UNIVERSITY OF GHANA

GOVERNANCE MECHANISMS AND SERVICE DELIVERY: A COMPARATIVE ASSESSMENT OF THE ATTRIBUTES, DYNAMICS AND ROLES IN SELECTED HEALTH INSTITUTIONS IN GHANA

BY

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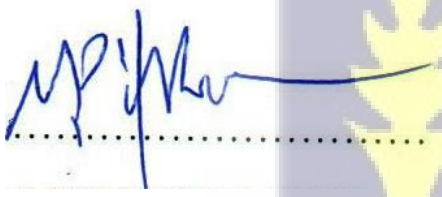
SEPTEMBER 2025

DECLARATION

I certify that this thesis presented for the award of PhD, is entirely my own work and has not been presented by anyone for any academic award in this or any other university. All references used in the work have been fully acknowledged.

This thesis has been prepared according to the regulations for postgraduate study by the University of Ghana, Legon.



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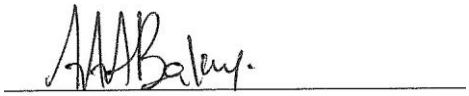
CERTIFICATION

I hereby certify that this thesis was supervised in accordance with procedures laid down by the University of Ghana, Legon.



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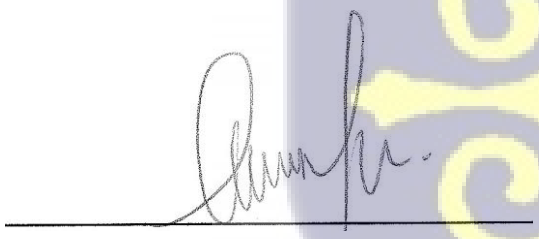

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DEDICATION

I dedicate this work to my family.

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TABLE OF CONTENTS

LIST OF TABLES

LIST OF FIGURES

LIST OF ABBREVIATIONS

CHAG- Christian Health Association of Ghana

CPD- Continuous Professional Development (CPD)

CPMR- Centre for Plant Medicine Research

FDA- Food and Drugs Authority

GDP- Gross Domestic Product

GHS- Ghana Health Service

HEFRA- Health Facilities Regulatory Agency

ICT- Information Communication Technology

MOH- Ministry of Health

NHIA- National Health Insurance Authority

PC- Pharmacy Council

ROA- Return on Assets

ROE- Return on Equity

WHO- World Health Organisation

ABSTRACT

The issue of hospital governance and its influence on quality of service delivery remains a conundrum that scholars have been attempting to unravel. Specifically, identifying effective governance mechanisms that are holistic and embody De Regge and Eecklo's (2020) typology of hospital governance comprising attributes, dynamics and roles of governance systems was the focus of this inquiry.

A qualitative approach underpinned by an interpretivist research paradigm was adopted in this study. The exploratory and descriptive research designs were used in this study. Face-to-face interviews with selected management, employees and clients of the aforementioned category of healthcare institutions were conducted. A sample of sixty-four (64) respondents were purposively sampled, comprising of sixteen (16) respondents made up of management, staff and clients from each of the four categories of healthcare institutions. The thematic analysis was used in the analysis of data, leading to some important findings.

Firstly, this study found that there were variations in the nature and composition of governance mechanisms among the selected public, private, quasi and mission-based healthcare institutions. This study found that the commonality among the governance mechanisms of these four institutions was the encapsulation of the attributes, dynamics and roles which further influenced the decision-making and quality-of-service delivery of the four institutions. This study also found that accreditation was an essential component in the legitimacy of all healthcare institutions, and formed part of the regulatory requirements needed to facilitate hospital governance. Furthermore, the study found that attributes, dynamics and roles influenced quality-of-service delivery by providing quality standards, employee behavioural controls and ethics, as well as customer service training to ensure that patients receive quality care at all times. The study also found that the four healthcare institutions mostly had challenges pertaining to financial challenges, decision-making challenges, logistics challenges, and employee migration/turnover challenges.

This study recommends that training be organised for administrators and management of healthcare institutions in Ghana on the role of attributes, dynamics and roles in facilitating quality healthcare service delivery. This will help provide clarity especially in relation to the dynamics and role elements of hospital governance. The study also recommends that management of healthcare institutions explore creative methods of financing to overcome the challenge of cash flow problems largely resulting from delays in insurance settlements.

In conclusion, this study has provided new insights on the nature and composition of governance mechanisms in Ghana's healthcare sector, whilst highlighting major challenges confronting public, private, quasi and mission-based healthcare institutions. The study's findings provide useful recommendations for policy, practice and future research.

CHAPTER ONE

INTRODUCTION

1.1 Background of the Study

Globally, it is an established notion that governance systems are imperative for organisational effectiveness and efficiency (Bentia, 2021; De Pourcq & Verleye, 2021; Unterhitzenberger & Moeller, 2021). Governance mechanisms refer to the established legal and institutional systems that direct and manage the resources of an organisation (Fan et al., 2022; Xia et al., 2021). Governance mechanisms entail the implementation of a system that is responsible for formulating policies, purpose and direction of an organisation, and ensuring that the right individuals are recruited to spearhead the vision and mission of the organisation (Brogi & Lagasio, 2021).

In the health sector, scholars have highlighted the need for effective governance systems that can help healthcare institutions operate efficiently and achieve patient satisfaction through quality service delivery (Price et al., 2020). The concept of service delivery has been at the top of the agenda for healthcare institutions given the nature of healthcare service delivery (Chakraborty et al., 2021; Gaobotse et al., 2022). For decades, scholars have been at pains to point out the various inefficiencies in healthcare service delivery which is largely the result of a lack of effective governance systems (Ismail, 2020). There are also some instances where governance systems in healthcare institutions have seen their output and influence on service quality questioned due to persistent service failure and other service delivery-related issues.

Good service delivery is characterised by the provision of timely, quality and client-centred solutions (Osei-Frimpong et al., 2020). This can only be possible if governance systems adopt inclusive mechanisms that entail roles and dynamics as part of the attribute component of governance in the health sector. Chakraborty et al. (2021, p.1) also assert that good service delivery is a mandate of national governments, who are responsible for ensuring that the necessary policy and regulatory frameworks are in place to facilitate and enhance the drive to provide quality healthcare services. They claim that "an efficient and affordable healthcare service delivery to everyone is a prerogative of the national governments" (Chakraborty et al., 2021, p.1). Thus, even though governance in the healthcare sector is an important matter for boards and management (Abor, 2016; De Pourcq et al., 2019; Azilaku et al., 2021), in public healthcare institutions, the government is usually tasked with making prudent appointments to the board and executive positions to ensure that competent personnel are in charge of decision making in healthcare institutions (Abimbola et al., 2017).

The goal of healthcare institutions (whether public or private) is to provide patients with quality healthcare services (Muniru & Abor, 2021). This requires effective governance mechanisms that transcend the attribute component and are inclusive of dynamics and roles which can ensure that healthcare institutions are run well from top to bottom (Aberese-Ako et al., 2018; Apore & Asamoah, 2019). In order to contextualise the study, it is important to briefly outline the characteristics of Ghana's three main healthcare institution types—public, private, and mission/quasi-governmental (Abor, 2015; Abor & Tetteh, 2023). Public healthcare institutions are state-funded and established to deliver essential services to a broad category of patients (Abor, 2015). This type of healthcare institution often facing challenges related to resource constraints and high patient volumes (Abor, 2015, 2016). Private healthcare institutions are profit-driven facilities established to provide more personalised and efficient care (Abor, 2015,

2016). These institutions are less accessible to low-income populations due to cost barriers (Anabila et al., 2019; Agyemang-Duah et al., 2020).

Mission healthcare institutions are operated by faith-based organizations or NGOs, and blend public service ethos with private management structures, serving underserved communities with relatively high standards of care (Nicol et al., 2022; Arbuckle, 2024). Quasi-governmental health institutions in Ghana refer to healthcare facilities established by government-owned or state-affiliated entities such as those in manufacturing, mining, and service industries, to provide primary, secondary, and tertiary health services to both their employees and the general public (Awoke et al., 2017). While these institutions are not directly managed by the Ministry of Health or Ghana Health Service, they operate under formal regulatory frameworks and often maintain collaborative ties with public health authorities (Abor, 2016). Examples include hospitals set up by organizations like COCOBOD, SSNIT, and the Ghana Ports and Harbours Authority (e.g., the International Maritime Hospital). These facilities embody a hybrid model, blending public service delivery with autonomous or semi-autonomous management structures (Abor, 2016; Awoke et al., 2017).

From the literature, it is clear that the issue of governance in healthcare affects all types of healthcare institutions, whether public, private or quasi- (Chakraborty et al., 2021). A recent study by Rusydi et al. (2020) revealed that some public hospitals were leveraging corporate governance principles to implement effective hospital governance systems. The study found that patient satisfaction and hospital performance were two important outcomes that hospital governance was intended to help improve. This suggests that there is a growing need to identify and implement governance mechanisms that can help healthcare institutions improve the

quality of care to patients, whilst also ensuring that other aspects of management such as financial and human resource management are properly carried out to ensure hospitals run efficiently.

De Regge and Eeckloo (2020) are of the view that when the three components of attributes, dynamics and roles are factored into healthcare governance systems, it will help these institutions to manage external constraints to achieve desired performance outcomes. According to De Regge and Eeckloo (2020), "attributes" refer to the structural features of governing bodies, such as their size, composition, professional background of board members, and formal responsibilities. They also defined "dynamics" as the internal processes, interactions, and relationships within the governing bodies. This includes how decisions are made, how power is distributed, and how board members engage with executive management (De Regge and Eeckloo, 2020). Roles describe the functional responsibilities and strategic focus areas of governing bodies such as oversight of quality, financial stewardship, and stakeholder engagement (De Regge and Eeckloo, 2020).

Another issue worth noting is that the nature and classification of health institutions determine which type of governance mechanism would be effective (Secundo et al., 2018; Larsen et al., 2018). However, the question that arises is whether it is reflected in practice. In hospital governance, do governance mechanisms mirror the unique characteristics of the healthcare institution or is one system of governance applied across board in the healthcare sector (Narayanamurthy et al., 2021)? The paucity of literature addressing these issues provide a platform for the current study to probe further into hospital governance mechanisms in the healthcare sector. As such, the focus of this study is to examine the nature and components of governance mechanisms of public, private, quasi and mission healthcare institutions in Ghana,

with a focus on how the attributes, dynamics and roles influence decision-making and service delivery within the healthcare sector.

1.2 Problem Statement

The healthcare sector has been bedevilled by various service delivery challenges that stem from poor organisation, inadequate staffing, poor logistics and supply chain systems, and bad employee behaviour, to name a few (Guan, 2019; Oleribe et al., 2019). In light of these challenges, there have been various calls for effective governance systems that can improve the quality of decision-making in the top hierarchy of healthcare institutions such as hospitals (Brunet, 2021). Previous research seems to suggest that the healthcare sector is fragile due to the various intricacies involved in the delivery of quality healthcare services to patients (Abor & Abor, 2021). There are various stakeholders whose needs require careful and systematic processes and solutions to address, and these include patients, employees/staff, suppliers, distributors and regulators (Abor, 2016).

Governance in the healthcare sector remains a hazy issue due to the lack of a defined set of governance mechanisms that can enhance operational efficiency and effectiveness, and ensure the delivery of quality services to patients (Swarnakar et al., 2021). Scholars are yet to agree on defined components and elements that make up the construct of healthcare governance resulting in some degree of ambiguity (Abor, 2017; Abimbola et al., 2017; Abimbola, 2020). This makes it difficult to evaluate the effectiveness of healthcare governance and identify its impact on certain important outcomes, especially service delivery. The study institutions exhibit notable variations in governance structures that directly influence healthcare delivery outcomes (Abor, 2016; Awoke et al., 2017). For instance, while public hospitals operate under

centralized government control with standardized protocols and budgetary constraints, quasi-governmental institutions such as those established by state-owned enterprises often function with hybrid governance models that blend public oversight with private-sector management practices (Abor, 2016; Amporfro et al., 2021). Private hospitals, on the other hand, are driven by market dynamics and managerial autonomy, which can lead to disparities in service quality, access, and accountability (Dzampe & Takahashi, 2022). These governance differences contribute to uneven resource allocation, staffing practices, and responsiveness to patient needs across the healthcare system (Abor, 2016). Such institutional heterogeneity underscores the urgent need for critical empirical research to unpack how governance models shape operational efficiency, equity, and health outcomes within Ghana's evolving healthcare landscape.

An exploration of the literature on various governance systems in use by healthcare institutions in various parts of the world has revealed that there is no consensus on what constitutes components and elements of healthcare governance. For instance, Dixit (2017) proposes a model for healthcare governance comprising synergy between corporate governance, corporate social responsibility, principles of public enterprise governance as well a stakeholder theory of governance. None of these studies have offered insight into the influence of governance mechanisms on employee behaviour specifically quality of service delivery. Also, it is unclear how the kind of governance mechanism in healthcare institutions affects the nature of decision-making through standard operating procedures and other policies that determine the quality of service delivery and patient care in hospitals. This provides an opportunity for this study to explore how governance mechanisms shape management decision-making.

Hastings et. al (2014) also discovered six (6) governance mechanisms in the healthcare sector namely: shared governance, magnet accreditation, professional development and education, quality-focused initiatives, reorganisation of healthcare delivery, and funding schemes. Whilst the above-mentioned study offers some form of framework for pursuing governance in the healthcare sector, other studies remain somewhat ambiguous about the composition of governance systems in the healthcare sector (Martins et al., 2020). A recent study by De Regge and Eeckloo (2020) mentioned that over the past fifteen years, research on healthcare/hospital governance has adopted a narrow perspective on the concept, and viewed it from the position of either hospital boards or management, or in some cases, both. They further observed that the concept of hospital governance is broad and should encompass not just the attributes (board and management), but also the dynamics and roles (De Regge & Eeckloo, 2020). This is an issue that is yet to be addressed in the literature and represents a gap that this study sought to pursue in relation to the effects of attributes, dynamics and roles on service delivery in public and private healthcare institutions.

A review of the current literature on healthcare/hospital governance reveals that there is a lack of consensus regarding components of healthcare governance, as well as a paucity of literature examining comparative cases amongst the public and private, which are gaps that need to be addressed (Abor, 2015; Simonet, 2014; Torchia et al., 2015). The few studies that exist in this domain have examined issues such as ownership structure and performance (Abor, 2014), patient perception of service quality (Abor, 2016), and the influence of governance and ownership structure on hospital performance (Abor, 2015), leaving room for further contribution. The lack of clarity on the nature and components of healthcare governance, coupled with the overreliance on the attribute feature of governance to explain hospital governance is one of the gaps in the literature that this study seeks to address.

Based on the above, the goal of this thesis is to bridge these important gaps identified in the literature. This study also seeks to make a modest contribution to the literature on healthcare governance and administration. The main contribution lies in assessing the effects of attributes, roles and dynamics in hospital governance in public and private institutions in relation to decision-making and service delivery. Investigating the added perspectives of dynamics and roles will add much-needed clarity to the literature on healthcare governance as it clarifies the other aspects of healthcare governance that have not been considered due to the narrow focus and emphasis on the attribute component. Exploring the nature of dynamics and roles in addition to the attributes of the healthcare governance system is expected to provide insight into the factors that account for the variation in decision-making and service delivery in public, private, quasi and mission healthcare institutions.

1.3 Research Objectives

The purpose of this study is to examine the nature and composition of healthcare governance systems in Ghana and to further explore the effects of attributes, dynamics and roles on quality service delivery in public, private, mission and quasi healthcare institutions in Ghana.

The study's main objectives are to:

(i) Comparatively assess governance mechanisms (attributes, dynamics and roles) in public, private, mission and quasi hospitals in Ghana.

(ii) Comparatively examine challenges faced by public, private, mission and quasi hospitals in implementing existing governance mechanisms (attributes, dynamics and roles).

(iii) Comparatively explore the influence of governance mechanisms (attributes, dynamics and roles) on decision-making, and quality-of-service delivery from employees in public, private, mission and quasi healthcare institutions in Ghana.

(iv) Comparatively examine the feedback loop in governance mechanisms in public, private, mission and quasi hospitals in Ghana

1.4 Research Questions

The overarching aim of this study is to assess the various governance mechanisms in place at selected health institutions in Ghana, and examine how attributes, dynamics and roles influence service delivery outcomes in the health sector in Ghana. To achieve this aim, some objectives have been formulated which result in the following research questions:

(i) What is the nature and composition of governance mechanisms in selected health Institutions in Ghana in relation to attributes, dynamics, and roles?

(ii) How do board attributes, dynamics and roles of hospital governance mechanisms influence the quality-of-service delivery in selected healthcare institutions in Ghana?

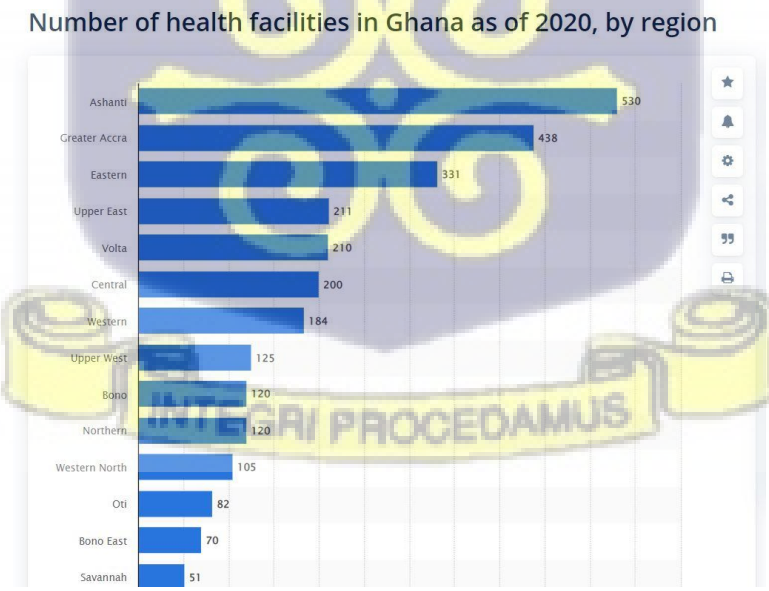
(iii) What are the challenges in hospital governance mechanisms that hinder decision-making and quality of care in selected healthcare institutions in Ghana?

(iv) How do governance mechanisms affect the nature of patient feedback in public, private, mission and quasi hospitals in Ghana?

1.5 Scope of the Study

This study focuses on the issue of governance mechanisms and service delivery in the healthcare sector in Ghana. Specifically, this study seeks to highlight the variations and composition of governance systems in public, private, mission and quasi healthcare institutions in Ghana and determine the influence of attributes, dynamics and roles on service delivery and other outcomes in the healthcare sector of Ghana. The study collected data from management, employees and clients of healthcare institutions in Ghana. This research selected a sample from the four core institutions under review, namely public, private, mission and quasi healthcare institutions. Healthcare institutions in the Greater Accra Regions were selected. Justification for the choice of the Greater Accra Region stems from the fact that it is one of the top three regions in terms of the number of healthcare institutions in Ghana as per a report from Sasu (2021). The report shows that the Ashanti Region has the most healthcare facilities in Ghana (530), followed by Greater Accra (438) and the Eastern Region (331). This is highlighted in Figure 1.1:

Figure 1.1- Distribution of Health Facilities in Ghana by Region (2020)



Source: Sasu (2021)

Based on the data provided in Figure 1.1, this study selected the Greater Accra Region as the geographical area for the selection of healthcare institutions in Ghana. The choice of Greater Accra Region was also predicated on the fact that due to its regional significance, especially in relation to situating the capital city of Ghana, Accra, the healthcare facilities in the region are likely to have diverse hospital governance structures and management/operation styles which can provide insight into the nature of attributes, dynamics and roles being explored in this study. Furthermore, anecdotal evidence has shown that oftentimes, trends in hospital governance commence in Accra and are replicated by healthcare institutions in other parts of the country.

1.6 Significance of the Study

This study contributes to knowledge by addressing a key issue in the healthcare management literature; that is, healthcare governance systems, and their influence on service delivery within the healthcare sector. The findings of this study contribute to the literature by identifying and highlighting the differences in governance systems in public, private, mission and quasi health institutions within a developing economy setting. Specifically, this study brings to the fore the nature of healthcare governance systems in relation to attributes, dynamics and roles, and their influence on decision-making and service delivery outcomes in the healthcare sector.

Secondly, the findings of this study add to theory by highlighting the use of the Signalling Theory and Managerial Hegemony Theory. By adapting Signalling Theory, the study conceptualises governance mechanisms such as board decisions, leadership styles, and policy directives as deliberate signals that communicate expectations, priorities, and values to healthcare employees. These signals shape perceptions and guide behaviour, ultimately

influencing the quality of care delivered. Managerial Hegemony Theory complements this by illustrating how dominant managerial interests and power structures within hospital governance can subtly shape organisational culture, resource allocation, and strategic focus, often privileging certain outcomes or stakeholder groups.

Together, these theories informed the development of a conceptual framework and flow chart that visually maps how governance mechanisms function as signals within institutional settings. This theoretical integration not only deepens our understanding of governance-performance linkages but also provides a practical tool for analysing institutional behaviour and designing interventions that enhance quality care. Scholars such as De Regge and Eeckloo (2020) have highlighted the overreliance on theories such as Agency, Stakeholder, Institutional, Stewardship, and Resource Dependency and called for the use of other theories which can offer alternative insights into the nature of healthcare governance mechanisms. Accordingly, by using the signalling and managerial hegemony theories, this research offers a unique theoretical contribution by integrating two theories in the quest to explain how healthcare governance systems can contribute toward effective service delivery in the healthcare sector.

From a practice-based perspective, the findings of this study can inform managerial decisions with regard to the nature of governance mechanisms in the healthcare sector, which may lead to reforms that can help to improve the quality of healthcare delivery in Ghana, and the effectiveness and efficiency of public, private, mission and quasi healthcare institutions in the country. In turn, this study also offers some policy relevance by highlighting and explicating major policy recommendations which can help to improve the system of healthcare governance

in Ghana. Overall, the completion of this study offers significant contributions to knowledge, theory, practice and policy in relation to healthcare governance mechanisms and service delivery from a developing economy perspective.

1.7 Organisation of the Study

This thesis is developed into seven (7) chapters. The first chapter, Chapter One contains the background of the study, problem statement, research objectives and research questions. The chapter also highlights and discusses the scope of the study as well as the significance of the study in relation to literature, theory, practice and policy. The chapter's disposition highlighting the structure of the thesis is also discussed in this chapter. The second chapter, Chapter Two contains the context of the study where public, private, mission and quasi healthcare institutions and the regulatory frameworks governing these institutions are discussed. The nature of healthcare service delivery in Ghana are also examined in this chapter, as well as other contextual issues on healthcare governance mechanisms and service delivery in Ghana. The third chapter is the literature review chapter where discussions on conceptual, empirical and theoretical issues were held. This chapter provided definitions, classifications and other important issues concerning healthcare governance and also expounded on the theoretical framework underpinning this study. The fourth chapter of the study is the research methodology where the various research methods such as research philosophy, research approach and design are discussed. The fifth chapter of the study contains the presentation of findings, after which the sixth chapter of the study presents a discussion of the findings. The seventh chapter provides the conclusion, contributions, recommendations and limitations of the thesis. These seven chapters provide a framework for the conduct of this study on healthcare governance mechanisms in public and private healthcare institutions in Ghana.

CHAPTER TWO

CONTEXT OF THE STUDY

2.0 Chapter Overview

This chapter explores key contextual issues underpinning the study, with a focus on healthcare governance in selected institutions in Ghana. It examines the interplay of governance attributes, dynamics, and roles, while highlighting governance as both an organizational and policy concern shaped by regulatory bodies. The chapter provides an overview of Ghana's healthcare sector, its regulatory framework, classification of institutions, governance challenges, and relevant government policies. It also offers a comparative assessment of public and private healthcare institutions, thereby establishing the broader environment within which these institutions operate.

2.1 An Overview of the Healthcare Sector in Ghana

The healthcare sector in Ghana is a sector that plays a vital role in the Ghanaian economy (Abekah-Nkrumah et al., 2009; Saleh, 2012). Even though other sectors (such as manufacturing, services, export etc.) are heralded for their contribution to GDP, the healthcare sector plays an important role in ensuring that Ghanaians are provided with quality health services for overall wellness for productivity and increased life expectancy (Couttolenc, 2012; Saleh, 2012).

The Ghanaian healthcare sector comprises of four (4) categories of healthcare institutions licensed and dedicated to providing quality health services to the population. These institutions are public, private, mission and quasi hospitals (Abor et al., 2008; Abor, 2015). Public

healthcare institutions are hospitals established by the Government and run by the state through public officials and agencies (Abor, 2016). In Ghana, public hospitals sit at the top of the healthcare value chain due to the fact that most of the referral and teaching hospitals in the country are all public hospitals (Sasu, 2024). Even though private hospitals have sprung up and contributed to the quality of service delivery in the health sector (Mensah & Adams, 2014), the fact still remains that public hospitals such as Korle-Bu Teaching Hospital, 37 Military Hospital, Komfo Anokye Teaching Hospital still represent the pinnacle of health service delivery in the country with most critical health cases referred to these institutions (Abor, 2015; Abor, 2016).

Private hospitals in the country are mostly established by medical practitioners, and cater for basic healthcare needs with some also developing the capacity to handle some degree of complex procedures and cases for patients, albeit at a high cost (Appiah et al., 2017). Mission hospitals established by Christian, Muslim and other religious organisations are also playing a key role in managing the load on public hospitals in the country (Abor, 2016). The religious healthcare institutions are complementing the efforts of Government of Ghana and the Ministry of Health to ensure that every Ghanaian has access to quality health services (Gill & Carlough, 2008). Some government institutions have also taken the initiative to establish hospitals, and this is further contributing to extensive and all-inclusive delivery of healthcare services (Abor, 2016). Quasi hospitals such as Cocoa Clinic, International Maritime Hospital and SSNIT Hospital are all playing key roles in providing alternative source of treatment from the public, private and mission hospitals.

Generally, there are various perceptions on the effectiveness and nature of service quality of the different category of hospitals (Abor, 2016). Public hospitals for example, are largely perceived to have the capacity in terms of government funding, staff depth, and advanced technology and equipment, yet, they are the most culpable when it comes to quality service delivery due to issues such as long queues and waiting times, deplorable state of some facilities, poor maintenance culture, bad staff attitude towards customer service, to name a few (Govindaraj et al., 1996). It is largely perceived that if public hospitals were managed like private ones, they would be more efficient and quality standards would increase phenomenally (Erniaty & Harun, 2020). Public hospitals are largely patronised by individuals in the lower class and lower middle-class (Abor et al., 2008; Abor, 2016). Although in the case of complex surgeries and emergencies, individuals in the upper-middle and upper class are compelled to either seek treatment outside the country or patronise the public hospitals especially the teaching hospitals (Abor, 2016).

Private hospitals on the contrary are perceived to be worth the price they charge for those who can afford it (Mensah & Adams, 2014). Nonetheless, private hospitals are often limited in terms of scope; they are not as large as public hospitals, and due to a lack of government funding, they are not able to recruit all the specialists they need therefore resulting in understaffing in vital areas that would have helped them match up with public hospitals in terms of depth of health services provided (Mensah & Adams, 2014). Quasi hospitals are viewed as quality hospitals which often serve the healthcare needs of employees of the parent institutions (Jehu-Appiah et al., 2014). Mission hospitals are generally viewed as being reliable healthcare outposts that also provide quality healthcare services to complement public and private healthcare institutions (Abor, 2016).

The health sector in Ghana is a broad sector that falls under the remit of the Ministry of Health (MoH). The ministry is in charge of ensuring quality healthcare services across board, and the subsequent section provides the profile of the ministry, its organisational structure and its functions. This is an important contribution to the study as it highlights one of the key regulatory and oversight bodies in the healthcare sector in Ghana. This provides a unique perspective on the role of government through the Ministry of Health in ensuring that each category of hospital complies with the requisite regulatory requirements.

2.1.1 The Ministry of Health (MoH)

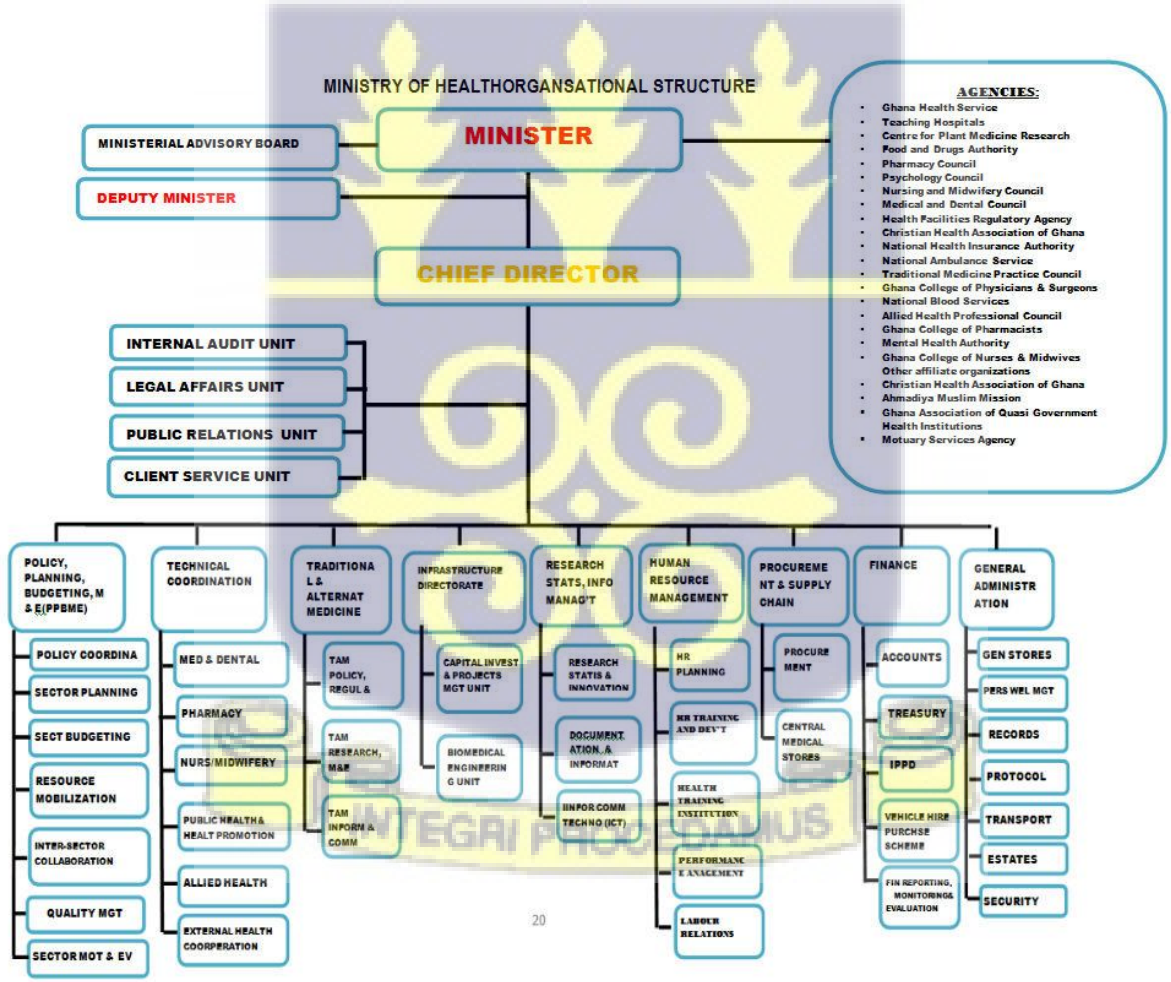
The Ministry of Health is the section of the government's machinery dedicated to overseeing all policy and regulatory issues about the health of Ghanaians. According to information obtained from the website of the ministry, "…the Ministry of Health seeks to improve the status of all people living in Ghana thereby contributing to Government's vision of universal health coverage and a healthy population" (MOH, 2023). From this statement, it is evident that the Government of Ghana seeks to achieve extensive health coverage in all regions of the country to ensure that each member of the population, which includes all foreigners living in Ghana have access to quality healthcare. The ministry is thus responsible for executing this vision and providing the necessary policy regulations and institutional framework to make this vision a reality.

2.1.1.1 Hierarchical Structure of the Ministry of Health

The Ministry of Health can be classified as a hierarchical organisation as its organogram depicts (See Figure 2.1). The MoH has its headquarters in Accra, the capital city of Ghana, and agencies in other regions, and sub-districts (MoH, 2023). The mission of the MoH is "…to contribute to socio-economic development and the development of a local health industry by promoting health and vitality through access to quality health for all people living in Ghana using motivated personnel" (MoH, 2023). This mission is based on the overall vision of the

organisation which is "…to have a healthy population for national development" (MoH, 2023). The mission and vision of the MoH suggest that this institution has been empowered with the mandate to ensure that healthcare is made accessible to all people living in Ghana, and to facilitate the development of a healthy populace to spearhead national growth and development. This ministry has a very important role to play in ensuring that all healthcare institutions deliver excellent services to enable the vision to be achieved. Figure 2.1 presents an illustration of the hierarchical structure of the Ministry of Health, and provides insight into the structure and layers within Ghana's health ministry. The associated agencies are also highlighted in the diagram. This is presented on the next page.

Figure 2.1- Hierarchical Structure of the Ministry of Health



Source: MoH Files (2023)

From Figure 2.1, the Hierarchical organizational structure of MoH is presented and provides an overview of the various layers within the organization, as well as its extended branches and partner agencies. The figure reveals that the ministry is headed by the Minister of Health, an individual appointed by the government, specifically by the President of Ghana, and approved by Parliament. The minister and his deputy are both candidates nominated by the President and submitted to Parliament for vetting and approval (MoH, 2023). The Minister of Health apart from being assisted by a Deputy Minister is also supported by the Ministerial Advisory Board, comprising fourteen (14) members with vast experience and expertise in the health sector of Ghana. According to the MoH (2023), "…the functions of the Ministerial Advisory Board, include promotion of constant interaction between the Ministry and users of its service, and the Board's advisory role for adjustments in policy directions, planning objectives and operational strategies where necessary."

