AN EVALUATION OF THE MANAGEMENT PRACTICES IN THE HEALTHCARE DELIVERY SYSTEM OF GHANA: A CASE STUDY OF DUNKWA MUNICIPAL HOSPITAL, DUNKWA-ON-OFFIN

By

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DECLARATION

I hereby declare that this submission is my own work towards the Master of Business Administration (Strategic Management and Consulting Option) Degree and that, to the best to my knowledge, it contains no material previously published by another person nor material which has been accepted for the award of any other degree of the University, except where due acknowledgement has been made in the text.

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DEDICATION

I dedicate this thesis to my wife Mrs. Monaliza Armah Matey and my children, Sylvester, Christopher, Stephen, Dede, Korkor and Junior.

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Though only my name appears on the cover of this dissertation, a great many people have contributed to its production. I owe my gratitude to all those people who have made this thesis possible. First and foremost I offer my sincerest gratitude to my supervisor, Dr. Wilberforce Owusu Ansah, who has supported me throughout my thesis with his patience and knowledge. I attribute the level of my Master degree to his encouragement and effort and without him this thesis, too, would not have been completed or written. One simply could not wish for a better or friendlier supervisor. I am also indebted to my wife, Monaliza and Ms. Rita Darko for their constant encouragement and support in diverse ways without which this thesis would not be possible. I am grateful to Mr. Alfred Adu-Bobi for his encouragement and practical advice. I am also thankful to him for reading my draft; commenting on my views and helping me understand and enrich my ideas. I thank Prince Amoako, George Philip Tetteh and Cephas A. Tetteh for helping me administer my questionnaires. My final appreciation goes to the management, staff and patients of Dunkwa Municipal Hospital for their various forms of support during my graduate study, responding to my questionnaires I used for the analysis.

ABSTRACT

Many healthcare delivery issues are managerial rather than policies. There is therefore the call for effective management practices in healthcare facilities.However, there is no specific management training system for doctors and others who become chief executive officers of these facilities. This study thus evaluates the management practices of healthcare delivery in Dunkwa Municipal Hospital and how it relates with quality of healthcare delivery. The study was a case study. The population of this study was 200 health staff and 50 patients. A sample size of 112 health staff; included 22 management and senior staff, 90 junior staff and 27 patients who visited the hospital were used. The purposive sampling method was used to select the management and senior staff of Dunkwa Municipal Hospital. The simple random sampling technique was used in this study to select the junior staff and patients. The instruments used for the study were questionnaires and interviews. The data was organized into frequency tables, pie-charts, bar charts and line graphs using MS-Excel

2007 and SPSS (version 16.0). Pearson' Correlation Coefficient was used to test for significant relationship between healthcare management practices and healthcare delivery systems. The hospital had amenities and facilities were functional. Doctors, nurses, midwives, pharmacists, physician assistants, laboratory technicians, labourers, orderlies and security personnel were not sufficient. Healthcare management practices and healthcare delivery were positively and significantly related. Self-medication, superstition, cost of health care, attitude of the medical staff affected health care delivery in the hospital were challenges to efficacy healthcare management practices. The study recommends that the management should continue to improve management practices in hospital. Ghana Health Service should to post dieticians, physiotherapist and more doctors, nurses, midwives, pharmacists, physician assistants, laboratory technicians, labourers, orderlies and security personnel to the hospital. The management of the hospital should undertake outreach programmes in the communities to sensitize the people on the bad effects of self-medication and superstition among the people, and use strategic planning in the management of health care delivery in the hospital.

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CHAPTER ONE

INTRODUCTION

1.0 Background to the Study

The health enterprise is one of the most important parts of Ghana's social system. Ghana cannot be strong or wealthy and citizens cannot lead fully productive lives without good health. Everyone has helped a loved one who faced significant health challenges. "Life as we know it" stands still in the face of a life- threatening or an activity limiting illness. We would sacrifice almost anything to restore the health of a loved one; we are willing to pay higher taxes to make sure that our friends, relatives, neighbours and strangers have the health care services they need. This special significance of health in our lives makes careers in the health sector so important and so attractive (Jonas &Kovner, 2008). Assuredly, "health is a fundamental human right indispensable for the exercise of other human rights." Every human being is entitled to the enjoyment of the highest attainable standard of health conducive to living a life in dignity" (UN, 2000). Article 25 of the Universal Declaration of Human Rights (UDHR) further indicates that "everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, medical care and the right to security in the event of sickness, disability" (UN, 1948) and therefore, the right to good health care is not only essential, but also a major responsibility of the government (Constitution of Ghana, 1992).

In 2005, the Government of Ghana spent about 6.2% of GDP on health care, or US $30 per capita. Of that, approximately 34% was government expenditure (WHO, 2008). Life expectancy at birth is 66 years with males at 65 years and females at 67 years, and infant mortality is at 39 per 1000 live births as at 2013 (www.cia.gov,

2013). The total fertility rate is 2.12 children per woman among the 15 million Ghanaian nationals. There was about 15 physicians and 93 nurses per 100,000 persons in 2010 (www.afro.who.int, 2010). 5.2% of the country's GDP was spent on health in 2010 (ww.cia.gov, 2013), and all Ghanaian citizens that have access to primary healthcare constitutes 97.5% of the Ghana population. Ghana's universal healthcare system has been described as the most successful healthcare system on the African continent by the renowned business magnate and tycoon Bill Gates.

The healthcare industry has now become the most vibrant industries across the world. With growing size of this industry, demand for potential and skilled mangers and healthcare professionals is also increasing. The demand and requirement for the managers have mounted because there is urgent need for meeting the challenges of this potential market. With the globalisation of the healthcare industry, healthcare managers and professionals must possess practice-oriented, international and intellectual skills. Healthcare managers have the potentials that are needed for the future global healthcare facilities. They are imbued with the extensive managerial skills to enhance the quality while decreasing the cost at a same time (Thompson,
Buchbinder & Shanks, 2011).

Health care managers must adopt new models of health care organisations if they are going to develop creative and innovative strategies for the management of health care organisations. Health care organisations are often seen as the model of professional organisations. They are, however, unique among professional organisations in that rather than one profession occupying all of the major professional roles, there are several different professions that are central to organisational success. Historically physician roles and the medical model of health care have dominated (Anderson & McDaniel, 2000). As healthcare managers, they supervise community health workers

and clinic staff; track, monitor and order supplies and medicines, even see patients throughout the cycle of care. They also develop budgets, manage relationships with stakeholders in the community, and assess the performance of teams. To achieve these targets, it will require not only resources, but also better leadership and management which are strategic to using these resources effectively to achieve measurable results. Good leadership and management can help to gain commitment from staff and other stakeholders which help to achieve better health services through efficient, creative and responsible deployment of people and other resources (Egger, Travis, Dovlo & Hawken, 2005). Good managers ensure effective organisation and utilisation of resources to achieve results and meet the aims of the health institutions.

In most developed countries, the healthcare sector encompasses anything from 8 per cent to over 15 per cent of the economy, making it one of the largest industries in any country bigger generally than education, agriculture, IT, tourism or telecommunications, and a crucial component of wider economic performance. In most countries, around one worker in ten is employed in the healthcare sector – as doctors, nurses, scientists, therapists, cleaners, cooks, engineers, administrators, clerks, finance controllers and, of course, as managers. This means that almost everyone has a relative or knows someone who works in healthcare, and the healthcare workforce can be a politically powerful group with considerable influence over public opinion. Almost everyone uses health services, or has members of their family or friends who are significant healthcare users, and everyone has a view to express about their local healthcare system (Smith &Walshe, 2011).

1.1 Statement of the Problem

Management of people, processes and resources is an important part of health care delivery system. Only a good manager can train and get work done from people under

him. The lack of leadership and management capacity is a constraint, especially at operational levels of both the public and private health sectors. The health sector has been hindered by process inefficiencies, widespread variation in the quality of patient care and a lack of well-defined and appropriately aligned leadership systems. Unfortunately, there is no specific management training system for doctors and other healthcare professionals during their study in the universities and other institutions. For example, in the selection or appointment of managers to manage healthcare institutions, the senior medical doctor who has worked in a particular health institution for a considerable number of years is made either the chief executive officer or the director of a unit of that health institution. Medical doctors who are not fine-tuned with managerial issues are made managers and a lot of them tend to create more problems rather than solve the ones they inherited. Hence, a lot of health-care problem is a management problem. Many health-care delivery issues are managerial rather than policy issues. There is a deliberate demarcation between management practice, focused on business processes, and clinical practice, focused on the activities and decisions of diagnosis and treatment. The traditional administration of appointing these doctors to lead health care organisations is not helping them to cope with the dynamics of the changing health systems. An improved management would thus lead to an optimisation of health care delivery processes and a more effective use of resources. It is therefore the wish of the researcher to evaluate the management of healthcare delivery at Dunkwa Municipal Hospital in the Central region of Ghana.

1.2 Objectives of the Study

The objectives of the study are grouped under general and specific objectives.

1.2.1 General Objective

The general objective of the study was to evaluate the management of healthcare delivery in Dunkwa Municipal Hospital.

1.2.2 Specific Objectives

The specific objectives of the study were to:

i. Identify the defining characteristics of the Ghanaian healthcare system ii. Establish relationship between the management practices and quality of healthcare delivery.

iii. Explore the challenges to the efficacy of management in healthcare delivery

1.3 Research Questions

The following are the research questions for the study.

1. What are the defining characteristics of the Ghanaian healthcare system?
2. To what extent does the management affect the quality of healthcare delivery in Ghana?
3. What are the main challenges to the efficacy of management in healthcare delivery?

1.4 Significance of the Study

The study would impact on leadership analysts and experts, management of health institutions, academia and the general public.

Management of health Institutions

To the management of health institutions and the Ghana Health Service, the findings and results would provide a more reliable scientific measure and perspective to

ascertain the impact of effective management practices on the output of health workers. It would also serve as an invaluable source of information that brings to lime light the management practices of the targeted managers at the Dunkwa Municipal Hospital. This would provide empirical support for management strategic decisions in several critical areas of their operations, and above all, provide a justifiably valid and reliable guide to designing workable management practices, which can help create and deliver value, achieve patient satisfaction and loyalty, build long-term mutually beneficial relationship with health workers and achieve sustainable and quality health care in Ghana.

The results from this study can help managers especially medical doctors who are made to head hospitals improve healthcare delivery. It would thus enable managers to design the way they work and as such lead organisations in an efficient way to deliver a service effectively and reliably. It would enable them at the same time to learn systematically from their own experience. It would help appointing authorities (like the Ghana Health Service) of managers of health institutions to pay serious and closer attention not only to the clinical competence but also the managerial competence of the physician as the efficient management of the health institution is paramount to the delivery of quality healthcare.

Policy Makers

To the Ministry of Health, the policy maker, the findings and results of this study would provide invaluable insights and a more reliable guide to monitoring the impact of management practices on health workers' performance. It would also be a yardstick for measuring partly their respective policy goals and objectives on healthcare delivery in the country. Particularly, it would serve as a means for the Ministry of Health to enhance the reliability and efficiency in the management of healthcare delivery. It would help

them to assess the policy of appointing medical doctors as managers of healthcare institutions.

Health workers

To stakeholders like physicians, nurses, pharmacists, laboratory technicians, orderlies, etc., the study would provide invaluable information that would allow them to provide useful suggestions for the improvement in management practices of managers.

Academia

The outcome of this study is to augment the existing store of knowledge on the subject. This study would serve as a scholarly article for review in further studies. It would thus be used as a document or a material of reference by other people who will be conducting a study into a similar topic in the future.

1.5 Overview of the Research Methodology

The descriptive case study was used as the research design for the study. The population used for the study included the management, senior and junior staff and patients/clients of Dunkwa Municipal Hospital. The purposive sampling technique was used to select the sample from the population. Data was collected from both primary and secondary sources. The data collection instruments were questionnaires and interviews. Data were analysed through the use of frequency tables, pie charts, bar charts and line graphs obtained from the MS-Excel 2007. The study further used

Pearson's Correlation Coefficient to significantly test the relationship between healthcare management practices and efficacy of healthcare delivery system.

1.6 Scope of the Study

This study is limited to the management, senior and junior staff of Dunkwa Municipal Hospital and patients/clients patronizing the hospital. The study looked at the key importance of management of healthcare delivery at Dunkwa Municipal Hospital.

1.7 Limitations of the Study

This study is limited in several respects. Information from certain key respondents was difficult to access, as they needed permission from the medical superintendent to divulge any information to the researcher. The majority of hospital staff that were interviewed were mainly those who were not involved in the any form of management of healthcare delivery. It would have been desirable to also interview a lot of the health workers who were involved in the management of healthcare delivery to get an objective view of the study findings. These people were however in the minority.

Also, the given time frame for which this study was to be completed made it difficult and impossible for the researcher to cover more than one hospital in the Central region, not to talk of other hospitals across the country. Budget restraint also made it improbable for the research to be carried out for more than one organization. The sample size used for the study was small due and this might affect the comprehensiveness of the study.

1.8 Organization of the Study

This study is in five chapters. Chapter one is the introduction. It deals with the background of the study, the statement of the problem, the objectives of the study, the research questions, significance, overview of the research methodology, scope, limitations and organization of the study.Chapter two is the literature review. Literature

is reviewed according to the research questions used in the study. Various books, journals, articles and the internet helped the researcher to extract information on the topic for this write up. The theories of health care management for the study are also outlined.

Chapter three is the research methodology adopted for undertaking this research study. It outlines the research design, the research population, sample size and sampling techniques used in the study. It explains the sources of data, the data collection instruments that were employed in obtaining the data used for this study. It also describes the data analysis methods and provides a brief outline of the organizational profile.

Chapter four is the data presentation, analysis and discussion. It presents the data, analyses and discusses the results of the study. Chapter five presents the summary of findings, conclusion and recommendations for the study. It also provides suggestions for further research.

CHAPTER TWO

LITERATURE REVIEW

2.0 Introduction

In this chapter, literature is reviewed according to the research questions used in the study. Various books, journals, articles and the internet helped the researcher to extract information for this research. This chapter thus sought to review relevant existing literature on the defining characteristics of the Ghanaian healthcare system, the relationship between the management (of people, processes and resources) and quality

of healthcare delivery, the challenges to the efficacy of management in healthcare delivery. The theories of health care management for the study are also outlined.

2.1. Defining Characteristics of the Ghanaian Healthcare System

In general terms, a healthcare system needs to accomplish two basic things: improve the health status of the population (according to certain criteria and targets) and deliver services in the most efficient way possible in order to accomplish the first goal (Dorros, 2006).

2.1.1 Healthcare Delivery during Colonial Times

According to Senah (2001), the development of modern health care system in Ghana can be categorized into three phases. The first phase started in 1471 and ended somewhere in 1844. This period saw the emergence and the subsequent establishment of biomedicine. The health care system was the sole preserve of the colonial masters and it was established to protect them against the possible contraction of infectious diseases from the "unhygienic" conditions of the "natives' environment" who they interacted with on a daily basis. The funding of healthcare before independence was the sole prerogative of the colonial government or the missionaries who were involved in the provision of healthcare at that time (Dummett, 1993).

The second phase of the colonial health system was marked by the signing of the bond of 1844 between the British and some local chiefs in Ghana. The signing of the bond did not only enhance European commercial and Christian missionary activities in the hinterland, but it also promoted the realization that the colonial masters could not only enjoy good health without ensuring that the health needs of the natives were also met (Senah, 2001). The colonial era saw massive discrimination in the dispensation of

health care to the natives and even against health workers. Colonial health services and other sanitary facilities were however extended to the domestic servants, those in the civil and military service that were in constant contact with their colonial masters (Senah, 2001).

The third phase which started in 1868 was the period when the first hospital was built in Cape Coast, as well as dispensaries in several rural communities (Senah, 2001). In 1923 the first national hospital, the Korle Bu Teaching Hospital was built to purposely serve the health needs of Ghanaians. After independence in 1957, effective social and welfare services were prioritized as a consequence of the devastating effect of colonialism on the health sector. The Convention People's Party, first national government revamped the health sector as it enlarged and modernised facilities and also trained more medical personnel (Boakye Frimpong, 2013). As a result, Ghanaians could seek medical care in any government hospital, health center and pharmacy at zero financial cost as the health sector was financed by the State.

