter et al., 2007).

## **CHAPTER THREE**

### **PROFILE OF THE STUDY AREA AND RESEARCH METHODOLOGY**

#### **3.1 Introduction**

The previous chapter revised relevant literature on the system of healthcare delivery, embracing institutional and policy regulations and frameworks. The other key issues found are as regards implementation of health policies and interventions as well as challenges confronting the process. In the context of the study, this chapter will continue to profile the study area and outline an overview of healthcare delivery within the Kumasi Metropolis through public and private hospitals. The chapter also discusses the methods and techniques used to gather data: the research design, the population, sample and sampling technique, instrumentation, data collection procedure and methods of data analysis.

#### **3.2 Profile of Kumasi Metropolis**

##### **3.2.1 Location and Size**

The focus of the study was on the CBD of the Kumasi Metropolis. Kumasi has an estimated population of 2,035,064 people (Ghana Statistical Service, 2014) and functions as the regional capital of Ashanti Region of Ghana. It remains the second largest city in Ghana and from just around 1 million people in 2000, its population is now 2,396,458 in 2013. Kumasi Metropolis falls within latitude  $6.35^{\circ} - 6.40^{\circ}$  and longitude  $1.30^{\circ} - 1.35^{\circ}$  and covers a total land area of about 254 square kilometres (KMA, MTEF Budget

Document, 2014) and about 270km north of Accra, the national capital as well (Figure 4.1).

The strategic location of Kumasi Metropolis renders it an economic hub in the West Africa. In Ghana, it serves as the main transport linkage between the south and north of Ghana besides its central location in the Ashanti Region (Figure 4.1) of Ghana. The central location of Kumasi within the region is a major factor enabling it to serve as the business centre for the neighbouring Brong-Ahafo Region, the three northern regions of Ghana and parts of the Western and Eastern regions, creating a prospective market of about 12 million people (The Kumasi City Investment Promotion Unit, 2013).

Kumasi is therefore a key transport and commercial centre for both national and international traffic, according to its recognition as the „commercial capital of Ghana“ (The Kumasi City Investment Promotion Unit, 2013). Its attractiveness contributes to its cosmopolitan nature and it being the most populous city within the Ashanti region.

In spite of the economic benefits, the health implications of the above characteristics of Kumasi could be enormous. The likelihood of contagious diseases in the event of epidemics could be devastating. The through traffics including inter-city and international freights are potential means of transporting diseases to destination towns including corridor villages, towns and cities. Another demand on health facilities and professionals is road accidents resulting from the high traffic volumes.

### 3.2.2 Demographic characteristics and sector of employment

Kumasi Metropolis“ population at 2,035,064 people as at 2010 comprised females and males of 50.2 percent and 49.8 percent respectively, while population density was about

8012.06 persons per km<sup>2</sup>, experiencing a 4.8 percent growth rate (KMA, MTEF Budget Document, 2014). The high growth rate is explained by the attractiveness of the metropolis (Kumasi Metropolitan Assembly, 2012) defined by its strategic location, wider sphere of influence shown by higher order facilities that are of service to neighboring districts. The Kumasi Airport, Kwame Nkrumah University of Science and Technology, University of Education, Winneba, Kumasi Campus (and other private universities and educational institutions), Komfo Anokye Teaching Hospital, KNUST Hospital (and other numerous private health facilities), the Kejetia and Central Market, Barekese Dam among others are among the pull factors.

About 60 percent of the population of the Metropolis is at least 18 years old, constituting a potential labour force (KMA, MTEF Budget Document, 2014), of which 86 percent are economically active. The majority (72 percent) is productively employed in the commerce

and services sector (KMA, 2012). The others are industry (23 percent) and agriculture (7 percent) (KMA, MTEF Budget Document, 2014).

### 3.2.3 The health sector and health facilities within the metropolis

The population of the metropolis and other non-residents are serviced by six government hospitals, four quasi government hospitals and clinics, three mission hospitals and clinics, 44 private hospitals, 67 private clinics, 55 maternity homes and 20 homeopathic clinics. The other health facilities include 15 private laboratories and 169 outreach stations. The health facilities found in the five health districts in the metropolis are evenly distributed (Kumasi Metropolitan Assembly, 2006). The health districts are; Asokwa, Subin, Bantama, Manhyia North and Manhyia South. Komfo Anokye Teaching Hospital (KATH), the second largest hospital in Ghana is located at Bantama Sub-Metropolitan area provides care to the whole city as well as its immediate environs (see Figure 3.1). It also serves as referral hospital for Ashanti and other hospitals outside the region. The Suntreso Government Hospital is situated at North Suntreso and attend to the people of South and North Suntreso, Kwadaso, Asuoyeboah, Patasi, Adoato, Suame and Breman. Finally, the Manhyia Polyclinic, found at Ashanti New Town close to the Manhyia Palace, provides healthcare to the people of Manhyia, Ashanti Newtown, Krofrom, Aboabo and Asawasi communities.



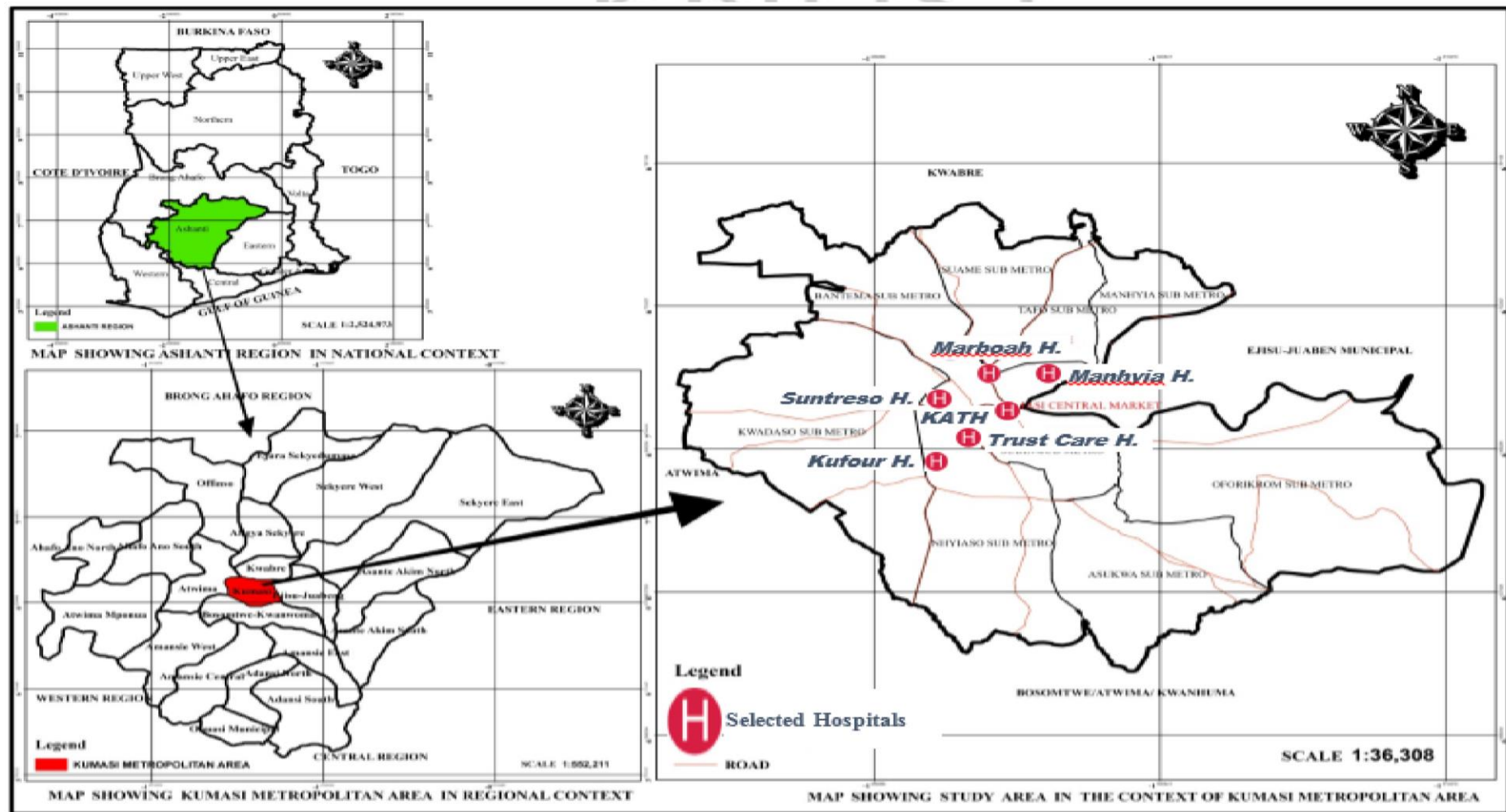


Figure 3.1: Map of study areas in national, regional and metropolitan context

Source: Kumasi Metropolitan Assembly, 2010

25  
KNUST



#### 3.2.4 Common Diseases and health service provision in the metropolis

The top ten OPD diseases in Ashanti Region are malaria, acute respiratory infection, hypertension, diarrheal disease, skin disease, rheumatic conditions, intestinal worms, urinary tract infection, acute eye infection and anaemia (GHS, 2012). In treating these diseases, the Ghana Health Service in partnership with the private sector offer clinical and public health services. The Kumasi Metropolitan Assembly (2014) identified the clinical services to include Out-Patient, In-Patient, eye, obstetrics, dental care, eye care, surgery and gynaecology. Expanded Programme on Immunisation, Nutrition, Reproductive and Child Health, Disease Control, Social Mobilisation for Community Support, Health Information Management are provided by the Public Health Services in association with other sectors, community and the Environmental Health Department.

#### 3.2.5 Hospital Attendance

The Kumasi Metropolitan Assembly (2014) identifies that a lot more people seek medical attention at the public health facilities than the private ones. The Assembly attributes this to low fees charge by public health facilities relative to the private ones even though the waiting time at the public facilities are longer than private facilities. Again, according to the Kumasi Metropolitan Assembly (2014), the public health facilities have sophisticated and essential equipment that the private ones do not have. The differences were expected to be extensive with the establishment of the National Health Insurance Scheme, giving that public health facilities are usually the service providers under the NHIS scheme.

#### 3.2.6 Challenges and potentials for healthcare delivery within the metropolis

The Kumasi Metropolitan Assembly (2006) indicate the number of health delivery facilities as sufficient for the people of Kumasi and its environs, inadequate logistic support and high ratio of patient/doctor (39,153/1, GHS-Ashanti Region – 2012) militate against equitable health delivery. According to the Assembly, the metropolis has enough qualified and committed personnel, basic logistics, NHIS, fund for malaria control and tuberculosis. The Ghana Health Service and the Regional Health Administration gives technical assistance in respect of healthcare; and these are seen as potentials and opportunities for promoting health service delivery within the Metropolis.

### 3.3 Research Methodology

This section outlines the research design the researcher used to assess the perception of patients and challenges confronting public and private healthcare delivery within the Kumasi Metropolis. Steps leading to the determination of the sample frame and size and sampling for the study are outlined. Data sources, methods of data collection and analysis are also described under this section. All the above activities carried out were necessary and directed towards addressing the set research questions.