From Figure 2.1, it can also be observed that there are quite a number of agencies who fall under the scope of the Ministry of Health, and contribute towards the effective management of health services within the country. The most important agency under the MoH is the Ghana Health Service (GHS). The Ghana Health Service was commissioned in 1996 as part of the health sector reforms in Ghana (GHS, 2023). It is reported that the passage of Act 525 in 1996 established the Ghana Health Service (GHS) as the implementing body for public sector health services. The institution of the Ghana Health Service ensured that the MoH could focus more on policy and regulatory activities, whilst the GHS focused on the public sector service delivery component. GHS was officially launched in February 2003, and one interesting point about the GHS is that even though it falls under the umbrella of MoH agencies, its staff are not classified as civil servants, thus allowing for more flexible managerial decision-making and appointments.

The other agencies which fall under the auspices of the MoH include: Teaching hospitals, the Centre for Plant Medicine Research (CPMR), the Food and Drugs Authority (FDA), Pharmacy Council, Psychology Council, the Nursing and Midwifery Council, the Medical and Dental Council and Health Facilities Regulatory Agency (HEFRA). Others include the Christian Health Association of Ghana (CHAG), National Health Insurance Authority (NHIA), National Ambulance Service, Traditional Medicine Practice Council, Ghana College of Physicians and Surgeons, National Blood Services, Allied Health Professional Council, Ghana College of Pharmacists, Mental Health Authority, and Ghana College of Nurses and Midwives. The group of agencies also include the Ghana Association of Quasi Health Institutions, Mortuary Services Agency and Ahmadiya Muslim Mission.

The hierarchical structure of the Ministry of Health indicates that a high degree of collaboration and cooperation is needed to ensure that the various agencies interface with each other to ensure that service delivery within the health sector is delivered efficiently and effectively and with the necessary hallmarks of service quality such as assurance, responsiveness, empathy, competence and tangibles (Anabila, 2019; Anabila et al., 2019). It is worth mentioning that DeRegge and Eeckloo (2020) have found that most studies on hospital governance have adopted the stakeholder theory to highlight the need for stakeholder cooperation within the health sector. Therefore, the hierarchical structure of the MoH is a testament to the fact that stakeholder cooperation is vital for quality service delivery within the health sector of Ghana. In terms of the structure, the vast layers within the MoH institution also clearly demonstrate that the Ministry of Health in some ways have some of the attributes, dynamics and roles that are characteristic of effective governance systems as postulated by DeRegge and Eeckloo (2020).

2.1.1.2 Role and Functions of the Ministry of Health in Ghana

In the previous sections, the overview of the ministry and the hierarchical structure was discussed. This section takes a closer look at the role of the MoH in healthcare management in Ghana. The purpose of this section is to determine which specific roles the MoH plays in relation to its role within the Ghanaian healthcare sector. The MoH, as the leading institution responsible for overseeing the healthcare sector in Ghana, is tasked with three core duties namely: (1) Formulating healthcare policies (2) Regulating the healthcare sector and (3) Ensuring that all actors, agencies and institutions within the healthcare sector are coordinated efficiently.

The first major role of the MoH is to provide policy direction for all stakeholders in the health sector (MoH, 2023). This means the ministry is supposed to identify relevant policies which can address some of the institutional challenges confronting the sector. The Ministry of Health is the beacon for all institutions in the sector; ideas, inspiration and operational policies are taken from the ministry, and this is symbolic of the role the MoH plays in the healthcare sector in Ghana. In relation to this role, the ministry is also supposed to play the role of being an effective advocate in the health sector, especially in relation to intersectoral action. Effectively, this means that the MoH is supposed to facilitate coordination amongst the various agencies and entities in the health sector in Ghana. This is in relation to knowledge exchange, sharing of resources, synergy and monitoring and evaluation (MoH, 2023). The Ministry as part of its remit, is supposed to collect, collate and provide relevant information for the management of health services in Ghana.

The Ministry of Health is also responsible for mobilizing and allocating resources to all providers in the health delivery services in Ghana (MoH, 2023). This role pertains to securing funding from within and outside the country to facilitate healthcare delivery. Moreover, it is also the function of the MoH to provide funding support to certain agencies to enable them to carry out their work effectively. As part of its duties, the MoH is also in charge of regulating the activities of all healthcare service providers in the country, and this pertains to public, private and even quasi-healthcare institutions (MoH, 2023). Finally, one of the important duties of the ministry is to monitor and evaluate health services in Ghana. In this regard, the ministry plays the role of watchdog, overseeing health compliance standards and ensuring that all health service institutions are adhering to acceptable standards as required.

2.2 The Industry Regulatory and Governing Bodies in Ghana's Health Sector

Ghana's health sector is overseen generally by the Ministry of Health, as discussed in the previous section. However, the ministry does not work alone; it has other agencies and sub-divisions responsible for overseeing specific areas within the sector. This section discusses the various agencies and regulatory bodies in Ghana's healthcare sector.

2.2.1 Health Facilities Regulatory Agency (HEFRA)

In Ghana, one of the leading agencies responsible for overseeing the registration and licensing of health facilities in Ghana is the Health Facilities Regulatory Agency (HeFRA). The Health Institutions and Facilities Act, 2011 (Act 829) established the Health Facilities Regulatory Agency (HeFRA) in Part 1 of the Act. HeFRA was set up to license facilities for the provision of public and private health care services., and the organisation's mission is to "…transform the regulation of health care facilities through quality standard setting, enforcement and client-focused partnerships." HeFRA aims to ensure that both public and private healthcare facilities

are managed effectively and implement the highest standards to ensure that patients receive quality care in the best environment possible.

The strategic objectives of HeFRA include: (1) To work in partnership with stakeholders across the public and private sectors, so that health care is delivered within well-designed and structurally appropriate facilities (2) To contribute to developing and supporting identified professions to improve the management of Ghanaian health facilities (3) To advocate for patients and clients, through a greater focus on safety, compassionate care and transparency in the operations of health facilities (4) To establish a system that ensures health care delivery is fairly priced and involves competent and accredited professionals, utilizing the right type and well-functioning equipment and (5) The private sector also plays a significant role in Ghana's health sector, representing about 40 percent of total healthcare delivery in the country.

As stated earlier, HeFRA's purpose is to assess, evaluate and license health facilities in Ghana to ensure that they meet up to acceptable standards in healthcare service delivery. This mandate extends to both public healthcare institutions (state-owned & funded) as well as private healthcare institutions. In Ghana, private healthcare institutions usually comprise of practitioner-owned facilities and mission-based providers (MoH, 2023). Practitioner-owned facilities are those healthcare institutions and facilities established by private medical and dental practitioners, whilst mission-based providers refer to the healthcare facilities established by Christian or Moslem institutions. There are numerous mission-based hospitals and health facilities in Ghana established by Christian institutions such as the Catholic Church, Methodist Church, Church of Pentecost and other Charismatic Churches in Ghana. Similarly, there are

several health facilities established by Muslim institutions such as the Ahmadiya Muslim Mission.

It is the job of HeFRA to ensure that all these facilities are duly inspected and licensed before they can operate, in order to maintain the highest possible standards in healthcare delivery in Ghana. Even though HeFRA does not determine or influence the governance mechanism of healthcare institutions in Ghana, its role as the regulator in charge of facilities licensing is a vital part of healthcare/hospital governance since it is the role of executive management to ensure that all licenses required for a healthcare institution to operate are obtained. Thus, HeFRA plays an important role in ensuring that hospital governance does not neglect important issues related to healthcare facility licensing and authorisation. In the next section, the classification of healthcare institutions in Ghana are discussed.

2.2.2 Medical and Dental Council

In the previous section, the role of HEFRA was examined in relation to how they regulate and licence healthcare facilities in Ghana. This captured the institutional perspective of healthcare regulation in Ghana, but in this section and the subsequent ones, regulatory bodies that establish codes of conduct and ethics for key personnel and staff in the healthcare sector in Ghana are discussed. These include institutions such as the Medical and Dental Council, the Allied Health Professionals Council, the Nurses and Midwifery Council and Pharmacy Council are discussed.

The Medical and Dental Council in Ghana is one of the respected health regulatory bodies. This council as the name suggests is responsible for the training, supervision and regulation of medical doctors and dentists in Ghana. The council was established initially through the Medical and Dental Council Decree (1972) NRCD 91, and then later given further authority and legal backing through the Health Professions Regulatory Bodies Act, 2013 (Act 857). Given the important role doctors and dentists play at the forefront of healthcare delivery in Ghana, the Medical and Dental Council can be said to be one of the influential councils in Ghana that regulates the conduct and professional standards of two important categories of staff in Ghana's healthcare sector.

The vision of the Medical and Dental Council in Ghana is "Ensuring the highest level of training of Medical and Dental Practitioners, and determining the adequacy & quality of service facilities." This vision is executed through the mission which boldly declares that the council seeks to be "An internationally acclaimed competent regulatory authority for medical and dental practice in Ghana, for the public good." Some of the functions performed by the Medical and Dental Council in Ghana include: "Ensuring that courses of study and training in medicine or dentistry at any medical school or University in Ghana are such as can sufficiently guarantee possession of the knowledge and skill needed for the efficient practice of medicine or dentistry, prescribing standards of professional conduct, upholding and enforcing such standards by the disciplinary powers conferred upon it by this Decree and also being responsible for the keeping of registers of duly qualified practitioners" (MOH, 2023).

The Medical and Dental Council therefore by its role contributes to healthcare governance in Ghana by ensuring that medical doctors and dentists are properly regulated in

every area pertaining to the practice. This includes their training at the university, post-graduate levels and during their professional practice. The presence of this council has helped to create a safe space within the healthcare sector, as patients are assured of the highest possible standards for the training and practice of medicine and dentistry in Ghana.

2.2.3 Allied Health Professionals Council

The Allied Health Professionals Council refers to the regulatory body in charge of training and certifying allied health professionals in Ghana. Allied health professionals refer to a group of technical staff who provide a range of healthcare services such as diagnostic, technical, technical, therapeutic and other support services in the healthcare sector (Dodd et al., 2009; Turnbull et al., 2009; Browne et al., 2017). Allied health professionals include but is not limited to laboratory staff, radiographers, physical therapists, dieticians, etc. (Reddick et al., 2012; Somerville et al., 2015). In Ghana, the body that is responsible for regulating the conduct of this category of health workers is the Allied Health Professionals Council.

The council was established and given regulatory authority through an Act of Parliament, specifically, Act (857, 2013). This act empowered the council to regulate the training and practice of Allied Health Professions in Ghana. As with the other councils discussed, the Allied Health Professionals Council is responsible for ensuring that professionals within this category receive the appropriate training to prepare them for the demands of the job, and to ensure that health institutions in Ghana are staffed with quality and competent staff who can execute their duties with quality care as the main focus.

As part of its remit, the Allied Health Professionals Council is tasked with ensuring that members undergo constant upgrades to meet up to global standards of healthcare delivery in Ghana. To be able to achieve this goal, the council partners with other institutions and organisations to organise Continuing Professional Development (CPD) programmes designed to help allied health professionals upgrade their skills. In Ghana, the council takes this task seriously and has developed a point system which each member is required to adhere to to achieve the necessary qualifications for renewal of license. Information on the website of the council indicates that "All professionals must show evidence of a minimum of 20 CPD points before they are allowed to renew their PINs for the year…" The various point systems range from the level of qualification; from degree and above, a minimum of 20 points is expected, whilst, for members holding diplomas, a minimum of 15 points is expected. For members holding certificates, a minimum of 10 points is expected. On the website of the council, it has been stated that "The Council does not organise CPD programmes. However, it reviews, and accredits CPD programmes and awards the respective points for the accredited organization. This is done to ensure quality control." Thus, the Allied Health Professional Council facilitates the training and continuous development of its members to ensure that they make a positive impact on the job and contribute towards quality service delivery in Ghanaian healthcare institutions.

2.2.4 Nurses and Midwifery Council

In Ghana, all nurses and midwives fall under the umbrella and remit of the Nurses and Midwifery Council. This body is one of the long-standing regulatory bodies for personnel in Ghana's health sector. Initially, the mandate for the Nurses and Midwifery Council was gained from the NRCD 117 of 1972 and the LI 683. This was the legal instrument backing the operations of the council, and for years held the council afloat in its role as the sole body licensed and permitted to regulate the operations and conduct of nurses and midwives in Ghana.

In 2013 however, Part III of the Health Professions Regulatory Bodies Act 2013 (Act 857) granted further clarity and authority to this council to perform its role as the body responsible for providing the highest standard of training and operational excellence standards for nurses and midwives in Ghana.

The vision of the Nurses and Midwifery Council is "Optimizing the use of ICT solutions in line with the 4th Industrial Revolution for Improved nursing and midwifery regulation." This vision is executed through the following mission: to "Secure in the public interest the highest standards of training and practice of nursing and midwifery." The council's sole remit is to ensure that nurses and midwives in Ghana receive quality training which prepares them for the expectations and demands of the job, where they are required to demonstrate the highest form of standards in service to patients.

All nurses and midwives in Ghana are required to be registered by this council and renew their membership annually. This council is the only legally recognised body in charge of regulating the behaviour of nurses and midwives in Ghana. From a healthcare governance perspective, the Nurses and Midwifery Council defines the content of training, stipulates the duration of the training, and ensures that all the professional requirements for being a nurse and midwife in Ghana are fulfilled before an individual is certified as either a nurse or midwife.

2.2.5 Pharmacy Council

Last but not least, the Pharmacy Council (PC) of Ghana is another important regulator which oversees the training, appointment and conduct of pharmacists in Ghana. The Pharmacy Council in Ghana was established through the fourth and fifth aspects of the Health Professions Regulatory Bodies Act (Act 857) which was passed in 2013. The purpose of the PC in Ghana is to oversee and regulate the behaviour, conduct and professional ethics of pharmacists in the country. The vision of the Pharmacy Council is "To guarantee the highest levels of pharmaceutical care". This is supported by their mission which states that "The mission of the Pharmacy Council is to secure the highest level of pharmaceutical care by ensuring competent pharmaceutical care providers who practice with agreed standards and are accessible to the whole population." From this statement, the purpose of the council is clear; to ensure that members contribute to the highest level of professional pharmaceutical care through adherence to established standards of practice.

The existence of the pharmacy council ensures that all pharmacists in the healthcare sector in Ghana are under regulation and certification. This implies that only qualified individuals are granted the license to practice and operate or manage a pharmacy. This role is an important governance role as it ensures that the roles and dynamics of pharmacists in Ghana's healthcare sector are clearly defined for members, and also regulated to ensure strict compliance. The pharmacy council also ensures that members act ethically to ensure that quality and affordable pharmaceutical care is made available to the population. This is an important regulatory role due to the important role of pharmacists in healthcare service delivery and within the healthcare value chain. The extended form of the mission of the Pharmacy Council also states that "…In addition, we shall collaborate with related local agencies and international pharmaceutical organisations to enhance our effectiveness and our contribution to rational drug use in the

nation. This mission shall be carried out with dedication, integrity and professionalism." The council therefore also acts as a bridge to other international agencies whose partnership and collaboration efforts can help to raise the collective standards in the Ghanaian pharmaceutical industry.

2.3 Classification of Healthcare Institutions in Ghana

In Ghana, various healthcare institutions provide services to patients across the length and breadth of the country. These institutions are classified according to district, regional and teaching hospitals (MoH, 2023).

2.3.1 District Hospitals

According to information from the Ministry of Health (MoH), district hospitals are the first point of call in the primary healthcare system in Ghana. There are three levels of healthcare institutions namely: (1) Primary (2) Secondary, and (3) Tertiary health institutions (MoH, 2023). District hospitals form part of the primary healthcare system which comprises all institutions (clinics, health centres, and hospitals) and individuals whether private, public or traditional (MoH, 2023). The MoH describes district hospitals as healthcare institutions that provide services such as clinical (outpatient and inpatient) and maternity services and serve as backups for health centres in the district (MoH, 2023). They are important in the general healthcare structure of the country.

2.3.2 Regional Hospitals

Regional hospitals are classified as second referral-level health institutions (MoH, 2023). Regional hospitals in Ghana are healthcare institutions which have facilities that offer specialized clinical and diagnostic care in broad specialized areas like medicine, general surgery, paediatrics, and obstetrics and gynaecology (MoH, 2023). When cases are beyond the capacity of the district hospitals, they are usually referred to the regional hospitals.

2.3.3 Teaching Hospitals

Last but not least in terms of the classification of healthcare institutions in Ghana are the teaching hospitals. According to the MoH, teaching hospitals are at the zenith of healthcare management and specialized care in Ghana (MoH, 2023). Teaching hospitals play a dual role in handling complex health cases, whilst also serving as a hub for training undergraduate and postgraduate doctors as well as other health professionals such as nurses, and laboratory technicians, to name a few (MoH, 2023).

2.4 Challenges in Healthcare Governance in Ghana

The governance of healthcare institutions is a complex issue especially when viewed from a public perspective (Abor et al., 2008; Saleh, 2012; Anabila et al., 2020). Private healthcare institutions appear to have a more straightforward governance system, which is not too different from private corporate entities (Abor et al., 2008; Abor, 2015).

2.4.1 Member Selection

One of the challenges in healthcare governance in Ghana pertains to the selection of members to occupy certain positions within the hierarchy of healthcare institutions in Ghana. There are various positions within the healthcare system which are designated to certain candidates who may not necessarily be the most qualified or competent, but who due to certain affiliations and professional connections may have access to such positions (Troisi & Guida, 2018). Leadership positions within healthcare institutions are a much-debated topic (Doherty et al., 2018), and anecdotal evidence suggests that in some cases, medical professionals occupy certain leadership positions in the healthcare sector which would have been better served being managed by experienced administrators. Such incidents are often rife in the public sector and sometimes contribute to various challenges in healthcare administration and service delivery. In private organisations, there are clear structures and appointment and recruitment are based

on competence and also the ability of the institution to remunerate the experts suitable for the roles required (Kiyak et al., 2011; Nicol et al., 2014; Restivo et al., 2022).

2.4.2 Political Interference and Succession

One of the main challenges when it comes to healthcare governance, especially in the public sector is political interference and succession (Abor et al., 2008; Carbone, 2011). In Ghana, political parties that win power form their government and make appointments to various government institutions (Koduah et al., 2016). The healthcare sector is also affected by this situation, leading to changes in the management and leadership of healthcare institutions depending on the outcome of elections (Abor et al., 2008). This severely impacts strategy and succession planning for the continuity of projects as each regime often has their own vision, policies and ideologies for the health sector. This is one of the challenges that this study has identified in relation to the governance mechanism and leadership of public healthcare institutions in Ghana. Abor et al. (2008) commented on this issue in their paper examining the nature of hospital governance in Ghana. this suggests that this challenge is very much a practical issue and not merely theoretical.

2.4.3 Organisational Culture and Climate

Lastly, the issue of organisational culture is a significant challenge to hospital/healthcare governance in Ghana especially in the public sector. As discussed in earlier sections, there is a general perception that public sector health institutions are fraught with various service delivery challenges (Azila-Gbettor et al., 2013; Adua et al., 2017; Assan et al., 2019). Some of these challenges have been attributed to staff attitude, which can be traced to the organisational culture and climate inherent in public healthcare institutions in Ghana (d'Ambruoso et al., 2005; Alhassan et al., 2013). Unfortunately, there is little empirical evidence to substantiate this point,

however, substantial anecdotal evidence does suggest that this is very much a real institutional challenge, which calls for further research attention.

2.5 Comparative Assessment of Service Delivery between Selected Healthcare Institutions in Ghana: The Role of Governance Mechanisms

It has been a long-held perception that private healthcare institutions perform better than public institutions in Ghana (Abor et al., 2008). This perception is rooted in anecdotal experience and some research findings which suggest that private institutions tend to operate with higher standards of quality, coupled with employee proactive citizenship behaviours. This view is also supported by existing notions on the state and quality of service delivery by all forms of public institutions in Ghana, not just limited to the health sector (Atinga et al., 2011; Abuosi & Atinga, 2013). Ghanaians have for decades complained about the lax service delivery and attitude of staff in public institutions (Azila-Gbettor et al., 2013; Abuosi & Atinga, 2013). In the healthcare sector, it appears this situation is not dissimilar. Even though on paper, public health institutions are supposed to be more equipped both in terms of financial, human resources and government funding and backing, the reality is that these supposed resource advantages have not exactly translated into the dynamic capabilities that are required to positively transform the state of healthcare delivery in Ghana.

Some existing studies have attempted to offer insight into the nature of service delivery in public and private health institutions in Ghana (Hutchinson et al., 2011; Azila-Gbettor et al., 2013; Anabila et al., 2019). These past studies have however focused on issues pertaining to…unfortunately, there has been little attempt to investigate how the governance mechanism of healthcare institutions influences service delivery outcomes in the health sector. This is where the present study seeks to contribute, by explicating the influence of governance

mechanisms on service delivery outcomes within the health sector, and specifically amongst public and private healthcare institutions in Ghana.

This study has become essential due to the need to consider how the type of governance system in place in healthcare institutions impacts service delivery. It has also become necessary to examine the nature and effectiveness of governance mechanisms in the healthcare sector in relation to their attributes, dynamics and roles, and how these three elements combine to enhance the efficiency and effectiveness of service delivery to patients. Table 2.1 offers some perspective on perceived service delivery challenges between public, private, mission and quasi healthcare institutions in Ghana.

Table 2.1- Comparison of Service Delivery Challenges between Public, Private, Mission and Quasi Healthcare Institutions in Ghana

Challenge #	**Public Healthcare Institution**	**Private Healthcare Institution**	**Mission-Based Healthcare Institutions**	**Quasi Healthcare Institutions**	**Supporting References**
1.	Employee attitudes and customer complaints	Funding challenges	Limited resources	Legal and ethical considerations	Abor et al. (2008) Abor (2015) Abor (2016) Afriyie et al. (2020)
2.	Queuing and delays in service delivery due to inefficient systems	Limited scope as compared to government institutions (number of facilities, regional coverage etc.)	High patient load	Challenges in integrating and collaborating with traditional healthcare systems	Mital (2010) Ir et al. (2011) Bhattacharjee, et al. (2014).
3.	Bureaucracy in service delivery	High cost of recruiting specialist health practitioners	Competition with private hospitals	Public perception	Oliviera et al. (2020) Veronesi et al. (2019)

4.	Low technology adoption in customer management	High cost of acquiring technology to enhance service delivery	Financial sustainability	Funding and sustainability	Feibert & Jacobsen (2019) Zhu et al. (2022)
5.	Low staff motivation reflected in service delivery	Regulatory and administrative challenges	Recruitment and retention of staff	Regulatory and quality control compliance	Hastings et al. (2014) Lopez-Valeiras et al. (2018)

Table 2.1 presents some of the challenges in service delivery by public and private healthcare institutions in Ghana. In public healthcare institutions, the major challenge includes employee attitudes and customer complaints. Some studies have found that the behaviour and attitude of staff during service delivery contributes to negative patient experiences and perceptions (Abekah-Nkrumah et al., 2021). Some staff behave rudely and demonstrate unhospitable/uncivil customer service behaviours such as shouting on patients, fidgeting on mobile phones and displaying rude facial demeanours (Amporfro et al., 2021). Another challenge plaguing public healthcare institutions is the systemic inefficiencies leading to bureaucracy during procurement and consequently queuing for service delivery at hospitals (Abor, 2016). Public hospitals are also deemed to be slow to adopt modern technology to monitor employee and customer processes unlike private hospitals that are innovative and deploy cutting edge technology to enhance patient satisfaction (Oppong et al., 2023). Another major challenge confronting public healthcare institutions is low staff motivation emanating from poor conditions of service, resulting in poor customer service attitudes (Adongo et al., 2022).

Private healthcare institutions are constrained by inadequate funding and limited government support. As a result, they have limited scope, capacity and equipment compared to public and teaching hospitals (Abor, 2016). Due to the service standards and expectations of private healthcare institutions, they pay more to recruit staff (Adongo et al., 2022). Private healthcare institutions are also constrained by the high cost of procuring medical equipment for specialised services as well as administrative and operating expenditure (Abor, 2016; Adongo et al., 2022). Mission hospitals have limited resources but high patient volumes due to subsidised services and prices for treatment (Kumah et al., 2025). Mission hospitals compete with private hospitals and are similarly constrained by financial limitations. Attracting and maintaining staff is another challenge that mission hospitals encounter (Kumah et al., 2025).

Quasi healthcare institutions are not immune from challenges in fulfilling their healthcare mandate. These institutions are also hindered by bureaucracy, legal and ethical considerations emanating from their ownership model and management structure (Abor, 2015, 2016). Their ownership model also presents some challenges in integrating traditional healthcare management systems (Abor, 2016). Some studies note that these institutions are not immune from funding and sustainability issues whilst also contending with quality control and regulatory compliance (Agbatsi et al., 2024).

2.6 Chapter Summary

This chapter provided a background on the health sector in Ghana by identifying the major institutional stakeholders within the Ghanaian health sector whose activities, policies and actions impact the performance of public and private healthcare institutions in Ghana. The chapter commenced by profiling the Ministry of Health, in terms of its function, purpose, mission, vision and hierarchical structure. This led to further discussions on the other related

agencies that work hand in hand with the MoH. The chapter also highlighted the role of regulatory agencies such as HEFRA, who play a critical role in licensing and regulating public and private healthcare facilities/institutions. Other important issues which were captured within this chapter included government policy influencing the governance of healthcare institutions, as well as challenges in healthcare governance in Ghana. Furthermore, a comparative assessment of service delivery between public and printer healthcare institutions was presented, thus providing ample contextual information for this study. The next chapter presents a review of pertinent literature related to the concept of healthcare governance systems and its influence on service delivery within the healthcare sector.

CHAPTER THREE

LITERATURE REVIEW

3.0 Chapter Overview

This chapter presents a review of literature. This entails a conceptual, empirical and theoretical review of hospital governance literature and the underpinning theories of this study. The Signaling Theory and Managerial Hegemony Theory are discussed as the underpinning theoretical framework. This chapter commences with the conceptual review of hospital governance and its outcomes. Additionally, the chapter provides an empirical review which highlights existing studies that have focused on hospital governance, the key issues examined, methodologies and underpinning theories. A conceptual framework is also provided to depict the key relationships being examined, albeit from a qualitative perspective as highlighted in the fourth chapter of this study. Essentially, this chapter provides a conceptual, empirical and theoretical examination of hospital governance literature and related theories.

3.1 Conceptual Review of Hospital Governance Literature

It is important to note that the concept of hospital governance is a macrocosm of organisational governance and borrows its foundations from the practice of corporate governance applied in mainstream organisations (Abor, 2008; Abor, 2015; DeRegge & Eeckloo, 2020). However, over the years, researchers have investigated the nature of governance within the health sector and developed conceptualisations of governance which can be applied in the management of healthcare institutions.

3.1.1 The Concept of Governance in Organisations

Presently, the concept of corporate governance has permeated various industries from banking, retail, insurance even to the healthcare sector (Bhagat & Bolton, 2019; Puni & Anlesinya, 2020). Corporate Governance "pertains to the organization (firm) as a nexus of contracts. At one level, a firm's governance can be viewed as the set of structures that provides the boundaries for the operation of the enterprise. This entails not only participants such as workers, managers, and suppliers of capital, but also the returns to those participants and the constraints under which they operate" Gillan and Starks (1998, p. 12). From this definition, corporate governance can be construed as the management of contracts and relationships within an institution which is underpinned by a defined structure and boundaries which regulate the operations of the enterprise. From this definition, the practice of corporate governance can be deemed to be relevant to healthcare institutions as it represents a mechanism for overseeing the successful operations of an organisation.

OECD (2004) defines corporate governance as a system that influences how business corporations are directed and controlled. The corporate governance structure specifies the distribution of rights and responsibilities among different participants in the corporation, such as, the board, managers, shareholders and other stakeholders, and spells out the rules and procedures for making decisions on corporate affairs. By doing this, it also provides the structure through which the company objectives are set, and the means of attaining those objectives and monitoring performance". The concept of governance in organisations has largely been centred on corporate governance (Purbawangsa et al., 2020; Tibiletti et al., 2021). The extant literature reveals that how organisations are managed and overseen has over the years been categorized under corporate governance practices (Aslam & Harod, 2020; Gerged, 2021).

Sheikh & Alom (2021, p.260) also argued that corporate governance is a practice which "mainly controls how well the interest of the stakeholders are being maintained, reflecting the need for accountability in handling money and the ways of commercial activities. It primarily aims to enhance corporate transparency and accountability." Governance in organisations is therefore an activity that is meant to manage the expectations and resources of stakeholders. In the next section, the concept of hospital governance is discussed.

3.1.2 Hospital Governance: Definitions of Concept

Hospital governance refer to the various mechanisms healthcare institutions use to oversee day-to-day operations in order to facilitate the delivery of quality healthcare services to clients (Eeckloo et al., 2004; Abor et al., 2008; DeRegge & Eeckloo, 2020). Before establishing the premise for the concept of hospital governance, it is important to note that previous studies by scholars such as Abor et al. (2008) have questioned whether corporate governance principles applied in mainstream organizations can be applied in the healthcare sector and used to achieve similar outcomes or results. The general consensus from Abor et al. (2008) is that corporate governance principles can be applied in the healthcare sector to enhance the management and operations of healthcare institutions. This view is in contrast to the recent claim by Dion and Evans (2023, p.2) that "Health governance can be broadly divided into two categories: health system governance and corporate governance." According to Dion and Evans (2023), both levels of governance play important roles within their respective domains.

The World Health Organization (WHO, 2020) defines hospital governance as a set of processes and tools that manage decision-making, shape organizational behaviour and address the complex relationships among stakeholders (Saltman et al., 2011). The scope of hospital

governance includes values such as ethics and equity, access, quality, patient responsiveness and patient safety (Saltman et al., 2011). Hospital governance aims to improve the quality and safety of healthcare by fostering an environment that supports excellence in clinical care (Scally & Donaldson, 1998). It requires healthcare professionals to act as stewards of the healthcare system and to prioritize improvement and patient safety (Gauld, 2017; Scally & Donaldson, 1998). Hospital governance can take various forms, including establishing boards that bring together professionals from different organizations, partnerships between management and professionals and the creation of professional leadership roles (Brennan & Flynn, 2013; Gauld & Horsburgh, 2020; Travaglia et al., 2011). However, the view of scholars in the area (e.g. Dion & Evans, 2023) is that for hospital governance to be effective, it requires a commitment from healthcare professionals and strong management support, to ensure that it does not operate in parallel with corporate or managerial leadership (Scally & Donaldson, 1998). Hospital governance is a system that aims to improve the quality and safety of healthcare through accountability and transparency. It originated in the UK, Canada and Australia in the 1990s as a response to increased litigation and dissatisfaction with healthcare institutions (Dion & Evans, 2023).

The key objective of hospital governance is to ensure that the quality and safety of medical services and procedures are given top priority within healthcare institutions, operations and performance, with the ultimate goal of improving patient outcomes (Dion & Evans, 2023). Adhering to good hospital governance practices can lead to a change in culture and systems, resulting in increased transparency, accountability and opportunities for continuous learning and improvement. Additionally, hospital governance also fosters greater involvement in governance by both clinicians and patients (Gauld, 2014). Hospital governance provides the impetus for cross-functional governance that involves network governance within a healthcare

organization. Health professionals, who have first-hand experience with the healthcare system and can lead change, are viewed as stewards of the system and play a crucial role in improving quality and patient safety (Gauld & Horsburgh, 2014; Scally and Donaldson, 1998).

The focus of hospital governance is to promote quality improvement in healthcare, with a particular emphasis on patient outcomes. Empirical research on hospital governance remains limited (DeRegge & Eeckloo, 2020), with most studies focused on the theories of corporate governance (Brown, 2019), board functions (McDonagh, 2006) and hospital autonomy (Saltman et al., 2011). The healthcare industry is undergoing significant changes and transformations, as many industrialized countries seek to improve access, reduce costs and eliminate excess capacity (Weil, 2003). Governments are promoting integration through legislation and incentives, resulting in a wave of mergers and divestitures in the US and the creation of integrated delivery systems (IDS) that often span multiple states (Weil, 2003). Despite these efforts, research has shown mixed results regarding the success of IDS, with some studies finding that they have not had a significant impact on quality or costs (Weil, 2003). Possible reasons for this lack of success include oligopolistic behaviour, integration and coordination issues and a disconnect between boards and local communities (Weil, 2003). The increasing complexity of governance structures in healthcare systems is also noted.

3.3 Examining the Structure and Components of Hospital Governance

Hospital governance has been measured in different dimensions from various research studies (Abor et al., 2008; Abor, 2015; DeRegge & Eeckloo, 2020). Some studies have focused on the traditional corporate governance structure which includes the board of directors and management (Dixit, 2017; Duran et al., 2019). These studies have largely conceptualised

hospital governance structures as comprising of ownership, oversight and implementation team (DeRegge & Eeckloo, 2020; Gautier et al., 2023). Studies focusing on the ownership dimension of hospital governance have been focused on establishing the variations between public, private and other types of healthcare facilities such as religious/mission-based and quasi healthcare institutions (Abor et al., 2008; Abor, 2015). However, in terms of structure, there is a consensus amongst researchers that every healthcare institution has an ownership structure which comprises of shareholders who fund the operations of the hospital (Ditzel et al., 2006; DeRegge & Eeckloo, 2020).

In public healthcare institutions, governments typically own the healthcare facility and are responsible for funding the payroll of staff, operations, processes and maintenance of the healthcare institution and its facilities (Akortsu & Abor, 2011; Abor, 2015). Indeed, when contrasting public healthcare institutions with the other types of healthcare institutions (private, mission-based and quasi), one argument that can be advanced is that public healthcare institutions tend to have larger budgets and funding capacity due to the influence, networks and resources the government is able to mobilise and harness (Abor et al., 2008; Abor, 2015; Quah & Neo, 2015). Private healthcare institutions are also owned by private individuals, often medical practitioners or individuals with a vested interest in the health sector who seek to establish private facilities to promote quality healthcare delivery (Pillay, 2008; Jha & Epstein, 2010).