2.1.2 Healthcare Delivery after Independence

Following independence in 1957, effective social and welfare serviceswere prioritized as a consequence of the devastating effect of colonialism on the health sector. The first national government revamped the health sector by enlarging and modernizing facilities as well as training more medical personnel (Opare and Mills, 2000). Subsequently, Ghanaians could seek medical care in any government hospital, health center and pharmacy at zero financial cost as the health sector was financed by the

State. Senah (2001) suggested that "between 1957 and 1963 the number of health centers increased from 1.0 to 41", and of the £144 million that government budgeted, between 1963 and 1964, for projects, as part of public expenditure, about 31 % went towards the social services with much attention given to the health sector (p.85).

Moreover, government's health expenditure increased from 6.4% in 1965 to 8.2% in 1969 (Patterson, 1981). The above statistics show that the government spent more on the health care and human resource development compared to other departments.

According to Osei-Boateng (1992), the quality of care however began to decline in the late 1960s, mainly because subsequent governments failed to invest in the health care system. Thus, user fees were introduced in 1969 and continued in some variety until the introduction of the "Cash-And-Carry" or "Pay-As-You-Go" System in 1985. The full burden of paying for health care was borne by patients as the government was charged to reduce expenditure drastically upon adoption of the International Monetary Fund's (IMF) and World Bank's Structural Adjustment Program (SAP).

Government expenditure on health was reduced from 10% of the national budget in 1982 to 1.3% in 1997 (Asenso-Okyere & Dzator, 1997). As many people could not afford to pay the requisite fees at point of delivery to seek medical attention, they avoided going to hospitals and health centers; instead, they engaged in self-medication or other cost-saving behaviours or practices (Asenso-Okyere, Anum, Osei-Akoto, &Adonuku, 1998). As a result, in 2003 the New Patriotic Party (NPP) government introduced and passed into law a National Health Insurance Scheme (NHIS) bill, with the view to providing affordable safe health care to all residents of Ghana. The objective was to remove the financial barriers of Ghanaians to access healthcare services and to ensure equitable access to quality services especially by the poor and vulnerable. Thus the Government of Ghana initiated and passed the National Health Insurance Law, 2003 (Act 650) and the National Health Insurance Regulations,

2004 (L.I. 1809) which was aimed at abolishing the 'Cash and Carry' system and limiting out-of-pocket payments at the point of service delivery
(Government of Ghana, 2004; Adjepong &Adjei, 2008).

This tremendous appreciation of outpatient and inpatient utilisation of healthcare seems to suggest that, the scheme has increased accessibility particularly to the poor because healthcare has become somewhat affordable (NHIA, 2011). In a sense, however, relative to its antecedent 'Cash and Carry' system, the current NHIS can be said to be more equitable (Boakye Frimpong, 2013). In Ghana, two governmental bodies oversee health care infrastructure and delivery in Ghana – the Ministry of Health (MOH) and Ghana Health Services (GHS). Until 1996, the MOH oversaw the direct provision of health service delivery in Ghana. Today, health service delivery is provided by GHS (Pehr, 2010). The healthcare system has five levels of providers: Community-based Health Planning Services (CHPS) which are first level primary care for rural areas, health centers and clinics, district hospitals, regional hospitals and tertiary hospitals. These programs are funded by the government of Ghana, financial credits, Internally Generated Fund (IGF), and donors-pooled health fund (Sudharshan & Xiao, 2001). Hospitals and clinics run by Christian Health Association of Ghana also provide healthcare services. There are 200 hospitals in Ghana. Some for-profit clinics exist, but they provide less than 2% of health care services.

Health care is very variable through the country. Urban centres are well served, and contain most hospitals, clinics, and pharmacies in the country. However, rural areas often have no modern health care. Patients in these areas either rely on traditional African medicine, or travel great distances for health care. The health care system in Ghana encompasses a sprawling set of activities and enterprises. Many fundamental

forces keep individual actors working in tandem to produce and maintain good health in the population (Jonas &Kovner, 2008).

The first defining characteristic of the health enterprise is the distinction between activities directed at keeping people healthy and activities directed at restoring health once a disease or injury occurs. Keeping people healthy is the domain of the public health care system and the activities associated with behavioural health. Public health involves activities aimed to keep the population healthy, for example, protecting the environment, making sure hygienic water supplies and restaurants and food are safe, and providing preventive health services. Behavioural health focuses on helping people make behavioural choices that improve or protect health, for example, not smoking, eating well, exercising, and reducing stress. Once people become ill, the medical care sector takes over and delivers a wide variety of services and interventions to restore health. However, the medical care part of the system, which dwarfs the public health and behavioural health parts, tends to ignore its potential to promote and maintain health. One puzzle of the health sector is that changing an individual's behaviour has much greater impact on health and mortality than does spending money on medical care.

Another defining characteristic is the importance of institutions in delivering care. Hospitals, nursing homes, community health centers, physician practices, and public health departments all are complex institutions that have been established to meet various needs of the people. Each type of institution has its traditions, strengths, weaknesses, and a defined role in the health enterprise.

Also, the healthcare system is identified by the role of professionals in running the system. Many different types of professionals make the system work, and each type has

distinct roles. Physicians, nurses, pharmacists, administrators, policy leaders, researchers, technicians and many more professionals play important roles in running the system (Jonas &Kovner, 2008).

One other feature of the healthcare system is the developments in medical technology, electronic communication, and new drugs that fuel changes in service delivery. Recent advances in technology and technique have exploded, making it possible to aggressively intervene to restore health in ways that were not dreamed of a generation ago. New techniques in imaging, electronic communication, pharmaceuticals, and surgical procedures are remarkable. These advances, however, have added costs to the system and have made health care unaffordable for a greater percentage of the population.

The health care system is also characterised by tension between "caring" and "big business" that shapes the system's culture. There is some form of tension between running health as a social good or as a big business. Most people are not able to access health care services because some aspects of it are being run as a business. For example, in the bigger hospitals, like Komfo Anokye Teaching Hospital (KATH), there is a special delivery ward for women who can afford. Women, who visit this ward to be delivered of their babies, pay as much as 500 Ghana cedis for normal deliveries and as much as 1700 Ghana cedis for deliveries where operations are involved. The private hospitals are charging higher amounts of money for the services they render. Health care is seen more as a business driven by market forces, profits, and efficiency rather than as a social good, run by nonprofit organisations with benevolent missions. Many of the people who choose health care as a career are motivated at least in part by the potential to be a caring person. However, the system is driven by many for-profit

corporations from pharmaceutical companies to medical device manufacturers, to insurance companies, to for-profit hospitals and nursing homes. Salaries are relatively high in the health sector, especially for physicians, administrators, and corporate executives. Although money clearly is an important shaper of the system, the caring aspect of health care should be central when they need services.

Also, there is a dysfunctional financing and payment system. The health care system is expensive to maintain. A huge chunk of the country's budget is spent on health care. In 2010, 5.2% of the Ghana's GDP was spent on health (www.cia.gov). Most people have health insurance to pay for services when they become ill, the way hospitals, physicians, and other providers are paid has become very complex because of the role of insurance. Remarkably, efficient, effective care is not rewarded. In the Ashanti region, the introduction of the Capitation Grant for health has brought in it's a lot of agitations among the people and they are even calling for its abolition. The providers are in the lead for this.

In many countries, the history of the healthcare system is intertwined with the development of communities and social structures. Religious groups, charities, voluntary organisations, trade unions and local municipalities have all played important roles in building the healthcare organisations and systems we have today, and people in those communities often feel connected in a visceral manner to 'their' hospitals, community clinics, ambulance service, and other parts of the healthcare system. They raise funds to support new facilities or equipment, and volunteer to work in a wide range of roles which augment or support the employed healthcare workforce (Smith &Walshe, 2011).

2.2 Concept of Management

Management has been defined as the process, comprised of social and technical functions and activities, occurring within organisations for the purpose of accomplishing predetermined objectives through humans and other resources (Longest, Rakich & Darr, 2000). A manager is anyone in the organisation who supports and is responsible for the work performance of one or more other persons (Lombardi &Schermerhorn, 2007).Management is seen as a social discipline that deals with the behaviour of people and human institutions, and a manager sets objectives, organises, motivates and communicates and develops people (Drucker, 1999); the manager is the dynamic, life giving element in every business. Without him the "resources of production" remain resources and never become production. Management is getting people to work harmoniously together and to make efficient use of resources to achieve objectives (McMahon, Barton, Plot, Gelina, & Ross, 1992). Management can thus be seen as a process of reaching the set objectives of an organisation through usage of human, physical, and financial resources with the best possible means combination and making the appropriate decision while taking into consideration the external environment.

Management is quite a unique concept because rather than having a universal approach it is rather contingent as Goodwin argues - there is no equivalent science of managing since management is contingent upon particular circumstances and contexts and has no universal application (Goodwin, 2006). The same point of view is shared by Dorros (2006) who sees the management of any institution or organization as determined by the policies, structures, processes and cultural values in which it is practiced and adapted to the context in which it seeks to achieve results. The single most important

purpose of management is to make effective and efficient use of institutional and organizational resources to achieve results outside the organization.

Management is learnt by doing, by experiencing the challenges and opportunities of leadership (Mintzberg, 2004). But the best and most successful managers are reflective practitioners – profoundly aware of their own behaviours, attitudes and actions and their impact on others and on the organization, and able to analyze and review critically their own practice and set it in a wider context, framed by appropriate theories, models and concepts (Peck 2004). In healthcare management, it should be realized that management occurs through many others who may not have

"manager" in their position title. Examples of some of these managerial positions in healthcare organisations include supervisor, coordinator, and director, among others (Thompson, Buchbinder& Shanks, 2011).

Management positions within healthcare organisations are not confined to the top level; because of the size and complexity of many healthcare organisations, management positions are found throughout the organisation. Management positions exist at the lower, middle, and upper levels; the upper level is referred to as senior management. The hierarchy of management means that authority, or power, is delegated downward in the organization and that lower-level managers have less authority than higher-level managers, whose scope of responsibility is much greater. For example, a health services administrator in a hospital may be in charge of several different functional areas such as human resource, laundry, diagnostic imaging services and laboratory services; while a head of Medical Records, a lower-level position, has responsibility only for the function of patient medical records. Furthermore, a supervisor within the Environmental Services department may have responsibility for only a small housekeeping staff, whose work is critical but confined to defined area of the

organization. Some managerial positions are line managerial positions because the manager supervises other employees; other managerial positions are staff managerial positions because they carry out work and advise their bosses, but they do not routinely supervise others. Managerial positions also vary in terms of required expertise or experience; some positions require knowledge of many substantive areas and significant working experience, and other positions are more appropriate for entry-level managers who have limited or no experience.

The most common organizational structure for healthcare organisations is a functional organizational structure whose key characteristics is pyramid-shaped hierarchy. This structure defines the functions carried out and the key management positions assigned to those functions. The size and complexity of the specific health services organization will dictate the particular structure. For example, larger organisations such as teaching hospitals, regional hospitals, and district hospitals will likely have deep vertical structures reflecting varying levels of administrative control for the organization. This structure is necessary due to the large scope of services provided and the corresponding vast array of administrative and support services that are needed to enable the delivery of clinical services. Other characteristics associated with this functional structure include a strict chain of command and line of reporting, which ensure that communication and assignment and evaluation of tasks are carried put in a linear command and control environment. This structure offers key advantages, such as specific divisions of labour and clear lines of reporting and accountability (Thompson, Buchbinder& Shanks, 2011).

Moore (1996) catalogued the different approaches to management in four major categories:

i. Traditional bureaucracy – with an emphasis on clear structure, hierarchical chains of command, clear accountability for performance (Taylor, 1911); ii. New Public Management – with an emphasis on making organisations more like firms, operating in markets through the introduction of competition to improve performance (Hood, 1991); iii. 'Japanese' organization model or 'clan'– 'solidarity' model of organisation in which a sense of identity with, and pride in, the organisation itself is the main source of motivation; iv. Professionalism – shares the 'Japanese' model's assumption that people work better when they are trusted and their performance is not closely monitored; the sense of identity is with the profession rather than with the organisation, or possibly loyalty to both exists.

Regarding the role of a manager, Mintzberg (2004) classified them in three major categories with specific sub roles and tasks linked to them:

1. Informational - this includes monitoring (seek and acquire work-related information), dissemination (communicate/disseminate information to/with others within the organisation) and public relation (transmit information to the external environment).
2. Interpersonal - this includes representation (perform social and legal duties, act as symbolic leader) being a leader (direct, motivate, train subordinates) and creating the liaison (establishing and managing contacts within and outside the organisation).
3. Decisional - the third role includes entrepreneur (identify new ideas and initiate improvement projects) conflict manager (solving disputes or problems and overcoming crisis situations) allocating resources (set and distribute resources according to priorities).

The central point about these world-views, or doctrines, is that management is not a purely technical enterprise; ideas, culture and ideologies make a real difference (Hunter, 2007). From all the above definitions and opinions regarding management, the following are some basic characteristics of management:

a. It involves having a goal/set of goals, objectives that are shaped by the organisation and its environment;
b. Managers need to have a clear understanding of the available resources (from financial to human) in order to allocate them for the defined objectives;
c. As a process it involves a set of actions like planning, organizing, control, budgeting, evaluation (probably the most famous reference for this is Gullick's POSDCORB);
d. Although having a set of common characteristics, management does not have a universal character but rather it is influenced by the type of organisation and the external environment (Goodwin, 2006);
e. Probably the most important characteristic is that management is focused on getting the things done, achieving results - the ultimate goal of any manager;
f. Last but not least important, management is also about individuals, thus their personal beliefs, values and motivations have a major role in the activity of any manager.

2.2.1 Roles of Healthcare Managers

Healthcare organizations are complex and dynamic. The nature of organisations requires that managers provide leadership, as well as the supervision and coordination of employees. Organisations were created to achieve goals that were beyond the capacity of any single individual. In healthcare organization, the scope and complexity of tasks carried out in provision of services are so great that individual staff operating

on their own could not get the job done. Moreover, the necessary tasks in producing services in healthcare organisations require the coordination of many specialized disciplines that must work together seamlessly. Managers are needed to make certain that organizational tasks are carried out in the best way possible to achieve organizational goals and that appropriate resources, including financial and human resources, are adequate to support the organization (Thompson, Buchbinder & Shanks, 2011).

Healthcare managers are appointed to positions of authority, where they shape the organization by making important decisions. Such decisions relate, for example, to recruitment and development of staff, acquisition of technology, service additions and reductions, and allocation and spending of financial resources. Decisions made by healthcare managers not only focus on ensuring that the patient receives the most appropriate, timely and effective services possible, but also address achievement of performance targets that are desired by the manager. Ultimately, decisions made by an individual manager affect the organisation's overall performance (Thompson, Buchbinder & Shanks, 2011).

Managers must consider two domains as they carry out various tasks and make decisions (Thompson, 2007). These domains are termed external and internal domains. The external domain refers to the influences, resources, and activities that exist outside the boundary of the organization but that significantly affect the organization. These factors include community needs, population characteristics, and reimbursement from commercial insurers, as well as government plans such as the National Health Insurance plans (Thompson, Buchbinder & Shanks, 2011). The internal domain refers to those areas of focus that managers need to address on a daily basis, such as ensuring the appropriate number and types of staff, financial performance, and quality of care. These

internal areas reflect the operation of the organization where the manager has the most control.

In practice, managers frequently to some extent rely on plans, they coordinate and control and use bureaucratic means, but they also try to create commitment or at least acceptance for plans, rules, goals and instructions (Alvesson, 2002). Making people understand the purpose of, and create meaning around the goals and objectives of the organization means both formal procedures and instruments and informal ones. Managersaffect thinking and feeling in connection to managing specific tasks and goals (Alvesson, 2002).

The health manager spends a substantial proportion of his/her time managing volume and coverage of services (planning, implementation and evaluation); resources (e.g. staff, budgets, drugs, equipment, buildings, information) and external relations and partners, including service users (Egger, Travis, Dovlo & Hawken, 2005). Management of people, processes and resources is very essential compared to other challenges in health care because it is believed a frustrated health care provider will always deliver frustrating results. Mismanagement of resources leads to mismanagement of health problems that people show up with at the health center
level.

