

**UNIVERSITY OF GHANA
COLLEGE OF HUMANITIES**

**ASSESSING THE PERFORMANCE OF AN EXECUTIVE AGENCY IN GHANA: THE
CASE OF THE KORLE BU TEACHING HOSPITAL, 2008-2018**

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DECLARATION

I hereby declare that this MPhil thesis is the product of my own independent research work and contains no previously published materials except works which have been fully acknowledged, and was carried out at the Department of Political Science, under direction and supervision of Prof. J.R.A. Ayee and Dr. Abdulai Kuyini Mohammed.

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ABSTRACT

The weaknesses of the public sector in the delivery of effective and efficient services in developing countries is a policy problem that is well documented in the literature. The public sector is noted for being unresponsive to customer needs and also fraught with corruption and rigid regulations. Consequently, the new public management ideas including the executive agency concept were proposed as an antidote to the problems associated with quality in public service provision.

Against this backdrop, this thesis examines the Korle Bu Teaching Hospital (KBTH) as a semi-autonomous public health organization and executive agency. Although the executive agency concept is a model that has been applied in several public sector organizations, the health sector is one area whose impact has not been examined in detail. This study approaches the KBTH as an executive agency and examines its impact in the delivery of health service.

The study employed the qualitative design methodology of interviews and focus group discussions. The sampling technique used included the purposive sampling and the snowballing technique. The respondents for the study included former Board chairpersons and Board members, former directors of the hospital, current directors and unit heads. Others included senior members of the College of Health Sciences, clients and patients of KBTH who constituted the focus group sessions.

The study found that the KBTH was structurally segregated from the mainstream civil service and the Ministry of Health. The KBTH therefore had a flexible management Board and the management team to determine operational matters such as budget, recruitment of personnel and development, administrative and management autonomy in its day-day activities. However, institutional, legal and regulatory weaknesses have undermined the capability of the hospital to

fulfil in fullest its mandate as a health sector executive agency. Some of the recommendations to deal with the weaknesses include the enactment of the legislative instrument to operationalize the Ghana Health Service and Teaching Hospitals Act 525, 1996 and devolution of the sub-budget management centres such as the Department of Child Health, Department of Obstetrics and Gynaecology, Department of Surgery and the Department of Medicine and Therapeutics as separate hospitals to improve management and operational efficiency, control and quality of care in the KBTH. Also, the use of improved technological infrastructure is crucial to enhance effective and efficient healthcare.

DEDICATION

I dedicate this work to my wife, Mrs. Deborah Addobea Ponku, my parents, Mr. David Roland Ponku and Madam Mary Tetteh and the entire Naachey Asharkor Twidan Royal family of Awutu Bawjiase.

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LIST OF ABBREVIATIONS

AHPC	Allied Health Professions Council
CCTH	Cape Coast Teaching Hospital
CEO	Chief Executive Officer
CHPS	Community Based Health Planning Services
CHS	College of Health Sciences
CSPIP	Civil Service Performance Improvement Programme
CSRP	Civil Service Reform Programme
CWSA	Community Water and Sanitation Agency
DDNS	Deputy Director of Nursing
GCPS	Ghana College of Physicians and Surgeons
GHOSPA	Government Hospitals Pharmacists Association
GHS	Ghana Health Service
GICG	Ghana Institute of Clinical Genetics
GOG	Government of Ghana
HTH	Ho Teaching Hospital
IGA	Income Generation Activity
IGCC	Income Generation and Consultancy Committee
IGF	Internally Generated Funds

IGOs	Intergovernmental Organizations
IMF	International Monetary Fund
KATH	Komfo Anokye Teaching Hospital
KBTH	Korle Bu Teaching Hospital
LI	Legislative Instrument
MDA	Ministries, Departments and Agencies
MDC	Medical and Dental Council
MDGs	Millennium Development Goals
MOH	Ministry of Health
MOU	Memorandum of Understanding
NCA	National Communications Authority
NCTC	National Cardiothoracic Centre
NDC	National Democratic Congress
NMC	Nursing and Midwifery Council
NPM	New Public Management
NRONMC	National Radiotherapy Oncology and Nuclear Medicine Centre
NRPSBC	National Reconstructive Plastic Surgery and Burns Centre
OECD	Organization for Economic Cooperation and Development

O&G	Obstetrics and Gynaecology
PAHO	Pan American Health Organization
PNDC	Provisional National Defense Council
PURC	Public Utilities Regulatory Commission
SAP	Structural Adjustment Programme
SBAHS	School of Biomedical and Allied Health Sciences
SDGs	Sustainable Development Goals
SMD	School of Medicine and Dentistry
SOEs	State Owned Enterprises
SOP	School of Pharmacy
TTH	Tamale Teaching Hospital
THs	Teaching Hospitals
UDS	Units, Departments and Sub-Budget Management Centres
UGCHS	University of Ghana College of Health Sciences
UGMS	University of Ghana Medical School
WHO	World Health Organization

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CHAPTER ONE

BACKGROUND OF THE STUDY

1.0 Introduction

Over the past three decades, a number of new public management (NPM) approaches and values, typically associated with the market and the private sector, have been introduced to improve administration and management practices in government, in the developed, developing and transitional economies (Larbi, 1998; Ofosu-Adarkwa, 2000; Kickert, 2001; Caulfield, 2006). These reform strategies and approaches have been driven and influenced by several factors and circumstances including changing economic, social, political conditions and technological development (Larbi, 1999; Yamamoto, 2006; Caulfield, 2006).

The executive agency concept is a key element of the NPM and arguably, one of its most adopted policy options and proposals (Laking, 2002; Moynihan, 2006; Massey, 2006). Moynihan (2006) further points to the apparent worldwide acceptance in the use of the agency approach for enhancing administrative and management capacity of the state and improvement in the public sector delivery of services. Consequently, the 1980s and 1990s witnessed a rise in the emergence of autonomous organizations and executive agencies in virtually all the countries in the global arena (Verhoest et al. 2010; Sulle, 2010). The concept of an executive agency according to Mutahaba and Kiragu (2002: 63) “was in search for alternative options for improved public service delivery of services” and for the promotion of efficiency and effectiveness in government (Dodoo 1997). Scholars of executive agencies have argued that autonomous public organizations are more efficient and effective than civil bureaucracy in view of the autonomy powers, control and accountability mechanisms embedded in the agencies

(Joshi and Ayee, 2009; Sulle, 2010; Atta-Mills, 2002; Manasan, 2003; Kim and Cho, 2016). Due to this NPM reform, managerial, operational, and administrative autonomy have been strengthened through the reduction of control often applied to inputs in the execution of public policies and the provision of services (Ohemeng and Adusah-Karikari, 2017; Kim and Cho, 2016; Verhoest, 2018; Moynihan, 2006).

The resultant effect of this phenomenon is the introduction of accountability mechanisms and tools such as the performance contracting, financial incentives and stronger competition. According to Kim and Cho (2016), though the structural designs of agencies may differ, two main control mechanisms such as result-oriented performance contracts and performance-enhancing reward systems are used to regulate the conduct and behaviour of executive agencies. Some of the key assumptions of the NPM doctrine which favour the creation of autonomous public organizations are result control and financial incentives which the organizations enjoy, empower them to improve on their performance and quality standards in service provision through the use of their autonomy and self-governing powers to deal swiftly with financial and human resource issues (Pollitt et al, 2001; Joshi and Ayee, 2009; Kim and Cho, 2016; Ohemeng and Adusah-Karikari 2017). According to Van Thiel and Pollitt (2007), the ideas of autonomy and result control have their root and origin from the principal-agent theory. Kim and Cho (2016) have further argued that civil bureaucrats and public managers usually pursue agenda that are not consistent with the concerns and aspirations of the national government. The setting up of executive authorities is therefore, an effort towards organizing the focus and interests of the principal and the agents by restructuring the incentive system.

This pattern in public service management and organizational reform across the globe is aimed at enhancing decentralization of management, involving more managerial, operational, financial and administrative autonomy and devolution of budgets and financial control for semi-

autonomous public entities on the British 'executive agency' lines (Ofosu-Adarkwa, 2000; Larbi, 1998) and debureaucratize public services (Ingraham, 1996). The executive agency concept has resulted in the focus on the creation of independent bodies as single purpose organizations mandated and empowered for the provision of specific tasks and/or services leading to a movement from unitary public administration, and separation in policy design, implementation and evaluation (Ohemeng and Adusah-Karikari, 2017). The hiving off of agencies from the civil service was also aimed at building the capacity of the sector by instituting an increasingly flexible and performance-oriented sector (Laegreid and Verhoest, 2010; Overman and Thiel, 2016).

According to Verhoest (2018), agencies as organizational reform strategy is not a new idea but the NPM period change the rationale behind agency creation and the governance mechanisms of agencies. The traditional executive agency was aimed at creating checks and balances to counter the royal power in the case of Sweden, partnering with other societal interests' groups in corporatist environments such as Belgium and minimizing political risks and maintaining stability in the execution of national goals, objectives and programmes in the ever changing public space. However, the NPM styled agency model was developed in 1980s in Europe by the United Kingdom government and other Anglo-American states and intergovernmental organizations (IGOs) such as the International Monetary Fund (IMF), the World Bank and the Organization for Economic Cooperation and Development (OECD) (Verhoest, 2018). Pollitt et al (2001) also posit that policy prescriptions and loan conditionalities of IGOs caused astronomical rise in the creation of agencies across the globe.

Essentially, the NPM agency model sought to make governments lean by making public sector organizations function like private entities and incorporate market values into them. The NPM executive agency, therefore, seeks to promote specialization, efficiency, service innovation and

responsiveness to customer groups in diverse market situations and organizational environments. The executive agency concept is based on the principles of structural and functional disaggregation, competition and performance contracting and independence in management matters such as personnel, finance and budget (Dunleavy et al, 2006; Sulle, 2010; Ohemeng and Adusah-Karikari, 2017; Moynihan, 2006; Overman and Van Thiel, 2016; Verhoest 2018).

Likewise, Ghana in the 1980s and 1990s followed the executive agency approach towards reforming its public sector through the changes in its tax revenue administration (Atta-Mills, 2002; Joshi and Ayee, 2009), water and health sectors (Larbi, 1998; Ohemeng and Adusah-Karikari, 2017). In the view of Ohemeng and Owusu (2015), Ghana is the first developing economy that established the executive revenue agency in the mid-1980s, with a ministerial level secretariat which became fully integrated in 2010. Similarly, the executive agency model is manifested in the creation of the Local Government Service Act 656, 2003, with a secretariat mandated for the management, development and provision of local government services and functions to the Ghanaian citizenry in the various sub-national and local government areas. Again, the establishment of the Community Water and Sanitation Agency (CWSA) in 1997, charged with the responsibility for providing all year-round access to efficient, quality and sustainable and clean water and sanitation services and facilities to the underserved and rural districts in Ghana is also indicative of the setting up of an executive agency.

According to Aryeetey and Ahene (2005), the post-Cold War period witnessed a minimal role for central government in economic activities including the delivery of public services in developing countries. Consequently, private sector ownership and involvement in critical areas of the public service delivery implied the setting up of independent supervisory agencies to provide regulatory and oversight roles, and ensure compliance, efficiency, competition, affordable pricing and quality of services (Aryeetey and Ahene, 2005). In the light of this, two

major regulatory executive agencies such as the Public Utilities Regulatory Commission (PURC) and the National Communications Authority (NCA) were set up to oversee the activities of corporate entities and players involved in utility service provision, namely, water, electricity and telecommunication in Ghana.

According to the OECD (2005), the implementation of decentralized health policy is the most pronounced development idea in several developing countries. Similarly, Bossert and Beauvais (2002) argued that health sector management reform policies in developing societies are issues of keen interests to many international organizations such as the World Bank, Pan American Health Organization (PAHO), World Health Organization (WHO) etc. The concept of autonomous hospitals according to Govindaraj et al (1996), refers to hospitals that decide on their own governance framework and policies relating to finance, administration and management. Govindaraj et al (1996) views hospital autonomy in two perspectives of ‘type’ and ‘degree’. According to them, the first approach involves ownership and authority whilst the second approach relates to the hospital management functions – general administration, human resource management, governance and financial management. The organizational, operational and management changes in Ghana’s health service delivery began with the promulgation of the Hospitals Administration Law 1988, (PNDCL 209) which became effective in 1990. The Law granted limited managerial powers to the Korle Bu Teaching Hospital board (KBTH) and for the first time created a board of governors’ model with substantive management functions (Frimpong-Boateng, 2015).

The health service reforms were further boosted and strengthened in the mid-1990s with the enactment of the Ghana Health Service and Teaching Hospitals Act 525, 1996. The Act 525 reinforced the autonomy powers of the KBTH and granted the board extensive policy making and management functions in the areas of governance, financial management, general service

administration and human resource management (Govindaraj et al, 1996). Specifically, Act 525 mandates the KBTH to undertake three main primary goals: (i) the provision of advanced clinical healthcare to support the ones provided by the Ghana Health Service; (ii) serve as the training ground for the teaching and training of both undergraduate and postgraduate health personnel and (iii) undertake research into health issues to improve public health standards and quality in Ghana (Republic of Ghana 1996).

1.1 Problem Statement

Even though Ghana implemented one of the most comprehensive political decentralization policies in Africa in 1988 with the creation of 110 District Assemblies (Ayee, 1994), not much attention was paid to management decentralization within the public service. In the health and other major public services, decision-making on operational and implementation matters as well as allocation and control of human and financial resources continued to be centralized (Larbi, 1998; Gbagbo, 2015 and Adane, 2015). According to Ayee (2001), the Mills-Odoi Commission on the Structure and Remuneration of the Public Service and the Okoh Commission on the Structure and Procedures of the Civil Service highlighted the weak and disorganized public organizations involved in service delivery and policy implementation, and recommended a separation between ministerial bodies in charge of policy making, strategic planning, monitoring and evaluation and the decentralized agencies responsible for implementing policies and decisions.

To rectify the situation, the Provisional National Defense Council (PNDC) and the National Democratic Congress (NDC) governments implemented a Civil Service Reform Programme (CSRP) and Civil Service Performance Improvement Programme (CSPIP), and a parallel reorganization of the public health bureaucracy in Ghana as components of the Structural

Adjustment Program (SAP) (Ayee, 2001). Another attempt at restructuring the health service in Ghana began in 1994 (Frimpong-Boateng, 2015), which was aimed at increasing the efficiency and effectiveness of services provided by the Ministry of Health (MOH) and making it more decentralized, customer-oriented and managerial public sector (Caulfield, 2006).

One of the consequent major organizational changes in the health sector has been the establishment of autonomous hospitals with their own boards of directors. The five teaching hospitals in Ghana, namely, the Korle Bu Teaching Hospital (KBTH), Komfo Anokye Teaching Hospital (KATH), Tamale Teaching Hospital (TTH), Cape Coast Teaching Hospital (CCTH) and the Ho Teaching Hospital (HTT) were granted autonomous status in 1988 by the Hospital Administration Law (PNDC Law 209). Though hospital boards were created in 1989 and formally inaugurated in 1990, full implementation was not done until 1996. The delay in implementation was due to the limitations that were imposed on the Teaching Hospitals Boards by PNDC Law 209, which provided that the performance of the functions of the Teaching Hospitals Board is subservient to policy directions and advice as the Minister responsible for Health may determine (Frimpong-Boateng, 2015). Additionally, the majority of the Hospital's Board members were composed by the central government through the Minister of Health, and moreover, the hospital board had no authority to review upwards hospital fees and charges (Frimpong-Boateng, 2015).

The current organizational and operational structure of the Ghana's health sector is intended to create a Ghana Health Service (GHS) and Teaching Hospitals (THs) as an autonomized executive agencies of the Ministry of Health, based on the UK's National Health Service arrangement. The legal and regulatory framework for the GHS and THs is catered for under the Ghana Health Service and Teaching Hospitals Act 525, 1996. The GHS and THs were separated from the traditional public administration structure to promote a higher form of managerial

flexibility and pragmatism to undertake their duties. However, the supervisory Ministry of Health (MOH) remains part of the civil bureaucracy and is responsible for policy making, strategic planning and performance monitoring of the GHS and the THs. A clear separation has therefore been made between policy-making on one hand, and policy implementation and delivering of services on the other. By law, the teaching hospital boards have substantive management roles.

Despite the progress made in the establishment of the autonomous public organizations in the health sector (GHS, KBTH, KATH, TTH, CCTH and HTH), they have not been successful in dealing with their mandates including public health delivery and clinical services, leading to a loss of public confidence in their ability to deliver their services and questions surrounding why they have been created in the first place as executive agencies. Even though a number of studies such as that of Frimpong-Boateng (2015) and Govindaraj et al, (1996) have been directed at explaining why the KBTH has been ineffective, inadequate attention has been paid to explaining the mandate of the KBTH as an executive agency to make its health service delivery more effective and efficient.

Against this backdrop, this study examines the performance of the KBTH as an executive agency in delivering value-for-money health service. The focus on health service delivery is due to the particular importance of quality healthcare service to succeeding governments, corporate entities and the individual. Health service delivery is an important social service that has implications on everyone. Specifically, it discusses the contribution of the KBTH to health service delivery since its creation as an executive agency in 1996, the challenges encountered and what more needs to be done to enhance its performance.

1.2 Objectives of the Study

The overarching objective of the study is to examine the contribution of the Korle-Bu Teaching Hospital (KBTH) to the delivery of advanced clinical and public healthcare services in Ghana as a tertiary health institution.

Specifically, the objectives of the study are to:

1. Assess how the KBTH contributes to health service delivery since its creation as an executive agency.
2. Examine the factors which have contributed to either the success or failure of the KBTH in health service delivery since it was established as an executive agency.
3. Identify ways to make KBTH more functional to be able to deliver on its core functions.

1.3 Research Questions

The overarching research question to be addressed is: How does the KBTH contribute to health service delivery since its creation in 1996 as an executive agency?

The two secondary questions are:

1. What are the factors which have contributed to either the success or failure of the KBTH in health service delivery in Ghana since 1996?
2. How can the KBTH be made more functional to be able to deliver its health service mandate?

1.4 Significance of the Study

The study seeks to make the following contributions to the literature:

1. It complements the existing knowledge on executive agencies, teaching hospitals and health service delivery with direct focus on the Korle-Bu Teaching Hospital, which has not received much attention in the literature.
2. It provides policy relevance insights for policy makers in healthcare policy making and implementation.
3. It discusses the gaps in the literature on executive agencies and teaching hospitals, which will form an agenda for further research.