Mission-based or religious healthcare institutions are established and owned by religious organisations such as churches or mosques, and in Ghana, there are various examples of healthcare institutions that have been established by orthodox and charismatic churches as well

as the Ahmadiyya Muslim Hospital and other related mission hospitals (Abor et al., 2008; Abor, 2015). Quasi health institutions are owned by state institutions that function as private entities without much government interference (Buse & Waxman, 2001; Reich, 2002; Bary & Nundy, 2008). Examples of such healthcare institutions are the Volta River Authority (VRA) Hospital, Social Security and National Insurance Trust (SSNIT) Hospital, Ghana Ports and Harbour Authority (GHAPOHA) Hospital, to name a few (Abor et al., 2008; Abor, 2015).

Another recognised element of healthcare or hospital governance structure is the oversight dimension. Oversight pertains to the group of individuals appointed to safeguard the interests of shareholders or owners (Buse & Harmer, 2007). Previously, the dimension of ownership as a component or hospital governance was discussed. When owners establish a healthcare facility, they often appoint a board of directors to oversee the formulation of policies and guidelines to ensure the institution is able to achieve its goals and objectives (Abor et al., 2008; DeRegge & Eeckloo, 2020). Board of directors therefore represent the oversight dimension of hospital governance (Eeckloo et al., 2004; Abor, 2015), and can determine the success or failure of healthcare institutions. Over the years, Abor et al. (2008) and DeRegge and Eeckloo (2020) have investigated various factors influencing the oversight dimension, including issues such as board diversity, board size, board representation, to name a few. The increased attention of governance scholars on the nature, composition and activities of the board suggests that it represents an important component of hospital governance which primarily sets the tone for decision-making and implementation in the institution.

Abor et al. (2008, p.47) noted that "Most hospitals have their own governing board and a professional team of executive managers. Together they constitute the axis of 'hospital governance', which is the process of steering the overall functioning and effective performance of a hospital". This perspective suggests that the oversight dimension of hospital governance pertains to the role of the hospital board in overseeing the affairs of the hospital through interactions and delegation of power to an executive management team. The oversight dimension mainly comprises of the board of directors, and this element or component of hospital governance is present in public, private and other forms of healthcare institutions (Abor et al., 2008; Abor, 2015; DeRegge & Eeckloo, 2020). The presence of a board of directors is largely regarded as a signal of quality governance within organisations, and the same remains true for healthcare institutions.

Another conspicuous component of the governance structure of healthcare institutions is the implementation team. Much like in the case of corporate organisations, hospitals are also run by management teams (Koufopoulos et al., 2008; Kashmiri & Brower, 2016; Al-Matari, 2022). The management team are in charge of implementing the policies formulated by the board and ensuring that the day-to-day operations of the institution are geared towards positive results (Belbin, 2010; Al-Matari, 2022). The board of directors, headed by the board chair are not responsible for overseeing the implementation of strategy; that is the duty of the implementation team comprising of the chief executive/managing director, and their team of functional heads across the various departments (Chen, 2011; Brunninge et al., 2007). In the hospital setting, literature reveals that this structure is true and executive management members are appointed and remunerated to oversee the operational affairs of hospitals and ensure quality care, patient satisfaction and other related outcomes are a reality and not an illusion (DeRegge & Eeckloo, 2020).

3.4 Classification of Healthcare Institutions and Implications on Hospital Governance

An enduring theme in the literature on hospital governance pertains to the nature and classification of healthcare institutions and its implications for the management and direction of these institutions (DeRegge & Eeckloo, 2020). It has been established that the type of institution and form of ownership plays an important role in the governance of the healthcare facility and its related processes and services (Abor et al., 2008). Abor (2015) in a study titled "the effects of healthcare governance and ownership structure on the performance of hospitals in Ghana" argued that hospitals with a governing board perform better than those that operated without one. This study acquiesces with this notion and further advances the argument that hospitals that have clearly defined governance structures are run better than those without one.

One key determinant of hospital governance structures however, is the classification of the healthcare institution according to form of ownership and management (Jha & Epstein, 2010; Brandao et al., 2013). In support of this argument, Abor et al. (2008) posited that three types of healthcare systems exist namely liberal healthcare system, plural healthcare system, and socialistic healthcare system. The type of healthcare system in place determines the nature of healthcare institutions that are populous within the system (Abor et al., 2008; Stritecky & Pirozek, 2002). The study by Stritecky and Pirozek, (2002) as cited in Abor et al. (2008) reveals that "a liberal healthcare system prefers private ownership of healthcare organizations; in a plural healthcare system, both private and public ownership are recognized; in a socialistic healthcare system, all the healthcare organizations are owned publicly". This indicates that the nature and plethora of healthcare institutions in a country depends on the kind of healthcare system in place.

A review of the extant literature on healthcare management and governance reveals that there are four (4) major classifications of healthcare institutions namely (i) Public Healthcare Institutions (ii) Private Healthcare Institutions (iii) Mission-Based/Religious Healthcare Institutions and (iv) Quasi Healthcare Institutions (Abor et al., 2008; Eeckloo et al., 2007; Abor, 2015; DeRegge & Eeckloo, 2020). These institutions gain their status from the form of ownership and control, which further influences the type of governance and organisational hierarchy and processes inherent within the institution. In the healthcare sector, the nature of service delivery and the implications on human health and life have led to a highly regulated industry/sector where the establishment of healthcare facilities entails many rigorous regulatory processes (WHO, 2011). As such, these four general healthcare facilities are widely regarded to be the recognised forms of healthcare institutions that deliver services to citizens in various economies around the world (Anderson, 2012; Simonet, 2013; DeRegge & Eeckloo, 2020). These four healthcare institutions are discussed in the ensuing sections.

3.4.1 Public Healthcare Institutions

Abor (2015, p.107) claims that "the capacity of any government to provide a good standard of healthcare is considered as one of the most important elements contributing to a country's standard of living, and hospitals play a major role in the delivery of healthcare." This assertion is valid as governments are largely considered to be the overlords of a country, and primarily responsible for quality healthcare services. Abor's (2015) assertion further highlights the role of governments in providing quality healthcare to citizens. It is on this basis that public healthcare institutions have been established all over the world. Eeckloo et al. (2004) report that in Europe, most hospitals were established by the state and are classified as public healthcare institutions. As stated earlier, evidence supports the assertion that public healthcare institutions can be defined by their ownership, management appointment and power dynamics.

Eeckloo et al. (2004) reasons that one of the conspicuous major characteristics of commercial enterprises lies in their ownership. “In a for-profit context, a well-defined relationship between ownership and control is the predominant aim of any model of corporate governance” (Eeckloo et al., 2004, p.4). Therefore, public institutions are defined by their ownership and control, and this is evident in the appointment of individuals for the board and management committees. Public healthcare institutions are also bound by the concept of accountability, and are subjected to regular audits and reviews (Dixit, 2017; Duran et al., 2019). The purpose of these reviews is to ensure that management and board of directors are fulfilling their fiduciary duties towards shareholders.

Public healthcare institutions are established based on the notion that healthcare is a social good, and governments owe it to citizens to provide the conditions for this social good to be delivered at reasonable prices but at the highest possible quality (Ditzel et al., 2006). Public healthcare institutions cater for a large group of stakeholders, and each group of stakeholders’ merit recognition of its interests (Duran et al., 2020; Duran et al., 2019; DeRegge & Eeckloo, 2020). Public healthcare institutions owe a duty of responsibility and care to all its stakeholders and is expected to contribute to the added value of other groups (Eeckloo et al., 2007; Lipunga et al., 2019). Together with a clear ownership structure, non-profit healthcare institutions also lack the principle of maximisation of profit. In corporations, profitability and share value constitute the most important criterion to assess decisions (Jha & Epstein, 2010; Al-Matari, 2020). In hospitals the objectives are less unequivocal and often contradictory. The main objective is of course to provide qualitative specialised care. But next to this, hospitals must also pay attention to the accessibility of this care and the financial equilibrium of the hospital’s exploitation.

3.4.2 Private Healthcare Institutions

Private healthcare institutions are hospitals and clinics which are established to deliver care and health services to patients (Eeckloo et al., 2004; DeRegge & Eeckloo, 2020). The distinguishing characteristics between private and public healthcare institutions is that whilst public healthcare institutions are owned by the government, and financed largely through government subventions, grants and resources, private healthcare institutions are often established and financed by private entities, mostly health practitioners who have decided to invest in the business of healthcare (Akmaz & Çadırcı, 2017; Maljichi et al., 2022). Private healthcare institutions are characterised by proper governance systems, professional Human Resource Management (HRM) practices and overall greater attitude and service delivery from staff (Maljichi et al., 2022).

3.4.3 Mission-Based/Religious Healthcare Institutions

Mission hospitals or healthcare institutions are healthcare facilities established by churches or other religious institutions to provide universal healthcare services to patients (Green et al., 2002; Abor et al., 2008; Levin, 2016). Whilst some mission hospitals initially set out to offer healthcare services to clients from their mission/church/religious institution, these services are generally extended to the public (Levin, 2014; Levin, 2016). Healthcare services provided by mission-based or religious healthcare institutions are prevalent not just in Ghana, but in various parts of Africa and other continents in the world (Eklof, 2008).

The church, and other religious organisations have become major stakeholders in the healthcare sector and have set up several healthcare institutions which are providing useful and urgent medical attention to clients all over the world (Habiyambere, 2018). In Ghana, the Catholic Church is an example of an institution that has established many healthcare facilities (Antwi et

al., 2014; Apedani et al., 2021). The Methodist, Presbyterian and other orthodox churches have also participated in the mandate of providing an outlet for the delivery of quality healthcare services (Antwi et al., 2014). It is worth noting that mission-based hospitals are not just established by churches, but also by other religions as mentioned earlier.

3.4.3 Quasi Healthcare Institutions

The last classification of healthcare institutions that are featured in this study are quasi healthcare institutions. These healthcare institutions can be defined as hybrid institutions that combine public-private ownership and administration (Abor et al., 2008; Abor, 2015; Smiley et al., 2019). They are often established by organisations that are public entities, but that have a large degree of autonomy from the government (Ofori, 2016). Quasi healthcare institutions have not been featured much in the extant literature on hospital governance, with this study aiming to make a contribution to the literature by examining the nature and composition of quasi healthcare institutions along with the other selected healthcare institutions. While both mission-based and quasi-governmental hospitals contribute significantly to healthcare delivery in Ghana, they differ in origin, governance, and operational ethos (Abor, 2016). Mission-based hospitals are typically established by faith-based organizations, religious missions, or charitable NGOs, driven by a moral or spiritual commitment to serve vulnerable populations (Abor, 2016; Kumah et al., 2025). Their governance structures are often independent of the state, though they may collaborate with government agencies for funding, training, or policy alignment. These hospitals prioritize community service, compassion, and equity, often operating in underserved regions with a strong emphasis on holistic care (Walker, 2022; Kumah et al., 2025).

In contrast, quasi-governmental hospitals are founded by government-owned entities or state-affiliated organisations, such as COCOBOD, SSNIT, or the Ghana Ports and Harbours Authority (GPHA), not directly under the Ministry of Health but still part of the public sector ecosystem (Abor, 2016). These institutions serve both employees of the parent organisation and the general public, operating with hybrid governance models that blend public oversight with private-sector management practices (Abor, 2016; Adongo et al., 2022). Their strategic decisions may reflect bureaucratic priorities, institutional mandates, or sector-specific interests (Abor, 2016). The key distinction lies in mission versus mandate: mission-based hospitals are guided by altruistic values and community service, while quasi-governmental hospitals are shaped by organisational mandates and semi-autonomous governance linked to state structures. Understanding this difference is crucial for analysing governance dynamics, accountability mechanisms, and service delivery models across Ghana's healthcare landscape.

3.5 New Public Management and Hospital Governance: Establishing the Link

The quest to improve public service delivery has resulted in various innovations in processes, systems, products and services which are underpinned by a concept referred to as New Public Management (NPM) (Schedler & Proeller, 2000; Christensen & Lægreid, 2017). An underlying and fundamental aim of New Public Management (NPM) reform program is to transform the organizational identity of public organizations into a business-like identity (Gruening, 2001; Pollitt et al., 2007). Scholars have over the years investigated the application of the NPM paradigm in the public sector, with increasing attention being paid to its application within the healthcare sector (Simonet, 2008; Simonet, 2015).

In the healthcare sector, Alonso et al. (2013) in their study on "the impact of new public management on efficiency: an analysis of Madrid's hospitals" revealed that New Public Management (NPM) policies have been adopted and implemented across a number of OECD countries as early as the 1980s. Alonso et al. (2013) reported that the adoption of NPM policies and strategies in the healthcare sector was in relation to various concerns from stakeholders emanating from increasing healthcare expenditure, advancements in technology in the healthcare sector and a rapidly ageing population. These findings were similar to the evidence submitted by Acerete et al. (2011) and Simonet (2013) who also unearthed some findings pointing to increasing costs of healthcare which was becoming a major concern, requiring new policy initiatives and innovations within the health sector.

A review of the extant literature led to some studies which have identified countries setting the pace in NPM implementation in the health sector. For instance, according to Alonso et al. (2013), Spain is one of the leading countries in the European Union (EU) who have successfully accelerated and implemented NPM reforms. Per the study by Alonso et al. (2013), NPM reforms in the healthcare sector in Spain were first introduced in the early 1980s, in parallel with political decentralization. The report further revealed that this decentralization enabled Spain's seventeen (17) regional governments to gain autonomy with regards to decisions to introduce or reinforce NPM into healthcare, including the adaptation of new hospital management models, such as different forms of Public Private Partnership (PPP) (Petmesidou & Guillén, 2008; Alonso et al., 2015). Since then, regional governments in Spain have increasingly introduced NPM reforms into healthcare, particularly in Catalonia and, at an accelerated rate, in Madrid (Gallo & GenéBadia, 2013). This study argues that the emergence of NPM and its focus on improving quality service delivery in public institutions can be one of

the anchors of the concept of hospital governance and can result in innovative governance structures, systems and processes in the healthcare sector.

In Ghana for example, even though there have been various examples of NPM adoption in the public sector, as evidenced by e-Governance implementation in state institutions like the Passport Office and Registrar General's Department, the healthcare sector is one vital area within the public sector that can also benefit from the adoption of NPM. Based on the evidence from the extant literature, the adoption and implementation of NPM in the healthcare sector can be a catalyst to innovation, reduced costs and greater overall efficiency and quality service delivery. The four selected healthcare institutions in Ghana that are examined in this study; that is, private, public, mission and quasi health institutions can benefit from the adoption of the NPM paradigm as it propagates the adoption of efficient strategies to improve service delivery, innovation through technology and overall greater accountability for stakeholders.

3.6 Relevance of Governance Mechanisms in the Healthcare Sector

Governance mechanisms play an important role in ensuring that quality healthcare services are delivered to patients (Simonet, 2015; Al-Matari, 2020). Over the years, various scholars have pursued diverse interests pertaining to the concept and practice of hospital/healthcare governance in order to unravel key components and dimensions (DeRegge & Eeckloo, 2020). New themes and issues are still emerging and the area of hospital governance represents a distinct research domain, which is still being compared to the practice of governance in the corporate world (DeRegge & Eeckloo, 2020). One of the core benefits of governance mechanisms is accountability (Eeckloo et al., 2004; Eeckloo et al., 2007). Corporate governance stands for the system by which companies are directed and controlled, and the core

benefit it bestows is to ensure that management are upholding their duty to manage the resources of the firm to maximise shareholder returns on investments (Pilon & Brouard, 2023).

Accountability has a qualitative and quantitative connotation and thereby has become a general designation for all kinds of rules and guidelines intended to optimise the governance structures of corporations (Abor, 2015; Bakalikwira et al., 2017). Hospital governance is relevant as it is based on the two pillars of transparency and accountability towards shareholders, and should ultimately lead to quality service delivery and maximum long-term shareholder value in the health sector (Nunes et al., 2023; Pilon & Brouard, 2023). It also involves a consideration of the interests of the stakeholders, which refer to any group or individual who can affect or is affected by the achievement of an organisation's purpose. This automatically includes employees and clients who are two primary stakeholders being explored in this study.

Another reason underscoring the need for hospital governance in the healthcare sector is oversight for quality service delivery. governance mechanisms act as frameworks for improving service delivery (Eeckloo et al., 2004; Abor et al., 2008; DeRegge & Eeckloo, 2020). One of the research questions underpinning this study pertains to the influence of healthcare governance mechanisms on quality-of-service delivery within the health sector. Quality service delivery has long been perceived as the core mandate of all healthcare institutions (Abor, 2015; Muniru & Abor, 2021), and the existence of governance mechanisms helps to facilitate the delivery of quality services to clients.

3.7 Healthcare Governance Mechanisms: Exploring the interrelations between Attributes, Roles and Dynamics in the Management of Healthcare Institutions

DeRegge and Eeckloo (2020) in a recent review of the literature on hospital governance over a fifteen (15) year period highlighted some major deficiencies in the hospital governance literature. These deficiencies pertain to the issues that have been neglected, whilst the literature has focused extensively on exploring the attribute dimension of governance which merely examines the characteristics of governance in terms of board size, board composition and representation. DeRegge and Eeckloo (2020) noted that over the past fifteen years, various scholars have investigated the nature of hospital governance but have limited their discourse to the "attributes" of healthcare governance which can essentially be described as board size, composition and representation. DeRegge and Eeckloo (2020) in their paper noted that the issue of hospital governance cannot be restricted to the attributes dimension.

The systematic review spanning a period of fifteen (15) years revealed that issues on hospital governance extend beyond board size and composition, and include elements pertaining to dynamics and roles which are two other broader elements that DeRegge and Eeckloo (2020) have introduced in the hospital governance literature. These observations also reflect earlier studies by Eeckloo et al. (2004) and Eeckloo et al. (2007) where it was established that even though governing boards were essentially in hospital governance, there was the need to consider how the extension and influence of the board can be executed through the management of healthcare facilities. This study therefore acquiesces with DeRegge and Eeckloo's (2020) proposition for new elements to be included in the study of hospital governance.

The dynamics element of hospital governance proposed by DeRegge and Eeckloo (2020) pertain to the behavioural dynamics, processes and transparency, whilst roles pertain to oversight roles, mission, strategy, and quality. DeRegge and Eeckloo (2020) also confirmed that other studies have increasingly posited that the governance of healthcare firms extends beyond the attributes and encompasses internal processes and dynamics that occur within boards (Brown et al., 2018; Büchner et al., 2014; Freeman et al., 2016; Kane et al., 2009; Millar et al., 2015). In general, the three components namely: attributes, processes, and roles are theorized as having an important role to play in clearly defining the structure of hospital governance (Nicholson & Kiel, 2004; Zahra & Pearce, 1989).

3.9 Empirical Studies on Hospital Governance

The extant literature has documented some empirical studies on healthcare/hospital governance over the years, and this section of the review is dedicated to reviewing the existing literature in order to unearth the issues, outcomes and gaps. Twenty (20) relevant articles pertaining to hospital governance were found in the extant literature and are reviewed in relation to their core issues and journal of publication.

Over the past three decades, empirical research on hospital governance has evolved from foundational models to nuanced, context-specific analyses. Early work by Weiner & Alexander (1993) laid the groundwork by distinguishing between corporate and philanthropic governance models, highlighting how structural orientation influences decision-making and accountability in hospital settings. Building on this, Eeckloo et al. (2004, 2007) advanced the conceptual shift from corporate governance to hospital governance, emphasising the need for sector-specific frameworks that account for clinical complexity and stakeholder diversity.

The pursuit of "good governance" was further explored by Ditzel et al. (2006), who identified key principles such as transparency, accountability, and stakeholder engagement. In Ghana, Abor et al. (2008, 2015) provided critical insights into how ownership structures and governance practices affect hospital performance, offering one of the few empirical lenses into governance dynamics in sub-Saharan Africa. Gorsky (2008) introduced the role of community involvement, underscoring the democratic potential of inclusive governance models.

The relationship between governance and quality of care was empirically validated by Jha & Epstein (2010), while Duran et al. (2011, 2019, 2020) developed comprehensive frameworks for assessing public hospital governance, integrating structural, functional, and contextual dimensions. Brandao et al. (2013) expanded the discourse by framing social responsibility as a governance imperative, aligning hospital missions with broader societal goals. Recent studies reflect a growing interest in reform, responsiveness, and resilience. Khulmann et al. (2016) and Rotar et al. (2016) examined shifts in governance roles and the involvement of medical professionals, while Dixit (2017) advocated for multi-perspective approaches to public hospital governance.

The COVID-19 pandemic prompted Gautier et al. (2023) to investigate governance adaptations under crisis conditions, revealing both vulnerabilities and innovations. A notable body of work by Lipunga et al. (2019–2023) systematically analysed emerging governance models, reform trajectories, legal frameworks, and actor awareness within public hospitals, particularly in African contexts. These studies collectively underscore the importance of aligning governance structures with institutional realities, regulatory environments, and performance expectations.

Together, this empirical corpus provides a rich foundation for conceptualizing governance as a dynamic interplay of attributes, roles, and signals, offering valuable insights for both theory development and practical reform in healthcare systems. Table 3.1 presents an overview of the results from a review of hospital governance literature from 1990 to 2020.

Table 3.1-Empirical Review on Hospital Governance Literature

No.	Author & Year	Journal	Issue/Concepts
1.	Weiner & Alexander (1993)	Health Services Research	Corporate and Philanthropic Models of Hospital Governance
2.	Ditzel et al. (2006)	Health Research Policy and Systems	Good Hospital Governance
3.	Eeckloo et al. (2004)	Health Policy	From Corporate Governance to Hospital Governance
4.	Eeckloo et al. (2007)	The Journal of The Royal Society for the Promotion of Health	Governance in Hospital Sector
5.	Abor et al. (2008)	Leadership in Health Services	Hospital Governance in Ghana
6.	Gorsky (2008)	International Journal of Health Services	Community Involvement in Hospital Governance
7.	Jha & Epstein (2010)	Health Affairs	Hospital Governance and Quality of Care
8.	Duran et al. (2011)	Governing Public Hospitals	Framework for Assessing Hospital Governance
9.	Brandao et al. (2013)	Health Care Analysis	Social Responsibility As a New Paradigm of Hospital Governance
10.	Abor et al. (2015)	International Journal of Law and Management	Healthcare Governance, Ownership Structure and Performance
11.	Khulmann et al. (2016)	BMC Health Services Research	Changing Hospital Governance
12.	Rotar et al. (2016)	BMC Health Services Research	Involvement of Medical Doctors in Hospital Governance
13.	Dixit (2017)	International Journal of Healthcare Management	Multi-perspective Emphasis on Public Hospital Governance
14.	Duran et al. (2019)	International Journal of Health Policy and Management	Assessment of Public Hospital Governance
15.	Duran and Saltman (2020)	Understanding Hospitals in Changing Health Systems	Hospital Governance
16.	Gautier et al. (2023)	Health Systems and Reform	Hospital Governance During COVID-19 Pandemic
17.	Lipunga et al. (2019)	International Journal of Health Governance	Emerging Structural Models for Governance of Public Hospitals

18.	Lipunga et al. (2021)	International Journal of Health Governance	Analysis of Public Hospital Governance Reforms
19.	Lipunga et al. (2022)	International Journal of Public Leadership	Organisational Governance Awareness Amongst Public Hospital Governance Actors
20.	Lipunga (2023)	Evidence Based Health Policy, Management and Economics.	Legal Framework of Public Hospital Governance

Source: Author's Review (2024)

From Table 3.1, it can be observed that there is a paucity of research on hospital governance. Tracking the chronology of literature on the subject, it can be noted that publications on the subject matter have increased since 2019, indicating that scholars are becoming more interested in the area of hospital governance. This study intends to follow suit and build upon the systematic review findings by De Regge and Eeckloo (2020) to unearth important insights pertaining to governance mechanisms in healthcare institutions.

3.10 Theoretical Framework

This study is anchored on two theories namely: Managerial Hegemony Theory and the Signaling Theory. The theoretical framework for this study comprises the integration of the aforementioned theories in explicating the influence of hospital governance mechanisms (attributes, dynamics and roles) on employee behaviour as well as quality service delivery in hospitals.

3.10.1 Managerial Hegemony Theory

The managerial hegemony is believed to have originated from the work by Kosnik (1987). Managerial Hegemony refers to the nature of organisational governance where management members have more power in the day-to-day operations of a firm than directors (Vallas, 2003). The managerial hegemony theory argues that boards are a "legal fiction" controlled by management (Mace, 1971). This instrumental view sees management as increasing domination due to the weakness of shareholders' exercise of ownership and control, for instance, where shareholders are dispersed or passive, and management is self-serving (Hendry & Kiel, 2004; Kosnik, 1987).

Furthermore, the theory argues that given the power owned by management within the organization, the board plays a supportive role at best, or at worst, agency issues are dominant, and the board's role is to certify management actions merely, whereas management will resist a more substantial role for the board (Zhang, 2015). The theory essentially explores and delineates the power dynamics in organisations particularly between boards and management teams. Cohen et al. (2008) also noted that managerial hegemony could trigger the onset of governance problems in organizations, especially when a management with very strong power can lead to the election of a supervisory board, for example, an audit committee. In such a

condition, the audit committee would be like a toothless "paper tiger" (Cohen et al., 2008), and then potential corrupt behaviour might emerge (Sofyani et al., 2022). The theory has over the years been applied in various domains such as management, accounting, and public administration.

3.10.1.1 Assumptions of the Managerial Hegemony Theory

The managerial hegemony theory operates with certain assumptions which shall be applied to the objectives of this present study. One of the core assumptions of the theory is that the ruling elite is management (Kosnik 1987; Mace 1971; Stiles and Taylor, 2001; Vance 1983). The board is a "de jure" but not the "de facto" governing body of the organisation. This means that whilst the role of the board is established and they play a role in the appointment of management members, the individuals that actually run organisations are not board members but management. Sofyani et al. (2022) alluded to the fact that the real responsibility for running the organisation is assumed by corporate management. The board of directors is in effect a legal fiction and is dominated by management making it ineffective in reducing agency conflicts between management and shareholders.

3.10.1.2 Application of the Managerial Hegemony Theory in This Study

The Managerial Hegemony Theory was used to explain how the governance mechanism established in a hospital depends on the nature of ownership and its corresponding operating philosophy. In public hospitals for example, this study applies the managerial hegemony theory to establish the fact that selection of executives and management depends on political influences due to the nature of public hospitals. The theory helps explain the degree of co-operation between hospital boards and management members to implement policies and operating procedures that influence employee behaviour towards quality service delivery. The managerial hegemony theory also highlights the channels of communication from hospital

governing boards to employees in the frontline who attend to customers (patients) and provide healthcare services during the service encounter. The theory is also used in this study to explain how the type of board varies across institutions which also influences the standard of service delivery and client perception of service delivery.

The theory is used in this study to assess the role of hospital management in overseeing policy formulation and implementation. The managerial hegemony theory is explicit in stating that whilst directors have oversight for policy formulation, executives/management are responsible for the day-to-day operations of the institution. Therefore, the choice of executives is dependent on the influence of the directors, which is also a decision that depends on the nature of ownership. In private hospitals, this study argues through the lens of the managerial hegemony theory that selection of management will also depend on the nature of ownership, which often comprises of medical professionals and practitioners (Numerato et al., 2012). It is therefore likely that selection of management will be limited to competent professionals also with medical background and expertise and appointed strictly based on competency.

The theory is used to analyse how the nature of ownership influences the calibre of management and employee behaviour within hospitals. This is vital in tracing the link between governance mechanisms and quality-of-service delivery in hospitals. Based on the postulations of the theory, this study explores how the existence of attributes, dynamics and roles of hospital governance mechanisms influences employees in the performance of their duties to ensure that patients receive quality care. The theory further establishes the hierarchy of authority and power structure within hospital boards and management that ensures that there are behavioural

control systems to monitor, regulate and evaluate employee behaviour in relation to quality service delivery.

Indeed, the notion that hospital boards are "fictional" as suggested in some critiques (Abor & Tetteh, 2023) is not unfounded. While boards may exist formally, their influence is frequently symbolic or procedural, lacking substantive autonomy or strategic control (Abor & Tetteh, 2023; Oppong et al., 2023). This is particularly true in government hospitals, where the Ministry of Health and its affiliated agencies retain significant control over appointments, budgets, and policy directives (Abor, 2015). The managerial class within these institutions often operates within a tightly centralized framework, reinforcing the dominance of bureaucratic logic over participatory governance (Abor, 2016). Moreover, it is impossible to disentangle politics from hospital governance in Ghana. Public sector administration is inherently political, shaped by shifting government priorities, partisan appointments, and the broader political economy of health (Abor, 2016; Adongo et al., 2022). Decisions about infrastructure investment, staffing, and even service delivery models are often influenced by electoral cycles, political patronage, and national development agendas (Bawontuo et al., 2022). As such, any analysis of governance in government hospitals must account for the interplay between political authority and administrative control, recognizing that governance is not merely a technical exercise but a deeply political one.

The managerial hegemony theory is further applied in this study to highlight the need to ensure balance and cooperation between governance boards and management within the health sector to ensure that the health institutions are able to run effectively without top level conflict between the board and management. The theory thus explains the nature and composition of

governance mechanisms and the power dynamics that is often manifest in the appointment of executive members and board members especially in public health institutions.

3.10.2 Signaling Theory

The signalling theory originated from the work by Spence (1973) who examined the role of signals in job interviews and recruitment decisions. According to Spence (1973) certain information, qualifications and cues act as signals which can determine how an individual may appear before a panel of decision makers. Over the years, the signaling theory has been applied in different fields and contexts, from marketing, human resource management, and psychology (Cronk, 2005; Connelly et al., 2011; Karasek & Bryant, 2012; Mavlanova et al., 2012).

The signaling theory has also been used to delineate the effects of information asymmetry and how firms can avoid that by communicating effectively over a signaling timeline which ends with a feedback loop from the receiver to the sender (Connelly et al., 2011). The signaling theory is largely used to explain how information asymmetry can be circumvented or how certain cues can be used to project or depict quality assurance to stakeholders. Information asymmetry often creates confusion amongst stakeholders as the lack of information or the failure to properly present cues as signals can often create hindrances to effective exchange, communication or service delivery (Suazo et al., 2009; Celani & Singh, 2011; Connelly et al., 2011; Kharouf et al., 2020).

3.10.2.1 Assumptions of Signaling Theory

According to signaling theory, signals are generated and communicated by senders who own internal knowledge about a specific product or service (Connelly et al., 2011; Spence, 1974). Senders benefit from producing and sending signals, while receivers rely on signals to make

decisions (Spence, 2002). Signal communication between senders and receivers can help reduce information asymmetry and influence the decision-making of receivers (Siering et al., 2018; Spence, 1974). This can be achieved through clear communication through approved channels. This helps combat grapevine information that contributes to information asymmetry. Information disclosure, as one of the important tools for improving patient–provider alignment, can help patients understand professional medical information and improve the efficiency of the healthcare market.

3.10.2.2 Application of Signaling Theory

The Signalling Theory is used in this study to explain how the presence of governance mechanisms (attributes, dynamics and roles) influences the policies, operating procedures and charters within a hospital. By having a board and management team underpinned by clear and transparent ownership, governance mechanisms are able to effectively influence the behaviour of employees positively towards quality service delivery. This study argues that hospitals without holistic governance mechanisms comprising attributes, dynamics and roles, are likely to have challenges with quality service delivery. The absence of holistic governance mechanisms creates gaps in service delivery due to a lack of signalling which affects employees and even patients. On the other hand, hospitals that have fully functioning and integrated governance mechanisms comprising attributes, dynamics and roles are likely to be more efficient and effective in the delivery of quality healthcare services to clients (patients). Such hospitals often have managerial oversight that comprises of role clarity, accountability and monitoring systems, employee training and customer (patient) feedback channels. The signalling effect of the existence of governance mechanisms is felt in the rules, regulations and operating procedures in hospitals.

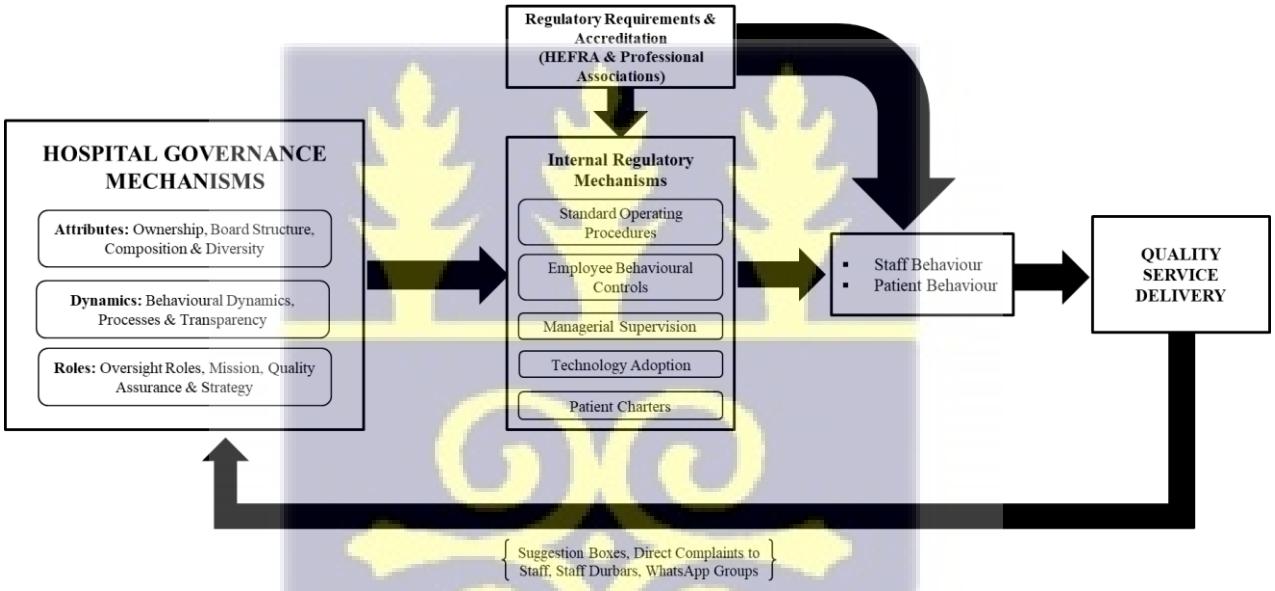
The signalling theory essentially explains how certain elements can act as cues/signals which individuals/organisations can use to communicate with stakeholders and elicit feedback (Taoketao et al., 2018). In this thesis, the Signalling Theory was used to explain how governance mechanisms in healthcare institutions can influence the behaviour of stakeholders especially healthcare staff to improve and enhance service delivery. Liu et al. (2022) also provide further justification for the adoption of the signaling theory in the healthcare sector and aver that the theory can help to explain how the existence of structures and information signals can lead to improvements in the accountability and quality service delivery of service providers.

The core argument being proffered in this study is that to achieve quality service delivery, hospitals need to establish governance mechanisms that can provide a signal which runs through the entire institution and upholds the values of the institution and its commitment to delivering quality healthcare services as expected by the regulatory authorities and other stakeholders. In this study, the signalling theory also helps in establishing the role of feedback in improving performance outcomes of hospitals. The signalling feedback loop which has been illustrated in the conceptual framework demonstrates how the existence of governance mechanisms (attributes, dynamics and roles) provides data collection and feedback monitoring systems in hospitals where patients and staff are allowed to provide feedback to management which is in turn used to refine operating procedures and improve the quality of service delivery in the hospital. This study leans on the postulations of the signalling theory to argue that feedback is a vital signal that can result in performance improvements. The study further argues that the signaling theory is instrumental in delineating how the existence of hospital governance structures influences the behaviour of employees and clients towards quality service delivery.

3.11 Conceptual Framework

In view of the application of the managerial hegemony and signaling theories, this study proposes a conceptual framework which seeks to delineate and highlight the key variables and its effects from the integration of the two theories adopted. The conceptual framework is rooted in the qualitative philosophy that seeks to offer an interpretivist perspective on the concepts of governance mechanism, decision-making, stakeholder behaviour and quality. Figure 3.1 offers an overview of these elements and the relationships amongst the variables.

Figure 3.1- Conceptual Framework Delineating the Effects of Healthcare Governance on Decision-Making, Stakeholder Behaviour and Quality Service Delivery



Source: Author's Conceptualisation (2023)

3.11.1 Operationalisation of Conceptual Framework

The conceptual framework depicted in Figure 3.1 examines the nature and composition of hospital/healthcare governance and its corresponding influence on behaviour of primary stakeholders (employees and clients) and ultimately quality service delivery. This study set out to explore the nature and composition of hospital governance, and from the framework in Figure 3.1, the elements of ownership, management structure and power roles and dynamics

clearly represent the critical underpinnings of healthcare governance across the four selected healthcare institutions being examined (public, private, mission and quasi).

The framework further highlights the influence of the two theories on the various relationships being delineated. The Managerial Hegemony theory is used to explain how the type of governance mechanism (attributes, dynamics and roles) influences the composition of management teams and structures in hospitals. The application of the managerial hegemony theory helps in affirming the need for a clearly defined structure within hospitals which outline the power dynamics and hierarchy of authority. In this study, the theory is used to connect the dots between governance mechanism, board and management composition, operating policies and employee behaviour. The type of management structure in place determines the kinds of policies that will be developed to regulate employee behaviour towards quality service delivery.

The theory posits that management members are often in an advantageous position within the governance structure as they are seen to be more active and are actually responsible for the day-to-day implementation of strategy and policies (Vallas, 2003; Sofyani et al., 2023). Thus, the framework highlights the role of the management structure as important catalysts for institutional service delivery through their policies, decisions and actions which translate into organisational policies, standard operating procedures and employee charters.

The Signaling theory also helps to delineate the influence of regulatory bodies who grant accreditation to the various healthcare institutions and their staff. The signaling influence of accreditation also influences the policies, standard operating practices, and charters.

Additionally, the signalling influence of accreditation and regulatory compliance impacts employee and client behaviour within the hospital setting. Staff of healthcare institutions respond to signals from accreditation authorities and agencies, and are required to comply and exhibit best standard practices for service delivery to patients. This study therefore leans on the arguments of the signaling theory to advance the case for the influence of governance mechanisms on employee and client behaviour, as well as quality service delivery.

Furthermore, the conceptual framework amplifies the role of governance mechanisms in affecting the nature of decision-making and implementation through policies, SOPs and charters, which are often initiated from the governance mechanism, especially the board and management team. Finally, the framework buttresses the postulations of the signaling theory by highlighting the feedback loop from the outcome of service delivery back to the governance mechanism. This study argues that in the hospital setting, the feedback loop can comprise of suggestion boxes, customer complaints, employee complaints and other feedback received through direct/indirect channels.

3.12 Chapter Summary

This chapter provided insight into the concept of hospital governance mechanisms through a review of conceptual, empirical, and theoretical literature. The chapter commenced with a discussion on the concept of governance in organizations before proceeding to define the concept of healthcare/hospital governance. This was crucial in delineating the concept and providing operational definitions which are crucial to the understanding of the concept and how it is being operationalised in this study. Other discussions in the chapter highlighted issues such as the structure and components of healthcare governance, the relevance of governance

mechanisms in the healthcare sector, and new public administration and the link with hospital governance mechanisms. The role of healthcare governance as a framework for delivering quality service in the health sector was also elaborated on, as well as antecedents of quality service delivery in the healthcare sector. The link between healthcare governance mechanism and organizational culture was explicated, which resulted in the conclusion that the governance mechanism adopted by a healthcare institution influences the culture of the institution, which in turn influences the behaviour of primary stakeholders, namely: employees and clients (patients).

CHAPTER FOUR

METHODOLOGY

4.0 Chapter Overview

This chapter reviews the various research methods that have been adopted in the development of this study. The chapter forms an integral part of the quest to achieve the research objectives outlined in the first chapter of this work and presents a detailed discussion of each research method selected in the attempt to examine the concept of governance mechanisms and their influence on decision-making and quality service delivery amongst selected health institutions in the Greater Accra Region. Research methodology has been highlighted as an important part of the research process (Eifler & Howard, 2018; Mohajan, 2018), and is a key part of the doctoral thesis (Rodricks, 2018). This chapter therefore pays attention to various issues related to methodology such as research philosophy, research approach and design, population of the study, sampling and sources of data collection. Other issues such as the data collection instrument, data collection process, and method for data analysis are also elaborated on in this chapter. Finally, the chapter discusses the ethical principles and considerations which are adopted in the conduct of this study.

4.1 Research Philosophy

In spite of the existence of various research paradigms such as positivism, interpretivism, pragmatism and realism (Saunders et al., 2009; Rivas, 2010; Gray, 2013; Ryan, 2018), this study opts to embrace an interpretivist research philosophy in examining the concept of healthcare governance and service delivery in selected health institutions in Ghana. Based on the purpose and objectives of the study, the interpretivist research paradigm best suited the

needs of this research. The interpretivist research philosophy has been chosen due to its underlying assumptions which the researcher believes is essential to the creation, development and propagation of knowledge. Interpretivism holds that reality is subjective and socially constructed (Bleiker et al., 2019; Kankam, 2019). The goal of the interpretivist researcher is to obtain an understanding of a phenomenon through close interaction with research subjects (Irshaidat, 2019).

Ryan (2018) explains that in interpretivism the basic premise is that truth and knowledge are subjective. This implies that knowledge is distilled from the experiences of people and how they understand what occurs to them over time. This further implies that in the research process, a researcher is intertwined with the knowledge creation process, and the value of researchers influence how meaning is construed. Other perspectives on interpretivism suggest that interpretivism has a 'relativist' ontological perspective (Potrac, 2014; Ryan, 2018). As such, interpretivism argues that reality can be viewed through multiple social perspectives and not restricted to a singular perspective (Ritchie & Lewis, 2003; Saunders et al., 2009; Gray, 2013; Ryan, 2018).

In the context of this study on governance mechanisms of healthcare institutions, reality can be constructed through the experiences of the primary stakeholders, that is, employees and patients. Patients who receive healthcare services from the various designated healthcare institutions (public, private, quasi and mission-based) are chosen due to their ability to communicate their perceptions and generate meanings to evaluate quality service delivery based on their experiences. This is one of the reasons why the interpretivist paradigm has been selected as the underpinning philosophy for this study.

Krauss (2005) further reinforced the notion that interpretivism allows individuals to evaluate their experiences and reflect on its meaning and implications. Krauss (2005) also explained that meaning is obtained through the reflections from individuals which are obtained from their assessment and social interpretation of a situation. Therefore, based on the above discussions, the interpretivist research philosophy is chosen as the underpinning guideline that influences other methodological choices made in the attempt to understand the governance mechanisms and service delivery in selected health institutions in Ghana. Interpretivism is ideal for this study as it enabled the researcher engage in direct dialogue with management, employees and patients of selected health institutions, in order to capture and assess their perceptions of governance mechanisms and its influence on decision-making (internally) and quality service delivery (externally).

Research philosophy refers to paradigms which shape how a researcher perceives the world and the approaches that are adopted in the process of creating new knowledge (Saunders et al., 2009; Ryan, 2018; Nickerson, 2022). Over the years, it has been established that the paradigm a researcher adopts, influences how they view reality (Goldkuhl, 2012; Hürlimann & Hürlimann, 2019). Research philosophy has therefore become one of the important elements of research methodology and is considered as such in this study on governance mechanisms, decision-making and quality service delivery. Notably, the extant literature identifies prominent research paradigms such as Positivism, Interpretivism, Pragmatism, Realism and Post-Positivism (Fox, 2008; Saunders et al., 2009; Weideman, 2012; Ryan, 2018). These are various worldviews which shape how a researcher understands the nature of knowledge and the factors that contribute towards reality (Hürlimann & Hürlimann, 2019; Tamminen & Poucher, 2020).

Positivism is a philosophy that espouses that reality is objective and can be measured using theory and hypothesis testing approaches through empirical studies (Saunders et al., 2009; Ryan, 2018). Positivists are often pro-quantitative and lean more towards the development and testing of frameworks that explore causal relationships (Saunders et al., 2009; Ryan, 2018). The strengths of positivism are that it relies on statistical data which often tend to minimise biases and have more robust validity and reliability checks (Saunders et al., 2009). The weakness of positivism is that it does not foster in-depth meaning and understanding of contextual issues influencing the research variables (Gray, 2013; Ryan, 2018).

Interpretivism is a research philosophy that holds the view that reality depends on the subjective interaction between researchers and respondents influenced by the values of researchers (Potrac et al., 2014; Sullivan, 2016). In interpretivism, researchers are allowed to have closer engagements with respondents in their natural setting, and this paradigm further leans towards qualitative methods of inquiry (McChesney & Aldridge, 2019). The strengths of interpretivism are that it provides multiple perspectives and views which help to shape reality and the narrative of a particular concept or phenomenon (Gray, 2013; Ryan, 2018). The limitation of interpretivism is that anything can be claimed without validation (Primus, 2009).

Pragmatism is a research philosophy that does not hold a rigid position, but that allows flexibility of method choice based on the nature, purpose and objectives of a research (Saunders et al., 2009; Hall, 2013). In pragmatism, researchers can choose qualitative, quantitative or mixed methods (Biddle & Schafft, 2015; Shannon-Baker, 2016). Realism is a research philosophy that holds the view that reality is independent of our knowledge (Saunders et al., 2009). Realism comprises of two branches; direct realism and critical realism (Mingers, 2006;

Cruickshank, 2016). In direct realism, human senses are used as a measure of reality, whilst in critical realism expressions and images of the world are viewed to be independent of human interpretations, whilst at the same time acknowledging that subjective interactions can inform reality (Easton, 2010). Closely associated with the various paradigms are the terms ontology and epistemology (Rawnsley, 1998; Blaikie, 2007). Ontology is concerned with the nature of reality, and seeks to determine what is real (Saunders et al., 2009; Blaikie & Priest, 2017). Epistemology on the other hand focuses on the nature of knowledge and is concerned with the structure and limits of knowledge (Blaikie & Priest, 2017; Blaikie & Priest, 2022).

This study was anchored on the interpertivist paradigm and facilitated the qualitative examination of hospital governance mechanisms in four category of hospitals, namely: public, private, mission and quasi hospitals.

4.2 Research Design

Researchers conduct research within a defined framework which helps to bring order and structure to the research process and outcomes (Noor, 2008; McDaniel & Gates, 2018; Benitez et al., 2020). Research design refers to the strategic framework a researcher adopts to achieve their research objectives (Saunders et al., 2009). In this study, the exploratory and descriptive research designs are selected in the quest to identify and profile the various healthcare governance systems in place in the various selected health institutions in Ghana.

The exploratory design is selected because it enables researchers to explore and probe into issues that have not received adequate research attention (Hunter et al., 2019). The exploratory research design also enables researchers to use open-ended questions to interview respondents

to "explore" the concept or issue under research (Kieft et al., 2018). This study intends to explore the concept of hospital/healthcare governance from the perspective of four different healthcare institutions namely: private, public, mission-based and quasi health institutions. As such, the adoption of the exploratory research design is essential in facilitating the use of probing questions in the design of the interview guide that helped create an interactive dialogue with respondents, and obtain answers which can help create meaning in relation to the nature and composition of governance mechanisms and their influence on decision-making and quality service delivery in health institutions in Ghana.

The issue of healthcare or hospital governance is a relatively under-explored area in the healthcare and public administration literature, and this study therefore adopts the exploratory research design to aid in uncovering new knowledge on the governance mechanisms and their influence on service delivery in healthcare institutions in Ghana. Similarly, the descriptive research design is chosen because the researcher seeks to describe the nature of governance systems in healthcare institutions, and the descriptive research design has been touted as a research design that allows researchers to describe elements of a population or a research phenomenon (Tobi & Kampen, 2018). Combining these two research designs contribute to the holistic appraisal of the governance mechanisms and their outcomes in relation to decision-making and quality service delivery in the healthcare sector in Ghana.

4.3 Research Approach

In this study, the qualitative research approach is selected. The choice of qualitative research is consistent with the interpretivist research philosophy which holds that reality is subjective and can be measured through interactions between the researcher and participants in the social environment (Bleiker et al., 2019).

The purpose of this study is to examine healthcare governance systems and service delivery in Ghana by conducting an assessment of public, private, quasi and mission-based healthcare institutions in Ghana. The choice of a qualitative research approach is to enable the researcher examine the concept of healthcare governance through close interactions and interviews with management members, employees and clients of the selected healthcare institutions. The qualitative approach via comparative case study also allows the researcher to explore similarities and differences in management and governance structure through face-to-face interviews which entail the use of open-ended questions and in-depth discussion of the concept of hospital governance and its outcomes. Additionally, the relatively under-explored nature of the issue of healthcare governance requires the use of a qualitative study to explore further and identify critical underpinnings which described and delineate the concept of healthcare governance.

The influence of the adopted research philosophy also accounts for the decision to use a qualitative research approach. Interpretivists believe that the qualitative approach offers a unique and unrestrictive approach to collecting data through interviews, focus group discussions and other qualitative data collection methods such as (McChesney & Aldridge, 2019). This study's aim of exploring the governance structures of public, private, quasi and mission-based healthcare institutions required the use of such qualitative data collection methods. This enabled the researcher capture data in the form of audio, text and recordings which can be transcribed and interpreted to form meaning and offer clarity to the concept of healthcare governance. The qualitative research approach in itself refers to the approach which entails an attempt to explain how people experience the world in which they live (Alase, 2017).

4.4 Research Strategy

In-depth interviews and the multiple case study strategy have been selected as the underpinning research strategies. According to Saunders et al. (2009), interviews and case studies are research strategies that qualitative researchers can use in the journey to discover new knowledge. In this study, the interview strategy was used in collecting data from respondents comprising of management members, senior employees and clients of healthcare institutions in Ghana. The comparative case study strategy was also used to establish the differences in governance mechanisms amongst public and private health institutions in Ghana. These strategies enabled the researcher to explore the concept of healthcare governance systems within the health sector in Ghana.

This study adopts the multiple case study approach (Fox-Wolfgramm, 1997; Bartlett & Vavrus, 2016; Bartlett & Vavrus, 2017). The multiple case study is selected because the purpose of this research is to explore the governance mechanisms of public, private, quasi and mission-based healthcare institutions in Ghana. The choice of these selected institutions warrants a multiple case study strategy to identify the differences and similarities within the governance systems of the selected healthcare institutions. The multiple case study strategy is being used in this study because it is a qualitative research strategy which allows for "…an in-depth inquiry into a specific and complex phenomenon (the 'case'), set within its real-world context" (Yin & Riddle, 2012; Yin, 2014). In this study on healthcare governance mechanisms, the case study strategy allowed the researcher to conduct an in-depth enquiry into the nature of governance systems present in the healthcare sector in Ghana, specifically amongst public and private health institutions.

It has also been argued that the merits of adopting a case study strategy includes enabling researchers to explore the interaction between the case and its context (Yin, 2013). In view of this, this thesis adopts the case study strategy because it facilitated the examination of the concept of hospital governance mechanisms in relation to its context, which undoubtedly helped to create more meaning and understand the interplay of contextual factors on the research issue (Yin, 2013; Yin, 2014). This type of case study is useful in achieving the objectives of this study because it is a case study strategy that enables researchers to "…uncover patterns of explanation…and to detect patterns of convergence and divergence across these…" (Kantor & Savitch, 2005, p. 135; Nadin & Stead, 2013, p. 1543). Furthermore, according to Pierre (2005, p.449), multiple case studies also include comparative benefits and are one of the "most rewarding research strategies for uncovering causal patterns of explanation." This case study strategy was instrumental in achieving the objectives of this study.

The study adopts a multiple case study design embedded within a descriptive exploratory framework to investigate governance dynamics across selected healthcare institutions in Ghana. The multiple case study approach allows for in-depth, context-sensitive analysis of governance structures, mechanisms, and outcomes across diverse institutional types: public, private, mission-based, and quasi-governmental. This design is particularly suited to capturing institutional variation and drawing comparative insights (Saunders et al., 2009) that reflect the complexity of Ghana's healthcare landscape. The descriptive exploratory design complements this by enabling the researcher to systematically document and interpret governance attributes, roles, and dynamics without imposing rigid theoretical assumptions (Anaker et al., 2021). It is especially appropriate given the limited empirical literature on hospital governance in Ghana,

allowing the study to uncover patterns, generate grounded insights, and refine conceptual frameworks.

Together, these designs offer a robust methodological fusion: the multiple case study design provides depth and comparative richness, while the descriptive exploratory approach ensures openness to emergent themes and contextual nuance. This integration strengthens the study's ability to illuminate how governance mechanisms function across institutional settings and how they influence employee behaviour and patient care outcomes. Some scholars have noted that "comparative case study research is a rewarding strategy for territorial cohesion research as it can deliver in-depth insights how processes, outcomes or relations are interlinked. Findings on potential (process) mechanisms are invaluable to policy-makers and public funding bodies…" (Rau, Goggins, & Fahy, 2018, p. 266).

This study drew significant value from employing a multiple case study approach, which enabled a nuanced examination of governance mechanisms across diverse healthcare institutions in Ghana. By capturing institutional variations and contextual realities, the approach provided rich insights into how governance structures influence decision-making processes and the delivery of quality care. As such, the multiple case study design was strategically chosen to support the study's overarching aim of exploring healthcare governance practices within selected institutions.

4.5 Population of the Study

The population of the study consisted of management members, employees and clients of private, public, quasi and mission-based healthcare institutions in the Greater Accra Region. This population has been selected because it represents the general pool of respondents from which the study's sample was chosen (Malhotra et al., 2017). In this study, management members, senior employees and clients (patients) in the selected health institutions in Ghana constituted the population.

4.6 Sample Size and Selection Techniques

In this study, four (4) healthcare institutions were selected from the Greater Accra Region. The institutions as mentioned earlier, comprise one (1) each of the four categories namely: public, private, quasi and mission-based. From these selected institutions, a sample of sixteen (16) respondents per institution was selected, made up of three (3) management members, seven (7) employees and six (6) clients from each of the selected institutions. As such, a total of sixty-four (64) respondents were selected from the four institutions in the Greater Accra Region. Out of the sixty-four (64) respondents, twelve (12) management members, twenty-eight (28) employees and twenty-four (24) clients were selected. An overview of the sample composition is presented in Table 4.1.

Table 4.1- Sample Composition

Category	Sample Size	Purpose
Management	3	Provide insight into governance mechanisms, power dynamics and oversight roles
Employees	7	Provide insight into how governance mechanisms influence service delivery to patients
Clients (Patients)	6	Assess the quality-of-service delivery based on the type of governance mechanism in place

According to Smith (2015) in qualitative studies, the focus is to gain in-depth insights and understanding of a phenomenon as opposed to generalising findings, thus qualitative studies

do not seek to select a sample based on population size, but on relevance and concern for data saturation. This was also confirmed by Creswell and Poth (2018) who also noted that data saturation often occurs after 12-25 participants per case study have offered their opinions. Thus, justification for the sample size stems from the study by Boddy (2016, p.426) who stated that "In qualitative research, the determination of sample size is contextual and partially dependent upon the scientific paradigm under which investigation is taking place."

Other scholars such as Marshall et al. (2013) also opine that an appropriate sample size for qualitative studies comprises of "a range of 20-30 interviews for grounded research and 15-30 interviews for case studies." This forms the basis of selecting the sample for this study. Since a multiple case study approach is being used, a total sample of sixty-four (64) respondents is deemed appropriate for this study. These respondents were selected from the four institutions highlighted in Table 4.2.

Table 4.2- Institutional Selection and Classification

No.	Institution	Classification	Location
1.	International Maritime Hospital	Quasi Health Institution	Tema
2.	Port Clinic	Private Health Institution	Tema
3.	Achimota Government Hospital	Public Health Institution	Achimota
4.	St John of God Hospital	Mission-Based Institution	Adenta

Researchers have argued that in choosing a sample for qualitative studies, there must be some deliberateness about the whole process (Allan, 2020; Braun et al., 2021). As such, the choice of sample for this study was informed by the availability of management and staff in the various health institutions. This is an important inclusion criterion because healthcare governance comprises of the presence of a board and management (DeRegge & Eeckloo, 2020), and it is a

vital hallmark of governance which was considered during the selection of the sample. Also, only staff who have worked with the various institutions for a minimum of three (3) years were considered for selection. This was due to the need to select respondents who have in-depth knowledge of the governance structures of the various healthcare institutions.

The respondents were selected using the purposive sampling technique. The purposive sampling technique is a non-probability sampling technique that leverages the discretion and judgement of the researcher in selecting respondents who possess the required characteristics necessary to provide good data (Campbell et al., 2020). This sampling technique was used in the selection of respondents because this study requires the selection of management members of the selected health institutions as these individuals are likely to be more acquainted with the governance mechanisms of these institutions as opposed to employees in the lower hierarchy of the organisation. As such, the purposive sampling technique represents a viable sampling technique to select these respondents. The purposive sampling technique was used in selecting respondents from these institutions comprising employees/management members as well as clients.

4.7 Data Collection Sources and Instrument

In this study, primary data was collected to ascertain the variations in governance mechanisms in the various health institutions in Greater Accra Region. An interview guide was designed based on the objectives of the study, and this was used in the collection of data. Secondary data in the form of documents on the governance mechanisms of healthcare institutions such as organograms, organisational charts or any relevant documents providing insight into the governance mechanisms of healthcare institutions was also collected and analysed. Summerise

here the type of data collected. You can use the sub-heading of your instruments so the reader knows the nature of variables you collected.

4.7.2 Data Collection Instrument

Three (3) interview guides were designed based on the objectives of the study and review of relevant literature on hospital/healthcare governance mechanisms, decision-making and quality service delivery. Based on the review of literature and considerations for the research objectives, an interview guide was designed for each targeted sample, that is, for management, for employees and for clients (patients).

Table 4.3- Interview Guide Structure for Data Collection

Category	Sections	Number of Questions
Management	5 sections	40 questions
Employees	3 sections	32 questions
Clients (Patients)	4	30 questions

The management questions sought to explore the role of management in healthcare governance. Also, the questions sought to examine management perception on the role of attributes, dynamics and roles in healthcare governance. This entailed questions regarding ownership, management structure, hierarchy of authority and related questions. Questions that were posed to employees also sought to obtain their perspective on the nature of healthcare governance especially in relation to the composition of ownership, management structure and oversight roles and operating procedures influencing patient care and quality of service delivery. The interview questions for clients (patients) were focused on exploring client perception of healthcare quality of service delivery based on governance mechanisms in healthcare institutions. Clients were also asked questions pertaining to the challenges they had encountered as patients of the various healthcare institutions.

4.8 Data Collection Process

In collecting data for this study, the researcher distributed an introductory letter and ethical consent forms to the management of selected health institutions to obtain permission before the selection of respondents and the collection of data. Once permission is granted, the researcher drew up a schedule for data collection, and book appointments with the respondents in various institutions for the interviews. On the scheduled date, the researcher along with trained research assistants visited the various healthcare institutions to interview respondents using an audio recorder which was used to capture the interviews and record the data being collected. After the data was collected, the audio recordings were transcribed and the contents used for data analysis.

4.9 Data Analysis Techniques

The study analysed data using qualitative data analysis techniques namely Thematic Analysis (TA) (Maher et al., 2018; Lowe et al., 2018). The thematic analysis was used to sort and categorise data collected into specific themes based on the objectives of the research (Belotto, 2018). The thematic analysis was approached using Braun and Clarke's (2012) technique which entails an iterative process comprising six (6) steps which commence from development of codes to the identification of exemplars. Braun and Clarke's (2012) methodology for executing thematic analysis is presented in Table 4.4, and was adopted in this study:

Table 4.4- Braun and Clarke's (2012) Thematic Analysis Process

Step	Activity
Step 1: Data Familiarization	Becoming familiar with the data
Step 2: Code Generation	Generating codes from the data
Step 3: Theme Generation	Generating themes within the data
Step 4: Theme Review	Reviewing themes
Step 5: Theme Definition	Defining and naming themes
Step 6: Locating Exemplars	Locating exemplars for the various themes

The steps in Braun and Clarke's thematic analysis method are highlighted in Table 4.4 and constitute the procedure for analysing the data collected from management, employees and clients of the selected healthcare institutions in the Greater Accra Region.

4.9.1 Data Coding and Theme Generation

After the process of data familiarization, one of the key tasks that was performed pertained to data coding. Table 4.5 provides an overview of the various codes and their link to the themes that were generated in analysing the data.

Table 4.5- Data Coding and Theme Generation

Open Coding	Subthemes	Main Themes (Selective Themes)
"*…we have management and we have heads of units.*" **PUHI** "*it's management. Hospital management. Yes, functional management…*" **PUHI** "*yes, we have a functional and active board of directors…and eight management members…*" **QUHI** "*…we have almost head specialist in different areas who comprise of the management team… we are forming a board of trustees. We are in the process; we are in the registration. We are forming a board of trustees now where we, first of all we have a board.*" **MIHI** "*It's owned by archdiocese of Accra. We are under archdiocese even because our work permit and everything is provided by the archdiocese.*" **MIHI** "*…this is private and partnership… the major shareholders in this institution…we are four partners...three of us are practicing partners. The third one is not practicing. She's on*	Governance Structure	Nature & Composition of Governance Mechanisms

the partnership because her husband actually established the facility." **PRIHI**		
"*Our hospital does not have a board of directors, but rather a management team comprising of the medical superintendent, hospital pharmacist, head of nursing, clinical lead, that's the head of the doctors. And then administrator, hospital administrator and then hospital accountant*" **PUHI** "*In terms of gender diversity, apart from myself and the finance guy, the rest are females.*" **PUHI** "*We have a functional and active board of directors…there are eight members on the board, made up of eight males, and two females…*" **QUHI** "*…We have the provincial, the provincial superior. He's the main owner even though we have provincial councils…We have a brother in charge of charismatic management. We have a chairman of management advisory board. All these people are brothers. We are all brothers. That is what I will like you to understand. They see all as brothers.*" **MIHI** "*On the management team, we have five males and two females…*" **MIHI**	Attributes, Dynamics & Roles	

	Institutional Challenges	

Source: Field Data (2024)

NB: PUHI= *Public Healthcare Institution* (Achimota Government Hospital); **PRIHI=** *Private Healthcare Institution* (Port Medical Centre); **MIHI=***Mission Healthcare Institution* (St. John of God); **QUHI=** *Quasi Healthcare Institution* (International Maritime Hospital)

4.9.2 Respondent Labels and Codes

The respondents who participated in this study comprise of management members, employees and clients (patients). For the purpose of anonymity and confidentiality, their identities have been concealed and replaced with respondent labels and codes which are meant to help identify the category of respondents providing the narrative in the analysis.

Table 4.6- Respondent Labels and Codes

Institutional Labels	**Respondent Labels**	**Examples**
Public Healthcare Institution- **PUHI**	Management Member- **MM** Employee- **EM** Client (Patient)- **CL**	**PUHIMM1-** Management Member of Public Healthcare Institution **PUHIEM1-** Employee of Public Healthcare Institution **PUHICP1-** Client of Public Healthcare Institution
Private Healthcare Institution- **PRHI**		
Quasi Healthcare Institution- **QUHI**		
Mission Healthcare Institution- **MIHI**		

Table 4.6 provides insight into the labels used to describe respondents who participated in the study. Each institution has its own label, the same with the three category of respondents. Management members are identified with their code MM, affixed after the institutional code, and then a number. Employees are similarly identified with the code EM, also affixed after the institutional code, and then a number. Finally, clients/patients are also identified with the code Cl, followed by a number.

4.9.3 Ensuring Validity and Reliability of Data Collected

In order to ensure validity and reliability of the data collected, the transcripts of all the institutional heads were sent back for cross-checking to ensure that respondents corroborated the contents of the transcripts, to ensure they were a true reflection of the interviews conducted. It was impossible to engage in member-checking for all respondents due to the constraint of times, therefore the researcher emailed the transcripts with the management members for cross-checking, after which phone calls were initiated to confirm that respondents acquiesced with the contents of the transcript to ensure accuracy, reliability and trustworthiness. This is in line with established data validity and reliability methods of qualitative researchers (Carlson, 2010; Birt et al., 2016; Thomas, 2017; Candela, 2019).

4.10 Ethical Principles and Consideration

In this study, the ethical principles of consent, permission seeking, disclosure of intent, respect for respondents were observed in the design and collection of data. Ethical principles are an important part of the research process and entail the adoption of guidelines which enable researchers to understand what is right and acceptable especially when dealing with respondents in the collection, analysis and reporting of data (Harriss et al., 2019). In this study, ethical considerations were made to ensure that in the process of collecting and reporting data, best practices are observed and adhered to in order not to compromise the integrity of the research process and output (Wilmer et al., 2021). This falls in line with recommended procedures as far as ethics in research is concerned (Farrugia, 2019).

In this study, respondents were informed of the nature and purpose of the research through consent letters that were obtained from the Department of Health Services Management at the University of Ghana Business School. The data collection instrument was also subjected to ethical review and clearance. Respondent privacy and confidentiality were protected during the data collection process. This information applies to other healthcare institutions such as the private healthcare institutions in Ghana. The researcher ensured that all these ethical considerations are made in the course of conducting this study. The researcher therefore applied for ethical clearance from the Humanities division of the University of Ghana Ethics Committee. Ethical clearance was granted (ECH 095/23-24) and is included in the Appendix of this document.

4.11 Chapter Summary

This chapter provides a discussion of the various research methods underpinning this study on governance mechanisms, decision-making and quality service delivery amongst selected healthcare institutions in Greater Accra Region. The chapter commenced with a delineation on the choice of research philosophy which then informed the research approach and strategy. A multiple case study strategy was adopted which supports the use of the exploratory and descriptive research designs to delineate the nature and composition of hospital governance mechanisms in private, public, quasi and mission-based healthcare institutions in Greater Accra Region. The chapter also provided insight on the population of the study, the sample size and the choice of purposive sampling as the underpinning technique used in selecting respondents. The source of data and the data collection instrument was highlighted as well as the data analysis technique. This chapter further provided an overview of the ethical procedures and principles underpinning the conduct of this work. Essentially, the chapter has fulfilled its

purpose of providing insight and justification for the choice of research methods adopted to achieve the objectives of this study.

CHAPTER FIVE

PRESENTATATION OF FINDINGS

5.0 Chapter Overview

The previous chapter provided insight into the various research methods selected in collecting empirical data for this study. This chapter proceeds to present an overview of the data analysis process, specifically about how data was coded, and analysed, and what themes were used in the analysis of data. This chapter commences by providing a profile of respondents, before proceeding to state the analytical technique that was used in analysing the data. Furthermore, the chapter presents a thematic analysis anchored on the objectives of the study and ends with a cross-case analysis providing answers to the underpinning research questions, and drawing similarities and differences between the case analyses.

5.1 Respondent's Profile

This study collected primary data from respondents comprising staff and management members of selected healthcare institutions in Accra, Ghana. The study targeted a total of sixty-four (64) respondents, comprising sixteen (16) respondents from the respective Public, Private, Mission and Quasi Health Institutions. The introductory and consent letters obtained from the department, and signed by the supervisor and head of department facilitated the cooperation and collaboration from the management of the four (4) healthcare institutions sampled in this study. Table 5.1 provides a breakdown of the respondents who participated in the study.

Table 5.1- Respondent Profile

No.	Respondent Category	Frequency	Profile	Institution
1.	Management Members	7	Medical Superintendent Head of Administration Head of Finance Head of Pharmacy Head of Nursing Services Head of Clinical Services Head of Laboratory	Achimota Government Hospital
		6	Medical Director Director of Administration Head of Nursing Head of Finance Head of Pharmacy Head of Clinical	Port Medical Centre
		6	Hospital Director Medical Director Nurse Manager Head of Finance (Accountant) Human Resource Officer Brother's Representative	St. John of God Hospital
		7	Chief Executive Officer Head of Administration Head of Finance Head of Nursing Head of Pharmacy Head of Audit Head of Clinical Services	International Maritime Hospital

2.	Employees	1 1 1 1	Doctors Nurses Lab Technician Physician Assistant	Achimota Government Hospital Port Medical Centre St. John of God Hospital International Maritime Hospital
3.	Clients (Patients)	6	Outpatient department	Achimota Government Hospital
		6	Outpatient department	Port Medical Centre
		6	Outpatient department	St. John of God Hospital
		6	Outpatient department	International Maritime Hospital

Source: Field Data (2024)

From Table 5.1, the composition of respondents who participated in this study is presented according to each institution. Table 5.1 indicates the profile of each category of respondents, namely: management, employees and clients. Each institution has a different management composition, albeit similar in function and responsibilities. For example, the Public Health Institution (Achimota Government Hospital) is headed by a Medical Superintendent, whilst the Private Health Institution (Port Medical Centre) is headed by a Chief Executive Officer. Comparing this to the Mission Hospital (St. John of God), it was found that the head of their management team is classified with the title "Hospital Director", whilst the Quasi Health Institution is headed by a "Chief Executive Officer". From the profile of respondents, it is evident that there are three different terms for the same role in health institutions in Ghana.

5.2 Theme Definition

After going through the various coding iterations, the study arrived at three core themes which underpinned the analysis of data. These themes are presented and explained in this section.

Table 5.2- Theme Definition

No.	Objective	Main Themes	Sub-Themes
1.	Examine the nature and composition of governance mechanisms of public, private, mission and quasi health institutions in Ghana in relation to attributes, dynamics and roles	1. Nature of Ownership and System of Governance 2. Board Structure, Diversity and Gender Representation 3. Board Meeting Times 4. Role of Accreditation in Hospital Operations 5. Employee Behavioural Controls	i. Government owned institution ii. Privately owned institution iii. Owned by State Institution iv. Originates from Catholic Church v. Gender diversity is not actively pursued vi. Competence preferred over gender inclusion vii. Accreditation is vital to hospital operations vii. Employee behavioural controls shape staff behaviour
2.	Explore the influence of attributes, dynamics and roles of hospital governance mechanisms on the quality-of-service delivery in public, private, mission and quasi healthcare institutions in Ghana	1. Attributes, Dynamics and Roles Influence Quality Outcomes 2. Hospital Quality Benchmarks and Staff Quality Delivery	i. Oversight roles ii. Staff adhere to rules and regulations iii. Code of Ethics influences quality service delivery

		3. Monitoring and Evaluation Key to Improved Quality Service Delivery	iv. Patient satisfaction surveys used to monitor service quality and staff performance v. Clear employee job descriptions vi. In-Service Training used to educate staff
3.	Investigate the challenges in hospital governing mechanisms that hinder decision-making and quality of service delivery in public, private, mission and quasi healthcare institutions in Ghana.	1.Challenges of Hospital Governance 2.Logistic Challenges 3. Financial Challenges 4. Human Resource Challenges 5. Legal Challenges	i. Transportation (Ambulance challenges) ii. Bureaucracy & delays in decision-making iii. Delays in insurance payments iv. Cash flow issues v. Staff migration for greener pastures vi. Legal disputes with clients

5.3 Thematic Analysis of Data

This section explores the various themes and sub-themes extracted from the responses provided by participants comprising management members, employees and patients of the four profiled healthcare institutions. Each theme is examined according to a unique case, with Cases A-D representing the four healthcare institutions.

5.3.1 Theme 1: Nature of Ownership and System of Governance

The first theme used in this analysis pertained to exploring the nature ownership and system of governance in healthcare institutions in Ghana. This was in line with the first objective of the study which sought to examine what kind of governance mechanisms in operation in public, private, quasi and mission hospitals. Under this theme, the nature of governance mechanisms of the four sampled institutions are analysed to determine how each of these institutions are structured.

Case A: Public Healthcare Institutions

Achimota Government Hospital was the selected public healthcare institution for this study. An analysis of the responses obtained from this institution reveals that they are operating a basic structure of hospital governance which reflects most of the attributes, dynamics and roles from De Regge and Eeckloo's (2020) archetype on hospital governance. Interestingly, the Achimota government hospital has a peculiar structure, as it does not have a board of directors, which is usually considered an important part of the governance mechanism of healthcare institutions. There are various reasons accounting for this, as the hospital falls under the remit of the Ministry of Health, and is one of the many healthcare institutions managed by the state. The institution is managed by the Medical Superintendent, who oversees the affairs of the hospital in conjunction with the management team. However, the Medical Superintendent reports to an external force in the chain of command in the public health sector. Some of the responses highlighting the composition of governance mechanisms in the health sector from the selected health institution are provided below:

Sub-Theme: Government Owned Institution

Respondents were asked to clarify the nature of ownership of the institution. The responses provided indicated that the Achimota Government Hospital was 100% owned by the state, thus making it a public healthcare institution. The response provided below captures that fact:

> "*…it's 100% government owned*." **PUHIMM1**

The response from the medical superintendent, captured above, indicates that the Achimota Government Hospital is fully owned by the government. This confirms that it is indeed a public healthcare institution with direct influence from the government through the Ghana Health Service and the Ministry of Health.

Sub-Theme: Board Diversity and Gender Representation

Respondents were asked to clarify if the institution had a board of directors overseeing the affairs of the hospital. The response obtained indicated that the Achimota Government Hospital did not have a board of directors, but rather a management team. This is captured in the following quote:

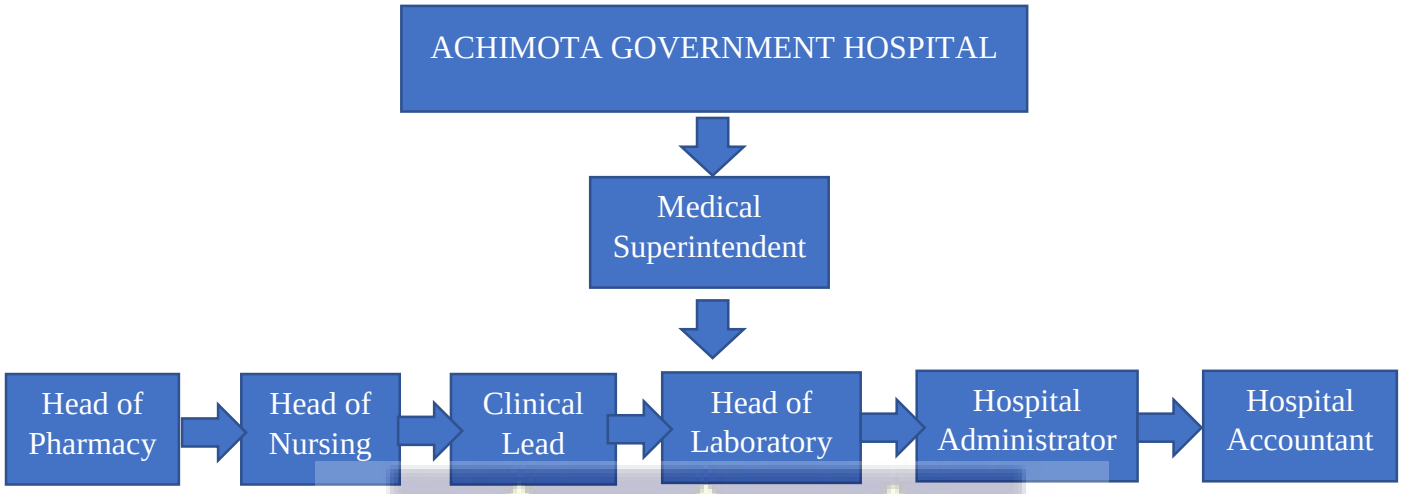
> "*…no, it's not board of directors, it's management. Hospital management. Yes, functional management but not board of directors…*" **PUHIMM1**

The response above indicates that the Achimota Government Hospital was run by a management team, and did not have a board of directors. A follow-up question was then asked to determine the composition of this management team. The respondent provided the following response:

> "*…the medical superintendent, hospital pharmacist, head of nursing, clinical lead, that's the head of the doctors. And then hospital administrator, hospital accountant, and head of laboratory.*" **PUHIMM1**

The response indicates that the management team of the hospital comprised of seven (7) members whose roles were specified. This is illustrated in Figure 5.1.

Figure 5.1- Management Structure of Achimota Governance Hospital



Source: Field Data (2024)

Sub-Theme- Gender Diversity is Not Actively Pursued

One of the key attributes this study sought to examine was gender diversity of healthcare governance mechanisms. Respondents were asked to state the degree of diversity among staff. The response obtained from the public healthcare institution was that out of the seven (7) management members, two (2) were males, whilst five (5) were females, indicating that majority of management members were female. The ratio suggests that there was a gender imbalance with females dominating the management positions. This is reflected in the following responses:

> "*So, gender diversity, I think for now it's only two of them. The finance is the only guy among them, male among them.*" **PUHIMM1**

Another response which captures the gender diversity of the management team is provided below:

"*We are all females. And then only the accountant; we are seven in number. So, five females, two males*." **PUHIMM4**

The responses provided confirm that at the Achimota Government Hospital, there are more females than males, indicating gender imbalance.

Sub-Theme-Board Meeting Times

To ascertain the frequency of policy and strategic direction of the governance mechanism of the institution, respondents were asked to state the board meeting times. From the responses obtained, it is clear that Achimota Government Hospital does not have a board, but a management team. Therefore, the questions were aligned towards the frequency of meeting times for the management team. The responses revealed that management of Achimota Government Hospital met every Monday, representing a weekly frequency. This is commonplace in most corporate organisations and is reflected the following responses:

"*I think every other Monday. So, that should be weekly*." **PUHIMM1**

The response above obtained from the medical superintendent confirms that management meets once a week, usually on Mondays. Another response also confirmed the same, but further revealed that a recent decision was taken to change the frequency to twice a month, meaning instead of meeting weekly, the meetings would take place every other week. That response is captured here:

"*…once a week but recently we have made it twice a month so that is every two weeks.*" **PUHIMM2**

The above response from the senior health administrator indicated that management members met once a week, but a new decision had been taken to change that to twice a month.

Sub-Theme-Role of Accreditation on Hospital Operations

Respondents were asked to provide insight into the role of accreditation on operations of the hospital. The responses provided generally indicate that accreditation plays an important role in establishing and monitoring quality standards at the healthcare institution. This is confirmed through the following responses:

> "*So, they don't directly play a role but I think routinely they ensure that people who work, health professionals who work in the institution are registered and duly authorized to work in the institution and are qualified. The Hefra, the medical and dental council, the nurses and midwifery council, yeah. Because yearly they access us yearly to make sure that everybody is up to scratch with the registration*." **PUHIMM1**

Another response which confirmed the role of the regulatory authorities on quality standards at the hospital is also captured below:

> "*I can certainly say that periodically they come to access our standards, whether we are following, what we are supposed to do in the healthcare facility.*" **PUHIMM3**

These responses confirm that the regulatory bodies such as HEFRA are in charge of ensuring that the health facilities maintain the very best standards in terms of patient care. The medical and dental councils also ensure that staff of the hospital are in good standing through various continuous professional development initiatives as well as annual registration and licensing.

Sub-Theme-Employee Behavioural Control Tools

Respondents were asked to clarify the nature of employee behavioural controls in the hospital. The purpose of this enquiry was to ascertain the influence of the governance mechanism on employee behaviour within the facility. The responses obtained indicate that staff training was a vital component of employee behavioural controls. Also, employee code of ethics and staff appraisals were identified as other forms of control at the Achimota Government Hospital.

> "*…We gave targets to staff; we appraise workers. Again we have on the other side we have client service test. That is acceptably back from clients, complaints and all of that. That are forwarded to the appropriate manager to resolve.*" **PUHIMM1**

Another response reflected the role of training and the organisational vision and culture as elements of employee behavioural controls. This is captured below:

> "*…We also have trainings; trainings for staff. Especially the vision of culture of excellence that we do every week. We go down and engage with staff and then we talk about things from their wellbeing and clients wellbeing and everything within*." **PUHIMM4**

Another management member offered the following insight:

> "*…We have our employee code of ethics and our professional code of ethics*." **PUHIMM3**

These responses as well as the others received from other members confirm that Achimota Government hospital has various initiatives directed towards regulating employee behaviour.

Case B: Private Healthcare Institutions

Port Medical Centre was the private healthcare institution selected for this study. The responses obtained from their management team reveals that the hospital is operating as a private healthcare institution, registered as a limited liability company and partnership. The management and ownership structure of this healthcare institution is different from the structure operated by the public healthcare institution profiled in the earlier section (Achimota Hospital).

From the responses, the Port Medical Hospital has four shareholders who also constitute the board of directors and oversee the strategic direction of the hospital. Thus, in terms of the composition of the governance mechanism of this institution, the presence of a board sits at the top hierarchy of decision-making but is complemented by a management team comprising of a manager, medical officers and unit heads.

At the Port Medical Centre, there are five board members, comprising four partners and the board secretary who also functions as the hospital manager. Out of the four partners, three are practicing, and the fourth individual is non-practicing, but serves as a partner due to her spouse being the one who established the facility. At the management level, there are medical officers who perform administrative duties, and then unit heads comprising of head of the laboratory, head of dispensary, head of maternity, head of theatre, head of nursing, head of housekeeping and head of security. Clearly, these roles are extensive and pertain to various functional dynamics of the institution.

Interestingly, there was conspicuously no mention of a head of human resource or finance within this structure. This implies that whilst the institution may have an accountant overseeing its finances, it does not constitute a role assigned on the management team. Furthermore, it appears the hospital manager's role is a multi-purpose role which may include overseeing human resource activities including recruitment and development of HRM policies. Some responses highlighting the composition of the governance mechanism of Port Medical Hospital are analysed below:

Sub-Theme-Privately Owned Institution

One of the main questions posed during the interview to management members pertained to the ownership structure of the facility. Respondents were asked to state the composition of ownership. The following response reflects the perspective of the Medical Director:

> "*The institution is built around four partners…. Three of us are practicing partners, but the third one is not practicing; she's on the partnership because her husband actually established the facility…*" **PRIHIMM1**

The response from the medical director of the Port Medical Hospital when asked about the major shareholders of the institution revealed that the ownership model comprised of four partners, three of which were practicing members, whilst the fourth was a dormant non-practicing partner, whose position on the board and ownership was because her husband was the founder of the establishment. This is an interesting composition, as the facility is now being owned by four individuals, who are partners. In order to gain a better understanding of this composition, further questions were asked to determine the criteria for becoming a partner.

The following response was obtained in relation to that:

> "*…the partnership virtually determines who will form the board. So, once you come in as a partner, and you coming in that will depend on your qualification. And of course, because it's a partnership you should acquire shares. So, it's both your financial clout and also your qualification.*" **PRIHIMM1**

The response from the medical director confirms that the partners are the owners, and they make up the board structure of the hospital. Thus, unlike in traditional management structures where shareholders appoint board of directors, in this case, the owners were themselves board members, who were also practicing medical personnel. Furthermore, the responses revealed an underlying sub-theme contributing to board appointment and representation.

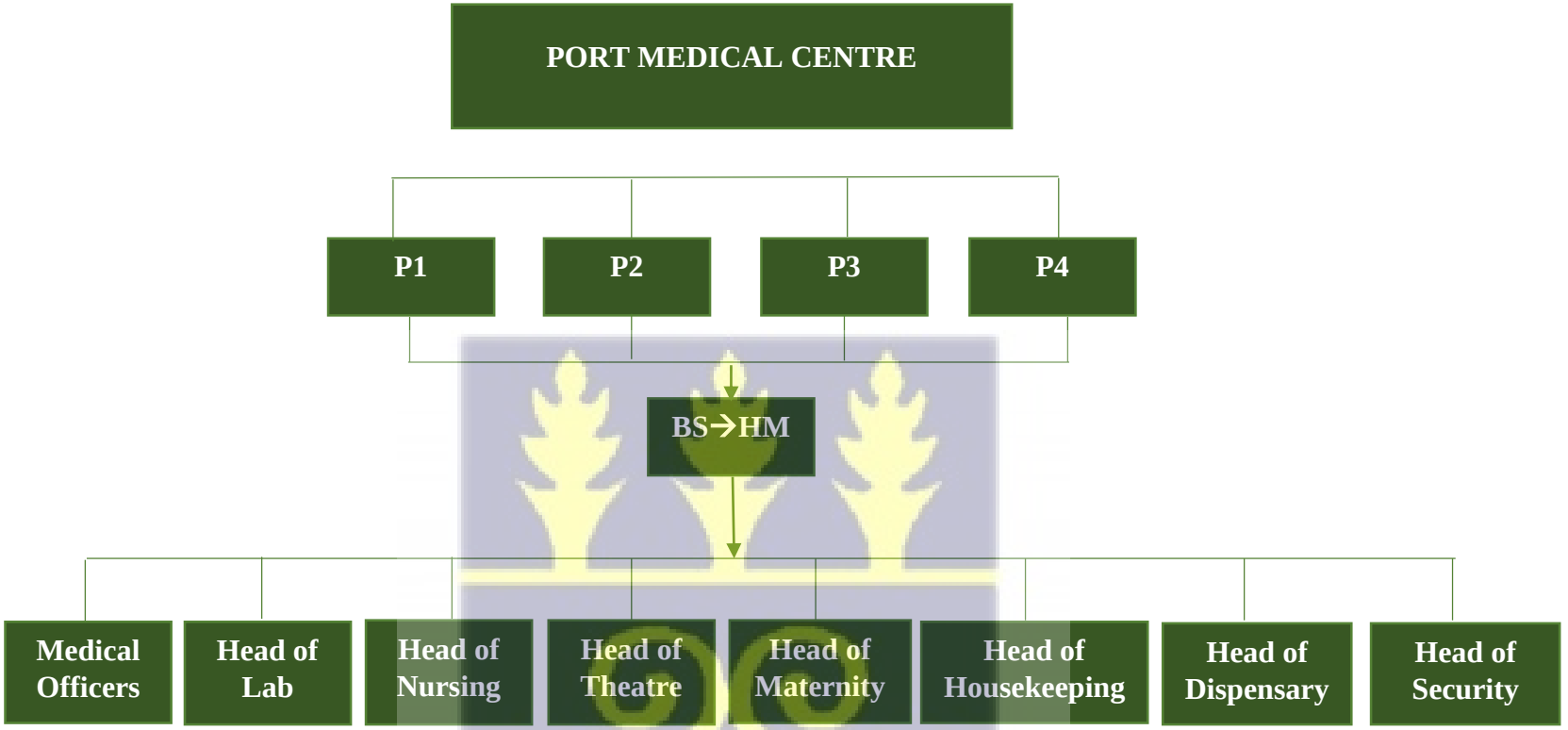
Sub-Theme: Board Structure, Diversity and Gender Representation

It was unearthed through the responses from management members of Port Medical Hospital that an individual's position as a partner determined their seat on the board of the institution. Furthermore, to become a partner, an individual needed to possess the technical qualifications as well as financial capacity to acquire shares in the institution. This is reflected in the following statement:

> "*…once you come in as a partner…that will depend on your qualification…because it's a partnership, you should acquire shares. So, it's both your financial clout and also your qualification.*" **PRIHIMM1**

Three codes led to the formulation of these sub-themes, mainly: the qualification, the shares and the financial commitment. Thus, to become an owner and a board member of Port Medical Hospital, you need to be a qualified and practicing medical professional and you need to have a solid financial capacity to be able to acquire shares and contribute to the operations of the facility. Figure 5.2 presents a pictorial depiction of the management structure at Port Medical Hospital.

Figure 5.2- Management Structure at Port Medical Hospital



Source: Field Data (2024)

NB: P1-P4 represents the four partners of Port Medical Hospital, who own the institution, and thus function as shareholders.

Another important attribute specified in De Regge and Eeckloo's (2020) typology is gender diversity. This study explored this dimension and examined the gender composition on the board of Port Medical Hospital. The response obtained indicated that the board was dominated by males, with minimal female representation. There are five members on the board, including the board secretary, who also doubles as the hospital manager. Three members out of the five, are males, whilst one partner and the board secretary are female. This appears to be a suitable gender mix, as the ratios are not extremely unmatched. The responses highlighting the gender diversity of the Port Medical Hospital are analysed below:

> "*…it just happened that we are males and the fourth partner is a female and the manager is also a female.*" **PRIHIMM1**

The response confirms that majority of board members were males (N=3), whilst female representation was in a respectable minority (N=2).

Sub-Themes-Board Meeting Times

The responses indicated that the board met at least once a month. There was no clear and established meeting time, even though the Medical Director indicated that at first the board used to meet every Friday of the month, but that has changed over time. The following response provides insight into the board meeting times at Port Medical Hospital:

> "*We were meeting every Friday of the month, one Friday of the month but now it's difficult so we have emergency meetings but then... and then also, at least one meeting a year to discuss the financial status. But as much as possible, we try to have one meeting in a month. First it was mandatory but now as much as possible*." **PRIHIMM1**

Another response however indicates that the meeting is not as frequent as monthly, but can sometimes be once in every two months depending on the nature of activities. This response is provided here:

"*The board of partners meet at least once every quarter just to review kind of what the board of management has put out, sort of. And then the board of management meets roughly ones every two months just to firm up issues because they are more or less the people that oversee to the fact that everything is in place and everything is being done right*." **PRIHIMM2**

These responses when triangulated imply that the board of the institution meets at least once in every two months, but sometimes also meet as frequently as once a month.

Sub-theme- Role of Accreditation on Hospital Operations

Respondents from the management team of the hospital were asked to provide insight on the role of accreditation on the operations and standard operating procedures of the hospital. Judging from the responses obtained, it was evident that accreditation underscored the clinical ethics and structure and ensured that staff recruited to perform specialist and medical roles had the requisite qualifications to safeguard patient health and safety. An analysis of the responses further indicated that HEFRA played a key administrative role in ensuring that a health facility met the requirements before being granted the license to operate. Some of the analysed responses are presented here:

"*So, legally we are supposed to acquire accreditation from Hefra by virtue of the fact that we are a private facility. We actually have accreditation from Hefra. We have just applied for renewal ship because our accreditation ended in august. So, we have done payment. We are waiting for Hefra to come for inspection and renew our license. So, we pay that which is legal. It is also legal to also get accreditation from NHIA by virtue of the fact that we run insurance, private health insurance companies. So, if you want to have that facility then we also need accreditation from NHIA which we also have passed. Then your clinical personnel are supposed to be accredited by all agencies. Their professional agencies which according to the health professional's regularity act, it's, so, all medical officers and physician assistant by medical and dental councils. All pharmacists and pharmacy technicians by pharmacy council. And then we have the*

other allied health and that includes lab, x ray, so radiographer, medical lab scientists and their other lower caders by bye allied and professional health council. And then we have the nurses and midwife council which registers and licenses the practices of nurses and midwives. So, we deal with all of those entities." **PRIHIMM2**

Another response which captures the role of accreditation in the healthcare service delivery is presented below:

"*First before we do the physical structure, Tema development corporation and Tema metro assembly will have to approve the structure. And then Hefra comes in to both look at structure and functions and even staffing. Now, the medical association will also look at the doctors and then the nurses and midwives' council will also look at the nurses and there is the, the biomedical sciences or... they have a name they call them in other books. They also have a governing body. And everybody who is employed here will have to satisfy those criteria for them to be employed over here. Now, as we go on, they do this thing yearly. So, on yearly basis all these people have to come. If you also intend to introduce new services, then you have to bring them in to certify that you have the capability or the team to do this service. Of course, TMA will be here on a yearly basis. EPA, also on yearly basis will come in.*" **PRIHIMM1**

From the responses obtained above, it is clear that HEFRA and also other municipal assemblies play a key role in granting the health facility license to commence operations. Whilst the municipal assembly checks the physical location mainly, HEFRA is concerned with the facility as well as the staff quality and qualifications. The other professional associations also monitor and regulate the quality of staff recruited in the institution.

Sub-themes- Employee Behavioural Control Tools

The responses were analysed to determine the kind of behavioural controls that the institution had established to influence and regulate staff behaviour. From the responses, it could be determined that Port Medical Centre relied on direct supervision as a form of employee behavioural control. Direct supervision from the various unit heads and also the use of technology such as WhatsApp groups were facilitating employee communication and

behavioural monitoring. Other forms of employee behavioural control tools used by the Port Medical Hospital include a code of ethics, employee attendance and awards. These are reflected in the following extracts:

> "*Our internal mechanisms, we usually rely on the unit heads and the unit supervisors who are currently because again of technology, we are all on one platform which we share ideas and if there are any issues that arise, it's either a memo is directly written to that particular unit head or I make it a general thing for all the unit heads to assess*." **PRIHIMM3**

Other responses highlighting the employee behavioural controls are provided below:

> "*First thing you are taught about the ethics. On yearly basis, at least the senior group we expose them to ethics lecture. Which is now almost a requirement for all the medical protections bodies. Now definitely I can't go standing there and doing it. So, it depends on the unit heads. They give reports. Of course, the Ghanaian will not like to dictate people to my back. As much as possible, we stress to them that your performance as a unit depends on people in the unit. If you shield them, your performance goes down. And it is even expressed. End of year we give awards. And those units that are performing will be, they get more awards and recognitions. Off course we wouldn't kick those who are not doing well. We sit down with them and find out what is preventing them from performing. It could be even not being provided the well needed tool to perform. And of course, we look at attendance. The register every day and we watch them…*" **PRIHIMM4**

Judging from the above responses, Port Medical Hospital has three main forms of employee behavioural control, namely: direct supervision from unit heads, the enforcement of a code of ethics, and also the use of employee awards to reward proactive and positive service behaviour. The hospital also monitors attendance to determine staff who are punctual and those who are not, and these form the basis of annual performance evaluation metrics. It is clear from the data

that there are conscious measures in place to ensure staff behaviour is regulated towards quality service delivery.

Case C: Quasi Healthcare Institutions

One of the interesting institutions that were profiled in this study was the quasi health institutions. Quasi healthcare institutions are described as having dual-ownership comprising of a government-owned organisations establishing independently managed healthcare facilities. Clearly, this implies a unique ownership dynamic. In this study, the International Maritime Hospital (IMAH) was the selected quasi health institution.

An analysis of the responses obtained indicated that the hospital was owned by a single entity, that is, the Ghana Ports and Harbours Authority (GPHA). This institution is a state-owned institution, and has also established its own healthcare facility. Thus, in terms of ownership, IMAH cannot be classified as a public health institution, but as a quasi-health institution because it is owned by an organisation that operates under the government.

The responses further revealed that IMAH previously did not have an established board of directors, but in recent times one have been established. The institution therefore fulfils the core attribute dimension of hospital governance according to De Regge and Eeckloo (2020). By having a board in place, the basics of governance is established. This is explored further in the following sub-sections and themes.

Sub-Theme-State-Owned Institution

One of the cardinal questions management members were subjected to pertained to the ownership of the institution. This study sought to find out who owns the healthcare facility and who constitutes the majority shareholder. In the case of IMAH, the quasi-healthcare institution, the institution was owned by the GPHA, a government institution which oversees all activities pertaining to the ports in Ghana. Some answers revealing the nature of ownership of IMAH are analysed below:

> "*…it's GPHA…they own the entire hospital.*" **QUHIMM1**

This response was provided by the Clinical Coordinator, and reveals that the Ghana Ports and Harbour Authority are the sole custodians and shareholders of the IMAH health facility. This information was corroborated by the Head of Finance, another management member who also stated that:

> "*…this hospital is quasi. Why quasi? It is 100% owned by GPHA as a shareholder and it's also registered with the registrar general or registrar of companies as a private company. But once that you are set up with public funds, you are seen as a public institution. But since our parent company is fully government, in the ministry of health, they see as a quasi-company.*" **QUHIMM2**

In terms of ownership, the respondent cited above indicated that the Ghana Ports and Harbour Authority (GPHA) owns the facility. The key word here is *own*. In terms of ownership, the IMAH is not owned by the government directly. Indirectly, it can be argued that the government will have some form of stake in the facility due to the fact that GPHA is a state institution. However, per the composition and nature of IMAH's setup, there are no direct links between the central government and this facility. This was aptly explained by the head of finance who stated that, "*…this hospital is quasi. Why quasi? It is 100% owned by GPHA as a*

shareholder and it's also registered with the registrar general or registrar of companies as a private company." **QUHIMM2**

Finally, the Head of Administration also shared the same view, thus confirming that the IMAH was a quasi-healthcare institution duly registered as a private facility, but owned by a government institution. The response is captured below:

> "*I will say since we say 'GPHA born us'; they gave birth to us. So, they are the owners and that is the composition.*" **QUHIMM3**

The above responses indicated that the ownership of the quasi-health institution was clear and without ambiguity. The GPHA was a state institution that had established a privately-owned healthcare facility called IMAH. The responses provided insight into the nature of ownership and the legal registration status of the company. This clarifies that IMAH is a quasi-healthcare institution.

Sub-Theme-Board Structure, Diversity and Gender Composition

Another key aspect of the attribute dimension of De Regge and Eeckloo's (2020) typology which was explored in this case pertained to the board size and composition, which is an element of the attribute dimension of hospital governance. Respondents, specifically the management members, were asked to state the board size and composition. Their answers indicated that there are seven (7) members on the board of the hospital. This is reflected in the following responses:

> "*There are seven members on our board…the board chairman is a retired Anaesthesiologist…we also have two doctors on the board, a lawyer, an auditor and an HR director…in all, there are seven members.*" **QUHIMM1**

According to the clinical coordinator, whose response is captured above, IMAH's board comprises of seven individuals, who have diverse backgrounds in the medical field, law, auditing and human resource management. This response was corroborated by the head of administration who also made the following statement:

> "*…we have lawyers, we have professors and we have human resource directors before and we also have... basically that's it.*" **QUHIMM2**

From the response from the head of administration (QUHIMM2) it can be established that the board of IMAH is diverse and made up of competent professionals. The head of finance also shared some insights regarding the board composition. This is analysed below:

> "*…so, on the board, the sole management member on the board is the CEO. All the others are external members.*" **QUHIMM3**

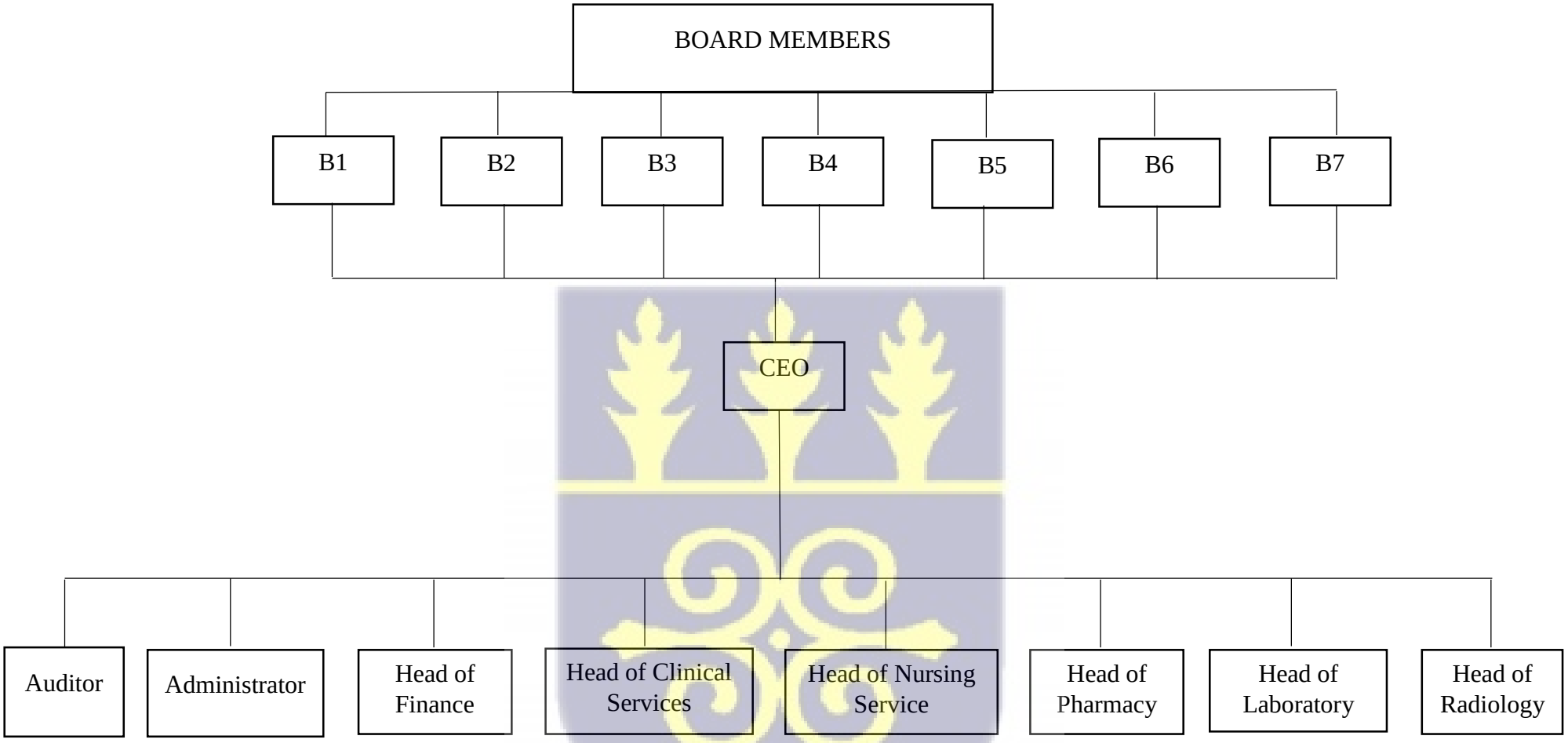
From this response, it is evident that the board is made up of one internal member, that is, the chief executive officer, whilst the other members are all external members. Further analysis of the responses indicated that the board was also supported by a management team comprising eight (8) members namely: auditor, administrator, head of clinical services, head of nursing, head of pharmacy, head of laboratory, head of finance and head of radiology. The response profiling these management members is presented here:

> "*Alright. So at the top, we have the CEO, and the auditor reports to the CEO directly. So counting from the management members, auditor is one. umm… Administrator two. Head of clinical services three. Head of nursing four. Head of pharmacy five. Head of lab six, head of finance seven. Head of radiology eight.*"
>
> **QUHIMM1**

The response above was from the clinical coordinator, and reveals that the management members report to the CEO, who is the link between the board and management. On the management team, the eight members comprise of an auditor, administrator, and heads of

clinical services, nursing, pharmacy, laboratory, finance and radiology. This information has been illustrated in Figure 5.3, which depicts the management structure at IMAH, the profiled quasi healthcare institution in this study.

Figure 5.3- Management Structure at International Maritime Hospital (IMAH)



Source: Field Data (2024); NB: B1-B7 are the board members.

Respondents were asked to state the nature of board composition in terms of gender diversity. In the previous section, it was confirmed that there were seven (7) members of the board, including the chief executive officer. However, the key question the sub-theme sought to explore was "how many of the board members were males, and how many were females?" The response presented below gives an adequate description of the gender representation on the board of the quasi healthcare institution profiled in this study.

"…*There are two females and five males.*" **QUHIMM2**

Another response confirms the gender distribution on the board of the hospital:

"*I think they are seven in number and two of them are females…*" **QUHIMM3**

The analysis of the data revealed that the male to female ratio was greater, implying that there was underrepresentation of females on the board of the hospital. According to respondents, membership on the board of the institution was determined by the Ghana Ports and Harbours Authority. In terms of representation, IMAH needs to do more to ensure equitable gender representation of females on the board.

Sub-theme-Board Meeting Times

Respondents were also asked to clarify the frequency with which the board of the institution met. This was a useful metric for measuring the decision-making dynamics of the institution. Based on the responses obtained, it was confirmed that board members of IMAH met once every quarter. This is captured in the following responses:

"*We have a schedule and we're supposed to meet every quarter…*" **QUHIMM1**

In the response above, the clinical coordinator stated that there is a fixed schedule which stipulates the frequency with which the board is supposed to meet. According to that schedule, the board is supposed to meet once every quarter, implying that the board should four times a

year. However, probing the data further, it was established that the board actually met at least once a month according to responses obtained from the head of administration and the head of finance. Their responses are presented below:

> "*The board meets once a month*." **QUHIMM2**

The response above reflects the statement made by the head of administration. According to this respondent, the board of IMAH convened once every month. This was corroborated by the head of finance who stated that the board convened once a month. That statement is presented here as well:

> "*…they meet once every other month and they also have sub committees that meet often*." **QUHIMM3**

The response above indicates that the board of IMAH meets once a month. This is similar to the previous response from the head of administration, but at odds with the schedule mentioned by the clinical coordinator. Possibly, it could imply that even though there is a schedule which stipulates that the board should meet once a quarter, in practice, they meet once a month. To be able to confirm the true nature of the board meeting frequency, other responses were consulted in order to triangulate the data and establish the board meeting times.

The response from the head of nursing, another management member, was analysed. According to the head of nursing, because a new board had been constituted, in these initial stages they are meeting once a month, but a gradual plan is in place to limit that to quarterly meetings. This response confirms the assertion by the clinical coordinator whilst also not contravening the responses from the head of administration and head of finance. The response from the head of nursing is presented below:

> "*So this is a new board. So they meet every other month. As and when there's need to meet. They also have board committees. So if the board meet this month, the following month will be a committee meeting and then the following month the board will meet. But I'm sure moving on they'll limit their meeting…the frequency of their meeting and probably meet quarterly.*" **QUHIMM4**

Based on the response above, the new board meets every other month, which implies a regular frequency. The statement also hinted at contingency meeting times as and when a need arose. Therefore, it is clear that the board of IMAH meets regularly and this can fall within the classification of monthly meetings as specified by the head of administration and head of finance respectively. However, the response sheds light on the fact that once the board settles in its role, it is likely that the frequency of meetings will be limited to quarterly meetings.

Sub-theme- Role of Accreditation on Operations and Standard Operating Procedures

Some pertinent questions were posed to respondents in a bid to ascertain the influence of accreditation agencies on hospital governance within the Ghanaian healthcare sector. This sub-theme explores the responses and establishes the role of accreditation on the operations of healthcare institutions, in this context, the quasi healthcare institution, IMAH. Respondents were asked to specify the role of regulatory bodies such as HEFRA, and the Medical and Dental Council in the management and administration of the facility and institution.

The responses obtained and analysed indicate that the accreditation agencies play a significant role in the operations and practices of the quasi healthcare institution. It was established that HEFRA in particular was a fundamental license and approval that needed to be obtained before work at the facility can even commence. HEFRA's authorisation was essential for the

legitimacy of the healthcare institution, whilst the Medical and Dental Council accreditation was relevant to ensuring the competency of medical staff at the institution.

> "*So, we need all those accreditations before we can operate…we needed that to start. And every year, we need to renew those things.*" **QUHIMM1**

The response above examines the key descriptors "accreditation", "operate" and "renew". From this statement, the accreditation is an essential part of the process of legitimacy for healthcare institutions. As such, it was established that even after receiving the requisite accreditation to commence operations, the institution needed to renew the licenses every year. Some of the processes are conducted annually as confirmed in the response provided below:

> "*Yeah, they normally come for inspections. I believe yearly. And they will make sure we adhere to the rules and regulations laid down. They emphasize on that.*" **QUHIMM2**

From the response above, it can be deduced that the regulators aside from granting an initial license to commence operations also come for annual inspections. The purpose of these inspections are to ensure that the healthcare institutions comply with the expected standards and regulations in order to ensure quality patient care and healthcare service delivery.

Another response highlighting the role of accreditation in hospital governance is captured below:

> "*So, for Hefra, by law if you don't have that Hefra license, there's no way you can operate as a hospital. It was the first one we got, and…is renewed every other year. Then medical and dental council, though it's not direct, but they have to ensure that all the medical professionals they are working with renew their license and also validate their certificate or license, that is, their professional license with the Ghana medical and dental council*." **QUHIMM3**

From the response above, HEFRA plays a key role in providing licenses for healthcare institutions in Ghana. The medical and dental councils also provide accreditation for doctors and other medical professionals, but do not validate or provide accreditation for the healthcare

facilities. These various regulatory agencies and councils play an important role in ensuring that the facilities and personnel of health institutions are up to the required standards.

Sub-theme-Employee Behavioural Control Tools

The interviews also sought to explore the employee behavioural control mechanisms that quasi healthcare institutions were adopting to shape the behaviour of their employees. From the analysis of responses, it emerged that staff targets, client service tests and performance reviews were the employee behavioural tools used to regulate employee behaviour in International Maritime Hospital. Some of the responses are featured below:

> "…*We have targets set for every staff. And then we appraise workers. Again we have on the other side we have client service test. That is acceptably back from clients, complaints and all of that. That are forwarded to the appropriate manager to resolve.*"
> **QUHIMM3**

The response above indicates that management sets certain performance targets for staff and regulates them to ensure that staff achieve the set goals. Another behavioural control tool is direct feedback from clients through the client service test. This enables the hospital to get feedback from clients, complaints and other issues that may arise during the service delivery process.

Overall, the responses indicate that IMAH has put in place various controls to regulate the behaviour and performance of staff, especially in relation to quality service delivery. This forms part of the effects of having a clearly defined governance mechanism that comprises of attributes, dynamics and roles.

Case D: Mission Based Healthcare Institutions

The fourth case this study explored under the theme of nature and composition of governance mechanisms was mission based healthcare institutions. These are healthcare institutions owned by religious organisations.

Sub-Theme-Originates from the Catholic Church

The researcher sought to determine and clarify the nature of ownership of the mission-based hospital profiled in this study. As a result, some questions were posed to respondents in order to ascertain the ownership of the mission hospital. It must be noted that mission-based healthcare institutions are owned by religious organisations such as churches or Islamic based institutions. In the case of St. John of God hospital, the logical inference, is that the institution was owned by the Catholic Church. An analysis of responses obtained confirmed that this assertion was valid. The director of the institution confirmed that the hospital was owned by the Catholic church. This is reflected in the following response:

> "*…it's a mission-based hospital; a Catholic hospital.*" **MIHIMM1**

From the response above, it has been specifically stated that St. John of God Hospital is a mission-based hospital owned by the Catholic Church. According to the respondents, St. John of God Hospital had a unique status as it represented the flagship medical outreach programme of the Catholic church. The respondent claimed that there are many St. John of God hospitals all over the world. This is captured in the following response:

> "*…we are everywhere in all the seven continents in the world. We are present everywhere, in Europe, Asia and that's where everywhere you go and say 'St. John of God', they will say 'hospitality'…*" **MIHIMM1**

The response above indicates that the Catholic Church has developed the St. John of God brand into a global outreach in all the seven continents, with a slogan which says "hospitality". Hospitality unsurprisingly emerged as one of the core values of this institution. Other responses from some of the other management members confirmed that the hospital was totally owned by the Catholic Church. These are captured below in the following extracts:

> "*This institution is owned by the Catholic Church…*" **MIHIMM2**

The above response from the clinical coordinator confirms that the St. John of God Hospital is owned by the Catholic Church. A similar response was captured in the following extract:

> "*…let me just say catholic. It's owned by archdiocese of Accra. We are under archdiocese even because our work permit and everything is provided by the archdiocese.*" **MIHIMM4**

This was confirmed by other responses from the other heads on the management team. From the various responses, it is clear that the hospital is a mission-based hospital wholly owned by the Catholic Church.

Sub-theme-Board Structure and Gender Composition

After determining the nature of ownership, respondents were asked some questions to examine the board size and composition of St. John of God Hospital. The responses obtained indicated that St. John of God Hospital was run by a board which comprised of a medical director, finance, human resource, nursing administrator, and a legal practitioner. The composition of the board is specified in the following response:

> "*…we have almost head specialist in different areas. We have a medical director, we have a medical doctor, we have financial people, we have the human resource, we have the nursing administrator who forms part. We also have legal people who are also part that we consult them. They are like co optics really. We call them when we need them.*

> *They are not always in the day to day running of the hospital but when we need them, we consult them…*" **MIHIMM1**

Other responses obtained also indicated that there are six (6) individuals on the board of the institution.

> "*…the board of directors we have the chief accountant, deputy chief accountant, the director himself, we have the matron, the nurse manager. We call them the nurse manager. We have the Doctor Afede, that's the superintendent medical doctor, he's part of them. Then HR is also part of them…we have two females among them. The rest are all males… we have four males*." **MIHIMM3**

Based on these responses, it was evident that the board of the hospital (St. John of God) was functioning like a management team. As a follow-up question, respondents from the management team were asked to clarify the nature of the board and management structure at the hospital. From the responses obtained, it appeared that indeed St. John of God had a unique structure where board members were actually functioning as management members involved in the day-to-day operations of the hospital.

> "*…we have the hospital board. The board that is running like the management team. That is running the day-to-day activities of the hospital. But the other board, the board of trustees is in the courier where the provincial is leader and you have other members.*" **MIHIMM1**

The response provided above is from the director of the facility, and he indicated that at St. John of God, the governance structure is different due to the influence of the Catholic Church, and its management requirements. Therefore, even though there is a board for the hospital, it is more of a functioning management team. However, above the management team is a board of trustees, which is headed by the Provincial leader, who is a brother. The individuals on the board of trustees do not directly influence the operations of the hospital, but leave those duties to members of the management team. Furthermore, the influence of the catholic church on the

nature and composition of the governance mechanism at St. John of God was confirmed by the clinical coordinator who also stated that:

> "*…because it's under catholic, they have this catholic health trust so they are saying the hospital shouldn't have board of directors…but they have the bishops who function as the board of directors at the bishop level, and other members who are also taking care of, and are in charge of the facility.*

In order to clarify this response, the participant was asked a follow-up question; "*So, as at this afternoon which is two o'clock, there's nothing like an active and a functional board of this institution?*" The respondent provided the following response:

> "*…there is but not within the facility. It's a general one for all the catholic facilities…but this hospital has a management team made up of six people, however, if you include the secretary, then they are seven in total; three females, and four males.*" **MIHIMM2**

From the response above, the clinical coordinator indicated that there is a board of trustees which is general for all catholic facilities, but not specifically for St. John of God Hospital. However, the respondent stressed that a management team was in place which oversaw the administration and operation of the facility.

When probing further into the structure of the organisation, the accountant provided the following insight:

> "*The provincial superior sits at the top, the management advisory board comes then the administrative director comes and the line managers follow. The financial administrator as well as the medical director, and then unit heads.*" **MIHIMM3**

Other respondents were consulted to share their views on the nature and composition of the governance mechanisms of St. John of God Hospital. The Head Nurse claimed that the

structure was headed by the Provincial Superior, who heads the province, followed by the board of directors, provincial advisors and then the management teams at the hospital. It appeared that the mission-based hospital had a different governance structure from the public, private and quasi healthcare institutions sampled in this study. The following response attests to that:

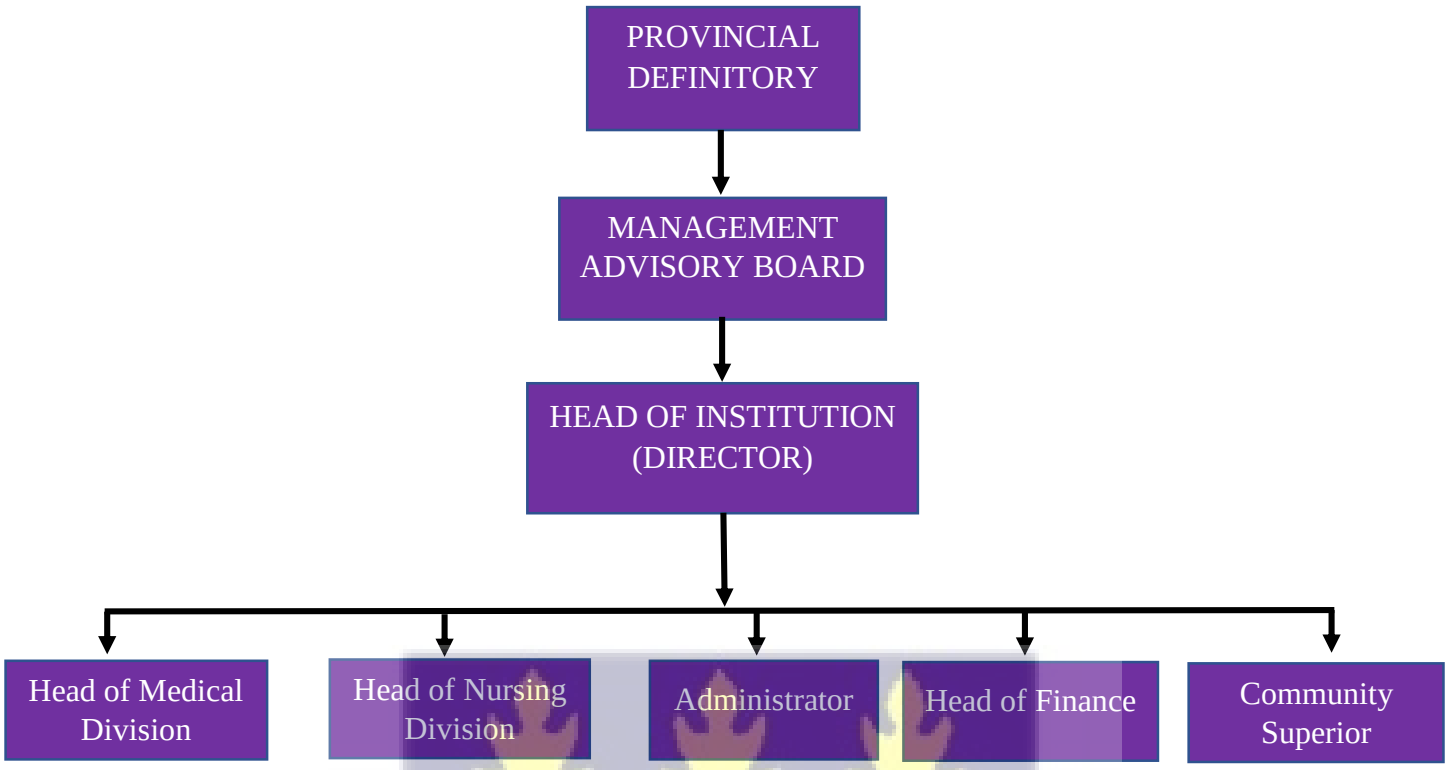
> "*…okay, they have this provincial superior. He's the head of the province. Then there is the board of directors, then the provincial advisors, then the management teams in the hospitals*." **MIHIMM4**

Respondents were further asked to clarify the calibre of people who were appointed on the management team of the hospital. The following responses were obtained;

> "*So, they are professionals, medical professionals and we have the auxiliary staff too*." **MIHIMM5**

Overall, these responses provide insight into the nature and composition of the board and management structure at the hospital, which helps in describing the attributes, dynamics and roles of the governance mechanism in place at the institution. Figure 5.4 provides a pictorial representation of the management structure at St. John of God hospital.

Figure 5.4- Management Structure at St. John of God Mission Hospital



The gender diversity of board and management of St. John of God was also explored. From the responses provided, it was evident that there was an equitable distribution of gender among the top roles especially in the management team that oversaw the day-to-day operations of the hospital. The responses indicated that the male to female ratio was not negatively skewed, but almost having an equitable distribution.

> "*So, they are seven people; we have a secretary included so seven. So, three females and four males.*" **MIHIMM2**

The response above indicates that there are seven members on the hospital management team. This was confirmed in another response provided below, and proves that there were no extreme imbalances in gender representation on the management team of St. John of God.

> "*…We have four males and three females. It wasn't... I don't think there was any specifics to it.*" **MMIMM3**

Sub-theme-Board Meeting Times

Management members from St. John of God were asked to state the meeting times for their board, and based on the responses received, it appears as if the board met every month unless there were mitigating circumstances such as the absence of key members and other unexpected events. Some of the responses pertaining to board meeting times are captured below:

> "*Oh, for these things usually we meet except something happens, but we meet every month*." **MIHIMM1**

> "*Every month. Except someone travel and we also have emergency meeting and all those things but normally, almost every month*." **MIHIMM5**

Based on these responses, it can be deduced that the management members of St. John of God Hospital meet at least once a month, and this can be classified as regular meetings.

Sub-theme-Role of Accreditation on Operations and Standard Operating Procedures

An important issue explored within the interviews, and related to the conceptual framework of this study was the role of accreditation on the operations of the various hospitals and their standard operating procedures. In the interview with respondents (management members) from the St. John of God Hospital, some pertinent questions were asked to unearth the role of accreditation on the hospital governance and quality-of-service delivery.

From the responses obtained and analysed, it was evident that the accreditation sets the tone for quality standards required to commence operations, and continual development and professional license renewals also helped ensure that staff were in tune with the latest developments within their area of expertise. It was further established that accreditation was adhered to as a matter of law, and this was non-negotiable. Thus, from the responses, the law

played a big part in ensuring that the hospital received the necessary accreditations and licenses before commencing operations.

When quizzed on the role of accreditation from HEFRA, the medical and dental council played in the management of the facility, the following responses were obtained:

> "*…without the Hefra accreditation, we cannot work. So, once, you need to first register with them for them to give you that accreditation. So, once you have the accreditation and I think it is renewable. So, when the certificate gets expired, you have to renew. So, it has become a tool which you had to get before you can go ahead and operate. So, without Hefra accreditation, you cannot operate. And management is in constant touch with them. They normally come here for inspection and to see how things are done in the facility then maybe give advice on how to improve on certain things. And when the certificate is about to expire, you need to register with them, upload series of document for them to come over and inspect before the certificate is given to you before you go ahead to operate.*" **MIHIMM1**

The above response from the director of the institution offers insight on the nature and role of accreditation. First of all, it was established that accreditation from HEFRA in particular is essential for the commencement of operations, and is renewable upon expiration of the certificate. The response further reveals that aside from obtaining a certificate to operate, officials from HEFRA engage management in dialogue to ensure that constant improvements are made to guarantee quality healthcare service delivery. This was confirmed in another response from the head of nursing. This is captured below:

> "*It really helps because they put us on our toes and they make sure the right thing is being done here. And even as a hospital or facility, when you are able to go through all those processes, you know that you are fit to operate as an institution.*" **MIHIMM5**

The response from the Head of Nursing explained that accreditation served as a catalyst for quality service delivery. From the response above, the respondent made it clear that the

accreditation ensures that the right thing is done in the institution. This clearly suggests that accreditation is an integral part of external mechanisms that contribute to the effectiveness of the governance mechanisms of healthcare institutions in Ghana.

Respondents were asked a follow-up question pertaining to the nature of accreditation, in order to determine whether visits from the accreditation agencies were scheduled or unscheduled. The responses obtained indicates that there were variations in the nature of visits from accreditation agencies; sometimes, the visits were scheduled, and other times, they were unscheduled. Responses capturing these views are presented below:

> "*oh, sometimes it's not scheduled. Yes, and as it stands now, we are number four on safe care in the whole of Ghana. We have safe care, grade one, level one, level two, level three, level four. So, for a hospital to have a level four status, it means that all your things are in order. Not 100% but about 75 to 80.*" **MIHIMM5**

These responses clearly indicate that accreditation plays an important role in the governance of St. John of God Hospital. Another sub-theme that was explored is employee behavioural control, and is captured in the next section.

Sub-theme-Employee Behavioural Control Tools

One of the features of the governance mechanisms this study sought to explore was in relation to employee behavioural control tools used by the various hospitals. The purpose of this enquiry was to identify the way the various healthcare institutions were regulating the behaviour of employees to ensure that it aligns with the values and the performance expectations of the institution, especially in relation to client (patient) care.

From the responses obtained from management members of St. John of God Hospital, it was evident that the institution had a number of employee behavioural control tools which was helping regulate the behaviour of staff. These controls included: disciplinary manuals, disciplinary committees, and performance reviews. The responses convey the sense that these controls are effective in shaping staff behaviour towards the delivery of quality services to clients in the hospitals. Some of the responses are examined in relation to this sub-theme:

> "*oh yes, we have disciplinary committee. But we don't do this thing like victimization. We always on to improve on the process. So, we don't really attack staff who maybe in course of their behaviour... unless maybe it's against patient safety because quality, or the priority of quality is to ensure patients safety unless maybe you do something that goes against the patient and then you will face the disciplinary committee and we go with the manual. We have a disciplinary manual that we follow to mete out sanctions…And we do annual performance review…I have also introduced peer performance review.*" **MIHIMM5**

The response above from the head nurse at St. John of God reveals the employee behavioural control mechanisms that are part of the governance structure of the hospital. These mechanisms such as the disciplinary committee takes actions when there are incidents that compromise patient care and the delivery of quality healthcare. Furthermore, the response indicated that the disciplinary committee has been constituted to regulate the behaviour of staff of the hospital.

Other responses from the management members also revealed the nature of employee behavioural controls present at St. John of God Hospital. Some of these include: CCTV monitoring systems and employee time clocking devices. Other employee controls include: customer care training,

> "*We have a CCTV monitoring device that we use to monitor activities within the hospital and also check behaviour of staff…We also have a clocking device at the*

entrance there. At least before you enter the hospital as a worker, at least the HR will be able to pick the time of entry and the time of exit." **MIHIMM1**

Other responses especially from the clinical coordinator also pointed to mechanisms such as customer care training in addition to the mandatory orientation as employee behavioural control mechanisms. Additionally, it was noted that St. John of God Hospital uses employee reward schemes to motivate staff towards delivery quality healthcare to patients. Lastly, the hospital has created a suggestion box which acts as a mechanism for clients to complain to management about the behaviour of staff or any other service issue.

The following responses provide insight into these controls:

"*…we have regular customer care training for aside the mandatory orientation on entry. Then afterwards regular customer care service that we give, there is also a disciplinary committee that issues are referred to if there are any staff misconduct. We also have in place award schemes for awarding staff who are of quality standard or giving their best in terms of their services. So, we reward them and that also encourages other staff to improve upon their services. And there is also a suggestion box and complaint box where clients can drop in their clients. And also, they can also do a walk in complaints. They can complain to any management member there*." **MIHIMM2**

The response above effectively provides clarity on some of the other employee behavioural controls which include the customer care training, staff behaviour rewards and also suggestion boxes for clients. These controls are deemed to be effective in regulating staff behaviour at the hospital.

5.3.2 Theme 2: Attributes, Dynamics and Roles and Quality Service Delivery

The second theme of the study pertained to the exploration of the link between attributes, dynamics and roles and quality service delivery in the healthcare sector in Ghana. In exploring this theme, the responses from management members, employees and patients were triangulated and analysed. This was done to provide a holistic and multi-stakeholder perspective of the influence of the components of governance mechanisms on quality service delivery within the various profiled healthcare institutions.

From the analysis of data across the various cases, it emerged that having a governance mechanism with clearly defined attributes, dynamics and roles contributed to quality-of-service delivery. The influence of the governance mechanisms was through the development of standard operating procedures, policies and directives that are implemented on a day to day basis, and that form part of the culture of the institution. The responses further revealed that having clearly defined roles within the governance structure provided transparency and accountability. Quality service delivery therefore became a norm at the various healthcare institutions due to the presence of the attributes, and their corresponding interplay with the dynamics and roles. Employees had direct supervisors who monitored performance and ensured that quality standards were being adhered to. The ensuing sections provide a case-by-case analysis of the influence of attributes, dynamics and roles on quality-of-service delivery.

Case A: Public Hospitals

In Achimota Government Hospital, the researcher sought to explore the connections between attributes, dynamics and roles, and quality service delivery. Staff of the hospital comprising doctors, nurses, laboratory technicians and pharmacists were interviewed to gauge their perspectives on the issue. Majority of respondents appeared to confirm that attributes, dynamics and roles as elements of healthcare governance contributed positively towards quality service delivery. In-depth review and analysis of responses confirmed that the main influence of attributes, dynamics and roles within the healthcare institution was to establish the quality standards which employees were to adhere to in their dealings with patients. Some of the analysed responses are captured in this section:

> "*We have disciplinary committees, staff durbars and training sessions. These things are done to ensure that we are able to deliver up to the expected standards*." **PUHIEM1**

The response above cited three effects of the attributes, dynamics and roles on shaping employee behaviour towards the delivery of quality services. The disciplinary committees are used to ensure that staff comply with directives that emanate from management in relation to the specific roles during the service encounter. When staff engage in behaviour that contravenes established precepts from the management, they are queried and asked to appear before the disciplinary committee. Furthermore, there is the issue of staff durbars where management interact with staff to know their concerns and challenges pertaining to the service delivery process. During these staff durbars which occur four times a year, nurses and other hospital staff are able to communicate directly with management and provide feedback on issues related to service delivery. A response confirming the frequency of staff durbars is provided below:

> "*it's done four times in a year*." **PUHIMM2**

The staff durbars are examples of institutional arrangements that are established by management to ensure a direct connection and feedback loop between management and staff. From a signalling theory perspective, Connelly et al. (2011) emphasize the significance of feedback in providing an efficient communication system that yields desired outcomes. In the context of this study, it has been found that hospitals which have governance mechanisms comprising of attributes, dynamics and roles, are able to put in place essential feedback mechanisms that ensure that staff are rewarded and reinforced to continually deliver quality services.

Case B: Private Hospitals

The second case explored in relation to the effects of attributes, dynamics and roles on quality-of-service delivery was the Port Medical Hospital. Respondents were asked to provide insight into how the governance mechanism influenced service delivery. From the responses obtained, it was evident that the management system in place had established operating protocols, rules, code of ethics and employee monitoring systems which ensured that staff were primed towards delivering quality services to patients. Some of the responses which reflect this perspective are provided below:

> "*We have the head of directorates; the management and we have head of department for all…we have…clearer the rules and regulations for staff.*" **PRIHIEM1**

The response above highlights the role of directorates and department heads which provide clear rules and regulations that guide staff behaviour. This is a direct influence of the governance mechanism especially in relation to dynamics and roles on quality healthcare services. From the response above, it is evident that the attribute function (management) contributes towards the constitution of employee controls which starts from the top with unit

heads to oversee and directly supervise the behaviour of staff. This is further accentuated through the next response presented:

> "*The management seem to serve as a link between the directorates and we the health personnel… that helps to communicate all the basic rules that are required. The SOPs are required for the management and the health delivery that goes on here. So that's what they do. And also, they tend to communicate our needs also to the directorate. So that's where the link thing comes in. So, they serve as a mediator*." **PRHIEM3**

The response above further provides context into the influence of the attributes, dynamics and roles on quality healthcare delivery. The management structures put in place in the hospital has provided a bridge between staff and management through the directorate, and this two-way communication is evident of the signalling influence within the governance mechanism. Further questions were posed in order to ascertain how the behaviour of staff were regulated to ensure quality healthcare delivery. Based on the responses, it was evident that management had established regulations and standard operation procedures which impacted on quality standards. According to respondents, other regulatory authorities also come around and monitor service delivery processes to ensure that the right standards of delivery are being adhered to. This is reflected in the following response:

> "*Yes, but we have a standard regulation yeah, we have it. SOPs are…. we have the benchmarks alright and then from time to time, you know… is it FDA… FDA comes round… yes… they monitor… and ministry of health also comes… from time to time, they come round and if you're doing the right thing…*" **PRHIEM5**

The response above indicates that there are external factors which come in to complement the efforts of the governance mechanisms to ensure that quality service delivery is consistently being implemented. Again, some respondents noted that management constantly

communicated to staff through meetings and this helped to convey a sense of purpose regarding expected behaviour and quality standards. This is reflected in the following response:

> "*Management uses meetings to communicate their quality service delivery expectations and policies to staff*." **PRHIEM2**

Case C: Quasi Hospitals

The third case explored under this theme pertained to the quasi healthcare institutions. The analysis of responses indicated that essentially, the governance mechanism facilitated quality service delivery by equipping, empowering and rewarding staff for behaviour that culminates in quality service delivery. Staff were oriented on their job roles and descriptions, and informed on staff targets which formed the basis for appraisal. The strength demonstrated by the management team in establishing quality standards contributed to staff developing competencies in their roles, and contributing towards quality service delivery. This is reflected in the respective responses analysed below:

> "*Alright so we do have our job descriptions for every staff, which is communicated to every staff*." **QUHIMM2**

The response above highlights the role of job descriptions as an influence emanating from the attributes, dynamics and roles within the hospital. Because of the strong management structure, employees know what is expected of them, and this enables them to perform and contribute towards quality service delivery. Another response highlights the role of management targets and appraisals as a control mechanism for regulating employee behaviour. This is presented below:

> "*We have targets set for every staff. And then we appraise workers*." **QUHIMM1**

In addition to setting targets for employees, the composition of hospital ownership, management structure, hierarchy of authority and flow of regulations from management to staff represents the sum total of attributes, dynamics and roles of the hospital's governance. These mechanisms also ensure that there is a code of ethics which is vital especially within the context of healthcare service delivery. This code of ethics educates employees on how to treat patients and all stakeholders who visit the healthcare facility. This is captured in the following response:

> "*Management has an employee code of ethics and our professional code of ethics which guide our behaviour*." **QUHIEM1**

Additionally, the presence of the governance mechanism within this private healthcare institution has facilitated the creation of a culture of excellence which is influencing employee interactions with customers. One of the main areas of impact is employee communication with clients (patients) as illustrated in the following response:

> "*Normally that is one area that the culture of excellence has emphasized and it's still emphasizing on. The way you talk to the customer. Make sure you call them by name at the end of service. Oh, Mr John, how are you today? Is there anything we can do to add more to what we have done or? You know, communication is key. Yeah, and making the customer satisfied. So yes, we always make sure they are... and we have this survey that we give and we also have patient input. And they will write whether they are satisfied or not. Any comments and we have boxes they put in*." **QUHIMM3**

Further responses such as the one below confirms that the management structure works very well and is regulating staff behaviour to ensure that quality services are the norm and not the exception.

> "*okay so, the management structure here works really well. Okay so, for the nursing aspect, you will see the head of nursing always doing supervision. Supervising how the nurse's work. And for the doctors too, the same thing. And for the other parts too, there's the paramedics...*" **QUHIEM5**

It was also established that the kind of management structure in place at the institution helps to avoid information asymmetry which is a concept associated with the signalling theory adopted as one of the theoretical anchors of this study (Spence, 2002; Connelly et al., 2011). The response below highlights the nature of the management structure and its connection to information transparency and dissemination. This not only affects employees, but also helps clients (patients) know how to behave as well.

> "*The management structure is strong. So, because of that... because of the strong nature of the management, we try to put our information outside so that you will not come here and come and mess up. Like you have to know what really goes on here before you come*." **QUHIEM2**

Case D: Mission Hospitals

Analysing the responses from the mission hospital, it was evident that the attributes, dynamics and roles influenced the approach towards quality healthcare delivery. St. John of God is a Catholic healthcare institution and is heavily influenced by its core values which permeates every aspect of the attributes, dynamics and roles. The core values emanate from the church and is factored into the strategy of the hospital. As a result, the attributes, dynamics and roles are directed towards reflecting the core values of the hospital in service delivery and patient satisfaction. Furthermore, as a result of establishing a robust and effective governance mechanism, St. John of God has been able to develop mechanisms such as employee and patient charters which influence behaviour of staff, also patient satisfaction surveys, quality improvement teams and a procurement team for ensuring that quality healthcare products and medicine are procured for patients. Some of these responses are analysed below:

> "*We do patients satisfaction survey, at the end of the day, the result that comes out from those exercise we make sure that we pass the message to the people so that they know*

what is happening. They know that our patients are either happy on this aspect or they are not happy. So, how should we improve. We look at it and see, most o the time, they are the ones that will bring in suggestions. And then when they bring in suggestions, since the suggestions are coming from them, we also make sure that we implement them and what I have noticed is that most of the time, when we discuss things, if you don't put someone in charge to make sure... for example if we say we should do this. At least there should be someone to follow up to make sure that whatever we discuss, all those things that we plan to do, we are really implementing them. Because at the end of the day, if we don't have someone who is following up, we can just discuss in the hall and we agreed. But at the end of the day who is going to do this to make sure that we achieve this." **MIHIMM1**

Other responses which confirm the presence of a quality improvement team and a procurement team are also captured here:

"*In addition, we also have quality improvement team in place who also go round in making sure that whatever is discussed is enforced. And when it comes to drugs too, we have the procurement team also in place who also make sure that the right drugs are available for the kind of treatment that we see here.*" **MIHIMM3**

There were other insights gained which also reflect the influence of attributes, dynamics and roles on quality-of-service delivery in healthcare institutions. Such responses include:

"*Oh yeah. That is why I mentioned the quality improvement team. Effectiveness, efficiency, equity, patient and family centred care. We have a staff manual and the patient charter too. These are all as a result of management expectations and safeguards to ensure that quality services are delivered to patients.*" **MIHIMM5**

From the response above, it is evident that the institution's governance mechanism has put in place quality improvement teams to ensure that there is constant improvement in standards of healthcare service delivery. The responses further reveal that the staff manual and patient charters are by-products of the attributes, dynamics and roles, and contribute to quality service delivery. Other responses also highlight the vision and mission of the institution, which is championed by the governance mechanism, as well as the code of ethics and patient charter.

Per the responses, the attributes, dynamics and roles are the framework within which these institutional checks and balances exist to regulate quality standards. This is reflected in the following response:

> "*Yes, we have the vision and mission statement of the hospital. Then we have our code of ethics and the patients charter…service delivery is also measured using feedback from clients and the monitoring chains. These things exist because we have a proper management structure in place, and this structure ensures that we are focused on providing quality care to our patients.*" **MIEM2**

Another response indicates that the existence of the attributes, dynamics and roles causes the institution to prioritise staff training and development. That is also mentioned as a key contributor to the delivery of quality health services. The following response supports this assertion:

> "*Through monthly in service training, by whole staff…to the whole staff and then we have departmental presentation…These activities are organised by management to ensure that we are constantly evolving and upgrading our skills to deliver quality services to patients.*" **MIHIEM3**

The response above reflects the sentiments of other nurses, and staff who highlighted employee training as a critical feature of the influence of attributes, dynamics and roles on staff ability to deliver quality services to patients.

Client perspectives of Governance Mechanisms and Quality Service Delivery

Clients of the selected healthcare institutions were also sampled to determine their perspectives on governance mechanisms and service delivery across public, private, quasi and mission healthcare institutions. Their responses brought to the fore issues that linked the ownership and type of institution to perceptions of quality care and service delivery. Respondents from clients attending public and quasi institutions highlighted delays in service delivery, whilst private and

mission spoke of good staff attitude and professionalism as anchors of the service delivery experience.

Public Healthcare Institution

Clients at the public hospital frequently described long waiting times, limited communication, and a sense of being "lost in the system." One respondent shared:

> *"I came at 9 a.m. and left at 12 p.m. without seeing the doctor because I had to rush to work. The nurses were overwhelmed, and no one could tell me what was happening. After waiting for 3 hours, I decided to leave. It's like the system runs itself."* **CLPUBHI2**

Another added:

> *"Unless you know someone inside, your file can sit there for hours. The way they treat patients is sometimes confusing."* **CLPUBHI5**

These reflections point to bureaucratic overload and weak accountability mechanisms, often linked to centralised governance and resource constraints.

Private Healthcare Institution

Clients at the private hospital emphasised speed and professionalism but raised concerns about cost in the absence of health insurance. One respondent said:

> "*I was seen within 45 minutes. Everything was smooth, but the bill was more than I had budgeted, and more than a quarter of my monthly salary. My health insurance had expired so I had to pay from pocket. Charlie, it wasn't easy…*" **CLPRIVHI1**

Another added:

> "*They treat you well, but if you don't have money, forget it. No money, no service*." **CLPRIVHI3**

These reflections highlight the governance realities within Ghana's private hospitals, where operational autonomy and efficiency are often prioritised, with the downside being that access to care can be limited for patients without financial means, reinforcing a system where quality service is available but not always inclusive.

Quasi Healthcare Institutions

Clients accessing the quasi hospital namely IMAH owned by GPHA described the environment as structured and well-resourced. Their experiences revealed a governance model that was efficient in appearance, though not entirely inclusive for the general public especially those from lower income households.

> "*You could see that systems were in place. From registration to pharmacy, everything was orderly. And when I had a concern about my prescription, the administrator came out personally to assist. I think they deliver quality healthcare services, just that looking at the price range, it is clear that not everybody can afford this if you do not earn a certain basic income.*" **CLQUHI1**

Another respondent noted:

> "*The staff here are good. They didn't just treat my illness, they treated me like a person, they showed care and I was surprised, because this is Ghana. Even the security man asked if I was okay. You don't see that everywhere. Even when I looked confused, someone came to help me find the lab. They didn't act like I was disturbing them*." **CLQUH4**

Mission Healthcare Institution

At the St. John of God hospital, patients said they could feel the care and attributed it to the fact that the institution was mission-based. Some of the responses illustrate this general sentiment:

> "*From the moment I came in, they didn't rush me like I was just another patient. The nurse actually sat down and asked me how I was coping at home… Even when I couldn't pay everything, they didn't embarrass me. They said I could come back and settle it "small-small". You could feel that they were working from their hearts, not just following rules. It's not just a hospital, it feels like a place where people care, that's why I like coming here."* **CLMIH1**

Another respondent also stated that:

> "*I came with my child yesterday, late in the evening, and you could see the nurses were tired, but they still smiled and said, 'Let's see what we can do.' They didn't ask for money first. They asked what was wrong and listened properly before showing me where to go and what to do. When I was with the doctor, he took his time, explained everything in plain language, and made sure I understood the treatment my child would receive. These people are good. God bless them.*" **CLMIH3**

These responses indicate that quality care at the mission-based hospital was deeply intertwined with the institution's core values. Patients did not merely receive clinical treatment; they experienced a form of care that reflected empathy, respect, and attentiveness. The ethos of the institution was perceptible in staff interactions, communication style, and the handling of financial constraints, suggesting that governance rooted in faith-based principles can foster a relational model of care that prioritises human dignity, even within resource-limited settings.

5.3.3 Theme 3: Challenges of Hospital Governance

The third and last theme of the study pertained to the challenges of hospital governance mechanisms hindering decision-making and quality-of-service delivery.

Case A: Public Hospital

For the public institution (Achimota Government Hospital), some of the main challenges identified were delays in procurement, bureaucracy, lack of transportation logistics, and lethargic responses from tertiary institutions regarding the transfer or referral of patients. These challenges were associated with the governance mechanism of public healthcare institutions and are reflected in the following quotes:

Sub-Theme: Bureaucracy and Delays in Procurement

This sub-theme explored responses pertaining to delays in processing and acquiring the necessary materials and logistics from the hospital as evidenced by the following quote:

> "*well so… sometimes umm…it has to go through…. You know with private immediately you need something you just buy it and go. But with government, procurement there's a process. There's a process that they have to go through and sometimes you need something urgently but it has to go through all the processes… it delays a little. Yes*."
> **PUHIEM4**

This first quote reflects the challenge of delays in procurement. The respondent actually provided a comparison of systems in private hospitals and public hospitals, and noted that public hospitals are constrained by delays in securing supplies of medicine and other essentials when they run out. This challenge is connected to the bureaucratic system that most public sector organisations face, which is typified in the following response:

> "*…because it's government, the Ghana health bureaucracy some of them negatively affect us and cause delays in operations... the Ghana health service posting system, that's the employment of staff. Ghana health service, some of those systems negatively*

affects us because people are employed based on certain relationships... So, those are some of the issues." **PUHIMM1**

Sub-Theme: Logistic Challenges (Transportation)

When asked to state the greatest challenge that the institution has faced in relation to delivery of quality healthcare services, the following response emerged which highlighted transportation issues and also the lack of co-operation from tertiary healthcare institutions:

"*Well, from where I sit the lack of transportation system in the hospital is a major challenge. So, this one is a major challenge. Notwithstanding that, another major challenge you see, when you have a critically ill patient assuming through your own means you have gotten transport, where to accept or send the patient is another major problem. The bigger facilities think we are bringing in the patient to burden them. So, sometimes they want to dilly dally, they don't want to accept cases meanwhile that is what they are there for. They are tertiary institution to accept cases that cannot be managed in the smaller facilities but we go through a length of difficulties to convince them. And sometimes you have to send patients by force and more or less... usually we have to fall on 37 military hospital where they are our last resort when everyone is refusing. Even then you call and it's not going through... we have a funny system in Accra here where in the night you are referring a patient, you have to call before. You call and the phone lines are out. It's like, as if people have hanged the head. It will never go through. And those of us on the ground, it's a major challenge*." **PUHIMM1**

The response above identifies transportation logistics as one of the main challenges confronting the Achimota Government Hospital. This challenge pertains to the unavailability of ambulance services for conveying critically ill patients to referral hospitals such as the 37 Military Hospital. Judging from the response above, there are not always readily available ambulances, and sometimes staff have to arrange their own form of transportation. This is reflected in the statement: "…*assuming through your own means you have gotten transport, where to accept or send the patient is another major problem*." Exploring the challenges inherent in this

response, it is clear that the transportation issues comprise of the lack of adequate ambulance services, and also the personal sacrifices required by staff to transport critically ill patients.

Sub-Theme: Financial Challenges

Another example of the challenges that public health institutions face can be found in the following response which delineates the financial challenges that patients face, and the inefficiency of the National Health Insurance Scheme (NHIS). This poses resource constraint problems for the institution due to the delays in processing payments by the NHIS.

> "*So, from where I sit financial challenges. I know the national health insurance, most of about... possibly 60 to 70%, more than 70% of our patients are in NHIS. And sometimes the NHIS may owe in the arrears of sometimes over a year. So, the hospital will be in debt if services they've rendered. It's something. Sometimes we need some basic things to work and the hospital may not be able to provide. And not because it's intentional on their side, it's because they are financed constrained and if you trace it, it will be because national health insurance is owing in the arrears of over a year. So, that's a very big problem. Financially that the hospital is facing.*" **PUHIMM1**

The challenge captured above clearly highlights the issue of financial constraints which is also caused by the delays in fulfilling arrears by the national health insurance providers. According to the respondent, this causes resource adequacy issues at the hospital resulting in shortage of some supplies which the hospital is sometimes unable to cover.

Sub-Theme: Transportation (Ambulance Challenges)

Exploring the responses further, the issue of the ambulance (transportation logistics) also emerged as another critical challenge confronting the public healthcare institution. This is reflected in the following response:

> "*And again, certain things like you see ambulance, we don't have any ambulance in this hospital. In theory we have one district, one ambulance. Ambulance could be sitting close to us but it is not for the hospital. It's in the services of all the facilities, ten*

facilities in the district. And OBGYN and maternity, sometimes client emergency and we need to refer the patient. We have to call a private ambulance and sometimes we use or personal money to pay for it. Relatives may not have any money to pay but we guarantee pay just to make sure the patients get to the palace safely. So, for instance lack of ambulance for transportation purposes is another big problem that we are facing. And other logistics like you see, all things being equal, let's say lab facility, we need a lot of like duplicates of certain equipment at the lab so that if one brings down, we can fall on the other. But as government institution, we don't have the luxury of having backups. So, if it breaks down sometimes you have no option than to do certain labs outside which places a financial toil patient. So, that I am sure is another challenge." **PUHIMM4**

Sub-Theme: Human Resource Challenges

Another glaring challenge that was identified in the analysis of responses pertained to the exodus of staff. It was revealed that staff of public healthcare institutions were migrating in search of "green pastures" in foreign countries. This was causing a high rate of staff turnover which was highlighted as a possible long-term threat to the service delivery standards in the healthcare sector in Ghana. The following responses provides context to the aforementioned assertions:

"*And lack of staff, a lot of staff are running away for greener pastures and nobody can... they have the right of movement. So, we are losing a lot of staff who are experienced, who should be here to be helping us. We are losing them because they think that they are not well paid and they are going to places where they can be taken care of better. From doctors to nurses to midwives to all cater of staff, paramedics. It's happening across. If it continues a time will come there will be serious deficit in the country. A lot of experienced staff will now leave the shores. It will have a telling impact, a negative impact on health delivery system.*" **PUHIMM4**

The response above further encapsulates the major challenge of staff exodus that public health institutions such as Achimota Government Hospital are facing. From the response, it is evident that experienced staff are leaving due to poor working conditions, especially remuneration. These are issues that management of hospitals such as Achimota Government Hospital need to discuss with the Ghana Health Service as they represent long-term threats to quality service delivery.

Case B: Private Hospital

The private healthcare institutions had few peculiar challenges when staff were interviewed. Most staff stated that there were no challenges, whilst few declined to comment on that particular question. Almost all the clients (patients) interviewed also did not share any substantial challenge they had with the private healthcare institution.

Sub-Theme: Financial Challenges

The main challenge experienced by the private healthcare institution profiled in this study was financial challenges resulting from delays in paying insurance claims. This is captured in the following response:

> "*Our hospital provides services to company workers as well, that is people who have insurance...the problem is that the money doesn't come on a daily basis like being in a private hospital. So, when it come, cash in system, pay and receive. The pay can come over months. Yeah, so if you have to pay your workers and the company have received their care but they haven't paid. What can you do?*" **PRHIEM3**

From the response above, it can be deduced that the hospital's main challenge stems from the delay in insurance companies paying claims to the hospital after services have been rendered. Impliedly, this causes cash flow issues which is further highlighted in the next response presented below:

> "…*Insurance will also not pay the money in time. And the companies too, now just it then has joined insurance and they have slashed the charges. So, it goes really bad against hospitals*." **PRHIEM5**

The response above provides perspective to the major challenge being encountered by private hospitals according to the responses from staff of the institution. The issue of health insurance claims and payments is clearly the major challenge being encountered.

Case C: Quasi Hospital

The responses from management and staff of the IMAH indicate that the main challenge the hospital was facing comprised of delay in decision-making and also funding issues.

Sub-Theme: Bureaucracy and Delays in Decision-Making

The fact that the hospital was owned by the Ghana Ports and Harbour Authority meant that decisions have been to be ratified by their board, and that sometimes contributes to delays in decision-making. Other challenges identified pertain to employee promotion issues. These are captured in the following responses.

> "*umm not much. I I umm the the only challenge is funding*." **QUHIMM2**

The response above reveals the primary challenge of funding. The respondent claimed that the hospital did not have an infinite pool of financial resources to be able to execute all the projects it wanted to. Another response indicated that the type of governance structure being used in the institution also impacted decision-making through the hierarchy system. Furthermore, the institutional regulations also need to be complied with, and these sometimes causes some challenges with decision-making as illustrated in the following responses:

> "*It does influence. The governance you mean? Yes. Off course. And there are certain decisions you cannot, you have to follow the protocols laid in the health sector with the country*." **QUHIMM3**

Sub-Theme: Financial Challenges

Further clarity on challenges as a result of the ownership structure of quasi healthcare institutions is illustrated in the following response:

> "*when it reaches certain parts to be able to execute certain things it takes a while… the hospital is owned by a government institution., but when it comes to certain things we lack funding…so funding is one of the challenges…*" **QUHIMM4**

Per the response above, having access to funding to execute certain projects is one of the obstacles that quasi healthcare institutions face. The respondent claimed that because the hospital is owned by a government institution, they are constrained with limited funding opportunities and as a result encounter funding challenges.

> "*…here with promotion issues, we don't have. Yeah, but what we have is already being, we killed it. If you come with a different degree and you want to climb up, you have to wait for a position to open. Some people may come, maybe they do HND or something and then they are hired. And they went back to school and maybe continued their degree. Then they will be forcing you to... so, that is the issue that we have. And we manage that by issuing a disclaimer and to follow what we have.*" **QUHIMM3**

Case D: Mission Hospital

Responses from St. John of God were also analysed in order to determine the nature of challenges that the institution faced. From the responses obtained, it appears as if legal challenges, financial challenges, and patient expectations are the main challenges the mission hospital faces. Some of these challenges are encapsulated in the following responses obtained.

Sub-Theme: Legal Challenges

The first challenge pertains to legal challenges that arise when a procedure does not go according to the patient's expectations. According to one of the management members, this can result in a legal case against the hospital, something which has occurred before. The following response captures that perspective:

> "*a doctor performs a surgery and maybe it was a wrong, you will be sent to court…A client can sue you. So, these are some of the challenges we face.*" **MIHIMM3**

From the response above, mission hospitals in rendering services to patients (clients) can sometimes receive legal cases because of mistakes or patient dissatisfaction.

Sub-Theme: Financial Challenges

One of the cardinal challenges that was identified, which shares some commonality with challenges experienced by the other healthcare institutions is financial challenges. The director of the institution noted that having adequate or sufficient finances to run the operations of the hospital was a challenge that was frequently encountered. Financial challenges pertained to the costs incurred in operations which include cost of utilities, delays in payment of claims from insurance companies, and the general costs of maintaining the healthcare facility. This is poignantly captured in the following response:

> "*I think the main challenge I will say is just finances. That's the first challenge we are having. So, that's one of the biggest. Some of these challenges they come, they know like we are expecting, like payment of bills, even the insurance sometimes they don't pay on time. So, we always have challenges with the day to day running of the hospital. Sometimes it's very difficult for us*." **MIHIMM1**

Another challenge highlighted in the responses obtained pertains to the expectations of clients. The status and ownership of the institution has created a false impression among clients that the institution will provide free services to patients. This has become a challenge because according to management, some of the services being rendered have already been subsidised and the charges are relatively low compared to what other healthcare institutions are charging. This challenge is encapsulated in the following response:

> "*The challenge that we face is that many people who are coming to us here, they believe since this is a catholic institution, everything is free or almost free. For example, like the consultation, the whole of this area, we are the cheapest but people still complain. Consultation here is twenty cedis. You go for any hospital and they will ask from eighty to hundred. But when people come and they ask for that twenty, and for us here, if you have insurance, you don't even pay the consultation but people still complain. So, just because of that, the brand itself, it's a challenge to us*." **MIHIMM4**

5.4 Cross-Case Analysis

The responses obtained from participants pertained to the four (4) different healthcare institutions featured in this study; public, private, quasi and mission-based institutions. The purpose of the cross-case analysis was to explore the similarities and differences, as well as any inherent contextual nuances regarding the nature of governance mechanisms and its influence on quality-of-service delivery within the health sector of Ghana. Table 5.3 provides an analysis of the similarities and differences across the four cases.

The table reveals that there are similarities between the governance mechanisms of the four institutions. All these institutions have boards with the exception of the public hospital, Achimota Hospital, which does not have a board sitting above its management team. Nonetheless, there is governmental influence from the Ghana Health Service and that provides

oversight monitoring for the Achimota Government Hospital. All four institutions have management teams comprised of experts with skills across the various organisational functions.

Table 5.3- Cross Case Analysis

Case	**Composition**	**Influence on Service Quality of Delivery**	**Challenges**
Public Healthcare Institution	Management Team Government Oversight (GHS) Gender Imbalance (2 males, 5 females on management team)	Positive Influence through signalling role of quality standards, operational procedures and employee behavioural controls	Transportation issues (Lack of ambulances) Financial challenges Lethargic co-operation from tertiary institutions for transfer of patients Procurement delays and complexities Staff exodus for greener pastures
Private Healthcare Institution	Board of Directors (Equity Partners)	Positive Influence through signalling role of quality standards, operational procedures and employee behavioural controls	Financial challenges (delays in payment of insurance claims causing cash flow issues)
Quasi Healthcare Institution	Board of Directors Management Team Gender Imbalance (2 females, 5 males)	Positive Influence through signalling role of quality standards, operational procedures and employee behavioural controls	Financial issues (inadequate funding to execute projects) Bureacracy and delay in decision-making (Role of GPHA)
Mission Healthcare Institution	Board of Trustees Management Team Equitable Gender Representation	Positive Influence through signalling role of quality standards, operational procedures and employee behavioural controls	Financial Challenges (subsiding cost of treatment and services) Legal challenges (being sued by patients) Patient expectations (Free service expectation due to mission-based status)

Source: Field Data (2024)

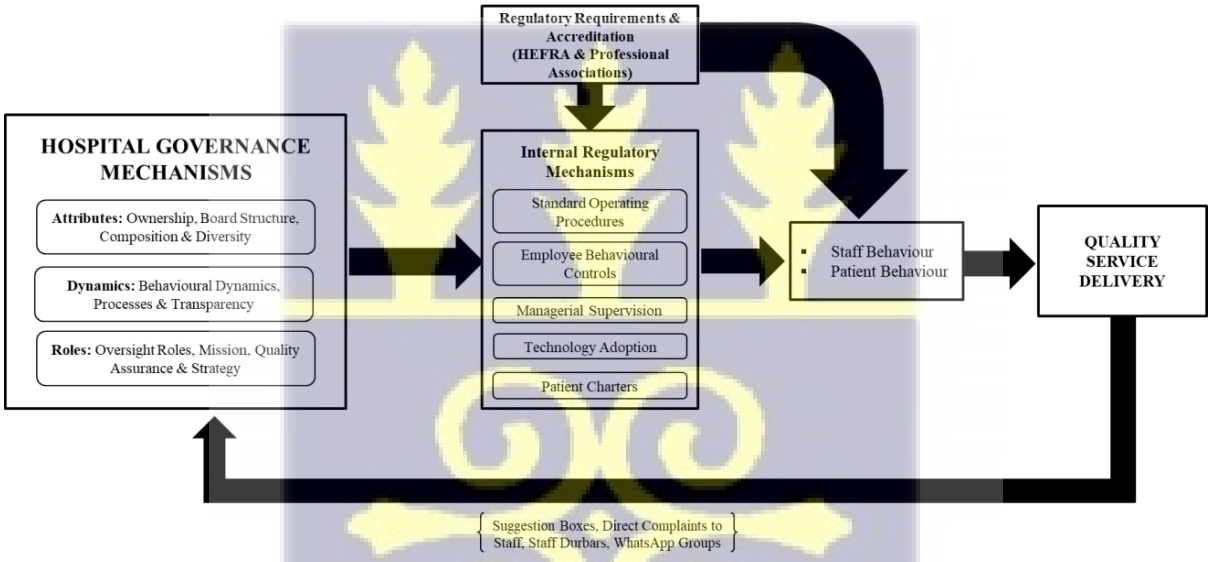
Table 5.3 provides a summary of the cues from the cross-case analysis and indicates that all the four healthcare institutions have management teams, even though not all of them had direct board of directors (example, Achimota Government Hospital). Furthermore, it was revealed that in all institutions, the attributes, dynamics and roles of the governance mechanisms had a positive influence on quality service delivery through the quality standards, policies and employee behavioural controls established to regulate staff behaviour and ensure quality service delivery. The four different institutions also had their unique challenges, but it is evident that financial challenges were one of the main themes that cut across the four cases. This implies that public, private, quasi and mission hospitals are constrained by financial impediments which impact their capacity to deliver quality healthcare services.

5.5 Summary of Results

After the analysis of data, a number of key results were achieved. These results provide clarity on the responses provided by participants, based on the interviews conducted. The first major result obtained in this chapter was that ownership of the various institutions varied, and this in turn influenced the nature and composition of governance mechanisms used to oversee the affairs of the respective public, private, quasi and mission-based hospitals. A major commonality of the four institutions was the presence of management teams that oversaw the operations of the institutions. This study found that whilst power dynamics were absent based on responses and were not a significant issue among the four institutions. However, employee behavioural controls represented a significant component of governance mechanisms that influenced the nature and quality of service delivery.

The results further demonstrated that accreditation also played a foundational role in shaping the quality standards in the various institutions. Furthermore, it was found that attributes, dynamics and roles influenced decision-making and quality-of-service delivery through communication between board and management which resulted in policies and operational strategies imbibed by staff, and implemented in the day-to-day service delivery to patients (clients). Notably, the challenges confronting these institutions varied based on the type of institution and the nature of governance mechanisms present, but among these challenges are financial challenges, logistic challenges, and human resource challenges.

Figure 5.5- Post-Study Framework



Source: Author's Conceptualisation (2023)

Note: The results from this chapter confirm that governance mechanisms have an influence on quality service delivery through the role of accreditation, policies and standard operating procedures, employee behavioural controls, and management decision-making outcomes. Thus, the conceptual framework that was developed to shape the conduct of this study was confirmed after the analysis of data.

5.6 Chapter Summary

This chapter provided insight into the data collected from respondents, and the results of the analytical process engaged in. The chapter revealed the codes and dominant themes used in classifying the data and generating analysis from the responses obtained from participants. A profile of the various participants was presented, and that entailed a demographic analysis of respondents to provide some clarity into the nature of participants. This chapter provided a thematic analysis of the data based on three core themes which captured the responses pertaining to the three objectives of the study. Overall, this chapter provided a thematic analysis of responses and further provided a discussion of results and a cross-case analysis which has helped to streamline the similarities and differences among the governance mechanisms of the four institutions. The analysis further provides added perspective to the conceptual framework of the study and provides a basis for the discussion of findings in the next chapter.

CHAPTER SIX

DISCUSSION OF FINDINGS

6.0 Chapter Overview

The previous chapter provided a narrative of the data analysis and the various processes and iterations that were involved before obtaining the results of the study. This current chapter builds on the output from the previous chapter and presents a discussion of findings, where the objectives are linked with the findings and theoretical perspectives. Furthermore, the findings are discussed in relation to the research philosophy and its influence on the research. Overall, this chapter provides a focused deliberation on the respective findings of the study discussed in relation to the research objectives, and the two theories adopted.

6.1 Discussion of Findings

The results of the data analysis led to a number of pertinent findings. In this section, the findings are discussed based on the research objectives and theoretical framework. This approach to discussing the findings facilitates a deeper understanding of the link between the purpose, objectives, theories and results of the study, and helps to provide meaning to the findings in the context of this study.

Table 6.1- Key Findings at a Glance

Research Objectives	**Key Findings**
Objective 1: To comparatively assess governance mechanisms (attributes, dynamics and roles) in public, private, mission and quasi hospitals in Ghana	I. All four healthcare institutions had some form of governance mechanism in place, although the structure varied across the category of healthcare institutions. II. The ownership of these respective healthcare institutions influenced the composition of the governance mechanism.

	III. All the four healthcare institutions reflect the attribute composition of De Regge and Eeckloo's (2020) typology of healthcare governance mechanisms. IV. All the four healthcare institutions had various internal processes created and vetted by management teams for ensuring quality healthcare standards. V. The behavioural dynamics within these institutions were also established through clearly stated hierarchy of authority and responsibility. VI. The roles within each of these institutions were also clearly delineated. VII. Staff confirmed that their institutions had organograms which highlighted key roles within the healthcare institution.
Objective 2: Comparatively examine challenges faced by public, private, mission and quasi hospitals in implementing existing governance mechanisms (attributes, dynamics and roles).	**Public health institutions** I. Bureaucratic Inertia and Operational Responsiveness II. Governance-Induced Workforce Volatility and Weak Retention Signaling III. Logistical Governance Gaps and Role Displacement in Emergency Care Coordination **Private health institutions** IV. Constrained Fiscal Autonomy **Quasi health institutions** V. Bureaucratic Inertia and Operational Responsiveness **Mission health institutions** VI. Signaling Dilemma and Stakeholder Misconceptions VII. Legal Issues (Court cases)
Objective 3: To explore the influences of attributes, dynamics and roles on quality-of-service delivery in healthcare institutions in Ghana.	I. All the four institutions have active management teams overseeing quality service delivery across units. II. The management teams were very active (regular meetings) and had direct engagements with staff. **Direct Supervisors & Staff Durbars,** III. Staff behaviour and performance was monitored & appraised.

Objective 4: Comparatively examine the feedback loop in governance mechanisms in public, private, mission and quasi hospitals in Ghana	I. All the four institutions have mechanisms for collecting feedback from patients and staff. II. Suggestion boxes were the main source of data collection from clients (patients), whilst staff durbars and meetings were used to obtain feedback from staff. III. Feedback from staff and clients were communicated to management through formal communication channels.

Source: Empirical Study

6.1 Composition of Governance Mechanisms in Healthcare Institutions in Ghana

This study found that all four healthcare institutions had some form of governance mechanism in place, although the structure varied across the category of healthcare institutions. This study found that the ownership of these respective healthcare institutions influenced the type of governance mechanism in place. From a signalling theory perspective, the fact that the ownership type influenced the kind of governance mechanism in place is a testament to the important role of ownership as a signalling force (Spence, 2002; Bicahra, 2008; Ahnefeld et al., 2008; Connelly et al., 2011). The kind of ownership an institution has, will determine the selection of board representation, management, and employees.

In this study, it was found that all the four healthcare institutions reflected the attribute composition of De Regge and Eeckloo's (2020) typology of healthcare governance mechanisms. Three out of the four institutions have functioning boards, with the exception being Achimota Government Hospital, which is exclusively run by a management team. However, Achimota Government Hospital is influenced directly by the Ghana Health Service. This was not viewed as a challenge since the postulation of the Managerial Hegemony Theory is that managers have more power in influencing the daily operations of organisations than

directors (Ogbor, 2001; Vickers, 2008; Zhang, 2015). The same scenario was evident in the mission hospital as the institution was headed by a management team even though there was the acknowledgement of a board of trustees and Provincial Superior appointed by the Catholic Church to oversee all facilities including the hospital.

In the private healthcare institution, the board of directors comprised of partners who were also active members of the organisation who contributed financial value through ownership shares, and also their expertise. Thus, the operations of the Port Medical Hospital were overseen by a competent and highly involved management team who also doubled as the board of directors. There was an extension from the management team to the operational heads of the hospital who oversaw the various departments within the hospital. From a signalling theory perspective, the fact that partners of the hospital were shareholders indicated a greater deal of involvement and commitment which contributes to operational excellence in quality healthcare service delivery.

In terms of dynamics and roles, this study found that all the four healthcare institutions had various internal processes created and vetted by management teams for ensuring quality healthcare standards. The behavioural dynamics within these institutions were also established through clearly stated hierarchy of authority and responsibility. The roles within each of these institutions were also clearly delineated according to feedback from staff who confirmed that their institutions had organograms which highlighted key roles within the healthcare institution. This structure reflects the attribute dimension of De Regge and Eeckloo's (2020) archetype of hospital governance, albeit in different strata as compared to the system used by Achimota Government Hospital.

The use of unit heads to establish supervisory controls also confirmed that each of the four institutions were practicing governance mechanisms that comprised of not just the attribute feature, but also dynamics and roles as proposed by DeRegge and Eeckloo (2020). This study also found that whilst most respondents acknowledged awareness of power dynamics, it was not found to be so prevalent or disruptive except in the case of the public healthcare institution where it was hinted that sometimes employee recruitment decisions were influenced by external forces outside the management of the hospital. These are some of the power roles and conflicts that the managerial hegemony theory hints at based on the extant literature (Hung, 1998; Brown & Humphreys, 2006; Lueg et al., 2020).

6.2 Influence of Attributes, Dynamics and Roles on Quality-of-Service Delivery in Healthcare Institutions in Ghana

This study established through the cross-case analysis that the attributes, dynamics and roles of the various healthcare institutions (public, private, quasi, and mission) had an influence on the nature and quality-of-service delivery in healthcare institutions. For public healthcare institutions, it was found that the governance mechanism was largely influenced by the directives and ethical policies of the Ghana Health Service, and this contributed to the internal efforts of staff towards ensuring quality service delivery. This confirms findings from previous studies (Abor, 2008; Abor, 2016) which highlight the role of the Ghana Health Service as a dominant regulatory and institutional factor in Ghana's health ecosystem. For private health institutions, it was also established that the attributes, dynamics and roles contributed to quality service delivery but within the framework of existing regulatory policies.

Private organisations were found to have their internal policies and standard operating procedures guiding the conduct of staff towards quality patient care. This study found that in private hospitals such as Port Medical Centre, employee training was vital as well as other employee behavioural controls such as performance review and direct supervision. These control mechanisms resulted in employees being primed to perform their roles in ensuring that patients received quality healthcare services. Quasi hospitals similarly demonstrated the presence of various internal mechanisms to regulate staff behaviour and ensure quality service delivery, whilst in mission hospitals, the values of the institutions contributed to the approach to service delivery.

Unsurprisingly, findings from this study indicate that all the four institutions have active management teams which meet within a frequency ranging from weekly, monthly and every other month. The management teams in all four institutions were very active and had direct engagements with staff. This contributed to a seamless feedback loop which ensured that staff were aware of management expectations for service delivery, whilst management was also aware of staff concerns and feedback. In some institutions, there was the use of technology such as CCTV to monitor staff behaviour in real time to ensure that the best practices in service delivery were being adopted. This confirms the observation by De Regge and Eeckloo (2020) who noted that hospital governance is evolving and aiming to become efficient in its operations. Wang et al. (2023) also hinted at increased technological adoption in monitoring outcomes within the health sector.

6.3 Challenges of Governance Mechanisms Hindering Decision-Making and Quality-of-Service Delivery

A number of challenges were identified regarding the type of governance mechanism and its influence on decision-making and quality-of-service delivery. Each type of governance mechanism had its unique challenges confronting the institution. For public health institutions, the main challenges this study found pertained to transportation and logistics issues especially in relation to ambulance services. Other challenges public healthcare institutions profiled in this study faced were financial issues, co-operation issues in the transfer of patients to tertiary health institutions, staff turnover issues and procurement delays and complexities. These problems are a reflection of the elements of managerial hegemony and the signalling theory.

The issue of logistics is a signalling problem that points to the lack of adequate resources and funding at the Achimota Government Hospital. According to Spence (1973) certain cues provide signals which inform behaviour of decision makers. The lack of adequate ambulance services is a clear signal that the governance mechanism in place at the hospital is not able to adequately mobilize resources to facilitate the delivery of certain healthcare services. The study found that oftentimes, staff could arrange alternative means of transportation to convey critically ill patients to tertiary institutions, but from a signalling perspective that is an anomaly as it is not the duty of staff to mobilize resources for patients, but rather the duty of management and the shareholders of the institution.

The signalling theory applied in the context of hospital governance suggests that hospitals are supposed to be equipped with certain basic resources and infrastructure in order to emit quality signals to patients or prospective clients (Bove & Benoit, 2020; Yasar et al., 2020; Wang et al.,

2023). The lack of adequate ambulance services at Achimota Government Hospital is therefore a symbolic representation of poor signalling not just to patients, but also to staff. This is an issue that can impact on staff morale and turnover intentions, which was another challenge this study unearthed. If staff are working under difficult conditions, with limited resources to facilitate patient transfer through readily available ambulances, it should not be surprising to discover that a number of experienced staff have resorted to leaving the country for "greener pastures" elsewhere. The conditions of service in public healthcare institutions such as Achimota Government Hospital clearly present a signal to employees, which is triggering their migration intentions as found in this study. Past studies in the area of healthcare management have also confirmed that these factors are key triggers of migration intentions (Blacklock et al., 2014; Labonte et al., 2015; Hajian et al., 2020; Toyin-Thomas et al., 2023).

The issue of lethargic responses to request for transfer of critically ill patients from district hospitals to tertiary hospitals is also another issue that can be ascribed to the managerial hegemony dynamics of healthcare institutions. The managerial hegemony theory applied in the context of healthcare institutions posits that individuals with background in the health sector and qualifications should be appointed to leadership positions (Carr & Beck, 2020; Chambers et al., 2020; Salmon & Thompson, 2020). With that in mind, it is expected that inter-institutional transfers will be easily facilitated by top-management co-operation among institutional heads. Therefore, if in the present day and age there are challenges regarding patient transfer between institutions, then the blame must somehow be laid at the feet of management. From a signalling perspective, there should be effective communication methods and briefings to facilitate smooth transfer of patients to avoid situations where patients are stranded and in critical conditions due to the lack of logistics.

Private healthcare institutions also faced the main challenge of financial problems caused by delays in insurance companies paying claims on health insurance. This tallies with the findings of Abeka-Nkrumah et al. (2009). This study found that such delays caused cash flow issues which hindered the operations of private healthcare facilities. The interpretivist philosophy was instrumental in unearthing the influence of delays in paying national health insurance claims on the financial management of private facilities. Through interactions with staff and management, it was unearthed that the introduction of health insurance was a benefit to patients, but a hindrance to the health facilities due to the long time it took to process the claims. From a signalling perspective, health insurance was a negative signal which impacted the cash flow of private health insurance companies. The study by Dalinjong and Laar (2012) revealed that from the perspective of healthcare providers, delays in paying insurance claims by the relevant authority caused financial problems which hindered effective service delivery. A recent study by Akweongo et al. (2021) also highlighted the same issue and raised concerns about how delays in the reimbursement of claims are having detrimental influence on service delivery in the health sector.

This study also found that quasi healthcare institutions were constrained by financial issues such as inadequate funding. Other issues plaguing quasi healthcare institutions were bureaucracy and delays in decision-making due to the need to seek permission from the board of the mother institution (in this case, GPHA). Mission hospitals were found to have similar issues with financial constraints, and this was mainly due to the fact that most services were subsidised in order to make it comparatively affordable than other healthcare institutions.

Notably, one of the challenges that was also found regarding the mission hospitals was that patients expected that because the institution was run by a catholic church, services should be provided for free. Lastly, the challenge of legal cases which emerged when patients were dissatisfied with some procedures was also another issue that the hospital encountered periodically. These challenges clearly demonstrate that irrespective of the governance mechanism in place, financial and resource capacity building was a major issue that healthcare institutions needed to account for. Past studies have noted that financial constraints were a major challenge faced by healthcare institutions especially in Africa (Kumar et al., 2011; McIntyre et al., 2018; Oleribe et al., 2019; Kabia et al., 2021).

6.2 Chapter Summary

The results of the analysis from the previous chapter were discussed as findings in this chapter. The chapter entailed the systematic discussion of findings in relation to the research objectives and the theories used. The major findings of this chapter provide the basis for the conclusions, implications and recommendations of the study which are discussed in the next chapter. The various findings were discussed in relation to the theoretical underpinnings and the paradigm for the study which facilitated a subjective exploration of meaning through interactions with the relevant sample. This chapter's output clearly provides clarity on the major findings of the study and confirms that presently, most healthcare institutions are embracing the attributes, dynamics and roles typology as proposed by De Regge and Eeckloo (2020). The next chapter provides a summary, conclusions, contributions and limitations.

CHAPTER SEVEN

SUMMARY, CONCLUSIONS, AND RECOMMENDATIONS

7.0 Chapter Overview

This chapter is the final section of the thesis and presents the summary of the study, the major conclusions drawn from the findings, the contributions as well as the limitations of the study. In this chapter, the summary which provides an overview of the purpose, methods and theoretical underpinnings of the study is provided, which then feeds into the conclusions of the study that are based on the findings from the previous chapter. The major contributions are delineated based on three categories namely: contributions to knowledge, contributions to practice and contributions to policy. Finally, the limitations of the study are presented, after which the directions for future research are also highlighted.

7.1 Summary of the Study

This study sought to examine governance mechanisms in the Ghanaian healthcare sector and largely focused on exploring the archetype of attributes, dynamics and roles from the typology of De Regge and Eeckloo (2020). This study was underpinned by three core objectives which were: to examine the nature and composition of governance mechanisms of public, private, mission and quasi health institutions in Ghana in relation to attributes, dynamics and roles, to explore the influence of attributes, dynamics and roles of hospital governance mechanisms on the quality-of-service delivery in public, private, mission and quasi healthcare institutions in Ghana and to investigate the challenges in hospital governing mechanisms that hinder decision-making and quality of service delivery in public, private, mission and quasi healthcare institutions in Ghana. The Managerial Hegemony and Signaling Theories represented the

theoretical framework which underpinned the postulations of this study, and were reflected in the data collection instrument and also the conceptual framework.

In order to achieve these objectives, a qualitative research approach underpinned by an interpretivist philosophy was adopted. This philosophy facilitated the in-depth interviews between the researcher and respondents comprising management members, employees and patients within the hospital setting. The discourse was underpinned by the ethical principles of consent, disclosure of intent and confidentiality. Primary data was collected through recorded interviews, which were later transcribed and analysed using the thematic analysis approach. The results of the analysis led to various findings which were discussed in the previous chapter, and which form the basis of conclusions in the next section of this chapter.

7.2 Conclusions of the Study

This study made a number of pertinent findings pertaining to the nature and composition of governance mechanisms in the Ghanaian healthcare sector among public, private, quasi and mission hospitals. These findings further provided clarity on how these governance mechanisms affect decision-making and quality-of-service delivery in these institutions. The conclusive evidence presented by the findings suggests that the various category of healthcare institutions in Ghana, namely: public, private, quasi and mission hospitals are all regulated by internal governance mechanisms that form part of the requirements for obtaining and maintaining accreditation from agencies such as HEFRA.

The study concludes that the nature of ownership influences the management and operations of healthcare institutions in Ghana, leading to various implications for service delivery. Then

bureaucracy that emanates from public and quasi healthcare institutions often leads to slower decision-making and procurement which can occasionally hinder quality and speedy service delivery. Private and mission hospitals are not encumbered by bureaucratic structures and have a flat organisational structure that facilitates quick decision-making for effective patient care. This study concludes that the nature of ownership of healthcare institutions can determine the challenges encountered by the institution in the delivery of quality patient care. This is evidenced by the fact that even though private and mission healthcare institutions sampled in this study did not suffer from the decision-making bureaucracies of public and quasi institutions, they were hindered by financing challenges that stemmed from delays in health insurance claims/payments.

This study concludes that governance mechanisms in healthcare institutions are signalling forces that influence management decisions, behaviours and operational standards. The governance mechanisms are aided by external regulatory and accreditation factors that further provide institutional pressures on staff to comply with institutional and professional code of ethics in the delivery of quality care to patients. The conclusion based on this finding is that external accreditation and employee professional associations are also signals that influence staff behaviour and contribute toward quality service delivery to patients.

Finally, the study concludes that employee behavioural controls through technology-assisted mediums such as CCTV cameras, time clock-in systems and WhatsApp communication platforms enhance operational oversight, whilst also providing real-time monitoring and feedback systems that can contribute to quality service delivery standards.

7.3 Contributions of the Study

The study makes a modest contribution to knowledge, practice and policy. The contributions are classified according to these three areas because scholars have averred that a PhD's contribution must be measured across its impact on knowledge creation, the industry of practice and also policy formulation based on the role of various regulatory and government bodies. Consequently, this section discusses the major contributions of this study according to the three categories stated.

7.2.1 Contribution to Knowledge

This study makes a unique contribution to knowledge by exploring the archetype of De Regge and Eeckloo's (2020) hospital governance mechanism in the context of public, private, quasi and mission-based hospitals. The comparative analysis engaged in this study reveals the variations and similarities in the nature and composition of governance mechanisms, and further delineates its influence on important outcomes such as quality-of-service delivery and decision-making. This study contributes to knowledge by providing an in-depth exploration of the attributes, dynamics and roles of governance mechanisms in public, private, quasi and mission healthcare institutions. By exploring De Regge and Eeckloo's (2020) typology of hospital governance, anchored on the managerial hegemony and signalling theory, this study has added new perspectives on how the ownership type, managerial dynamics and institutional policies influence and regulate employee behaviours leading to the conscious delivery of quality healthcare services.

Furthermore, this study has highlighted the signalling role of governance boards and management teams as important influences on the overall institutional commitment to quality service delivery. Additionally, the study explored the role of accreditation agencies in

complementing the efforts of governance mechanisms to ensure the delivery of quality healthcare, and this represents a unique contribution to the literature. Overall, the major contribution to knowledge in this study is the demystification of the nature and components of governance mechanisms, the development of a conceptual framework that has been verified through empirical data analysis, and the establishment of the linkages between ownership type, management structure, operating procedures and behavioural controls in facilitating quality service delivery among staff in hospitals. This study's findings have clarified the similarities and differences in governance structure among public, private, mission and quasi healthcare institutions. The study has also revealed that the underpinning regulatory framework in place in the health sector provides some general control of quality, which is further reinforced by internal processes established by hospitals.

7.2.2 Contribution to Practice

This study makes some notable contributions to practice. First of all, the study's main contribution to practice is to affirm the need for a specialised typology of governance for the health sector. Healthcare institutions are not purely profit making organisations, but are established primarily to deliver quality patient care. As a result, healthcare institutions require governance mechanisms that take into consideration the unique managerial hegemony required to install the ethical and compliant culture that can emit quality signals to the relevant stakeholders in the health sector.

This study's adoption of the managerial hegemony theory and the signalling theory provides healthcare practitioners with insight on factors that need to be considered when selecting board and management members. Achieving a right blend of managerial and industry competence is essential for the success of healthcare institutions, and therefore, this study contributes to

practice by providing a framework which can guide healthcare administrators and managers on how to ensure that governance mechanisms can be directed towards achieving quality service delivery through decision-making, employee behavioural controls, accreditation certification and compliance.

Furthermore, this study contributes to practice by highlighting the crucial need of employee training programmes as a catalyst for behavioural change in the health sector. This study raises awareness of the vital role that employee training plays in orienting staff towards embracing quality healthcare standards in the various types of hospitals in the country.

7.2.3 Contribution to Policy

This study contributes to policy by demonstrating the relevance of governance mechanisms especially in the healthcare sector and its contribution towards ensuring quality service delivery. This study's findings reveal that establishing governance mechanisms that reflect the attribute, dynamics and roles in unison facilitates a culture of quality standards and ethics which contribute to shaping the behaviour of management and staff towards quality patient care.

Furthermore, the study's focus on ascertaining how these governance mechanisms influence quality service delivery has also highlighted the relevance of accreditation and regulatory impact on continual quality standards in the various category of hospitals. Therefore, this study's contribution to policy is the validation of the relevance of ensuring that every classification of hospital has a governance mechanism, especially a management structure which comprises of competent healthcare personnel and other functional heads who are qualified, experienced and trained to oversee the operations of the hospital. The study amplifies

the need for regulatory focus and oversight in the healthcare sector in order to build on the progress made in the sector through years of regulatory due diligence.

Effectively, the findings of this study contribute to policy by highlighting the need for policy makers in the health sector to pay attention to the nature and composition of healthcare governance mechanisms, as they represent the nucleus of operations and are directly responsible for the quality of decision-making and service delivery. The study further highlights the important role of staff training and continuous professional development as vital elements of employee behavioural control, which regulators need to ensure are implemented frequently to drive staff of healthcare institutions to continually upgrade their skills and certifications to ensure quality service delivery to clients. Last but not the least, in relation to the findings on the challenges of healthcare institutions profiled in this study,

7.3 Implications and Recommendations of the Study

The study's findings provide insight and clarity on the issue of healthcare governance mechanisms, and some implications are drawn from these findings which further feed into the recommendations of the study. Both are discussed in this section.

7.3.1 Board Structure and Management Composition Vital to Quality Governance and Service Delivery

This study's findings imply that healthcare institutions in Ghana need to have a board of directors and management team comprising of seasoned healthcare practitioners and other competent functional professionals. This study therefore recommends that Ghana Health Service and HEFRA ensure that governance mechanisms of healthcare institutions in Ghana are structured to reflect attributes, dynamics and roles that are geared towards quality service

delivery through staff capacity building, employee behavioural controls, monitoring and evaluation systems and patient surveys. Also, the study recommends the formulation of policies to promote diversity and competence in the governance structure of the various healthcare institutions. Furthermore, the study recommends that the appropriate accreditation body run specialised managerial training courses for management members of healthcare institutions in Ghana. These specialised training courses can focus on core issues such as leadership within diverse environments, leading teams in high-pressured environments and managing bureaucratic and financial pressures to deliver service excellence.

7.3.2 Integrating Dynamics and Roles in Hospital Governance is Crucial for Governance Effectiveness

The findings of this study has confirmed that presently, healthcare institutions are moving away from the era where attributes were the only governance mechanism in place, with boards and management representing the only mechanism through which governance was administered. Presently, behavioural dynamics and roles have amplified the reach and effectiveness of governance mechanisms. Thus, it is recommended that training be organised for administrators and management of healthcare institutions in Ghana on the role of attributes, dynamics and roles in facilitating quality healthcare service delivery. This will help provide clarity especially on the dynamics and role elements of hospital governance. Practical training programmes that highlight important service encounter and patient care issues will be imperative in equipping management and staff to ensure quality service delivery is a norm and not an exception.

7.3.3 Employees Training and Development is Essential to Quality Performance

This study found that all the healthcare institutions ensured that staff received quality care training as part of their development and integration into the institution. This study recommends that continuous training and development programmes be organised for staff in the various institutions to equip them towards quality service delivery, whilst also broadening their knowledge and skills on latest practices in their field. Nurses and frontline staff especially need to be trained on customer service excellence to ensure that they understand customer expectations and service responsibilities in the line of duty.

7.4 Limitations of the Study and Directions for Future Research

The study attempted to explore the issue of governance mechanisms according the classification of De Regge and Eeckloo (2020). This classification delineated governance mechanisms as comprising of attributes, dynamics and roles. Based on the classification, a qualitative research approach was adopted to facilitate the collection of primary data from respondents comprising management members, employees and clients (patients) of public, private and quasi healthcare institutions in Accra, Ghana. Scholars have established that research limitations often include factors related to time, cost and other uncontrollable factors (Saunders et al., 2009; McDaniel & Gates, 2018). In accordance with this perspective, this section highlights a few limitations of the study that can form the basis for future research.

The first limitation of the study pertained to the sample area. Data was collected from healthcare institutions in Accra. The arduous and bureaucratic processes involved in securing permission and consent to interview management, staff and clients of health institutions meant that it was very difficult to extend the sample area to other parts and regions of Ghana. Indeed, the study could have benefitted from an extended scope, as it would have provided other

contextual insight into the nature of healthcare governance outside the Greater Accra Region. Nonetheless, in spite of this, Sasu's (2021) report indicates that the three regions with the populous healthcare institutions include: Greater Accra, Eastern and Ashanti. Therefore, in as much as the study has a limitation of being based in Accra, the choice of scope was also justified as Accra is one of the top three regions with the most healthcare institutions, and offered valuable insights into the nature of healthcare governance in our context. Future studies are therefore advised to build on the findings of this study, and conduct a cross-regional study to explore the nature and effects of governance mechanisms in the three regions with the most populous healthcare facilities in Ghana.

Another limitation that was identified pertained to the choice of research strategy. A cross-sectional strategy was adopted in conducting a multiple case study. This meant that data was collected at a particular point in time. A longitudinal study covering the various classification of health facilities and the influence of their governance mechanism on quality service delivery and patient satisfaction over a ten-year period could have yielded very insightful findings. As a result, future studies are urged to consider adopting a longitudinal approach towards investigating the effects of hospital governance mechanisms, especially in relation to patient and quality care outcomes.

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APPENDIX

UNIVERSITY OF GHANA
ETHICS COMMITTEE FOR THE HUMANITIES (ECH)
P. O. Box LG 74, Legon, Accra, Ghana

My Ref. No: ECH 095/ 23-24

December 20, 2023

Ralph Punamane
Department of Health Services Management
University of Ghana
Legon

ETHICAL CLEARANCE
(ECH 095/ 23-24)

The Ethics Committee for the Humanities (ECH) conducted a full-board review and approved your protocol titled:

GOVERNANCE MECHANISMS AND SERVICE DELIVERY: A COMPARATIVE ASSESSMENT OF THE ATTRIBUTES, DYNAMICS AND ROLES OF SELECTED HEALTH INSTITUTIONS IN GHANA

PRINCIPAL INVESTIGATOR: **RALPH PUNAMANE**

Please note that the final review report must be submitted to the Committee at the completion of the study. Your research records may be audited at any time during or after the implementation. Any modification of this research project must be submitted to ECH for review and approval prior to implementation.

Please report all serious adverse events related to this study to ECH within seven (7) days verbally and in writing within fourteen (14) days.

This certificate is valid until December 19, 2024. You are required to submit annual reports for continuing review.

Please accept my congratulations.

Yours Sincerely,

Professor C. Charles Mate-Kole
ECH Chair

Cc: Dr. Anita A. A. Baku, Department of Health and Services Management, UG

Tel: +233 30 393 3866 Email: ech@ug.edu.gh

GOVERNANCE MECHANISMS AND SERVICE DELIVERY: A COMPARATIVE ASSESSMENT OF THE ATTRIBUTES, DYNAMICS AND ROLES OF SELECTED HEALTH INSTITUTIONS IN GHANA

INTERVIEW GUIDE FOR MANAGEMENT

Section A- Institutional Profile

1.Name of Institution: _____

2.Location:_____

__

3.Date of Establishment/Number of Years in Existence: _____

4.Classification of Institution: Public Health Institution [ ] Private Health Institution [ ] Mission-Based [ ] Quasi Health Institution [ ]

5. Number of Staff in Institution: _____

6. What is the Mission Statement of this Institution?

_____

_____

_____

_____

_____

7. What is the Vision Statement of this institution?

_____

_____

_____

_____

_____

_____

8. What are the Core Values of this Institution?

_____

_____

_____

Section B: Participant Profile

1.Gender: Male [ ] Female [ ]

2.Age Range: 20-30 years [ ] 31-40 years [ ] 41-50 years [ ] Over 50 years [ ]

3.What year did you join the institution? _____

4.What was your entry level position in this institution? _____

5.What is your current position/portfolio in this institution? _____

6.Educational Background: Degree [ ] Master's [ ] PhD [ ] Professional Certifications [ ] (Kindly state here: _____)

Section C: Nature and Composition of Governance Mechanism

Attributes of Healthcare Governance

1. Who is the majority shareholder in your institution?

2. What is the composition of ownership in this institution?

3. (a) Does this institution have functional and active board of directors?

(b) What kind of individuals are present on the board of your institution, and what are their backgrounds in terms of expertise, gender, experience and public profile?

(c) Are there any specific criteria for selecting individuals onto the board of your institution?

(d) How many members sit on the board of directors? (What is the board size?)

(e) What can you tell us about the gender diversity on your institution's board of directors?

(f) How often does the board of directors of your institution meet?

Roles in Healthcare Governance

4. Is there an organogram that is well-known by members and staff in the institution?

5. How many management members are present in your institution's organogram and what is the hierarchical order in terms of chain of command and oversight/reporting roles?

6. How are the day-to-day operations of your institution managed? (What is the extent of co-ordination between management and employees?)

7. What role does accreditation from HEFRA, Medical and Dental Council and other regulatory bodies play in the management and administration of your institution?

8. (a) How does management ensure that patients received quality health care services in this institution?

(b) Are there any internal control roles which oversee staff behaviour to ensure ethical behaviour and delivery of quality health services? If yes, kindly describe the internal control mechanisms of your health institution.

(c) Does every employee have a direct supervisor who monitors their performance on the job and adherence to regulatory and quality healthcare standards?

10 (a) Does your institution have an internal audit function?

(b) Can you describe the internal audit function of your institution and the role they play in the governance of the institution?

Dynamics of Healthcare Governance

11. (a) How would you describe power dynamics in your institution?

(b) How does power dynamics influence decision-making and implementation in your healthcare institution?

(c) How does power dynamics in your institution affect quality service delivery to patients?

(d) Does the power dynamics in this health institution impact the quality of staff recruited? Kindly explain your answer

12. (a) How are decisions communicated from the board to management in this institution?

(b) Would you say the channels and method of communication described in Question 12a above are effective? If yes, kindly explain. If no, kindly provide reasons why.

13. How does management communicate to employees engaged in the day-to-day delivery of service to clients?

14. How are policies and strategies translated into day-to-day operational tasks by employees in the institution?

Section D: Influence of Governance Mechanisms on Quality-of-Service Delivery in Healthcare Institutions

1. Can you describe the measures your institution has put in place to ensure the delivery of quality service to clients (patients)

2. Are there any specific charters, policies and standard operating procedures that regulate the behaviour of staff with regards to quality service delivery? (If yes, kindly state them)

3. How is quality service delivery measured in this institution? (Are there any benchmarks, quality standards etc.? If yes, kindly state them)

4. In what ways do the core values of the institution influence the delivery of healthcare services to clients (patients)?

5. What mechanisms have the institution put in place to ensure that staff imbibe the core values and represent them during the service delivery process?

6. How does the kind of ownership influence quality service delivery in this institution?

7. In what ways does the management structure of your institution influence quality service delivery and standard of care?

8. In what ways are employees of this institution equipped to deliver quality healthcare services to clients?

9. Does your institution have a service blueprint which highlights the roles and duties of each employee at the frontline (that is, direct contact with patients) and backstage (direct contact with other staff)?

10. How does your institution obtain feedback on the quality-of-service delivery?

11. Does your institution have a data processing or management information system function which churns feedback into actionable strategies and policies for management consideration and action?

12. How do external regulators ensure compliance in terms of quality healthcare service delivery in your institution?

13. Can you kindly describe the ethical processes guiding patient access to quality healthcare in your institution?

14. Are there any considerations made for patient consent prior to medical procedures and interventions in this hospital? (If yes, kindly state the procedures requiring patient consent/guardian/family consent)

15. What measures have the institution put in place to ensure that patient medical data/records are safe and confidential?

Section E: Challenges in Hospital Governance Mechanisms

1. Can you kindly share some of the challenges your institution faces with regards to the governance and management of the operations of the health facility?

2. In your opinion, what challenges emerge from the type of ownership of your institution and its influence on decision-making and implementation?

3. Would you say that the organisational structure in your institution is clearly defined and facilitates the understanding of roles and responsibilities that contribute to quality service delivery? (Kindly explain your answer)

4. What have been some of the greatest challenges that the institution has faced with regards to delivering quality healthcare services that meets the expectations of all stakeholders?

5. Are there any other challenges that you would like to share with me regarding the effects of governance mechanisms and service delivery in your institution or the industry at large?

GOVERNANCE MECHANISMS AND SERVICE DELIVERY: A COMPARATIVE ASSESSMENT OF THE ATTRIBUTES, DYNAMICS AND ROLES OF SELECTED HEALTH INSTITUTIONS IN GHANA

INTERVIEW GUIDE FOR STAFF (NURSES, DOCTORS, PHARMACISTS, & LABORATORY STAFF)

Section A- Individual Profile

1. Gender: Male [ ] Female [ ]
2. Age Range: 20-30 years [ ] 31-40 years [ ] 41-50 years [ ] Over 50 years [ ]
3. Marital Status: _____
4. Religion: _____
5. Educational Background: Basic Education [ ] SHS [ ] Diploma [ ] Degree [ ] Master's [ ] PhD [ ] Other [ ] (Kindly state here: _____)
6. Which Educational Institution did you receive your training from? (E.g., Nursing College)

   _____
7. What year did you join the institution? _____
8. What was your entry level position in this institution? _____
9. What is your current position/portfolio in this institution? _____
10. Which department do you work under in this healthcare institution?

    _____
11. How many years have you been working in the department stated in Question 7?
12. Have you worked in any other category of health institution aside the one you're currently working at? (i.e., public, private, mission-based, or quasi)
13. Would you want to switch to another healthcare institution? (If yes, what would be the major motives for switching?)
14. What are the Core Values for this institution?

_____

_____

_____

_____

15. Are you aware of the mission and vision statement of this healthcare institution? (If yes, kindly state it)

Mission Statement

_____

_____

_____

_____

_____

_____

Vision Statement

_____

_____

_____

_____

_____

_____

Section B: Impact of Governance Mechanisms on Quality Service Delivery

Attributes

1. How does the kind of ownership influence quality service delivery by staff in this institution?
2. Does the healthcare institution you work with have the necessary management structures in place which oversees the administration and delivery of quality healthcare services by staff? (If yes, what structure(s) are in place?)
3. In what ways does the management structure of your institution influence quality service delivery and standards in healthcare service delivery?

Roles

4. Is the behaviour of staff of this healthcare facility regulated by any specific charters, policies and standard operating procedures? (If yes, kindly state them)
5. How is quality service delivery measured in this institution? (Are there any benchmarks, quality standards etc.? If yes, kindly state them)
6. What mediums does management use to communicate its quality service delivery expectations and policies to staff?
7. (a) How often does your healthcare institution evaluate your performance with regards to your role in quality service delivery?

   (b) After your performance is reviewed, what are the outcomes?

   (c) Does your institution have any reward or punishment system for regulating the behaviour of staff in relation to delivering quality healthcare services to clients (patients)? (If yes, kindly state them)
8. In what ways are employees of this institution equipped to deliver quality healthcare services to clients?
9. Have you ever received training on service quality delivery in the healthcare sector? (If yes, how long ago did this occur, and who facilitated the training?)

Dynamics and Processes

10. Does your institution have a service blueprint which highlights the roles and duties of each employee at the frontline (that is, direct contact with patients) and backstage (direct contact with other staff)?
11. Are there any guidelines on how staff in this healthcare institution are supposed to relate to each other in the delivery of services? (If yes, kindly state what guidelines are in place)
12. Does your institution have a mechanism for evaluating staff ethical behaviour at the workplace? (If yes, kindly describe this mechanism)
13. How would you describe the degree of transparency within the institution, from management through to employees?
14. Does management engage healthcare staff to solicit for your opinions on how to improve service delivery and achieve organisational goals? (If yes, how often?)
15. Are staff of this institution made to feel like they are part of a family? (If yes, in what ways?)

16. How does the hospital guarantee the well-being of staff?
17. Do you as staff receive feedback on the quality-of-service delivery from patients?
18. Does your institution have a data processing or management information system function which uses feedback from patients to improve service delivery?
19. Is employee behaviour in this institution influenced by external regulators in the healthcare sector? (If yes, which regulators are you referring to specifically?)

Section C: Challenges in Hospital Governance Mechanisms

1. Can you kindly share some of the challenges your institution faces with regards to the governance and management of the operations of the health facility?
2. In your opinion, what challenges emerge from the type of ownership of your institution and its influence on decision-making and implementation?
3. Would you say that your role as a health worker in this institution is clearly defined and enables you to understand your responsibilities that contribute to quality service delivery? (Kindly explain your answer)
4. (a) Are you aware of any power dynamics/power struggles at the top hierarchy of your institution?

   (b) If your answer to 4a was yes, how does the power dynamics/struggle impact on decision-making and implementation as well as quality service delivery?
5. What have been some of the challenges that you've encountered in this institution as a staff seeking to deliver quality service delivery that meets the expectation of patients and other stakeholders?
6. To the best of your knowledge, how does the hospital ensure that ethical principles are regarded in the care for patients and the delivery of healthcare services in this institution?
7. Are there any other challenges that you would like to share with me regarding the effects of governance mechanisms and service delivery in your institution or the healthcare sector at large?

GOVERNANCE MECHANISMS AND SERVICE DELIVERY: A COMPARATIVE ASSESSMENT OF THE ATTRIBUTES, DYNAMICS AND ROLES OF SELECTED HEALTH INSTITUTIONS IN GHANA

INTERVIEW GUIDE FOR CLIENTS (PATIENTS)

Section A- Client Profile

1.Gender: Male [ ] Female [ ]

2.Age Range: 20-30 years [ ] 31-40 years [ ] 41-50 years [ ] Over 50 years [ ]

3. Educational Background: Basic Education (BECE) [ ] SHS [ ] Diploma [ ] Degree [ ] Master's [ ] PhD [ ] Others [ ] Kindly state: _____

4.Occupation:

_____

5.When did you start visiting and patronizing healthcare services from this institution?

_____

___

6.What are the main considerations influencing your patronage of healthcare services from this institution? (You can choose more than one; as many as apply to you)

Proximity [ ] Occupational Health Benefits [ ] Social Influence (Family & Friends) [ ] Quality Service Delivery [ ]

7.Are you the only member of your family who patronizes healthcare services from this institution? (If no, kindly indicate which other members of your family use this healthcare facility)

_____

___

Section B: Influence of Governance Mechanism on Choice of Institution

1. Does the ownership of this healthcare institution (public, private, mission-based or quasi) influence your patronage of their services? (If yes, kindly explain how it does)

2. Do you care about the nature of ownership and management of this institution and its effect on the quality of services that are delivered? (if yes, why? If no, why not?)
3. In your opinion, how does the ownership and management of healthcare institutions influence your decision to patronize services offered by the institution?
4. (a) Have you ever bothered to check whether this institution has received all the necessary accreditation to operate?

   (b) Have you tried to check if the institution has a website, and whether the accreditation required is stated on the website?

   (c) In what way does the accreditation of this healthcare institution impact on your patronage?
5. Out of the various types of healthcare institutions that exist in Ghana (public, private, mission-based and quasi), which one do you prefer the most, and why?

Section C: Influence of Governance Mechanisms on Quality-of-Service Delivery in Healthcare Institutions

1. From your encounter with this health institution, how would you describe the orientation of this facility in terms of patient-centred care?

   (a) Per your assessment, would you say the behaviour of staff and the nature of service delivery indicates that the institution prioritizes patient-centred care?

   (b) What are some of the elements of patient-centred care that you observe in this health facility?
2. How would you describe the nature of patient waiting time in this health care institution? (a) Are you made to wait for long hours before being attended to?

   (b) What is the longest period of waiting time you have experienced in this hospital and how did it influence your perception of service delivery and management at this institution?

   (c) Since you started patronising health services from this institution, have you witnessed a reduction in patient waiting time? (If yes, tell us what you observed)
3. How would you rate the performance of this institution in terms of quality service delivery using any of these three terms: Excellent, Good, Satisfactory, Poor?

(a) Can you describe your experience with this institution in terms of the quality-of-service delivery to patients?

(b) In what ways do you think this institution strives to deliver quality services to its clients?

4. Do you think the type of ownership of this institution (public, private, mission-based and quasi) impacts on the quality-of-service delivery given to clients (patients)? Kindly explain your answer.
5. From your point of view, does the quality of healthcare staff in this institution impact on the delivery of quality healthcare services? (If yes, kindly explain how)
6. Aside from this institution, have you patronized healthcare services from other forms of healthcare institutions (public, private, mission-based, quasi)? -State the others that you've experienced.
7. From your perspective as a client, how do you think the form of ownership determines the quality of staff recruited to deliver quality services to yourself and others? (Do you think that the quality of staff performance varies across the various institutions; public, private, mission-based, and quasi?)
8. How would you describe the attitude of staff of this institution towards the delivery of quality healthcare services to clients (patients)?
9. Do you feel secured and confident in the quality of healthcare services rendered by this institution? (If yes, kindly explain. If no, kindly state your reasons why)
10. Do you perceive that the institution is well staffed to handle all patient needs and cater for a large number of people? (Kindly explain your answer)
11. From your experience as a client, do you think management of this healthcare institution is doing all that it can to enhance and ensure quality healthcare service delivery to clients (patients)? (Kindly explain your answer)

Section D: Challenges in Hospital Governance Mechanisms and Quality Service Delivery

1. Can you kindly share some of the challenges you have encountered as a client of this healthcare institution?
2. In your opinion, what challenges emerge from the type of ownership of this healthcare institution and how does it affect the delivery of quality healthcare services?
3. Have you encountered any ethical dilemma with staff of this institution, or the institution in general? (If yes, what was the issue and how was it resolved?)

4. In your encounter with staff of this healthcare institution, do you perceive that their behaviour reflects the values and mission of the institution?
5. (a) Has there been any situation or incident(s) that have left you less than impressed with the quality of healthcare services delivered by this institution? (If yes, kindly describe them)

   (b) In relation to the question above, when you experienced the negative incident or encounter, did you find a way to make your grievance known? (If yes, what did you do? If no, why?)

   (c) Has this institution provided visible mediums for expressing grievances and concerns? (e.g., suggestion boxes, online complaint forms etc.?)

   (d) Have you ever considered using the suggestion box present at the premise of the healthcare facility to inform management of the nature of service delivery and your feedback for improvement?
6. Have staff of this institution ever behaved rudely or unprofessionally to you before? (if yes, describe the incident)
7. In relation to the question above, what was the reaction of colleagues and other staff when this incident occurred? Were you consoled and assured, and was their colleague reprimanded for behaving in that manner?
8. Are there any other challenges that you have noticed about this institution's delivery of healthcare services that you would like to share with me?