2.2.2 Theories of Healthcare Management

Health care management is a growing field. Health care managers have the important task of administering entire health care systems, such as hospitals. Differing opinions exist as to how these health care systems should be run. The effectiveness of a hospital or other health care facility is dependent upon the type of health care management theory it subscribes to and how well that theory is implemented (Lewis, 2001).

2.2.2.1 Attribution Theory

Attribution theory, as applied to health care management, is a way of assessing the successes and failures of a health care system or program. The attribution theory is described as one possible health care management theory that can be used to create a safer environment for patients (Palmieri & Peterson, 2009). The attribution theory can be used as a conceptual framework to foster a positive and safe work environment for both health care workers and patients. Attribution theory assumes health care management can be improved by understanding that error in health care can sometimes occur. When it does, it can lead to feelings of cynicism and organisational inertia in the health care system. If health care managers understand where these feelings arise, they can learn to foster a positive work environment that will improve employee response to errors in health care. When health care workers learn to recognise these mistakes as simply "human" errors, health care workers can learn to focus on continuing to provide a positive environment for patient recovery rather than focusing on what they have not done successfully.

2.2.2.2 Evidence-Based Management

A second health care management theory is the evidence-based management theory. According to Walshe & Rundall (2001), health care managers have been slow to accept and apply the same theories to which they often hold health care workers, an evidence-based approach that requires doctors, nurses and other health care professionals to make decisions based on the best available evidence. They suggest that there is a need to impose these same standards on the decision-making process of health care managers and that doing so will bring a level of uniformity to the decisions of health care officials. Practical considerations such as time constraints and deadlines often make the transition from evidence-based theory to practice somewhat

difficult.

2.2.2.3 Utilization Management

The utilization management is a third health care management theory. It has received wider application in the health care industry than the more theoretical attribution and evidence-based theories. Utilization management is a proactive approach to managing health care through preset guidelines. The American College of Medical Quality identifies several tasks in utilization management that are essential to effective management of a health care organization. First it is essential to determine the organization's priorities. This is followed by research and a determination of who will benefit from the major decisions that are made. From this information, health care managers then determine what goals to set and how to go about implementing further research. Once data is collected and evaluated, policies, guidelines and procedures can be developed and implemented (Lewis 2001).

2.3 Challenges to the efficacy of management in healthcare delivery

There is no universal recipe for successful management, contextual factors like political system and socio-economic factors play a significant part in the outcomes. The healthcare system is caused by the acute lack of understanding of the direct link between the lack of "hard" management skills at all levels resulting in poor outcomes of the health systems. The shortage of staff and a lack of management training are some of the issues that have an effect on management practices (Hinţea, Mora &Ţiclău, 2009).

The challenges facing health care organisations and health care professionals today are more complex than at any other time in the history of our country particularly within

the context of globalisation and social, political and economic changes. The traditional challenges of managing cost, access and quality are still on the forefront of today's health care leaders. Managers of health care organisations, professionals and practitioners face current challenges including state legislation, advanced technology, information systems, patient demographics, skilled labor shortage and growing awareness of public opinion (Osbourne, 2011).

Healthcare managers face challenges around self-identity, particularly for those in 'hybrid' clinical-managerial roles, and around the negative perception of management in general. Managers struggle to maintain their professional identity, especially hybrids who see themselves primarily as clinicians. They often see their clinical role sidelined by managerial responsibilities (Paliadelis, 2008). Dopson (1996) argues that inherent tensions exist between the professional values of clinical and medical staff, and managerial demands for efficiency, cost control, and resource reallocation.They also have problems with human resources, lack of organisational support, and with too many systems and processes that are inadequate, outdated, complex, or simply inconsistent with their responsibilities (Osbourne, 2011).

They also cite other challenges as lack of preparation for a managerial role, balancing priorities, work pressures, lack of recognition, role conflict, and the absence of power, influence and authority, work pressures, job insecurity, work relationships, organisational communication, and conflicting government directives such as having cleaner hospitals, but being under pressure to save money by hiring fewer cleaners (Osbourne, 2011).

Negative perceptions of management: The negative perceptions of management in healthcare present several challenges to managers, especially as this stereotype is held both by the public and by colleagues (Preston & Loan-Clarke, 2000).Llewellyn (2001) argues that clinicians who take up management positions risk loss of respect and clinical visibility; they have to work to dispel suspicions that choosing a managerial track is not because they lack the ability to progress in their clinical careers. For hybrids, management values are seen as conflicting with their professional and personal values. The management role is also seen as one of increased pressure with no tangible rewards or recognition for the additional

responsibilities.

Many hospitals have problems recruiting enough appropriately skilled staff, and also retaining current high performing managers (Loo & Thorpe, 2004; Savage & Scott, 2004). Most managers also feel that their roles lack definition, compounded by the lack of definitive job descriptions. Most managers are given management roles without having had any prior management training.

Many of the challenges facing managers stem from government policies which are at times conflicting, unachievable, and create paperwork and problems instead of solving problems. Until these policies change, managers will continue to face these challenges. The healthcare organisations exist in a turbulent political and social environment, in which their actions and behaviour are highly visible and much

scrutinised.

In the developed countries, the healthcare system is subject to several inexorable and challenging social trends: the demographic shift, the pace of technological innovation, changing user and consumer expectations and rising costs within a context of global

economic recession (Smith &Walshe, 2011). The demographic challenge is that because people are living longer, the numbers of elderly and very elderly people are rising fast and those people make much heavier use of the healthcare system. People may live longer, but it cost them more to stay alive, they are more likely to have complex, chronic health conditions, and their last few months of life tend to be more expensive. A further dimension to this demographic challenge is the rising incidence of chronic disease in the wider population of developed countries. The World Health Organisation suggests that this is a direct result of risk factors such as tobacco use, physical inactivity and unhealthy diets (WHO, 2005).

The pace of technological innovation, the second challenge is related to the first in that it reflects an increasing ability to control chronic disease and thus extend life.

In pharmaceuticals, surgery, diagnostics, telehealth and other areas, there are new treatments which are more effective (and usually more expensive) than the existing ones. This however also means there new therapies for diseases or problems which simply could not be treated before. Previously fatal conditions have become treatable, and interventions to monitor and slow the progress of disease or manage its impact have become more available (Smith &Walshe, 2011).

This in turn connects with and feeds the third challenge – changing user and consumer expectations. People want more from the health service than their parents did. They are not content to be passive recipients of healthcare, prescribed and dispensed by providers at their convenience. Users are accustomed to the ever-widening choice and sovereignty in decisions in other areas of life like banking, shopping, housing, education and such they expect to be consulted, informed and involved by healthcare providers in any decisions that affect their health. They are better informed, more articulate and more likely to know about and demand new and expensive treatments

(Smith &Walshe, 2011).

The fourth challenge, rising costs is better informed by the first three challenges. Each of the challenge contributes to the constant pressure for more healthcare funding, a pressure which for many countries are currently more acute as a result of the global economic recession. The increase in spending by most governments never seems to be enough. Productivity is rising and costs are falling through competition and innovation in almost every sector of the economy, however in healthcare costs are stubbornly high and continue to rise, along with demand for services (Smith &Walshe, 2011).

The social, political and economic context in which healthcare organisations have to exist is often a hostile, fast-changing and pressured environment. Organisations are the product of their environment and context, and many of the distinctive characteristics and behaviours of healthcare organisations result from some of the social, political and economic factors. However, some also result from the nature of the enterprise – healthcare itself. The uniquely personal nature of health services, the special vulnerability and need for support and advocacy of patients, the complexity of the care process, and the advanced nature of the technologies used, all contribute to the special challenges of management in healthcare organisations.

For managers entering healthcare organisations from other sectors – whether from other public services, commercial for-profit companies or the voluntary sector – one of the first striking differences they notice is the absence of clear, hierarchical structures for command and control, and the powerful nature of professional status, knowledge and control. According to Sullivan (2013), managers in healthcare organisations are continually battling conflicting priorities. They need to focus on delivering high quality

patient care, preventing infections, maintaining hospital security, and ensuring patient safety all with extremely stretched resources. The challenges facing today's hospitals according to Smith &Walshe (2011) include the following:

i. **Financial challenges and hospital productivity:** Hospitals are the second most energy-intensive buildings after restaurants, and globally, healthcare

costs are on the rise. These financial challenges in addition to an aging world population and increasing energy costs are putting pressure on healthcare organisations to do more with less without compromising quality of care. ii. **Maintaining patient safety:** Every year an estimated number of people in the U.S. and in the U.K. die from an infection they received while in the hospital. Reducing the risk of infection, as well as other potential risks, such as power failures, is crucial in ensuring a high quality of care and maintaining the organisation's reputation.

iii. **Regulatory standards and emerging energy mandates:**Noncompliance with regulatory standards can lead to a disruption in operations, poor quality of care, safety issues, and substantial fines. At the same time, as energy demand rises, many countries are requiring healthcare facilities to reduce carbon output and meet mandates for energy reductions.

iv. **Hospital security:** Healthcare facilities are often open throughout the day, and those visiting are often under a great deal of stress when life and health are at stake. Violence, infant abductions, patient wanderings, and theft of drugs and hospital assets are major concerns.

v. **Patient satisfaction:** The well-being of patients is a key to reducing length of stay and preventing readmissions. According to the American Society for Healthcare Engineering (ASHE), in green hospitals, patients are discharged an average of 2.5 days earlier compared to traditional hospitals. Additionally,

patient satisfaction can also affect a hospital's revenue. If the systems are operating poorly or not at all, quality metrics such as Hospital Consumer Assessment of Healthcare Providers and Systems can be adversely affected.

In a similar vein, Mosquera (2014) contributing to the topic says that among the biggest challenges that healthcare executives are confronted with are:

i. **Pacing the shift to value-based models:** Healthcare leaders continue to put infrastructure and governance practices in place to support value-based models even as providers still have significant fee-for-service revenue. However, many providers are concerned that they may be reaching a point at which the cost of building and maintaining their value-based organisation is not supported by their fee-for-service reimbursement model.

ii. **Responding effectively to the economic dynamics of local markets:** Health organisations are migrating to value-based models. They must contend with the realities and limits of their local economies, the strategies of large employers for reducing their healthcare costs, concentration of the payer market and physician practice alignment.

iii. **Securing and growing market share:** Gaining market share remains a big concern regardless of the pace of the payment model change. Providers must weigh market strategies, including consolidation and traditional and nontraditional partnership and strategic relationships, even as volume continues to drive a large share of revenue.

iv. **Developing alternative revenue streams:** Health systems with cash reserves and strong margins are better positioned to make investments that are related to, but not necessarily directly in support of, their core patient care business. Investments that can supplement declining revenue from payers can include

ambulatory care centers, telemedicine, business software development and pharmaceutical research.

v. **Containing core operating costs:** Health executives continue to seek approaches to rein in the costs of their core operations, reduce utilisation through standardisation, and manage care variations. Even high-performing organisations can obtain additional cost containment by taking a systems approach that is rigorous and transparent.

According to Jonas & Kovner (2008), the key challenges that have been the focus of health care leaders' attention in recent years include among them the following: Improving quality: Despite the large investments that is been made in the health care system, serious concerns about the quality of care is still a challenge for healthcare managers to grapple with. In the U.S., reliable studies indicate that between 44,000 and 98,000 Americans die each year because of medical errors. Other respected reports show that a small number of people with mental health or substance abuse problems, asthma, or diabetes receive effective care.

1. **Improving access and coverage**: Care is virtually unaffordable for many Americans who are uninsured if they have a serious illness. People fail to get insurance coverage for many reasons, and political consensus about how to resolve this problem has not emerged over the past 20 years. Lack of coverage, however, is a peculiarly American problem. All other developed countries have public systems of insurance coverage or similar approaches to assuring that everybody can have the care they need). Many health leaders see the insurance challenge as the most important health issue facing the US today. Even when people have insurance coverage, access to health care is not always easy. Many rural areas have shortages of health care professionals especially doctors and

dentists and some services especially specialist care, long-term care, and even hospital care. Some services, such as mental health care, are woefully underfunded. Low-income groups, even when covered by public insurance programs, have a difficult time finding the services they need. As the country becomes more diverse, these types of access problems will become more acute.

2. **Keeping costs under control**: In the U.S., expenditures on health care have been increasing much more quickly than expenditures in the balance of the economy over the past 30 years. The explosion of expensive technology, the aging of the population, inflating salaries, and the growing prevalence of chronic conditions has made health care less and less affordable over time. A key challenge is determining which new technology that can be afforded (and is worth the cost) and the cost kept from growing too quick. Unfortunately, leaders have not identified effective ways to keep costs under control. Health care inflation remains one of the key challenges for health care managers. The problem has become so acute that every sector of the U.S. economy has to be concerned about the impact of rising health care costs.
3. **Encouraging healthy behaviour**: Avoiding illness and injury is the best way to keep health costs under control. Healthy behaviour choices can help people avoid disease and injury. Using seat belts, getting preventive services, eating well, exercising, avoiding tobacco, and not using drugs or overusing alcohol are all central to health maintenance. America is in the middle of a disturbing obesity epidemic that has led to ever-increasing rates of diabetes and heart disease. It remains a challenge, however, to encourage healthy behaviour.
4. **Improving the public health care system**: The safety of water, food, and restaurants is too often taken for granted by the American people. They fail to recognise the important roles the public health care system can play in

preventive health, health education, environmental health, and prevention of bioterrorism. Perhaps because public health, when done effectively, is invisible (it avoidsproblems rather than fixes them), the United States has historically underinvested in public health. There is an ongoing challenge to make a case for better public health, provide adequate funding, and inspire leading thinkers to take up public health careers.

5. **Addressing social determinants of health**: Substantial inequalities in health status - rates of disease and death - exist across income groups, social classes, and ethnic groups. Inequalities in health status are a key current challenge facing the health sector as most Americans believe they should have an equal opportunity approach to health maintenance. In essence, however, the health care system can only help address inequalities to a certain degree. Some of the inequality is driven by social factors such as poverty and ineffective education systems.
6. **Strengthening the health workforce**: There is an acute shortage of nurses, primary care physicians, and long-term care providers in the American health care system. The health care system must train and recruit the large and diverse cadre of workers that are needed to run health institutions. Without talented and caring people agreeing to devote their careers to health services, the system cannot function.
7. **Encouraging more realistic expectations**: Consumers should expect and demand better quality and better efficiency from the delivery system. People also should recognise that their health is, to some degree, their own responsibility. To make this point, some people should pay out of pocket for health problems caused by their own recklessness and should be rewarded for good health behaviour. Some insurance companies already do this, offering

lower premiums to people who do not smoke, are not obese, and have good driving records.

Most healthcare institutions in African countries are challenged by a double crisis of fragile health systems and weak human resources, the latter being an essential component of effective service delivery" (WHO Regional Office for Africa, 2007). Africa has 14% of the world population, harbours 25% of global disease burden and has only 1.3% of global health workers. There would be a need for 2.5 health workers per 1000 inhabitants to achieve the MDGs. However, the current health worker: population in Africa is only 2.3 health workers per 1000 inhabitants (WHO Regional Office for Africa, 2007). According to the World Health Report (2006) there are 57 countries that face crippling health workforce shortages and of these, 36 are located in Africa (WHO, 2006b).

Health systems in Africa are being drained by an exodus of health personnel to wealthy countries. According to WHO/AFRO (2006) the outflow of skilled health personnel from Africa has reached rate that there are more health workers from African countries overseas than in their countries of origin.

Rates of health worker migration range from 8% to as high as 60% in some African countries. Many health workers are unmotivated to stay because they are poorly paid, poorly equipped, infrequently supervised and informed, and have limited career opportunities within the civil service.

2.4 Addressing the Challenges to the Efficacy of Management in Healthcare Delivery

The task of management in healthcare organizations, defining the mission of the organization, setting out a clear and consistent vision, guiding and incentivizing the organization towards its objectives, and ensuring safe and high quality care – is one of

the ways to ensure that people work to achieve the objectives of the organization. Managers strive to balance competing, shifting and unrealistic demands from a wide range of stakeholders and do so while under close public scrutiny (Smith &Walshe, 2011). The managers of the nation's healthcare systems need to be able to integrate theory and practice, and to have the adaptability and flexibility that come from really understanding the nature of management. Individual managers can explore whether some of the challenges they face are of their own making and take the necessary steps to work rectifying those challenges.