1.5 Limitations of the Study

The limitations of the study included the difficulty in getting some respondents to cooperate with the researcher. This was due to the fact that the population included directors responsible for: Medical Affairs, Nursing Services, Pharmacy, Finance, Administration and Human Resources, the Chief Executive Officer and past Chief Executive Officers, the Board Chairman and former Board Chairpersons. Also, the directors of the hospital bear confidentiality responsibility as members of the management Board of the hospital which places restriction on disclosure of important discussions in board meetings. Nevertheless, they managed to volunteer information without compromising on their ethical responsibility as board members.

Again, the researcher used informal institutions and network of friends to overcome the challenge. In addition, the KBTH is a huge bureaucracy and given its complexity and size (Frimpong-Boateng, 2015), it was not possible to cover all the dynamics within the short time at the disposal of the researcher even though this did not compromise the findings of the study.

1.6 Delimitation of the Study

The study examines the contribution of KBTH to health service delivery since 1996 upon attaining the status of an executive agency established under the Ghana Health Service and Teaching Hospitals Act 525, 1996. The period 2008-2018 was selected because Frimpong-Boateng (2015) provides explanations for KBTH performance from 2002-2007. The study covers Korle Bu Teaching Hospital and the University of Ghana's College of Health Sciences (UGCHS) and its affiliated schools. The schools include the School of Medicine and Dentistry, School of Biomedical and Allied Health Sciences, School of Public Health, Noguchi Memorial Institute for Medical Research, School of Pharmacy and the School of Nursing and Midwifery.

The reasons for the choice of KBTH for the study emanates from the complexity in its administration, operation and location. More so, the KBTH has a unique but unusual connection with the UGCHS and its affiliated schools.

However, they are independent of each other in terms of administration, regulations, personnel and budget. Whilst the KBTH draws its financial resource allocation from the Ministry of Health, the UGCHS receives its budgets from the Ministry of Education through the University of Ghana. Significantly, the name of the hospital reminds people of a health institution but the KBTH is more than a health institution. Aside the hospital, there are many institutions which cooperate and collaborate with the hospital, and also provide support services to help it deliver on its health service delivery mandate. For instance, the UGCHS and its constituent schools train doctors, nurses, pharmacists and an array of allied health personnel and also conduct research in the broad spectrum of health sciences for professional faculty development and improving health conditions. Additionally, the UGCHS and its affiliated schools, professors, senior lecturers, medical consultants and other specialists serve as head of the clinical units in the KBTH and also provide clinical services to patients and clients.

In a nutshell, the KBTH comprises the Korle Bu Hospital and the three main centres of excellence such as the National Cardiothoracic Centre (NCTC), National Radiotherapy Oncology and Nuclear Medicine Centre (NRONMC) and the National Reconstructive Plastic Surgery and Burns Centre (NRPSBC), the Ghana Institute for Clinical Genetics (GICG) and the University of Ghana's College of Health Sciences (UGCHS).

1.7 Organization of the Study

The study is organized into five chapters. Chapter one, "Introduction" focuses on the general background of the study, statement of the problem, objectives of the study, research questions, significance of the study, limitations of the study, delimitation and chapter organization of the study. Chapter two, "Literature Review and Theoretical Framework" is divided into the following seven thematic areas: (i) studies on New Public Management approach; (ii) global studies on executive agencies; (iii) Ghanaian studies on executive agencies; (iv) studies on health service delivery; (v) studies on teaching hospitals; (vi) studies on the performance evaluation of organizations; and (vii) the executive agency model which underpins the study. Chapter three, "Methodology" is devoted to research design, methods of data collection, sources of data, population of the study, sampling methods and sampling size, data analysis procedures and the rationale for the selection of the Korle Bu Teaching Hospital. Chapter four, "Presentation and Analysis of Data" examines the data collected and discusses the findings. Chapter five, "Summary, Recommendations and Conclusion" summarizes the findings of the study and makes recommendations for improving the management and delivery of health service by executive agencies.

CHAPTER TWO

LITERATURE REVIEW AND THEORETICAL FRAMEWORK

2.0 LITERATURE REVIEW

2.1 Introduction

There is an abundant literature on executive agencies and hospital autonomy based on developing and developed countries. In order to ensure that this study is situated in a proper context, the existing literature will be reviewed. Although there have been several research studies on executive agencies on the Ghanaian situation, there is little or no efforts at explaining managerial autonomy as it exists in the Korle Bu Teaching Hospital (KBTH). Most of the studies that were directed to the Korle-Bu Teaching Hospital investigated clinical and medical related issues. Thus, no serious attention has been paid to the administrative and management performance of KBTH since becoming an executive agency under the Ghana Health Service and Teaching Hospitals Act 525, 1996. This study therefore, seeks to fill the gaps on the operational and management autonomy and its consequent effects on performance, quality of care, efficiency and effectiveness of the KBTH. Against this backdrop, the literature review is divided into the following six thematic areas:

1. Studies on the new public management approach,
2. Global studies on executive agencies,
3. Ghanaian studies on executive agencies,
4. Studies on health service delivery,
5. Studies on teaching hospitals, and
6. Studies on performance evaluation of organizations.

2.2 Studies on the New Public Management Approach (NPM)

Larbi (1999) in his work on “the new public management approach and the crises state” made the case that the NPM is a globally accepted private sector-based principle for enhancing public sector performance. In his view the NPM era has shifted attention to public management over the old public administration approach to the public sector management which is founded on the principles of the market. He asserted that the key aspects of the NPM included the establishment of autonomous public organizations, devolution of budgets and financial independence, introduction of performance contract, user fees and charges and target setting and contracting out of ancillary services to different providers and increased emphasis on customer care. He attributed the rise of the NPM approach to the rapidly evolving economic, political and social circumstances and the increasing effect of the development of information technology. Other factors responsible for the emergence of the NPM approach are the development of neoliberal policies, aid conditionalities imposed by the West and multilateral financial bodies and the use of international management consultants in the implementation of policy reforms. He pointed out that the NPM started as a developed countries idea, particularly by the Anglo-Americans, but the 1990s saw the spread of the NPM values in many under-developed societies such as Ghana, Zimbabwe, Bolivia, Senegal, Uganda, India and Sri Lanka. Larbi (1999) argued further that the introduction of the NPM practices had a cost saving effect on the national budget, but it has a practical challenge in using it in some states. He therefore, suggested tactfulness on the part of policy makers in the adoption of the elements of NPM. This study is relevant as it throws more light on the use of NPM principles such as autonomous executive agencies in enhancing the quality of public service delivery.

In another significant study which focused on the NPM approach, Osborne et al (2013) posited that recent public management theory is not appropriate due to two main weaknesses. First, it is

oriented towards intraorganizational processes when trends in public service delivery is interorganizational and second, it is based on a management theory which draws its experience from the manufacturing sector. The authors strongly make the case for a public service dominant approach in the delivery and management of public services. This is because it relies on the substantive service dominant theory which places users and citizens expectations and interests at the centre of service production and delivery. This publication is important to the study as it established users' needs and interests at the heart of the public sector led delivery of services.

Another key addition to the relevant literature on the NPM is Mwita (2000). According to him, the decision-making authority on the provision of services in developing economies is concentrated at the centre of management. The centralization of decision making took away the important role of the community for service provision from the local people, consequently, making it difficult for the citizenry to demand accountability and responsibility from managers of public service provision. Consequently, Mwita (2000) proposed greater involvement of local people and modernization of public service provision and the establishment of strong linkage between primary and secondary objectives of public sector organizations with their strategic plans and performance measures. He posited further that the concept of the NPM is a customer-oriented in approach and emphasized the importance of performance target in improving the quality of public service.

Gruening (2001) made a useful contribution to the literature on the NPM approach. He discussed the main characteristics of the NPM and highlighted the growth of administrative science within the broader scope of the NPM. He argued that the NPM had its roots in the public choice theory and managerialism, which started in the late 1970s and early 1980s. According to him, the first country to adopt the NPM approach was the United Kingdom under Prime Minister Margaret Thatcher, and then the municipal and other local governments' bodies in the United States. After

them was the government of New Zealand and Australia. He stated that the success story of the NPM-inspired policy reforms placed it on the reform agenda of the OECD countries and later developing countries.

Additionally, Fatemi and Behmanesh (2012) opined that the NPM emerged in the 1980s with the ultimate aim of addressing the fundamental problems associated with the public sector-led provision of services. They argued that the NPM approach developed through the combination of economic principles and private sector development practices. They indicated that the most crucial elements of the NPM include downsizing, decentralization of management authority and a focus on efficiency, effectiveness and economy in the provision of public services. Again, they discussed the effects the NPM has had on different forms of accountability in the public sector, and argued that the NPM has redirected the focus of accountability from political to managerial and from inputs and processes to output and outcomes. They put forward two main levels of accountability that emerged from the NPM; accountability to politicians and accountability to clients and customers. They made a case for five other forms of accountability such as operational, political, social, financial and management accountability. Moreover, they posited that, under the NPM, management and operational accountability fulfills financial and political lines of accountability.

Hope Sr (2001) and Naidoo (2015) made yet another important addition to the study of the NPM approach. Naidoo (2015) emphasized the inconsistency and contradiction between politics and policy of public sector management reform advocacy in South Africa. He observed difficulties in implementing reforms from traditional to NPM-led changes due to the capture of public institutions by vested political interest groups, capacity concerns and absence of commitment on the part of policy makers. Hope Sr (2001) argued that NPM related reforms have been successful in Africa in spite of a few exceptional cases of failure. He buttressed his argument that Africa has

improved its economy, attracted large volumes of foreign direct investment, with a reduced size of government and declined cost of managing the state. According to him, factors accounting for the rise of the NPM include institutional, fiscal deficit of the state, political and the international environment. Hope Sr outlined the characteristics of the NPM as management decentralization, private sector ownership, and devolution of management, performance contract and purchaser-producer split. These studies are relevant to the study as they focused on the effects of NPM-driven reforms in Africa, of which Ghana is part.

2.3 Global studies on executive agencies

Sulle (2010) focused on the application of the executive agency concept into public service delivery in Tanzania. He employed questionnaire and interviews, and sought the views of senior public officials of autonomized bodies on the effects of the executive agency concept. The findings indicated that operational autonomy improved in many agencies. However, there is less managerial and strategic autonomy in human resource and financial management. According to him, the agency model was formally introduced in Tanzania in 1997 with the intention to improve the delivery of public services. He posited that the executive agency concept is a doctrine of the new public management with key elements such as structural disaggregation from the core ministry, autonomy and contractualization of public sector management functions.

According to Sulle (2010), the executive agency concept is a preferred public sector reform strategy because agencies are assumed to be a good approach to enhancing quality of public service. However, the universality of the agency model is questionable due to differences in country's political system and national laws. He opined that executive agencies are independent bodies of the core ministry, funded from the national budget and undertake public functions and enjoys managerial autonomy. Moreover, the Tanzania Executive Agency Act of 1997 was an extension of the broader civil service reform programme introduced in 1992 to address the

challenges and inefficiencies associated with the public service delivery. Sulle further underscored several forms of autonomy including managerial, legal and financial autonomy. According to him, management autonomy is a relational policy that is examined in the context of control from higher authorities.

According to Dan (2014), the greater evidence about executive agencies focused on changes in organization, processes and management but there is little evidence about output and outcomes. He emphasized a renewed orientation towards customer needs and results. He raised issues about unintended implication of executive agencies. According to him the unintended concerns manifest in the areas of transparency, accountability, organizational stability and central coordination. This work is important to the study as it addresses the consequences of hospital autonomy in Korle Bu Teaching Hospital in issues such as responsiveness of management to client needs and clinical service delivery.

Overman and Van Thiel (2016), in a twenty-country study on executive agencies argued that the development of the autonomous organizations is founded on the hope of a possible improvement in service delivery. They negated the effects of agency creation on public sector efficiency and output. In their view, the agency concept is different within and between countries. They postulated that the features of the executive agency concept include structural disaggregation from the traditional bureaucracy, it undertakes public duties and works in a businesslike manner. According to them, other features of the agency creation is dependent on the constitutional regime, political and administrative values of the society. In the light of this, there is no consensus on the single kind of agencies accepted globally. However, they identified three main types of agencies such as semi-autonomous agencies in the state devoid of official independence, statutory bodies created by statute and granted legal independence and private law-based organizations such as state companies and foundations.

Moreover, Overman and Van Thiel (2016) argued that public sector performance involves many aspects such as effectiveness, efficiency, quality, compliance, implementation, sustainability and enforcing standards of good governance. They anchored their study on a model called inputs-outputs-outcomes of public sector organizational performance. They pointed out that output is concerned with quantity and quality of the public service delivery. Also, outcome is related to the results of the public service delivery. Furthermore, they highlighted the relationship between output and financial inputs (efficiency) and the linkages between outcome and financial inputs (value for money). Thus, a country's public sector is expected to perform creditably if outputs and outcomes are high, and if they are achieved at a lower unit cost, and there is efficiency and value for money. They also provided five main factors that shape the performance of individual public sector organizations. They are resources, market structure, regulation, organization and management. The view of Overman and Van Thiel is supported by this study as it assesses how executive agency phenomenon improved the quality of care, efficiency, effectiveness and independence of management of KBTH from the Ministry of Health and the core of the government.

Manasan (2003), on the other hand, posited that the weaknesses and perceived corruption in the collection and administration of taxes caused a reform in the organizational character of agencies responsible for administering taxes. Consequently, the autonomous revenue authority model was introduced to revamp the performance and efficiency of the revenue collecting institutions. This revenue authority model has become the 'game in town' in Latin America, Africa and Southeast Asian countries. According to her, changes in the organization of the revenues collection bodies became necessary due to the rigid civil service rules, corruption and lack of voluntary tax compliance that characterize the administration of taxes. Politicians therefore, sought to make a credible commitment to ensure fair, competent and objective tax administration. Manasan (2003)

also reiterated the key design features of the revenue authority model such as legal power, governance architecture, financing scheme, human resource system and established accountability relationship. In her view, the earliest semi-autonomous revenue authority was modeled after the central banks concept. She argued that revenue authorities were supposed to operate as autonomous organizations like central banks nor dependent as ministerial line departments. Hence, the term semi-autonomous. However, they are separate from the traditional tax collection agencies and conferred with a greater form of independence from the national authority. Even though these studies provided a detailed account of the agency form of organizational structuring, it did not focus on the health service delivery and autonomous hospitals which is the area of attention of this study. This study will therefore fill the gap on the effect of the executive agency concept on healthcare delivery in tertiary health institutions.

Verhoest (2018) and Laking (2005) opined that government placed policy implementation duties in the hands of arms-length bodies, through the creation of a periphery of autonomous public organizations, described as executive agencies from the traditional bureaucracy. According to them, the agency organizational form is prevalent in countries such as the United Kingdom, New Zealand, Netherlands, Canada and the United States of America. They asserted that the establishment of the agency concept is the result of vertical and horizontal specialization on geographical location and varied purposes, tasks and customer groups. According to these scholars, agencies as public sector reform instrument is not a new phenomenon, but the new public management era changed the rationale for agency establishment and their governance structure. Verhoest (2018) discussed important elements of the agency governance, which are the organizational autonomy of the agency and the ways in which they are supervised and controlled by their political principals. In his view, different agencies are granted different financial, personnel and managerial autonomy and also operate in a less hierarchical structure and receive

less control in the performance of their day-to day activities. However, agencies are formally under the control and direction of their parent ministries through policy making and regulations which guide the way agencies are administered.

Verhoest (2018) and Laking (2005) outlined three main types of agencies based on the formal-legal characteristics of autonomous public organizations. They are departmental agencies which are close to the core of the parent ministries. They are disaggregated and autonomous public organizations but they are not clothed with legal independence. Key examples include next step agencies in the UK and contract agencies in the Netherlands, the agencies established in the Italy and Germany. The second type of agencies are the legally independent public organizations established under statutes, which Laking (2005) termed public law administrations. Examples include public establishments in Portugal and Belgium and the non-departmental and statutory bodies in Australia and Ireland. The third type of the agencies are called law bodies, established either by government or on behalf of central government. They include a foundation, public corporations and public companies and enterprises in which government retains complete ownership right or majority shares. Related to this type is the quasi-non-governmental organizations (quangos) which have different legal status and character from the state.

According to Verhoest (2018), NPM inspired agency creation sought to make public sector organizations function as private entities and motivate them with market values such as efficiency, effectiveness and value for money. He asserted that managerial autonomy associated with agency creation enabled public entities to respond to changing operational environment and circumstances. He argued that the functional relationship between agencies and their parent ministries are guided by performance contract, which set target and benchmarks for management of public organizations. The achievement of the performance agreement is rewarded and non-achievement is sanctioned. Laking (2005) argued that executive agencies have improved the

quality and credibility of the public sector in the delivery and management of public services in OECD member states. However, Verhoest and Laking intimated that the excitement that followed the NPM agency model have been negated due to the fragmentation of state institutions and loss of transparency and accountability as a result of the proliferation of different bodies and absence of coordination and collaboration among public sector organizations. Consequently, a trend has emerged in the OECD countries towards rationalization of agencies through complete integration or sharing of support services such as information technology, human resource and financial administration to improve openness and broad-based public sector responsiveness to citizens concerns. These publications are significant to the current study as it examines the role of the agency concept in enhancing the performance of autonomous bodies in the health sector. Also, it will fill the gaps on the policy measures and arrangements that strengthen autonomy in the teaching hospitals in Ghana.

Kim and Cho (2014) also contributed to the global study of executive agencies based on a study of forty-four executive agencies in Korea. They posited that the practice of the setting up of autonomous public organizations based on a contractual arrangement has become a well-received global reform strategy. The result of the study indicated that human resource management autonomy and financial autonomy show an increasing negative effect with performance, whilst mechanisms of performance evaluation and reward for result are significantly related to the performance of executive agencies in Korea.