### 3.3.1 Research Design

The study adopted the case study design within which both qualitative and quantitative approaches were combined to assess patients' perception and the challenges in healthcare delivery in public and private hospitals in the Kumasi metropolis. The case study design made it possible to understudy six private and public hospitals within the Central Business District of Kumasi Metropolis. The researcher used these six hospitals as cases to undertake an empirical inquiry that focused on the effectiveness and challenges private and public hospitals are confronted with within the real-life context (Yin, 1994) in the CBD of Kumasi Metropolis.

The qualitative research methods adopted used interviews, observations and review of documents. This enabled the researcher to describe the factors affecting the operations of the hospitals. This also helped to establish the relationships among the factors found. The qualitative research was supported by quantitative research methods. The objective of the application of the quantitative research was to measure variables that have numerical characteristics to corroborate the findings of the study. The responses were coded and input into Statistical Package for Social Science to form a database for the quantitative analysis.

### 3.3.2 Study population

The study has two broad category of population; 1) the patients of the hospitals 2) the management of the hospitals including the hospital staff/employees (health professionals). The two categories were drawn from both private and public hospitals.



The grouping of the population of the study is informed by Sekaran's (1981) definition of a population of a research study as any group of individuals that has characteristics in common that are of concern to the researcher. And all persons or objects within a certain population usually have a collective, binding characteristic or trait. Thus, while the patients who visit the hospitals do so to get effective treatment of their ailments, the hospital staff (including nurses and doctors) has the expertise to diagnose and discharge treatment appropriately. The provision of equipment, drugs and administrative affairs becomes management responsibility; and it is the aim of management to ensure an effective functioning organization such as the hospitals for the attainment of their prime purpose as healthcare service providers.

Six hospitals were purposively selected for the study based on their proximity to the central business district. The selected hospitals include both publicly managed and privately managed hospitals within the Kumasi Metropolis (see Table 3.1 and Figure 3.1). The publicly managed hospitals include the Suntreso Hospital, the Komfo Anokye Teaching Hospital and Manhyia Hospital. The private hospitals include the Kuffour Hospital, Maaboah Hospital and the Trust Care Hospital.

### 3.3.3 Sample frame and size determination

A preliminary survey by the researcher revealed that 134 patients of the hospitals could be accessible for the study. The 134 patients became the sample frame (N) for the study. Based on this, a sample size (n) of 100 was calculated at confidence level of 95percent using a mathematical formulae suggested by Miller and Brewer (2003) as;

$$n = \frac{N}{1 + N(\alpha^2)}$$

Where n = sample size; N= sample frame (Total accessible number of patients) and  $\alpha$  = error margin at 0.05.

The sample size was equally distributed among the private and public hospitals. These are further apportioned to each sampled hospital as shown in table 3.1.

**Table 3.1 Selected hospitals for the study**

| <b>PUBLIC HOSPITALS</b>       | <b>NUMBER OF RESPONDENTS</b> | <b>PRIVATE HOSPITALS</b> | <b>NUMBER OF RESPONDENTS</b> |
|-------------------------------|------------------------------|--------------------------|------------------------------|
| Suntreso Hospital             | 15                           | Kuffour Hospital         | 17                           |
| KomfoAnokye Teaching Hospital | 20                           | Maaboah Hospital         | 15                           |
| Manhyia Hospital              | 15                           | Trust Care Hospital      | 18                           |

Source: Field data November, 2014

### **3.4 Sampling of respondents**

The study used multiple of sampling techniques. Hospitals are purposively selected out of health facilities. Hospitals offer more comprehensive healthcare delivery services and were deemed appropriate in the context of this study. The hospitals were again grouped based on ownership type (private ownership or public ownership) and selected due to their closeness to Adum (the Central Business District (CBD) of Kumasi). This was done anticipating population of the CBD which comprise the service area of the selected hospitals, the general economic activities of the CBD and the likely health demands that may result from especially work-related injuries. These factors presented by the CBD could help expose the performance and the true challenges faced by hospitals in healthcare delivery.

A convenient sampling technique was employed to select the respondents from each hospital. Thus, any patient at the out-patient department was interviewed with a questionnaire to elicit responses on their perception of performance of the hospital as well as challenges they are confronted with as patients. This, however, excluded patients visiting the hospitals for the first time.

Besides the patients, the management of the hospitals were purposively interviewed.

The hospital management gave an overview of factors affecting the hospitals' operations and made available some hospital documentations to assist the study.

#### **3.4.1 Sources of Data Collection**

Data sources comprised primary and secondary sources. The responses elicited from patients of the six selected hospitals and the management of the hospitals provided a primary data for the study.

The analyses of the primary data to address the set research questions was enriched by data from secondary sources. The secondary sources of data includes published and unpublished articles, theses, journals, books and news items. The Ghana Public Health Policy and the hospital progress reports and general records are among the documents used. The World Wide Web using the internet provides the broad mechanism for collecting the secondary data on health and healthcare delivery management practices as well as institutional challenges of healthcare delivery.

#### 3.4.2 Instrumentation, pre-testing and method of data collection

The researcher used observations and designed interview guide and questionnaires as instruments used for the data collection. A trial examination was done with a small group representative of the population of KNUST hospital to evaluate the face validity of the questionnaire and the interview guide. Thus patients and management who were accessible and were ready to answer the questionnaire were interviewed. Five employees and five patients were conveniently selected as statistical conditions are not necessary in the pilot study (Cooper and Schindler, 2003). Respondents were informed to fill out the questionnaire together with interviews in order to enhance the meaning, understanding, formatting and wording of the questionnaire. During the individual initial test, the researcher and with the help of the respondents went through the questions to know what they (respondents) think the questions are trying to ask. Likewise, a list of questions was used to crosscheck on relevant issues associated to the pretest questionnaire. Based on the feedback, recommendations and comments from respondents, revisions were made. Thus, it will be easy for respondents in the large survey to answer the questions.

Subsequent to this, the standard structured questionnaire was administered in the form of interviews and self-reporting responses to the targeted samples for the study. The selfreporting gave respondents a relaxed atmosphere to answer the questions at their own pace and convenience. Some of the respondents who needed more explanations were

guided in completing the questionnaires. The questionnaire was made to collect demographic data and information in relation to the research objectives. The questions were short in order to encourage participation, which guaranteed that it would not take more than 20 minutes to answer. The purpose of the study was explained in a paragraph in the questionnaire.

Management members were interviewed briefly to gather views and observations. Interview guides were used to facilitate the interaction with the management. The researcher also observed operations at the hospitals.

#### 3.4.3 Method of Data Analysis

All analyses were tailored towards achieving the set research objectives. Data collected were analysed both quantitatively and qualitatively. The Statistical Package for Social Sciences (SPSS) version 18 was used. The responses as contained in the questionnaires were coded and input into SPSS to form a database for the study. Analysis was conducted on the database to generate the measures of central tendencies (mean, mode and standard deviations), tables and figures based on which statistical analysis of findings relating to opinions shared by respondents were arrived at. This, to a large extent is quantitative.

A five-point likert scale was used to give respondents a wide range of options to rate the perception of performance of the hospitals by the respondents. The question was asked, does the hospital deliver healthcare up to your expectation? And the likert scale reads 1= Strongly Disagree, 2 = Disagree, 3 = Uncertain, 4= Agree, and 5 = Strongly Agree. These ratings were collated and compared to determine the mode perception of effective performance of the hospitals in each case. Another three-point likert scale (-1= Worse, 0 = same and 1 = Better) was used to complement the findings emanating from the above. The support the three-point likert scale offered was to compare the perception of patients who have in past received treatments from other hospitals (which belong to public/private type different from the current hospital) to the current one.



A stock taking analysis coupled with backlog and use of standards was also employed to estimate congestion at the hospitals. The stocking enabled the researcher to count the number of beds (and other logistics) available. The existing stocks compared with what is required, using a standard of one bed per patient (in case of hospital beds) resulted estimating the backlog.

Descriptive responses mainly emanating from the interview guides and interactions with the hospital management formed basis for the qualitative analysis. Content analysis and pattern matching were crucial in the qualitative analysis. The pattern matching helped to identify the challenges common to the public and private hospital healthcare delivery, while the content analysis tend to examine and extract the relevant data from the responses given by the respondents for the purposes of addressing the set research questions.

#### 3.4.4 Ethical Considerations

All social organizations have some ethical concerns to consider. Reveal of facts by staff that can affect the organisation includes many ethical concerns in relation to the workers of the hospitals selected. To address this, justification of the study was first explained to the respondent. The privacy of the data collected from respondents was considered by ensuring that their names and other information that could bring out their identities were not exposed in the data given. They were also made to recognise their role in the data collection activity to find answers to the research questions. To avoid imposing the questionnaires on respondents, they were given the choice to opt out if the exercise would disturb them in any way. The methods and procedures explained above were used in pursuing the needed data for the analysis which are captured in the next chapter.

## **CHAPTER FOUR**

### **HEALTHCARE DELIVERY BY PUBLIC AND PRIVATE HOSPITALS WITHIN KUMASI METROPOLIS**

#### **4.1 Introduction**

Chapter Four assessed the challenges and perception of patients about private and public hospitals to healthcare delivery within the Central Business District of Kumasi Metropolis. The assessment was based on the findings that were arrived at as a result of the application of the research methodology outlined in chapter three. Thus, the assessment was done to address the set research objectives.

#### **4.2 Assessment of healthcare delivery by selected hospitals in Kumasi Metropolis**

This section first analyses the bio-data of respondents and gives an overview of the selected hospitals (both private and public). The perceptions of the patient-respondents about healthcare delivery in the public and private hospitals are analysed. The next was the analyses of the challenges confronting (and its effects on) healthcare delivery in the hospitals and Kumasi. Finally, the challenges common and or peculiar to the private/public hospital type are identified and assessed. All the above are enriched with literature and discussed within a broad development context.

##### **4.2.1 Bio-data analysis of patient-respondents**

The bio-data analyses focus on the age, gender and marital status of the patientrespondents. It also includes the occupation and income, educational attainment as well as religion.

##### **4.2.2 Age and sex of patient-respondents**

Table 4.1 estimates the male-female ratio of respondents at a rate of 38 percent male and 62 percent females. This finding supports the assertion that the female gender frequently visits health facility as compared to their male counterpart. The same can be said of the age groupings the study found to be using the hospital services the most. Thus, the 1825 age cohort has been found by the study as the greatest proportion (49 percent) of

respondents using the services of the hospitals (see Table 4.1). This is followed by the 26-35 age cohort at 24 percent. This finding is consistent with the fact that the CBD is occupied by youth who undertake various economic activities in the metropolis as the labour force of the metropolis is 63.3 percent according to GSS, 2010.

**Table 4.1: Age and gender of patient-respondents**

| Age<br>Sex | 18-25 | 26-35 | 36-45 | 46-60 | 60+  | Total | Percentage |
|------------|-------|-------|-------|-------|------|-------|------------|
| Male       | 19    | 11    | 02    | 02    | 04   | 38    | 38.00      |
| Female     | 30    | 13    | 08    | 4     | 05   | 62    | 62.00      |
| Total      | 49    | 24    | 10    | 6     | 9    | 100   | 100        |
| Percentage | 49.00 | 24.00 | 10.00 | 6.00  | 9.00 |       |            |

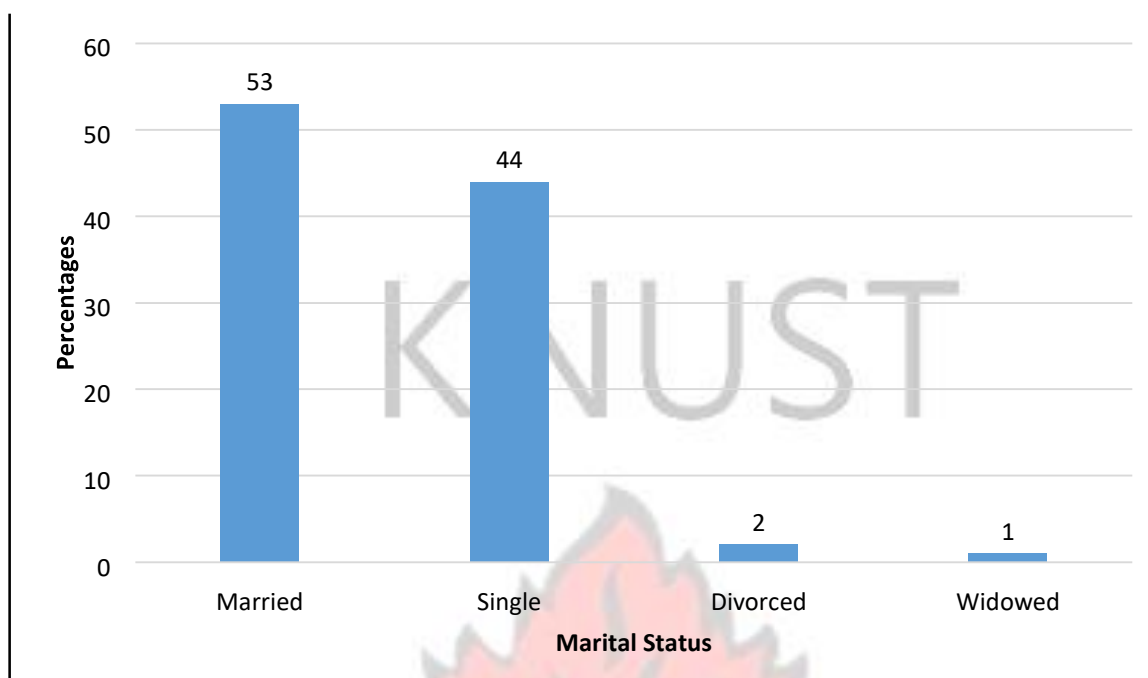
Source: Field data, November, 2014

#### 4.2.3 Marital status of patients

As shown by the Figure 4.1, 53 percent of patients were married while 44 percent were single, two and one percent are divorced and widowed respectively. The implication is that married patients are more likely to use hospital services. This may result from pregnancy issues, family planning and maternal healthcare. Dependents of the patients surveyed are another factor that could increase respondent's presence at the health facilities.

**Figure 4.1 Marital Status of patients**





Source: Field data November, 2014

#### 4.2.4 Employment status and income

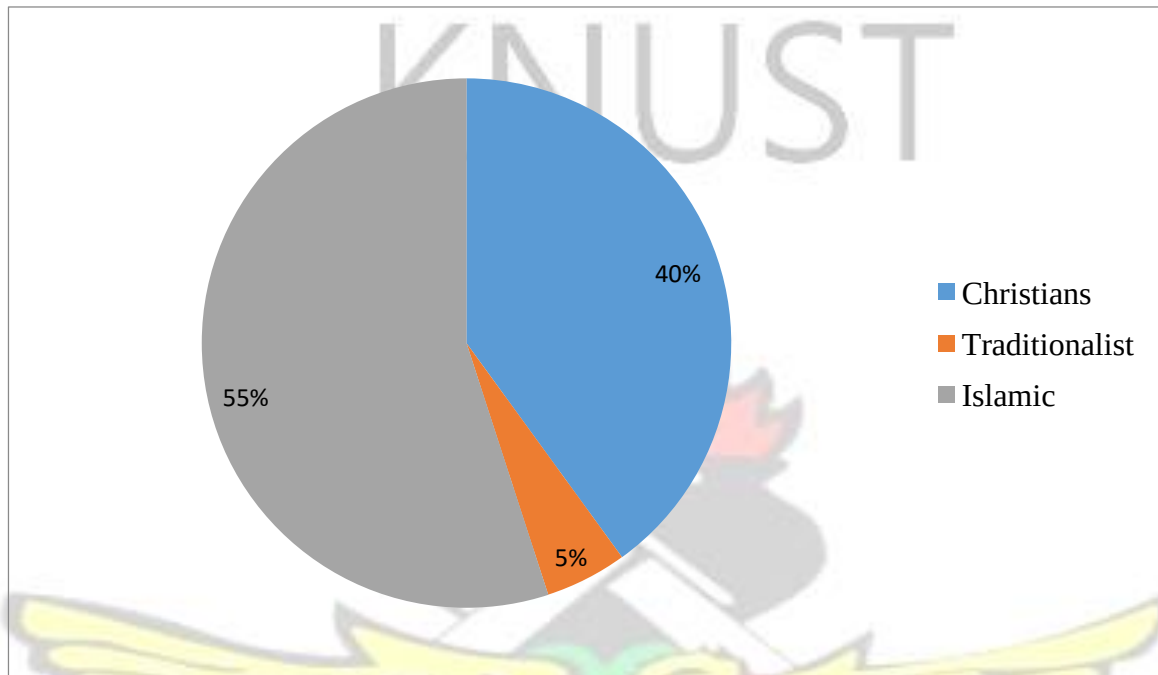
Approximately 80 percent of the patients surveyed are engaged in one economic activity or the other. These economic activities are predominantly service and sales work, craft and related trades, elementary occupations, professionals and plant machine operators and assemblers (GSS, 2010). It was clear from the interactions with the respondents that the work stress and injury increase health risks. This impression could explain the need to seek medical attention regularly. The other 20 percent considered themselves unemployed, though they undertake some casual works once a while.

The daily wages that accrue from undertaking the identified economic activities was found to be favourable compared to the Daily Minimum Wage of Ghana at GH¢ 7.00 as at May, 2015. None of the respondents earn below GH¢7.00 a day. Indeed, the least paid respondent earns an average of GH GH¢15.00 a day and the highest paid, earns GH¢ 50.00 a day (see Table 4.2). Table 4.2 estimates the daily mean wage among the respondents at GH¢17.36 plus or minus GH¢5.10005 standard deviation, showing that the wage distribution among the respondents was relatively fair.

**Table 4.2: Daily Wages of respondents**



| Measurements | Mean  | Standard Deviation | Median | Mode | Maximum | Minimum |
|--------------|-------|--------------------|--------|------|---------|---------|
| Wages (GH¢)  | 17.36 | 5.10005            | 15     | 15   | 50      | 15      |



Source: Field data November, 2014

#### 4.2.5 Religion of respondents

About 40 percent of patients surveyed identified themselves as Christians. Fifty five and five percent respectively profess the Islamic and Traditional faith. The dominant presence of Moslems at the CBD could explain their majority. Again, the study is in agreement with earlier study that some Christians believe that prayer improved their health (O'Cinnor, Pronk, Tan and Whitebird, 2005). Although, this could be a wild attribution, it does happen. Their hospital attendance could be reduced as a result of their religious background. The above is not too-well known of the other religions this study found.

**Figure 4.2: Religion of patient-respondents**

Source: Field data, November, 2014

#### 4.3 Perception of patients about healthcare delivery in private and public hospitals

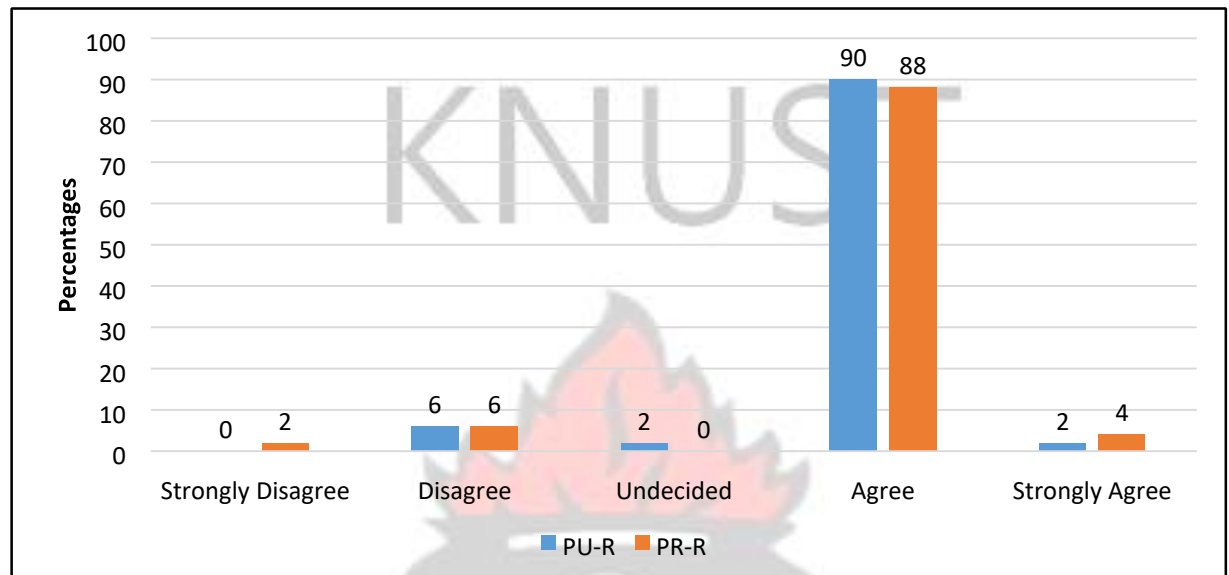
The study understands efficacy of treatment to have a relation with and /or as a factor of quality of healthcare. Studies have outlined indicators for assessing quality healthcare to have included 1) attitude of health workers as perceived by patients (Turkson, 2009) termed as friendliness of staff by Fenny et al. (2014), 2) waiting time 3) customers' satisfaction about the consultation process (Fenny et al, 2014), operationally defined by Turkson (2009) as whether patients were allowed to explain their problems well enough; patients were physically examined; were told what was wrong; were given instructions about illness; and whether other people were in the consultation room – privacy reasons. The fourth and fifth indicators literature mentioned are whether the prescribed drugs are received by patients and fifth, if the instructions given by the staff of dispensary are clear enough for the patient to follow (Turkson, 2009). Others are; 6) availability of facilities, drugs and essential materials and cleanliness of the hospital environment and facility. Quality of healthcare, however, appears to be matched with cost and affordability of services for effective healthcare delivery.

On this premise, this study assesses and compares the perception of patients of public and private hospitals about healthcare delivery within the CBD of Kumasi Metropolis. This was done using a likert scale assessment of the perception of patients on variables stated above including perception about cost and affordability of hospital services.

#### 4.3.1 Perception on efficacy of prescriptions, drugs and treatment

The study found no significant difference in the perception about whether treatment received at private hospitals cures ailments better than public hospital and vice versa. This is as shown in Figure 4.3 using a five-point likert scale. The statement each respondent answered was, "treatment receive at this facility cures my ailments effectively". In both public and private hospital respondents, the majority (90 percent and 88 percent) agree with the above statement. In the case of private hospitals, two percent strongly disagree citing an instance of what he suspected as wrong prescription leading to a prolong headache suffered. Six percent in both cases disagree with the explanation that they do not recover as speedy as they expected. This group, however, admitted that seeking medical attention from the hospital is a good decision; "it's better than dying from a curable disease" a respondent asserted.

**Figure 4.3: Likert scale ranking of perception of efficacy of healthcare at private and public hospitals**



Source: Field data, November, 2014

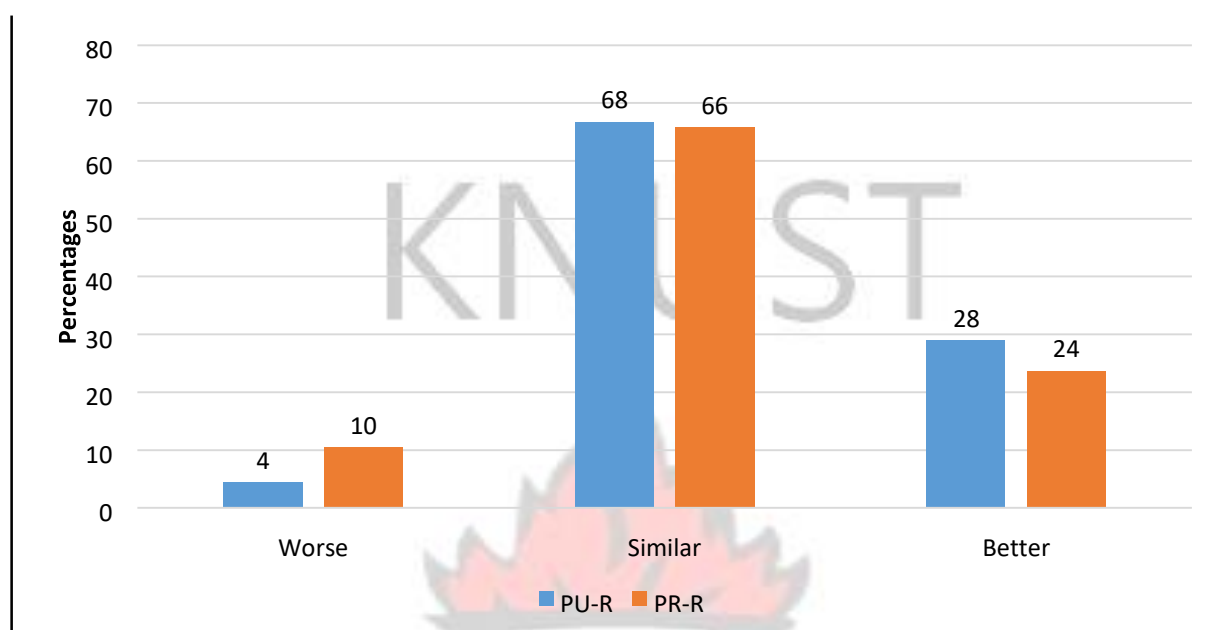
The researcher further used findings from Figure 4.4 to validate and compare the earlier perception on efficacy of treatment received at the facilities. To achieve this, the respondents were first asked whether they have received medical attention from other hospital type (thus, the PR-R<sup>1</sup> were asked if they had ever received treatment from public hospitals in the past; the PU-R<sup>2</sup> were also asked if they had received treatment from private hospitals in the past). About 84 percent of PU-R and 76 percent of PR-R answered in the affirmative.

A three-point likert scale interval indicating whether according to the patient-respondent, efficacy of treatment received at the previous other type (patient-respondent at public hospital has previous other type of hospital as a private hospital he/she has ever received treatment from and vice versa) of hospital was worse, similar or better, or than the current one.

<sup>1</sup> PR-R stands for patients of private hospitals

<sup>2</sup> PU-R stands for patients of public hospitals

Figure 4.4: Perception of efficacy of treatment at the current private/public hospital with previous other type.



Source: Field data, November, 2014

A critical analysis of results shown in Figure 4.4, appears to redefine the perception held among patients concerning efficacy of healthcare in private or public hospitals in Figure 4.3. In Figure 4.4, considering PR-R (10 percent) who rated past treatment experience with a public hospital as worse and PU-R (28 percent) who perceived past treatment experience with private hospitals as better alludes to the fact that perception of effectiveness of treatment at the private hospitals among patients could be higher. The same argument could be made for the 68 percent PU-R relative to 66 percent PR-R who see treatment of their current hospitals as effective/similar as the past other type of hospital. This perception of patients in Figure 4.4, the reception and the environment may explain why patients are not deter by cost and less affordability private hospital services (see Table 4.3)

#### 4.3.2 Assessment of perception of affordability of health services

The study defines affordability as how cheap or costly health services are to the patients considering the patients' income levels. The analysis of cost of treatment reported by the patients amount to an average cost of GH¢19.58 a month, plus or minus GH¢18.44 standard deviation. The mode was, however, GH¢2.10 a month. Forty eight percent of patients of private hospitals as against 96 percent of public consider cost of treatment affordable. The



income-health cost analysis conducted by the researcher further shows some variation. The income-health cost analysis showed that the least earned patients spent only about 2.6 percent of monthly income on health expenses. The average proportion of health expenses was, however, estimated at 4 percent of patients' monthly income on healthcare services accessed at the hospitals under study (see Table 4.4).

The cost of health services has shown to be more affordable for the patients on NHIS. From Table 4.3, an NHIS patient spends GH¢2.10 a month on healthcare while a nonNHIS patient would have to incur GH¢32.24 (over 153 percent). The least earned patient on NHIS spend only 0.5 percent of monthly income on healthcare at the facility, while the highest earned patient on NHIS spend about 0.1 percent. The reason being that a patient on NHIS pays an annual premium of GH¢25.00 to cover all health expenses insured under the NHIS. This is despite the frequency of hospital attendance. The study found 84 percent of patients at the public hospitals as active NHIS members and in all, identified 42 percent of patients surveyed to have subscribed to NHIS. None of the patients at the private hospitals could use the NHIS to cover cost of treatment even if the patients are active NHIS card holders. The private hospitals were not NHIS service providers at the time of the study.

**Table 4.3 Cost of healthcare delivery and income of patients**

| Variables          | Cost of healthcare services |            |                     |                         |                    | Income of patients (GH¢) |
|--------------------|-----------------------------|------------|---------------------|-------------------------|--------------------|--------------------------|
|                    | PR-R (GH¢)                  | PU-R (GH¢) | NHIS Patients (GH¢) | Non-NHIS Patients (GH¢) | All Patients (GH¢) |                          |
| Total Amount       | 1578.00                     | 380.20     | 88.20               | 1870.00                 | <b>1958.20</b>     | <b>48608.00</b>          |
| Mean               | 31.56                       | 7.60       | 2.10                | 32.24                   | <b>19.58</b>       | <b>48.61</b>             |
| Standard deviation | 13.91                       | 14.16      | 8.9E-20             | 14.22                   | <b>18.44</b>       | <b>142.80</b>            |
| Mode               | 19.00                       | 2.10       | 2.10                | 19.00                   | <b>2.10</b>        | <b>420.00</b>            |
| Minimum            | 11.00                       | 2.10       | 2.10                | 11.00                   | <b>2.10</b>        | <b>420.00</b>            |
| Maximum            | 65.00                       | 60.00      | 2.10                | 65.00                   | <b>65.00</b>       | <b>1400.00</b>           |

Source: Field data, November, 2014

Affordability of healthcare as regards private and public hospitals is therefore varied. The healthcare costs at private hospitals appear costly relative to the public hospitals. This is affirmed by Van den Boom et al. (2004) when the authors found that treatment at the private hospitals costs around 10 US Dollar for each visit while the minimum wage of Ghanaians was approximately 1.5 US Dollars a day, the two figures of which could inconvenience the poor from accessing health services. Table 4.3 shows that while PRR spent an average GH¢ 31.56 on healthcare, PU-R spent less at only GH¢ 7.60 a month.

#### 4.3.3 Perception about proximity, waiting time and duration of treatment

The study also assessed the perception of patients regarding physical access and duration of treatment including consultation periods at the two categories of hospitals. The results were compared. While the PR-Rs fall within an average distance of 2.94km, the PU-R are located within an average coverage of 7.68km (see Table 4.5). The wide difference was partly explained by the wider sphere of coverage of the Komfo Anokye Teaching Hospital due to its function as a referral centre. The inclusion of the Komfo Anokye Teaching hospital also partly contributes to the high average distance at 5.31km estimated in Table 4.4 for all hospitals. With the exception of the average distances covered by PR-R to hospitals, both the PU-R and all patients cover average distances higher than the maximum distance prescribe by the Ghana Health Service at 5km. About 40 percent of PU-R also access the hospitals from outside the 5km range. This figure was 4 percent for PR-R and 44 percent for all patients accessing the hospitals from beyond the 5km range.

**Table 4.4 Proximity to hospital**

|               | <b>Total Distance (km)</b> | <b>Mean (km)</b> | <b>Standard deviation</b> | <b>Mode</b> | <b>Minimum</b> | <b>Maximum</b> |
|---------------|----------------------------|------------------|---------------------------|-------------|----------------|----------------|
| Private       | 147                        | 2.94             | 2.34                      | 2           | 1              | 12             |
| Public        | 384                        | 7.68             | 6.12                      | 14          | 1              | 25             |
| All Hospitals | 531                        | 5.31             | 5.19                      | 2           | 1              | 25             |

Source: Field data November, 2014

The findings appear barely consistent with Van den Boom et al (2004) revelation that Ghanaians averagely live about 16km apart a healthcare facility. The same analysis above disagrees with the assertion by Van den Boom et al (2004) that half of the population cannot consult a doctor within 5km or one hour walking distance. The findings rather, to some extent, support Kumasi Metropolitan Assembly's (2010) position that there are enough hospitals and health facilities to serve the population of the metropolis.

The foregoing statistics notwithstanding, none of the patients has complaints about the distance. The patients' main concerns are the prolonged waiting time before treatment at the hospitals. The Institute of Medicine (IOM) recommends that, preferably, 90 percent of patients be seen around 30 minutes of their fixed scheduled time (O'Malley, et al, 1983). The extreme waiting time was estimated at 3 hrs 30 minutes (210 minutes)

(Table 4.5). In the public hospitals, a patient has to spend an average of 102.3 minutes (over 1 hour: 30 minutes.) before start of consultations with the doctor, while a counterpart patient at private hospitals spends less than 15 minutes before consulting with the doctor.

Duration of waiting time at the public hospitals has shown to be severe compared to the finding of Turkson (2009). Turkson (2009) estimated the average expected maximum waiting time for seeking medical assistance at rural public hospital at one hour. The difference to some extent reflects the rural-urban demand on public hospitals, however.

Patients in Turkson's study attributed long waiting times to avoidable delays at the pharmacy and injection rooms. In this present study, however, the inclusion of delays at the dispensary and injection rooms increase the estimated waiting time, which frustrate the patients, the more. The extreme case of waiting time has been implicit in Dalinjong and Laar's (2012) study of the Bolgatanga Municipality and the Builsa District both in the Eastern part of northern Ghana. The authors identified that patients spends the whole day at the hospital. There is evidence from the Netherlands and the US that motivation play a role in reference to reducing waiting times (Brouwer and Hermans 1999, Baker and Brown 1999). According to Blundell and Windmeijer (2000) waiting time is a price that influences people to choose alternative care from private hospitals, or not seek care at all when the waiting time gets too long.



**Table 4.5 Waiting time at hospitals in minutes**

| <b>Waiting time at hospitals</b> | <b>Total waiting time</b> | <b>Mean</b> | <b>Standard deviation</b> | <b>Mode</b> | <b>Minimum</b> | <b>Maximum</b> |
|----------------------------------|---------------------------|-------------|---------------------------|-------------|----------------|----------------|
| Private                          | 247                       | 4.94        | 4.76                      | 5           | 1              | 30             |
| Public                           | 5115                      | 102.3       | 66.83                     | 60          | 15             | 210            |
| All Hospitals                    | 5362                      | 53.62       | 67.94                     | 5           | 1              | 210            |

Source: Field data, November, 2014

On the whole, the study estimated the maximum waiting time before consulting a doctor at 30 minutes at private hospitals and 3hrs. 30 minutes at public hospitals. Congestions at the hospitals and especially for public hospitals, where the effects of NHIS on increased hospital attendance, inadequate staff and frequent breakdown of equipment have all been a factor undermining speedy administration of treatment. The prolonged waiting time has a major implication for reducing economic hour for hospital attendance (Kumasi Metropolitan Assembly, 2006). And because of this extreme hours spent at hospitals, people may ultimately be discouraged from seeking medical attention from hospitals or health facilities, a situation which could undermine the health of the population as well.

The study continues to assess patients' perception about the time they spend during consultations with the doctor. The issue of limited amount of consultation duration at the public hospitals relative to private hospitals was evident. The mean minutes spent by PR-R was estimated at 3.58 and 2.1 for PU-R (Table 4.7). While the majority of PR-R indicated to have spent 3 minutes with the doctor during consultation that figure for PUR stood at 2 minutes. The short consultation period found, especially at the public hospitals could be explained by what Marek (2003) and Ghana's Ministry of Health (2009) suggested. Marek (2003) argue that the introduction of free healthcare for everyone at hospitals and health posts in most developed countries led to crowding in clinics and a decline in consultation period and due partly to that, health workers felt pressurized into shortening the consultation time (Ministry of Health, 2009). Patients are, however, not dissatisfied with the short consultation duration. In fact, patients are rather not happy where it appears that a colleague in the consulting room is delaying, because they have waited in the queue for so long. This agrees with earlier finding that, consultation time was found to be influenced by the total number of patients seeking medical attention in a particular hospital (Heaney et al., 1991).



**Table 4.6: Consultation period at hospitals in minutes**

| <b>Duration of consultation</b> | <b>Total consultation time</b> | <b>Mean</b> | <b>Standard deviation</b> | <b>Mode</b> | <b>Minimum</b> | <b>Maximum</b> |
|---------------------------------|--------------------------------|-------------|---------------------------|-------------|----------------|----------------|
| Private                         | 179                            | 3.58        | 1.05                      | 3           | 2              | 5              |
| Public                          | 105                            | 2.1         | 1.18                      | 2           | 1              | 5              |
| All Hospitals                   | 284                            | 2.84        | 1.34                      | 3           | 2              | 5              |

Source: Field data, November, 2014

#### 4.3.4 Perception about the quality of consultation

The study adapted the operational definition of quality healthcare by Turkson (2009) as indicators for the consultation process and/or quality (Table 4.8). The researcher argued that the said indicators used by Turkson (2009) to assess quality of healthcare are inadequate and could rather be sufficiently use to assess quality of consultation, a subset of quality healthcare. The key finding from this assessment is that patients, either at private (76 percent) or public (90 percent) hospitals were not told what was wrong with them upon diagnosis. This contravenes Ghana Health Service Patients' Charter that provide for the right of patients to complete information on their situation and management and the possible risks associated with their ailment. The situation could be summarized in what one respondent indicated, "I was only given a sheet to send to the dispensary for drugs". Privacy was, however, assured in all cases except for two and four percent of PR-R and PU-R who explained that at the time of the consultation process some other hospital staff was around.

Unlike in the case of Turkson (2009) where only 46 percent of patients answered yes for being given clear instructions at the dispensary, the proportions of patients as found in this study are higher at 94 percent PR-R and 90 percent PU-R. The implication is that the hospitals appear to have complied with the Patient's Charter that charges health workers to inform and/or educate patients about their diseases. Turkson (2009) continue to argue that interaction between health workers and patients is an important element of patient satisfaction and that good communication and caring relationship are central in achieving patient satisfaction. Table 4.7 further shows the variations in the other responses given.

**Table 4.7: Indicators of consultation process: proportion of patients who answers ‘yes’**

| Indicators                                        | PR-R (n=50) | PU-R (n=50) |
|---------------------------------------------------|-------------|-------------|
| They were asked by doctor to explain problem      | 90.00       | 88.00       |
| They were physically examined                     | 94.00       | 88.00       |
| They were told what was wrong                     | 10.00       | 24.00       |
| They were given instruction /advice about illness | 66.00       | 48.00       |
| Other people were in consulting room (No privacy) | 2.00        | 4.00        |
| They received all prescribed drugs                | 64.00       | 80.00       |
| Instructions given by dispensary staff were clear | 94.00       | 90.00       |

Source: Field data, November, 2014

#### 4.3.5 Perception of attitude of health staff

The attitude of medical officers, OPD nurses, dispensary staff and record keepers at the hospitals were perceived satisfactorily friendly, friendly, normal, hostile and very hostile by patients. In Table 4.8, patients perceived staff to be friendlier in private hospitals than in public hospitals. In Ghana health professionals suggest that combining two jobs is tiring, leading to reduction in efficiency and undesirable attitudes toward patients. Invariably workers dedicate more time and energy to their private sector jobs (WHO, 2006). No patient reported a very hostile attitude from health workers. Nonetheless, four percent of P R-R relative to eight percent of PU-R said staff of the Record Keeping Department had ever been hostile to them. The same is said of OPD nurses; four percent PR-R and two percent PU-R and also two percent of public patients added that dispensary staffs are hostile sometimes. This revelation, however, appears to be an improvement upon what was observed as a general bad behavior of health workers towards patients (Ambler, G. et al., 2006). Generally, poor attitude of health personnel towards patients is seen as a likely source to tarnishing the image of the health service and frustrating efforts in enhancing quality and accessible healthcare for all Ghanaians. It is important therefore that hospitals become patient-friendly (Asante, A. D. et al., 2006). The expectation of the findings of this study therefore is that health personnelpatient relations will be enhanced as a form of doing away with human barriers of access to health service in the hospitals.

**Table 4.8 Attitude of health personnel towards patients <sup>3</sup>**

| <b>Perception<sup>3</sup></b> | <b>Record keepers</b> |                | <b>OPD nurses</b> |                | <b>Medical Officers</b> |                | <b>Dispensary staff</b> |                |
|-------------------------------|-----------------------|----------------|-------------------|----------------|-------------------------|----------------|-------------------------|----------------|
|                               | PR-R<br>(n=50)        | PU-R<br>(n=50) | PR-R<br>(n=50)    | PU-R<br>(n=50) | PR-R<br>(n=50)          | PU-R<br>(n=50) | PR-R<br>(n=50)          | PU-R<br>(n=50) |
| Satisfactorily friendly       | 30.00                 | 36.00          | 22.00             | 10.00          | 10.00                   | 10.00          | 6.00                    | 8.00           |
| Friendly                      | 44.00                 | 40.00          | 28.00             | 30.00          | 14.00                   | 10.00          | 86.00                   | 70.00          |
| Normal                        | 22.00                 | 16.00          | 46.00             | 58.00          | 76.00                   | 80.00          | 8.00                    | 10.00          |
| Hostile                       | 4.00                  | 8.00           | 4.00              | 2.00           | 0.00                    | 0.00           | 0.00                    | 2.00           |
| Very hostile                  | 0.00                  | 0.00           | 0.00              | 0.00           | 0.00                    | 0.00           | 0.00                    | 0.00           |

Source: Field data, November, 2014

Khali (2009), provided evidence that good patients were given special treatment while difficult patients were left unnoticed or their desired requests intentionally deferred. Non-cooperating patients could incur the displeasure of health staff and mar the kind of relation the staff would have offered – “patients sometimes behave like children”, a hospital staff indicated. This is yet not a justifiable reason for a hostile attitude of health workers towards patients - “there are even instances where patients who are of no fault got treated poorly by health workers” – one patient indicated. In reality, non-cooperating patients should be highly expected by health workers. It has shown that a patient in pain may be pre-occupied with what get him/her relieved and so may not heed to simple instructions.

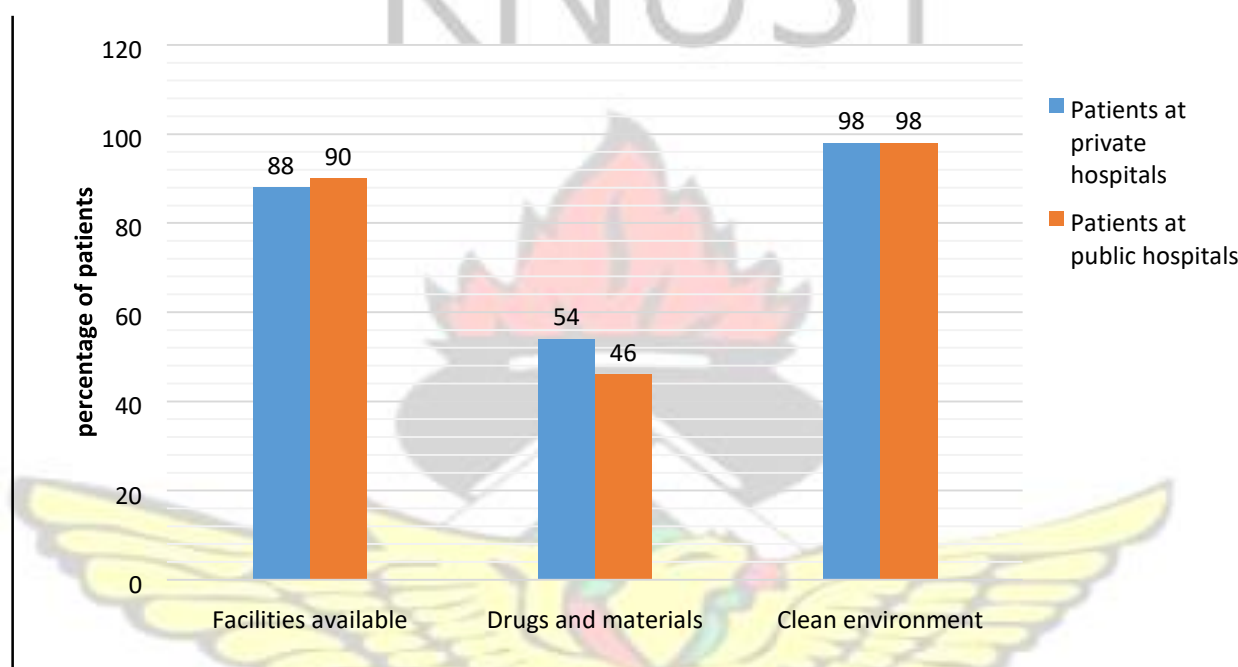
4.3.6 Availability of facilities, drugs and essential materials, and cleanliness of the hospital environment.

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<sup>3</sup> Figures on perception are in percentages of patients

Under this criterion, patients were asked to respond „yes“ or „no“ to three questions; per your experience with the hospital, 1) do you think this hospital has the facilities to provide for your need as expected, 2) do you get all the drugs you need for your treatment and 3) do you think the hospital environment including the wards are clean enough.

**Figure 4.5 Perception of availability of facilities, drugs/materials and cleanliness of hospital environment – the proportion that answers' yes'**



Source: Field data, November, 2014

In the case of question one, 88 percent as against 90 percent of patients at private and public hospitals believed that the hospitals have facilities to meet their health needs. Both proportions decrease sharply when it comes to drugs/materials, whereas on the reverse, more patients (54 percent) at private hospitals believed that the hospital has essential drugs and materials they need to be cured of their illnesses than 46 percent at public hospital. The issue of inadequate drugs has plagued especially, public hospitals for some time now. Non availability of drugs especially psychotropic drugs is another major issue mentioned in Ministry of Health Report, 2007. The issue of drug shortage is consistent with the finding of this study. Auditor General's audit report (2011) found out Public Hospitals owe their creditors for drugs supplied to them and the hospitals also treat NHIS insured patients which also locked physical cash. Patients at the public hospital said, "we are normally referred to private chemical sellers to buy drugs prescribed where unavailable" while another emphasized, "there was no instance I was not referred to go and buy the rest of my



prescribed drugs at a pharmacy shop”. For instance, the gravity of shortage of drugs amounted to a demonstration staged by nurses of the Accra Psychiatric hospital in May 2014 to register their displeasure over the unavailability of drugs and basic working equipment in hospitals (Daily Guide Newspaper Report by Stephen Zoure, Ghana News Agency, 2014). The third question on the cleanliness of the hospital and hospital environment recorded 98 percent each of patients acknowledging „yes“. This proportion is relatively high compared to the other two but consistent with the findings of Turkson (2009) where 97.4 percent of patients rated the hospitals and their surroundings as clean (very clean, clean and fairly clean).

#### **4.4 Challenges Affecting Healthcare Delivery in Private and Public Hospitals in CBD of Kumasi**

The third and fourth objectives the study achieved was to analyse challenges confronting healthcare delivery in public and private hospitals within the CBD of Kumasi Metropolis. As part of achieving this, challenges common and/or unique to public and private hospitals were itemized and analysed.

##### **4.4.1 Challenges common to public and private healthcare delivery in hospitals**

The Ministry of Health (MoH, 2008) and several other authors including Van den Boom et al. (2004) and IRIN (2008) point to the fact that the public health system in Ghana faces variety of obstacles. Van den Boom et al. (2004) mentioned inadequate personnel and funding among others for which the Ghana Health Service (GHS) calls forth the urgent need for more health infrastructure and skilled health professionals (IRIN, 2008). Similarly, in this study, inadequacies of equipment, logistics and staff were found to be major factors impeding effective healthcare delivery in public as well as private hospitals. Power outages, frequent breakdown of existing equipment and inadequate funding are the other challenges identified. There are varied degrees of these inadequacies between the public and private hospitals, however.

##### **4.4.2 Inadequate health professionals**

Shortage of doctors in hospitals has been attributed in part, to delay in posting of medical officers after house training, which (Nggaga, 2014) sees as potential grounds for doctors to seek „greener pastures“ abroad. He identified evidence that five doctors left for Namibia and Uganda in April, 2014. 268 doctors out of 486 finished the two years house job and were not engaged by the Ministry of Health (Daily Guide Newspaper Report by Thomas Fosu Jnr., Ghana News Agency, 2015) and those who completed Medical School almost seven months ago, are yet to start house job (Nggaga, 2014). He predicted that brain-drain in the health sector could re-emerged. This study, shown in Table 4.9, showed these inadequacies in both public and private hospitals surveyed. The overall backlog of staff is 50 percent and 38 percent for private and public hospitals respectively. Considering doctors, nurses, biostatisticians/record keepers and the workers of the dispensary unit, the public hospitals have shown to have less backlogs relative to the private hospitals. This difference is grave considering also that only two public hospitals are matched with three private hospitals. The high demands for public health personnel could be explained by the high public hospital attendance.

**Table 4.9 Health staffing of hospitals<sup>4</sup>**

| Staff positions           | Private hospitals |                 |         | Public hospitals |                 |         |
|---------------------------|-------------------|-----------------|---------|------------------|-----------------|---------|
|                           | Number Required   | Number Existing | Backlog | Number Required  | Number Existing | Backlog |
| Record keeping department | 08                | 06              | 02      | 12               | 10              | 02      |
| Nurses                    | 26                | 16              | 10      | 45               | 32              | 13      |
| Medical officers/doctors  | 15                | 04              | 11      | 18               | 11              | 07      |
| Dispensary unit           | 10                | 08              | 02      | 15               | 12              | 03      |
| Totals                    | 51                | 34              | 17      | 90               | 65              | 25      |

Source: Field data, November, 2014

#### 4.4.3 Inadequate logistics and facilities

<sup>4</sup> This statistics excludes Komfo Anokye Teaching Hospitals (KATH). The inadequacy of health personnel especially, doctors was also mentioned by KATH, but it was not possible to estimate in figures at the time of the study.

The study found among the hospitals that ambulance, computers, printers and photocopiers, chairs and televisions are inadequate. While erratic electricity supply coupled with water supply remain fundamental to all hospitals. This underlined

Dr. Kwabena Opoku Adusei's<sup>5</sup>, concern about lack of infrastructural facilities in the Government hospitals and appealed to the government to improve on the situation. A health worker also noted "The shortages render medical practice frustrating and as if is a wrong choice of profession. Generally, according to Dr. Oduro, the challenges included inadequate funds, transport and poor infrastructure in most hospitals and health centres; government should solve the problems to make the facilities more viable. Again, Table 4.10 shows, the situation to be more severe in the public hospitals relative to the private hospitals.

**Table 4.10 Hospital logistics and facilities**

| Logistics and hospital facilities | Private hospitals                        |              |         | Public hospitals <sup>5</sup> |              |         |
|-----------------------------------|------------------------------------------|--------------|---------|-------------------------------|--------------|---------|
|                                   | No. required                             | No. existing | Backlog | No. required                  | No. existing | Backlog |
| Vehicle-ambulance                 | 03                                       | 01           | 02      | 02                            | 01           | 01      |
| motor bike                        | 10                                       | 07           | 03      | 10                            | 06           | 04      |
| Hospital beds                     | 85                                       | 62           | 23      | 120                           | 100          | 20      |
| Desktop Computers                 | 25                                       | 14           | 11      | 35                            | 20           | 15      |
| Uninterrupted Power Supply (UPS)  | 25                                       | 05           | 20      | 35                            | 15           | 20      |
| Printer                           | 25                                       | 06           | 19      | 35                            | 04           | 31      |
| Photocopier                       | 03                                       | 02           | 01      | 02                            | 02           | 00      |
| Electricity                       | Erratic power supply                     |              |         |                               |              |         |
| Source of water                   | Erratic water supply due to power crises |              |         |                               |              |         |
| Plant/generator                   | 03                                       | 02           | 01      | 03                            | 02           | 01      |
| Chairs (pews)                     | 45                                       | 35           | 10      | 65                            | 45           | 20      |
| Television                        | 11                                       | 09           | 02      | 12                            | 05           | 07      |

Source: Field data, November, 2014

Inadequate materials, drugs<sup>6</sup> and equipment and frequent breakdown of equipment.

<sup>5</sup> Dr. Kwabena Opoku Adusei is a Medical Superintendent of Suntreso Hospital, Kumasi

Stationeries and communication gadgets including, computers and photocopiers are reported to be in short supply. Not only has specialist drugs for treating diseases such as diabetes, HIV and AIDS been found to be in short supply and/or unavailable, but patients sometimes have to be referred to private chemical shops for commonly demanded drugs such as amoxicillin and quick action. A half year report (2012) of Ministry of Health revealed that major component of the infant mortality is neonatal mortality (accounting for between 80-85% of deaths). This is due to inadequate numbers of trained staff, equipment and facilities to manage neonatal conditions that leads to death.

All hospitals visited reported breakdown of equipment. The study is consistent with the Auditor General's audit report (2011) which found out that all four hospitals complained about broken down equipment and machinery due to inadequate funds and lack of human capacity. It emerged that, blood pressure apparatus, dressing and delivery sets, auto-cliff and comber are normally in short supply. Scales, though break down sometimes, are not in short supply. It could be seen in Table 4.10 that dressing sets appears to be the most material with a high backlog. The breaking down of equipment will reduce revenue generation as new equipment needs to be purchased (Auditor General Report, 2011). At the same time existing health infrastructure are deteriorating and equipment are fast becoming obsolete thus undermining quality of care, (MoH, 2007).

<sup>6</sup> The question as to drugs required and available was not responded to. Rather, the drugs that usually fall short of demand were listed.



**Table 4.11 Materials and equipment assessment**

| Materials, and equipment | Private hospitals |              |         | Public hospitals |              |         |
|--------------------------|-------------------|--------------|---------|------------------|--------------|---------|
|                          | No. required      | No. existing | Backlog | No. required     | No. existing | Backlog |
| Auto-clif                | 03                | 01           | 02      | 03               | 01           | 02      |
| Comber „Fridge“          | 06                | 03           | 03      | 04               | 02           | 02      |
| Thermometer              | 15                | 06           | 09      | 08               | 06           | 02      |
| Scale                    | 03                | 03           | 00      | 02               | 02           | 00      |
| Blood pressure apparatus | 04                | 03           | 01      | 04               | 04           | 00      |
| Dressing Sets            | 30 <sup>6</sup>   | 05           | 25      | 25               | 10           | 15      |
| Sphygmomanometer         | 06                | NG           | -       | 06               | NG           | -       |
| Stethoscope.             | NG <sup>7</sup>   | NG           | -       | 03               | 03           | 00      |
| Delivery Set             | NG                | NG           | -       | NG               | NG           | -       |
| X-ray Scan               | 03                | 02           | 01      | 02               | 02           | 00      |

Source: Field data, November, 2014

#### 4.4.4 Frequent power outages

The toll of frequent power outages is also equally felt by the hospitals. There are a-12hour power outages every two days, with intermittent hour or less light outs. This happens every 2<sup>nd</sup> week and another. It was evident that electricity affects every aspect of hospitals' operations. Activities in the hospitals almost come to a complete halt when there is power outage. The effects of inadequate electricity supply on health are diverse and far reaching. From first aid to the giving of multi-faceted medical treatments, it is clear that healthcare delivery depends very much on electricity. Energy was considered by the United Kingdom's Department of Health as very paramount without which most other service will fail to work (Department of Health, 2007). In a survey undertaken in Japan, it was revealed that 65% of tragedy base hospitals (i.e. hospitals which serves as backups in times of emergency) estimates electricity to be the most vital link for the operation of their hospital. The survey further discovered that 60% of these hospitals felt that lifeline services such as

<sup>6</sup> Dressing sets are per week

<sup>7</sup> NG = Not given

immediate surgical treatment and haemodialysis could not be performed if electricity is absent would have to be stopped is absent. Basic apparatus allied services like laboratory services, imaging and sterilisation would also not work if electricity failed (Okamoto, 2013).

As found by the study, the hospitals cope by relying on installed power plants and generators, however, just like any other enterprise, using installed plants and generators increase cost of running the hospitals. This cost includes installation, fuel and maintenance costs. An alternative to completely adapt to the frequent power outages is for the hospitals to rely solely on the power plants since the electricity from the national grid has been disappointing. This suggestion was, however, unwelcome. A respondent express his disagreement with the suggestion as, “continuous reliance on the power plants could cripple the hospital’s operation in a week; the exorbitant cost being incurred is just unbearable”. Braimah and Amponsah (2012) for instance attributed GHC15.50 additional cost incurred per month by micro and small industries who adopted alternative power sources to cope with frequent unannounced power outages in Kumasi Metropolis for using alternative sources of power for their business operations. The hospitals surveyed also associated delayed service delivery and some deaths (from delivering, surgery among others)<sup>8</sup> with power outages.

#### 4.4.5 Challenges unique to public hospitals

Congestion was identified at the public hospitals as intense. The hospital faces on daily basis, challenges such as overcrowding and congestion of departments and wards by patient. These challenges pose a threat to effective and efficient health care delivery at the hospital (MoH, 2007). The study used two criteria to estimate congestion at the hospitals: 1) by using number of hospital beds required by patients relative to the existing ones and 2) sitting spaces provided at the OPD against the number required. The analysis based on observations and hospital records revealed an average of 8 percent backlog of hospital beds weekly. This, however, excludes Komfo Anokye Teaching Hospital, except in emergency

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<sup>8</sup> Suntreso and KATH mentioned that but for power outages, some deaths from delivery and surgery could be prevented.

cases where patients exceed the beds available. Its referral functions could also explain why congestion is prominent.

The poor and uncoordinated referral practices are made worse by congestion in almost all the referral hospitals (MoH, 2012). Maternal and child deaths are still unacceptably high. The situation is compounded by the congestions at both the Paediatric, Obstetrics and Gynaecology wards (MoH, 2007). Ghana Broadcasting Corporation, Ghana News Agency, 2015, reported that Medical Director of the hospital, Dr. Peter Bafour, who confirmed this, said though congestion at the facility has been an annual recurring issue, the current situation has been overwhelming considering the high number of people that visit the hospital on a daily basis. The worst hit of congestion is the children's ward, which now accommodates between 60-70 babies as against 41 beds.

Observations at the OPDs of surveyed public hospitals saw patients standing. The patients were standing as a result of the fact that the chairs (sitting spaces) provided were exhausted. It was observed that it took maximum of 6 minutes for one patient to move to the next chair to create space for the other patients. A count was undertaken revealed that at least 11 patients stand a while for the other patients occupying the seat to move forward to the next seat when one gets called to the consulting room. This "shift and create space for others" happens but very slowly. The issue is so disturbing that some expectant mothers involuntarily delivers on seats meant for visitors who call at the wards to see to their relatives. Daily Guide Newspaper Report by Vincent Kubi, Ghana News Agency, 2014, reported from Tema Hospital that some pregnant women due delivery as a result of the difficulty they go through all the time, sometimes experience stale birth or die at end. The report continued that nursing mothers stay on one bed, while those in labour manage on benches and wait for their turn. Situation at the hospital keep on getting worse each day as the population of Tema continue to grow.

Congestion at the private hospitals was non-existent during the visits to the hospitals. The information provided by the hospital administrators and from the hospital reports reviewed also confirmed the above observation that the private hospitals under study do not experience congestions.



#### 4.4.6 Challenges unique to private hospitals

Non-availability of doctors at the facility at certain hours was a challenge and it was observed that some of the doctors are regular medical officers in the government hospitals. When their services are needed in their formal facility where they have been employed, then they (patients) will not meet the doctors at the facilities and/or left unattended to. This also demonstrate the severity of inadequate doctors at the private hospitals (see also Table 4.9) and the implications it could have on emergency cases. The study contradict earlier findings by Brugha and Pritz-Aliassime (2003) where women living in rural Nigeria are reported to choosing private obstetric services over public services in that doctors were always present at the time of patients visits.

#### 4.5 Conclusion on findings

The study uncovered no significant difference in the perception of patients about effectiveness of treatment received at private and public hospitals in curing ailments. Yet healthcare cost was perceived less affordable and higher in private hospitals relative to the public hospitals. The NHIS was identified a major factor responsible for the low healthcare cost at the public hospitals. The NHIS on the other hand, was found to contribute to significant increase in hospital attendance, prolonged waiting time and congestion at the public hospitals.

In addition, hospital operations are undermined by frequent power outages and breakdown of equipment, inadequate staff and logistics. These challenge effective healthcare delivery in both private and public hospitals. Congestion, however, was found unique to have been constraining public hospitals' operations. And particular to the private hospitals, non-availability of doctors at certain hours was a challenge. Despite all, proximity to health facilities was found favorable by patients. This enhances physical access to the hospitals.

### CHAPTER FIVE

#### SUMMARY OF FINDINGS, RECOMMENDATIONS AND CONCLUSIONS

##### 5.1 Introduction

The study assesses the challenges of healthcare delivery in public and private hospitals in Kumasi metropolis and evaluates patients' perception about the healthcare delivery in these



facilities. This chapter gives a summary of the findings to which recommended possible actions are outlined for improved healthcare delivery within the Metropolis. The chapter therefore concludes based on the findings analysed and discussed in chapter four in line with set research objectives.

## 5.2 Summary of Findings

The study assessed patients' perception along the parameters of perception of 1) efficacy of prescriptions, drugs and treatment, 2) affordability of health services, 3) proximity, waiting time and consultation process/quality, 4) attitude of health staff and, 5) Availability of facilities, drugs and essential materials, and cleanliness of the hospital environment. The findings as compared between public and private hospital patients showed a mixed perception. This is consistent with the new evidence from a multicountry studies that suggest that quality of healthcare provision are the same in the public and private health sectors (Reinikka and Svensson, 2003). Another objective the study achieved was to ascertain and compare the challenges public and private hospitals are confronted with in their operations as well as establish the challenges that are common and/or unique to each hospital type.

### 5.2.1 Patients' perception of healthcare delivery

It was found that patients' perception about efficacy of healthcare delivery in public hospitals do not differ significantly from the private hospitals. About 92 percent of patients of public hospitals agree<sup>9</sup> that prescriptions, drugs and treatments received at the hospitals as effective to restoring their health conditions, the same proportion estimated at 92 percent (88 percent agreed and 4 percent strongly agreed) of patients of private hospitals also believes healthcare at private hospitals are effective. A further validation assessment (Figure 4.4) however, appear to suggest that patients perceived in the treatments received in the past in the private as more effective compared to the public hospitals than currently.

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<sup>9</sup> "Agree" is used here to combine agreed and strongly agreed proportions

Patients received the above treatments at an average cost of GH¢19.58 a month, plus or minus GH¢18.44 standard deviation. It emerged from a comparison between patients' income levels and healthcare cost that, the least earned patients spend about 2.6 percent (or 0.5 percent, if on NHIS ) of monthly income on health expenses whiles, the highest earned patient (who was also found to be on NHIS) spend 0.1 percent of income on healthcare. The average proportion of health expenses was, however, estimated at four percent of patients' monthly income on healthcare services accessed at the hospitals. All these were deemed affordable by the patients.

Nonetheless, the ease with which patients pay for the healthcare services at the public and private hospitals vary. The assessment of perception of patients about the affordability of services reveals that patients at the public hospitals pay less compared to private hospital patients. The private hospital patients incurred an average of GH¢

31.56 on healthcare, public hospital patients spend less at only GH¢ 7.60 a month.

Another factor of cost and affordability this study analysed is proximity to the hospitals. Private hospital patients fall within an average distance of 2.94km, the mode was 2km whiles, the minimum and maximum distances are within 1km and 12km. Except the maximum distances, the mean and mode fall within the permissible coverage of 5km prescribed by the Ghana Health Service for effective healthcare delivery. In the case of public hospitals however, average distances is estimated at 7.68km, whiles the mode is 14km.

The issue of waiting time and consultation duration at the hospitals was also considered. The study estimated the maximum waiting time at 30 minutes at private hospitals and 3hrs. 30 minutes at public hospitals. The low cost of treatment due to the acceptance of NHIS cards at the public hospitals appears to have attracted patients. This increases the numbers leading to congestions at the hospitals and especially the public hospitals, where also, the effects of NHIS on increased hospital attendance, inadequate staff and frequent breakdown of equipment have all been a factor undermining speedy administration of treatment.

The prolonged waiting time has a major implication for reducing economic hour for hospital attendance (Kumasi Metropolitan Assembly, 2006) who wished for more hours to undertake their economic activities to boost income and to better living conditions.

Patients expressed dissatisfaction about the extreme waiting time at the hospitals.

The study continued to assess patients' perception about the time they spend during consultations with the doctor and found that patients would even prefer a shorter consultation period than this study found. This is largely explained by the frustration from the extreme hours patients spend waiting. The mean minutes spent by public hospital patients was estimated at 2.1 and 3.58 for private hospitals. While the majority of PR-R indicates to have spent 3 minutes with the doctor during consultation, that figure for PU-R stood at 2 minutes. Patients, however, are not dissatisfied with the short consultation duration. In fact, patients are rather not happy where it appears that a colleague in the consulting room is delaying.

This study, however, argues that the short consultation period and the impression created by patients has treacherous implications which could amount to enormous health complications. The likelihood is that the doctor may not have the full appreciation of the patients' health conditions as a result of the short consultation period, a situation which may lead to incorrect diagnosis, wrong prescription and treatment. All this could culminate into complicating the health status of patients.

#### 5.2.2 Challenges confronting healthcare delivery in the facilities

Among the problems found to have been undermining effective health care delivery at the public and private hospitals are inadequate equipment, logistics and staff. Irregular water flow caused by power outages, frequent breakdown of existing equipment and inadequate funding are the other challenges identified. The needs assessment reveal that public hospitals are affected more compared to the private hospitals. There are varied degrees of these inadequacies between the public and private hospitals.

### 5.2.3 Challenges unique to hospitals

Particular to private hospitals, doctors are found to be unavailable at certain hours. This could have adverse implications on emergency cases. On the other hand, Public hospitals are identified with what could be termed severe congestion problem. This stems from the high hospital attendance exacerbated by inadequate staff. Both challenges, however, undermine responsiveness at the hospitals, leading to the frustration of both patients and the existing health personnel and complication of the health of patients seeking medical attention as well.

## 5.3 Recommendations

### 5.3.1 Implement doctor-spot in medical schools and post doctors/nurses promptly

It has been said that the problem of inadequate doctors and other health personnel in Ghana is partly a factor of unfair distribution or delayed posting of doctors within the country. One innovative measure to minimize this problem is for the Health Ministry, the Ghana Health Services and Medical Schools to implement a scheme that admit and train students allocated to areas and hospitals before they complete training. In this way, the allocation will be done fairly and each student doctor (student nurse) knows the area and facility he/she will be serving after training. This scheme will however give a strong support to efforts aimed at addressing the existing impediments at the Accountant Generals Department, the Ghana Health Services and Ministry of Health that tend to delay prompt posting of doctors to or after house training job.

### 5.3.2 Documentary on patients and staff behavior at hospitals

The Health Ministry and the Ghana Health Service in conjunction with the Ghana Medical Association and the media could compile a documentary on patients and staff interaction at hospitals or health facilities. The essence of this documentary will be to show instances that result into poor attitude either from the patients or staff towards the other. And more importantly, establish the strategies some health personnel has been using to successfully manage difficult patients and to maintain cordial staff-patient relations. This could be



shown on Television and/or uploaded on a Compact Disc (CD) and distributed to health facilities to be played for awaiting patients.

#### 5.3.3 Periodic information giving

The long waiting hours could be frustrating for patients and at the least provocation, lead to poor attitude from the patients. What this study recommends is that patients awaiting consultation should be given periodic updates on issues such as when a doctor will be taking a break, lunch, replaced by another doctor who is yet to come and any other challenges undermining efforts of health staff to speed up processes at the facility. For instance, “we beg your pardon, it’s time for doctor to have his lunch, he will be with you shortly”, “we are waiting for the next doctor, sorry, he has been caught up in a traffic” – these are the little magic that could ease tension and do away with suspense that patients are normally faced with, not knowing why „the queue does not seem to be moving“. But currently appears to be overlooked in many hospitals and/or ineffectively done in few hospitals or health facilities. A nurse or a student on attachment could be assigned this role.

#### 5.3.4 Organize a periodic patient management workshop for health workers

The study see the need for a periodic workshop that train and elicit feedbacks from health personnel on staff-patient relations within the health facilities. This is to equip personnel with better patient management skills and for them to learn from experience for the achievement of optimum staff-patient relations within the facilities.

#### 5.3.5 Implement a water-harvesting scheme in all hospitals

Irregular flow of water to hospitals could be minimized by drilling more boreholes and harvesting rainwater that could be treated to be used for all purposes within the hospitals. This is currently happening but more hospitals needed to be encouraged to adopt the strategy to augment water supply to the facilities. The cost involved could be financed from the hospitals’ Internally Generated Fund, government of Ghana and Nongovernmental organizations such as Action Aid, Ghana.

#### 5.3.6 Improve upon quality of consultation and communication between staff and patients about illness and lifestyle.

Physical examination of patients was not too high from the study and it emerged also that most patients were not told what was wrong after diagnoses. The study recommends that doctors ensure that patients are physically examined. At least, this will give patients the confidence that they have been properly diagnosed and that prescriptions are not based on guess work. It is also important that doctors ensure the patient know exactly what is medically wrong for them to manage their lifestyle. This study acknowledge that health personnel know these but, perhaps, due to the pressure as a result of the large number of patients, would want to speed processes by overlooking this all important requirement. This study emphasize that doctors inform patients always about their health conditions, not just because of its requirement by the Patients' Charter of the Ghana Health Service but more importantly, the practical benefit it will be for the patients to manage their lifestyle.

#### 5.3.7 Improve conditions of service of health workers

The persistent referral of patients to buying drugs from private chemical shops could be minimized by impressing on government to increase budgetary allocations to the health sector to buy more drugs to stock the public hospitals. Proposals should also be developed by hospitals to seek such support from non-governmental organisations whose focus is to ensure healthy population. Through this, facilities and logistics, clinical equipment, materials and drugs could be procured to augment government efforts. Issues to do with the fair emolument of health personnel could be addressed by reviewing the implementation of the single spine salary structure and the constitution of clear terms of service advocated by the Ghana Medical Association.

#### 5.3.8 Better management of the NHIS Scheme to encourage more private hospitals/health facilities to become service providers

The congestions at the public hospitals has been linked to increased hospital attendance influenced by NHIS subscribers and this congestion could be significantly reduced where

the NHIS is made attractive to the private health service providers. It is evident that not many private hospitals are interested in becoming service providers under the NHIS due especially, to delay in claims payment by the National Health Insurance Authority (NHIA). This paper sought to argue that effective implementation of the capitation grant under the NHIS will represent a strong management strategy to cut down leakages and cost, improve prompt claims payment and to render the NHIS attractive to the private health service providers.

#### **5.4 Suggestion(s) for Further Research**

The variables used in the study were not exhaustive. Further research could integrate other challenges such as worker morale, incentives, competence, training, etc. Other researches can continue to explore further, the impact of these stated challenges on quality, effectiveness and efficiency of healthcare in Ghana.

#### **5.5 Conclusion**

The study achieved the first research objective by showing that the difference in perception of patients about healthcare delivery in public and private hospitals within the CBD of Kumasi Metropolis was mixed considering the various factors assessed. The difference in perception among patients on effectiveness of treatments received at both facilities was not significant, while private hospital services were deemed relatively less affordable. Attitude of staff at private hospitals was perceived relatively friendlier than in public hospitals. The study was also able to estimate and to affirm patients' worry about the extreme waiting time before consultation at the public hospitals relative to the private ones.

Objective two of the research also shows that healthcare delivery in both private and public hospitals are undermined by challenges such as frequent power outages and breakdown of equipment, inadequate staff and logistics. These challenge healthcare delivery in both private and public hospitals. And for research objective three, congestions was found unique to have been constraining public hospitals' operations, while no challenges was identified particular to private hospitals. Despite all, proximity to health facilities was found favorable by patients. This enhances physical access to the hospitals.



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## **APPENDICES**

### **APPENDIX A: QUESTIONNAIRE**

#### **AIRBORNE CHALLENGES IN HEALTHCARE DELIVERY IN PUBLIC AND PRIVATE HOSPITALS IN THE KUMASI METROPOLIS: A STUDY OF SELECTED HOSPITALS**

#### **DEPARTMENT OF PLANNING**

#### **KWAME NKRUMAH UNIVERSITY OF SCIENCE AND TECHNOLOGY**

Dear Respondent,

I am carrying out a study on assessing the perception of patients about and challenges in healthcare delivery in public and private hospitals in the Central Business District of Kumasi metropolis. The following questionnaire is for patients like you. It is against this background that you have been selected to participate in the research by completing the questionnaire. It would thus be very helpful if you assist by answering the questionnaire as per instructions at the beginning of each section. You are required to provide the most appropriate answer in your opinion. Your responses will be kept confidential. In any case the questionnaire is anonymous. Thank you.

Yours faithfully,

.....

Mavis Ayensu

Researcher

#### **Respondents' Background Information**

Please help us classify your response by supplying the following facts about yourself and your opinion on the raised issues by ticking an appropriate box. There is no right wrong answer therefore no particular response is targeted.

1. Age.

18-25 [ ] 26-35 [ ] 36-45 [ ] 45-60 [ ] Over 60 yrs [ ]

2. Sex:

Male [ ] Female [ ]

3. Marital Status:

Single/Divorce [ ], Married [ ] Divorced [ ]

4. Educational level

[ ] 2nd Degree [ ] 1st Degree [ ] HND [ ] Basic / Secondary [ ] Uneducated [ ]

5. What is your occupation?.....

6. Income level (Minimum Wage)

[ ] GH¢ 1- GH¢ 14 [ ] GH¢15 - GH¢29 [ ] GH¢30 - GH¢44 [ ] GH¢45 - GH¢60

7. Which Religion do you belong to?

[ ] Christian [ ] Muslim [ ] Traditionalist [ ] Others

### **Perception of Patients about Healthcare Delivery**

8. Did treatment receive at this facility cures your ailments effectively?

[ ] Strongly Disagree [ ] Disagree [ ] Undecided [ ] Agree [ ] Strongly Agree [ ]

9. Have you ever received treatment from public/private hospitals in the past?

[ ] Yes [ ] No

If „Yes“ how do you rate the treatment from previous hospital?



☐ Worse ☐ Similar ☐ Better

10. Have you subscribe to any Health Insurance Scheme?

☐ Yes ☐ No

11. How much do you spend monthly on your health?

☐ GH¢ 1- GH¢ 15 ☐ GH¢16 - GH¢30 ☐ GH¢31 - GH¢45 ☐ GH¢46 and Above

12. What is the distance between your house and health facility?

☐ 1km – 3km ☐ 4km – 6km ☐ 7km -10km ☐ 11km and Above

13. How many minutes did you have to wait to see a doctor at this hospital? ☐ 1-30

minutes ☐ 31-60 minutes ☐ 61-90 minutes ☐ 91-120 minutes

☐ Others, specify .....

14. How many minutes did you spend with the doctor?

☐ 1 minute ☐ 2 minutes ☐ 3 minutes ☐ 4 minutes ☐ 5 minutes and Above

15. Were you given this information when you visited the hospital?

| Indicators                                        | Yes | No |
|---------------------------------------------------|-----|----|
| You were asked by doctor to explain problem       |     |    |
| You were physically examined                      |     |    |
| You were told what was wrong                      |     |    |
| You were given instruction /advice about illness  |     |    |
| Other people were in consulting room (No privacy) |     |    |
| You received all prescribed drugs                 |     |    |
| Instructions given by dispensary staff were clear |     |    |

16. How do you rate the attitude of the following health workers in this hospitals.

| Health Worker             | Satisfactorily<br>Friendly | Friendly | Normal | Hostile | Very<br>Hostile |
|---------------------------|----------------------------|----------|--------|---------|-----------------|
| Record Keepers            |                            |          |        |         |                 |
| OPD Nurses                |                            |          |        |         |                 |
| Medical Officers          |                            |          |        |         |                 |
| Pharmacy/Dispensary Staff |                            |          |        |         |                 |

17. How is your experience in this hospital per the following?

| Variables                                                 | Yes | No |
|-----------------------------------------------------------|-----|----|
| Did the hospital have the facilities to provide your need |     |    |
| Did you get the drugs you needed for your treatment       |     |    |
| Do you think the hospital environment was clean enough    |     |    |

Thank you for your time.

**APPENDIX B: INTERVIEW GUIDE ON CHALLENGES IN HEALTHCARE  
DELIVERY IN PUBLIC AND PRIVATE HOSPITALS IN THE KUMASI**

**METROPOLIS: A STUDY OF SELECTED HOSPITALS**

**DEPARTMENT OF PLANNING**

**KWAME NKRUMAH UNIVERSITY OF SCIENCE AND  
TECHNOLOGY**

The purpose of this interview guide is to collect data for academic purposes as a partial fulfillment of requirement for the award of Master Degree. I am carrying out a study on assessing the perception about and challenges in healthcare delivery in public and private hospitals in the Kumasi metropolis. It is against this background that you have been selected to participate in the research by helping to get answers to the questions in this guide. You are required to provide the most appropriate answer in your opinion. Your responses will be kept confidential. Thank you.

**SECTION A: General information**

1. Level of Education:

Basic [ ]      Secondary [ ]      Tertiary [ ]

2. For how long have you been working with this hospital?

Up to 3years [ ]      4 to 6years [ ]      7 to 10years [ ]      over 10year [ ]

3. What is your position in this hospital?

Management staff [ ]      Senior staff [ ]      Junior Staff [ ]

## SECTION A: Healthcare Challenges

4. What logistics and facilities do you have in this hospital?

.....

.....

.....

5. What materials and equipment do you have in this hospital?

.....

.....

.....

6. What challenges do you encounter in delivering health care as a health worker in this hospital?

.....

.....

.....

7. Do you think other hospitals (public/private) have these challenges too?

☐ Yes      ☐ No

8. Which of the challenges stated above would you consider peculiar to your hospital?

.....

.....