Organizations can be proactive in confronting their challenges by addressing issues within their control. For example, recognizing and rewarding managers who perform well, giving managers greater autonomy to innovate and implement change, providing training and development opportunities, and addressing organization culture issues.

Health care managers do not only have to be competent in the traditional practices of management and leadership but also be competent, knowledgeable and strategic in their approach to adapting their organization to the changing and often confusing challenges confronting the health care environment. Managers should be imbued with the core skills needed to thrive in a rapidly changing healthcare market. Healthcare executives will need to improve their performance by evaluating every key operational, clinical and governance function. They also need a strong vision for the future, the ability to act on it and the leadership to bring stakeholders along with them

(Mosquera, 2014).

Managers require well-functioning support systems in order for them to do their jobs effectively. The main support systems are planning, financial management,

information/monitoring, human resource management and management of stocks and assets – particularly, drugs, buildings, vehicles and equipment. Health managers should spend a lot of time learning about planning and formulating the plans. They must also make major efforts to improve the management of drugs and information. Many health managers should be trained in at least some aspects of financial management, often for particular sources of money. All support systems have a role to play and so it is important to have a balanced approach that avoids concentrating too heavily on one or two support systems.

Managers should be able to use information locally and to adapt systems to some extent to reflect local conditions. Managers should create an enabling working environment (roles and responsibilities, organizational context and rules, supervision and incentives, relationships with other actors) as the environment in which managers' work clearly influences their effectiveness. Good communications help to create an enabling environment. Managers should be informed promptly of new rules or policy directions and key documents such as national plans and guidelines should be readily available. Forums, associations and institutes for managers should be encouraged as these can be effective and motivating channels for capacity-building.

Health managers are regularly exhorted to "build partnerships for service delivery" as an efficient way of improving health outcomes. These partnerships can be with a variety of actors - private providers, NGOs, other public institutions such as schools or local councils, industry or community leaders. Managers are a vital part of the health workforce. The human resource system should have well-defined managerial posts with job descriptions and information on the managerial workforce (numbers, where posted, individual information on competences, etc.).

2.5 The Conceptual Framework of the Study

The conceptual framework for this study has been drawn from the literature review and a simple diagram to illustrate this has been constructed in Figure 2.1.

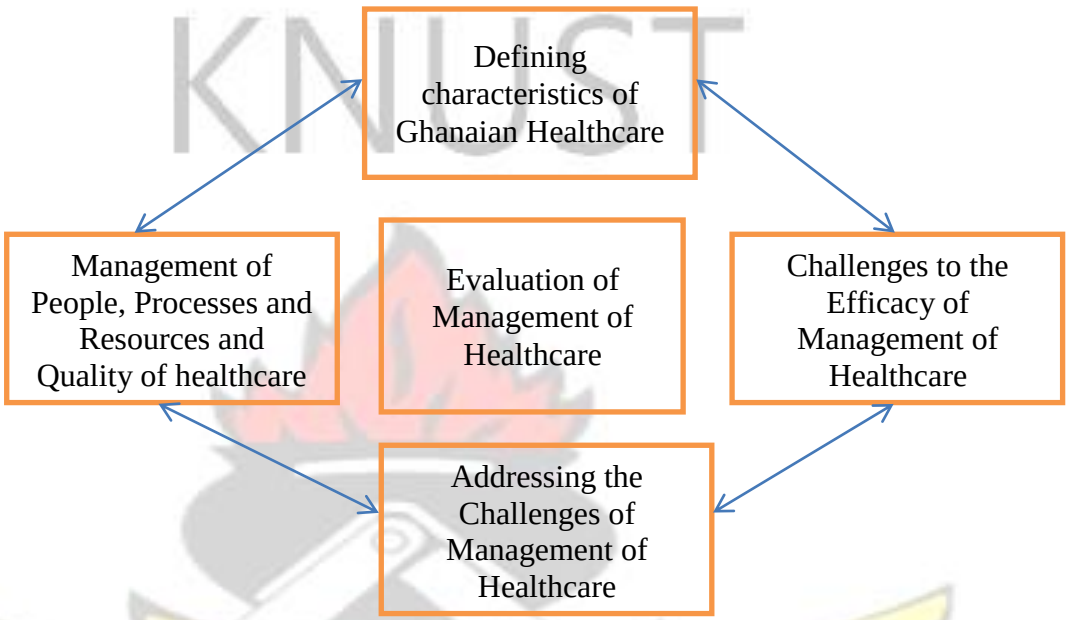


Figure 2.1 Conceptual Framework of the Study

Source: Researcher own Construct (April, 2014)

Governments, non-governmental and other stakeholders in the health industry are concerned with the management of healthcare in the various countries. This should therefore be indicators to evaluate the management of healthcare as the years roll on. When this is done effectively, it may be to the development of benchmarks to monitor, assessing, and managing health systems to achieve effectiveness, equity, efficiency, and quality.

The conceptual framework is interrelated in the sense that the defining characteristics of the healthcare system may be linked to a combination of management and leadership styles that could help to stimulate and manage performance and quality improvement.

It also comes out with some of the challenges of management and the ways to address these challenges.

CHAPTER THREE

METHODOLOGY AND ORGANISATIONAL PROFILE

3.0 Introduction

This chapter outlines the methodology used for undertaking this study. It describes the research design, the sources of data, the population, sample size and sampling techniques adopted for the study. It also describes the data collection instruments and

the data analysis technique used for this study. It also gives a brief outline of the organizational profile.

3.1 Research Design

A research design is a plan that guides the research study towardsachieving its objectives. The research design specifies the type of research approachused to gather information for the study (Marczyk &DeMatteo, 2003). This study adopted the case study strategy. The case study method was chosen because it enables the researcher to gain a general overview of the research's context and capture data on the knowledge of various stakeholders (Locke, 2001). Case study is an empirical inquiry, which focuses on contemporary occurrences within real-life context and boundaries between the phenomenon and its context which are not clearly obvious. It is suitable for studying complex social phenomena (Yin, 2009). The type of case study used was the descriptive study. The descriptive study was to determine relationships between management and quality healthcare delivery. The descriptive research was to establish the management and the quality of healthcare delivery and thus the satisfaction patient can enjoy from such services. The case study was a single case study as Dunkwa

Municipal Hospital was used for the study. A cross sectional study involves the collection of data at one point in time (Polit & Beck, 2004). Cross-sectional studies are appropriate for describing the status of the phenomena at a fixed point in time. The study adopted a cross-sectional study, which uses both quantitative and qualitative approaches to evaluate the management of healthcare delivery in Dunkwa Municipal Hospital(Bryman, 2004).

3.2 Population

Population denotes the total collection of all elements about which the researcher wishes to make some references (Denscombe, 2003). It is the total number of people in the community or organisation from which the sample was selected (Saunders, Lewis &Thornhill, 2007). Balnaves & Caputi (2001) contend that the population is operationally defined by the researcher. They further argue that the population must be accessible and quantifiable and be related to the purpose of the research.

The study chose Dunkwa Municipal Hospital, from which the data were collected. Thestudy population consists of management and staff of Dunkwa Municipal Hospital and patients who patronized the services of the hospital (see Table 3.1 for details).

Table 3.1 Population for the Study

CATEGORY	NUMBER
Management staff	5
Senior staff	20
Junior staff	125
Patients	**50**
Total	200

Source: Dunkwa Municipal Hospital (2014)

3.3 Sample Size

Cooper & Schindler (2006) state that a sampling frame is a whole and precise list of the population members and it comprises all the representative elements in the population selected for a given study. This list was sourced with permission from the human resource department of the hospital. A sample is a subset of the population, selected in such a way that their attributes reflect those of the group from which they are selected

(Henn, Weinstein & Foard, 2006). Selecting a sample is a very vital step for any kind of study. It is difficult to survey the whole population of a particular study due to limited funding and time constraint. Hussey & Hussey (1997) indicated that the sample should be large enough and balanced to fulfill the requirements of the research. Results from a small sample size may not properly represent the entire population. The sample size of 150 comprises of the following:

a. A purposive sample selection of all management and senior staff of the hospital. This constituted 25 management and senior staff.
b. A simple random sample size of 95 junior staff from the hospital.
c. A simple random sample size of 30 patients who patronize the services of the hospital.

3.4 Sampling Technique

Sampling is defined by Polit, Beck &Hungler (2001) as the process of choosing a part of the population to represent the total population. The purposive sampling technique is a type of non-probability sampling where the researcher purposivelychooses particular elements or subjects for inclusion in a study to ensure that the elements will have certain characteristics related to the study (Saunders, Lewis &Thornhill, 2007).

It normally aims at a particular group of people or units with specific characteristics, experience and behavior patterns, and one or more perspectives considered to be significant to the research goals (Moser &Kalton, 1992). Purposive sampling is very suitable for situations where a researcher intendsto reach a targeted sample quickly and where sampling for proportionality is not the primary concern (Trochim, 2000; Saunders, Lewis &Thornhill, 2007). Thus, the purposive sampling technique was used to select the management and senior staff of Dunkwa Municipal Hospital. The

researcher used the purposive sampling technique to limit the study to those who matter in the topic under consideration.

The simple random sampling technique was adopted in this study to select the junior staff and patients. According to Saunders, Lewis &Thornhill (2007), the simple random sampling technique is "a sampling technique in which every member of the population will have a known non-zero probability of selection." The simple random sampling technique was used to give each staff an equal chance of being included in the sample. A random number table was created. The cases in the sampling frame were given a unique number. The first case was numbered 0, the second 1 and so on. The cases were then selected using random numbers until the actual sample size was reached.

3.5 Sources of Data

Primary and secondary sources of data were collected for the study.

3.5.1 Secondary data

According to Saunders, Lewis &Thornhill (2007), secondary data is data that have already been collected for some other purpose, processed and subsequently stored.

The secondary data was collected from books, theses, annual reports, journals, newspaper articles, bulletins, documentary and archival information. S econd ar y data a re availabl e, be caus e the y wer e collected for some other purposes other than solving the basic problem. Secondary data was be used because it provides comparative and contextual data. It can result in unforeseen discoveries. It is unobtrusive and requires fewer resources to work on them (Saunders,

Lewis &Thornhill, 2007).

The disadvantage is that any secondary data that is used would have been collected for a particular purpose and that this purpose may not be equal to that of the person who is using it. Also, the secondary data is may not be current as compared to any data collected by the researcher (Saunders, Lewis &Thornhill, 2007).

3.5.2 Primary data

It is the new data collected from the respondents through structured scheduled questionnaire and interview (Saunders, Lewis &Thornhill, 2007). The primary sources of data for this study includeddata gathered from the questionnaires and interviews that were administered to the respondents. Data from primary sources are more reliable since they come from the original sources and are collected specifically for the purpose of the study (Axinn & Pearce, 2006).

3.6 Data Collection Instruments

The data collection instruments were questionnaires and interviews.

3.6.1 Questionnaire

A questionnaire is a sequence of questions that are written down for people to answer (Saunders, Lewis &Thornhill, 2007). Answering questionnaires could be done by the person from whom information is sought or through an interpreter. It is suitable for gathering data even beyond the easy physical reach of the researcher. The research instruments were a set of structured questionnaires which consisted of both openended and close-ended items. The close-ended questionnaire was included to elicit responses from hospital's management and senior staff who often have little time for long

scribbles (Sarantakos, 2005). A few open-ended questions were however included for the respondents to make responses they wish to in their own words. This helped the researcher to getdetailed information. A Likert scale, with anchors ranging from "strongly disagree" to "strongly agree", was used for some questions (Casely & Kumar, 1988). The respondents were asked to tick the correct option to the question according to their opinions.

The questionnaire was framed in a clear manner to avoid misinterpretations and also to enable the respondents to understand and answer the questions easily. The questionnaire was designed in such a way that the questions were short and simple and was arranged in a logical manner. The instrument consisted of four sections, A, B, C and D. Section A was in two parts: I and II. Part I had questions which focused on identify the defining characteristics of the Ghanaian healthcare system. Part II had question on the demographics of respondents namely their gender, age, marital status, education, academic qualifications, professional status, number of years of service, number of years in present positions. Section B consisted of questions which focused on the relationship between the management (of people, processes and resources) and quality of healthcare delivery. Section C contained questions on the extent to which the challenges to the efficacy of management in healthcare delivery would be explored. Section D contained questions on the recommendations to address the challenges to the efficacy of management in healthcare delivery.

Prior to the distribution of the questionnaire to the staff of the hospital, permission in the form of a letter was sought from the Medical Superintendent of the hospital to elicit information from the staff of the Dunkwa Municipal Hospital for academic purposes. The questionnaires were distributed to respondents during which brief explanations and clarifications of the purpose were made. The questionnaires were distributed to the

respondents to fill them out three weeks earlier before they were collected from them to be used for the analysis.

Respondents especially the management and senior staff were left on their own to complete and submit the questionnaires within one week. For the junior staff, some of them were guided to answer the questionnaire so that they would be able to give cogent answers.

One hundred and fifty five questionnaires were given to the respondents. In all, 139 out of the 150 questionnaires administered were returned. This represents 93% of questionnaires administered which is very encouraging. The number of responses to the questionnaires was considered reasonable and adequate for statistical analyses.

3.6.2 Interview Schedule

The interview served as an opportunity to get a vivid description of the management of healthcare delivery at Dunkwa Municipal Hospital. The unstructured interview schedule was carried out with the respondents. The main thrust of the interviews was to draw out those issues that were considered important to the topic and had not been captured by the questionnaire.

The interviewer interviewed the respondents in person. There was direct contact between the interviewer and the respondent. The researcher used his mobile phone with permission from the respondent to record the proceedings of the interview. The interview questions centered on management and some of the challenges of the of the health institution. The interview lasted 30 minutes. The interview enabled the researcher

to get first-hand information on the topic. The researcher after the interview listened to the recordings and made used of responses that address the objectives of the study.

The interview was done with theMedical Superintendent of the Dunkwa-on-Offin Hospital. Therefore theMedical Superintendent was the key informant during the interview. TheMedical Superintendent was singled out for interview because of his position as chief administrator and could share needed information on healthcare management practices and healthcare delivery system in the hospital.

3.7 Data Analysis

The information was analyzed and evaluated to determine their usefulness, consistency, credibility and adequacy. Data collected from the survey was inputted into the MS-Excel 2007 for analysis, discussion and presentation of the results. Statistical calculation such as frequencies and percentages, pie charts, bar charts, and line graphs was calculated using MS-Excel 2007 and SPSS (version 16.0).

Content analysis was used to analyze the interview data. The researcher makes direct quotation from the interview data to describe the opinion of Key Informant of the study. The researcher also summarizes some of the responses of the Key Informant to describe the state of healthcare management and healthcare delivery system in the Dunkwa-on-Offin Municipal Hospital. Specifically, the responses of the Key Informant on challenges facing healthcare delivery in the Municipality were listed or itemized to support or otherwise of the responses of the respondents of questionnaire.

The study quantitativelyemployed Pearson's Correlation Coefficient (R) to examine the significant relationship between healthcare management practices and quality of

healthcare delivery. Management of healthcare practices had ten items but the study considered overall management of healthcare practices by finding the average responses of the identified ten items under it. Overall management of healthcare practices was paired against overall quality of healthcare delivery in the hospital.

3.8Organizational Profile of Dunkwa Municipal Hospital

Dunkwa Municipal Hospital is located at Dunkwa-on-Offin, the Upper Denkyira East Municipal capital. Dunkwa-on-Offin had a population of 84,808 as at the year 2010. Dunkwa Municipal Hospital was established in 1948 and serves as the district hospital with a status of referral institution of other health facilities in the district. Planned periodic expansion works have been carried out since its establishment and this is evidenced by its present size. The hospital catchment area extends over its boundaries. Apart from the Municipal itself, it serves the following areas: Upper Denkyira West in the Central region, Obuasi Municipal in the Ashanti region, parts of Sefwi, Wassa in the Western region and parts of Assin in the Central region due to proximity advantage.