In 1999, the Parliament of Korea enacted the Executive Agency Law, and in 2000, the Korean government created executive agencies as a separate entities from the civil service, and brought into existence ten agencies including the National Medical Centre, Driver's License Agency and the National Theatre Agency. Public sector reforms based on the executive agency in Korea is founded on almost same global principles but there is a difference in how autonomy is granted

and how the parent ministry monitors and evaluates the agency's performance. They advanced the argument that the executive agency reform in Korea is modeled on the British type except that in practice it shows more similarities and characteristics with those in Canada. They indicated that there are thirty-eight agencies working under fifteen parent ministries in the central government in Korea, and three agencies operating in the local government system under the Seoul Metropolitan Government including the Seoul Museum of History. Currently, agencies in Korea are classified into six types: Medical Agencies, Statistics Agencies, Research Agencies, Education and Training Agencies, Culture Agencies and Facility Maintenance Agencies.

Moreover, Kim and Cho (2014) identified key elements of the executive agency concept in Korea. Firstly, they argued that there is open competition in the appointment of agency heads, and performance reward is granted to the agency heads based on annual performance reviews by the parent ministry and the Ministry of Public Administration and Security. Also, the parent ministry oversees the objectives of the agency by signing employment contract with the agency and reviews its operational framework and corporate plans. Secondly, executive agencies in Korea demonstrate hiving-in instead of hiving-off. Hiving-in means that agencies submit to a hierarchical norms and rules of their parent ministry, and employees of the agencies are public servants unlike the case of New Zealand where employees are not considered public servants. They contended that hiving-in agencies have little managerial autonomy than hiving-off agencies. In view of this, operational framework and business plans of agencies in Korea are controlled closely by the parent ministry and the number of employees is subject to presidential regulations, which impose additional constraints on management. Finally, executive agencies in Korea are designed and implemented by the Ministry of Public Administration and Security and the parent ministry monitors the performance of the agencies, thereby creating two-tier principal and control system. This shows a contrast with the western model as practiced in Canada and

New Zealand. For example, in these countries, executive agencies are monitored by the Ministry of Finance, but those in Korea are controlled by the Ministry of Public Administration and Security that deals with human resource management matters. This work supports the view of Kim and Cho due to its focus on issues such as appointment processes of agency heads, performance review of agency heads and senior management which form an integral part of the executive agency model.

Moynihan (2006) opined that societal and political contexts are important in determining the selection and adoption of executive agencies in different countries as United Kingdom, Sweden and Slovakia. He contended that the executive agency concept is an important aspect of the NPM approach, and presented three basic elements of the executive agency concept such as structural disaggregation, performance contracting and deregulation. He argued that public management reform ideas can be interpreted and adopted in different ways to obtain varying outcomes. The UK is the well-known example of NPM agency reform which began in 1988, in a government report on, “Improving Management in Government: The Next Steps”. Despite this, Sweden has had a longstanding history of experience with the executive agency concept. However, the motivation for the earliest agencies has little to do with the NPM-style of agency creation. Furthermore, he argued that Slovakia did not make a deliberate attempt at executive agency reform; its post communism administrative measures were influenced by multilateral banks, OECD, Non-governmental organizations in general and the European Union in particular. He re-emphasized that agencies are mechanisms for ensuring professional public service, eliminating the evil influence of party politics and ensuring decentralized power arrangement. He further asserted that fiscal indiscipline and the need to enhance legitimacy and democratic renewal largely prompted NPM agency reform. The focus of this study opens the discussion on how

executive agency concept is adopted and practiced in Ghana and its effects on health service delivery.

Verschuere and Bach (2012) argued that creation of executive agencies has been key elements of administrative reforms in Europe. They examined the role of agencies in the policy cycle and offers three explanation on the levels of agency's influence in policies and programs and posited that agency's influence in policy making is contingent on factors such as the attitude of the agency towards the policy, functionality for the agency or potential gains and losses of the policy to the agency and discretion of the oversight authorities to involve agencies in the decision making. They argued that agencies play crucial policy making role in parliamentary system of government, through interaction with elected public officials and support staff. Also, the level of the agency's involvement in policy making depends on a number of conditions such as the exact content of the policy proposal, the stage of the policy in the policy cycle, the agency's core mandate, the interest of the political actors and the agency's perceived threats and avenues to advance those interests. They further indicated that, from the theoretical perspective, the functional division between policy making and implementation is not empirically sound. Consequently, they proposed cooperation and collaboration between government and agencies in view of the expert advice and rich ideas professionals working in the agency can bring to bear on the quality of policies. Again, collaboration will enhance mutual trust between principals and agents. Even though this work is based on the European setting, it is helpful in understanding how agencies operate in Ghana and interact with other key actors in the policy spectrum.

Egeberg and Trondal (2009) also argued that agency officials place premium on user needs and clients' interests more than their counterparts working in ministerial departments. Thus, executive agencies pay little or no attention to views from politicians in the performance of their functions. However, the higher the technical capacity available at the parent ministry, the more

the agency officials' place weight on their considerations. This study supports this view as it contributes to autonomous public organizations effectiveness and efficiency and improvement in public service delivery in the light of its orientation to customer and public concerns.

2.4 Ghanaian studies on executive agencies

Ohemeng and Owusu (2015) argued that Ghana's quest to improve domestic revenue mobilization necessitated the setting up of the autonomous revenue agencies. Using the social learning theory, they held that Ghana's success story in the implementation of the revenue authority model is as a result of lessons drawn from its own earlier attempts and experiences acquired from other countries. Similarly, Joshi and Ayee (2009), in their study on autonomous revenue authorities argued that executive agencies are popular organizational reform strategy adopted in developing economies to improve the financial freedom and managerial autonomy of the revenue collection agencies and, consequently, enhancing efficiency and effectiveness in revenue administration. The explanation for the high performance of the autonomous revenue authorities has focused on autonomy but the Ghanaian case is increasingly attributable to factors other than autonomy. These factors include reforms that brought revenue collection and administration closer to the people and policies that targeted the informal sector through decentralization and customer-oriented service delivery. Though these studies provide explanations for the creation and the effects of the autonomous revenues authorities, they do not extend the discussion to autonomous hospitals, which is the focus of this study. For instance, whilst this study's concentration is directed to executive agencies in the health sector, specifically, the Korle Bu Teaching Hospital (KBTH), Ohemeng and Owusu focused on the Ghana's main revenue agencies such as the Internal Revenue Service, Customs, Excise and Preventive Service and the Value Added Tax Service.

Ohemeng and Adusah-Karikari (2017) also examined the emergence of executive agencies and their effects on the civil service in Ghana in a study that employed qualitative methodology and nonprobability sampling. In their view, the executive agencies idea developed in the 1980s and was adopted in the late 1980s and early 1990s in Ghana in the form of creation of autonomous public organizations with the view to reforming the dysfunctional public service and enhance the effectiveness, efficiency and overall performance of the public sector organizations in public service delivery. Ohemeng and Adusah-Karikari (2017) opposed the view that the establishment of autonomous agencies will improve the quality of public service delivery, effectiveness and efficiency of the public sector. It highlighted the significance of the executive agencies idea including the promotion of managerial autonomy and flexibility, enhancement in public sector efficiency and effectiveness and improving managerial accountability and responsibility. However, they underscored some negative effects about the creation of executive agencies such as despondency among civil servants, and unattractiveness of the civil service due to huge disparities in salaries and wages and incentive structure as against those working in the autonomous organizations. They also held that the executive agency concept results in reduction in the budgetary allocation to the civil service and also weakens the capacity of the civil service to develop and implement public policies. Even though the study contributed to our knowledge on executive agencies in the Ghanaian context, it was too general about the civil service and failed to look at the effects of the concept on health service administration and management in Ghana. Thus, it does not consider important aspects of this study which examines the implications of the autonomous executive agency concept in the health sector.

Furthermore, Ayee (2001) pointed out that the Civil Service Reform Programme (CSRP) and the Civil Service Performance Improvement Programme (CSPIP) were introduced to enhance the capacity of the Ministries, Departments and Agencies (MDAs) to deliver quality services to the

public. However, the absence of bottom-up implementation strategies, motivation and political commitment did not help produce the needed reforms in the civil service and its constituent agencies as a value for money public organizations. Whilst this study examines an aspect of the post-Cold War neo-liberal reforms initiatives, there are some limitations which need to be explained with regards to management autonomy, efficiency and effectiveness in the health service delivery. In a related study, Ohemeng and Anebo (2012) opined that administrative reforms have been integral part of Ghana's efforts at improving the civil service ability to design and implement policies. However, Ghana's reform initiatives have not been successful in addressing in full the weaknesses of the public service due to factors such as discontinuity in reform programs by successive governments, absence of national development agenda, reliance on foreigners as consultants, reliance on multinational financial institutions for financial support and absence of developmental state agenda. Whilst these publications examined generally the failure of public sector reform initiatives in Ghana, the current study, however, directs attention to the tertiary health sector and fill the gaps on the performance and contribution of the autonomous health organizations.

According to Larbi (1998) and Caulfield (2006), the executive agency concept was adopted by sub-Saharan Africa as a result of multilateral and bilateral conditionalities for aid and loans and donor advocacy. Thus, the World Bank and the International Monetary Fund (IMF), Britain and France required their former anglophone and francophone colonies to restructure their inefficient state-owned enterprises (SOEs), public utilities and civil service based on the tenets of the executive agency concept. Larbi and Caulfield recognized Ghana's attempt towards hospital autonomy from the late 1980s upon the adoption of the Hospitals Administration Law (PNDCL 209) and the 1996 Ghana Health Service and Teaching Hospitals Act. Additionally, Caulfield (2006) attributed NPM reform challenges in sub Saharan Africa to the extremely partisan and

political environment within which reforms take place and the institutional limitations that impede the introduction of changes into the public sector. These limitations include the activism of the labour unions and the weight of public opinion that oppose reforms that take responsibility for distribution of public goods and services outside the control and management of government. Moreover, Caulfield (2006) argued that agencies that are clothed with more managerial autonomy are interested in customer care and clients service satisfaction. Also, agencies that are able to mobilize funding and resources from the private sector are more competitive and responsive to clients' needs than those that rely largely on the central government for budgetary support. More so, Larbi (1998) identified two main effects of management decentralization in Ghana's public health service including the organizational and operational changes in the delivery of health service.

This study will extend the current discussion on hospital autonomy and provide explanation on how KBTH status as an autonomous organization helped to improve its performance and enhanced managerial flexibility. Thus, this study is focused on evaluating how the organizational and operational changes in public health management helped to advance the performance of KBTH as an executive agency since 1996.

2.5 Studies on health service delivery

In the view of Abor et al (2008), corporate governance is an important indicator that affects organizational effectiveness of hospitals. However, there is no consensus on the kind of corporate governance structure necessary for efficient hospital governance. They defined hospital governance as the overall responsibility and accountability systems for the running of the hospital. They argued that, though the principle of ultimate responsibility makes the governing board the highest accountability authority, the Chief Executive Officer, senior management members and clinical leaders play an important management function. Thus, the

governing board and the management team constitute the fulcrum around which major hospital decisions are taken and implemented. They posited that effective hospital governance requires the judicious use of funds, competent and dedicate professional management and proper governing structures. They contended that, the relevance of healthcare to socio-economic development motivates clients to anticipate the quality of care, efficiency, responsive and easy access to health service provision and these expectations impose significant demands on the governing Board and management.

Moreover, they recognized hospitals as forming a key part of the health delivery system in Ghana. In their view, there are three types of healthcare systems such as liberal healthcare which comprises private ownership, plural healthcare system, which refers to both the private and public ownership and socialist healthcare system which emphasizes public ownership. They further argued that there are four main healthcare delivery mechanisms in Ghana including public, private-for-profit, private-non-profit and traditional delivery mechanisms. They averred that the health system in Ghana revolves around the Ministry of Health (MOH) and its decentralized agencies at the regions, districts and sub-districts. The health service delivery is provided through health centres and district hospitals which offer primary care, regional hospitals provide secondary care and the teaching hospitals offer tertiary service including teaching and training of medical and allied health professionals and students and conducting of research.

In the public health sector, Abor et al (2008) indicated that, the Ghana Health Service, Teaching Hospital Board and the quasi-government institution hospitals are the execution and implementation authorities of the MOH policies, guidelines and instructions. Again, the private sector is a significant player in Ghana's healthcare delivery system. They asserted that private hospitals are responsible for about forty percent of total national health deliveries. This study

supports and builds on the views expressed by Abor et al (2008) as the study emphasizes health service delivery and the contribution of KBTH to healthcare in the country and measures to improve its effectiveness, efficiency and quality of care.

Nyonator et al (2005) held that Community-Based Health Planning Services (CHPS) represented an evidence-based health sector reform that addressed the gap between research and policy adoption and implementation. They argued that CHPS increased the innovation and ideas from health policy research into a nation-wide programme of healthcare delivery reform that has enhanced the efficiency, accessibility and quality of community healthcare. According to them, CHPS was introduced in 1999 as a national health programme with the intention to reduce impediments to geographical access to healthcare. Even though CHPS was originally targeted at deprived and interior parts of rural districts, it has succeeded in improving primary healthcare by directing attention to a system of community-based health service delivered by a nurse resident in the community, as against the traditional facility-based and outreach programmes.

The CHPS concept is considered a major health policy initiative for reaching those who are unreached, and is considered an important part of the health sector component of the poverty reduction strategies. According to them, the Nkwanta District in the Oti Region was the first practical demonstration of the CHPS initiative. Lessons from the implementation indicated that the introduction of CHPS into district healthcare programme require proper planning and extensive dialogue between the District Health Management Team (DHMT) and the community members including opinion leaders and traditional authorities. Accordingly, the strengths of CHPS rely on the participation, engagement and mobilization of the traditional political structures and social institutions for improved service delivery.

Eggleston et al (2008) also indicated that the 1980s marks China's departure from complete government control in the country's health sector. As a result, market reforms which received the commendation of policy makers and health specialists, were introduced to improve quality and efficiency of care. However, the health service in China is argued to be ineffective, poor in quality and excessively centred on high-technology care and drugs to the neglect of public health quality. Eggleston et al (2008) argued for a further reform in the China's health sector in the form of stronger competition in the sector, wider expansion in the private sector participation and higher control and intervention in the sector by the government. They also argued for improvement in medical and management quality, proper distribution of health personnel based on the need of each hospital and the establishment of right horizontal and vertical integration of the hospitals. The publication is relevant to this research as it seeks to improve the performance of healthcare delivery, years after the introduction of autonomy in the public health system in Ghana.

Gbagbo (2015) asserted that administrative decentralization was introduced into the sub-structures of KBTH to enhance quality of care, efficiency and responsiveness of clinical leaders to the needs of clients and patients. He noted both positive and negative effects of administrative decentralization in KBTH's Medical Sub-Budget Management Centre. He held that Ghana's efforts at health sector decentralization began with the enactment of the Ghana Health Service and Teaching Hospitals Act, 1996, resulting in the establishment of GHS and the Teaching Hospitals Board, and the integration of the district hospitals into the local government structure. He argued further that the managerial autonomy granted to the KBTH enabled it to develop the idea of the sub-budget management centres to enhance standard of care, efficiency and swiftness of clinical leaders to adopt policies and decisions in health service delivery. However, he acknowledged that, administrative decentralization has not advanced standards in management

matters such as human resource management, financial sustainability and improvement in governance and procurement practices. The focus of Gbagbo (2015) is significant to this study since it examined how medical sub-budget management centre improved health service delivery and also its contribution to hospital governance in matters such as human resource and personnel management, financial management and quality of services to clients.

2.6 Studies on teaching hospitals

Govindaraj et al (1996) also explored the experience of hospital autonomy in Ghana's two main teaching hospitals – the KBTH and KATH. This was an evaluative study that sought to examine the performance of the two teaching hospitals based on the autonomy powers granted them under the Hospitals Administration Law on four management functions such as governance, general administration, financial administration and human resource management. They argued that the experience of hospital autonomy in the two teaching hospitals has ensured some progress but has not advanced the quality of care, efficiency and public accountability. Whilst this study was based on the KBTH and the KATH under the Hospital Administration law of 1988, this current research seeks to examine the performance of KBTH as an executive agency established under the 1996 Health Service and Teaching Hospitals Act. Again, the differences in time period justify the need and direction of the study. Furthermore, major operational and organizational reforms have taken place under the 1996 Health Service and Teaching Hospitals Act, which ceded ultimate responsibility, management accountability and governance authority and functions to the hospital's management board.

Frimpong-Boateng (2015), on the other hand, focused on the administration, key management decisions taken and critical projects undertaken during his tenure as the Chief Executive Officer of the hospital. He outlined major equipment, installations and facilities which were procured by

the management of the KBTH from the period of 2002- 2007. According to him, these major infrastructure and development projects were done with the intention of improving the quality of care and promoting professional and ethical workforce that will deliver best health service to patients and clients. However, he did not discuss issues such as management systems including governance, financial control systems and human resource management which are important aspects of autonomous public health organizations. Moreover, Frimpong-Boateng's (2015) assessment of KBTH focused primarily on the period he served as the Chief Executive Officer of the hospital. This study will contribute to the literature on management autonomy in teaching hospitals by filling the gap on how the executive agency organizational form has helped to improve the quality of care and services rendered by the KBTH.

According to Ayanias and Weisseman (2003), teaching hospitals are positioned to offer high-quality care and that mandate is largely responsible for the relative higher cost and charges imposed by teaching hospitals compared to the non-teaching ones. Despite their huge mandate, teaching hospitals have often relied on internally generated funds from their routine services to augment the cost of providing specialized clinical care, research and medical training. They asserted that teaching hospitals often offer better quality of care and promote standards and ethics for basic medical conditions than non-teaching hospitals do. This assertion is supported by this study since it looks at factors that account for the successes and failures of KBTH and what needs to be done to further improve it

According to Trendwatch (2015), produced by the American Hospital Association, teaching hospitals constitute the centre for training medical professionals and innovation whilst helping to create an environment where clinical research and specialty care can be sustained. Thus, teaching hospitals are centers for specialty care, biomedical, behavioral and clinical research and are also critical element of the healthcare safety net. According to the report, teaching hospitals offer

many services which are not common in many hospitals. Consequently, teaching hospitals are allocated two medicare payments with an education label: Direct Graduate Medical Education (DGME) and Indirect Medical Education (IME), to support their roles in graduate medical education and higher patient care costs respectively. Though the report captured aspects of this study, it is not based on the Ghanaian system which is the focus of this study. This work will unravel the institutionalized support arrangements and funding schemes granted to the KBTH to enable it deliver on its mandate.

Another significant addition to the literature on teaching hospitals was offered by Ofili and Ofovwe (2005) who discussed patient's satisfaction in a study to assess the efficiency of services at a teaching hospital in a developing country. They argued that a key factor that determines a patient's satisfaction is efficiency of services provided. According to them, efficiency of service is the swiftness of care and attention given to patients by clinical staff. They suggested that efficiency of service is also manifest in the time a patient spends in the hospital before consultation, time spent during consultation and the quality of time spent with the doctor, prompt response to emergency situations and quick administration of drugs. They emphasized the willingness on the part of patients to pay more when they receive satisfied care. Even though this study is based on Benin, it is significant to understanding the efficiency and quality of services granted clients by the KBTH.

A recent study by Langabeer et al (2018) recounts the financial strength of eighty (80) teaching hospitals in the United States and the designation of teaching hospitals as representing the clinical dimension of academic health institutions. They argued that teaching hospitals are responsible for providing graduate medical education and training, fundamental medical and clinical research and also offer inpatient and ambulatory services. Nevertheless, due to the complex health services and specialized care teaching hospitals provide, they usually incur

higher operating cost relative to other hospitals. This challenge puts teaching hospitals in a financial challenge, making it difficult to maintain their facilities. To them, government could become effective in healthcare delivery if it builds operational competence and business strategy of the teaching hospitals. Thus, a hospital's financial position depends on maximum combination of business strategy, operational efficiency and environmental conditions. The challenges of healthcare financing and management require complete restructuring and privatization of teaching hospitals to make them competitive and efficient in their operations. Even though this study is not based on the Ghanaian health system, it provides insights and ideas which are necessary to improving the performance, effectiveness and efficiency of the public health delivery systems in Ghana, especially autonomous health delivery agencies.

Jaye et al (2009) in their study opined that teaching hospitals are crucial for the clinical training of medical students. They posited that clinical leaders facilitate students learning experience by deliberately involving students in ministering to the needs of patients. This work is important to the study since it clarifies the significance of the linkage between tertiary health service institutions and the schools of medicine, dentistry, allied health and biomedical sciences for the education and training of prospective health professionals.

2.7 Studies on performance evaluation of organizations

Bogt (2003) discussed the evaluation of senior public managers by politicians. He argued that the focus of the performance evaluation of organizations concerns the measurement and assessment of the performance of organizations and their staff. Moreover, the study emphasized accountable management and transparency of organizational outputs and outcomes. He analyzed the evaluation criteria adopted by the Netherlands local government system and argues that to a large extent, the elected politicians evaluate senior managers and the organizations they lead based on the extent to which they operate in a businesslike fashion. In line with this view, he

recommended that, the assessment of high-ranking public officers must be based on the private sector principles, performance-orientedness, efficiency management and control of public organizations, consistent with the ideals of the new public management. He argued that the Netherlands authorities make use of job appraisal interviews to analyze and evaluate the performance of civil servants. The study favours the views expressed by Bogt because he underscored the relevance of performance contract as a key component of the executive agency model to improve public service delivery.

Spekle and Verbeeten (2014) opined that, the rising levels of national budget deficit and legitimacy concerns about the state's development capacity have made the new public management the underpinning concept that guides public sector reforms in the developed and developing world. They posited that NPM promotes results-based accountability and the use of private sector values and approaches in the public sector. They argued that the key aspects of the NPM are the use of performance contracting and performance target to control the behaviour and attitudes of public servants towards the achievement of organizational goals and objectives. In their view, performance measurement indicators are instrumental in championing effective, responsive, efficient and accountable public sector. Performance measurement systems set the incentive and motivation for aligning the interests of an individual with that of the organization, and also offer useful feedback on efforts towards meeting the objectives of the organization. Thus, it serves as an instrument of accountability, both internally and externally. Spekle and Verbeeten (2014) believed that when contractibility is high, performance contract will lead to an improvement in the performance of an organization. However, where contractibility is low, performance of an organization will rely on the exploratory means of using performance measurement systems. They also contended that public sector organizations that use performance measurement systems which are in line with their work perform better than organizations whose

performance measurement systems are not consistent with their work. More so, they posited that political factors and organizational stakeholders play a crucial role in the way performance and reporting information are used.

Mihaiu (2014) in her study on “measuring performance in the public sector” emphasized the tools and methods of assessing public organizations in Romania and its associated problems. Performance analysis in public sector organizations is an important exercise for government and policy makers due to the increasing amount of government’s debt servicing obligations. She argued that increasing efforts at improving the performance of the public sector was aimed at lowering tax demands, improving the confidence of the citizenry in government and increasing productivity of the sector. She intimated that public sector performance measurement is a difficult exercise arising out of the complicated role of the sector. One way of defining performance is to establish the relationship between objectives, means and results. Therefore, performance is the combination of factors such as efficiency, effectiveness and proper budgeting practices. She offered possible tools and methods of measuring performance in the public sector including: (a) measuring economy of resources (b) measuring cost (c) measuring output (d) measuring the effect (e) measuring efficiency (f) measuring effectiveness, and (g) measuring the quality of services.

She admitted that the systems for measuring performance in the public sector is challenging because they focus on the financial aspects of the organization such as efficiency, effectiveness and economy (3Es), without looking at the social and environmental implication of their activities. Accordingly, the answer to this problem is a movement from the 3Es to an emphasis on the 5Es such as efficiency, effectiveness, economy, environmental and equity. She opined that attempts at measuring performance is made difficult by the complexity and multidimensionality of the concept. This work is relevant to this study as it establishes the importance of evaluation

of organizations and also makes a case for a comprehensive evaluation that takes into account social and environmental impact of public organizations. Additionally, it discusses the criteria for performance evaluation which are relevant to evaluate the performance of KBTH in health service delivery.

Hyland et al (2009) stated that the objective of the performance measurement system is to articulate and implement strategies that ensure consistency between organizational actions, objectives and goals. They stressed that performance measurement is interested in understanding how processes and activities closely work together in meeting organizational goals and enhancing performance. According to them, the measure of organizational performance revolves around five main perspectives including: (a) the achievement of strategic objectives (b) user and customer satisfaction (c) organizational excellence (d) meeting of financial targets, and (e) innovation and learning. This study is relevant as it helps to understand the indicators and standards for assessing the performance of KBTH's mandate.

Furthermore, Agostino and Arnaboldi (2018) studied the concept of network performance measurement systems and how it helps organizations to achieve goals and objectives. They made a separation between hierarchical and socializing parts of a system and point out that the co-existence of hierarchy and socializing parts work together to achieve results. According to them, some actors involve themselves in the performance measurement in order to improve the system whilst others participate in performance measurement systems for selfish and individual gains. Contrary to the widely held opinions that service users are passive players, Agostino and Arnaboldi (2018) suggested that users are integral players in the public network, playing a crucial role in controlling the delivery of public goods and services. The view of the authors is significant in understanding the role of clients in expanding and improving the quality and

efficiency of services rendered by public service organizations in developing and transitional economies including KBTH.

Balaboniene and Vecerskiene (2015) asserted that assessment of performance of organizations is a difficult task. They argued that performance measurement is considered a critical tool which helps to assess the efficiency of organizations towards improving quality of services they provide. They indicated that, in the light of public bodies responsibility to provide public services in a timely and non-profit making lines, it makes it difficult to assess them using tools and methods used for the private sector. Nevertheless, in view of the understanding that, benefits of the public service delivery are felt after a long period of time, they stressed the need to assess its performance systematically and consistently with the view to improving performance of management and enriching satisfaction of clients.

Geisler (1994) also contributed towards understanding the evaluation of organizations. He stated that there is no universally agreed means for performance evaluation; many organizations employed bias approaches which are subjective and based on personal feelings. He proposed a means of evaluating the performance of a research and development organizations by focusing on what he called key output indicators (KOIs). He asserted that when assessing organizations, one needs to focus on the outputs and the views of customers and clients. He held that KOIs are achieved by combining elements of performance of four stages of research and development process, which he called, immediate, intermediate, penultimate and ultimate. He stated that performance measurement system in the public sector organization must be linked to the objectives of the organization, considering strategic plans of the organization. In the view of Geisler (1994), challenges of public sector performance measurement arise from the factors such as uncertainties in the process and results, practical challenges in tracking positive and negative impacts, and political factors. This study will contribute to our understanding on how

performance evaluation is planned and coordinated in KBTH. This study will also generate findings for comprehensive evaluation system that is based on the views of clients.

2.8 THEORETICAL FRAMEWORK

2.8.1 The Executive Agency Model

The study is grounded in the executive agency model. The model was the idea of Sir Robin Ibbs in his recommendation in a 1988 review of the Civil Service of the UK entitled “Improving Management in Government: The Next Steps” to improve public sector performance. According to Trondal (2014), the executive agency concept is explained by several approaches. These include, organizational, functional, contingency and institutional approaches. The organizational and institutional explanation suggests that autonomous agencies come into being as a result of power struggles and compromises, shaped by already existing organizational arrangements. Public sector organizational reform is influenced by endured structures and institutions, and new agencies are created within already existing organizational environment. The functionalist perspective also argues that the executive agency is an approach towards addressing broader-based societal problems and the principal-agent theory is a demonstration of it.

According to Trondal, the strength of the executive agency model is grounded on its ability to reduce political transaction cost, by offering new solution to challenges that affect the entire society. The contingency argument, on the other hand, posits that agencies are established to deal with specific events, and in most cases to deal with crisis. More so, Trondal (2014) contends that the adoption of the agency concept in countries around the world is considered as a regular pattern in public policy and an innovative idea within the context of the new public management. Thus, delegating specific task to an executive agency was a well adopted policy option in the

Organization for Economic Cooperation and Development (OECD) states and spread to many other countries.

The emergence of the executive agency model in the 1980s and 1990s emanated from the key weaknesses identified by governments such as the work overload of the civil bureaucracy, the over-bloated civil service and inadequate attention given to the service delivery function, the need to cut spending and make services to the citizens more responsive and accountable, the increasing demand for quality in public services and the absence of clear lines of responsibility and accountability (Ohemeng and Adusah-Karikari, 2017). Further to the search for solution for inefficient and underperforming civil service, the emergence of the executive agency model was influenced by democratic renewal and legitimacy on the part of elected public officials (Pollitt et al. 2004). The model was thus, seen as an answer to the dysfunctional civil service in the delivery of public services in developed and developing countries.

It therefore implies the creation of autonomous public organizations that operate independently of the central government, to undertake public functions such as service provision, implementation of policies and regulatory duties (Ohemeng and Adusah-Karikari, 2017; Bowornwathana, 2006; Pollitt et al, 2001; Sulle, 2010).

2.8.2 Features of the Executive Agency Model

The distinctive features of the executive agency model are as follows:

1. It refers to an organization that is structurally disaggregated, devolved and hived off from the core government's public administration. The executive agency organizational form represents a shift in government programmes to authorities that are vertically specialized, out of cabinet level departments (Trondal, 2014; Sulle, 2010)
2. It undertakes performance contracting and operates under more business-like conditions than the traditional public administration (Talbot, 2004:5). The appointment of senior

management members and agency heads is done through advertisement and open competition. Performance reward is granted to the agencies based on annual reviews by the political principals. This practice promotes competent and professional administration system dedicated to service provision and customer needs (OECD, 2005).

3. The agency's organizational form is also characterized by geographical relocation from the national capital. Thus, the concept is a means of bringing public service delivery mechanism and institutions closer to the people. This view validates other description of executive agency as distributed governance (Moynihan, 2006, Laking, 2002).
4. There are deregulation and autonomy of its operations in terms of finance, administration, budget, personnel and other management matters (Moynihan, 2006). This principle enables autonomous public organizations to deal promptly with organizational issues, taking into account the business environment and customers' interests.
5. The status and powers of executive agency are clearly defined in public law (Ohemeng and Adusah-Karikari, 2017). There are two main ways in which agencies are established. Firstly, they are established by individual enabling law, and secondly, they could be created through the promulgation of a general law that sets the processes and procedures for setting them up (Kim and Cho, 2014 & Yamamoto, 2006).
6. Furthermore, the autonomous public organization performs public tasks at a national level on a permanent basis.
7. Executive agencies are funded largely by the state budget and subject to the public accountability procedures and processes (Egeberg and Trondal 2009).
8. The executive agency concept directs attention from inputs processes to results based accountability, with a special focus on the needs of customers and clients (Trondal,

2014; Moynihan, 2006; Ohemeng and Adusah-Karikari, 2017; Caulfield, 2006; Dan 2014).

2.8.3 Strengths of the Executive Agency Model

Studies conducted on the effects of the executive agency model in terms of present management practices show positive and negative outcomes (Van Thiel and Van der Wal 2010; Overman and Van Thiel, 2016; Ohemeng and Adusah-Karikari, 2017). The strengths of the executive agency model are largely four-fold. Firstly, scholars such as Pollitt et al 2001 posit that specialization in service delivery functions in the public sector promotes professionalism, proper management strategies and better quality and standards in service provision, regulation and implementation of policies. Secondly, hiving-off of public agencies from the core of the public bureaucracy enhances a sense of ownership, identity and motivation of senior and lower management. Members of the specialized organization consider themselves as belonging to a specific public agency with its own corporate design, personality, functions and powers. Thirdly, the separation of agencies from the main civil service promotes flexibility and managerialism in decision making. This allows the agency to ensure merit-based recruitment, promotion, and determination of salaries, wages and other conditions of service (Christensen and Laegreid, 2007; Klijn, 2012; Ohemeng and Adusah-Karikari, 2017). Fourthly, the creation of executive agencies allows for improved transparency and accountability (Verhoest, 2018 and Klijn, 2012). The use of result-based accountability mechanisms such as performance contracting and performance related reward systems help to subject agencies to control by political principals and stakeholders. Thus, it permits principals and clients demand for greater efficiency and effectiveness.

2.8.4 Weaknesses of the Executive Agency Model

Notwithstanding the strengths associated with the executive agency model, it is fraught with weaknesses in its application in public service in both developed and developing countries.

Firstly, the agency concept has not produced noticeable distinction between policy making functions and service delivery and policy implementation duties. Secondly, public sector reform programmes to enhance efficiency and effectiveness in the provision of public services usually run opposite to the Millennium Development Goals and the Sustainable Development Goals to reduce poverty, inequality and unemployment (Caulfield, 2006). This assertion is based on the mass protest and opposition to market reforms and the introduction of user fees and charges. According to Caulfield, evidence suggests that poor households and citizens abandon basic health and educational services when user fees and charges are instituted. Thirdly, the establishment of executive agencies is characterized by path dependence instead of rapid anticipated change in quality of service delivery (Moynihan, 2006).

Fourthly, Yesilkagit and Van Thiel (2011) and Verhoest (2018) argue that the pattern of the executive agency formation has resulted in a large scale fragmentation of the public sector, and causing the emergence of many informal accountability mechanisms in the public sector which makes coordination and harmonization of broader based public sector activities difficult to undertake. Fifthly, executive agencies have undermined central government capacity and oversight capabilities over the agencies, thereby leading to information asymmetry between agencies and principals and stakeholders (Ohemeng and Owusu, 2015; Caulfield, 2006; Moynihan, 2006). This development is exacerbated by the apparent transfer of the cream of skilled, technical and professional staff from the core ministry to the agency.

Sixthly, there is little or no evidence to show how agencies have reduced the cost of running government, increased performance or reduced the size of the public sector. Moreover, the agency phenomenon has resulted in disparity in incentive structure in the civil service relative to the executive agencies (Manning and Shepherd, 2009). Personnel working in agencies receive attractive conditions of service and incentive packages and salary levels compared to those in the

civil service. This has resulted in despondency and ill feeling among those who work in the main civil service (Ohemeng and Adusah-Karikari, 2017). Furthermore, the agency concept reduces the budgetary allocation of the civil service and creates the difficulty in reconciling autonomy and control in the quest to ensure equity in the delivery of services that are fundamental to the entire society (Verhoest, 2018). Also, the creation of autonomous public organizations appeared to have increased the appointing powers of the political executive (Bowornwathana, 2006). Bowornwathana argues that ministers are enjoined to look after many public organizations, and also granted the power to appoint board members, chairpersons and chief executive officers. The increase in the appointing powers of the executive branch of government results in the development of clientelism, spoilt system, corruption and conflict of interest.

However, the weaknesses of the executive agency model do not negate or undermine the findings of the study. The strengths of the model significantly outweighs its weaknesses.

2.9 Deployment of the Executive Agency Model to the Study

The model is suitable to the study in view of the status of KBTH as an executive agency whose three-fold mandate is clearly stated in the Ghana Health Service and Teaching Hospitals Act 525, 1996. The mandate of the hospital include: (i) the provision of advanced clinical health services to augment the ones performed by the Ghana Health Service; (ii) teaching and training of undergraduate and postgraduate students in medicine, nursing, pharmacy, dentistry and other para-clinical and technical disciplines; and (iii) undertake research into health issues to improve condition of health of the people (Republic of Ghana, 1996).

The model is helpful in understanding the extent to which the KBTH is structurally disaggregated from the civil service, its independence from the MOH and central government to

decide on issues such as finance, budget, procurement and recruitment of personnel and introduction of private sector practices and business-like ideas into the hospital's management for improved service delivery. Again, the model helps us to explain the approaches and procedures for the appointment of the Chief Executive Officer (CEO), Directors of the hospital, and the composition of the hospital's Governing Board. Moreover, it helps us to appreciate the use of performance contract, accountability and control mechanisms to ensure effectiveness, efficiency and quality of service delivery in KBTH. Additionally, the model is relevant to understand how the KBTH is funded in its operations and the legal and regulatory framework that guide its operations.

2.10 Conclusion

This chapter focused on the literature review and the theoretical framework guiding the study. The review of the relevant literature was organized along the following thematic lines: studies on the new public management approach, global studies on executive agencies, Ghanaian studies on executive agencies, studies on health service delivery, studies on teaching hospitals and studies on performance evaluation of organizations. Additionally, the chapter discussed the development and emergence of the executive agency organizational form, the features, the strengths and weaknesses of the model.

CHAPTER THREE

METHODOLOGY

3.0 Introduction

This chapter focuses on the methodology used to examine the performance of the Korle Bu Teaching Hospital (KBTH) in fulfilling its following three mandates: (i) the provision of advanced clinical health services to augment the ones performed by the Ghana Health Service; (ii) teaching and training of undergraduate and postgraduate students in medicine, nursing, pharmacy, dentistry and other para-clinical and technical disciplines; and (iii) undertake research into health issues to improve condition of health of the people (Republic of Ghana, 1996). Specifically, the chapter examines the research design, methods of data collection, sources of data, population of the study, sampling methods and sampling size, data analysis procedure and the rationale for the choice of the KBTH.

3.1 Research Design

According to Creswell and Poth (2017), research design denotes the complete plans and strategy that a researcher uses to connect various parts of the study into one coherent form, to ensure that he addresses the problem effectively. It represents an instrument for determining the data to be collected, measurement and analysis of the data. This study employed qualitative design strategy of data collection and analysis to assess the contribution of the KBTH to health service delivery since it attained the status of an executive agency.

Qualitative research is defined by Shank (2002:5) as “a form of systematic empirical inquiry into meaning”. It is thus, a type of research approach that focuses on obtaining data through open-ended questions in an interactive manner (Creswell and Poth, 2017). It seeks to gain deep and

rich understanding of an organization, event or a group of people. Qualitative research approach is interested in understanding what people think about a phenomenon and why they think that way (Rubin & Rubin, 2012; Kapiszewski et al, 2015; Creswell and Poth, 2017). Thus, the qualitative research method allows for in-depth and further probing and questioning of respondents based on their responses, whereby the researcher also tries to understand their interests and feelings. However, the qualitative approach to research enquiry presents weaknesses in its application. According to Osuala (2007), the quality of the data collected is often subjective and time consuming in the data collection process. Data rigidity is difficult to ascertain and the biases and influences of the researcher could also have negative effect on the data (Panneerselvam, 2004 and Novikov&Novikov, 2013). In addition, qualitative research is often not representative. This is because, in qualitative research the intention is not to generalize the findings but rather to generate in-depth and detailed perspective of the participants about the issue under investigation.

3.2 Methods of data collection

According to Fielmua and Bandie (2011), the research instrument is a tool for the purpose collecting research data. The researcher employed data collection methods such as interview guides and focus group discussions. Kapiszewski et al (2015) argue that in a focus group interview, a group of people are called upon to participate in a group discussion based on pre-determined questions and topic. The participants are asked to share their views, perceptions and experiences regarding the subject under study. The aim and purpose of focus group interview is to create interaction and discussion among group participants in order to create group data (Kapiszewski et al, 2015; Kvale, 2008 and Krueger, 1994). Thus, focus group interview supports the quality and efficiency of the interviewing, helping researchers to elicit the views of more individuals. Also, Creswell and Poth (2017) describe interview as a social interaction in a

conversational form. Brinkmann and Kvale (2015) indicate that during the interview process, knowledge and ideas are constructed and shared between the interviewer and the interviewee. Additionally, Creswell (2012) indicates that qualitative interview style is considered as an effort to understand the world and the issue under study from the perspective of the participants. The researcher used methods such as probing to elicit detailed and concrete answers to the research problem. A semi-structured interview guide was employed for the study. This allowed for flexibility and encouraged the respondents to shed more light and perspectives on the issue under investigation. The methods helped the researcher to ascertain from the respondents the contribution of the KBTH towards health service delivery since becoming an executive agency.

3.3 Sources of data

The sources of data for the study were primary and secondary data. The primary data included in-depth interviews with directors, former Board members, Board chairpersons and leaders of the senior staff association and the health service workers union. Also, the primary data covered interviews with senior members of the University of Ghana College of Health Sciences (UGCHS) and focus group discussions with patients and clients of the hospital. Secondary data were collected from journals, books, operational framework of the hospital, annual reports and government publications on the KBTH. The participants of the study were purposively selected to ensure that people with a lot of insight and experience about the operation of the KBTH were considered for the study.

3.4 Population of the Study

Population refers to the entire members of the group which the researcher is seeking to study (Lawrence, 2007 and Rubin&Rubin, 2012). The population of the study included the directors, deputy directors, unit heads and patients and clients of the KBTH. It also extended to the former board members and chairpersons of the hospital board. Others were senior members of the

UGCHS including deans and provosts. Participants in this study were aware of the Ghana Health Service and Teaching Hospitals Act 525, 1996, that regulates the mandate and activities of the hospital.

3.5 Sampling Methods and Sample Size

Creswell and Poth (2017) explain sampling as the process of selecting a group of people, events or attitudes which forms the basis for the conduct of the study. A qualitative methodological design was used. It comprised of a purposive sampling technique and snowballing sampling to select appropriate respondents for the study. The use of the purposive and snowballing sampling technique helped to choose directors, officials, patients and clients who are well informed and experienced about the activities of the hospital. Purposive sampling is a technique of sampling where the researcher intentionally decides on who should be part of the study and who should not be part based on convenience and capacity to offer necessary responses to the issues making up the research questions (Panneerselvam, 2004; Denzin and Lincoln, 2011; & Yin 2017). The purposive sampling and snowballing techniques were used to select respondents like former board members and chairpersons and the directors of KBTH with responsibility for finance, general services, human resource, pharmacy, nursing, medical affairs and the chief executive officer. Purposive and snowballing samplings were also employed to select provosts, deans and heads of department in the College of Health Sciences and other senior members who were interviewed.

Foddy (1994) explains sample size as a sub-unit of the population that is often used for the study because of constraints such as time, money, accessibility and other factors. For the sake and purpose of ensuring reliability and representation of the population, a sample size of seventy six (76) respondents were drawn from the population. The choice of this sample size was meant to ensure convenience, whilst guaranteeing the quality of information. The sample size consisted of

the following: 11 senior managers and directors of the hospital, 2 former Deans, 1 dean, 1 Vice Dean, and 5 heads of department in the College of Health Sciences, 3 Lecturers and 1 former head of department. Others included 4 former board chairpersons, 5 former CEOs, and 4 former directors. The rest are 2 leaders of the Korle Bu Senior Staff Association and 4 leaders of the Korle Bu Health Service Workers Union and 1 office manager and 32 focus group respondents.

3.6 Data Analysis Procedures

Qualitative strategy was used to analyze the data. The data collected was analyzed using thematic content analysis. The data was recorded, typed and grouped into appropriate themes. The analysis of the data was based on the research questions underlying the study and also situated within the executive agency model which guided the study. Also, relevant literature and remarks from the field interviews were cited to support the analysis and discussions.

3.7 Evaluation Criteria

According to Sapru (2004), the criteria for performance evaluation includes effectiveness, efficiency, equity, appropriateness and responsiveness. The study assessed the performance of the KBTH based on its deaths statistics, the number of people trained as medical doctors, the number of trained medical specialists and fellows from the postgraduate medical colleges and the number of researches done by the hospital and applied to improve service delivery. Furthermore, the number of outpatient and admission cases reported in the hospital were analyzed to assess the hospital performance. Also, the hospitals' social support to poor patients were also discussed.

3.8 Rationale for the Choice of Korle Bu Teaching Hospital (KBTH)

The KBTH was established in October 9, 1923 as a general hospital with an initial 200-bed capacity. It is now a 2000-bed capacity facility, and regarded the biggest and leading national referral centre in Ghana. The KBTH was elevated to the level of a teaching hospital in 1962,

upon the establishment of the Ghana Medical School for the training of medical doctors and other health personnel. Currently, the University of Ghana School of Medicine and Dentistry and five other schools such as the School of Pharmacy, School of Public Health, School of Nursing and Midwifery, Noguchi Memorial Institute for Medical Research and the School of Biomedical and Allied Health Sciences, operating under the banner of the College of Health Sciences (CHS) collaborate with the hospital to provide clinical services, training of health personnel and the conduct of research.

The focus of the study on the KBTH is due to the complexity in its administration, operation, location and the undefined but conventionally established working relationship between the hospital and the CHS and its affiliated schools. Specifically, heads of academic departments in the schools located in the hospital also double as the heads of the clinical units in the hospital. The KBTH is a unique and prototype health service executive agency in Ghana. It is the model for nurturing and developing other teaching hospitals in Ghana such as the Komfo Anokye Teaching Hospital (KATH) in Kumasi, Tamale Teaching Hospital (TTH), Cape Coast Teaching Hospital (CCTH), and the Ho Teaching Hospital (HTH).

Importantly, the KBTH is the first general hospital in Ghana and also the first teaching hospital to be established. According to Frimpong-Boateng (2015) KBTH is the best tertiary health institution in the West Africa sub-region, and arguably, the third best in Africa. The name of the hospital suggests to clients and the general public of a healthcare institution but the KBTH is much bigger in scope, size and function than a health service agency. It is a complex and utility hospital because, aside the hospital itself, there are many institutions and public sector organizations which rely on the services and facilities of the hospital for their operations. For instance, there is a College of Health Sciences (CHS) with several affiliate schools and research centres such as the School of Medicine and Dentistry, School of Biomedical and Allied Health

Sciences, School of Nursing and Midwifery, School of Public Health, School of Pharmacy, Centre for Tropical Clinical Pharmacology and Therapeutics and the Noguchi Memorial Institute for Medical Research which depend on KBTH for its clinical training. Whilst the administrative set up of the College of Health Sciences, Centre for Tropical Clinical Pharmacology and Therapeutics, the School of Medicine and Dentistry and the School of Biomedical and Allied Health Sciences are located in the KBTH compound, the rest of the schools under the CHS are located in the main campus of the University of Ghana in Legon.

Furthermore, KBTH hosts a number of programme units and departments of the Ministry of Health (MOH) and Ghana Health Service (GHS). These include the National Tuberculosis Control Programme, National Disease Control and Prevention Department, National Aids Control Programme, National Disease Surveillance Department, Health Promotion Division, Buruli Ulcer Control Unit, the Communication for Health Unit and the Biomedical Engineering Unit. The MOH basic school and professional health sector-based associational groups such as the Ghana Medical Association and the Ghana Association of Biomedical Laboratory Scientists also have their national secretariats located in the KBTH.

Significantly, there are other autonomous health training and educational institutions located in KBTH. These include the Korle Bu Nursing and Midwifery Training College, the Korle Bu Community Health Nursing School, the School of Hygiene, Public Health Nurses' School, Ophthalmic Nursing School and the School of Peri-Operative and Critical Care Nursing. Others include the Public Health Reference Laboratory, Centre for Health Information Management, Ghana Prevention of Maternal Mortality, the Ghana Institute for Clinical Genetics (GICG) and the Medical and Surgical Skills Institute. Interestingly, the Ophthalmic Nursing School and the School of Peri-Operative and Critical Care Nursing are affiliated to the University of Cape

Coast. Moreover, the KBTH hosts the Ghana chapter of the West African College of Physicians and the West African College of Surgeons on its premises.

Significantly, the three autonomous national centres of excellence with huge international significance are also situated within the KBTH. These are the National Cardiothoracic Centre (NCTC), National Radiotherapy Oncology and Nuclear Medicine Centre (NRONMC) and the National Reconstructive Plastic Surgery and Burns Centre (NRPSBC). Whilst the NCTC and NRPSBC are budget management entities of the Ministry of Health, the NRONMC is an agency of the Ghana Atomic Energy Commission under the Ministry of Environment, Science, Technology and Innovation (MESTI). Also, the national secretariat and administration of the Ghana National Blood Service (Blood Bank) and the Allied Health Professions Council (AHPC) are located in the KBTH.

Another equally important dimension to the KBTH bureaucracy is the presence of over seventeen (17) vibrant professional associations and close to six thousand (6,000) workers. The number of staff and professional groups present its own challenges for the management and the Board. This is evident in the numerous demands and agitations by different associations and groups, making regulation, coordination and control difficult. It is instructive to note that the presence of the security services poses another relevant dimension to the KBTH complexity. The KBTH maintains the District Police Command and the administration of the District Fire Service. Aside the office accommodation, the hospital management also accommodates some senior officers of these security services.

3.9 Ethical Consideration

The researcher was granted ethical approval by the Institutional Review Board of the KBTH and the Ethics Committee for the Humanities of the University of Ghana. The researcher obtained

informed consent of the participants before conducting interviews and adhered to the highest ethical standards during the study. Data was handled with care by the researcher and secured from the knowledge of third parties.

3.10 Conclusion

This chapter focused on the methodology for the study. It highlighted the research design, methods of data collection, and sources of data, population of the study and the sampling methods and sample size. It also explained the data analysis procedure of the study, rationale for the choice of the KBTH and the ethical considerations for the study.

CHAPTER FOUR

DATA ANALYSIS AND PRESENTATION

4.0 Introduction

This chapter presents the findings of the fieldwork from the Korle Bu Teaching Hospital (KBTH). The data covers responses from seventy six (76) respondents which includes patients and clients of the KBTH, former Chief Executive Officers, senior officials and directors of the hospital, medical consultants and Professors, Provosts, Deans, and heads of department in the College of Health Sciences. It also includes responses from former chairpersons and members of the board of the KBTH. The chapter focuses on the (i) activities and operations of the KBTH towards the provision of advanced clinical health service to support the ones provided by Ghana Health Service facilities and institutions; (ii) teaching and training of undergraduate and postgraduate medical students, nurses, pharmacists, allied health professionals and other para-clinical personnel, and (iii) the conduct of research to improve the health condition of people of Ghana.

In addition, the chapter examines the factors responsible for the relative success of the KBTH, challenges and failures as well as the measures and policies required to enhance its effectiveness, efficiency and quality of patients care. The data analysis and discussions are situated within the research questions underpinning the study. The research questions are: (i) How does the KBTH contribute to health service delivery since its creation in 1996 as an executive agency? (ii) What are the factors which have contributed to either the success or failure of the KBTH in health service delivery in Ghana since 1996? (iii) How can the KBTH be made more functional to be able to deliver its health service mandate? The analysis and presentation are also discussed based

on the key elements of the executive agency model which guides the study. Also, remarks from the field interviews were cited to support the findings.

4.1 KBTH Contribution to Advanced Clinical Health Service Delivery

The analysis of the findings indicates that the KBTH operated as a tertiary health service agency with several sub-specialization centres and units. The KBTH functioned as a national referral centre for the Komfo Anokye Teaching Hospital, Tamale Teaching Hospital, Cape Coast Teaching Hospital, Ho Teaching Hospital and the Ghana Health Service agencies such as the regional hospitals, district hospitals and polyclinics. The KBTH had sub-specialization units in its Departments of Child Health, Obstetrics and Gynaecology, Medicine and Therapeutics and Surgery. For instance, the Urology, Trauma and Orthopaedics, the Eye Centre and the Neurosurgery were under the Department of Surgery. Again, the Diabetics Centre, Fevers Unit, Institute for Clinical Genetics, Renal Dialysis Unit were also under the Department of Medicine and Therapeutics.

The existence of the three Centres of Excellence including the National Cardiothoracic Centre (NCTC), National Radiotherapy Oncology and Nuclear Medicine Centre (NRONMC) and the National Reconstructive Plastic Surgery and Burns Centre (NRPSBC) in KBTH positioned it to offer specialized clinical care to patients (KBTH Bulletin 2018). A respondent asserted that:

“KBTH is a tertiary referral centre so all cases that cannot be handled by other hospitals are referred to Korle Bu, if Korle Bu cannot handle them, then it means one has to be flown outside the country, so Korle Bu at the moment is the last stop when it comes to our health services, be it surgical, obstetrics and gynaecology, medical or child health”. Another respondent noted that: “when it comes to specialty care, we have the Cardiothoracic Centre, Renal Dialysis unit, Trauma Centre, Radiotherapy Oncology and Nuclear Medicine Centre, Reconstructive Plastic

Surgery and Burns Centre, all providing advanced medical care''. In a study conducted by Ayantias and Weisseman (2003), they established that teaching hospitals have a wider mandate and well positioned to offer quality care to patients. This view is in line with the findings of the field work which show a total of 3, 972,932 outpatient attendants and admissions of 533,516 in the KBTH, NCTC and the NRPSBC. This is further illustrated in the table 4.1,4.2 and 4.3.

The NCTC provided clinical care for all diseases related to the heart and the performance of the functions of the heart. It had a team of consultants and specialists who provided heart related care at the tertiary level. The NRONMC also provided advanced treatment and care for patients of cancer related diseases. The findings indicate that the NRONMC collaborated with the Ghana Atomic Energy Commission in the use of chemical radiation to diagnose and treat all cancer ailments (KBTH bulletin 2019). Additionally, the NRPSBC offered advanced recovery and clinical care to victims of explosion and other domestic accidents with effects on the skin. Furthermore, a respondent asserted during the group discussions that: "in Korle Bu, there are a lot of positive things to mention; it has a decent, clean and hygienic environment at the wards and the best of care". Another respondent stated that: "unlike other institutions, in KBTH there are several specialists who share ideas about patients' condition before major clinical decisions are taken". The table 4.1, 4.2 and 4.3 show the attendance, admissions and death statistics in the KBTH, NCTC and the NRPSBC. Also, table 4.4 and 4.5 demonstrates how the clinical departments in the College of Health Sciences contribute to health service provision in KBTH.

Table 4.1: KBTH Attendance, 2008-2018

	REPORTED CASES		
YEAR	OPD ATTENDANCE	ADMISSIONS	DEATHS
2008	323,752	48,558	3,641
2009	319,365	48,542	3,629
2010	357,086	45,634	3,022
2011	317,122	50,010	5,069
2012	362,775	50,189	3,800
2013	365,387	48,252	3,421
2014	369,798	48,218	3,530
2015	328,832	43,626	3,261
2016	323,234	43,542	3,515
2017	339,128	43,616	3,181
2018	381,830	44,908	3,407
Total	3,788,309	515,095	39,476

Source: Field work May, 2019.

Table 4.1 shows the outpatient attendance, admissions and death rate in the KBTH. It indicates that the hospital attended to 323,752 outpatients in the year 2008. The year 2018 recorded the highest number of outpatient attendance of 381,830. On the other hand, 2011 marked the lowest outpatient cases of 317,122. Again, the table shows that 2012 had the highest admission cases of

50,189. However, year 2016 recorded the lowest admission rate of 43,542. Furthermore, the table indicates significant number of deaths in the KBTH. This is supported by the highest number of 5,069 deaths reported in the year 2011. Also, the table shows that the year 2010 had the lowest number of deaths cases of 3,022. Overall, the table shows total outpatient cases of 3,788,309, admission statistics of 515,095 and deaths of 39,476 for the period of 2008-2018.

Table 4.2: The National Cardiothoracic Centre (NCTC) Attendance 2008-2018

	REPORTED CASES		
YEAR	OPD ATTENDANCE	ADMISSIONS	DEATHS
2008	13,061	841	81
2009	15,331	737	85
2010	17,090	831	90
2011	17,251	933	100
2012	17,728	1,002	110
2013	16,881	820	99
2014	16,910	885	91
2015	16,122	843	74
2016	17,408	950	110
2017	17,192	1,052	83
2018	19,649	974	77
Total	184,623	9,868	1,000

Source: Field work May, 2019

Table 4.2 shows the number of outpatient attendance, admissions and deaths in the NCTC. The year 2018 produced the highest number of outpatient attendance of 19,649 with the lowest yearly figure recorded in 2008 for 13,061. Again, the year 2017 had the highest number of admissions of 1,052 patients followed by 1,002 in 2012. On the other hand, the lowest admission figure was 737 in the year 2009. In addition, the year 2012 and 2016 reported the highest incidents of deaths in the NCTC of 110 each.

Table 4.3: National Reconstructive Plastic Surgery and Burns Centre Attendance 2008-2018

	REPORTED CASES	
YEAR	ADMISSIONS	DEATHS
2008	678	37
2009	645	34
2010	752	73
2011	787	78
2012	790	111
2013	810	75
2014	920	83
2015	916	63
2016	819	75
2017	755	78
2018	681	53
Total	8,553	760

Source: Field work May, 2019.

Table 4.3 shows the admissions and deaths statistics in the NRPSBC. The year 2014 had the highest number of admissions of 920 at the centre. However, the lowest admission was 645 in the year 2009. Also, the NRPSBC recorded total death rate of 760 between 2008 and 2018, with the highest number of 111 reported in the year 2012. Moreover, 2009 recorded the lowest number of 34 deaths.

4.2 Income Generation and Consultancy Committee (IGCC)

The College of Health Sciences (CHS) established the Income Generation and Consultancy Committee (IGCC) in 1989 to coordinate the income generation activities of the clinical departments in the School of Medicine and Dentistry (SMD) and the School of Biomedical and Allied Health Sciences (SBAHS). The field work indicated that IGCC supervised the commercial clinical activities in the departments of Pathology, Physiology, Medicine, Medical Illustration and Anatomy. The setting up of the IGCC emanated from the need to regulate clinical and commercial activities in the SMD and the SBAHS (Field work 2019). Table 4.4 shows that, there were four clinical departments in SBAHS and SMD and a supporting administrative unit that constituted the IGCC. It confirms the complementary role of the CHS and its IGCC member departments in the provision of clinical and para-clinical services to the clients of the KBTH.

Table 4.4: Income Generation Activities of the IGCC Departments

Department	School	Services
Anatomy	Biomedical and Allied Health Sciences	Operation of an improved mortuary services, preservation and embalming of dead

		bodies
Pathology	Biomedical and Allied Health Sciences	Provision of postmortem services and investigation into causes of diseases such as cancer and its effect on the human body. Thus, cytopathology and histopathology investigations.
Medicine and Therapeutics	School of Medicine and Dentistry	Provision of advanced medical and consultancy services.
Physiology	Biomedical and Allied Health Sciences	Provision of lung functioning test and assessment.
Medical Illustration	School of Medicine and Dentistry	Provision of commercial services such as passport pictures, identification cards and other support services to the main clinical departments and clients of the hospital.

Source: Field work May, 2019

Table 4.4 shows that the Department of Anatomy ran a mortuary service and preserved dead bodies from the main Korle Bu hospital, whilst the Department of Pathology offered postmortem services and investigations into development of diseases and its effect on the human body. Again, Department of Medicine and Therapeutics provided advanced medical care and consultancy services whilst the Physiology Department conducted lung functioning assessment. Medical Illustration Unit on the other hand, offered commercial services in support of activities in the clinical department. A respondent made a point worth noting about the IGCC operations:

“the main KBTH mortuary is not well managed and so we go to the Anatomy Department Mortuary for better preservation and safe keeping of our dead relatives. The officers managing the Anatomy Department mortuary are better trained and professional compared to those in the Korle Bu mortuary”. Another respondent also had this to say: “the medical doctors attending to my wife gave her samples to me and directed me to the Pathology Department to conduct breast cancer test”. However, due to the high number of patients in need of these services, and coupled with limited logistics and space at the Pathology Department, the KBTH referred some cases and samples to the Ghana Standards Authority and other private facilities within its catchment area for examination.

4.3 Faculty Practice and Intramural Services

There were clinical departments and units in the CHS which did not form part of the Income Generation and Consultancy Committee. Nevertheless, these departments and units performed income generation activities through the provision of clinical health services. Thus, all the clinical personnel in the CHS including those in the IGCC departments undertook patients’ management, medical consultancy and special clinics. In view of the number of specialists and medical consultants in the CHS, the KBTH referred patients and advanced cases to the specialists in the CHS. For instance, the Dental unit of SMD served as the referral centre for all dental cases. A respondent who plays a crucial role in the operations of the Dental hospital observed that: “the dental hospital serves as referral centre for KBTH, the Ghana Health Service agencies and private hospitals. As a matter of fact, this is the best facility in the country because all the consultants and specialists are here”. He stated again that: “the Dental hospital cooperates fully with the Korle Bu Hospital, which has resulted in the setting up of the Oral Surgery Department in the main KBTH to support surgical operations”. The table 4.5 indicates the

additional clinical departments in the CHS and the roles they play in clinical service delivery. It reinforces the strategic importance of the CHS and its affiliated units in health service delivery.

Table 4.5: Faculty Practice

DEPARTMENTS/UNITS	SCHOOL	SERVICES
Heamatology	Biomedical and Allied Health Sciences	Provision of services such as the full blood count, bone marrow aspirate and film comments.
Dental unit	Medicine and Dentistry	Provision of advanced dental care including oral medicine, oral surgery and oral pathology etc.
Obstetrics and Gynaecology	Medicine and Dentistry	Provision of reproductive, maternal and gynaecological care.
Surgery	Medicine and Dentistry	Provision of advanced surgical operations
Radiology	Medicine and Dentistry	Study and interpretation of scans and MRI reports.
Psychiatry	Medicine and Dentistry	Provision of mental healthcare and addictive diseases management
Child Health	Medicine and Dentistry	Provision of all kinds of advanced healthcare relating to children.
Anaesthesia	Medicine and Dentistry	Provision of anaesthetic pain management and care.

Source: Field work May, 2019.

Table 4.5 shows that, there are eight (8) major departments in the CHS that ran additional clinical services in support of the ones provided by the mainstream Korle Bu hospital. They included departments such as Heamatology, the Dental Unit, Obstetrics and Gynaecology,

Psychiatry, Child Health, Surgery, Radiology and Anaesthesia. All the personnel in these departments added to the technical capacity of the KBTH and provided consultancy services to patients in the KBTH. For example, CHS personnel in the Obstetrics and Gynaecology supported efforts towards provision of care for women, whilst those in the Child Health Department provided specialty care to children. Also, personnel of the CHS in the Department of Surgery contributed towards advanced surgical operations and consultancy. As a result of these consultancy duties provided by the CHS, the KBTH is fraught with challenges in coordinating the clinical activities in the CHS and the main hospital. The absence of coordination strategy created parallel structures, resulting in frustration of patients and needless deaths. A respondent noted that: “service provision, teaching and training of health personnel are not properly organized in KBTH. Medical consultants from the CHS and doctors in KBTH go to the ward to perform their roles, but these different roles are not coordinated to enhance quality of care and efficiency in service provision”.

4.4 KBTH Contribution to Teaching and Training of Health Personnel

The findings indicate that KBTH played important role in the teaching and training of health personnel. KBTH’s facilities and equipment were used by the UGCHS and its constituent schools for the purposes of teaching, clinical work and demonstrations. For instance, the School of Medicine and Dentistry, School of Biomedical and Allied Health Sciences, School of Public Health, School of Nursing and Midwifery and the School of Pharmacy used the hospital’s facilities for practical academic work. The KBTH also provided specimen for research study in the various schools. Moreover, the hospital served as an important training ground since 2003 for Residents doctors from the Postgraduate Medical Colleges such as the Ghana College of Nurses and Midwives (GCNM), Ghana College of Physicians and Surgeons (GCPS) and the Ghana

College of Pharmacists (GCP) (Field work 2019). The others include the West African College of Surgeons (WACS) and the West African College of Physicians (WACP). Trendwatch report (2015) indicated that teaching hospitals remained the important health institution for training medical professionals, sustaining clinical research and specialist care. The report is in line with the findings of the study which demonstrates the use of KBTH as a training centre by the postgraduate medical colleges for developing specialists for advanced healthcare. Table 4.6-4.14 demonstrates the use of the KBTH as a clinical training ground for the members and fellows of the postgraduate medical training colleges in Ghana. It shows that the KBTH has been instrumental and successful in the training of postgraduate health personnel.

Table 4.6: GCPS Members Trained in KBTH- Division of Physicians

FACULTY	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	Total
Radiology	0	3	4	1	2	4	1	3	4	7	4	5	38
Radiation Oncology	0	0	0	0	2	1	0	0	2	3	0	0	8
Psychiatry	0	0	2	1	1	0	0	0	2	1	1	2	10
Internal Medicine	2	0	2	12	10	7	2	8	7	9	10	10	79
Laboratory Medicine	1	0	1	1	1	2	2	4	2	0	2	8	24
Family Medicine	0	1	1	2	1	3	4	2	3	6	4	13	40
Child Health	0	4	4	5	3	5	6	11	6	6	8	10	68
Public Health	0	1	5	3	4	4	8	12	6	8	6	5	62
Total	3	9	19	25	24	23	23	40	32	40	35	53	32

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Source: Field work May, 2019.

The table 4.6 shows eight faculties in the Physician Division of the Ghana College of Physicians and Surgeons that trained specialists in the KBTH. The highest number of the specialists were in the faculties of Internal Medicine, Child Health, Public Health, Family Medicine and Radiology with numbers of 79, 68, 62, 40 and 38 respectively. However, faculty of Radiation Oncology produced the lowest number of specialist of 8. In total, the Physician division of the college trained 329 residents in the KBTH.

Table 4.7: GCPS Members Trained in KBTH- Division of Surgeons

FACULTY	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	TOTAL
Surgery	1	5	8	9	16	8	10	15	10	9	10	7	108
ORL	1	0	2	4	0	0	2	1	2	2	1	1	16
Dental Surgery	2	1	2	1	1	1	3	2	1	4	4	2	24
Anaesthesia	0	4	5	1	1	1	2	1	1	4	5	3	28
O&G	0	5	7	12	4	10	6	5	10	16	9	14	98
Ophthalmology	0	2	0	1	2	4	1	1	2	3	1	4	21
Emergency Medicine	0	0	0	0	0	4	3	0	6	5	5	1	24
Total	4	17	24	28	24	28	27	25	32	43	35	32	319

Source: Field work May, 2019.

Table 4.7 shows seven faculties in the Surgeons Division of the Ghana College of Physicians and Surgeons. The table reveals the Faculty of Surgery as the specialty that trained the highest number of specialists of 108. This was followed by the Faculty of Obstetrics and Gynaecology

with the number of 98. In sum, the KBTH trained 319 surgical specialists admitted by the Ghana College of Physicians and Surgeons.

Table 4.8: GCPS Fellows Trained in KBTH- Division of Physicians

FACULTY	2010	2011	2012	2013	2014	2015	2016	2017	2018	TOTAL
Child Health	0	0	0	0	0	0	0	0	0	0
Family Medicine	0	0	0	0	0	0	1	2	1	4
Internal Medicine	0	0	0	0	0	1	0	1	0	2
Laboratory Medicine	0	0	0	0	0	0	0	1	1	2
Psychiatry	0	0	0	0	0	0	1	0	0	1
Public Health	0	0	0	0	0	4	0	2	2	8
Radiation Oncology	0	0	0	0	0	0	0	1	0	1
Radiology	3	0	0	0	0	0	0	0	0	3
Total	3	0	0	0	0	5	2	7	4	21

Source: Field work May, 2019.

In table 4.8, a total of 21 fellows were trained in different fields in the Division of Physicians.

However, contrary to the 68 members trained in Child Health in the Division of Physicians, no fellow was trained in the Faculty of Child Health throughout the period of 2008-2018.

Table 4.9: GCPS Fellows Trained in KBTH- Division of Surgeons

FACULTY	2010	2011	2012	2013	2014	2015	2016	2017	2018	TOTAL
Anaesthesia	0	0	0	2	0	3	0	1	2	8
Emergency Medicine	0	0	0	0	0	0	0	4	0	4
General O&G	0	0	0	0	0	0	0	1	2	3
Reproductive Health and Family Planning	0	2	0	0	1	1	1	0	0	5
Urogynaecology	0	0	0	0	0	1	0	1	0	2
Ophthalmology	0	0	0	0	1	0	0	1	0	2
Oral and Maxillofacial Surgery	0	0	1	0	0	1	1	0	0	3
Restorative Dentistry	0	0	1	0	0	0	0	0	1	2
Oral Pathology	0	0	0	0	0	0	1	0	0	1
Orthodontics	0	0	0	0	0	0	0	0	1	1
Periodontology	0	0	0	0	1	0	0	1	0	2
Orthorhinolaryngology	0	0	0	0	1	1	1	0	0	3
Orthopaedics	0	1	0	1	1	0	2	0	1	6
Paediatric Surgery	0	0	0	0	0	0	0	0	0	0
Plastic Surgery	0	0	0	0	0	0	0	0	0	0
Cardiothoracic Surgery	0	0	0	0	0	0	0	0	0	0
General Surgery	0	0	0	0	1	0	1	0	1	3
Neurosurgery	0	0	0	0	0	0	0	0	0	0
Urology	0	0	0	1	1	0	0	1	0	3
Total	0	3	2	4	7	7	7	10	8	48

Source: Field work May, 2019.

Table 4.9 indicates the number of surgeons from the GCPS trained in the KBTH. It shows that the KBTH trained the highest number of fellows in the faculties of Anaesthesia, Orthopaedics and Reproductive Health and Family Planning. Their relevant graduating numbers were 8, 6 and 5 respectively. On the contrary, faculties such as Cardiothoracic Surgery, Neurosurgery, Plastic Surgery and Paediatric Surgery did not train any fellow at the KBTH.

Table 4.10: The West African College of Physicians' Specialists Trained in KBTH

YEAR	Community Health	Family Medicine	Internal Medicine	Laboratory Medicine	Paediatrics	Psychiatry
2007	3	1	3	2	5	0
2008	4	1	3	0	5	0
2009	1	2	4	0	4	0
2010	2	1	13	4	4	0
2011	0	2	6	1	2	1
2012	0	4	2	0	6	0
2013	0	3	7	0	4	0
2014	0	2	1	0	2	0
2015	2	1	4	1	3	0
2016	1	3	5	0	6	0
2017	0	4	10	1	2	1
2018	1	4	3	0	4	1
Total	14	28	61	9	47	3

Source: Field work May, 2019.

Table 4.10 shows six faculties in the West African College of Physicians who had their residency training in the KBTH. It shows that KBTH trained 61 internal Medicine specialists, 47

Paediatricians, and 28 Family Medicine Specialists. Again, there were 3 Psychiatrists trained during the period under investigation etc. This evidence confirms KBTH role in the training of specialists for the West African sub-region.

Table 4.11: The West African College of Surgeons' Members Trained in KBTH

Faculty	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	Total
Anaesthesia	1	5	4	3	1	0	0	0	0	5	4	3	26
Dental Surgery	0	1	1	0	0	0	0	2	0	1	0	1	6
O&G	3	3	3	5	4	8	3	5	11	4	8	9	66
Ophthalmic	0	1	0	0	0	0	0	2	0	0	0	1	4
ORL	0	0	0	0	1	0	0	0	0	3	0	0	4
Radiology	0	0	1	2	0	0	0	3	1	2	0	5	14
Surgery	3	4	7	9	14	7	3	5	7	6	1	6	72
Total	7	14	16	19	20	15	6	17	19	21	13	25	192

Source: Field work May, 2019

From table 4.11, the KBTH could be seen to have played a critical role in the training of the Fellows of the West African College of Surgeons in seven specialties. It shows that the KBTH was an important clinical institution for turning out specialists for the health sector in Ghana and the West African sub-region as a whole. It indicates a total of 72 Surgery specialists and 66 Obstetricians and Gynaecologists were trained in KBTH. Again, 26 Anaesthetists and 14

Radiologists were trained in the KBTH. In total, the KBTH contributed to the training of 192 medical specialists for the health sector for the period of 2007-2018.

Table 4.12: The West African College of Surgeons' Fellows Trained in KBTH

Faculty	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	Total
Anaesthesia	0	1	3	0	0	0	1	0	1	0	0	0	6
Dental Surgery	0	0	0	0	0	0	0	0	2	0	1	1	4
O&G	2	4	2	3	4	0	1	1	1	4	6	5	33
Ophthalmic	0	2	0	1	0	0	0	0	0	0	0	0	3
ORL	0	1	0	1	0	0	0	1	0	0	0	0	3
Radiology	0	1	1	0	1	0	2	0	0	1	4	1	11
Surgery	6	5	5	5	2	6	8	9	5	5	10	9	75
Total	8	14	11	10	7	6	12	11	9	10	21	16	135

Source: Field work May, 2019

The table 4.12 demonstrates the critical role played by the KBTH in the education of senior health personnel for the Ghana's health sector. It reveals that a total of 135 fellows were trained in the hospital in seven specialized areas. Of the 135 fellows, 75 of them were specialists in Surgery, 33 in Obstetrics and Gynaecology, whilst 11 were Radiologists etc.

Table 4.13: Ghana College of Nurses and Midwives Members Trained in KBTH

Year	Number of Members Trained in KBTH
2018	20
Total	20

Source: Field work May, 2019

The table 4.13 demonstrates the role of the KBTH in the training of members of the Ghana College of Nurses and Midwives as specialist nurses. A total of 20 members underwent training in the KBTH. Thus, KBTH played important role in postgraduate education of Nurses and Midwives. Although the Specialist Health Training and Plant Medicine Research Act 833, 2011, created the Ghana College of Nurses and Midwives, its implementation was delayed until 2015 (Field work 2019). The delay in implementation of the Act 833 accounts for the relatively fewer number of specialist Nurses and Midwives trained in the KBTH (Field work 2019).

Table 4.14: Ghana College of Pharmacists Members Trained in KBTH

Year	Clinical Pharmacists
2018	5
Total	5

Source: Field work May, 2019.

Table 4.14 further clarifies the role performed by KBTH in the training of postgraduate Clinical Pharmacists in Ghana. A respondent argued that: “the KBTH is the most preferred institution for the Ghana College of Pharmacists in the training of Clinical Pharmacists in Ghana”. Even though the Ghana College of Pharmacists Act 833, was passed in 2011, full implementation did not take

place until 2015 leading to the training of only 5 Clinical Pharmacists in KBTH in 2018 (Field work 2019)

4.5 KBTH's Contribution to Public Health Research

The field interviews confirmed KBTH as an important institution for the conduct of clinical and academic research, and collection of cases. Research studies were undertaken by the individual staff of KBTH and students. In addition, individual doctors and academic staff from the School of Medicine and Dentistry, School of Biomedical and Allied Health Sciences undertook research using the hospital environment and cases for their investigation. However, two respondents who served as CEOs indicated that there is no centre in the hospital that focuses on the conduct of research except for the recently established Research and Training Unit in 2015 which streamlines individual and group research studies, protocols and ethical standards. The table 4.15 indicates the number of research studies approved by the Institutional Review Board and undertaken in the KBTH from the period of 2015-2019 June. The table is relevant in understanding the role of the KBTH for health research.

Table 4.15: Number of Research Studies Conducted in KBTH

Year	Number of Studies Undertaken
2015	10
2016	40
2017	75
2018	122
2019	105
Total	352

Source: Field work May, 2019

The table 4.15 reveals that, there was 352 research studies conducted in the KBTH from 2015-2019 June. This indicates that KBTH provided the institutional setting for the conduct of research in the health sciences in Ghana. However, these research studies were initiated and conducted largely by individuals and not KBTH as an institution. Thus, the Research and Training Unit of the KBTH only coordinated the research studies, hence it was not applied in the hospital's activities. In other words, the researches did not contribute to enhancing health outcomes.

4.6 Collaboration Between the KBTH and the College of Health Sciences

The field work indicated that KBTH and the College of Health Sciences (CHS) collaborated in operational responsibilities. For instance, there was collaboration in the provision of clinical health service, conducting of research and the teaching and training of doctors, nurses, pharmacists, allied health professionals and other para-clinical personnel. The CHS was the main human resource basket of the hospital. All the one hundred and forty one (141) clinical personnel in the CHS offered consultancy services to the hospital. The services they rendered included patient management and care, advanced medical consultancy, provision of mentorship and training of postgraduate medical students. They were also involved in the teaching and training of undergraduate students in the various clinical and para-clinical health disciplines. Thus, whilst the Ministry of Health employed general doctors and specialists who work in the hospital, other advanced medical services were provided by the clinical personnel who work with the CHS. It can be seen from table 4.16-4.34 that KBTH provided the institutional setting and training ground for the undergraduate students in the School of Medicine and Dentistry, School of Biomedical and Allied Health Sciences, School of Pharmacy and the School of Nursing and Midwifery. The tables confirm the use of KBTH by the CHS and its constituent schools for

clinical trainings and ward exposure of its students. Jaye et al (2009) posited that, teaching hospitals are critical institution in the training of medical students and other health professionals. Also, Langabeer (2018) argued that teaching hospitals constitute the clinical dimension of academic health training institutions. The findings of this study support the views expressed by Jaye et al (2009) and Langabeer (2018) as table 4.16-4.34 shows that a total of 5,417 undergraduate health personnel were trained in the KBTH.

Furthermore, the Heads of Department in the hospital were appointed by the CHS and its affiliated units such as the School of Medicine and Dentistry (SMD) and the School of Biomedical and Allied Health Sciences (SBAHS). Thus, the heads of the clinical units in the hospital were usually from the School of Medicine and Dentistry and the School of Biomedical and Allied Health Sciences. A respondent who doubled as head of academic and clinical department in the CHS and KBTH indicated that: “the appointment of clinical heads of the KBTH by the CHS and the constituent schools is a matter of history and the circumstances under which the Ghana Medical School was established in 1962 by Kwame Nkrumah’s CPP government”. Another respondent who went through the Ghana Medical School added that: “the Ghana Medical School which is now known as the University of Ghana Medical School (UGMS) started with the staff of the Korle Bu Teaching Hospital and the Ministry of Health”. In other words, the original staff of the University of Ghana’s Medical School came from the KBTH which resulted in the development of a strong and unique relationship between the hospital and the Medical School (Field work 2019).

However, the practice of appointing clinical heads of KBTH from the CHS contravened the provision of the Act 525 of 1996, which stipulated that: “the Board of a Teaching Hospital shall in consultation with the appropriate medical school, appoint heads of such units of the Teaching Hospital as the Board may determine”. Nonetheless, the field work revealed renewed efforts by

the current Board of the hospital led by Hon. Dr. Bernard Okoe Boye to regularize the appointment procedures of the clinical heads through an open and competitive process. This albeit, had generated simmering tension between the staff of the CHS, particularly those in the SMD and the SBAHS on one hand and the staff Korle Bu hospital on the other. A respondent who is a head of department in the CHS and also a head of a clinical unit in the KBTH indicated that: “the Korle Bu management have advertised the positions of heads of department and asked all of us to apply, but I will not apply. Let them go ahead and do whatever they want to do and they will see what will happen”.

Table 4.16: Graduation Statistics of the School of Nursing and Midwifery

Academic Year	Total No. of Graduates
2007	23
2008	120
2009	124
2010	136
2011	168
2012	145
2013	81
2014	79
2015	91
2016	117
2017	89
2018	85
	Total: 1,258

Source: Field work May, 2019.

Table 4.16 shows the number of nurses and midwives from the School of Nursing and Midwifery trained in the KBTH. It indicates that 2011 marked the year the highest number of 168 nurses were trained, with 2012 and 2010 producing 145 and 136 nurses respectively. The year 2007 produced the minimum number of 23 Nurses. Overall, the KBTH contributed to the training of 1,258 nurses from the CHS between 2007-2018.

Table 4.17: Graduation Statistics of the School of Medicine and Dentistry

Year	Male	Female	Total No. of Graduates
2000	8	3	11
2001	42	22	64
2002	58	29	87
2003	52	16	68
2004	50	20	70
2005	59	19	78
2006	61	24	85
2007	53	31	84
2008	65	23	88
2009	71	34	105
2010	88	23	111
2011	95	51	146
2012	114	57	171
2013	119	69	188
2014	89	58	147

2015	135	77	212
2016	146	75	221
2017	130	104	234
2018	117	104	221
Total	1,552	839	2,391

Source: Field work May, 2019.

Table 4.17 shows the number of Medical Officers and Dentists trained in the CHS and KBTH for the period of 2000-2018. The table shows an increasing numbers of doctors trained, from the initial 11 in the year 2000 to 234 in the year 2017. In a nutshell, the CHS and the KBTH trained 2,391 Medical Doctors. Thus, KBTH provided the clinical setting for the education of undergraduate medical students, consistent with the mandate of the hospital under the Act 525, 1996.

Table 4.18: Graduation Statistics of the School of Pharmacy (SOP)

Year	Total No. of Graduates
2012	31
2013	25
2014	28
2015	29
2016	41
2017	42
2018	40
Total	236

Source: Field work May, 2019.

The table 4.18 demonstrates the yearly graduation statistics of the School of Pharmacy (SOP) in the UGCHS. It indicates that SOP begun producing Pharmacists in the year 2012 with an initial 31 graduates. The highest number of Pharmacists trained in the SOP and KBTH was 42 in 2017 and the lowest being 25 in the year 2013. Overall, the KBTH trained 236 Pharmacists since the SOP was established in 2008.

Table 4.19: SBAHS 2003 Graduation Statistics

Department	Total No. of Graduates
Medical Laboratory Sciences	10
Total	10

Source: Field work May, 2019.

Table 4.19 shows the initial graduates of the School of Biomedical and Allied Health Sciences. It establishes that the KBTH and SBAHS graduated 10 biomedical laboratory scientists in 2003 upon the establishment of the SBAHS in the year 2000.

Table 4.20: SBAHS 2004 Graduation Statistics

Department	Total No. of Graduates
Medical Laboratory Sciences	9
Total	9

Source: Field work May, 2019.

Table 4.20 also indicates the number of biomedical laboratory scientists trained in the year 2004 in the KBTH. The number dropped marginally from the initial 10 in 2003 to 9 in 2004.

Table 4.21: SBAHS 2005 Graduation Statistics

Department	Total No. of Graduates
Medical Laboratory Sciences	19
Physiotherapy	13
Radiography	11
Total	43

Source: Field work May, 2019.

The table 4.21 reveals the training of additional allied health professionals in the KBTH. The CHS introduced other courses such as physiotherapy and radiography. The number of medical laboratory scientists trained went up from 10 in 2003 to 19 in 2005 whilst the Physiotherapy and Radiography departments graduated 13 and 11 professionals respectively. Overall, the allied health professionals trained in 2005 was 43.

Table 4.22: SBAHS 2006 Graduation Statistics

Department	Total No. of Graduates
Medical Laboratory Sciences	24
Physiotherapy	21
Diagnostic Radiography	5
Therapy Radiography	3
Total	53

Source: Field work May, 2019.

In table 4.22, the number of allied health professionals trained in KBTH increased over the previous year by 10. Additionally, the table shows the introduction of other courses such as Diagnostic Radiography and Therapy Radiography. The total number of allied health professionals trained in 2006 was 53.

Table 4.23: SBAHS 2007 Graduation Statistics

Department	Total No. of Graduates
Medical Laboratory Sciences	25
Physiotherapy	27
Diagnostic Radiography	16
Therapy Radiography	1
Total	67

Source: Field work May, 2019

The table 4.23 shows a continuous increase in the number of allied health professionals trained in the KBTH. It indicates an increase over the previous year by 14. The overall number of allied health professionals trained in that year was 67. This affirms the role of the KBTH in the training of professionals in allied health and other para-clinical disciplines.

Table 4.24: SBAHS 2008 Graduation Statistics

Department	Total No. of Graduates
Medical Laboratory Sciences	43
Physiotherapy	24
Diagnostic Radiography	14
Total	81

Source: Field work May, 2019.

The table 4.24 further confirms the strategic importance of the KBTH in the training and education of allied health professionals in Ghana. It reveals a major increase in the number of Biomedical Laboratory Scientists trained in the year 2008 with the total number of 43. In total, the KBTH trained 81 allied health personnel in the year 2008.

Table 4.25: SBAHS 2009 Graduation Statistics

Department	Total No. of Graduates
Medical Laboratory Sciences	61
Physiotherapy	30
Diagnostic Radiography	16
Therapy Radiography	6
Total	113

Source: Field work May, 2019.

The table 4.25 additionally confirms the involvement of the KBTH in the training of allied health professionals in Ghana. It shows an improvement in the number of students trained in 2009 over the previous years; a further testament of the supporting role of the KBTH in the training of allied health professionals in Ghana. The number of Laboratory Scientists went up to 61 whilst the number of physiotherapists were 30. In total, 113 allied health professionals were trained in the year 2009.

Table 4.26: SBAHS 2010 Graduation Statistics

Department	Total No. of Graduates
Medical Laboratory Sciences	51
Physiotherapy	32
Diagnostic Radiography	15
Therapy Radiography	11
Total	109

Source: Field work May, 2019

The table 4.26 also shows a consistent performance of the KBTH's mandate for training and education of medical and allied health professionals for the country. It is a further proof that

KBTH provided practical setting for the training of health personnel. The total number of the health personnel from the SBAHS trained in the KBTH was 109 for the year 2010.

Table 4.27: SBAHS 2011 Graduation Statistics

Department	Total No. of Graduates
Medical Laboratory Sciences	48
Physiotherapy	31
Diagnostic Radiography	35
Total	114

Source: Field work May, 2019

From table 4.27 we can see the continuous performance of the teaching and training mandate of the KBTH. It shows that the hospital supported the allied health departments in the CHS to train personnel to meet the health service needs of the country. Additionally, the table indicates the graduation of 48 Laboratory Scientists and 31 Physiotherapists and a significant 35 Diagnostic Radiographers for the 2011 academic year. Thus, an overall allied health professionals of 114 were trained in 2011.

Table 4.28: SBAHS 2012 Graduation Statistics

Department	Total No. of Graduates
Medical Laboratory Sciences	61
Physiotherapy	31
Diagnostic Radiography	31
Dietetics	20
Total	143

Source: Field work May, 2019

Table 4.28 adds credence to the consistent role KBTH played in the training of allied health personnel in Ghana. The KBTH and SBAHS graduated 143 students in the 2012 academic year.

It demonstrates a consistency and commitment of KBTH and CHS in the education and training of health personnel in Ghana. Again, the table shows the incorporation of Dietetics into the allied health professional training by KBTH and CHS.

Table 4.29: SBAHS 2013 Graduation Statistics

Department	Total No. of Graduates
Medical Laboratory Sciences	46
Physiotherapy	32
Diagnostic Radiography	20
Dietetics	17
Total	115

Source: Field work May, 2019

The table 4.29 supports the continuous role of the KBTH in the practical training of allied health professionals in Ghana. The Medical Laboratory Scientists and Physiotherapists trained in the year under review was 46 and 32 respectively. On the other hand, there were 20 Diagnostic Radiographers and 17 Dieticians trained in 2013.

Table 4.30: SBAHS 2014 Graduation Statistics

Department	Total No. of Graduates
Medical Laboratory Sciences	37
Physiotherapy	17
Diagnostic Radiography	12
Dietetics	7
Total	73

Source: Field work May, 2019

In table 4.30, the KBTH and the CHS continued in their role of training health professionals for the country. A total of 73 allied health personnel were trained and graduated in 2014. However, the number trained for 2014 was woefully short of the previous year number of 115.

Table 4.31: SBAHS 2015 Graduation Statistics

Department	Total No. of Graduates
Medical Laboratory Sciences	73
Physiotherapy	35
Diagnostic Radiography	31
Dietetics	28
Occupational Therapy	8
Total	175

Source: Field work May, 2019

Table 4.31 shows a major improvement in the number of allied health professionals trained in 2015 over the previous year. In the year 2015, 8 new set of Occupational Therapists were trained. Again, 2015 represented the year the largest set of allied health professionals were trained in the KBTH and CHS. In total, 175 allied health personnel graduated.

Table 4.32: SBAHS 2016 Graduation Statistics

Department	Total No. of Graduates
Medical Laboratory Sciences	65
Physiotherapy	23
Diagnostic Radiography	23
Therapy Radiography	4
Dietetics	14

Occupational Therapy	7
Total	136

Source: Field work May, 2019.

Table 4.32 shows the consistency in the use of the KBTH facilities, equipment and environment as a training site for the development of allied health professions in Ghana. It can be observed that 2016 was the year professionals in all the six allied health disciplines in the CHS were trained in KBTH. They included Medical Laboratory Scientists, Physiotherapists, Diagnostic Radiographers, Therapy Radiographers, Dieticians and Occupational Therapists. There was a total of 136 allied health personnel trained in 2016.

Table 4.33: SBAHS 2017 Graduation Statistics

Department	Total No. of Graduates
Medical Laboratory Sciences	60
Physiotherapy	30
Diagnostic Radiography	23
Dietetics	20
Occupational Therapy	6
Total	139

Source: Field work May, 2019

Table 4.33 informs us about the continuity in the use of KBTH as a training ground for the allied health students from the CHS. It shows the training of students in five allied health disciplines in the KBTH. There was a total of 139 personnel trained in the Medical Laboratory Sciences, Physiotherapy, Diagnostic Radiography, Dietetics and Occupational Therapy.

Table 4.34: SBAHS 2018 Graduation Statistics

Department	Total No. of Graduates
Medical Laboratory Sciences	81
Physiotherapy	20
Diagnostic Radiography	40
Dietetics	9
Occupational Therapy	2
Total	152

Source: Field work May, 2019

Table 4.34 also indicates the number of allied health personnel that were trained in the CHS and Korle Bu Hospital and graduated in the year 2018. It reveals that 2018 was the year the highest number of 81 Medical Laboratory Scientists were trained in the KBTH. Overall, a total of 152 allied health professionals were trained in five disciplines in 2018.

4.7 Structural Disaggregation of the Korle Bu Teaching Hospital

A universally accepted feature of the executive agency form of organizational reform is its separation and structural disaggregation from the core civil service (Moynihan, 2006; Ohemeng and Adusah-Karikari, 2017; Overman and Van Thiel, 2016). Scholars of the executive agency phenomenon argue that the separation of the agencies from the civil bureaucracy is crucial to free them from the rigid and rigorous rules and regulations of the civil service in order to ensure swift and prompt decisions in response to changing circumstances. The field work showed that, the Korle Bu Teaching Hospital (KBTH) was structurally separated from the Ministry of Health

(MOH). The Ministry of Health concerned itself with policy making, strategic direction and monitoring and evaluation whilst the KBTH focused on policy implementation and clinical service delivery. The Ghana Health Service and Teaching Hospital Act 525, 1996 created the KBTH as an executive agency of the Ministry of Health responsible for providing advanced clinical care, public health research and training and education of prospective health personnel.

The KBTH had a management Board made of a Chairman and three other persons appointed by the government, the Chief Executive Officer (CEO), the Dean of the School of Medicine and Dentistry and five directors of the hospital. The governing Board provided a policy making, strategic direction and leadership for the hospital. In line with the views of Bowornwathana (2006) and the Yesilkagit and Van Thiel (2011), the autonomous health status of the KBTH increased the appointing powers of the executive branch of government. The four non-executive members of the governing board were appointed by the central government through the Ministry of Health. Interestingly, most CEO's appointment were made by the President through the MOH instead of the competitive appointment process. For example, a respondent who was in a senior management role before the upgrade of the hospital into executive agency status noted that: "apart from the appointment of Prof. Nii Otu Nartey as the Chief Executive Officer which went through the competitive and interview process, the rest of the CEOs of the Korle Bu Teaching Hospital were appointed by the government through the Ministry of Health".

Even though the KBTH had been decoupled from the Ministry of Health, there was an incongruent situation where the MOH imposed projects and supplier's contract on the hospital. Thus, there were projects which were directly contracted by the Ministry of Health without the direct involvement of the hospital's board and management. For instance, a respondent asserted that: "the Belster Project under which government provided catering services, kitchen and laundry and the MRI/CT Scan were contracted by the MOH and imposed on the hospital to

service the cost’’. He went further to indicate that: “due to the absence of the hospital’s board and management in the contractual negotiation, the Belster Project agreement did not have standard operating and maintenance clauses to ensure value for money and regular servicing of the equipment’’.

It is instructive to note that, the KBTH performed service delivery and implementation of policies for the MOH. The field work showed that the KBTH undertook several functions such as the provision of advanced clinical care to enhance those provided by the Ghana Health Service agencies such as the regional, and district hospitals and polyclinics, facilitation of teaching and training of undergraduate and postgraduate students in medicine, dentistry, nursing, pharmacy, allied health sciences and other para-clinical disciplines by the CHS and its affiliated schools and the postgraduate medical colleges such as the College of Nurses and Midwives, Ghana College of Physicians and Surgeons, West African College of Surgeons and the West African College of Physicians etc. In addition, the KBTH conducted research in conjunction with the CHS to improve the conditions of health of citizens and also served as a site for the conduct of health research by individuals and organizations. The KBTH also undertook community and technical outreaches, and mentorship of the lower level health facilities. These interventions helped in educating and sensitizing the general public about public health challenges and training of local health personnel to deal with health crisis.

The executive agency concept empowered the governing Board and management to set up the Public Health Unit in 2009, which enabled the hospital to pursue series of preventive health outreaches. For example, in 2011 and 2012, the KBTH undertook major health outreaches to the northern part of Ghana which supported Ghana Health Service facilities to handle pressing and emergency health challenges at the time. A respondent observed that: “one of the effects of the

health sector executive agency phenomenon in KBTH is the creation of the Public Health Department”.

4.8 Autonomy and De-regulation in Management and Operations

Executive agencies are vested with the power to undertake their activities devoid of influence from their political principals and central government (Verhoest et al, 2012). The evidence from the field work showed that KBTH enjoyed a measure of autonomy in matters such as budget, daily operation, administration and appointment of the directors of the hospital. Additionally, the field work indicated that, the KBTH Board exercised autonomy in its ability to recruit additional staff who were paid from the hospital’s internally generated fund. Moreover, the KBTH retained the right to manage its security matters, the operation of sub-budget management centres, discipline and administration of the staff independently.

However, personnel recruitment, finance and the introduction of private sector principles to manage the KBTH were highly controlled by the Ministry of Health and Ministry of Finance. One respondent remarked that: “both the Ministry of Health and Ministry of Finance have set controlling mechanisms and administrative measures which constrain management”. Another respondent stated that: “in all recruitment processes, the hospital management is enjoined by public policy to secure financial clearance from the Ministry of Finance before it can employ”. Also, budgets, procurement and operational activities involving amount beyond Ghc50,000 require approval by the Ministry of Health and Ministry of Finance.

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4.9 Devolution of Budget and Financial Independence

The field interviews revealed that, the KBTH exercised financial autonomy in its operations. The hospital prepared its own budget and the Centres of Excellence had a budget line on what was prepared by the central administration. The hospital managed its own accounting system and also

managed its own revenue and operational accounts. Furthermore, the hospital retained all of its internally generated fund (IGF) and applied it the way management considered it appropriate (Field work 2019). The retention of the IGF granted the management flexibility to move funds around to manage different responsibilities and recruited additional support staff such as administrative assistants, clinical psychologists and other allied health professionals etc. for the execution of its mandate. Again, the IGF supported the procurement of goods and essential service needs of the hospital. A senior manager of the KBTH had this to say: “essentially the IGF is what is used by the hospital to fund its operations such as the purchase of consumables and medical equipment”.

In spite of the financial independence enjoyed by the hospital, its broad financial policies were subjected to the direction of Ministry of Health, Ministry of Finance and Parliament. In addition, the hospital management was constrained by central government from adjusting its fees and charges to reflect operational cost. The Fees and Charges Act 793, 2009 amended by a Legislative Instrument (LI 2228), 2016, enjoined the management of KBTH to seek parliamentary approval before making upward adjustment to the hospital’s fees and charges. Most often, the requests by the hospital management for upward review of its fees did not receive the support of the government and parliament because of the negative effect of higher healthcare cost on government legitimacy and citizens’ support for it. A respondent stated that: “government is always unwilling to support proposed increases in hospital fees and charges because of public outcry and effects on its re-election”.

Additionally, policies and measures involving intensive capital investment were referred to the Ministry of Health, Ministry of Finance and central government for funding approval. This finding is supported by the provision of section 36 (2) of Act 525, which states that “A Teaching Hospital Board shall not enter into any contract in respect of a movable or immovable property

or works or services for the hospital the total value of which exceed in any one financial year such sums as the Minister may determine” (Republic of Ghana 1996). Consequently, this provision limited the capacity of the hospital’s Board to mobilize private sector funding and participation in the development of critical infrastructure, operational and investment projects.

4.10 Corporate Governance

The field work indicated that there was an established corporate governance structure in the KBTH in line with the Ghana Health Service and Teaching Hospitals Act 525, 1996. The management Board of the hospital was the highest decision-making body and provided the strategic direction, policy guidelines and oversight duties over the management and activities of the hospital. KBTH had a functional eleven- member management Board composed of a chairman and three other persons appointed by the President and six executive members including the Chief Executive Officer and the directors responsible for Administration, Finance, Pharmacy, Nursing and Medical Affairs. Other members included the Dean of the University of Ghana’s School of Medicine and Dentistry (Republic of Ghana, 1996). The Ghana Health Service and Teaching Hospital’s Act 525 made provision for the Deans of the University of Ghana’s School of Medicine and the Dental School as members of the hospital’s board. However, the membership of the Board reduced due to the collegiate reforms in the University of Ghana which merged two separate schools into School of Medicine and Dentistry.

Moreover, the composition of the Board raises concerns as far as modern public hospital board composition is concerned. The presence of the directors in addition to the CEO on the Board blurred the distinction between governance and management. This practice did not help in courting outside expertise to help the running of the hospital. In fact, the executive members of the board outnumbered the government appointees which did not promote innovation and

adoption of new policies for the hospital management. As one respondent articulated: “most often, the ideas and proposals the management takes to the Board are the ones that are adopted”. Furthermore, the presence of the directors on the Board with the CEO did not help in the smooth implementation of the Board directives. A respondent argued that: “the inclusion of the directors on the board is problematic and challenging when it comes to enforcement of the Board decision”.

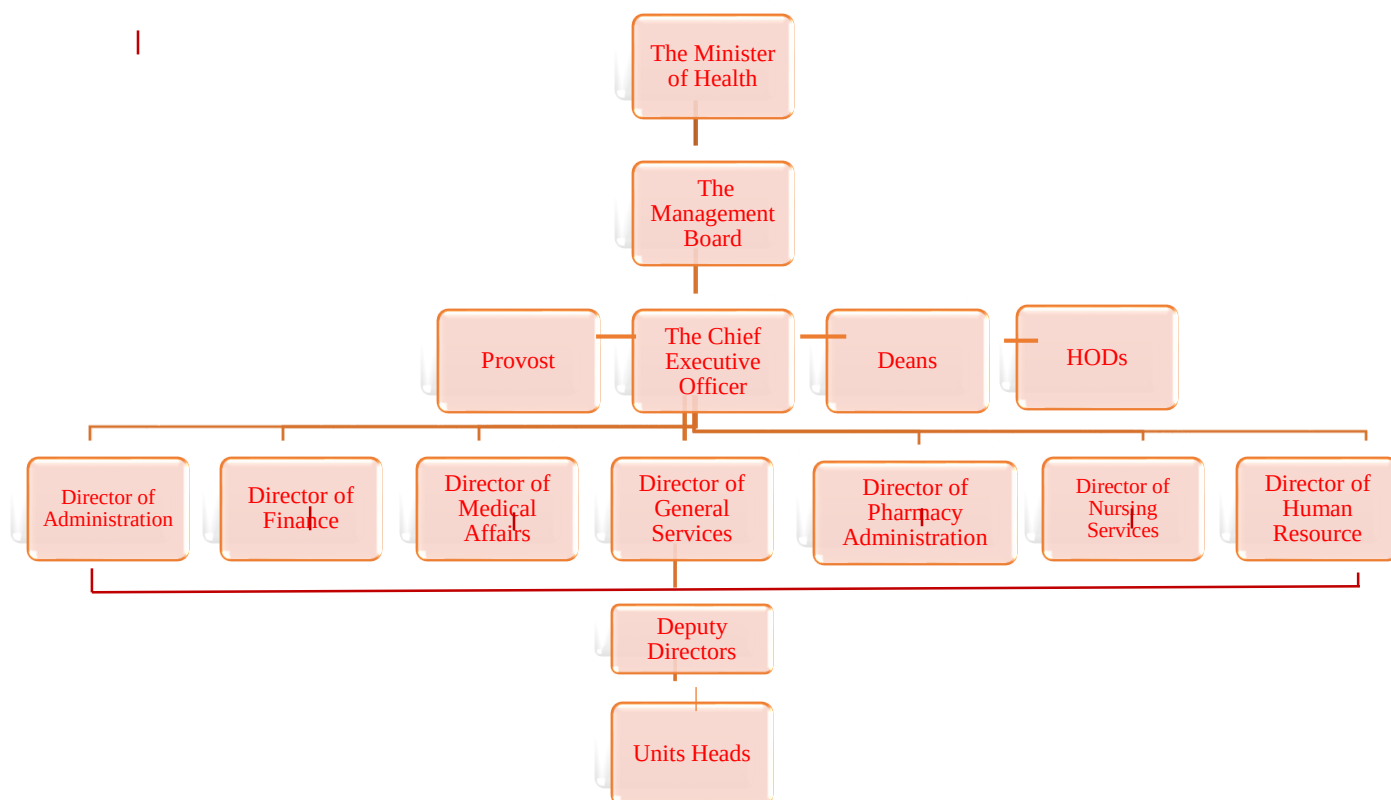
The KBTH had seven Directorates in the central administration including Finance, Administration, Medical Affairs, Nursing Services, Pharmacy Administration and General Services in line with the Act 525, 1996. In 2010, through an administrative measure, a seventh directorate, Human Resource was created and in charge of personnel recruitment and development (Field work 2019). The day-to-day administration of the hospital was carried out by the Chief Executive Officer (CEO) who was assisted by the directors in charge of the various directorates.

It is important to point out that KBTH is one of the many agencies of the Ministry of Health which did not have Legislative Instrument (LI) to operate the Act 525, 1996. The LI is expected to define the processes towards the operation of the Act, appointment of senior managers, qualifications, experiences and other requirements of senior officers, human resource development and management. The absence of the LI was attributed to three reasons. First was the inertia and lack of interest by the MOH and central government to pass the enabling law that will give true meaning to the executive agency concept. Secondly, the lack of interests and necessary advocacy on the part of health service administrators about the law. Third was the failure of government to give publicity to the Act when it was passed in order to generate the interests of key stakeholders. A respondent who is familiar with the Act 525 intimated that: “the Act 525 is highly unknown, there are many health service practitioners, lawyers and judges who

have no knowledge about the Act”. The absence of the LI to guide the implementation of the Act did not help in the development of proper and effective management systems in the hospital. This development created room for politicization and undue influence in the appointment of the CEO, directors and board members. For instance, a respondent asserted that: “through the influence of a Board Chairman, a highly unqualified individual was appointed the Director of Administration”. The respondent further indicated that: “the incompetence and poor performance of the director had a heavy toll on the overall efficiency and effective administrative system required for the management of the hospital” (field work 2019).

Figure 1 indicates the administrative structure and operational hierarchy of the KBTH and its relationship with the CHS. It suggests a strong working relationship between the KBTH and the CHS and its constituent schools and departments in the execution of the teaching, research and service delivery responsibilities of the hospital. It also shows that the KBTH is structurally disaggregated from the main public administration of the state and operated as an autonomous agency with the Minister of Health being the political principal over it.

Figure 1: Organogram of the Korle Bu Teaching Hospital



Source: Fieldwork May, 2019.

Figure 1 shows the organizational structure of the KBTH which begins with the Minister of Health who is the supervising minister of the hospital. The management Board provided leadership and direction for the hospital management team led by the Chief Executive Officer who was assisted by the directors in the seven directorates. The Directors were supported by an array of Deputy Directors and unit heads. The CHS, headed by the Provost and the Deans of the affiliated schools offered operational and technical assistance for service delivery, research and teaching and training of health personnel.

4.11 Human Resource Recruitment and Development

The Ghana Health Service and Teaching Hospital Act 525, 1996 did not provide for a directorate responsible for human resource management and development. Evidence from the field interview suggests that personnel recruitment and development were subsumed into the directorate in charge of General Administration until 2010. The management Board in consultation with the Public Services Commission advertised administrative, clinical and management positions, and qualified applicants were interviewed before selection. However, the field work found that some management positions were reserved for only internal applicants. Again, it was revealed that, there was no specified procedure, experience, qualification and job descriptions for filling senior management positions of the hospital, resulting in abuses and undue influence by some members of the management Board in the appointment of senior officials of the hospital.

Contrary to the managerial autonomy vested in the management Board of the KBTH, the MOH decided the number of doctors and nurses that were allocated to the hospital. Top level staff like Doctors, Medical Consultants, Laboratory Technologists and Technicians were appointed by the MOH with the help of regulatory agencies such as the Medical and Dental Council (MDC), Nursing and Midwifery Council (NMC) and the Allied Health Professions Council (AHPC). Nevertheless, the hospital from its IGF recruited other category of staff to augment its human resource strength.

Significantly, the IGF staff were paid the same salary and working condition as those paid by the central government. In a publication by Verhoest et al (2012), they argued that a central element of executive agency phenomenon is deregulation and autonomy enjoy by management to determine matters such as administration, finance, budget and personnel. This view is in line with the findings of the study as KBTH was able to use its IGF to hire additional clinical and

support staff for its activities. The table 4.35 reveals the staff strength of the KBTH and their allocation in the various clinical and non-clinical departments of the hospital. The table 4.36 on the other hand indicates the number of staff recruited and paid from the IGF. In addition, table 4.37 throws lights on the level of cooperation between the KBTH and CHS in the delivery of advanced health service to patients. Moreover, tables 4.35, 4.36 and 4.37 shows the human resource strength of the hospital, justifying its huge bureaucracy.

Table 4.35: KBTH Departmental GOG Staff Distribution-June, 2019

Department	Clinical	Non-Clinical/ Administrative	Grand Total
Accident and Emergency	229	10	239
Accident Centre	263	23	286
Anaesthesia	291	10	301
Audit	-	7	7
CEO's Secretariat	1	12	13
Dental	37	5	42
Ear, Nose and Throat (ENT)	86	7	93
Eye	86	10	96
Finance	2	55	57
General Administration	90	268	358
General Services	5	83	88
Human Resource	1	31	32
Laboratory	167	24	191
Medical and Therapeutics	472	33	505
Obstetrics and Gynaecology	595	42	637
Surgery	384	19	403
Child Health	305	25	330
Medical Directorate	75	20	95
National Cardiothoracic Centre	115	5	120

National Reconstructive Plastic Surgery and Burns Centre	151	12	163
Nursing Directorate	15	4	19
Pharmacy	122	10	132
Polyclinic	169	21	190
Psychiatry	60	2	62
Radiology	54	19	73
National Radiotherapy Oncology and Nuclear Medicine Centre	56	12	68
Grand Total	3,831	769	4,600

Source: Field work May, 2019

The table 4.35 shows the staff strength of the KBTH in its administrative and clinical units. It reveals that 3,831 of the staff were clinical personnel whilst 769 played administrative and support service roles. Significantly, the four main departments of Child Health, Medicine and Therapeutics, Obstetrics and Gynaecology and Surgery accounted for 1,875 out of the total staff of 4,600, representing 41%. Also, the NCTC, NRONMC and NRPSBC accounted for 351 employees, representing 8%. Thus, the table confirmed KBTH as a health sector agency with a large staff strength.

Table 4.36: KBTH IGF Employees and the Year of Recruitment- June 2019

Year	Number of People Recruited
2019	7
2018	16
2017	43
2016	74
2015	101
2014	81
2013	32
2012	40
2011	5
2010	7
2009	18
2008	1
2007	16
2006	2
2005	43
2004	15

2003	31
2002	8
2001	2
2000	6
1990-1999	10
1980-1989	3
Total	561

Source: Field work May, 2019

Table 4.36 shows the total IGF staff of the KBTH from the 1980 to June, 2019. It indicates a total IGF staff of 561 with the lowest number employed in the year 2008. It can be seen that a total IGF staff of 425 were hired from the period of 2008 to June, 2019. The 425 IGF staff recruited between 2008-2018 represented 76% of the overall IGF staff.

Table 4.37: UGCHS Clinical Personnel Working in KBTH

Department	Number of Staff
Accident Centre	1
Anaesthesia	10
Child Health	13
Community Health	5
Dental	5
Ear, Nose and Throat (ENT)	2
Eye	4
Laboratory	13
Medicine and Therapeutics	27
National Cardiothoracic Centre (NCTC)	4
National Reconstructive Plastic Surgery and Burns Centre (NRPSBC)	1
Obstetrics and Gynaecology	18
Polyclinic	2
Psychiatry	5
Radiology	4
Surgery	27
Total	141

Source: Field work May, 2019

Table 4.37 shows the number of clinicians from the CHS that supported clinical service delivery in Korle Bu Hospital. It indicates a total number of 141 clinical staff from the CHS that performed additional duty in the Korle Bu Hospital. Of the 141 personnel, the Departments of Surgery and Medicine and Therapeutics had the highest number of 27 each. Also, the

Department of Obstetrics and Gynaecology had 18 personnel, followed by the Department of Child Health and Laboratory receiving 13 each. On the other hand, the Accident Centre and the NRPSBC had the least number of personnel from the CHS, with each receiving one (1). It reinforces the supporting role of the CHS in the performance of KBTH's mandate as stipulated under the Ghana Health Service and Teaching Hospitals Act 525, 1996.

4.12 Administrative Decentralization

The hospital operated broadly on units, departments and sub-budget management centres (UDS).

The field work showed that KBTH functioned as a budget management centre of the Ministry of Health. This implies that the hospital enjoyed certain level of independence from the central government and the MOH. