CHAPTER 1

INTRODUCTION

Over the past decades a lot has been said about strategies for improving the socioeconomic standards in developed and developing nations. In the case of developing countries some of the most important initiatives are increasing the literacy level, enhancing environmental sustainability, improving community health, and public-private sector collaboration in providing social and economic services.

With regard to health, governments and international donor agencies are collaborating to make healthcare accessible and more affordable to all because of the importance of this sector in socioeconomic development. Healthcare became a common issue of discussion in many conferences and summits with the purpose of forging ahead a better healthcare delivery reforms and policies. A recent reform targeting developing nations was the implementation of the Millennium Development Goals (MDGs) in which health formed a major component. Studies indicate that most health reforms adopted in many developing nations have helped in bridging the gap between the poor and the rich (Roos et al., 2006: 124).

In Ghana, the policy makers have perceived the public health sector as one of the basic services for the people and, therefore, given a priority in State spending and planning in the country. Such importance given to the healthcare is driven from the constitution of Ghana which accords the citizen the fundamental right to attain universal and equitable access to basic health services. A most recent policy in the health sector was the implementation of National Health Insurance Scheme (NHIS) as part of the
MDGs aimed at increasing accessibility and affordability of health services. Despite the efforts made by successive governments to improve better health delivery, there still remain a lot to be done. Health services are said to have only improved in the urban centers leaving the majority of rural areas with less access to health facilities. The nation suffers from diseases such as malaria, tuberculosis, measles, trachoma, and diarrhea. Many regions still lack facilities for the treatment of mentally disabled people coupled with the migration of health professionals outside the country. Infrastructure provision is unevenly distributed and rural people are negatively affected while investment in the health sector has not been favorable over several years. In addition, government subsidies to the rural people have not been favorable in the past decades: 12.3% in 1989, 11.6% in 1992, and 12.5% in 1998 (Canagarajah and Porter, 2003: 10).

Considering the above problems there is a need for studies to investigate how the nongovernmental health sector complements the government in providing healthcare. The supply of healthcare is not correspondent to the demand for the services. Healthcare providers would like to increase their services but due to scarcity of both financial and technical resources they are unable to supply large amount of services demanded by patients.

Private health providers refer to those individuals (civil society) or groups (Non-governmental Organizations [NGOs]) who provide health services outside the direct control of the government and they are mostly based on curative services. These providers can also be described as nonpublic health sector. In some developing countries (i.e. Ghana), the private sector comprises both modern and health providers. In the case of modern private health providers on one hand, governments on certain occasions sub-
contract preventive services (i.e. immunization) to them as the case of Ghana. The private health providers are also divided into for-profit and not-for-profit health providers. For-profit providers include those who charge fees for the services they provide and they are mostly found in urban centers. Some of them are the individual private clinics and pharmacists/drug stores. As for Not-for-profit healthcare providers, they refer to individuals or organizations providing health services with either for free or for a relatively low fee. These not-for-profit providers are also divided into three groups: religious organizations mostly found in rural areas, community-based organizations common in rural areas, and local and international NGOs found in both urban and rural areas (i.e. Plant Parenthood Association of Ghana). The traditional health providers (traditional healers) on the other hand provide spiritual healing and they formed a significant source of rural healthcare especially in areas where modern services are not available. They may be described as both for-profit (those in groups) and not-for-profit health providers (individuals in rural areas). However, this study is based on the sector that provides modern healthcare.

Private participation in the provision of social services was one of the issues that gained prominence in Ghana in recent years in the light of shrinking public budgetary allocation which inhibits the government’s capability to provide essential amenities for the people. Both the public and the private sectors have shared responsibilities for providing social services in the country. In the part of private sector, one of these responsibilities is the private health sector’s contribution in the provision of modern healthcare. Their operations is said to be accelerating in the country but this was done in the Southern part of the country. For instance, one of the studies carried out in Greater
Accra region investigated the historical perspectives of private health providers in the region including their potentials, strengths, and weaknesses. The study found that the private health sector serves about 35% of the population nationwide, and with regard to Greater Accra region, they provide about 50% to 60%, mostly based on curative care (Obuobi et al., 1999: 33). A comparative study between two private health providers (one in Ghana and the other in Uganda) on community health insurance found that the number of people who usually sell their properties and those who used to borrow monies for healthcare have reduced after joining the scheme (Okello and Feeley, 2004). However, the studies were limited in scope and also based on only the private health sector. There is however, little information about the private health sector services in the Northern part of the country and comparatively with the other stakeholders like the public health sector. This is what the current study critically analyzed.

The study investigates whether the private health sector promotes equitable access to health services, and provides affordable and quality healthcare to all categories of people in the Northern region. The region witnessed a number of both inter and intra-ethnic conflicts between 1981 and 2001, and this alone could discourage most workers to accept postings to the area especially the medical personnel. Again, less than 10 out of the 20 districts in the region have private health facilities and majority of these providers are found in the regional capital, Tamale.

The study employs comparative study between two public health providers and two private health providers (one for-profit and the other not-for-profit). The study will contribute directly to the understanding of the role of private health sector to the
socioeconomic development of the country. This study will also be vital source of information for policy making consideration and encourage further research in this area.

**Background to Research Problem**

The major threat of people’s health in the Northern region is malaria and the region is leading among the 10 regions in the country. Others are cerebral spinal meningitis, guinea worm, and increases in malnutrition. One of the reasons could be attributed to unequal distribution of health facilities in the region that led to less accessibility to majority of the people as shown in table 1.1.

Table 1.1 The Share of Total Population and Public Health Facilities

<table>
<thead>
<tr>
<th>Regions</th>
<th>Northern</th>
<th>Brong Ahafo</th>
<th>Volta</th>
</tr>
</thead>
<tbody>
<tr>
<td>Share of total population (a)</td>
<td>10.1%</td>
<td>9.9%</td>
<td>8.8%</td>
</tr>
<tr>
<td>Public health facilities (b)</td>
<td>129</td>
<td>202</td>
<td>476</td>
</tr>
</tbody>
</table>

*Source:* (a) Ghana Population Census, 2000; (b) Canagarajah and Porter (2003: 10).

This health statistics show that the northern region has the lowest public health facilities among the three mentioned regions, but with higher share of population comparatively. Others are the shortage of qualified medical personnel and poor sanitary conditions.

In the case of the Tamale Metropolis, there are still lot of problems in the health sector despite the existence of three public hospitals\(^1\) and nine health centers, in addition to 10 accredited private health providers. The problems include inadequate laboratory

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\(^1\) Teaching hospital (regional), Tamale West hospital, and Central hospital (Old).
equipment that make diagnosis difficult and coupled with unequal distribution of medical personnel across the entire district. These health sector problems result in a very high doctor-patient ratio of 1:5901 which was more than the national rate of 1:5000. Preventing malaria, diarrhea, and anemia were among the highest problems and life expectancy at birth (50) was below national level of 57 years in 2002. It is reported that HIV cases increased from 93 in 1999 to 118\(^2\) in 2002\(^3\).

The Savelgu/Nanton District has one public hospital and some other public health centers which are poorly distributed across the district. The district, like the Tamale Metropolis, has malaria, typhoid, and anemia as the highest morbidity cases and it is also among the districts with highest mortality rates in the region\(^4\). These problems of health services in the districts and the region, coupled with national health problems explain that dependence on public healthcare alone would be devastating to the health needs of the people in the country and the region in particular.

**Study Objectives and Research Questions**

The general objective of this study is to assess the role of private health sector in the provision of primary healthcare in Ghana. The indicators used in examining the extent to which the sector achieves this role are accessibility, affordability, efficacy, and quality of service compared to the public health providers.

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\(^2\) Islam could be a factor because Muslims formed the largest population in the Metropolis.

\(^3\) www.ghanadistricts.com

\(^4\) www.ghanadistricts.com
Main Research Question

Are private healthcare providers more effective compared to the public health providers in the provision of primary healthcare in the Northern Region of Ghana?

Secondary Research Questions

A. Do private healthcare providers complement the State for the provision of primary healthcare in Ghana?
   (i) In what locations do private health providers mostly base their services in the country?
   (ii) In what types of medical fields do private health providers have expertise?

B. Does the economic background form the major reason for seeking one type of healthcare?
   (i) What are the characteristics of the people who seek private healthcare compared to public healthcare?
   (ii) Are patients able to settle the consultancy fees?

C. What are the major factors driving patients to seek medical care at private health facilities instead of the public?
   (i) Are there motivational schemes available to attract more medical professionals to enhance better health delivery?
   (ii) Does the availability of medical personnel/specialists determine the effectiveness of healthcare?
The Hypotheses

As a result of the general perception of health service provision in the country the following hypotheses are used in the analysis of the research:

A. There are numerous state strategies to make public healthcare affordable, but private healthcare is still more affordable.
   (i) Some private health providers serve both rural and urban population with relatively low fee.
   (ii) Private health providers have expertise in many medical fields in the health sector.

B. People of different socioeconomic backgrounds seek private health services.
   (i) Private health providers serve both the poor and the rich in society.
   (ii) The location of private health facility influences patients’ decision for medical care.

C. The presence of qualified medical professionals is not the only determinant factor to enhancing better healthcare.
   (i) The availability and level of facility and laboratory equipment determine the effectiveness of a health facility.
   (ii) Private healthcare is more efficient as compared to public as a result of favorable conditions of service.
Research Methodology

For the purpose of collecting the data, field work was carried out in the Northern Region, Ghana, from March 4 to April 23, 2008. The period of study for secondary data was seven years (2001-2007). This section looks at the selection of case study districts, health facilities, and the respondents.

Selection of the Districts

Two districts (Tamale Metropolis and Savelgu/Nanton) were purposively selected from 20 districts in the region. The Tamale Metropolis is selected because it has the largest share of health facilities in the region. It also has a concentration of large numbers of private clinics. The research was structured to cater for any district that lies from the distance of 10 to 15 miles away from the regional capital, Tamale. The Savelgu/Nanton District was approximately 15 miles from Tamale. It has one public hospital and one private health facility. The distinctive features of these districts would surely reveal the people's access to quality services.

Selection of Public Hospitals

Two public hospitals were purposively chosen for the study. The Tamale West Hospital (TWH) on one hand was selected because it is located in the city center of the metropolis and also in the midst of numerous private clinics. It serves more urban population. The Savelgu Hospital (SH) on the other hand is also selected because it was
the only public hospital in the Savelgu/Nanton District and it serves more rural population. However, there were other public health centers in some villages.

Selection of Private Clinics

There were eight for-profit health facilities and two not-for-profit health facilities, bringing the total number to 10 accredited private health facilities in the Tamale Metropolis. Two clinics were purposively selected. The health facilities are in services for more than 15 years compared with the remaining private facilities. These include one for-profit making namely, the Haj Adam’s Clinic (HAC) and one purely not-for-profit namely, the Shekhinah Clinic (SHC). The SHC was faith-based which offers free healthcare and located in a traditional setup at the outskirts of the metropolis. It was the only clinic in which villages contribute through building structures in the clinic premises to accommodate inpatients. The HAC was independent and purely for-profit making health facility located in the heart of the metropolis.

Giving the distinctive features of the above public and private health facilities, peoples’ desire to consult a particular health provider instead of the other would be adequately understood. It would show the proportion and socioeconomic characteristics of people who seek both health services.

Selection of Respondents

The category of respondents interviewed included the doctors, the directors, the patients, and the opinion leaders.
**Health Facility Level**

Doctors: A total of eight doctors were selected, two from each of the four health facilities. In the case of the public health facilities, there were five doctors in the TWH and four doctors in the SH. Stratified sample and simple random sample techniques were used to select two doctors from each health facility. They were first put into two layers, those doctors who serve for more than five years and those who serve for less than five years. Through the use of simple random sampling technique, one doctor from each layer was picked. As for private health providers, there were only two doctors in the HAC and all of them were chosen. However, simple random sampling technique was used to select two among the three doctors in the SHC. Data collected from these doctors include their length of service, field of expertise, their limitations, and factors that motivate them to stay and serve. Other areas investigated include time spend with a patient, public-private doctor relationships, and problems they face.

Directors: There was one director from each health facility and they were all selected for the interview, bringing the total number to four. Information gathered from them includes demographics of directors, strength of medical personnel, average outpatient attendance per doctor, and the number of referral cases. Others were the type of services provided, motivational scheme available, equipments available and its conditions, consultation charges, and sources of drugs and finance.

Patients: A total of 60 patients were selected for the interview, 15 from each health facility. Stratified sampling technique was first used. The patients were put in to two layers: inpatients and outpatients. Simple random sampling technique was used to select five inpatients and 10 outpatients from each facility. Information gathered includes the
demographics of patients, origin of patients, number of visits for healthcare, cases reported by patients, and reasons for attending a particular type of healthcare. Other areas investigated were the time spent before meeting a doctor, patients’ accessibility to drugs, mode of paying consultation, inpatient opinion about doctor-patient relationships, and the satisfaction derived from the service.

Community Level

Stakeholders: Key informant interview was conducted at each locality of the health facility. A simple random sampling technique was used to select five opinion leaders. In all 20 stakeholders were chosen. Information collected were their contribution to public/private healthcare, and their views on how the two health sectors enhance better health services.

Regional/District Level

Areas visited for secondary data included the Northern Regional Health Directorate, and the two Districts’ health offices. The rest were libraries of the University for Development Studies Medical School, Tamale, and the University of Ghana Medical School, Accra for literature.

Data Collection and Analysis

Technique for data collection was survey through the use of both open-ended and close-ended questionnaires. Others were secondary sources and direct observation. The study employs comparative method as well as qualitative and quantitative measurements to analyze the data. Qualitative analyses on one hand were used for all responses and
these responses were aggregated into relevant themes followed by editing the data for consistency of the information. Quantitative analyses on the other hand were used to translate various responses into absolute figures, followed by conversion of such figures into percentages, charts, tables, and diagrams.

Research Instruments

Accordingly, varied research techniques were employed to be able to collect the expected data. These include face to face interviews of the patients and the stakeholders, and trends of Out Patient Department (OPD) attendance from the official documents of the various health facilities. Other method was the inspection of equipments and wards of the health facilities.

Research Ethics

The research was carried in line with the Ghana Health Service (GHS) rules and regulations. Due to this provision, permission was requested first from the information directorate of the Ministry of Health (MOH). Other areas requested for permission were the Northern Regional Health Directorate, the Health Directorates of the two districts, and finally from the directors of the various health facilities. The photocopies of the school’s Introductory Letter were issued to all the above offices for reference. In most cases the school Identity Card was requested to be seen before information could be made available and this was common in some government offices and public health facilities.
Limitation of the Study

The most difficult problem faced in collecting the data was the provision of incomplete quantitative data. Most of the information required was said to be confidential to GHS. Other problems encountered were the timing of respondents and their desire to cooperate for the interview. It was mostly common when interviewing inpatients. The questions were considered to be too much by some of the inpatients.

Organization of the Study

The study is divided into six chapters. Chapter one examines the background of the health sector in Ghana. These include both public and private healthcare provision and the problems of the public health sector. Other sub-sections included the objectives and hypothesis, methodology, followed by data analyses and limitations of the study. In Chapter two, related literature in both public and private healthcare was reviewed. Chapter three analyzes the historical perspective of healthcare in Ghana since the colonial period while Chapter four includes the analyses of the two indicators of the field work. These included patients’ equitable access to healthcare and how patients pay their health services in both types of health facilities. Data gathered were the distance of health facility, availability and adequacy of drugs, facilities available for inpatients, equity in paying for health fees and others. Chapter five covers the other two indicators: efficiency and quality of service. Information gathered were the qualification of health personnel, capabilities of management, availability of infrastructure and laboratory equipment,
doctor-patient and nurse-patient relationships, and the institutions’ relationships with the external stakeholders. The final Chapter takes into consideration summary and recommendation of the study, and followed by conclusion.
CHAPTER 2

LITERATURE REVIEW

There is a wide range of studies on healthcare as a result of its importance in socioeconomic development. However, the approaches differ from one researcher to another concerning studies on a particular country or comparatively with other countries. Some of these studies take the form of examining the strength of medical personnel, mortality levels, or diseases morbidity situations. This section of the study investigates literature on the importance of healthcare, whether healthcare is a human right, and whether healthcare can be considered a public good. It is followed by an assessment of public and private health providers’ efforts in promoting access and quality healthcare and finally the conclusion.

Importance of Healthcare

Having good health is essential because people with good health could provide their minimum contribution to the socioeconomic development. Thus, governments making healthcare accessible and affordable to a majority of people contribute positively to the socioeconomic development of individual nations. Due to this importance, healthcare formed a major component of the MDGs. This component comprises goal four, reducing child mortality; goal five, improving maternity health; goal six, combating HIV/AIDS, Malaria, and other diseases; and goal seven, enhancing environmental sustainability\(^5\).

\(^5\) [www.unmillenniumproject.org/goals](http://www.unmillenniumproject.org/goals)
Findings from the study of universal medical care and inequalities in healthcare revealed that most healthcare interventions have valuable outcomes. When health services are accessible to the majority of people especially the poor, those people become better equipped to contribute positively to social development. It would further reduce vulnerability and inequalities which are common in many societies. Thus, ensuring equality of access to health services by all categories of people would promote the socioeconomic well-being of people (Roos et al., 2006: 124). The poor is said to be mostly people in rural areas and those found in slums in most cities in many developing countries. Most rural people have limited choices of good healthcare as a result of their inability to access these facilities in their localities while many of them depend on the unhygienic traditional care. These authors suggested that States’ health initiatives should be geared towards reaching these underserved groups. Also, there is a need for policy makers to promote basic skill developments to produce qualified primary health professionals who stand the chance to serve large population including the remote areas (ibid).

To understand the economic importance of health, consider the impact of poor health on employers or a nation. Studies on the negative impact of poor health caused by HIV/AIDS revealed that family income would be affected if workers stay home for several days without going to work due to poor health. It could also result in reduction in output of the employers. If large population in a country is in poor health conditions it would have negative influence on the total production and revenue of a nation. Majority of people in many developing countries can not access better healthcare due to factors such as the scarcity of qualified medical personnel and uneven distribution of
infrastructure. Prolong sicknesses may have negative implications on the population and the economy of a country (Bloom and Mahal, 1997: 106; also see De Waal, 2003: 2&8).

Another study revealed that people’s health is one of the most important capabilities that demand much attention in public policy implementation. For instance, the nutritional level of a person determines his or her welfare. In this respect, the provision of the essential services (i.e. healthcare) would improve the person’s capability (i.e. nutrition) to contribute to the nation’s socioeconomic development (Dasgupta, 1993: 12).

Environmentalists believed that health has direct relation with the environment. Erbstand and colleagues’ discussion of the impact of environment on health and healthcare revealed that when there is high pollution it has a direct corresponding impact on human health where people have higher need for healthcare. Thus, poor health not only has negative impact on a nation's budget but also on the labor availability for social and economic development. All efforts to serve the environment would have positive impact on people's well-being and any negligence on the sanitation in communities will have a negative impact on people's health (Erbstand et al., 1998: 32; World Bank, 1975: 357).

The need to have more access to healthcare has been one of the general demands in the developing nations. For instance, health issues and its negative impact on development in the developing countries were the major discussion in the Gleneagles summit in Scotland. It is also reported that the African Commission requested for more budgetary allocation from governments and coupled with continuous support from stakeholders (the developed) to health sector. This demand for more funding in the sector happened as a result of doubts that several countries may not be able to fulfill the MDGs
especially countries in sub-Saharan Africa. One of these factors is unequal resource endowment which impact negatively in forging ahead to making these goals a reality. Governments were encouraged to pursue vigorous policies to promote easy access through the distribution of health infrastructure, especially to those in need of it, improve quality of care through the provision of basic equipment and skill development, and to make healthcare relatively affordable. It is believed that with good health there would be socioeconomic improvement, increase in adult life expectancy, reduction of maternal deaths and mortality rates, and promotes sound environmental sustainability (Whiteside, 2006: 330).

**Healthcare as Human Right**

There is a debate as to whether healthcare can be regarded as human right. Many international and regional bodies, and coupled with individual nations considered healthcare as the most important element in human life. One of these provisions is the World Health Organization’s constitution which stated that “*the enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being*”\(^6\). In this respect governments and heads of States have the duty to make healthcare one of the first priorities in nation’s development. The leaders must develop human resource development strategies and approaches in the health sector including the provision of infrastructure and basic equipment to promote effective and quality health delivery.

Studies on human development and human rights revealed that both have different approaches but they serve common goals in certain cases. Human rights are more on

\(^6\) [www.who.int/hhr/Right](http://www.who.int/hhr/Right)
political and democratic freedoms and these issues become difficult to quantify while human development is based on the socioeconomic issues (i.e. health indicators) in general. The compatibility of these concepts is that human rights on one hand promotes people’s claim over others. These include individual and group participation in politics, and civil society freedom on issues which do not go contrary to the rules of a country. Human development on the other hand aims at ensuring the well-being of mankind (i.e. literacy and healthcare). Since both aimed at providing people the freedoms to develop themselves and others, they are compatible in promoting human development (UNDP, 2005: 48).

Amartya Sen’s “Development as Freedom” also provided an intellectual contribution to the human rights perspective. He supported other writers’ opinions that the concept of human right is still not clear because of certain factors. He noted that since the exercise of these rights had to be legalized or one has to provide others by performing certain duties before it is realized the concept of fundamental human rights does not lend itself to easy conclusion. It should have been something a person is born with and the exercise of these rights to be universal regardless of the person’s origin. Again, there are differences of cultures in individual nations and across countries. However, he concluded that since the value of personal freedom and equality of human beings promotes the sustenance of human well-being it is essential to have these rights in society. For instance, the provision of healthcare not only increase people’s capabilities to contribute their quota to socioeconomic development of a nation but also impact positively on people’s freedoms and they stand the chance to participate in “political activities” (Sen, 1999: 39).
However, other writers had different opinions with regard to this human rights debate. During a discussion of human right to healthcare, Hessler and Buchanan (2002: 91) noted that although world leaders embrace healthcare as basic human right, this right has limitations. Accordingly, all citizens have the right to the enjoyment of healthcare but majority of them are being denied access to certain services, hence, healthcare as a fundamental right, becomes questionable. These factors include scarcity of resources to ensure equity in the distribution of health facilities; the shortage of medical doctors which impact negatively on quality care; uneven distribution of health professionals especially to those in high need of their services (i.e. rural people) and individual’s inability to access certain services (i.e. abortion). Due to the above limitations health could not be considered a universal and fundamental human right. Hessler and Buchanan recommend that the practice of democracy should be the cornerstone guiding the principle of what is good. In this respect, local differences could be utilized and people’s participation in nation building be promoted. Now that we understand that healthcare could not be described as basic right due to the denial of individual access to certain health needs, the next section examines whether healthcare could be considered a public good.

**Healthcare as a Public Good**

The debate goes on, like the above discussion, as to whether healthcare is a public good or private good. Hyman (2005: 140) analyses the characteristics of public good and private good. On one hand he considered certain things that have positive benefits or externalities when made available in the marketplace to be a public good. In this respect, large number of people stands the chance to benefit from the good and it becomes
difficult to be withheld from those who do not contribute to acquiring it. He added that such goods are usually politically motivated as a result of the high cost involved in producing them (i.e. healthcare).

On the other hand, Hyman described rival goods as private. But in certain cases private goods have externalities unlike the public goods. In this case he considered the determinant factor to be prices in allocating such goods (ibid: 141). The above analysis shows that healthcare is both public and private good, when made available in the marketplace it benefit a significant number of people. Looking at the importance of good health in society it is good for healthcare to be a public good. However, since the state could not provide it for all due to scarcity of both financial and technical resources to cater for different socioeconomic sectors including health, it is advisable for private involvement to complement State’s efforts in providing healthcare.

Despite the important contribution of Hyman, others had different views with regard to this topic. Smith analyses of justice, health, and the price of poverty concluded that healthcare could not be termed public good but it only becomes so during emergency. For instance, an outbreak of diseases like cholera or cerebral spinal meningitis would definitely draw the attention of governments or policy makers to act immediately to control the situation. At that moment, healthcare becomes a public good since those affected are given the right attention. Smith, like Hessler and colleague, suggested the need to have a democratic society where individuals would have opportunity to participate in the development of a society. Such idea would lead to the understanding of cost sharing for all to benefit (Smith, 2002: 306). I do agree with Smith in the sense that public good is not supposed to be enjoyed by few while the majority of the population is
highly in need of it. In some developing countries, the rural people who are mostly poor are highly in need of not only drinkable water and good sanitation but also accessibility to better health facilities. Only the urban dwellers enjoyed easy access and relative affordable healthcare to the disadvantage of the rural people. It is understood that healthcare could only be considered public in certain cases and both public and private could make it available to the people who need it. The next section looks at how both make healthcare available to the people.

**Public Healthcare**

The level of the health status of a population is one of the most important determinants of good standard of living worldwide. As a result of the sensitivity of health, regimes in many countries have taken the leading role in curbing health deprivations through the provision of basic healthcare aimed at providing it for all.

In the discussion of food, nutrition, and population revealed that public healthcare emerged between 1830 and 1840 in Great Britain. The most important public health strategy was preventive care especially on improving the nutritional status of children (Dubois, 2006: 137). Since then governments and international organizations have devised many policies and strategies for the improvement of public health services. For instance, the World Health Organization (WHO) has proposed health strategy in some few decades ago aimed at improving children health status. Mothers were asked to breastfeed their children for six months before they could give them any liquid food. The

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7 Some of the elements of Human Development Indicators on health are infant mortality and maternal health, availability of medical personnel, share of total government expenditures on health, and the rates of deaths per 1000 people.
program was welcomed by world leaders and the practice still exists (ibid: 146; also see Lyons, 2004: 88).

Information on basic healthcare\(^8\) revealed that many governments in developing nations have introduced several programmes to curb maternal deaths and mortality rates. Most of these programmes have been successful in some countries especially in Africa and Asia over the past decades. It includes skilled delivery before and during childbirth; continuous breastfeeding for more than a year; the use of oral rehydration therapy; immunization against the six killer diseases and pneumonia prevention strategies. An example of the success of these programmes in Africa was Egypt. Mortality rates for children below five years was reduced from 104 to 33 (68%) per thousand live births between 1990 and 2005. In the case of Asia, Indonesia also cut its mortality rates from 91 to 36 (60%) during the same period.

Several multilateral and bilateral organizations were working with governments through sponsorship in public health services. The WHO support to developing countries in 1972 was 13% in Latin America, about 40% in Asia, and 21% in Africa. The United States Agency for International Development (USAID) also spent 7% on health in Africa and 19% in Latin America in the same period (World Bank, 1975: 410). With regard to country specific, the African Development Bank (ADB) study showed that USAID invested reasonable amount of money into the Egyptian family planning program since 1980s. It yielded a fruitful result as average number of children per woman reduced form 5.3% to 3.5% between 1980 and 2000 (ADB, 2007: 56).

Despite the improvement in public healthcare that relieved majority of the world population the situation is still not different. Many developing countries’ public health

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\(^8\) Save the Children annual report, 2007.
systems still lag behind on many health indicators and one of the reasons was inequalities in societies. The most important of all were continuing losses of children’s lives in developing countries which is caused by preventable diseases (Kaseje, 2006: 4; also see Roos et al., 2006: 124).

Studies on healthcare situation of mothers and children indicated that the high maternal deaths and mortality rates in some parts of the developing world were due to mothers’ inability to access maternal services. For instance, in Africa, more than 58% of deliveries were not attended by professional health personnel. In the cases of Southeast Asia and Latin America, there were more than 68% and 19% respectively (Belsey and Royston, 1987: 4).

Health services in Africa are still not equitably distributed to reach those who need them most, followed by poor communication barriers and inadequate technological development in the sector. The continent has about 10% of population globally but it is said to have the highest share of world diseases: 90% of malaria incidences and more than 60% of “individuals living with HIV/AIDS” (Kaseje, 2006: 7). In support of the above findings, further study reported that the sub-Saharan Africa has a population of 614 million as of mid 1997 but two out of every three adults (68%) and about 90% of children were infected with the HIV virus. Women are the highly affected group (61%). It was estimated that about 1.7 million were infected with the virus in 2007, bringing the total to 22.5 million. The sub-region had a share of 1.6 million deaths out of the global total of 2.1 million in 2007 alone.9

Several governments have not been able to make healthcare available to their citizens. Majority of the population especially in developing countries could not be able

to access basic health needs. The sub-Saharan Africa in particular has the highest records of malnutrition in the world from 1990 to 2001. It happened as result of the shortage of basic facilities and human resource development which impacted negatively on people’s lives.\textsuperscript{10}

Discussion on improving children’s mental health revealed that majority of public medical personnel and administrators are nonprofessionals. They also have poor health procedures in enhancing effective healthcare and these problems were common in developing nations. It is suggested that for an effective and efficient public healthcare delivery to be achieved there is a need to increase training of health personnel and upgrading the existing ones’ knowledge. This training program should be coupled with appropriate code of conduct for personnel to know their duties (Lyon, 2004: 93).

Budgetary allocation to health sector has not been favorable in many developing countries. For instance, the share of total government expenditures on health in Ghana was 5% as of 2003 (World Bank, 2006: 80). In the case of reproductive healthcare, the percentage of women on childbearing with access to contraceptives was below 43% in Asia, 24% in South Asia and less than 13% in Africa as of 1983. The accessibility and affordability to healthcare need to be reconsidered. Policy makers and stakeholders in health must include all categories of people to benefit from national health programmes (Black, 1987: 2; also see Belsey and Royston, 1987: 7).

Capacity building is said to be worsening in Africa. The efficiency and quality reflects the desire to maximize the ratio of inputs to outputs in any management activities. However, these factors are being compromised in delivering healthcare in many developing countries due to the inadequacy of qualified health professionals and

\textsuperscript{10} \url{www.unmillennuimproject.org/goals}
could with inadequate equipments. The quality and effectiveness of healthcare depend upon the availability of qualified medical professionals, laboratory equipment, infrastructure, and positive attitudes towards patients. The deficiency or lack of any of these would have adverse impact on national healthcare (Awases et al., 2004: 2).

As a result of increased brain-drain of health professionals in most developing nations\(^\text{11}\), the efficacy and quality of public healthcare delivery are severely affected. Some of these reasons were due to increasing population which impacted negatively on scarce States’ resources to train and retain medical professionals, and to provide more health facilities and better condition of services. For instance, Ghana registered a ratio of 1:22970 people per doctor as of 1990 (Awases et al., 2004: 5). These authors added that between 1991 and 2000 the country lost a total of 1,300 health professionals in the public health sector alone to either outside the country or to other health facilities (ibid: 34). The above findings show that the brain drain of health professionals in Ghana coupled with unequal distribution of those left in the public health sector impacted negatively on quality care especially the rural areas.

But do governments bear responsibility for this? The developed nations’ governments share responsibility for this blame as a result of poor international conventions governing the movement of health personnel in the world and from developing countries to the developed ones in particular. A case is where many developing countries’ public health professionals who were trained under the public resources of their native States migrated to either private health establishments or the developed nations. A study on migration of health professionals in six African\(^\text{12}\) countries


\(^{12}\) Cameroon, Ghana, Senegal, South Africa, Uganda, and Zimbabwe.
found that although there were significant increases in the recruitment of medical doctors in countries such as “Cameroon, Senegal, and Uganda” between 1991 and 2000, the migration of health professionals still continued. It recorded a marked decline of pharmacists and nurses in all the case study countries. Reasons for movement to private establishments were the availability of better motivation factors, equipments, and drugs; and reasons for migration outside the countries were the desire for further and different learning experiences in new environments (Awases et al., 2004). The study further found that doctors migrated to countries such as the UK, France, USA, and Belgium. Empirical evidence was Cameroon where nine pharmacist, 50 midwives, 155 trained nurses, 50 dentist, and 173 doctors migrated to countries such as France, USA, and UK between 1990 and 2000. In the case of Ghana, the total cumulative loss was 6,771 between 1991 and 2000 and this led to the recruitment of 492 foreign doctors and 26 dentists within the same period. The cumulative effects were increased workload on those doctors left. Other negative impacts were uneven distribution of health professionals especially to rural areas and reduction in the quality of healthcare (ibid: 33).

Private Healthcare

The private health sector has gained prominence in many developing countries especially with regard services in reproductive and family healthcare systems. One reason for the private involvement in providing healthcare could be due to scarce State resources to provide universal healthcare for majority of the people in many countries.
The private health providers serve to complement governments especially in rural areas. Studies on problems of rural development, education, and health in Thailand found that more that 30% of the sampled population visited private healthcare while only 17% used public healthcare within a year (World Bank, 1975: 379).

Similar findings were revealed during a study on the role of private providers in family planning services. It noted that private pharmacy shops in many developing countries serve majority of people especially on family planning (i.e. contraceptives). Private providers were quick in offering services and were able to reach majority of the population and individuals (Fincanciogly and Isaacs, 1987: 12). It added that services of private pharmacy stores and physicians were easily accessible to majority of the people in countries such as Egypt, Korea, and Taiwan (ibid: 13).

Okello and Feeley comparative study on the role of two private providers (Ghana and Uganda) in local health insurance plan found among other issues the Lacor health insurance in Uganda to be one of the best local insurance schemes by private health providers. The percentage of those people who used to sell properties before they could seek healthcare dropped from 39% to 15% while those who usually borrow money for healthcare also dropped from 12% to 6% (Okello and Feeley, 2004: 18).

The private health providers serve about 35% of the population in Ghana. With regard to Greater Accra Region, the private sector provides about 50% to 60% mostly based on curative healthcare. These providers are mostly retired medical professionals from the public health sector and so have experience in offering quality health services (Obuobi et al., 1999: 33).
A study conducted in the health sector in Ghana revealed that out of the total of 2,100 doctors serving, 20% of them were private professionals serving in different locations as of 2006. Empirical evidence was the Akatsi District in the Volta Region without a public hospital. There were two private health facilities serving the district and the doctor-patient ratio was 1:40000. Due to the importance of the private sector in society the policy makers have been encouraged to as a matter of urgency to include all private health providers in the National Health Insurance Scheme (Sodzi-Tettey, 2007). In relation to what Sodzi-Tettey described above, Habicht and Berman were quoted to have said: “Technology is not the main problem limiting the spread of effective primary healthcare. The limiting factors are organizational. We must provide technically effective services on a large scale which are widely accessible, fiscally affordable, yet humane enough to be acceptable to all who need them” (Fincangiogly and Isaacs, 1987: 13).

The share of total private sector investment on family healthcare in the 1980 was above 50% in Latin America. Other regions were sub-Saharan Africa with 38%, Southern Asia with 25%, while in Middle East it was 15%, and the East Asia was less than 9%. Globally, the private sector was said to have spent relatively large amount of money that amounted to a total of US$370 million (20%) during the same period. As a result of shrinking public services and declining quality of care patients were ready to pay for the services rendered (Financially and Isaacs, 1987: 13).

Notwithstanding the above role played by the private sector in enhancing access and quality healthcare delivery, other writers had different opinions about their activities. World Bank report indicated that although the private providers play a vital role in the health sector, their services may neglect large portion of the population, especially the
poor. Some of the private providers charge high fee and those of poor groups could not afford their services. The management of health institutions needs huge capital to be able to acquire all basic facilities; but left to private entities they may not be able to invest such amount of money for many people to enjoy (World Bank, 1975: 371).

**Conclusion**

The literature explored above show that both public and private sectors perform well in their efforts to enhance better accessibility and quality healthcare delivery. The private health sector on one hand did well in complementing governments in the provision of healthcare although their services could not reach majority of the population, unlike the public. Despite that some of them operate without governments’ support, the private sector still provides better healthcare delivery.

The public sector on the other hand serves majority of population in developing countries but due to declining expenditures on social services such as healthcare, accessibility to health facilities, the provision of relative cost of care, and promoting efficiency and quality care are all affected. The provision of healthcare appropriately needs to be the responsibility of both providers. These services could be done through better collaboration and partnership between the two sectors, and coupled with external support for both sectors to enhance effective health delivery.
CHAPTER 3
THE PERSPECTIVES OF HEALTH SECTOR IN GHANA

The chapter examines the profile of the country and describes the study region and the two districts. It is followed by a brief discussion of historical development of the health sector which comprises the pre-colonial period to 1990. Other issues discussed are health services from 1990s to 2007 which comprises major policies and health sector programs of work, donor partners in health, and private sector participation in the provision of healthcare.

The Profile of Ghana

The Republic of Ghana is one of the West African countries which shares boundaries with the Burkina Faso to the North, La Cote d’Ivoire to the West, the Gulf of Guinea to the South, and Togo to the East. It has a land area of 238,537 square kilometers with a coastline of 560 kilometers.

The population of Ghana was 18,845,265 million as of 2000. The age structure was 42% of those from 0-14 years, 55% of those from 15-64 years, and 3% of those from 65 years and above (Ghana Population Census, 2000). The population increased to 20,263,582 in 2002, and then to 21.83 in 2005 with a population growth rate of 2.45% from 2002 to 2005. Total life expectancy at birth from 2000 to 2005 was 57.2 years with male having 56 years while the female has 58.5 years. The Portuguese were the first to come to Ghana but it was later colonized by British and the official language is English.

The modern day Ghana was named in 1874 from the British Gold Coast Colony. The struggle for self rule started in 1950s and elections began in 1951, and it also took place in 1954 and 1956. The country was second to have won its independence from the British on 6 March 1957 in sub-Saharan Africa after Sudan which had her independence on 1 January 1956.


Administratively, the country has 10 regions and sub-divided into 169 districts. It practices a local government system that has the Regional Coordinating Council, the Metropolitan Assembly system with a population of 250,000, the Municipality with a population of 95,000, and a District system with a population of 75,000 or more. The governing structure is made up of the President, the Cabinet Ministers who are also the same time the Heads of the various Ministries, the Regional Coordinating Councils being occupied by the Regional Ministers, and the Metropolitan/Municipal/Districts being occupied by Chief Executives. Out of the 169 districts in the country, six of them were Metropolitan Assemblies while 32 were Municipalities as of December 2007.

The country has more than 55 different dialects which are made up of ethnic groups and being sub-divided into clans, then into families and finally into households. According to the 2000 Population Census, the major religious groups in the country are
Christianity (69%), Islam (15.6%), the Traditional believers (indigenous religion-8.5%), and others (non-affiliated to any of the above-6.9%).

Economically, as of 2005, the country has GDP per capita to be US$512, GDP real growth was 5.80%, inflation rate was US$ 15.1%, and balance of trade stood at US$2.54 million. Also, the nation had unemployment rate of 10.20%, and foreign debts was US$7.40 billion as of 2004 (Africa Review, 2007). The nation was among the Heavily Indebted Poor Countries that benefited debt reduction of US$258 million from the International Monitory Fund\textsuperscript{14}.

Export products are Cocoa, Gold, Timber, Bauxite, Manganese, and Diamond. The national currency is the Cedi (GHC\textsuperscript{15}). It has external trading partners with Togo, Nigeria, Japan, China, USA, and the European Union. The nation is among the following international organizations: the African Union, the Economic Community of West Africa, Commonwealth Nations, the United Nation, and the Non-Aligned Movement.

**Study Region: The Northern Region**

The Northern Region is not only the largest of among the 10 regions but also among the four poorest in Ghana. It has a land area of 70,383 kilometers and share boundaries with Upper West and Upper East Regions to the North, and the Volta and the Brong Ahafo Regions to the South. It has international boundaries with the Peoples Republic of Togo to the East, and La Cote d’Ivoire to the West. According to the 2000 population census, the region has 1,854,994 (10.1%) million people. The region has 20 administrative districts as of 2007 and Tamale is the regional capital and also the only

\textsuperscript{14} [www.fco.gov.uk/en](www.fco.gov.uk/en)
\textsuperscript{15} Currency of the republic of Ghana. Exchange rate was US$1 to 0.97 GH pesewas as of March 2008.
town with metropolitan status. It is also among the few regions with less public and private health facilities. Malaria and guinea worm are the leading morbidity cases in the region and it is among the highest poverty and illiteracy rates in the country.

**Study Districts**

*The Tamale Metropolis*

Tamale Metropolis is among the 20 administrative districts in the Northern Region. It is located in the center of the Region and shares boundaries with Savelgu/Nanton District to the North, West and East Gonja Districts to the South, Tolon/Kumbungu District to the West, and Yendi District to the East. The population of the District was 356,552 and the Metropolis was 293,881 with a share of female being 146,902 and the male was 146,979. (Ghana Population Census, 2000). The Metropolis has an annual population growth rate of 3.5% which was more than the Regional (2.9%) and National rate of 2.45% from 2002 to 2005. It has a population density of 334 persons per square kilometers. Islam formed one of the largest religious groups with 84%, followed by the Catholics with 6% and the remaining groups (other church denominations and the traditional believers) formed 10% (Tamale Metropolitan Health Directorate Annual Review, 2007).

Health system is managed at the following stages: The Metropolitan Health Administration level, the Sub-district level, and the Community level. Health services in the metropolis are divided into five units. The sub-district has six units and the Community level has four units. It has a total of 33 health facilities with 10 being privately owned. About 41.9% still used unsafe sources of drinking water and 35.6% of
the people are without any kind of toilet facility. Malaria has been the leading disease for several years (Tamale Metropolitan Health Directorate Annual Review, 2007).

*The Savelgu/Nanton District*

The district was created from the West Dagomba District in 1988 with a land area of about 1,760 kilometers. It shares boundaries with the Tamale Metropolis to the South, Tolon/Kumbungu District to the West, Gushegu/Karaga District to the East, and West Mamprusi District to the North. The district is sub-divided into four sub-districts.

It has a population of 109,154 with 51% female and 49% male. Health services are provided by the District health directorate. It has nine health facilities and one of them is a private health facility. Malaria was the highest morbidity cases over the past two years and followed by guinea worm. The district registered 18 HIV cases out of the 603 blood donors in 2005 (Savelgu/Nanton District Health Service Annual Review, 2007).

**Health Services in the Pre-colonial Period to 1990**

The involvement of private health providers in complementing government’s role in providing healthcare has been in existence for a long time. Health services during the pre-colonial era were under the auspices of the traditional healers. People’s health problems were attributed to supernatural beings and the village priest was in charge of determining the causal agent after libation and some sacrifices in certain cases for the ancestors. The priest finally prescribed herbs and in certain cases with animal (s) needed to apiece gods to protect the sick person. Though the practice of traditional healthcare is still in
existence, its importance has been reduced due to factors such as the unhygienic way of offering services and the introduction of modern medical healthcare. They provide about 20% of health services in the Northern region. Today there exist Traditional Healers Association formed in 1960s with the aim of preserving and modifying their services in line with the modern healthcare procedures.

The Christian Missionaries introduced the modern system of healthcare during the colonial era and they continued the services until after the First World War. Some older Catholic missionary hospitals are still in Tamale and Sunyani, and Presbyterian hospital in Agogo. Some of the Moslem leaders were also involved in providing healthcare through the use of some Quranic verses when Islam was introduced in the fourteenth century.

The colonial administration under the governorship of Frederick Gordon Guggisberg (1919-27) promoted the development of health sector under his ten-year development plan. It was this ten-year plan that the first teaching hospital, Korle Bu, was built in 1925. Records from the immediate post-colonial era indicated that there was little documentation of health statistics (1960s to 1970s) and only incomplete or partial data was available\textsuperscript{16}. Though there was a lot of development in the health sector especially during the Acheampong regime (1970s) when most regional and district hospitals were built.

The Economic Recovery and Structural Adjustment Programs (ERSAP) implemented in the early 1980s were not favorable to the development of the health sector. Subsidies to the health sector including other social services (i.e. education) were

\textsuperscript{16} www.countrysudies.us/54.
withdrawn and ‘Cash and Carry’ system introduced. The policy affected majority of the population access to health services especially those of poor groups.

**Policies and Programmes in the Post ERSA to 2007**

The health sector is under the MOH and healthcare is being provided by the GHS. Several policies and programmes were implemented over the past decades aimed at increasing access and quality healthcare delivery in the country. The complete documentation on the health sector started after the 1984 Population Census. Other records were from the 1980s policy documents and reports from conferences, seminars, and newspapers. The health sector was decentralized to the local level (districts) more than 10 years ago aimed at making planning, budgeting, monitoring, and evaluation simple for better health services. This led to the establishment of new district hospitals across the country (i.e. the Savelgu/Nanton District Hospital). Also, under the GHS and Teaching Hospital Act 525 1996, teaching hospitals were given autonomy to be the public health sector tertiary service provision.

The health indicators in the country (see appendix E) showed improvements in the health sector due to the implementation of several strategies. However, current statistics indicated backward trend in the health sector. The average life expectancy was 55 years while infant mortality increased to 87% and mortality rate of children below five years was also 143 per thousand live births. The population of the country with access to health services was said to have dropped to 45%.\(^{17}\)

\(^{17}\) [www.iicd.org/articles](http://www.iicd.org/articles)
**Vision 2020 and Highly Indebted Poor Country Initiative**

The introduction of the Vision 2020\textsuperscript{18} in the 1995 supported the national health sector objective to improve the health status of all Ghanaians but health problems were not reduced\textsuperscript{19}. The country joined the Heavily Indebted Poor Countries’ initiatives debt relief from the International Monetary Fund (IMF) and the International Development Associations (IDA). They supported the country with a sum of US$2,186 million which was made up of 56.2% debt reduction in 2002. The trickle down effect of this support was to improve the socioeconomic development in which health was part. However, results from the health sector were not successful as expected and infant and children below five years mortalities were still high\textsuperscript{20}.

**Health Sector Programmes of Work**

Apart from the annual health sector Programme of Work (POW) which is aimed at specific development certain sectors within a year there are others like the Medium Term programmes which cover many years. The first (1997-2001) Medium Term Strategic Plan in the health sector was adopted in 1995 as part of the Vision 2020. It was aimed at providing infrastructure, manpower needs, and the total development of the health sector. However, due to poor results of the first five POW a second 5-Year (2002-2006) POW was introduced as part of the Ghana Poverty Reduction Strategy Papers. The theme of the programme was “Partnership for Health: Bridging the Inequalities Gab”. It was meant to improve on the previous gains and develop more sector priorities to reduce inequalities,

\textsuperscript{18} It was a long-term national development policy adopted in 1991 aimed at transforming the nation from low-income country into a prosperous middle-income status by the year 2020. It was implemented through five year Medium-Term plans. First plan was from 1996-2000.

\textsuperscript{19} \url{www.iicd.org/articles}.

\textsuperscript{20} \url{www.imf.org}
and improve equity of access to basic health services (POW, 2002-06). Promoting the private health sector participation was one of the major priorities. It was structured to build the capacities of public and private health providers and to devise ways of contracting negotiations with the private sector. Other provision was to sign the memorandum of understanding between the government and the private health sector (POW 2002-06: 35).

**Strategies for Equitable Access and Affordable Healthcare**

**The National Health Insurance Scheme (NHIS)**

The Nkoranza Community Health Insurance was the first to be introduced in Ghana by the St Theresa’s Catholic hospital in 1992, followed by the Ministry of Health pilot insurance scheme in 1990s. The next was the establishment of Ghana Healthcare Company by the Social Security and National Insurance Trust (Adjei and Agyepong, 2008).

The NHIS is the most current policy implemented to improve equity, access, and affordable healthcare in the country under the constitutional provision of Act 650. It was introduced in some selected public health facilities as pilot project in 2002 and extended to all public hospitals and some selected clinics in 2005, and also to some selected private health facilities. Those people who were not under the National Social Security and Insurance Trust (SSNIT) were required to pay a registration fee of GHC7.2 pesewas for a period of one year. However, personnel who were under the SSNIT, GHC72 were to be deducted at source from their contributions to SSNIT. It revealed that approximately 38% of the entire population was already registered. And out of this 38%, 21% of them had
been issued identity cards and were benefiting health services as at the end of 2006 (Adjej and Agyepong, 2008).

As part of the implementation of the NHI, a pharmaceutical pricing recommendation was outlined to guide the sale and use of drugs and to make it available to the private sector. It was also suggested that there was a need for external/MOH financial support; creation of management training on the part of quality control and acquisition; introduction of competition between the public and the private drug suppliers, and monitoring of lower pharmaceutical suppliers. Others were to setup performance targets, introduce accountability mechanisms, and to provide clear responsibilities for managers of the drug commodity distribution system (Sarley et al., 2003: 61).

**Strategies to Enhance Efficiency and Quality Healthcare**

*Manpower Development*

The implementation of the 5-Year POW (2002-06) provided for capacity building of health personnel aimed at curbing the brain drain of health professionals and changing the geographical misdistribution of health personnel. The goal was to institute rewards for good performance; decentralized administrative decision making on budgets; ensure equity in the distribution of health personnel, and to ensure gender sensitivity in employing heath personnel (Health Sector POW, 2002-06: 20; also see Health Sector POW, 2004: 20).

In an effort to retain medical personnel in the country, a revolving fund of US$5 million was instituted in some years ago aimed at acquiring vehicles for the medical personnel who would accept postings to rural areas. The deductions of 20% from the net
salaries of the personnel were to be made through the Accountant General department. In 2002 alone, 63 saloon cars were imported for distribution to doctors in the deprived districts\textsuperscript{21}.

Under the Danish International Development Agency (DANIDA) health sector support, an amount of DKK10 million grants were offered to train doctors and dentists in the private sector in the year 2000. It was contracted to the Empretec Ghana Foundation, a business development enterprise with expertise on health sector (DANIDA Annual Report, 2002: 46).

\textit{Information and Regulatory Frameworks}

To improve the information system in the GHS, an Information Technology and Communication conference was organized in May 1998 by the International Institute for Communication and Development. Major priorities for development were the dissemination of information in areas of drug registration, patient and epidemiological data gathering, and the dissemination of environmental and financial information\textsuperscript{22}. A regulatory framework was also provided aimed at ensuring quality care, and to be excised by the health sector regulatory and statutory bodies. Areas considered were the revision of the existing statutory laws, strengthening the roles of these bodies, and regulating the activities of both public and private health providers for quality assurance (Health Sector POW, 2005: 26).

\textsuperscript{21} www.ghan.gov.gh/governing.
\textsuperscript{22} www.iicd.org/articles.
Donor Partners in Health

The health sector is one of the areas that attracted foreign support over the past decades. The government receives budgetary support from the World Bank, the Netherlands, European Union, the Nordic Development Fund, DANIDA, and DFID. In 2000 alone, they (excluding Nordic fund) contributed US$15,379,392 million to health sector accounts (DANIDA Annual Report, 2002).

Apart from the general donor pool funds towards the health sector each has specific grant allocation programme with the government. In the case of DANIDA, it supported the government with DKK57.3 million as part of the phase two (1998-2002) of its grant support and it increased the support to DKK225 million in 2002. Areas targeted were improving private health sector participation (DKK10 million); improving access to healthcare (DKK10 million); support to health estate and building management (DKK6.4 million); support to district and sub-district capacity building (DKK16.2 million), and DKK14.7 million to the Upper West Region (DANIDA Annual Report, 2002).

The Private Health Sector

The well known and most organized private health providers are the Christian Health Association of Ghana (CHAG) and the Society of Private Dental and Medical Practitioners (SPDMP). The SPDMP was formed in 1980 and it has a membership of 263 as of 2007. The association celebrated its twenty-ninth annual congress in August 2007. During its twenty-seventh congress in 2005, the Society called on the Food and Drug Board, and the Media Commission to help check advertisement on herbs and drugs on the media. It also called on the government to support the establishment of the district mutual
health insurance scheme, private commercial health insurance schemes, and private mutual health insurance to reduce the cost of malaria treatment. Other demand was a need for the MOH to develop courses for the training of private health facilities’ technicians\textsuperscript{23}.

In the case of CHAG, the association was formed in 1967 with a membership of 25. It increased to 135 in 2002 and then to 152 in 2005. It comprises 56 hospitals, 83 primary clinics and 8 manpower-training centers (CHAG Annual Report, 2006: 10). The aim of the association was to encourage collaboration and partnership between all churches and the MOH to provide accessibility to health services by majority of the population. The association is the second largest to GHS in the health sector in Ghana. It provides both preventive and curative care and serves about 35\% to 40\% of the entire population.

In December 2003, the association signed a Memorandum of Understanding with the MOH to collaborate in the provision of health services. After the signing of this agreement, the government has been serving CHAG member health facilities with both medical and administrative personnel. The government pays the personnel and also provides infrastructure in the health facilities (CHAG Annual Report, 2006: 7). For more information about CHAG activities see appendix D.

Conclusion

The above information indicated that the MOH in conjunction with the GHS has instituted measures aimed at increasing access to health services. However, more need to be done to ensure total satisfaction in the provision of health services. There is a need for

\textsuperscript{23} www.ghan.gov.gh/news.
multiple strategies that cut across all areas in the health sector. These would include more human resource development to be accompanied with motivation to retain the personnel, and to develop internet communication technology in the administrative level in both public and private health facilities. Others would be the expansion of infrastructure and the supply of appropriate basic equipment.
This chapter attempts to answer the research question on how patients access and receive affordable healthcare in the four selected health facilities - two public and two private. The analysis in this chapter made use of several tools that seek the understanding of patients’ accessibility to health services. The chapter includes the demographic characteristics of patients, followed by their origin to health facilities, cases reported at the OPD, time spend before meeting a doctor, and patients’ access to drugs. Other issues discussed were the mode of paying consultation fees, factors that determine patients’ choice of a particular health facility and other related issues.

Access means the prospect of a patient who seek healthcare at any health facility devoid of financial and political barriers or patient cultural affiliation. In this respect health facilities should not only be equitably distributed but also located at areas where the services are mostly needed and must probably be handled to protect the rights of individuals and groups for access to healthcare. Equity is related to access in the sense that patients, of all demographics, have equal accessibility to all health facilities. Affordable healthcare here refers to the ability of a patient (especially the poor) to have access to healthcare be it in private or public facility.
Demographic Background of Respondents

Age and Marital Status of Respondents

This part of the study shows the socioeconomic characteristics of patients sampled. The analysis involves questions on the patients’ background in terms of sex, age, educational levels, marital status, and occupational standards. Tables 4.1, 4.2, and 4.3 show these variables.

The sampled patients include 13 females and 17 males in each type of health facility respectively. Table 1.1 indicates that out of the total of 60 respondents covered in the survey, 26 (21.6%) were females and 34 (78.3%) were males. The highest female age groups of respondents (61.5%) in the public health facilities were from the ages of 21 to 30 while the least age groups (7.6%) fell between 61 and 70. The males (29.4%) with ages between 31 and 40 formed the largest representation. Similarly, females in the sampled private health facilities represented the same rating like the public health facilities. However, males had equal representation between the ages of 21 and 30, and between 31 and 40 representing 29.4% respectively.

On marital status, married people formed a significant majority of respondents in both public (70%) and private (53.3%) health facilities. and there were no recorded divorce case in the public health facilities.
Table 4.1. Demographic Background of Respondents

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<tr>
<th>Age</th>
<th>Public Male</th>
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<th>Private Male</th>
<th>Female</th>
<th>Total</th>
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<td>%</td>
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<td>13</td>
<td>100</td>
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<th>Private Male</th>
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<td>12</td>
<td>92.3</td>
<td>21</td>
<td>70.0</td>
</tr>
<tr>
<td>Single</td>
<td>8</td>
<td>47.0</td>
<td>1</td>
<td>7.6</td>
<td>9</td>
<td>30.0</td>
</tr>
<tr>
<td>Divorce</td>
<td>0</td>
<td>0.0</td>
<td>0</td>
<td>0.0</td>
<td>0</td>
<td>0.0</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>17</td>
<td>100</td>
<td>13</td>
<td>100</td>
<td>30</td>
<td>100</td>
</tr>
</tbody>
</table>

Notes: the use of N refers to the number of responses; % is the percentage of respondents; and 0 refer to no response. Source: Author Compilation.

The following observations are made from the table above:

- Those respondents between ages of 21 and 40 are the most to seek both public and private healthcare;
- Married people formed the highest groups of respondents who seek public healthcare compared to the private; and
- The sample shows equal opportunities for female accessibility to both health providers.
Educational Status of Respondents

The majority of people in the country had the perception that private healthcare is costly and therefore only accessible to those with high income and high educational levels. This perception implies that those of poor financial background and the low educated would have less access to private health services.

Figure 4.1 below reverse this perception because illiterates and those with low educational levels formed the most groups who seek private care. It indicates that respondents who had no formal education (illiterates) and those with basic formal education (primary and junior high school) represented the highest groups (30% each) in the public health facilities with the lowest being holders of Higher National Diploma (HND). Similarly, illiterates were more (53.3%) in the private health facilities. It is

![Educational Status of Respondents](image)

Fig. 4.1. Educational Status of Respondents. Source: Author Compilation.
followed by those with basic qualification (30%) and the lowest represented qualification being those with Diploma in Business Studies (DBS) and HND (3.3% each).

The results show that the private health providers received more patients with low educational background or none (illiterates) compared to public health providers. The reason could be due to quality of care offered. It could also be that the private sector either provides free care or charge relatively low fee. Most illiterates and those with low educational qualification could have problems with their health needs. This category of people has inadequate information on good hygiene and proper sanitation. Other factors are their eating habits (less nutritious food) and poor self awareness for healthy living. This hypothesis is confirmed from the findings that the two levels formed the largest group of patients surveyed.

*The Occupation of Respondents*

The study investigates into the occupation of the sampled respondents. The findings show that students formed the largest occupational group (23.3%) in the sampled public health facilities while this recorded the least respondents (3.3%) who seek private healthcare. Teachers formed equal (20% each) representation in both types of health facilities while watchmen/laborers represented more in the private health facilities (16.6%) compared to the public (13.3). Figure 4.2 below illustrate the results.
Petty traders and farmers (23.3% each) formed the largest occupational groups in the private health facilities, while coming third and fourth in the public health facilities. The large number of students found in the public health facilities could be those with National Health Insurance (NHI) identity cards as the case of the Savelgu hospital where all the 15 sampled respondents were insured.

**Out Patient Department (OPD) Registration**

**Patients’ Attendance**

The OPD contains information of patients’ daily visits, such as name, sex, age, and marital status, and reasons for the visits in health facilities. The directors were asked to state the number of patients recorded at the OPD within the seven-year period (2001-
2007). The purpose of these records was to ascertain the trends of patient attendance in both types of health facilities and its impact on the health personnel.

*Savelgu Hospital*

The Savelgu Hospital (SH) in table 4.2 witnessed the highest OPD attendance in 2005 (22.9%), and the lowest recorded in 2001 (1.9%). The inpatients recorded highest in 2003 while the outpatients also registered high in 2007. The results show an increasing trend of total attendance from 2001 to 2005, and fell in the last two years especially in 2006. The total reduction of both inpatients and outpatients attendance in 2006 could be attributed to either less referral from the public health centers within the district or there was an improvement in healthy conditions of the people.

An upward increased of both inpatient and outpatient attendance in 2007 could also be due to more referrals from other health centers in the villages or increased equipment which led to increase health facility services.

Table 4.2. Patient Attendance from 2001 to 2007 (Public)

<table>
<thead>
<tr>
<th>Savelgu Hospital</th>
<th>Variables</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Inpatient</td>
<td>Outpatient</td>
</tr>
<tr>
<td>Years</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2001</td>
<td>-</td>
<td>4,165</td>
</tr>
<tr>
<td>2002</td>
<td>26,632</td>
<td>5,828</td>
</tr>
<tr>
<td>2003</td>
<td>38,091</td>
<td>7,095</td>
</tr>
<tr>
<td>2004</td>
<td>37,020</td>
<td>10,006</td>
</tr>
<tr>
<td>2005</td>
<td>35,812</td>
<td>12,129</td>
</tr>
<tr>
<td>2006</td>
<td>1,496</td>
<td>5,460</td>
</tr>
<tr>
<td>2007</td>
<td>3,842</td>
<td>20,995</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>142,893</strong></td>
<td><strong>65,678</strong></td>
</tr>
</tbody>
</table>

It is surprising to see inpatients registration more than the outpatients as shown in the table above. Most public health facilities in the country have inadequate accommodation for inpatients. But it could be that inpatients were not staying long in the health facility.

*Tamale West Hospital*

The statistics from the Tamale West Hospital (TWH) in table 4.3 below shows an increasing and decreasing trend over the seven-year period with the total outpatient attendance more than the inpatient. The year 2003 recorded the highest attendance with 22.6% while the lowest being in 2001 (6%). Both inpatients and outpatients recorded highest in 2003 with 25.7% and 20.3% respectively. The pattern of attendance showed significant increases from 2001 to 2003, and then experienced steady decreases from 2004 to 2007.

Table 4.3. Patient Attendance from 2001 to 2007 (Public)

<table>
<thead>
<tr>
<th>Tamale West Hospital</th>
<th>Variables</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Inpatient</td>
<td>Outpatient</td>
</tr>
<tr>
<td><strong>Year</strong></td>
<td><strong>Total</strong></td>
<td><strong>Total</strong></td>
</tr>
<tr>
<td>2001</td>
<td>9,323</td>
<td>11,348</td>
</tr>
<tr>
<td>2002</td>
<td>29,801</td>
<td>36,289</td>
</tr>
<tr>
<td>2003</td>
<td>37,601</td>
<td>39,648</td>
</tr>
<tr>
<td>2004</td>
<td>17,063</td>
<td>38,783</td>
</tr>
<tr>
<td>2005</td>
<td>23,008</td>
<td>28,723</td>
</tr>
<tr>
<td>2006</td>
<td>13,901</td>
<td>22,657</td>
</tr>
<tr>
<td>2007</td>
<td>15,550</td>
<td>17,856</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>146,247</strong></td>
<td><strong>195,251</strong></td>
</tr>
</tbody>
</table>

The health facility is located near the central market in the metropolis and this could be the reason for high total patient attendance within the first three years or it received more referrals from other health facilities. However, a steady decrease in attendance from 2004-2007 could be that patients seek care at other health facilities in the metropolis or it has less referrals from other health facilities.

Shekhinah Clinic

There was no data from the HAC, only the SHC data was used for the analysis. The table below summarizes the findings. The OPD registered steady increases in total attendance from 2001 to 2003 and fell in 2004. It increased again throughout the period except 2006 where it had a marginal reduction in attendance. Both inpatients (17.6%) and outpatients (16.7%) recorded highest in 2003 and 2007 respectively.

Table 4.4. Patient Attendance from 2001 to 2007 (Private)

<table>
<thead>
<tr>
<th>Shekhinah Clinic</th>
<th>Variables</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Year</td>
<td>Inpatient</td>
<td>Outpatient</td>
</tr>
<tr>
<td>2001</td>
<td>193</td>
<td>11,347</td>
</tr>
<tr>
<td>2002</td>
<td>160</td>
<td>12,057</td>
</tr>
<tr>
<td>2003</td>
<td>206</td>
<td>16,035</td>
</tr>
<tr>
<td>2004</td>
<td>150</td>
<td>14,168</td>
</tr>
<tr>
<td>2005</td>
<td>128</td>
<td>16,195</td>
</tr>
<tr>
<td>2006</td>
<td>154</td>
<td>15,893</td>
</tr>
<tr>
<td>2007</td>
<td>175</td>
<td>17,285</td>
</tr>
<tr>
<td>Total</td>
<td>1,165</td>
<td>102,980</td>
</tr>
</tbody>
</table>

The private health facility had very limited inpatient attendance compared to any of the two public health providers. The reason could be due to less patient admissions as a result of inadequate accommodation equipments. Also, the low total attendance could be due to its location. The health facility is located in the outskirts of the Tamale Metropolis. Many patients especially in the city center might see taking taxi to the place would be a waste of time.

Overall, the public health providers witnessed higher OPD registration compared to the private (SHC). However, the SHC showed relative increases throughout the period (except 2004) over the public health providers which had unsustainable trends in patient registration.

**The Destination of Respondents**

*The mix of Patient Origin*

This section of the study investigates the origin of respondents. The figure below indicates that respondents from villages within the districts seek more health services in public health facilities representing 47%. It is followed by those within the communities (40%) in which the facilities are located.

For the case of the private health facilities, majority of respondents (46%) came from different districts within the region while this formed the least (3%) representation in the public health facilities. This is followed by those (33.3%) from villages within the district.
This finding shows that the desire to seek medical care goes beyond the location of patients, and the private health providers in particular showed access to patients from far areas compared to the sampled public health providers. The high demand for public healthcare by patients from villages within the districts could be in the Savelugu/Nanton District where health facilities are limited. There was only one private clinic in the District capital but not better equipped with basic health facilities. Another issue could be that the clinic was newly established and many people especially those from the villages might not be aware of it or thought it was costly as many view private health service. Both public and private health providers (10% and 6.6% respectively) received patients from other regions but the public had more of this group compared with the private.
The Distance of Patients within the Communities to Health Facilities

To investigate more into the destinations of respondents, those from the communities were asked to indicate the distance from home to the health facility. This section tries to show the impact of patients’ nearness to health facilities. The results in figure 4.4 below showed that respondents with less proximity to public health services were more than those from the distance of 500-1000 meters (25%) and those from above the distance of 1000 meters (16.6%). However, the private health providers served patients from far areas within the communities compared with the public health providers. It means patients were more aware of the practice of private health providers especially those from different districts (figure 4.3 above) and those from far areas within the communities where the facilities were located.

![Graph showing distance from patient home to Health Facilities](image)

**Fig. 4.4. Distance from patient home to Health Facilities. Source: Author Compilation.**

The following observation can be deduced from the above findings:

- Easy propensity or nearness to health facilities formed a major factor by patients who seek public healthcare;
• Patients from far away within the communities formed the largest group who seek private healthcare; and

• The desire to seek healthcare from private providers goes beyond nearness to the facilities but other factors could be considered (i.e. expertise and quality service).

**Frequency of Patient Visits to Health Facilities**

In an attempt to ascertain interviewees’ opinions on the number of occasions they visit the health facilities, respondents were asked to state the number of times they seek medical care in that facilities within the last two years. The findings in figure 4.5 below show that respondents who seek healthcare more than three times formed the majority groups in both types of health facilities representing 30% and 36.6% respectively. It

![Graph showing frequency of visits to health facilities](image)

**Fig. 4.5. Frequency of Visits to Health Facilities.** *Source: Author Compilation.*
could be due to the acceptance of NHI identity cards in both types of facilities.

In the case of private health providers, it could be attributed to the free health services provided by the SHC. The high number of patient visits in the second (30%) time could also be due to the satisfaction of healthcare during the first visit. Similarly, the high number of patient visits in the third time (26.6%) to public health facilities could be due to more patients on review cases.

**Cases Reported by the Sampled Patients at the OPD**

Figure 4.6 highlighted the kinds of cases reported at the various health facilities by the sampled respondents.

![Chart showing cases reported at the OPD](image)

Fig. 4.6. Reported Cases at the OPD. *Source: Author Compilation.*
The results show that patients with malaria cases recorded the highest in both health facilities but more of this was from the public health providers (46.6%). Body pains (20%) and stomach pains (16.6%) formed the second and third highest cases reported in the public health facilities while these cases had equal number reported (26.6% respectively) in the private health facilities. The private health facilities registered hernia, stroke, and epilepsy cases but none of these were found in the public health facilities.

From the discussion the following observation can be made:

- Malaria continued to be a threat in Ghana as it recorded highest in both types of health facilities. Coincidently, Northern Region has the highest malaria cases among the 10 regions in Ghana;  
- It showed that apart from malaria incidences stomach pains and body pains formed a significant threat to people’s health within the two district; and  
- The private health facilities showed more accessibility to patients with complex cases such as hernia (surgery), stroke, and epilepsy. It could mean that they have more experience in these cases compared with the sampled public health providers.

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24 It includes body weakness, waist pains, chest, eyes, and joint pains.  
Internal Factors That Determine Patients’ Desire to Seek Healthcare

Reasons for Patient Choice of Health Facility (Pull factors)

Respondents were asked why they chose to seek care at the health facilities. It was a matter of finding whether patients presence at the health facilities were coincidence or an in-build desire. A patient found in a particular type of health facility may not mean that it is the only place quality healthcare could be provided.

Accordingly, the acceptance of NHI identity cards formed the highest (30%) reason in the public health facilities. Other group of respondents (6.6%) mainly from the Savelgu/Nanton District said they seek public healthcare because there were no other better health facilities in the district although there were other health centers in many rural areas.

Fig. 4.7. Reasons for patient choice of Health Facility. Source: Author Compilation.
It could mean that patient demand for better healthcare was directly linked to the SH. It further means that if well-established private health providers were present many patients would have sought healthcare with them instead of the SH. The nearness of patients (13.3%) to public health facilities also played a vital role. This reason confirmed the earlier findings (p.54) that majority of the sampled respondents came from distances less than 500 meters. Furthermore, a significant majority of patients seek public healthcare due to good medical services/expertise (26.6%) of the doctors and also because they waste little time when serving patients (23.3%). It could be attributed to the presence of more professional doctors and trained nurses. Also, the medical doctors were not performing dual functions as the case of doctors in the private health facilities.

Good medical care/expertise (66.6%) formed the most reasons patients seek private healthcare but this reason was second in the public health facilities. It is a fact that majority of private health providers are made up of retired personnel from the public health sector in the country\textsuperscript{26} and they could have more experience as a result of long services. Also, the high number of respondents who seek private healthcare due to personal reasons (16.6%) was an indication that private health providers performed well in offering the needed services. Thus, the sampled patients perceived private providers as those who offer more quality healthcare compared to the sampled public health providers.

\textbf{Patients’ Decision not to Seek Healthcare Sometimes (Push factors)}

On the question of whether there were certain factors that deter patients from seeking healthcare in the various health facilities, 22 (73.3%) respondents from the public

\textsuperscript{26} Sodzi-Tettey discussed the situation of the private health providers in Ghana. Further shows that private providers are retired personnel of the public health sector. Sodzi-Tettey, Sodzi. (2007). “Korle Bu between the myth and legend!” (www.ghanaweb.com).
health facilities said there is no factor, eight (26.6%) indicated there is at least one factor. Further investigation from the eight respondents revealed that four of them reasons were because the nurses were being impolite to patients on certain occasions. The remaining four respondents indicated due to occasional unavailability of doctors or waiting for longer hours either at the laboratory or the pharmacy for the purpose of taking drugs. Waiting of too much time as a reason here contradicts earlier findings (p.62) that a significant majority seek public care because they offer fast services. These findings show that waiting for longer hours, nurses being impolite to patients and doctors’ disobedience to time impact negatively on patients who prefer to seek public health services. For solution to these problems, the first four respondents said management need to enforce the ethics, rules, and code of conduct of health personnel in the GHS. The second four respondents indicated the need to increase doctors, technicians, and specialist in the public health facilities.

However, none of the 30 sampled respondents in the private health facilities stated any reasons that prevent them from seeking healthcare. This finding is fascinating because people might have thought private health providers charge fees or some of the nurses were nonprofessionals to be a factor but no one gave these reasons. Overall, many internal factors hinder patients desire to seek healthcare at the sampled public health facilities compared to the private and these factors have much effect on accessibility. The doctors’ behavior (lateness) formed one of the major reasons many patients would not seek public healthcare the subsequent times.
Hours/minutes Spend Before Meeting a Doctor

The results in figure 4.8 indicated that out of the 30 sampled respondents in the public health facilities, nine (30%) of them spent more than 4 hours. The next group of respondents spent from 1 to 2 hours (23.3%) while the third group spent from 2 to 3 hours, and 3 to 4 hours, both representing 16.6% respectively. For the case of the private health facilities\(^{27}\), majority of respondents (60%) spent less than 1 hour before seeing a doctor. The next group of respondents (23.3%) spent between 3 and 4 hours.

Fig. 4.8. Hours/minutes Spend before Meeting a Doctor. Source: Author Compilation

\(^{27}\) It excludes the number of days spend queuing in the Shekhinah Clinic. Patients may queue from two to more than five days before meeting a doctor. Management believed that this queuing will avoid cheating.
The findings revealed that patients have easy access to doctors in private health facilities compared to public health facilities. The large number of patients who spent more than 4 hours in the public facilities shows that there were problems with regard to obedience to time by health personnel and this is confirmed in the previous analysis.

To explore further into spending longer time those who spent 3 to 4 hours and those who spent above 4 hours were asked whether that would affect their decisions for next consultation. Six (42.8%) out of the 14 respondents in that category in the public health facilities, and three (42.8%) out of the seven respondents in the private health faculties said yes.

However, on both cases the respondents indicated that meeting a doctor early or not is relative. It depends on the patient punctuality to the health facility or the number of patients present before the patient gets to the health facility. Since public health providers achieved a very high OPD attendance compared to the private health providers the possibility of accessing doctor early was high in private facilities as a result of relatively low patient attendance.

The general lessons learnt are:

- Patients spend less time in private health facilities before meeting a doctor compared with the public health facilities;

- Few patients who seek private healthcare do not care much about the time utilize before meeting a doctor compared to those in the public health facilities; and

- Less obedience to public health ethics and code of conduct by doctors and nurses impact negatively on patients’ desire to seek public healthcare.
Patients Accessibility to Drugs

The results indicated that respondents (86.6%) who always received all the drug prescription in the private health facilities were more than those in the public health services (66.6%). Those who usually did not acquire all the drug prescription were asked how they get the remaining drugs, respondents (33.3%) from the public health facilities said they purchased from the private pharmacy shops in the market while those from the private health facilities stated they were given related drugs. The reason is that some of the drugs not found within the private clinics were not easily accessible in the pharmacy shops. The SHC receives large quantity of drugs from outside the country. In this respect higher opportunity to access drugs was predictive of continued patient attendance in private health facilities compared to the public health facilities.

The findings showed that there was little evidence that a public health provider has adequate drugs for patients compared to the private health provider. The private providers have more drugs for patients compared to the public and they also reduces cost of care by giving related drugs instead of patients buying outside with high prices.

Consultation Charges in the Health Facilities

Mode of Paying for Consultation

The sampled respondents were asked how they pay consultation fees. Figure 4.9 below revealed that majority of respondents were insured (15 in SH and 11 in TWH) in the public health facilities representing 86.6%. Similarly, some of the respondents (20%) in the private health facilities were insured (six) while majority of them (26.6%) paid directly. These categories of respondents were from the HAC. It is borne in mind that the
SHC clinic provides free health services. The least respondents (3.3%) were those supported by either a friend or a relative in both types of health facilities.

Respondents were asked to explain whether the NHI covered all the consultation charges apart from mortuary and ambulance services. Three insured respondents out of the 86.6% in the public health facilities indicated they were asked on certain occasions to purchase drugs outside the health facility but they could not explain whether such drugs were not covered by the scheme. However this reason was not recorded in the HAC.

![Mode of Paying for Consultation](image)

Fig. 4.9. Mode of Paying for Consultation. *Source:* Author Compilation.
Observations:

- The acceptance of NHI cards formed a significant reason for patients who seek public healthcare as in the case of the previous explanations (reasons for seeking care);
- Despite the implementation of the NHI, cash and carry system still operate in the public health facilities, some people were not registered;
- Private providers also serve patients with NHI identity cards;
- Note all services were covered by the NHI (i.e. ambulance and mortuary);
- Information on the use of NHI in public health facilities was more pronounced compared to the private health facilities; and
- Despite charges in the private health facility, it still received more patients who were ready to pay for the health services.

Inpatients’ Opinions on Doctor-Patient Relationships

A total of five inpatients were selected for the interview from each of the four health facilities (total 20). They were asked to rate their opinions about the doctor-patient relations based on poor, relatively good, and very good. Respondents indicated a very good doctor-patient relation, representing 60% in the public health facilities and 70% in the private health facilities. None of the two types recorded poor.

These results show that both health facilities accorded the inpatients very high respect and they were mostly satisfied in the private health facilities. The reason could be that doctors either encouraged the inpatients or paid daily visits to see the improvement of their health situations. Respondents (40%) considered doctor-patient relations to be
relatively good in the public health facilities while this factor recorded 30% in the private health facilities. The earlier analysis indicated that (only HAC) nurses in the private facilities were nonprofessionals; hence they might have problems with regard to serving inpatients and this factor could be reasons why some respondents considered them as relatively good.

**Patients' Perception about Nurses at the OPD**

The OPD formed the main entrance for registration and attendance for healthcare in all hospitals and clinics in Ghana. Good reception or the otherwise in this department may affect patients' desire to seek healthcare the subsequent times. It is borne in mind that only the HAC has no trained nurses among the sampled private health providers. Like the above analysis, respondents were asked to rate their perception about nurses’ services based on poor, relatively good, and very good as shown in figure 4.10 below.

The analysis revealed that services of nurses were very good (46.6%) in private health facilities but the public providers performed better (83.3%). However, respondents (13.3%) who perceived services of nurses as relatively good in the public health facilities were less than those (46.6%) in the private health facilities. The findings further show that on both cases there were patients who faced problems with nurses in the OPD but this reason was more in the private health facilities (6.6%) compared to the public (3.3%). The reason could be associated with private management inability to employ professional nurses as the case of the HAC. The fact is that those trained have relative advantage over the untrained in the activities of OPD services. The shortage of these trained personnel in the sampled private health facilities formed one of the major setbacks for enhancing quality health delivery.
Preferred Doctor for Healthcare

In order to determine whether preference works in seeking healthcare, a question was asked if respondents have a particular doctor who they always wish to seek advice with and how the person different from the rest. Twenty-one (70%) respondents in the public health facilities said no and they were always happy to meet any doctor at post. However, nine (30%) respondents indicated yes. The preference for those doctors was that they flatter patients. For the case of the private health providers, 20 (66.6%) respondents also said no while 10 (33.3) said they have preference. Four respondents out of the 10 shared similar views unlike the nine respondents from the public health facilities. The remaining six related their reasons to such doctors’ experience in solving patient health needs.
The findings show that the desire to meet a particular doctor for consultation forms insignificant reason by patients who seek healthcare in public health facilities compared to the private health facilities. It further confirmed the previous analysis (p.62) that the expertise of doctors formed a significant reason patients seek private health services.

**Satisfaction of Healthcare**

An in-depth probe was done for respondents to explain their satisfactory level of the health services attended. Table 4.5 below summarizes the results.

<table>
<thead>
<tr>
<th>Conditions</th>
<th>Public</th>
<th></th>
<th>Private</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>N</td>
<td>%</td>
<td>N</td>
<td>%</td>
</tr>
<tr>
<td>Generally less satisfied</td>
<td>1</td>
<td>3.3</td>
<td>1</td>
<td>3.3</td>
</tr>
<tr>
<td>Generally satisfied</td>
<td>24</td>
<td>80.0</td>
<td>26</td>
<td>86.6</td>
</tr>
<tr>
<td>Cordial relations</td>
<td>4</td>
<td>13.3</td>
<td>1</td>
<td>3.3</td>
</tr>
<tr>
<td>Satisfied both service</td>
<td>1</td>
<td>3.3</td>
<td>2</td>
<td>6.6</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>30</strong></td>
<td><strong>100</strong></td>
<td><strong>30</strong></td>
<td><strong>100</strong></td>
</tr>
</tbody>
</table>

*Source: Author Compilation.*

A majority of respondents in both types of services were generally satisfied with the services provided but the private health providers recorded the highest responses (86.6%) over the public (80%). It means that respondents were generally more satisfied with the care provided by private health providers compared with the public.

Those respondents who were satisfied with only the cordial relations of the personnel rated 13.3% in the public facilities while this reason formed one of the minute cases (3.3%) in the private health facilities. Respondents who were less satisfied with the
general health services formed one of the least cases recorded (3.3% respectively) in each types of health facilities. This reason could be attributed to patients waiting for longer period, preferential treatment being offered to some patients or poor reception at the OPD. Nevertheless, many patients did not see any difference in both types of health facilities but those people with that opinion were more (6.6%) in the private health facilities compared to the public health facilities (3.3%).

Recommendation

The final question demanded from respondents to say what they think good for the improvement of accessibility and affordable health delivery.

The Public Health Providers

The common suggestion of respondents in the two public health facilities was the need for management to employ more specialists and to improve nurse-patient relations. The absence of these medical doctors contributed to more referral by the health facilities. However, suggestions that were specific to each health facility were the need for an additional ambulance as the case of the SH. The reason was that if the one ambulance in the hospital breaks down, emergency services would be affected in the district. The respondents in the TWH wished that management enforce obedience to time and bye-laws of the health facility. It is confirmed in the previous analyses (p.63) that these factors deter patients from seeking public healthcare.
The Private Health Providers

The common suggestions of respondents were the need to employ more professional doctors and specialist, and also to employ qualified administrative staff and more trained nurses. Other recommendation was the need for better nurse-patient relations. The specific suggestions (SHC) were that respondents wished the accommodation provided by the communities be well furnished, and also the need for a continue community initiatives in building new rooms and renovating those rooms in deplorable conditions for inpatients. Other factors were the need for management to provide electricity in all the local rooms built by the communities, and the request for those on review not queue on subsequent visits. Inspection carried out in the local rooms revealed that most of the rooms were not properly furnished and some lacks basic hospital equipments. The respondents in the HAC suggested that cleaners always finish their duty on time.

Conclusion

The analyses show that each type of health provider has an advantage over the other with regard to accessibility and affordability. Public health providers are more accessible to patients from villages within the districts and those within the communities. An important strength is the acceptance of the NHI identity cards in the health facilities. These insured respondents formed the majority groups in the facilities especially in the Savelgu health facility. These providers also achieve very high OPD attendance though with marginal decreases in certain years. Nonetheless, other factors like disobedience to time and cost of healthcare for the non-insured patients are some of the most factors that
impact negatively on patient desire to seek services on subsequent times and those of poor group access to better healthcare.

As the private health providers, the analyses show that illiterates and those with basic education are the groups who mostly seek healthcare. It could be argued that patients have limited access and choice of better healthcare in districts and communities where there are no established private hospitals or clinics. These providers also have more access to majority of patients from different districts and those in far areas within the communities. The private sector enhances accessibility and affordability through offering of free services. Despite operating with few doctors they have fairly gender balance. They also have medical doctors with expertise in certain areas (i.e. stroke and epilepsy). It is also observed that punctuality of doctors, availability of drugs, and less waiting time by patients at the facilities form major factors patients prefer private healthcare. However, the limitations of these health providers include the use of nonprofessional administrators, and the shortage of trained nurses especially in the HAC. Other factor is also the shortage of medical doctors which impacted negatively on their speedy consultation.

Thus, respondents in both types of health providers recommended for an increase in medical doctors, professional administrators, and trained nurses. It means both types of health providers suffer the same way with regard to medical personnel but the public was better. The findings confirm the shortage of doctors in both public and private health facilities in the country.
CHAPTER 5

EFFICACY AND QUALITY HEALTHCARE

This part of the study assesses strategies devised to enhance the efficacy and quality health delivery by both public and private health providers. Assessment was based on the output of both types of providers in terms of the availability of staff, medical personnel, equipment and facilities, facilities’ external relations, and the government. The chapter is divided into two parts. Part one examines the demographics of directors and doctors, strength of medical personnel, and patient attendance. This is followed by an assessment of management strategies in the respective health facilities to promote efficacy and quality healthcare. The indicators for such assessment include services provided, accommodation for inpatients, categories served, cost of care, and sources of drugs and financing.

Part two analyses the service length of doctors, factors that motivate them to stay and serve, and their limitations. It also assesses how doctors provide health services which affect patients’ choice of healthcare. These include time spend per patient, official working hours utilize, and activities during off-duty. The rest are public-private doctor relations, doctors’ perceived constraints, and these are followed by recommendations.

Efficacy refers to the extent to which both public and private healthcare providers influence patients’ access to health services, reduce cost of care, and produce quality results. Doctors here referred to both Medical Doctor (MD) and Medical Assistant (MA) in certain parts of this chapter. The MAs are supposed to assist the MDs and their services are in the form of training to upgrade their knowledge and skills. However, they
also consult like the MDs and places where these MDs are few or not at all (remote districts and communities) the MAs occupy their positions. This becomes possible as a result of shortage of MDs in both public and private health facilities in certain cases.

PART I

Management of Health Facilities

*Demographics of Doctors and Directors*

The statistics in table 5.1 shows the age, sex, and educational status of both doctors and directors in the two types of health facilities. The results indicated that doctors with ages between 41 and 50 formed the majority in the public health facilities while the directors were between the ages of 31 and 40, and 41 to 50. The ages of the sampled doctors in the private health facilities falls between 51 and 60, and 61 and 70 representing two responses each. The directors’ ages falls from 31 to 40, and 51 to 60 with each recorded one response. With the exception of HAC which recorded one female MA, the rest of the sampled doctors and directors in both types of health facilities were males.

On the issue of educational status, the survey recorded two MDs and two MAs in both types of health facilities respectively. One public health provider has a professional director (SH) with first degree and the other three health facilities have one MD each as acting directors. However, their responses were taken independently in this table and the preceding text.
Table 5.1. Demographic Characteristics of Doctors and Directors

<table>
<thead>
<tr>
<th></th>
<th>Public Doctors</th>
<th>Public Directors</th>
<th>Total N</th>
<th>Total %</th>
<th>Private Doctors</th>
<th>Private Directors</th>
<th>Total N</th>
<th>Total %</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Age</strong></td>
<td>N</td>
<td></td>
<td></td>
<td></td>
<td>N</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>31-40</td>
<td>0</td>
<td>1</td>
<td>1</td>
<td>16.6</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0.0</td>
</tr>
<tr>
<td>41-50</td>
<td>3</td>
<td>1</td>
<td>4</td>
<td>66.6</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0.0</td>
</tr>
<tr>
<td>51-60</td>
<td>1</td>
<td>0</td>
<td>1</td>
<td>16.6</td>
<td>2</td>
<td>1</td>
<td>3</td>
<td>50.0</td>
</tr>
<tr>
<td>61-70</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0.0</td>
<td>2</td>
<td>1</td>
<td>3</td>
<td>50.0</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>4</td>
<td>2</td>
<td>6</td>
<td>100</td>
<td>4</td>
<td>2</td>
<td>6</td>
<td>100</td>
</tr>
<tr>
<td><strong>Sex</strong></td>
<td>N</td>
<td></td>
<td>N</td>
<td></td>
<td>N</td>
<td></td>
<td>N</td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>4</td>
<td>2</td>
<td>6</td>
<td>100</td>
<td>3</td>
<td>2</td>
<td>5</td>
<td>83.3</td>
</tr>
<tr>
<td>Female</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0.0</td>
<td>1</td>
<td>0</td>
<td>1</td>
<td>16.6</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>4</td>
<td>2</td>
<td>6</td>
<td>100</td>
<td>4</td>
<td>2</td>
<td>6</td>
<td>100</td>
</tr>
<tr>
<td><strong>Educational Status</strong></td>
<td>N</td>
<td></td>
<td>N</td>
<td></td>
<td>N</td>
<td></td>
<td>N</td>
<td></td>
</tr>
<tr>
<td>Medical Doctor</td>
<td>2</td>
<td>0</td>
<td>2</td>
<td>40.0</td>
<td>2</td>
<td>0</td>
<td>2</td>
<td>50.0</td>
</tr>
<tr>
<td>Medical Assistant</td>
<td>2</td>
<td>0</td>
<td>2</td>
<td>40.0</td>
<td>2</td>
<td>0</td>
<td>2</td>
<td>50.0</td>
</tr>
<tr>
<td>1st Degree</td>
<td>0</td>
<td>1</td>
<td>1</td>
<td>20.0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0.0</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>4</td>
<td>1</td>
<td>5</td>
<td>100</td>
<td>4</td>
<td>0</td>
<td>4</td>
<td>100</td>
</tr>
</tbody>
</table>

Notes: the use of ‘0’ refers to no recorded response; N refers to number of respondents; and % refers to percentage of respondents. Source: Author Compilation.

The general observations of these personnel characteristics revealed the following:

- The private health facilities employ senior doctors compared to the public. Seniority means more experience, and therefore more efficiency;
- It reflects the shortage of administrative professionals in all cases especially in private health facilities; and
• The survey indicates the shortage of female doctors but it was better in the private facilities. This may be explained in part that females also formed major groups of the continuous exodus of medical professionals in general to the West for greener pastures.

**The Strength of Medical Personnel**

The directors were asked to provide the total number of medical personnel available over seven-year period. The results in tables 5.2 and 5.3 below indicate that public health providers had more medical personnel than the private providers.

<table>
<thead>
<tr>
<th>Public</th>
<th>Personnel</th>
<th>2001</th>
<th>2002</th>
<th>2003</th>
<th>2004</th>
<th>2005</th>
<th>2006</th>
<th>2007</th>
</tr>
</thead>
<tbody>
<tr>
<td>Savelgu Hospital</td>
<td>MDs</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>MAs</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>Specialist</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td></td>
<td>Nurses</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>16</td>
<td>-</td>
<td>-</td>
<td>14</td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td>1</td>
<td>3</td>
<td>3</td>
<td>20</td>
<td>4</td>
<td>4</td>
<td>18</td>
</tr>
<tr>
<td>Tamale West Hospital</td>
<td>MDs</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>MAs</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>2</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Specialist</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Nurses</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>30</td>
<td>34</td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>35</td>
<td>39</td>
</tr>
</tbody>
</table>


One reason for this is that the public sector is supported by the government and therefore has more financial muscle to recruit more personnel than the private sector with
limited financial resources. Some of the private health facilities who are not affiliated to either CHAG or SPDMP (like the sampled private facilities) do suffer in getting MDs into their establishments.

Table 5.3. Medical Personnel in the Private Health Facilities (2001-2007)

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Shekhinah Clinic</td>
<td>MDs</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>MAs</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>Specialists</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td></td>
<td>Nurses</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>10</td>
<td>10</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td></td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>3</td>
<td>3</td>
<td>13</td>
<td>13</td>
</tr>
<tr>
<td>Haj Adam Clinic</td>
<td>MDs</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>MAs</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Specialists</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td></td>
<td>Nurses</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>6</td>
<td>6</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td></td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>8</td>
<td>8</td>
</tr>
</tbody>
</table>


**Average Outpatient Attendance (AOA) per Doctor**

The previous analysis in chapter four showed that the public health facilities received more patients (both in and outpatients) at the OPD compared to the private health providers. This aspect of the analysis tried to identify which type of health providers has more AOA per doctor. Due to lack of secondary of data from the HAC and the provision of incomplete information by the TWH, the study considered the SHC (private) and the SH (public) statistics.
Table 5.4. Average Outpatient Attendance per Doctor

<table>
<thead>
<tr>
<th>Years</th>
<th>Savelgu Hospital (Public)</th>
<th>Shekhinah Clinic (Private)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Outpatient MDs at Post</td>
<td>AOA per Doctor</td>
</tr>
<tr>
<td>2001</td>
<td>4,165</td>
<td>1</td>
</tr>
<tr>
<td>2002</td>
<td>5,828</td>
<td>3</td>
</tr>
<tr>
<td>2003</td>
<td>7,095</td>
<td>3</td>
</tr>
<tr>
<td>2004</td>
<td>10,006</td>
<td>4</td>
</tr>
<tr>
<td>2005</td>
<td>12,129</td>
<td>4</td>
</tr>
<tr>
<td>2006</td>
<td>5,460</td>
<td>4</td>
</tr>
<tr>
<td>2007</td>
<td>20,995</td>
<td>4</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>65,678</strong></td>
<td><strong>23</strong></td>
</tr>
</tbody>
</table>


Table 5.4 above showed that an increase of one MD in 2002 led to decrease in AOA per doctor in the SH. The AOA per doctor rises from 2003 to 2005 despite increased in one doctor in 2004 and 2005 respectively. The AOA per doctor fell in 2006 and increased in 2007. This unsustainable pattern of AOA per doctor is as a result of continuous increases in registration of outpatients at the OPD throughout the study period except 2006.

In the case of the SHC, the AOA per doctor increased for the first three years (2001-2003), and then fell in 2004. It also shows the same unsustainable trend like the SH over the rest of the study period. Due to the presence of more MDs in the SH it showed a relatively low AOA per doctor which results in less workload compared to the SHC. The high AOA per doctor in the SHC has negative impact on the efficiency and quality healthcare as a result of pressure on the same doctors every working day. Figure 5.1 below further presented the above analyses.
Fig. 5.1. Average Outpatient Attendance per Doctor. *Source:* Author Compilation.

**Referral of Patients**

The data from the SH was incomplete so the SHC and the TWH statistics are used for the analyses. The TWH witnessed large reduction of referral cases from 2002 to 2003 then showed marginal decreases throughout the period. The SHC on the other hand showed an increase in referral in the first three years (2001-2003), decreased in 2004 and 2005, and then increased again in the last two years. Large referral may mean that such health facility either lacks certain vital services (i.e. X-ray and laboratory) or it may be the shortage of MDs with the expertise for those referred. It could be argued that the SHC shows a better way of serving a majority of patients due to presence of more experience doctors which resulted in less referral over the public (TWH), though both had decreases in referral over the period as shown in figure 5.2.
The provision of incomplete data in certain cases in both health facilities shows the inefficiencies in record keeping by the administrative staff but the public was better. The public health providers should have provided complete information because they had computers in the facilities. The poor documentation witnessed means administrators could give incorrect information.

**Services Provided by Health Facilities**

Table 5.5 presents the type of health services provided by both types of health providers. The results indicated a wide coverage of basic health services provided by public health providers compared to the private providers. However, X-ray services appeared to be unavailable in the facilities and theatre services for the case of TWH.
Table 5.5. Expanded Services Provided by Health Facilities

<table>
<thead>
<tr>
<th>Health facilities</th>
<th>Available</th>
<th>Unavailable</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Public providers</strong></td>
<td>Antenatal and maternal care, child and family welfare, clinical and curative, laboratory service, pharmacy, ambulance, skill delivery (TBAs), blood transfusion, school health.</td>
<td>X-ray, mortuary, theatre.</td>
</tr>
<tr>
<td><strong>SH/TWH</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Private providers</strong></td>
<td>Clinical and curative, pharmacy, mentally disabled, family welfare, theatre, epilepsy, mortuary, X-ray, laboratory service.</td>
<td>Antenatal and maternal care, child welfare, ambulance.</td>
</tr>
<tr>
<td><strong>SHC</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>HAC</strong></td>
<td>Antenatal and maternal care, clinical and curative care, family and child welfare, pharmacy, laboratory service.</td>
<td>X-ray, mortuary, ambulance, theatre.</td>
</tr>
</tbody>
</table>

*Source: Author Compilation*

In the case of private health providers, the HAC shows some common services unlike the public while the SHC appeared to have more equipment but does not provide basic services like the antenatal and maternal care. The clinic has X-ray and laboratory departments but they were not in operation due to lack of qualified technicians at the time of the survey.

Thus, the analyses show that both types of health providers did not provide all the needed services and this reflected negatively in access to these health facilities. It means that healthcare is not equitably distributed especially in SH where it happened to be the only well equipped hospital in the Savelgu/Nanton District. The findings show the shortage of technicians in both types of health facilities especially the private (SHC) where most vital equipments were idle. It could be argued that the absence of X-ray in public facilities forms one of the reasons for large referral within the seven-year period. Despite the absence of some services in the public health facilities, they provided more
services (i.e. ambulance, school feeding, skill delivery, and blood transfusion) compared to the private health providers.

**Strategies for Better Healthcare Delivery**

**The Impact of National Health Insurance Scheme (NHIS)**

The NHIS is one of the latest policies implemented in 2002 by the MOH through GHS to provide equitable access and affordable healthcare to all. This policy is linked to the MDGs. This section was structured to determine the acceptance of the scheme by the citizens and its impact on total attendance from 2005 to 2007, especially in the private health facilities. The analysis in table 5.6 shows that both public health providers serve patients with NHI identity cards. Empirical evidence was the SH where all the 15 sampled respondents were insured and 11 of them in the TWH.

In the part of the private health providers, only the HAC served insured patients and the SHC provided free health services. There was an awareness of the scheme in both public and private facilities with the public being the best. The registration fee is GHC 7.2 pesewas (about US$8). It may be seen to be less costly because people register once a year and the total registration was 38% in the country as of December 2006. However, the registration fee could also be seen to be high because majority of Ghanaians live below the poverty line meaning that majority of the people could not afford the registration fee.

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29 It shows that share of population below national poverty line was 39.5% and those who lives under US$1 was 44.8% as of 1998-99 (African Development Indicators, 2006)
Table 5.6. Influence of NHIS on OPD Attendance

<table>
<thead>
<tr>
<th>Years</th>
<th>Public providers</th>
<th>Private providers</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>SH</td>
<td>TWH</td>
<td>SHC</td>
</tr>
<tr>
<td>2001</td>
<td>4,165</td>
<td>20,671</td>
<td>11,539</td>
</tr>
<tr>
<td>2002</td>
<td>32,460</td>
<td>66,090</td>
<td>12,217</td>
</tr>
<tr>
<td>2003</td>
<td>45,186</td>
<td>77,249</td>
<td>16,241</td>
</tr>
<tr>
<td>2004</td>
<td>47,026</td>
<td>55,846</td>
<td>14,318</td>
</tr>
<tr>
<td>2005</td>
<td>47,941</td>
<td>51,731</td>
<td>16,323</td>
</tr>
<tr>
<td>2006</td>
<td>6,956</td>
<td>36,558</td>
<td>16,047</td>
</tr>
<tr>
<td>2007</td>
<td>24,837</td>
<td>33,406</td>
<td>17,460</td>
</tr>
<tr>
<td>Total</td>
<td>208,571</td>
<td>341,498</td>
<td>104,145</td>
</tr>
</tbody>
</table>

Source: OPD records (2001-2007)

Observations:

- The scheme has little impact on attendance in the one private health facility with data available. The SHC registered steady increases in the OPD between 2005 and 2007 except in 2006 where it witnessed a marginal reduction in attendance;
- Most respondents were not aware that some private health providers (i.e. HAC) accept insured patients; and
- The scheme has relatively little impact on OPD attendance in the public health facilities as shown in the TWH (2004-2007) and also by comparing 2006 and 2007 figures in the SH.

Fees Paid at the OPD

The directors (except SHC) were asked to provide cost incurred by the non-insured patients before meeting a doctor.
Table 5.7. The Cost Incurred by Non-insured Patients at the OPD

<table>
<thead>
<tr>
<th>Health facilities</th>
<th>Fees paid</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Public health providers</strong></td>
<td></td>
</tr>
<tr>
<td>Savelgu Hospital</td>
<td>GHC 2.50 pesewas</td>
</tr>
<tr>
<td>Tamale West Hospital</td>
<td>GHC 2.00</td>
</tr>
<tr>
<td><strong>Private health provider</strong></td>
<td></td>
</tr>
<tr>
<td>Haj Adam Clinic</td>
<td>GHC 2.00</td>
</tr>
</tbody>
</table>

*Source: Author Compilation*

Table 5.7 above analysis indicates that public health providers charge high\(^{30}\) fee compared to the private and this might be above the poor. It means that majority of the people in the two districts could not seek public healthcare as a result of the high cost and most of them could turn to the help of the traditional health providers. The high fee limits patient access to these facilities and it also showed that public healthcare is less affordable.

In the case of the one for-profit private health provider (HAC), it charge equivalent fees with the TWH and less compared to the SH. The findings could mean that the facility is not entirely for-profit entity. It reverses doubts on the validity of the general opinion that private health providers charge high fee which deter many people for their services. Although it is not obvious that all private health providers charge low fee but this finding revealed that some private health facilities charge low fee and most of them even provide free service like the SHC. It further shows that some private health providers charge fees to ensure being in the business.

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\(^{30}\) Savelgu Hospital above US$2, and Tamale West Hospital approximately US$1.94.
Thus, most poor and the destitute have limited access to both types of providers but the private was better. Despite being for-profit oriented health facility, the HAC charged equal or less fees compared with the public health providers. The study further revealed that there was no uniform fee in the two sampled public health facilities.

On whether certain times patients were unable to pay consultation fee and any additional charges (i.e. drugs and laboratory expenses), the public health providers indicated yes. It ranges from GHC10 to GHC20 and GHC10 to GHC40 in the Savelgu and Tamale West health facilities respectively. Matters of this kind were handled by the social welfare committee in each health facility. For the part of the HAC, such cases rarely happen and this amount ranges from GHC1 to GHC2. Such matters were handled by the doctor who was also the director and the owner at the same time. Again, most patients may not like to seek public healthcare if they have debts to settle and this would have impact on patients with review cases. The issue was better in the private health facility compared to the public because debts incurred by patients in the public health facilities are higher.

**Accommodation for Inpatients**

It is a fact that all health institutions strive to provide conducive and affordable places for inpatients but the ways of doing so vary from one health facility to the other. The public health facilities have inadequate accommodation for the increased number of inpatient attendance. Other issue of major concern was inadequate beds. For the case of the private health providers, the SHC had enough accommodation for inpatients but with inadequate basic facilities such as beds and other necessary equipment. Many
communities in the Tamale Metropolis and some villages in other district do provide accommodation (local rooms) for inpatients. However, these local rooms have no basic equipment and were being furnished by the management of the institution. On other cases, inpatients come with mattresses or mats for use in the rooms. The HAC did not have permanent accommodation but only detain patients from about 6 to 10 hours. However, the clinic has relatively available basic equipment and facilities in the wards.

It could be argued that although all the two types of health providers have inadequate basic accommodation facilities and equipment but the public was better equipped with modern accommodation facilities compared to the private especially the Shekhinah clinic. In all cases in the three health institutions (SH, TWH, and HAC) most inpatients stay home and do seek daily or weekly review due to inadequate space to accommodate them.

**Source of Drugs for the Health Facilities**

The procurement of adequate drugs for patients enhances accessibility to health services. Health providers in the country have different ways of acquiring drugs. The directors of the respective health facilities were asked to indicate where they purchase drugs. Results show that public health providers acquire drugs through the Regional Medical Stores (RMS) and occasional from the Open Market\(^{31}\) (OM). The OM becomes possible when drugs get finished than expected and drugs at the RMS are not ready, or certain drugs are not available at the RMS. In the part of the private health providers, the HAC acquire drugs entirely from the OM while the SHC receives supply abroad and  

\(^{31}\) These are pharmaceutical companies producing drugs and medicine for sale to either the government or the private sector.
occasional supply from the government; although the facility also acquires drugs from the OM.

The occasional acquisition of drugs from the OM by the public health providers show that they are not better placed compared to the private. The private health providers stand the chance of acquiring drugs faster compared to the public providers who always depend on supply from the government which in most cases are either inadequate or some drugs not available. An interview of one respondent in the private facility revealed that patients are not always referred to outside pharmaceutical shops. Empirical evidence was the SHC that acquire drugs outside the country and most of the drugs are not easily accessible in the OM, hence related drugs were often given.

**Available Equipment and its Conditions**

The efficacy and quality of healthcare can not be realized unless the right (basic) equipment and other facilities (i.e. transport) are available in good conditions. The shortage or lack of these amenities would have negative impact on better healthcare delivery.

It is clearly seen from the findings below that none of the two types of providers has deteriorated equipment but rates either good or very good. The public health providers did not own the laboratories in their premises but they were being provided by a private health facility known as New Life Laboratory. Thus, both public and private providers are better equipped to offer quality healthcare as a result of having many equipments in better quality. Table 5.8 below summarizes the quality of the equipment based on poor, good, and very good.
Table 5.8. Available Equipment and its Conditions

<table>
<thead>
<tr>
<th>Equipment</th>
<th>Public SH</th>
<th>Public TWH</th>
<th>Private SHC</th>
<th>Private HAC</th>
</tr>
</thead>
<tbody>
<tr>
<td>Laboratory</td>
<td>Good</td>
<td>Good</td>
<td>Good</td>
<td>Good</td>
</tr>
<tr>
<td>Beds</td>
<td>Good</td>
<td>Good</td>
<td>Good</td>
<td>Good</td>
</tr>
<tr>
<td>Dispensary</td>
<td>Good</td>
<td>Very good</td>
<td>Very good</td>
<td>Very good</td>
</tr>
<tr>
<td>Vehicle</td>
<td>Very good</td>
<td>Very good</td>
<td>Very good</td>
<td>Very good</td>
</tr>
<tr>
<td>Maternity ward</td>
<td>Good</td>
<td>Very good</td>
<td></td>
<td>Very good</td>
</tr>
<tr>
<td>Children’s ward</td>
<td>Good</td>
<td>Very good</td>
<td></td>
<td>Very good</td>
</tr>
<tr>
<td>Theatre</td>
<td>Good</td>
<td></td>
<td>Very good</td>
<td></td>
</tr>
<tr>
<td>Ambulance</td>
<td>Very good</td>
<td>Very good</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Oxygen concentrator</td>
<td></td>
<td>Very good</td>
<td></td>
<td></td>
</tr>
<tr>
<td>X-ray</td>
<td></td>
<td>Very good</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Palpation room</td>
<td></td>
<td></td>
<td></td>
<td>Very good</td>
</tr>
</tbody>
</table>

Source: Author Compilation.

Sources of Finance for the Management of Health Facilities

This section tried to identify sources of finance by management of both types of health providers. Information from table 5.9 below show that public health providers receive large amount of its funding from the government (SH-90%) and this may not be different from the TWH. The SH has external support (not every year) from some international organizations32 and one local organization called Tuma Kavi. The remaining 5% is obtained from the Internally Generated Fund (IGF). The private health providers either depend on their own funding (HAC) or through external support (SHC).

Table 5.9. Sources of Finance for Management of Health Facilities

<table>
<thead>
<tr>
<th></th>
<th>Public SH</th>
<th>TWH</th>
<th>Private SHC</th>
<th>HAC</th>
</tr>
</thead>
<tbody>
<tr>
<td>Government</td>
<td>90.0 %</td>
<td>-</td>
<td>2.0 %</td>
<td>0.0 %</td>
</tr>
<tr>
<td>Independent</td>
<td>0.0 %</td>
<td>-</td>
<td>2.0 %</td>
<td>97.0 %</td>
</tr>
<tr>
<td>NGO</td>
<td>5.0 %</td>
<td>-</td>
<td>95.0 %</td>
<td>1.0 %</td>
</tr>
<tr>
<td>IGF</td>
<td>5.0 %</td>
<td>-</td>
<td>1.0 %</td>
<td>2.0 %</td>
</tr>
<tr>
<td>Other</td>
<td>0.0 %</td>
<td>-</td>
<td>0.0 %</td>
<td>0.0 %</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>100 %</strong></td>
<td>-</td>
<td><strong>100 %</strong></td>
<td><strong>100 %</strong></td>
</tr>
</tbody>
</table>

*Source: Author Compilation.*

The finding shows that public health providers have more opportunities to funding as well as the sustainability of the health facilities because they receive annual budgetary allocation from the Ministry of Health.

**Management of Private Health Services**

The idea of managing private entity depends upon several factors and these factors determining the sustainability of the organization. A question was asked whether it is difficult to manage a private health facility. The administrator in the SHC stated it is not difficult, and the reason is “we depend on divine providence” as it had its roots from a church denomination (Catholic). From the previous analyses it was shown that SHC has shortage of certain equipments and technicians to enhance better services despite having its source of funding outside the country. Thus, to say that managing the clinic is not difficult may be debatable considering the shortage of MDs and MAs, and the lack of professional administrator. The response from the HAC shows that the health facility is difficult to manage because in trying to ensure quality of service so many things need to
be done. These include the ability to pay staff salaries and hire technical personnel for the laboratory and X-ray departments. Other factors are funding for continues existence of the clinic and expansion of the facility. Although the responses differ on both cases on the issue of managing the health facilities but previous analyses in chapter four and this current chapter indicates that they all have problems of enhancing better healthcare delivery.

**Enhancing Efficacy and Quality Care**

*Motivation Factors for Better Health Delivery*

To enhance efficacy and quality healthcare, management of health facilities (public or private) initiates strategies for its staff and medical personnel. Better remunerations in certain cases draw personnel from one health facility to the other. The responses indicated that the sampled public health facilities have equal opportunities provided by either the government or the district assemblies. These include citations, annual awards, medical refund, scholarship for further education, vehicles and motorbikes for transportation, accommodation for some staff and doctors, sitting allowance during meetings, and in-service training.

In the case of the sampled private health providers, the SHC provided some opportunities for the health personnel. These include free family healthcare, sponsorship for further education, motorbikes and bicycles for transportation, and payment of rented accommodation for some staff. However, the HAC did not support the staff and medical
personnel. The major reason could be that, as observed in the previous analysis (sources of finance), the clinic was solely (97%) financed by the owner.

Although the private health providers have been operating for more than 15 years their sustainability is less assured compared to the public health providers. If they are not able to finance themselves or receive donor support it may have negative impact on the management of the facilities.

**Working hours of Health Facilities**

The actual operating time including off days (excluding national holidays which all abide) of the health facilities impact on the efficiency and quality healthcare either positively or negatively. When directors were asked to state the days and time utilize in the health facilities, the information in table 5.10 below was deduced.

**Table 5.10. Working Hours in Service and Off Days**

<table>
<thead>
<tr>
<th>Health facilities</th>
<th>Off Days</th>
<th>Opening (am)</th>
<th>Closing (pm)</th>
<th>Hours per Day</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Public</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>SH</td>
<td>1</td>
<td>8:00</td>
<td>5:00</td>
<td>9</td>
</tr>
<tr>
<td>TWH</td>
<td>1</td>
<td>8:00</td>
<td>5:00</td>
<td>9</td>
</tr>
<tr>
<td><strong>Private</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>SHC</td>
<td>2</td>
<td>7:30</td>
<td>10:30</td>
<td>15</td>
</tr>
<tr>
<td>HAC</td>
<td>1</td>
<td>7:30</td>
<td>5:30</td>
<td>10</td>
</tr>
</tbody>
</table>

*Source: Author Compilation*

The findings indicate that public health providers utilized more days compared to the private health providers (SHC has two off days) while the private health providers utilized more daily service hours compared to the public health providers. However, an
Interview with one personnel from the public health facilities revealed that personnel do not obey the time and lateness becomes the order of the day especially doctors. From this interview, it could be argued that public doctors do serve people in private pharmacy shops. Many of the doctors could also be attending to patients at home in the morning and may not have inadequate time to prepare for the formal assignment. It is confirmed in the previous findings (p.63) on why patients will not seek care in the public facility on the next consultation. Lateness and absenteeism of doctors were some of the main reasons given.

On how many doctors were posted each day, it indicated that the SH has two MDs, and two MAs (Cuban doctors) while the TWH has three MDs, and two MAs (Cuban doctors). The private health providers have one MD and one MA respectively on post each day. The findings show that apart from the HAC which has no resident doctors each of the other three health facilities has resident medical personnel.

It is obvious that the public health providers have more medical personnel posted each day compared to the private and this impact positively on their rate of services compared to the private health providers. Also, the few number of doctors posted each day in the private health facilities shows that there could be too much workload (average outpatient per doctor) on them. Although the use of foreign doctors in the public health facilities is laudable patients could face problems when seeking healthcare with them due to different linguistic barriers. Interpreters might not be able to convey the right message of the patient.
**Doctor-Nurse and Nurse-Patient Relationships**

When asked to indicate how the senior medical personnel cooperate with the junior ones as well as nurse-patient relationships, the responses indicated that public health providers showed favorable doctor-nurse and nurse-patient relationships. Doctors and nurses obeyed by the rules and regulations governing the health facilities and always show respect for the patients. The private providers also shared similar view but the relationship of doctors and nurses in the public health facilities was more favorable compared to the private health facilities. The public health providers have professional nurses who know much of the GHS code of ethics and conduct for health personnel. They also received regular in-service training organized by either by GHS or management to upgrade the nurses' knowledge. The private health providers on the other hand have non-professional nurses (only HAC) and they may have occasional problems with regard to health sector rules and regulations.

**In-service Training for Improved Healthcare within a Year**

Capacity building becomes one of the highest priorities in many health institutions in Ghana. This survey investigates into the number of in-service training organized within a year and who the organizers were. Table 5.11 below revealed that public health providers (61.8%) have a greater opportunity in upgrading the personnel knowledge and skills compared to the private health providers (38%). They have external collaborations with the international organizations (i.e. World Vision International) because the government works closer with these bodies.
Table 5.11. Number of In-service Training Organized within a Year

<table>
<thead>
<tr>
<th>Health Facility</th>
<th>Personnel</th>
<th>Total</th>
<th>Organizers</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff</td>
<td>Nurses</td>
<td>N</td>
</tr>
<tr>
<td><strong>Public</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>SH</td>
<td>1</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>TWH</td>
<td>2</td>
<td>6</td>
<td>8</td>
</tr>
<tr>
<td><strong>Private</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>SHC</td>
<td>1</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>HAC</td>
<td>1</td>
<td>3</td>
<td>4</td>
</tr>
</tbody>
</table>

Source: Author Compilation.

The private health providers on the other hand had fewer strategies for internal training apart from the GHS workshops. It means that if GHS does not organize in-service training for a certain year the private providers stand to lose because they did not have their own ways of personnel capacity building mechanisms.

The Rules and Regulations Governing the Health Facilities

The directors of the respective health facilities were asked to explain whether there are certain specific laws that regulate their operations. The four health institutions indicated that they were governed by the GHS code of conduct and ethics for medical personnel and administrative staff. Apart from these general requirements each health facility has its own bye-laws for better health delivery. These laws are observed through awareness and obedience. On the issue of salary levels directors were asked to respond in terms of poor, good, and very attractive. All the four sampled health facilities showed that the salaries were good and none of them chose very attractive. This finding revealed
that both types of health personnel were not satisfied with what they earn but the public health providers were better compared to private health providers due to other incentives provided by the government.

**Disciplinary Measures in the Health Facilities**

On the issue of disciplinary measures instituted in the health facilities, the responses from both health providers were the same. These measures include queries, suspension of duties, suspension of salaries, and the worst case was dismissal. Further question into whether some medical personnel were disciplined within the last two years, the responses were that two female personnel were suspended in the SH and none in the TWH for the case of public health providers. For the part of the private health providers, only one male was suspended in the HAC and none in the SHC. The last question on this disciplinary measure was whether some personnel left without management notice. Again, two female personnel left for abroad in the SH: one for marital purpose and the other for further studies. There were no responses from the TWH and the private providers.

This finding confirmed the previous hypothesis that the female formed part of the migration of health professionals in Ghana. The findings further indicated that disobedience to GHS rules and regulations or health facilities’ bye-laws and the exodus of health personnel were common in public health facilities compared to private.

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33 It found that majority of doctors migrate to France, Canada, USA, and UK. Awases et al. (2004) “Migration of Health Professionals in Six Countries”. South Africa.
Health Facilities’ External Relations

Community Relations

This aspect tried to investigate how management liaises with the communities in which they serve. The idea of community participation is said to have become a widely accepted concept and it is believed that when the beneficiaries take part either from the beginning (participatory) or on the process (participation) of development activities its sustainability becomes assured. Table 5.12 indicates that all the sample health facilities have relations with the communities in which they serve. Nonetheless, the private health providers show closer collaboration with the communities compared to the public health providers. The SHC has representatives from the communities within the Tamale Metropolis and some villages in other districts that see to the constructing and renovating of accommodation in the premises of the health facility.

The SHC could be a role model because it proved that community members could collaborate to manage a health facility either as a group or in partnership with others. This collaboration could reduce government expenditure in the country’s health sector. Many people might think that the HAC is a profit entity and so there is no need to help the facility in-kind or in cash. The key informant interview conducted in the four communities revealed that it was only the SHC (private) and the SH (public) that have formal relationships with the communities. However, many people were not aware of the presence of the health committee in the Savelgu Township compared to the SHC in the Tamale Metropolis.
Table 5.12. Relationship of Health Facilities with the Communities

<table>
<thead>
<tr>
<th>Health facility</th>
<th>Mode of Relationship</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Public</strong></td>
<td></td>
</tr>
<tr>
<td>SH</td>
<td>Cash and in-kind donations, public blood donation, cleanup exercise, use of musicians on health campaigns, use of volunteers for guinea worm exercises, opinion leaders advice on security and facility bye-laws.</td>
</tr>
<tr>
<td>TWH</td>
<td>Collaboration with opinion leaders on health facility matters.</td>
</tr>
<tr>
<td><strong>Private</strong></td>
<td></td>
</tr>
<tr>
<td>SHC</td>
<td>Community provision of accommodation for inpatients, cash and in-kind donations, cleanup exercises by community members.</td>
</tr>
<tr>
<td>HAC</td>
<td>Opinion advice on health personnel issues, use of musicians on health campaigns.</td>
</tr>
</tbody>
</table>

*Source: Author Compilation.*

**Public-Private Health Providers Collaboration**

It has been shown in several past studies that Africa is one of the continents with very weak pubic-private collaboration in the health sector. The survey results from the sampled health facilities were not different; it showed that there was a relatively weak institutional collaboration between the two groups of health providers. The only places the administrative personnel do meet are in workshops and meetings organized by the GHS. Other aspect was referral from one health facility to the other.

The public health providers have collaboration with some private health providers in the form of laboratory support (i.e. New Life Laboratory). The referral and laboratory support were individual health facility negotiations but not formal provision of the GHS.

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34 Reasons were attributed to limited resources that affect research, distrust of each party, poor communication among parties, disagreement on roles and objectives, and weak exchange of information. Berman et al. (1999) "Private and Nongovernmental Providers: Partners for Public Health in Africa" Conference Report.
Thus, there was no recognized collaboration between the two types of the sampled health providers in general in the districts. Directors do not visit each other for the purpose of mutual understanding in promoting better healthcare. They have poor communication (exchange of ideas, statistics, and results) among the two types of health providers.

**Challenges by the Health Facilities**

In an effort to improve the efficiency and quality health delivery the health providers are faced with many difficulties. These challenges include internal factors and their relationships with the government and the communities where the facilities are located.

**The Savelgu Hospital (Public)**

The challenge of the health facility with the government was that it receives inadequate resources from the MOH/GHS that makes managing resources and personnel difficult. Internal problems include inadequate motorbikes and vehicles, the shortage of clinical nurses and technicians, the absence of an anesthesia machine and anesthetists, and the facility using private laboratory. With regard to the community the challenges include community guinea worm volunteer fatigue; poor obedience to health facility bye-laws; inadequate supply of safe water which led to increase guinea worm cases, and the non utilization of mosquito bednets.
The Tamale West Hospital (Public)

The challenge of the health facility with government was not different from the SH above. The internal challenges include inadequate wards for admission, little space in the OPD and offices coupled with inadequate transport facilities. Other problems are lack of blood bank; non availability of functional theatre; improper layout for expansion of structures, and disobedience to time especially medical personnel. With regard to the community the challenges include little community support, non utilization of mosquito bednets, and less obedience to the health facility bye-laws.

The above findings show that there were more challenges within the premises of the public health facilities that have negative effects on the provision of quality healthcare. The common challenges to them within the community are the non utilization of mosquito bednets distributed at low cost to nursing mothers. This poor attitude contributed to the increases in malaria cases in the facilities. Others are poor attitude towards guinea worm issues, and disobedience to the facility bye-laws.

The Shekhinah Clinic (Private)

The challenges with the government include little support from MOH/GHS, no tax exemptions, and the posting of MDs and professional staff. Internal challenges were inadequate beds for inpatients and accommodation for staff, and shortage of doctors and transportation facilities. The major challenges in the community include disturbances from roaming animals, and occasional disobedience to hospital bye-laws (i.e. queue for a day (s) before seeing a doctor).

The Haj Adam’s Clinic (Private)
The challenges with the government and the community were not different from the SHC, and the internal problems include little local/individual support, lack of professional staff and nurses, and non permanent accommodation for inpatients. Others include lack of accommodation and transportation facilities for staff, little remuneration for staff, the non availability of functional theatre, and the facility functioning without X-ray department. The major setbacks of the private health providers were less attention by the government with regard to budgetary allocation, posting of both professional staff and medical personnel, and the absence of opportunity for tax exemption.

Thus, both types of health providers still face many challenges. The public health providers have many issues to be dealt with within the facilities to enable them offer quality (i.e. non existing equipment) care. The most important among them was disobedience to time by the health personnel. It has negative impact on access and also leads to long waiting time by patients in the health facilities. The private health providers were the best because they expanded their structures despite operating independently with little or without the government support. It means that they have been able to efficiently utilize the meager resources available to them compared to the public providers. Equitable access and free healthcare (SHC) are promoted as a result of constructing new health facility at different suburb of the Metropolis (Wamale) and the building (HAC) of new structures with enough space for better health delivery.
Recommendation

The public Health Providers

Accessibility: The SH aims at increasing impact and delivery strategies for accelerated accessibility. The TWH aims at changing the attitude of the people towards increasing hygiene to reduce cost of seeking healthcare. The common recommendation includes the need for continuous health awareness campaigns, increase community participation, and the establishment of more departments and sub-units in other communities.

Affordability: Both directors strongly recommended that patients register for the NHI and it was seen to be the safest way for affordable healthcare.

Efficacy: The directors demanded for increase in-service training, motivation in the form of accommodation, and availability of transport facilities for both staff and medical personnel.

Quality healthcare: The directors recommended the provision of basic equipment and the training of technicians. Other issues are the need to establish X-ray facilities and laboratory departments coupled with appropriate use of resources.

The Private Health Providers

Accessibility: The major recommendation of the SHC different from the HAC was the demand for the expansion of the clinic to other districts. The common suggestions include increase health awareness campaigns; government infrastructural support; expansion of departments, and the provision of accommodation equipment in the wards.
Other recommendations include call for increased community partnership, and the need for the establishment of more sub-units in other communities.

Affordability: The services of the SHC were entirely free. However, the HAC recommended that patients register for the NHI coupled with speedy disbursement of claims from the regional health insurance secretariat.

Efficacy: They both recommended for increase in-service training to upgrade the skills of the personnel, provision of accommodation and transportation facilities, and the employment of doctors, professional staff, and trained nurses.

Quality healthcare: The directors pointed out that tax exemption can be more effective support and recommended subsidies on drugs and equipment from the government. Other recommendations included the need to improve quality services and the employment of technicians for the laboratory and X-ray departments.

The responses from both types of providers indicate that they all have general opinions as well as specific suggestions peculiar to the respective health facilities for promoting equitable access, provision of affordable healthcare, improving the efficiency of the personnel, and provides quality health delivery. Generally, findings from both types of health providers indicate that they have devised means and strategies for getting closer to patients through improvements in efficiency and quality of healthcare. It further shows that both types of providers were still struggling to increase access, provide affordability healthcare (except SHC), and improve quality healthy delivery.
PART II

This aspect forms the remaining part of chapter five which investigates doctors’ efforts in delivery effective and quality healthcare.

The Activities of Doctors

Number of Years in Service

As table 5.13 indicates, one doctor each serves between 15 and 20, and between 21 and 25 years respectively in the sampled public health facilities, representing 25% each. The two remaining doctors served the highest period between 25 and 30. In the area of expertise they have two specialists and two doctors who offer general care. All the four doctors in the sampled private health facilities served between 25 and 30 years.

Table 5.13. Doctor’s Years in Service and Area of Expertise

<table>
<thead>
<tr>
<th>Years</th>
<th>Public Doctors</th>
<th>%</th>
<th>Private Doctors</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>15-20</td>
<td>1</td>
<td>25.0</td>
<td>0</td>
<td>0.0</td>
</tr>
<tr>
<td>21-25</td>
<td>1</td>
<td>25.0</td>
<td>0</td>
<td>0.0</td>
</tr>
<tr>
<td>25-30</td>
<td>2</td>
<td>50.0</td>
<td>4</td>
<td>100</td>
</tr>
<tr>
<td>Total</td>
<td>4</td>
<td>100</td>
<td>4</td>
<td>100</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Expertise</th>
<th>Public Doctors</th>
<th>%</th>
<th>Private Doctors</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>General</td>
<td>2</td>
<td>50.0</td>
<td>4</td>
<td>100</td>
</tr>
<tr>
<td>Curative</td>
<td>1</td>
<td>25.0</td>
<td>0</td>
<td>0.0</td>
</tr>
<tr>
<td>Clinical</td>
<td>1</td>
<td>25.0</td>
<td>0</td>
<td>0.0</td>
</tr>
<tr>
<td>Total</td>
<td>4</td>
<td>100</td>
<td>4</td>
<td>100</td>
</tr>
</tbody>
</table>

Source: Author Compilation
It means that the public health providers have an advantage of having more specialists than the private sector. The latter indicated more experienced personnel as a result of all the doctors being in service for longer period in the health sector. The provision of general care by private health providers in certain cases is possible as a result of shortage of medical personnel (i.e. the case of the sampled private facilities). In certain circumstances it could also be due to scarce financial resources to hire these doctors. However, offering general care is also common in many public district hospitals and community health centers especially the remote areas in the country. Empirical evidence was the SH where the only two doctors offers general care due to shortage of medical professionals (i.e. specialists). These finding further shows that there were other public health facilities and poly-clinics without MDs and were being manned by either medical assistants or trained nurses.

**The Limitation of Doctors**

The findings show that doctors in the SH only differ from those in TWH in the case of surgery, otherwise, they have the same limitations. The limitations include cancer services, cirrhosis, appendicitis, serious mental cases, and disabilities. In the case of the private health providers, the limitations of doctors in the SHC were cancer and cirrhosis while the limitations of doctors in the HAC were similar to doctors in the TWH. It could be argued that the private health providers have more expertise compared to sampled public health providers because the private health providers have little limitations and this means they serve patients with different health needs compared to the public health providers.
**The Utilization of Duty Hours**

A question was asked to find out the number of hours doctors spend and what they do when they are not on duty. Table 5.14 below shows that doctors in the two public health facilities spend the same time but they have different activities after work. The private health providers spend different hours on duty and it indicates that these providers spent more time on duty compared to the public. This can be explained by the fact that doctors usually combine administrative work with consultation as a result of shortage of professional administrators.

<table>
<thead>
<tr>
<th>Health facility</th>
<th>Hours on Duty</th>
<th>Off duty activities</th>
</tr>
</thead>
<tbody>
<tr>
<td>Public</td>
<td></td>
<td></td>
</tr>
<tr>
<td>SH</td>
<td>6-9</td>
<td>Rest, Research.</td>
</tr>
<tr>
<td>TWH</td>
<td>6-9</td>
<td>Rest</td>
</tr>
<tr>
<td>Private</td>
<td></td>
<td></td>
</tr>
<tr>
<td>SHC</td>
<td>10 and above</td>
<td>Rest</td>
</tr>
<tr>
<td>HAC</td>
<td>10 and above</td>
<td>Rest, Church activities</td>
</tr>
</tbody>
</table>

*Source: Author Compilation.*

The general understanding is that both types of the sampled doctors do not have extra medical service offering elsewhere apart from their formal assignments. Nevertheless, the long hours spent in both types of health facilities showed the severity of shortage of medical personnel, although public health providers fared better compared to the private
In response to the tricky question of whether patients meet doctors at home for consultation, one doctor from the public health facility admitted that patients meet him either during the early hours of the day or during off duty. The response is contrary to the above responses in the table that personnel rest during off duty and they also do not work in other health facilities. This finding confirmed the previous hypothesis that most doctors in the public sector in Ghana have extra medical assignments (serve patients in either private pharmacy shops or at home) apart from their formal duties.

*Consultation Time per Patient*

An interview with one public health doctor shows that there is no fix consultation time, it depend upon the intensity and type of case being handled but the average time may be 30 minutes. Two doctors in the sampled public health facilities used 5-10 minutes and the other two used 15-20 minute per patient during consultation. In the part of the private health providers, two doctors used 5-10 minutes while the other two used 10-15 minutes.

Thus, both types of providers spent below 30 minutes and this has negative implications on the quality of care but the public providers were better because two doctors used 15-20 minutes. The idea of doctors using less time could mean that there could be the possibility of not diagnosing the right case and this may form one of the reasons patients visit health facilities many times.
**Reasons that Motivate Doctors to Stay and Serve**

In Africa, several studies revealed that migration of health professionals out of the continent\(^{35}\) formed one of the reasons for shortages of public health professionals. One out of several major findings of such studies was poor motivation for health professionals. A section was structured to investigate what motivates the sampled doctors to serve in the respective health facilities. Figure 5.3 below summarizes the responses.

![Factor Graph](image)

**Fig. 5.3. Factors that Motivate Doctors to Serve in the Health Facilities. Source: Author Compilation.**

Improved facilities, opportunities for continue education, and free family health formed the highest factors for doctors in public health facilities representing 28.5% respectively. In the case of the private providers, two doctors (representing half of the

\(^{35}\) It found that better salaries formed the basic reason for most doctors serving in public health facilities (i.e. Ghana). Awases et al. (2004) “Migration of Health Professionals in Six African countries”. South Africa.
sample) said they served because of improved facilities in the work place while the remaining two have different reasons: one aimed to help the poor and the needy while the other serve due to love of God and his neighbor.

General observations:

- Improved health facility was the highest factor to explain why doctors in the four sampled health facilities served; and
- Better salaries formed the least reasons doctors in public health facilities serve. This finding does not lend support to the held opinion that better salaries formed the major reason why doctors serve in the public health sector in Ghana.\(^3\)

**Public-Private Doctor Relationship**

All the four doctors in the public health facilities responded that they have good relationships with the private doctors. Both groups do meet at workshops organized by the GHS. One doctor out of the four in the private facilities said there was less effective collaboration between the public doctors and the private doctors. There were no tangible relationships whereby these groups exchange ideas and facts for the promotion of effective communication and enhancement of public-private doctor partnership apart from GHS initiated workshops.

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\(^3\) The comparative study of six African countries revealed that doctors in Ghana serve because of better salaries (Awases et al, 2004)
Doctors’ Perceived Problems in Health Facilities

All, except one doctor in each type of health providers pointed out sources of difficulties in their respective health facilities. Those doctors who did not see the difficulties in the service in both facilities pointed the cordial relationships of doctors and the management. In the case of public doctors who said it is difficult, their views correlate with the directors’ recommendations in the previous section. These include inadequate accommodation and transport facilities for both staff and medical doctors, and lack of certain vital equipment (i.e. X-ray department) which leads to increases in referral. The doctors in the private health facilities stressed the unavailability of trained nurses especially in the HAC, professional staff, and specialist doctors. Thus, both types of doctors faced certain challenges but the public seems to be relatively better as a result of the presence of many medical personnel, professional staff, and more trained nurses.

Recommendation of Doctors

The solution to effective management and the provision of quality primary healthcare does not depend on management alone but more on the doctors who are the center of all activities in the health facilities. The doctors were requested to offer suggestion as to what should be done to improve service delivery.

With regard to public health providers, the building of a theatre was highlighted by TWH. Both public health facilities have the same responses which ranged from providing equipments, need for health facility-community/assembly collaboration; need to employ
specialists, and improving motivation to enhance better health service. Other impediments include increase accommodation for resident personnel, and the need for specialist and laboratory/X-ray technicians.

Doctors in the private health providers highlighted the need for complete government support similar to that of public health providers. These included tax exemption, either subsidize or free supply of drugs and equipment, and the posting and paying of medical personnel. Other demands included public-private doctor partnership and increase strong community relations.

**Conclusion**

The general analyses indicated that both types of health providers have strategies and procedures that led to efficient and quality health delivery. The management of both providers adequately responded to patients and medical personnel needs and aspired to promote better healthcare.

The strategies that enhance the efficacy of the personnel in the public health facilities included available motivating factors such as scholarships for further studies, housing for some administrators and the MDs, in-service training, annual awards, and transportation facilities. Quality of healthcare was promoted due to the presence of medical doctors, specialists, and trained nurses. The public health facilities also enjoyed a relative availability of basic facilities that cover wider services. Other factors that complements their activities and which results in better healthcare include the sustainability of their sources of funding, good doctor-nurse and nurse-patient
relationships, and the acceptance of NHI identity cards which formed one of the major reasons for increases in OPD attendance.

Despite the above strengths that enhance the efficacy and quality of healthcare, they still recorded some weaknesses. These include the unavailability of X-ray department, laboratories being owned by private health provider, the unavailability of well equipped theatre for complex surgery (TWH), and shortage of accommodation for medical personnel and administrative staff. One major issue that impacted negatively on efficiency was attendance to duty especially by doctors which results in delays in services.

The private health providers show little provision for motivating the personnel to enhance their efficiencies. Only the SHC had some form of motivating factors for the personnel but the HAC has none. Internal organization of in-service training was completely absent except the GHS workshops. However, they showed good dedication to work as they work for longer hours. They also perform speedy consultation as they did not spend too much time. Issues that promotes quality healthcare included the availability of experienced medical professionals who were also the same time having specific expertise (stroke, hernia, epilepsy). Other factors included the availability of drugs and equipment in very good quality. Factors that complement their services are low charges and free care, good doctor-nurse and nurse-patient relationships, and the acceptance of NHI (HAC) identity cards. Issues that impacted negatively on quality are the unavailability of professional staff and shortage of trained nurses; lack of technicians and specialists; unreliable financial backing, and lack of strategies to improve personnel knowledge and skills.
To sum up, the public health providers on one hand shows more opportunities for improving the efficiency of the personnel and this resulted in better healthcare delivery compared to the private health providers. Despite such opportunities in the public health facilities coupled with more doctors on post daily, it recorded decreasing demand for their services in some years. This reduce attendance was as a result of several factors such as patients waiting for long hours, doctors’ occasional unavailability, and the absence of certain vital services (X-ray, and theatre) which formed part of the reasons for more referral.

The private health providers on the other hand had experience medical personnel and coupled with the availability of equipment in good quality compared with the public health providers. The implementation of the NHIS in the country aimed at reducing the cost of healthcare and encourages equity of access to health facilities did not show any impact on attendance in the private health facilities. The private health providers had steady patient attendance (marginal decrease only in 2006) throughout the period under study.
CHAPTER 6
SUMMARY, RECOMMENDATION, AND CONCLUSION

The chapter presents the overall results from the analyses, followed by recommendations for stakeholders in both types of health services, individual philanthropies, and external donors in the health sector. The remaining part examines the hypotheses, and followed by a conclusion.

The analysis presented in this research was carried out in Ghana from March 4 to April 14, 2008. The period of study for secondary data was from 2001 to 2007. Four health institutions were selected, two from the public health facilities and two from the private health facilities in two districts (the Savelgu/Nanton and the Tamale Metropolis). The sample size was made up of 92 respondents: 60 patients, 20 key informants from the communities, eight doctors, and four health facilities’ directors. Other stakeholders contacted for information were the director of CHAG, director in charge of policy (GHS), the directors of the Northern Regional Health Directorate, and the directors of the two district offices. The study made use of both quantitative and qualitative data including direct observation. The limitation of the study was the presentation of incomplete data from all the selected health facilities in certain cases which made analysis a little difficult. However, despite the lapses the study met its planned objectives.
Overall Assessment

Equity of Access

Results from the sampled four health facilities showed steady increases of OPD attendance for the seven-year period. This was common in the private health facilities where total attendance increased throughout the period but for one year where it fell marginally. However, the public health facilities recorded large number of total OPD attendance compared with the private. The findings show that the facilities had more access to majority of patients from both urban and rural areas, but this was relatively more in the private health facilities as those who came from districts within the region formed the highest group represented. The cost of healthcare was equal in both health facilities, and even the private providers were relatively less costly compared to the public. The little charges paid at the OPD as well as free services offered formed a good strategy that the private providers used to encourage attendance over the years whilst the public use of the National Health Insurance also formed the major strategy. Both providers had equal access to females as they represented equally (21.6% respectively). The findings further show patients with various occupational categories and illiterates formed the significant proportion represented in the private health facilities compared to the public. On the whole respondents showed satisfactory healthcare they received.

Efficacy and Quality of Care

Access correlates with the availability of functioning equipment and number of qualified medical and administrative personnel. The study found that both providers lack
adequate doctors and specialists which impact negatively on access and quality especially in private health facilities. Medical assistants do perform the duties of professional medical doctors as a result of shortage of doctors in both types. Both providers had qualified personnel and the private facilities showed more experienced medical personnel compared to the public due to long services as the doctors were retired personnel from the public service.

The shortage of certain basic equipment (i.e. X-ray) affects not only equitable access to health facilities but also the efficacy and quality, and these were common in the public facilities. The absence of some of these vital equipments could be associated with large referral cases recorded in the public health facilities. The private health providers showed more utilization of duty hours compared to the public. They also showed dedication to work through being punctual which impact positively on patients’ high attendance, a rather negative observation in the case of public health providers.

**Training and Motivation**

The study also found that public health providers had more opportunities for in-service training than the private providers. Apart from the occasional workshops organized by the GHS where private providers participate, there were no strategies for upgrading the skills of the administrative staff and the nurses. The public health providers revealed significant number of remunerations for both administrative staff and the medical doctors. These include study leave with pay, sitting allowances during meetings, accommodation and transport equipment (though seen to be inadequate) for personnel, and reimbursement of personnel healthcare and others.
Workload

Findings from the AOA per doctor indicated that both providers had large number of outpatient ratio due to the shortage of medical doctors, especially in private health facilities. The workload has affected both providers’ closing time especially in private facilities where they work into the night.

Policy Recommendation

The above analyses show that there is the need for policy makers to take stringent measures to curb future re-occurrence of the negative implications that affect access, equity, efficacy, and quality healthcare in general. Stakeholders such as the government, management of both types of health providers, the stakeholders in the communities, and the external donors in health need to forge a common goal for the improvement of health sector in the country.

The Government

One major constraint found in the sampled health facilities is the shortage of medical doctors and specialists and it was more in the private health facilities. The government needs to increase investment into the training of more doctors, professional staff, and nurses. Though the two sampled public health facilities had Cuban medical doctors attached to home doctors, linguistic and cultural differences are likely to impact negatively on their services.
Another very important issue was the increase in the provision of infrastructure and the supply of equipment to help health facilities function well. The introduction of the National Health Insurance (NHI) has relatively increased OPD attendance, however, with corresponding little improvement with regard to infrastructure and equipment supply.

Specifically to the private health providers, the government needs to devise approaches to include all private health providers into the national payroll, support them with logistics and infrastructure unlike CHAG health facilities. Only the SHC receives trained nurses from the government and they were also being paid by the government. The government recognizes that private health providers contributes about 42% to the provision of health services\(^{37}\) in the country and since CHAG does not make up the totality of private providers in the country, including those non-affiliated health providers would be laudable.

The policy makers need to extend NHI accreditation process for many years instead of the provisional two years given for private health providers. Information about the acceptance of NHI in the private health facilities is not widely known, there is a need for more media advertisement to sensitize the public on private health facilities acceptance of insured patients with the National Health Insurance.

Tax exemption for private health providers has been one of the problems indicated. Thus policy makers need to recognize private health providers as partners in development and not as money making ventures. Empirical evidence was the SHC whose entire services were free. Also, the HAC charges relatively low fee compared to the sampled

public health providers. There should be some subsidy for private health providers in areas such as electricity, drugs, and other equipment.

The promotion of public-private sector partnership in development was one of the major priorities of the government since early 1980s as a result of the implementation of the ERSAP. Theoretically a lot has been said about private health sector participation in the health sector but implementation has been slower than expected. Policy makers should apply as a matter of urgency, the 2005\(^{38}\) programme of work in the GHS which makes more provision for private health sector involvement in the delivery of healthcare.

**Donor Partners in Health**

The Donor partners in health sector such as the European Union, the World Bank, DFID, the Nordic Development Fund, and the Netherlands need to channel some percentage of their health support to the private health sector. The DANIDA showed strong support to the private health sector but this partnership was being limited to CHAG. There is a need for the organization to extend this support to other non-affiliated private health providers.

**The Public Health Providers**

The most important factor affecting efficiency and effective operation of healthcare delivery, according to this survey, was the punctuality of doctors to work. There is a need for management of public health facilities to enforce the GHS code of ethics, code of conduct, and patient charter regulations.

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There has been poor public-private institutional collaboration within regions and districts. Management of both providers needs to devise means and strategies to encourage this partnership and this would pave ways to take the advantage of local needs and potentials. This should include exchange of ideas, statistics and any vital information for the betterment of all health providers.

**The Private Health Providers**

First of all individual private health providers need to encourage the formation of associations or group practices where they would stand the chance of benefiting from the government unlike CHAG. It is noted that most private health providers in the Accra Region were “solo practitioners”\(^{39}\); this was not different from the sampled health facilities. It seems they were not affiliated to any association and many others in the region could be operating in the same way.

The activities of private health providers proliferate in the urban centers to the disadvantage of the rural people. There are 10 accredited private health providers in the Tamale Metropolis and one in the Savelgu Township. There are many districts in the region which has no even one private health provider. The private health providers should expand their services to rural areas where they are needed most.

Poor documentation has been noted in the private establishments and there is a need for these providers to equip the administration with computers, photocopiers, and other materials necessary for effective health delivery.

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\(^{39}\) Obuobi et al (1999:p.34) “Private Health Care Provision in the Greater Accra region of Ghana” The survey found that 61% of for-profit health providers in the region were individual practitioners while 39% were group practitioners.
The Community

Among the sampled health facilities, only the SHC has formal relationship with the community and other villages, and the SH also has relative collaboration with a group of people in the capital. The other two providers had loose relationships. They need to find ways of strengthening this relationship with the communities. Opinion leaders (chiefs, Assembly-persons, Unit Committees, and Area Councils) need to establish and encourage formal relationships with both types of health providers. Management of health facilities also need to include the views and opinions of these stakeholders especially with regard to bye-laws and security issues in the health facilities.

Test of Hypotheses

The following hypotheses were stated in the methodology to examine the findings:

A. “There are numerous State strategies to make public healthcare affordable, but private healthcare is still more affordable”. The findings revealed that the government has implemented NHI scheme with less registration fee for the poor and the rich to have equal access to health facilities. Despite the existence of this scheme some private health providers still offer relatively affordable healthcare to majority of the people compared to the public providers. Health services in the SHC are entirely free of charge and only on certain occasions that patients may contribute any amount as donation after consultation. The HAC (for-profit) also charges equal fee (TWH) or less (SH) as shown in Chapter five (p. 86). Majority of patients in the sampled private facilities were from other districts within the region which shows that the facilities are not only accessible to those near
them but also to those from remote villages. The cases reported among the sampled patients indicate that the private health providers had expertise in some fields which the public lacks. Hernia and stroke cases were recorded (with none in public health facilities) meaning that the patients believed the private providers could solve these problems. Thus, the private health services remain efficient, less costly and they serve both rural and urban populations.

**B. “People of different socioeconomic background seek private healthcare”**. Under the mode of paying consultation fee (Chapter four, p.67), it revealed that 50% out of the 30 sampled patients in the private health facilities were consulted free of charge while 29.9% paid from their pockets, and the remaining 20.1% of patients were insured. It means that private health providers serve both the poor and the rich but they have even more accessible to the poor. Patients’ choice of private healthcare was not based on the location unlike the public health facilities but because of the expertise and quality of care (Chapter four, p.62: 66.6% against 26.6% in the public facilities) and this even formed the most pull factors patients seek private health services. It shows that the private facilities do not only serve both poor and the rich but they also offer better and quality care as a result of the doctors’ experience.

**C. “The presence of qualified medical professionals is not the only determinant factor to enhancing better healthcare”**. Nonetheless, the availability and the level of facilities and laboratory equipment determine the efficiency and effectiveness of health facilities. The findings indicate that the SHC had its own laboratory while the other one private (HAC)
and the two public health providers were using privately owned equipment. However, the view that private healthcare is more effective as a result of favorable conditions of service could not be substantiated. The survey shows that the public health providers had more motivational opportunities that led to more efficacy and better healthcare delivery compared to the private. These include scholarships for further studies; accommodation and transport facilities; sitting allowances after meetings, and overtime service allowance and. The private providers either have little or none of the above, especially the Haj Adam’s Clinic.

**Conclusion**

On the whole, the findings, and proofs of the hypotheses indicate that private health sector provide better healthcare unlike the public health providers. They reached out to reasonable number of the population in the districts; served both the poor and the rich; had doctors with more experience; the existence of equipments in better quality; and among others being the less affordable places among the sampled health facilities. Thus, there is a need for policy makers to ensure that private health providers contribute their quota to national healthcare delivery.
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APPENDIXES

APPENDIX A
PROFILE OF PRIVATE HEALTH FACILITIES

The Shekhinah Clinic

The Shekhinah is one of the non-affiliated faith-based health institution located in the Northern suburb of the Tamale Metropolis. The beginning of the clinic in 1989 came into reality when the owner, Dr David Abdulai, successfully operated a lady in the bush under a mango tree. Well established structures were finally put in place in 1991. The Mission of the clinic is: serving the poor and the destitute, purely for the love of God and neighbor; and are absolutely free. We depend unconditionally on divine providence. The first cite of the clinic was at Gurugu, a suburb of the Tamale Metropolis and since 2005 Dr. Abdulai has established another branch at Wamale, a different suburb of the Metropolis.

Dr. David Abdulai is a Catholic; however the clinic is not part of the CHAG member health institutions where Catholic health institutions dominate. According to him the Mission tried to take over the clinic with the aim of making it a fee charging clinic but he refused and maintained that it operate without charging fees which the authorities of the Mission rejected. This is one of the reasons why it is not part of CHAG member health facilities. The following are the pictures of Shekhinah Clinic (Gurugu).

The health facility had successful hernia operations for several years (no deaths) and also established another health center in different suburb of the Metropolis (Wamale). It still received continues provision of accommodation by communities and increased donor support over several years. Below are the pictures of the clinic.
Haj Adam’s Clinic

The Clinic was first established in 1990 at Sang where the doctor was serving. Sang is about 30 miles away from Tamale and Yendi, hence his decision to establish the Clinic to serve people from the deprived rural areas.

It was moved from Sang to Tamale in 1993 as a result of the Konkomba-Dagomba war in that year. The Mission is to “meet the health needs of the rural people”. In Tamale, the health facility operates from 1994 to January 2008 in rented premises. Fortunately, it was finally moved to a new infrastructure, built by the doctor himself in February 2008. The health facility gained accreditation for serving people with National Health Insurance cards as on October 2007. The Clinic served a total of 629 insured patients of NHI from February 2007 to January 2008. It has partnership with another private health facility, Nanette Laboratory Limited, which provides laboratory service sin the clinic. Below is a picture of the Clinic. As of February 2008, it has moved from the rented structures to a newly built facility with well furnished health equipments. Below is the picture of the clinic.
APPENDIX B
PROFILE OF PUBLIC HEALTH FACILITIES

Tamale West Hospital

It was established in April 1, 1998 with the aim of easing up the burden of the Regional hospital (Teaching Hospital). It offers both preventive and curative care. The health facility achieved approximately 43% reduction in guinea worm cases, including reduction in referral of mal-presentation and placenta cases. It recorded no maternal death in 2007 and it was able to expand the pharmacy department. Below is the picture of the hospital.
Savelgu Hospital

The health facility was established in 1967 as Polyclinic and it gained district hospital status in 2004. The health facility achieved a reduction of guinea worm cases from 666 in January 2007 to 20 as of December 2007. It distributed 820 mosquito bednets out of the targeted 873 (94%) to pregnant women. Below is the picture of the hospital.
APPENDIX C
DISTRICT HEALTH SERVICE INFORMATION

Tamale District and Savelgu/Nanton District

Tamale District (Metropolis) Health Service
The Tamale District has one Community Initiated Clinic at Kpanvo. It also has one rehabilitation/nutrition education center including 205 trained Traditional Birth Attendants with 151 being active out of the total 510 traditional Birth attendance. Others are the Red Cross mother which numbered 480 and 833 Community Based Surveillance Volunteers. The Metropolis is divided into the following Sub-districts: Bilpeila, Choggu, Tamale Central, Taha/Kamina, Sagnerigu and Vittin.

Table C1. Health Facilities in the Tamale Metropolis

<table>
<thead>
<tr>
<th>#</th>
<th>Government Facilities</th>
<th>Health</th>
<th>Quasi-Government Health Facilities</th>
<th>Private Health Facilities</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Bagabaga Clinic</td>
<td></td>
<td>6 MRS, Kamina Barracks</td>
<td>As-Salam Maternity Home</td>
</tr>
<tr>
<td>2</td>
<td>Bilpeila Health Center</td>
<td></td>
<td>ABF Medical Center, Bawa Barracks</td>
<td>Deaha Maternity Home</td>
</tr>
<tr>
<td>3</td>
<td>Central (old) Hospital</td>
<td></td>
<td></td>
<td>Father Tryer’s Clinic</td>
</tr>
<tr>
<td>4</td>
<td>Choggu Health Center</td>
<td></td>
<td></td>
<td>Fulera Maternity Home</td>
</tr>
<tr>
<td>5</td>
<td>Garizegu Clinic</td>
<td></td>
<td></td>
<td>Haj Adam’s Clinic</td>
</tr>
<tr>
<td>6</td>
<td>Industrial Area Clinic</td>
<td></td>
<td></td>
<td>Rabito Clinic</td>
</tr>
<tr>
<td>7</td>
<td>Kalpohin Health Center</td>
<td></td>
<td></td>
<td>Seventh-Day Adventist Clinic</td>
</tr>
<tr>
<td>8</td>
<td>Nyohini Health Center</td>
<td></td>
<td></td>
<td>Shekhinah Clinic (Gurugu)</td>
</tr>
<tr>
<td>9</td>
<td>Tamale Central RCH Clinic</td>
<td></td>
<td></td>
<td>Shekhinah Clinic (Wamale)</td>
</tr>
<tr>
<td>10</td>
<td>Teaching Hospital (Regional)</td>
<td></td>
<td></td>
<td>Tania Specialist Clinic</td>
</tr>
<tr>
<td>11</td>
<td>Vittin RCH Clinic</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>12</td>
<td>Tamale West Hospital</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Source: Regional Health Directorate, Tamale.

The District health sector achieved 22.60% of Tuberculosis (TB) detection and cured about 84%. Malaria was the leading OPD reported incidence in 2004 and 2007. The District also achieved trachoma service of 64% in 2005, 92% in 2006, and 31% in 2007. Some of the public health facilities incorporate school health (feeding) in their programmes. The District achieved 26.8% out of the 27,316 school children in 2005, 19.4% out of 19,792 children in 2006, and 23.8% out of 24,188 children in 2007. Guinea worm cases reduced from 461 cases in 2006 to 265 in 2007 (43%). Meningitis cases also
decreased from 82 in 2005 to 20 in 2006 and then to 15 in 2007. Out of the total of 1,031 patients seen and tested, 324 were HIV positive (31.4%), and out of 3,160 blood donors, 152 were HIV positive representing 4.8% (Tamale Metropolitan Health Directorate, 2007).


<table>
<thead>
<tr>
<th>Contraceptives</th>
<th>2005</th>
<th>2006</th>
<th>2007</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male condom</td>
<td>2,302</td>
<td>2,155</td>
<td>16,325</td>
<td>20,782</td>
</tr>
<tr>
<td>Female condom</td>
<td>58</td>
<td>91</td>
<td>29</td>
<td>178</td>
</tr>
<tr>
<td>Combined pill</td>
<td>2,892</td>
<td>2,212</td>
<td>3,202</td>
<td>8,306</td>
</tr>
<tr>
<td>Foaming tab</td>
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</table>

*Source: Tamale Metro Health Directorate Annual Performance Review 2007*

Tamale Metropolis within the Map of Northern Region
Savelgu/Nanton District Health Service

The Savelgu/Nanton District has one district hospital and it is the only health facility that provides inpatient services. The District also has one private clinic (Bruham) situated in the District capital, Savelgu. Other public health facilities include three clinics located at Tampion, Janjori-Kukuo, and Moglaa. It has health centers at Nanton, Pong Tamale, and Diare. The District also has one Community-Based Health Planning and Services.

Malaria has been the leading case for more than three decades. The health directorate supplied 40,035 bed nets to pregnant women and nursing mothers from 2003-2005, and also provided 4,440 in May 2007. The district is among the leading guinea worm and trachoma cases in the Region. It witnessed increased mortality but with reduced maternity deaths as a result of increased number of antenatal visits from 4% in 2004 to 4.1% in 2005. Out of the total of 603 blood donors in 2005, 18 were tested HIV positive. Supervised deliveries also increased from 1043 in 2003 to 1434 in 2005. As of 2006, the district hospital has 23 beds, four wards and four toilet rooms.

On the case of National Health Insurance Scheme, it registered 17,354 (16%) of the entire population of the district as at September 30, 2006. Insured patients make up 53% of total attendance in 2007. The health directorate also sponsors students to pursue programs such as nursing training, community health nursing, and medicine. Below is the picture of the Savelgu hospital.

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<td>16</td>
<td>52</td>
<td>81</td>
<td>20</td>
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<td>10</td>
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<td>79</td>
<td>411</td>
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<td>415</td>
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<td>5964</td>
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*Source: Savelgu/Nanton District Health Services Annual Performance Review, 2007.*

Savelgu/Nanton District within the Map of Northern Region
The CHAG was formed in 1967 through the initiative of the World Council of Churches with a membership of 25. The main aim of the organization is to “foster closer partnership between church related services and the Ministry of Health to promote competent total health care to the people being served”. The overall objective is: to improve the health strategy of the people in Ghana, especially the marginalized and the poorest of the poor in fulfillment of Christ healing ministry. It is registered No. 154/6 as not-for-profit nongovernmental organization in 1968 and has 152 member health institutions as of 2005. It serves about 30-40% of the nation’s population.

Table D1. Health Facilities of CHAG in Ghana

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<th>Denominations</th>
<th>Total # of Hospitals</th>
<th>Total # of Institutions</th>
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<tr>
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<tr>
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<td>10</td>
</tr>
<tr>
<td>Anglican</td>
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<td>8</td>
</tr>
<tr>
<td>Salvation Army</td>
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<td>8</td>
</tr>
<tr>
<td>Evangelical Presbyterian</td>
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<td>7</td>
</tr>
<tr>
<td>Church of Pentecost</td>
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</tr>
<tr>
<td>Methodist</td>
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<td>5</td>
</tr>
<tr>
<td>Assemblies of God</td>
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<td>3</td>
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<td>Baptist</td>
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</tr>
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<td>World Evangelical Crusade</td>
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</tr>
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<td>Church of God</td>
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</tr>
<tr>
<td>Church of Christ Mission</td>
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</tr>
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<td>AME Zion Mission</td>
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</tr>
<tr>
<td>Global Evangelical Church of Ghana</td>
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</tr>
<tr>
<td>Total</td>
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### Table D2. Proportion of CHAG’s Contribution to District Level Healthcare

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<th>#</th>
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<th>Government District Hospitals</th>
<th>CHAG District Hospitals</th>
<th>Total</th>
<th>Proportion of CHAG (%)</th>
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<td>Beds</td>
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<td>12,900</td>
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*Source: CHAG Annual Report (June 2005-May 2006).*

### Table D3. CHAG and GHS Doctor-Nurse Ratio

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<th>Variables</th>
<th>Doctors</th>
<th>Nurses</th>
<th>Others</th>
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<td>CHAG</td>
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<td>1418</td>
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<tr>
<td>%</td>
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<td>18.2</td>
<td>20.8</td>
<td>14.1</td>
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<td>GHS</td>
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<td>359</td>
<td>5054</td>
<td>8653</td>
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<tr>
<td>%</td>
<td>90.6</td>
<td>81.8</td>
<td>79.2</td>
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*Source: Peer and Participatory Health Appraisal for Action of CHAG Hospitals, November 2006*
APPENDIX E
BASIC INFORMATION OF GHANA HEALTH SERVICE

Table E1. Country Health Indicators

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<tr>
<td>Infant Mortality Rate (per 1000 live births)</td>
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<td>57</td>
<td>64</td>
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<tr>
<td>Neonatal Mortality Rate (per 1000 live births)</td>
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<td>41</td>
<td>30</td>
<td>43</td>
</tr>
<tr>
<td>Under 5 Mortality Rate (per 1000 live births)</td>
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<td>119</td>
<td>108</td>
<td>111</td>
</tr>
<tr>
<td>Post-Natal Mortality Rate (per 1000 live births)</td>
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<td>26</td>
<td>27</td>
<td>21</td>
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<tr>
<td>Crude Death Rate (per 1000)</td>
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<td>12.5</td>
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<td>10</td>
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<tr>
<td>Crude Birth Rate (per 1000)</td>
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<td>44</td>
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<td>33</td>
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<tr>
<td>Life Expectancy at birth (years)</td>
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<td>57</td>
<td>58</td>
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<td>Total fertility Rate</td>
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Table E2. National Guinea Worm Surveillance

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<td>4,979</td>
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<td>Brong Ahafo</td>
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<td>152</td>
<td>222</td>
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<td>6</td>
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<td>Volta</td>
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<td>37</td>
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Source: National Guinea Worm Eradication programme
### Table E3. National Medical and Nursing Situation-2006

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<th>B. A</th>
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<th>U.W</th>
<th>N</th>
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<td>1145</td>
<td>757</td>
<td>485</td>
<td>1011</td>
</tr>
</tbody>
</table>

Map of Ghana showing the 10 Regions
APPENDIX F
QUESTIONNAIRES

A case of Savelgu District and Tamale Metropolis in the Northern Region.

FOR PATIENTS

Basic Information

1. Name of the health center______________________________________________
2. Type of Health institution (tick)   Public ( )   Private ( )
3. Gender of Patient            Male ( )   Female ( )
4. Age_____
5. Level of education: Basic level ( ), Senior high school ( ), 1st degree ( ) Other_______
6. Occupation of patient____________________________________________________
7. Marital Status: Single ( ) Married ( ) Devoiced ( )

Equity and Access

8. Where do you come from? Different region ( ) Different district within this region ( )
   village within this District ( ) this community ( )
9. If this community, what is the distance from your house to this health center? Less than
   500m ( ) 500-1000m ( ) 1000m and above ( ).
10. How many times have you been to this health center within the last two years? First
    time ( ), Second time ( ), Third time ( ) Other_______
11. What type of sickness are you here to seek medical attention for? _____________
12. Why do you seek medical attention here instead of the other health centers? ______
    _______________________________________________________________________
13. Are there some factors that prevent you from seeking healthcare in this center in
    other times? Yes, No.
    a) If yes, what are they? _________________________________________________
    a) How can those issues be addressed? _____________________________________

14. How many minutes/hours do you spend before meeting a doctor in this
    hospital/clinic?
    a) Can spending from 3-4 hours plus affect your decision not to come here again?
15. Do you get all the drug prescription in this health facility? Yes, No
    a) If No, what do you do? _________________________

Affordability

16. How do you pay consultancy fees? Free ( ) Own pocket ( )
    State Health Insurance ( ) Other (specify) ________________________________
17. If State health insurance, does it cover all your health bills? Yes, No
    a) If No, what other things do you spend on? ______________________________
**Efficacy and Quality of Health service**
18. Have you ever been admitted in this hospital/clinic? Yes, No
   a) If yes, what is your opinion about doctor-patient relations in this hospital/clinic? __________
   ____________________________________________________________
19. How do you rate the level of reception at Out Patient Department (OPD) in this Hospital/clinic? Poor ( ), Relatively Good ( ) Very Good ( )
20. Do you have a particular doctor whom you always wish to meet for consultation? Yes, No , If yes, how is the Doctor different from the rest? __________
21. What is your general satisfaction of health service in this hospital/clinic? __________
   ____________________________________________________________

Thank you.

**FOR DOCTORS/MEDICAL ASSISTANTS**

**Basic Information**
1. What is your name_____________ Name of Health Center? _______________
2. Gender of medical officer Male ( ) Female ( )
3. Educational Status_____________
4. Age ______
5. What is your area of expertise? ___________________________
6. How many years have you been in this service? ____________________________

**Access and Equity**
9. Are there some particular health problems you can not treat (apart from HIV/AIDS)? Yes, No
   a) If yes, what are they? __________________________________________
10. What do you do when you are not at post? _______________________
11. How many minutes/hours do you spend per patient in the hospital/clinic? ______
12. How many hours do you spend at this hospital/clinic?
13. Do patients meet you at home for consultation? Yes, No
    If yes, at what time: before work ( ) after work ( ) days I am off duty ( )

**Efficacy and Quality Services**
14. What factors motivate you to serve in this institution (You may tick more than one)?
    better salary ( ) opportunities for continue education
    ( ) improved facilities and resources ( ) good plans for family education and health
    ( ) other (specify) __________________________
15. Do you work in another health center? Yes, No.
16. Is there relationship between public and private doctors?
    a) If no relationship, is there the need for this to be encouraged and in which ways?
17. Based on your experience is it difficult to work in this hospital/clinic? Yes, No
    a) If yes, what are the difficulties? __________________________
    b) If no, what factors make it easy?
18. How do you describe doctor-nurses relations in this center? Poor ( ), Relatively good ( ), Very Good ( ).
   a) If poor, what do you recommend to be done? ________________________________
19. What will you recommend to enable this health facility attract more personnel and improve its service delivery ________________________________

Thank you.

FOR DIRECTORS

Basic Information
1. What is your name? __________________ Name of health center________________
2. Type of Health center: Public ( ) Private ( )
3. Gender Male ( ) Female ( )
4. Age _______
5. Level of education:
6. Number of years spent in this hospital/clinic________________

Access and Equity
7. Please provide the number of the following medical personnel

<table>
<thead>
<tr>
<th>Health center</th>
<th>Personnel</th>
<th>2001</th>
<th>2002</th>
<th>2003</th>
<th>2004</th>
<th>2005</th>
<th>2006</th>
<th>2007</th>
</tr>
</thead>
<tbody>
<tr>
<td>Doctors</td>
<td></td>
<td></td>
<td></td>
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<td></td>
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<tr>
<td>Specialist</td>
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<td></td>
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<tr>
<td>Nurses</td>
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<tr>
<td>Total</td>
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</tr>
</tbody>
</table>

8. Please provide Client attendance from 2001 to 20007.

<table>
<thead>
<tr>
<th>Health centers</th>
<th>Variables</th>
<th>2001</th>
<th>2002</th>
<th>2003</th>
<th>2004</th>
<th>2005</th>
<th>2006</th>
<th>2007</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>No. of inpatient</td>
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<td></td>
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<tr>
<td></td>
<td>No. of outpatient</td>
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<tr>
<td></td>
<td>Average Outpatient Attendance per doctor</td>
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</tr>
</tbody>
</table>

9. Please provide total number of referral cases (in and out) in this hospital/clinic

<table>
<thead>
<tr>
<th>Health Center</th>
<th>Clients</th>
<th>2001</th>
<th>2002</th>
<th>2003</th>
<th>2004</th>
<th>2005</th>
<th>2006</th>
<th>2007</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Referred in</td>
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<td></td>
<td></td>
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<td></td>
<td>Referred out</td>
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</tbody>
</table>
10. Please list the expanded services provided at this hospital/clinic __________________________

11. Are there available beds for inpatients? Yes, No.

12. Do you serve users of State health insurance? Yes, No
   a) If yes, how does it encourage patient patronage to this hospital/clinic? __________

13. How do you procure drugs and medicine in this health center? ________________
14. List the number of equipments available in this institution base on good and very good ______________

Affordability
15. Where are your sources of finance in this institution? Government ( ) NGOs ( )
   Independent financing ( ) User fees ( ) Other (specify) __________________________
   a) In which proportion of such funding if not independent? ________________
16. Were patients unable to settle their consultancy and treatment fees? Yes, No
   a) If yes, how is that handle? ________________
   b) What is the proportion of the amount? ________________

Efficacy and Quality of Service
17. What kind of motivation factors provided to enhance better health delivery?

18. When do you start work and close each day? __________________________
19. Is there some days the institution does not work? Yes, No
   a) If yes how many days? One ( ) two ( ) three ( ) Other ________________
20. How many doctors are on post each day? __________________________
21. Are there any relations of this center with the community? Yes, No
   a) If yes, in which ways? __________________________
   b) If no, is there the need for community participation in health services? ________________

22. Comment on the following issues:
   Doctor-Patient relations __________________________
   Nurse-patient relations __________________________
23. What challenges you faced in providing services?
   a) with government __________________________
   b) with the Community __________________________
   c) within the health institution __________________________
24. Are there specific laws that regulate your services? Yes, No
   a) If yes, since when and what are they? __________________________
   b) How do you cope with it? __________________________
25. How many times in-service training is organized here within a year?
   a) for Nurses __________    b) for Staff __________
   a) Who organizes it? __________________________
26. Is there disciplinary action against staff and medical professionals? Yes, No
   a) If yes what are they? __________________________
27. Has any medical personnel (s) being disciplined within the last three years? Yes, No.
   a) If yes, how many of them? Males_______ Females____________
28. How many medical professionals left this center within the last two years.
   without management notice? Males, __________ Females __________
   a) Can you explain the major reasons why those personnel left? ________________
29. In which ways do you collaborate with public/private health providers? __________
   a) If your outfit does not cooperate with public/private in any way what should be
      done to promote public/private cooperation? ______________________________
30. Suggest ways needed to enhance access and affordable health services in this
    health center?
31. What would you suggest done to improve efficiency and quality of health care in this
    hospital/clinic?

Thank you