3.8.1 Vision statement

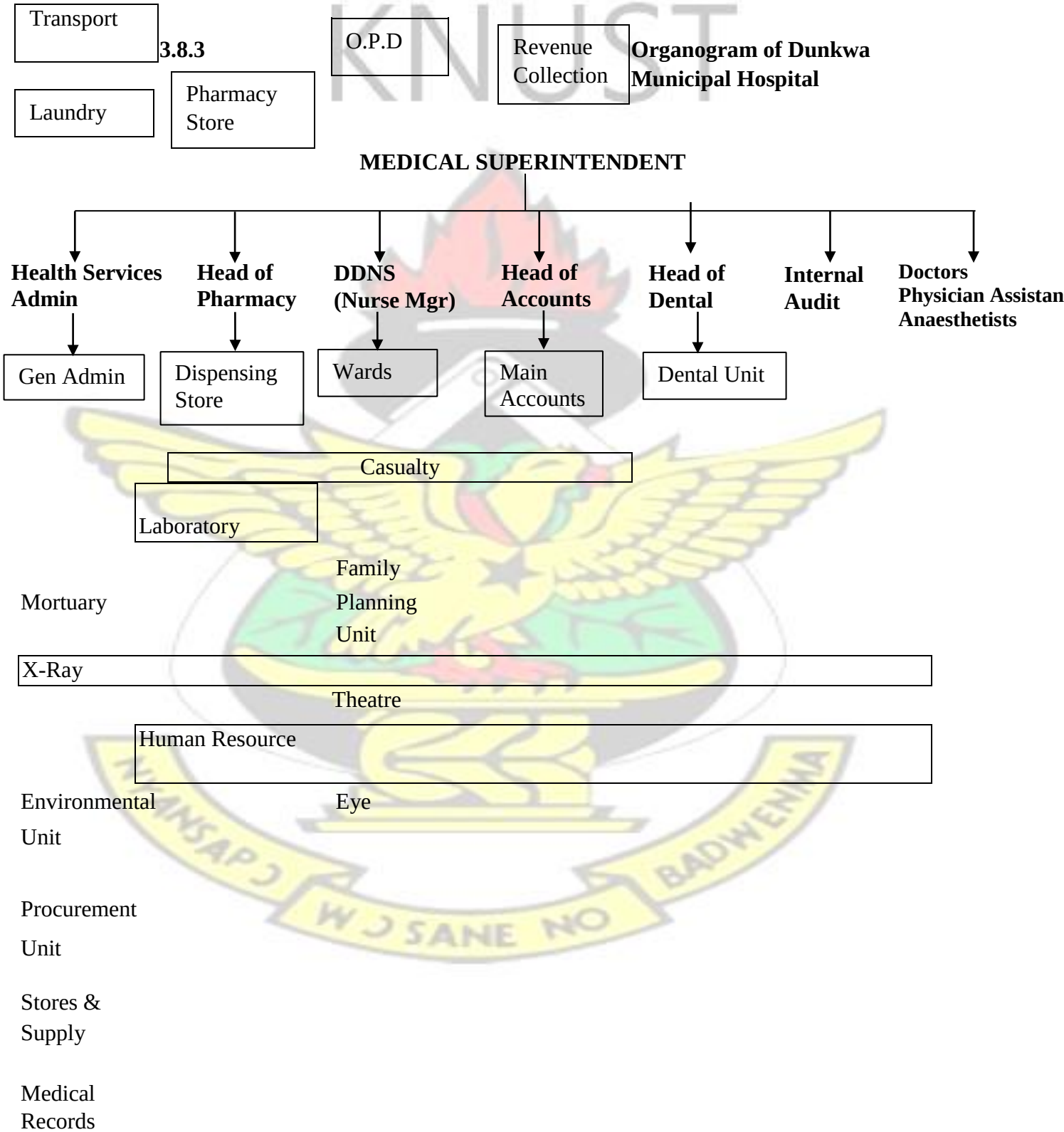
The vision statement of the hospital is to provide quality health care and reduce avoidable mortalities.

3.8. 2 Mission statement

The mission statement of the hospital is to provide accessible and quality health care to meet the expectations of their clients through:

i. The development and implementation of proactive systems and procedures for good health and longevity ii. Provision of basic logistics to health care delivery at all times iii. A well-motivated and committed staff on collaboration with all stakeholders

3.8.3 Organogram of Dunkwa Municipal Hospital



Security

Figure 3.1 Organogram of Dunkwa Municipal Hospital
Source: Dunkwa Municipal Hospital Annual Report (2012)

CHAPTER FOUR

DATA PRESENTATION AND ANALYSIS

4.0 Introduction

This chapter presents and analyses data generated from the study.

4.1 Response rate

Of the 150 questionnaires sent out, 139 were returned representing a response rate of 92.7%. This made up of 112 healthcare staff and 27 patients. The healthcare staff was drawn from several departments of the hospital and patients were sick people who visited the hospital at the time of questionnaire administration.

4.2 Results and Analysis of the Study

The results and analysis of the study have been presented here.

4.2.1 Characteristics of Respondents

The characteristics of respondents which formed the basis of the analysis of this study are gender, age, marital status, educational level, number of years worked and job positions of respondents.

Table 4.1: Gender of Respondents

Gender	Frequency	Percentage (%)
Male	42	30
Female	97	70
Total	139	100

Source: Researcher's Field Study (2014)

Table 4.1 shows that 42 respondents representing 30% were males whilst 97 representing 70% were females.In analyzing the data, the study revealed that more females were represented than males.

Table 4.2: Age of Respondents

Age (in years)	Frequency	Percentage (%)
20-24 years	10	7
25-29 years	17	12
30-34 years	26	19
35-39 years	33	24
40-44 years	29	21
45 years and above	24	17
Total	139	100

Source: Researcher's Field Study (2014)

Table 4.2 shows that 10 respondents representing 7% were within the age group of 20-24 years. Table 4.2 shows that 17 (12%), 26 (19%), 33 (24%), 29 (21%) and 24 (17%) were within the age group of 25-29 years, 30-34 years, 35-39 years, 40-44 years and 45 years and above respectively.

In analyzing the data, the study revealed that those in the age group 35-39 years were in the majority. They were followed closely by those in the age group 40-44 years. This was followed by those in the age group 30-34 years. The respondents in the age group, 20-24 years were in the minority.

Table 4.3: Marital Status of Respondents

	Response	Frequency	Percentage %

Marital status of respondents	Single	31	22
	Married	55	40
	Divorcee	17	12
	Widowed	4	10
	Co-habitating	22	16
	Total	139	100

Source: Researcher's Field Study (2014)

Table 4.3 shows that 31 respondents representing 22% were single. The married (40%) constituted the majority whilst divorced, widowed and co-habitation constituted 12%, 10% and 16% respectively.

Table 4.4: Educational Level of Respondents

	Response	Frequency	Percentage %
Highest Education	Primary	29	21
	Secondary	32	23
	Tertiary	51	37
	Others	27	19
	Total	139	100

Source: Researcher's Field Study (2014)

Table 4.4 shows that 29 respondents representing 21% were primary school leavers, 32 respondents representing 23% were secondary school leavers. Fifty-one respondents representing 37% were tertiary level leavers and 27 respondents representing 19% held other educational qualifications. They mentioned them as vocational and technical qualifications.

The study revealed that most of the respondents were educated. The respondents who had completed their tertiary education were in the majority and they were followed closely by those who had completed their secondary education.

Table 4.5: No. of years working in Dunkwa Municipal Hospital

	Response	Frequency	Percentage %

Number of years working in this hospital	Less than one year	15	13
	1-5 years	31	28
	6-10 years	28	25
	11-15 years	13	12
	16-20 years	16	14
	21 years and above	9	8
	Total	112	100.0%

Source: Researcher's Field Study (2014)

On the issue of the numbers of years respondents have worked at Dunkwa Municipal Hospital, Table 4.5 shows that 15 (13%), 31 (28%), 28 (25%), 13 (12%) 16 (14%)and 9 (8%) had worked with the hospital for less than one year, 1-5 years, 6-10 years, 1115, 16-20 years and 21 years and above respectively. In analyzing the data, it could be seen that most of the respondents have worked with the hospital for a considerable number of years. The long number of years the respondents had worked at the hospital may be explained by the level of commitment to the hospital.

Table 4.6: Job Description of Respondents in Dunkwa Municipal Hospital

	Response	Frequency	Percentage%
Job description of respondents in the hospital	Medical Officers	2	2
	Nurses	46	41
	Pharmacists	2	2
	Laboratory Technicians	6	5
	Ward Assistants	17	15
	Accountants	3	3
	Midwives	12	11
	Others	20	18
	Total	112	100

Source: Researcher's Field Study (2014)

Table 4.6 shows that 2 (2%) were doctors, 46 (41%) were nurses, 2(2%) were pharmacists, 6 (5%) were laboratory technicians, 7 (15%) were ward assistants. The remaining 3 (3%) were accountants, 12 (11%) were midwives and 20 (18%) mentioned

other job descriptions. When the results are analyzed, it can be seen that most of the workers were nurses.

4.2.2 Defining Characteristics of Ghanaian Healthcare System

This section of the analysis addresses the objective one: *"Identify the defining characteristics of the Ghanaian healthcare system"*. This objective is answered by looking at availability of amenities or facilities, healthcare services, staff, doctorpatient ratio and time spent at health facility.

Table 4.7: Functionality of Available Amenities and Facilities in the Hospital

Amenities & facilities	Never functional	Rarely functional	Sometimes functional	Always functional
Water (Pipelines)			50 (36%)	89 (64%)
Electricity/solar			61 (44%)	78 (56%)
Radio/telephone for communication			56 (40%)	83 (60%)
Fridge for drugs and vaccines			50 (36%)	89 (64%0
Dispensary (pharmacy)			44 (32%)	95 (68%)
Separate delivery/maternity room			51 (37%)	88 (63%)
Toilet for patients and staff			30 (28%)	100 (72%)
Mortuary			57 (41%)	82 (59%)
Counseling room		10 (7%)	81 (58%)	48 (35%)
Examination room		15 (11%)	39 (28%)	85 (61%)
Ambulance/vehicle		20 (14%)	58 (42%)	61 (44%)
Bungalows for staff				

Source: Researcher's Field Study (2014)

From Table 4.7, the Likert scaled responses to the prompt, "functionality of amenities and facilities in the hospital," revealed that 50 (36%) said water (pipelines) in the hospital were sometimes functional whilst 89 (64%) it was always functional. Table 4.7 shows that 61 (44%) said electricity was sometimes functional whilst 78 (56%) said it

was always functional; 56 (40%) said telephones were sometimes functional whilst 83 (60%) said it was always functional.

Table 4.7 shows that 44 (32%) said the dispensary (pharmacy) was sometimes functional whilst 95 (68%) said it was always functional; 51 (37%) said the delivery or maternity room was sometimes functional whilst 88 (63%) said it was always functional. From Table 4.7, 30 (28%) said toilet for patients and staff is sometimes functional whilst 100 (72%) said it was always functional; 57 (41%) said the mortuary was sometimes functional whilst 82 (59%) said it was always functional. It is shown in the Table 4.7, 10 (7%) said the counseling room was rarely functional but 81(58%) said the counseling room was sometimes functional whilst 48 (35%) said it was always functional. The Table further shows that 15 (11%) said the examination room was rarely functional but 31 (28%) said the examination room was sometimes functional while 85 (61%) said it was always functional. From Table 4.7, 20 (14%) said the ambulance in the hospital was rarely functional but 58 (42%) said the ambulance was sometimes functional whilst 61 (44%) said it was always functional.

This confirms that most of the amenities and facilities in the hospital are functional.

The responses received during an interview section confirmed the responses of the staff and the patients with regard to availability and functionality of amenities and facilities. The interviewee stated:

"*the hospital has facilities and equipment for quality healthcare delivery in the Dunkwa-on-offin and its environs. The hospital is the main government healthcare facility in the Dunkwa-on-offin Municipality. Equipment and facilities available are functional but the hospital needs more infrastructural support to accommodate the increasing demand" (The Key Informant).*

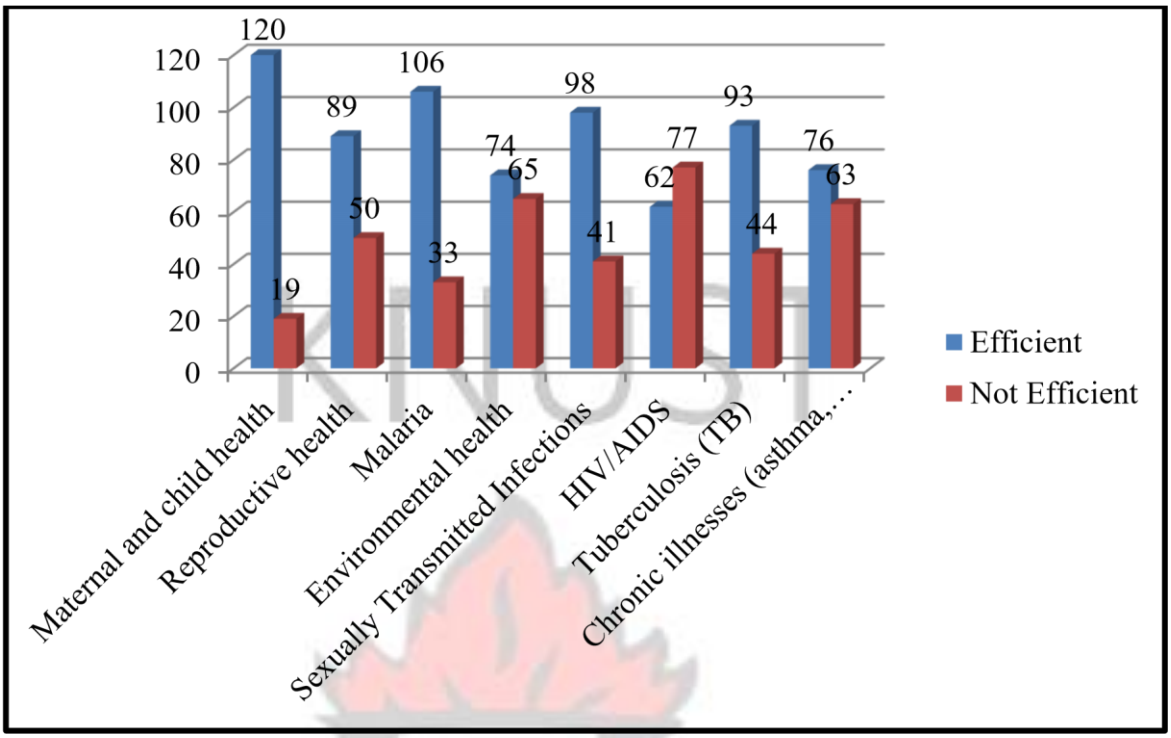


Figure 4.1: Provision of health care services

Source: Researcher's Field Study (2014)

From Figure 4.1, the Likert scaled responses to the prompt, "the provision of health care services," revealed that 120 (87%) said the provision of maternal and child health service in the hospital was efficient whilst 19 (13%) it was not efficient, 89 (64%) said the provision of reproductive health service in the hospital was efficient whilst 50 (36%) was not efficient. Figure 4.1 shows that 106 (76%) said the provision of malaria service was efficient whilst 33 (24%) said it was not efficient, 74 (53%) said the provision of environmental health service was efficient whilst 65 (47%) said it was not efficient. From Figure 4.1, 98 (71%) said the provision of sexually transmitted infection service was efficient whilst 41(29%) said it was not efficient.

From Figure 4.1, 62 (45%) said the provision of HIV/AIDS service was efficient whilst 77 (55%) said it was not efficient, 93 (68%) said the provision of tuberculosis service

was efficient whilst 44 (32%) said it was not efficient; 76 (55%) said the provision of chronic illnesses service was efficient whilst 63 (45%) said it was not efficient.

Table 4.8: Available Staff in the Hospital

Staff	Not Available	Rarely Available	Sometimes Available	Always Available
Doctors				139 (100%)
Nurses				139 (100%)
Midwives				139 (100%)
Pharmacists				139 (100%)
Physician Assistants				139 (100%)
Laboratory Technicians				139 (100%)
Physical and Occupational Therapists	139 (100%)			
Dieticians	139 (100%)			
Labourers				139 (100%)
Orderlies				139 (100%)
Security Personnel				139 (100%)

Source: Researcher's Field Study (2014)

Table 4.8 shows that all the respondents said doctors, nurses, midwives, pharmacists, physician assistants, laboratory technicians, labourers, orderlies and security personnel were always available. On the other hand, all the respondents again said that physical and occupational therapists and dieticians were not available in the hospital. This goes to show that the hospital has a certain category of staff available.

Table 4.9: Ratio of Staff to Patients

Staff	Enough	Not Enough
Doctors	-	139 (100%)

Nurses	-	139 (100%)
Midwives	-	139 (100%)
Pharmacists	-	139 (100%)
Physician Assistants	-	139 (100%)
Laboratory Technicians	-	139 (100%)
Physical and Occupational Therapists	-	
Dieticians	-	
Labourers	-	139 (100%)
Orderlies	-	139 (100%)
Security Personnel	-	139 (100%)

Source: Researcher's Field Study (2014)

Table 4.9 shows that all the respondents said the ratio of doctors, nurses, midwives, pharmacists, physician assistants, laboratory technicians, labourers, orderlies and security personnel was not enough. The hospital has two medical officer as against a population of 75, 742 as at the year 2013. There is only one laboratory technician in the hospital. This goes to show that even though the hospital has a certain category of staff available, they are not enough. This may affect the delivery of health care services in the hospital.

It was revealed during an interview that:

"the hospital lacks required number of health personnel. The number of nurses and doctors are not enough and the hospital lacks other important personnel. For example, the hospital does not have dietician and physiotherapist. The doctors are not enough and this is stressing the two doctors we have. One doctor attends to about fifty patients a day and this is stressful situation" (The Key Informant).

This goes to confirm the responses of the staff and the patients that the number of health professional at Dunkwa-on-offin Government Hospital was not enough to deliver effective healthcare services to people within and outside the Municipality.

Table 4.10: Time Spent Before Seeing the Doctor

Factor	Response	Frequency	Percentage %
Time spent before seeing a doctor	Less than 30 minutes	4	15
	30 minutes-1 hr	20	74

	1-2 hrs	3	11
	2-3 hrs	0	0
	4 hrs and above	0	0
	Total	27	100

Source: Researcher's Field Study (2014)

In Table 4.10, 4 (15%) said they spent less than 30 minutes before seeing a physician while 20 (74%) said they spent between 30 minutes and 1 hour before seeing a physician. The remaining 3 (11%) said they spent between 1 and 2 hours before seeing a physician. None of the respondents waited for between 2 and 4 hours before seeing a physician.

Most patients had to wait up to one hour to be called into the consultation room. Levels of patients' satisfaction with the services rendered decreases with increasing waiting times. Time spent waiting to see the physician directly influences patient's evaluation of the health care being delivered. This significantly reduces satisfaction with healthcare given. Time is valuable commodity in the life of patients who are eager to meet the doctor and find cure to their problems. The waiting time often results in missed work, wasted time and loss of money so it is not surprising that increased waiting time influences patients' perceptions in a negative way.

Table 4.11: Time Spent with the Doctor

Factor	Response	Frequency	Percentage %
Time spent with the doctor	Less than 30 minutes	3	11
	30 minutes-1 hr	21	78
	1-2 hrs	3	11

	2-3 hrs	0	0
	4 hrs and above	0	0
	Total	27	100

Source: Researcher's Field Study (2014)

Table 4.11 shows that 3 (11%) said they spent less than 30 minutes with the doctor, 21 (78%) said they spent between 30 minutes and 1 hour with the doctor and 3 (11%) said they spent between 1-2 hours with the doctor. None of the respondent spentmore than two hours with a doctor. A significant number of the patients spent a considerable amount of time with the doctors. This time a patient spends with doctor helps to establish a rapport between them and promote confidence and understanding between the parties. Thus, the patients come out and talk about all their ailments and possible anxieties regarding treatment. When doctors attend well to patients, they (the patients) become satisfied with their encounter with these doctors.

Table 4.12: Complaints

		Kinds of Complaints			
		Service delivery	Attitude of staff	Unavailability of drugs and vaccines	Total
Complaints	Yes	6 (22%)	14 (52%)	7 (26%)	27
	No	0	0	0	0
Total		2	16	9	27

Source: Researcher's Field Study (2014)

Table 4.12 shows whether or not patients have ever made a complaint and the kinds of complaints they have made. From Table 4.12, 6 (22%) said they had ever made a complaint about service delivery in the hospital, 14 (52%) said they had ever made a complaint about attitude of the staff and 7 (26%) also said they had ever made a complaint about unavailability of drugs and vaccines. A high proportion of patients

expressed dissatisfaction with some aspects of the services, especially with what they perceived as long waiting times, attitude of staff as well as unavailability of needed supplies. Unavailability of drugs and vaccines in the hospital is something that patients grieve over.

An interview on whether or not the hospital receives complaints from patients confirmed the responses of the patients that patients from time to time lodged complaints with management of the hospital. The Medical Superintendent said during the interview that:

> *"my outfit from time to time receives complaints from patients. The hospital has created platform and encourages patient to lodge their concerns and I am not surprise they do so. Most of the complaints have to do with misconduct of health personnel and we have resolved most of the complaints" (The Key Informant).*

4.2.3 Healthcare Management Practices and Healthcare Delivery

The second objective of the study is "*to establish the relationship between healthcare management practices and quality of healthcare delivery*". This is answered by first considering the respondents' (staff) perception on healthcare management practices as shown in Table 4.13.

Table 4.13: Respondents' Perception on Healthcare Management Practices (N=112)

Healthcare management practices	Disagree	Indifferent	Agree	Strongly agree
Decision making involves all staff	29(25.9%)	13(11.6%)	31(27.7%)	39(34.8%)
Information is easily disseminated within the hospital	0(0.0%)	0(0.05)	72(64.3%)	40(35.7%)

Management relates well with staff	0(0.0%)	27(24.1%)	53(47.3%)	32(28.6%)
Staff are well motivated	12(10.7%)	22(19.6%)	61(54.5%)	17(15.2%)
Management timely resolve disputes fairly	7(6.3%)	33(29.5%)	72(64.3%)	0(0.0%)
Financial resources are efficiently allocated	0(0.0%)	26(23.2%)	59(52.7%)	27(24.1%)
Management encourages development of staff	0(0.0%)	0(0.0%)	54(48.2%)	58(51.8%)
Management encourages staff initiatives	60(53.6%)	11(9.8%)	41(36.6%)	0(0.0%)
Management ensures culture of maintenance of infrastructural facilities	0(0.0%)	0(0.0%)	71(63.4%)	41(36.6%)
Management promotes infrastructural development	0(0.0%)	0(0.0%)	37(33.0%)	75(67.0%)

Source: Researcher's Field Study (2014)

From Table 4.13, 25.9%, 11.6%, 27.7% and 34.8% of the respondents (staff) disagreed, were indifferent, agreed and strongly agreed respectively that decision making within the hospital involves all staff. Staff agreed (64.3%) and strongly agreed (35.7%) that information is easily disseminated within the hospital. In terms of management-staff relationship, the respondents were indifferent (24.1%), agreed (47.3%) and strongly agreed (28.6%) that management relates well with staff. Table 4.13 shows that out of 112 staff respondents, 10.7%, 19.6%, 54.5% and 15.2% disagreed, were indifferent, agreed and strongly agreed respectively that staff are well motivated.

From Table 4.13, out of 112 respondents, 6.3% disagreed, 29.5% were indifferent and 64.3% agreed that management timely resolves dispute fairly among staff. The respondents agreed (48.2%) and strongly agreed (51.8%) that management encourages staff development but 53.6% disagreed, 9.8% were indifferent and 36.6% agreed that management encourages staff initiatives.

Table 4.13 shows that respondents agreed (63.4%) and strongly agreed (36.6%) that management ensures culture of maintenance of infrastructure and promotes infrastructural development (agreed [33.3%] and strongly agreed [67.0%0]). The respondents were indifferent (23.2%), agreed (52.7%) and strongly agreed (24.1%) that financial resources are efficiently allocated within the hospital.

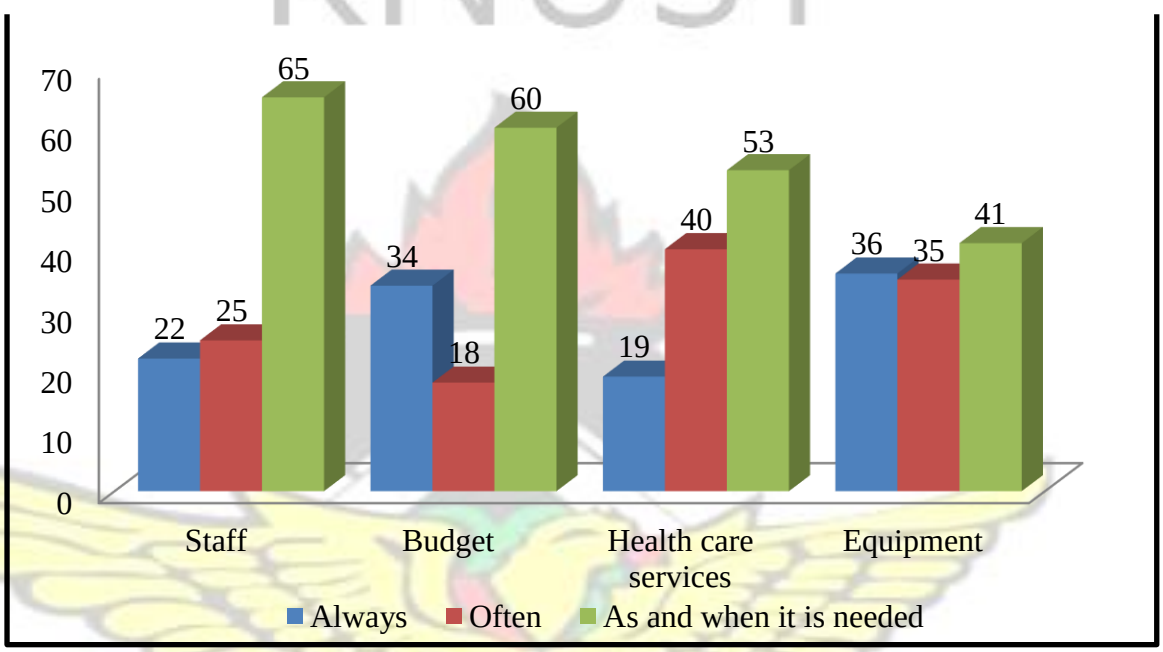


Figure 4.2: Frequency Management Evaluates Key Features
Source: Researcher's Field Study (2014)

From Figure 4.2, the response to the frequency management evaluates key features in the hospital revealed the following: On the issue of staff, 22 (20%) said the staff was always evaluated, 25 (22%) said the staff was often evaluated, 65 (58%) said the staff was evaluated as and when it is needed. On the issue of budget, 34 (30%) said the budget was always evaluated, 18 (16%) said the budget was often evaluated and 60 (54%) said the budget was evaluated as and when it is needed.

On the issue of health care services, 19 (17%) said the service was always evaluated, 40 (36%) said the service was often evaluated and 53 (47%) said the staff was evaluated as and when it is needed. On the issue of equipment, 36 (32%) said the equipment was

always evaluated, 35 (31%) said the equipment was often evaluated and 41 (37%) said the equipment was evaluated as and when it is needed.

The Medical Superintendent said in an interview that:

"the management takes management practices of the hospital seriously and we make sure that key amenities and facilities that are necessary for provision of healthcare are always available. The management focuses most importantly on staff appraisal, budgeting and planning, provision of drugs and vaccine and infrastructure and equipment". I believe we are on course and the management practices of the hospital are improving" (The Key Informant).

This result confirms that the management of the hospital evaluates certain key features in the hospital as when it is needed. This is done to find out whether there are any deficiencies and corrective actions are taken to correct them.

Table 4.14: Perception on Overall Quality of Healthcare Delivery (Staff only)

Healthcare delivery is effective (staff only)	**Frequency (F)**	**Percentage (%)**
Disagree	18	16.1
Indifferent	32	28.6
Agree	51	45.5
Strongly agree	11	9.8
total	112	100.0

Source: Researcher's Field Study (2014)

Table 4.14 shows that out of 112 staff as respondents, 18 (16.1) disagreed, 32 (28.6%) were indifferent, 51 (45.5%) agreed and 11 (9.8%) strongly agreed to overall quality of healthcare delivery system in the hospital.

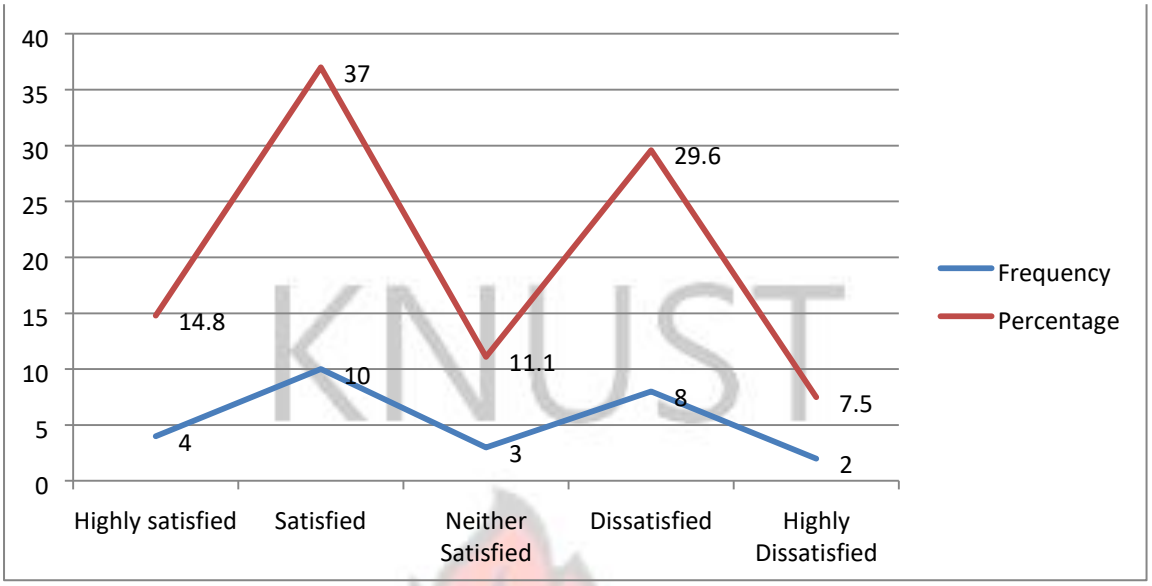


Figure 4.3: Patients Overall Satisfaction of Services Rendered by the Hospital
Source: Researcher's Field Study (2014)

From Figure 4.3, out of 27 patients, 4 (14.8%) were highly satisfied with the services provided by the hospital and 10 (37.0%) were satisfied. Figure 4.3 shows that8 (29.6%) were dissatisfied with the services provided by the hospital, 2 (7.5%) were highly dissatisfied and 11 (11.1%) held a neutral view. When the 'satisfied' results are put together, it can be seen that 14 (51.8%) are satisfied with the services provided by the hospital. Patient satisfaction is regarded as the most important indicator of quality of care. Satisfied patients lead to improved financial outcomes, reduced risk management claims and increased patient loyalty.

Pearson' s Correlation Coefficient test was performed to test for significant relationship between efficacy healthcare management practices and quality of healthcare delivery in the Dunkwa-on-Offin Municipal Hospital.

Table 4.15: Pearson's Correlation Coefficient

	1	2	3	4	5	6	7	8	9	10

Quality healthcare delivery (1)	1.00	0.870*	0.667*	0.872*	0.824*	0.807*	0.826*	0.674*	0.784*	0.822*
Involvement in decision making (2)		1.00	0.789*	0.855*	0.895*	0.859*	0.834*	0.789*	0.884*	0.864*
Timely Dissemination of information(3)			1.00	0.614*	0.775*	0.515*	0.719*	0.981*	0.524*	0.722*
Staff motivation (4)				1.00	0.841*	0.834*	0.683*	0.616*	0.820*	0.889*
Quality mgt-staff relationship(5)					1.00	0.728*	0.719*	0.770*	0.740*	0.958*
Effective dispute resolution (6)						1.00	0.716*	0.525*	0.890*	0.715*
Encouragement Staff development(7)							1.00	0.733*	0.728*	0.688*
Enhancing culture of Maintenance (8)								1.00	0.534*	0.718*
Infrastructure development (9)									1.00	0.727*
Efficient allocation financial resources (10)										1.00

Source: **Source: Researcher's Field Survey (2014). Significance level is 5%**

From Table 4.15, management practices of involvement in decision making, timely dissemination information, staff motivation, quality management –staff relationship, effective dispute resolution, encouragement of staff development, enhancing culture of maintenance, infrastructure development and efficient financial resource allocation positively and significantly relate with quality of healthcare delivery. Staff motivation (R=0.87) had the strongest relationship with quality healthcare delivery.

This was followed by involvement in decision making (R=0.870), staff development (R=0.826) and efficient allocation of financial resources (R=0.822). This means that improvement in each of item under healthcare management practices would significantly improve quality of healthcare delivery in Dunkwa-on-Offin Municipal Government Hospital.

Table 4.16: Pearson's Correlation Coefficient to test Result (Overall Result)

	Overall Healthcare management practices	Overall Quality of Healthcare delivery
Overall Healthcare management practices	1.000	0.902*
Overall Quality of Healthcare delivery		1.00

Source: Researcher's Field Survey (2014). Significance level is 5%

From Table 4.16, healthcare management practices and healthcare delivery are positively and significantly correlated and the Pearson's Correlation Coefficient is 0.902. This means that as healthcare management practices improves, healthcare delivery systems improves. A unit improvement in healthcare management practices, improves healthcare delivery systems by 0.902.

The Medical Superintendent in an interview on related how healthcare management practices have improved healthcare delivery in the hospital said:

"Yes, management practices have improved quality of healthcare delivery in the hospital dramatically. We used to have a lot of complaints from patients on misconduct of workers of this hospital but nowadays the complaints have reduced. I think this is due to intensive in-service training for staff on customer care, timely appraisal of workers and encouragement of patients to lodge grievances. Management and staff friendly relationship with patients encourages them to report to the facility on time when sick and I think is has reduce mortality in the hospital" (The Key Informant).

4.2.4 Challenges to Efficacy of Management in Healthcare Delivery

The third objective of the study was *"to explore the challenges to the efficacy of management in healthcare delivery in the Dunkwa-on-offin Government Hospital*". The responses on challenges facing management of healthcare delivery system in Dunkwa-on-Offin Government Hospital are summarized in table 4.17.

Table 4.17: Factors affecting health care delivery services

Factor	Strongly disagree	Disagree	Agree	Strongly agree
Self-medication (by people)	20 (14%)	28 (20%)	81 (58%)	10 (7%)
Superstition	31(22%)	33 (24%)	55 (40%)	20 (14%)
Confidentiality of patients' records	15(11%)	20 (14%)	69 (50%)	35 (25%)
Cost of health care			82(59%)	57(41%)
Attitude of medical staff	25(18%)	40 (29%)	32 (23%)	42 (30%)
Proximity to the hospital	25 (18%)	57 (41%)	20 (14%)	37 (37%)
Low salary			79(57%)	60 (43%)
Inadequate medical facilities			17 (12%)	122 (88%)
Production of incompetent health care professionals			48 (40%)	91 (65%)
Shortage of health care professionals			56 (40%)	83 (60%)
Low participation in health insurance		74 (53%)	37 (27%)	29 (20%)
Dissatisfaction from health care professionals		28 (20%)	67 (48%)	44 (32%)
Service quality	15(11%)	12 (9%)	53 (38%)	59 (42%)

Source: Researcher's Field Study (2014)

From Table 4.17, the Likert scaled responses to the prompt, "self-medication is a factor affecting health care delivery services," revealed that 81(58%) agreed that selfmedication by the people was a factor and 10 (7%) strongly agreed. Comparatively, 28 (20%) disagreed that self-medication by the people was a factor and another 20 (14%) strongly disagreed. Aggregating the "agree" results together shows that 91 (65%)

agreed that self-medication was a factor. This confirms that self-medication was factor that affects health care delivery in Dunkwa Municipal Hospital.

The respondents' results to the prompt "superstition is a factor affecting health care delivery services," shows that 55 (40%) agreed that superstition was a factor and 20 (14%)strongly agreed. Opposing this were 33 (24%) who said they disagreed that superstition was a factor and 31 (22%) strongly disagreed. In putting the 'agreement' results together, there is an indication that superstition was a factor affecting health care delivery in Dunkwa Municipal Hospital.

When respondents were asked how they agreed or disagreed with the statement "confidentiality of patients' records is a factor affecting health care delivery services," 69 (50%) agreed and 35 (25%)strongly agreed. Conversely, 20 (14%) disagreed and 15 (11%) strongly disagreed. Aggregating the "agreement" results together, a large number of the respondents agreed that confidentiality of patients' records affect health care delivery in Dunkwa Municipal Hospital. When health care professionals are not discreet with patients' records, the people lose confidence in them and this serves as a disincentive for them to patronize the hospital.

Responding to the prompt, "cost of health care is a factor affecting health care delivery", reveals the following responses. Table 4.17 shows that 82 (59%) agreed with the statement and 57 (41%)strongly agreed. Aggregating the results together, it can be inferred that the cost of health have an effect on how patients access health care services at the Dunkwa Municipal Hospital.

Responses to the prompt "attitude of medical staff is a factor affecting health care delivery service," showed that 42 (30%) strongly agreed with this statement and 32 (23%) agreed. Opposing this were 40 (29%) who disagreed with the statement and 25 (18%) strongly disagreed. The results from this data indicate that most respondents are in agreement with this prompt. The attitude of the medical staff is a factor that can compromise the way and manner people access health care services in the hospital. A patient's consumption of health care service in a particular hospital to some extent depends on the attitude of the medical staff. The attitude put up by medical staff towards patients is a key factor that can affect health care delivery.

When respondents are asked how they agreed or disagreed with the statement that "proximity to the hospital is a factor affecting health care delivery," the results showed that 37 (37%) strongly agreed and 20 (14%) agreed. Conversely, 25 (18%) strongly disagreed and 57 (41%) strongly disagreed. From the totality of response, it can be seen that 82 (59%) disagreed that proximity to the hospital cannot affect the way and manner people can access the hospital.

The respondents' responses to the prompt "low salary (for workers) is a factor affecting health care delivery" shows that 60 (43%) strongly agreed with this statement and 79 (57%) agreed. It can be seen that all the 139 respondents agreed with this statement. The results from this data imply that low salary given to the workers is a demotivating factor that can affect in a significant way the delivery of health care service in the hospital.

From Table 4.17, responses to the prompt "inadequate medical facilities is a factor affecting health care delivery" showed that 122 (88%) strongly agreed with this prompt

and 17 (12%) agreed. Totaling the results together, it can be seen that all the 139 (100%) were in agreement with this statement. The inadequate medical facilities in one way or the other affect quality of health care delivery in the hospital.

From Table 4.17, the response to the prompt "production of incompetent health care professionals is a factor affecting health care delivery" revealed the following: 91 (65%) strongly agreed and 48 (40%) agreed. In putting the results together, it can be seen that all the respondents were of the opinion that the production of incompetent health care professionals by the training schools is a major factor affecting health care delivery in the hospital. When the people are not trained adequately, they tend to offer substandard services to the people who patronize the hospital.

The respondents' response to the question of "shortage of health care professionals is a factor affecting health care delivery," 83 (60%) strongly agreed and 56 (40%) agreed. Aggregating the results together, it can be seen that the results are heavily in favour of this statement. When there is shortage of the health care professional, it affects the quality of services being rendered to the people who visit the hospital. The respondents' responses to the prompt "low participation in health insurance is a factor affecting health care delivery" shows that 29 (20%) strongly agreed with this statement and 37 (27%) agreed. However, 74 (53%) disagreed. It can be seen that most respondents disagreed with this statement. This result indicate that low participation in the health insurance scheme do not affect health care delivery in the hospital. This implies that people in the district still access health care in spite of their low participation in the health insurance scheme.

From Table 4.17, responses to the prompt "dissatisfaction from health care professionalsis a factor affecting health care delivery" showed that 44 (32%) strongly agreed and 67 (48%) agreed. However, 28 (20%) disagrees. Totaling the 'agree' results together, it can be seen that 111 (80%) were in agreement with this statement in comparison with 28 (20%) who were in some level of disagreement with the prompt. Dissatisfied health care workers may deliver substandard services to people who visit the hospital.

When respondents are asked how they agreed or disagreed with the statement that "service quality is a factor affecting health care delivery," the results showed that 59 (42%) strongly agreed and 53 (38%) agreed. On the contrary, 15 (11%)strongly disagreed and 12 (9%) strongly disagreed. From the totality of response, it can be seen that 112 (80%) agreed that the quality of service being rendered to people who visit the hospital can affect the way and manner they patronize the hospital. The degree to which health services meet patients' needs and expectations is of concern to both health workers and patients.

The Medical Superintendent in an interview confirmed that the hospital is facing many challenges like any other hospital. He stated:

"*the challenges retard growth of the hospital and most of our plans are not materialized because of the challenges.The financial resources, human resources, staff attitude, dissatisfaction of healthcare from staff and infrastructure are our main challenges" (The Key Informant).*

The Medical Superintendent explained some of the challenges as follows:

1. The National Health Insurance Authority (NHIA) does not refund the money spent on services rendered on time and this put constraint on our financial

resources. It averages extends to about five months before money used for providing services are refunded to the hospital.

2. The hospital is facing high cost of drugs and non-drug consumables. The depreciation of the cedi makes the cost of these items high. For example, paracetamol which used to be sold at 0.25 cedis is not selling at 0.35 cedis. A pack of needles and syringes which used to cost 1cedis now cost 1.5 cedis.
3. Shortage of healthcare professional. The hospital is facing acute shortage of healthcare professional. This may be due to the fact that the hospital is far from the regional capital (Cape Coast) and healthcare professionals are reluctant to accept posting the facility. As a result the number of nurses, midwives and medical doctors at the hospital are woefully inadequate.
4. Late attendance of patients to hospital. Patients normally come for healthcare when their diseased conditions are well advanced. This is a challenge because more resources are used by the hospital to provide healthcare for them. Delay for healthcare when sick, sometimes lead to avoidable deaths which affect the image of the hospital.

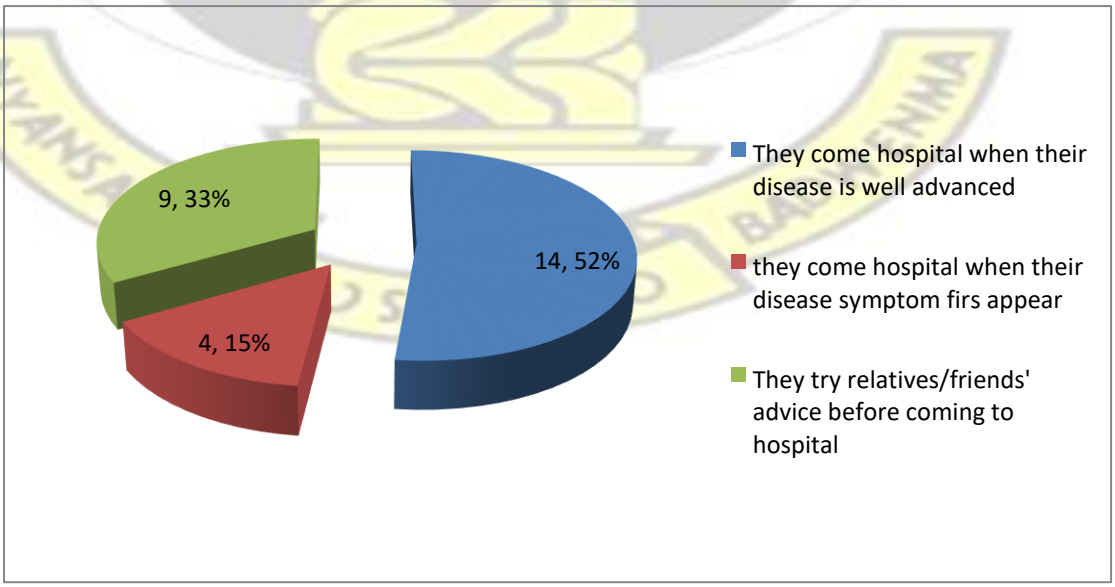


Figure 4.4: Action Taking by Patients When Sick Source: Researcher's Field Study (2014)

Figure 4.4 shows the responses of the respondents (patients) on the action taken when sick. It shows that 52% said they come to the hospital when their disease is well advanced,15% said they come to the hospital when disease symptoms first appear and33% said they try relatives/ friends' advice before coming to the hospital. From the data, it can be seen the majority of the patients visit the hospital when their disease is well advanced. There are some people who do not think much about their health while there are others who are aware of medical issues but chose to go against medical advice. For such people, they would chose to stay at home and only report to the hospital when their condition has deteriorated.

The patients' responses confirmed the responses of the Medical Superintendent on the challenges facing the hospital. Most patients delayed to hospital for healthcare when sick but rather consult non healthcare professionals (relatives and friends) for medical advices.

CHAPTER FIVE

SUMMARY OF FINDINGS, CONCLUSION AND RECOMMENDATIONS

5.0 Introduction

This chapter summarizes the findings of the study, recommendations by the researcher, limitations encountered and suggestions for future research.

5.1 Summary of Findings

The study outlines the following major findings:

5.1.1 Defining Characteristics of Healthcare Delivery System

This study revealed that most of the amenities and facilities in the hospital are functional.It was found out the hospital provided the following health care services: maternal and child health, reproductive health, malaria, environmental health, sexually transmitted infections, HIV/AIDS, tuberculosis and chronic illnesses (asthma, diabetes).The study revealed that the certain category of health care professionals namely doctors, nurses, midwives, pharmacists, physician assistants, laboratory technicians, labourers, orderlies and security personnel were always available in the hospital. However, physical and occupational therapists and dieticians were not available in the hospital.

The study showed that the ratio of doctors, nurses, midwives, pharmacists, physician assistants, laboratory technicians, labourers, orderlies and security personnel was not good.

It was found out that most patients spent a considerable amount of time with the doctors. The study showed that most patients made complaints and they complained about the service delivery, attitude of staff and unavailability of drugs and vaccines in the hospital. The study revealed that about half of the patients were satisfied with the services provided by the hospital.

5.1.2 Management of Healthcare Practices

The study revealed that the management of the hospital evaluated key features such as the staff, budget, healthcare services and equipment as and when it was needed. It was realized that management of the hospital promoted culture of maintenance of

infrastructure and equipment and development of infrastructure, staff development, involve staff in decision making and timely disseminate information within the hospital. However respondents attested that management did no encourage staff initiatives.

5.1.3 Relationship between Management Practices and Quality Healthcare Delivery

The Pearson's Correlation Coefficient showed strong positive and significant relation between management practices and quality healthcare delivery and the coefficient was 0.902. Staff motivation had the strongest significant relationship with quality of healthcare delivery in the Dunkwa-on-offin Municipal Government Hospital.

5.1.4 Challenges to Quality Healthcare Delivery

The study found out several factors affected health care delivery by the health care professionals in the hospital. Among these factors are self-medication, superstition, confidentiality of patients' records, cost of health care, attitude of the medical staff, low salary (for workers), inadequate medical facilities, production of incompetent health care professionals, shortage of health care professionals, dissatisfaction from health care professionals and quality of service. It was also found out that proximity to the hospital and low participation in the health insurance scheme do not affect health care delivery in the hospital.

The study showed that most patients attended the hospital when their disease is well advanced. It was found out that most patients had to wait for a considerable length of time before seeing the doctor

5.2 Conclusion

Healthcare is on a collision course with patient needs and economic reality. Without significant changes, the scale of the problem will only get worse. Low salary, shortage of and dissatisfaction of healthcare givers are among the causes of poor healthcare in the Municipal Hospital. Even though, the problems in Dunkwa Municipal Hospital are many and varied, they are surmountable in many ways.The fragmented health care delivery system delivers poor-qualitycare. The health care professionals who can helpachieve a higher-performing health care system are in limited supply at the periurban and rural areas in Ghana. The health care system in Dunkwa Municipal Hospital is limited in terms of clinicians and health care facilities. As a matter of fact, quality health care delivery is something that professionals and patients alike crave for. Good ways exist for improving the quality of health care. Health care managers must adopt creative and innovative strategies for the management of health care organisations. It is therefore important that from time to time, health care services are evaluated to find out whether the deficiencies (if any) do exist and the measures that can be taken to rectify them.

5.3 Recommendations

The following recommendations are made:

1. The management of the hospital should continue to improve healthcare management practice. This is because management practices significantly improve quality of healthcare delivery.
2. The management of the hospital should write to the Ghana Health Service to post the following category of health care professionals namely doctors, nurses, midwives, pharmacists, physician assistants, laboratory technicians, labourers, orderlies and security personnel to the hospital.

3. The management of the hospital should undertake outreach programmes in the communities to sensitize the people on the bad effects of self-medication and superstition among the people.
4. The management of the hospital should organize training and sensitization programme for their workers to be discreet with records of the patients who attend the hospital. This can help the patients to build trust in the workers.
5. The management of the hospital should be innovative and come out with programs and activities that help them to generate internally generated funds to put up facilities to help in smooth delivery of health care services
6. The management of the hospital should improve efficiency of services to reduce the waiting time in accessing health care. In the absence of adequate physicians at the hospital, the hospital should assign more health professionals in peak periods or days to enable them to cater for patients.
7. The management of the hospital should adopt strategies such as increasing salaries of workers, flexible scheduling of duties and decentralizing decision making by junior staff.
8. The management of the hospital should institute a patient reminder or recall strategy in the hospital. This strategy involves delivering to patients areminderthat they are due for a specific preventive service (such as a vaccination or a follow-up appointment for chronic disease management), or a recallthat they are overdue for that service. Reminders and recalls can be delivered by telephone, electronic medium, or a combination of these.
9. The management of the hospital should come out with a strategy that involves efforts to provide insurance coverage for all patients who visit the hospital. This would help to reduce out-of-pocket costs for certain health care services.

10. The management of the hospital should adopt strategic planning techniques in the management of health care delivery in the hospital in general.

5.4 Limitations Encountered

Several limitations need to be recognized in this study. The first is that the participants in this research were not representative of all the workers and patients that are working or visited the hospital.This study was also affected because the researcher did not get accurate response from the respondents as most of the workers and patients did not provide appropriate answer to the questions because some of the workers and especially the patients did not have a unique technical view of the questions asked thought it would be disclosed to others.Most of the respondents, especially the workers of the hospital were unable to give time for personal interview because of their busy schedules. The patients also thought that it was worthless to give time to answer questions because to them nothing good would come out of the result and so they were not very cooperative.

5.5 Suggestions for Future Research

It is recommended that future research should be conducted on the topic:

i. Over a long period of time across different hospitals in several districts of the economy to allow for comparative analysis to be undertaken.

ii. By collecting data from a bigger sample to increase the precision of the analysis and to enable firmer conclusions to be drawn from the study.

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APPENDIX A:

QUESTIONNAIRE FOR STAFF OF DUNKWA MUNICIPAL HOSPITAL, DUNKWA

KWAME NKRUMAH UNIVERSITY OF SCIENCE AND TECHNOLOGY

SCHOOL OF BUSINESS

AN EVALUATION OF THE MANAGEMENT PRACTICE OF THE HEALTHCARE DELIVERY SYSTEM IN GHANA: A CASE STUDY OF DUNKWA MUNICIPAL HOSPITAL, DUNKWA

Dear Respondent

This is a research being conducted in partial fulfillment for the award of Master of Business Administration degree. This research is conducted for academic purposes and you are assured of confidentiality and anonymity of the information you provide. Thank you

Instruction: Please tick (√) where applicable and supply details where required

PART I: DEMOGRAPHIC CHARACTERISTICS

1. Gender:

[ ]$_1$Male

[ ]$_2$Female

2. Age:

[ ]$_1$20-24

[ ]$_2$25-29

[ ]$_3$30-34

[ ]$_4$35-39

[ ]$_5$40-44

[ ]$_6$45 and above

3. Marital Status of Respondents:

[ ]$_1$Single

[ ]$_2$Married

[ ]$_3$Divorced

[ ]$_4$Widow/Widower

[ ]$_5$Co-habitating

4. What is your highest academic qualification?

[ ]$_1$Primary

[ ]$_2$Secondary [

]$_3$Tertiary

[ ]$_4$Other (please specify)……..…….…….

5. What is your main occupation in this hospital?

[ ]$_1$Medical Officer

[ ]$_2$ Nurse

[ ]$_3$Pharmacist

[ ]$_4$Laboratory Technician

[ ]$_5$Ward Assistant

[ ]$_6$ Accountant

[ ]$_7$ Midwife

[ ]$_8$Other (please specify)…….....

6. How long have you been practicing?

[ ]$_1$Less than one year
[ ]$_2$1-5 years

[ ]$_3$6-10 years

[ ]$_4$11-15 years

[ ]$_5$16-20 years

[ ]$_5$21 years and above

7. How many years have you practiced in this hospital?

[ ]$_1$Less than one year

[ ]$_2$1-5 years

[ ]$_3$6-10 years

[ ]$_4$11-15 years

[ ]$_5$16-20 years

[ ]$_6$21 years and above

PART II: WHAT ARE THE DEFINING CHARACTERISTICS OF THE GHANAIAN HEALTHCARE SYSTEM?

8. To what extent are the following amenities and facilities available at your hospital? ***(Please remember there are no right or wrong answers)***

S/N	Amenities & facilities	Never available	Rarely available	Sometimes available	Always available
A	Water (Pipelines)				
B	Electricity/solar				
C	Radio/telephone for communication				
D	Fridge for drugs and vaccines				
E	Dispensary (pharmacy)				
F	Separate delivery/maternity room				
G	Toilet for patients and staff				
H	Mortuary				
I	Counselling room				
J	Examination room				
K	Ambulance/vehicle				
L	Bungalows for staff				

9. To what extent is the hospital able to provide the following health care services efficiently?

S/N	Factor	Efficient	Not Efficient
A	Maternal and child health		
B	Reproductive health		
C	Malaria		
D	Environmental health		
E	Sexually Transmitted Infections		
F	HIV/AIDS		
G	Tuberculosis (TB)		
H	Chronic illnesses (asthma, diabetes, etc)		

10. To what extent is the following staff available in Dunkwa Municipal Hospital?

S/N	Staff	Not Available	Rarely Available	Sometimes Available	Always Available

A	Doctors				
B	Nurses				
C	Midwives				
D	Pharmacists				
E	Physician Assistants				
F	Laboratory Technicians				
G	Physical and Occupational Therapists				
H	Dieticians				
I	Labourers				
J	Orderlies				
K	Security Personnel				

11. To what extent are the following sufficient considering the patient-to-doctor ratio?

S/N	**Staff**	**Enough**	**Not Enough**
A	Doctors		
B	Nurses		
C	Midwives		
D	Pharmacists		
E	Physician Assistants		
F	Laboratory Technicians		
G	Physical and Occupational Therapists		
H	Dieticians		
I	Labourers		
J	Orderlies		
K	Security Personnel		

PART III: HEALTHCARE MANAGEMENT PRACTICES

12. To what extent do you agree or disagree to each of the following statement related to healthcare management practices in the Dunkwa-on-Offin Government Hospital.

(Please remember there are no right or wrong answers)

1=Strongly Disagree, 2=Disagree, 3=Neutral or Don't Know, 4=Agree, 5=Strongly Agree

KEY:
SD: STRONGLY DISAGREE
D: DISAGREE

N: NEUTRAL
A: AGREE
SA: STRONGLY AGREE

Healthcare management practices	**SD**	**D**	**N**	**A**	**SA**
Decision making involves all staff					
Information is easily disseminated within the hospital					
Management relates well with staff					
Staff are well motivated					
Management timely resolve disputes fairly					
Financial resources are efficiently allocated					
Management encourages development of staff					
Management encourages staff initiatives					
Management ensures culture of maintenance of infrastructural facilities					
Management promotes infrastructural development					

13. How often do management plan, implement and evaluate the following?

S/N	**Items**	**Always**	**Often**	**As and when it is needed**
A	Staff			
B	Budgets			
C	Health care services			
D	Equipment			

PART IV: CHALLENGES TO THE EFFICACY OF HEALTHCARE MANAGEMENT

14. The following are a number of items that describe how the following might affect health care delivery services rendered to the people in this hospital. Please use the scale to the right of each item to indicate the extent to which you agree or disagree with each item ***(Please remember there are no right or wrong answers)***

1=Strongly Disagree, 2=Disagree, 3=Neutral or Don't Know, 4=Agree, 5=Strongly Agree

KEY:

SD: STRONGLY DISAGREE
D: DISAGREE
A: AGREE
SA: STRONGLY AGREE

S/N	Factor	SD	D	N	A	SA
A	Self-medication (by people)					
B	Superstition					
C	Confidentiality of patients' records					
D	Cost of health care					
E	Attitude of medical staff					
F	Proximity to the hospital					
G	Low salary					
H	Inadequate medical facilities					
I	Production of incompetent health care professionals					
J	Shortage of health care professionals					
K	Low participation in health insurance					
L	Dissatisfaction from health care professionals					
M	Service quality					

APPENDIX B:

QUESTIONNAIRE FOR PATIENTS (WHO VISIT DUNKWA MUNICIPAL HOSPITAL, DUNKWA)

KWAME NKRUMAH UNIVERSITY OF SCIENCE AND TECHNOLOGY

SCHOOL OF BUSINESS

AN EVALUATION OF THE MANAGEMENT PRACTICE OF THE HEALTHCARE DELIVERY SYSTEM IN GHANA: A CASE STUDY OF DUNKWA MUNICIPAL HOSPITAL, DUNKWA

Dear Respondent

This is a research being conducted in partial fulfillment for the award of Master of Business Administration degree. This research is conducted for academic purposes and you are assured of confidentiality and anonymity of the information you provide.

Thank you

Instruction: Please tick (√) where applicable and supply details where required

PART I: DEMOGRAPHIC CHARACTERISTICS

1. Gender:

[ ]$_1$Male

[ ]$_2$Female

2. Age:

[ ]$_1$20-24

[ ]$_2$25-29

[ ]$_3$30-34

[ ]$_4$35-39

[ ]$_5$40-44

[ ]$_6$45 and above

3. Marital Status of Respondents:

[ ]$_1$Single

[ ]$_2$Married

[ ]$_3$Divorced

[ ]$_4$Widow/Widower

[ ]$_5$Co-habitating

4. What is your highest academic qualification?

[ ]$_1$Primary

[ ]$_2$Secondary [

]$_3$Tertiary

[ ]5Other (please specify)……...…….…….

5. Was there any delay before you saw the doctor?

[ ]1Yes

[ ]2No

6. If your answer to question 5 is 'yes,' how long did you wait before seeing the doctor?

[ ]1Less than 30 minutes

[ ]230 minutes-1 hour

[ ]31-2hours

[ ]42-3hours

[ ]53hours and above

7. How long did you spend with the doctor?
[ ]1Less than 30 minutes

[ ]230 minutes-1 hour

[ ]31-2hours

[ ]42-3hours

[ ]53hours and above

8. Were you satisfied with the waiting time?

[ ]1Yes

[ ]2No

9. To what extent were you satisfied with the consultation?

[ ]1Very satisfied

[ ]2Not satisfied

PART II: CHARACTERISTICS OF THE GHANAIAN HEALTHCARE

SYSTEM

10. To what extent are the following amenities and facilities available at the hospital?
(Please remember there are no right or wrong answers)

S/N	Amenities & facilities	Never available	Rarely available	Sometimes available	Always available
A	Water (Pipelines)				
B	Electricity/solar				
C	Radio/telephone for communication				
D	Fridge for drugs and vaccines				
E	Dispensary (pharmacy)				
F	Separate delivery/maternity room				
G	Toilet for patients and staff				
H	Mortuary				
I	Counselling room				
J	Examination room				
K	Ambulance/vehicle				
L	Bungalows for staff				

11. To what extent are the following functional?

S/N	Amenities & facilities	Never functional	Rarely functional	Sometimes functional	Always functional
A	Water (Pipelines)				
B	Electricity/solar				
C	Radio/telephone for communication				
D	Fridge for drugs and vaccines				
E	Dispensary (pharmacy)				
F	Separate delivery/maternity room				
G	Toilet for patients and staff				
H	Mortuary				
I	Counselling room				

J	Examination room				
K	Ambulance/vehicle				
L	Bungalows for staff				

12. To what extent is the hospital able to provide the following health care services efficiently?

S/N	Factor	Efficient	Not Efficient
A	Maternal and child health		
B	Reproductive health		
C	Malaria		
D	Environmental health		
E	Sexually Transmitted Infections		
F	HIV/AIDS		
G	Tuberculosis (TB)		
H	Chronic illnesses (asthma, diabetes, etc)		

13. Have you ever complained about the services that are rendered to you?

[ ]$_1$Yes
[ ]$_2$No

14. If your answer to question 19 is 'yes,' what do they complain about?

[ ]$_1$Service delivery

[ ]$_2$Attitude of staff

[ ]$_3$Unavailability of drugs and vaccines

[ ]$_4$Others (please specify)…….....

……..

15. To what extent is the following staff available in Dunkwa Municipal Hospital?

S/N	Staff	Not Available	Rarely Available	Sometimes Available	Always Available
A	Doctors				
B	Nurses				
C	Midwives				
D	Pharmacists				
E	Physician Assistants				
F	Laboratory Technicians				
G	Physical and Occupational Therapists				

H	Dieticians				
I	Labourers				
J	Orderlies				
K	Security Personnel				

22. To what extent are the following sufficient considering the patient-to-doctor ratio?

S/N	Staff	Enough	Not Enough
A	Doctors		
B	Nurses		
C	Midwives		
D	Pharmacists		
E	Physician Assistants		
F	Laboratory Technicians		
G	Physical and Occupational Therapists		
H	Dieticians		
I	Labourers		
J	Orderlies		
K	Security Personnel		

23. To what extent are the following personnel available in this hospital?

S/N	Factor	Never Available	Rarely Available	Sometimes Available	Always Available
A	Doctors				
B	Nurses				
C	Midwives				
D	Pharmacists				
E	Physician assistants				
F	Clinical officers				
G	Technicians				
H	Physical and Occupational therapists				
I	Dieticians				
J	Labourers				
K	Security				

PART III: CHALLENGES TO EFFICCAY OF HEALTHCARE MANAGEMENT

24. The following are a number of items that describe how the following might affect health care delivery services rendered to the people in this hospital. Please use the

scale to the right of each item to indicate the extent to which you agree or disagree with each item ***(Please remember there are no right or wrong answers)***

1=Strongly Disagree, 2=Disagree, 3=Neutral or Don't Know, 4=Agree, 5=Strongly Agree

KEY:
SD: STRONGLY DISAGREE
D: DISAGREE
A: AGREE
SA: STRONGLY AGREE

S/N	Factor	SD	D	A	SA
A	Self-medication (by people)				
B	Superstition				
C	Confidentiality of patients' records				
D	Cost of health care				
E	Attitude of medical staff				
F	Proximity to the hospital				
G	Low salary				
H	Inadequate medical facilities				
I	Production of incompetent health care professionals				
J	Shortage of health care professionals				
K	Low participation in health insurance				
L	Dissatisfaction from health care professionals				
M	Service quality				

25. How satisfied are you with the services rendered by the hospital?

[ ]$_1$Highly satisfied

[ ]$_2$Satisfied

[ ]$_3$Indifferent

[ ]$_4$Dissatisfied

[ ]$_5$Highly dissatisfied

26. What action do you take when sick?

[ ]$_1$go to hospital when disease is well advanced

[ ]$_2$go to hospital at the first sign of symptoms of sickness

[ ]$_3$seek the advices of relatives and friends before attending hospital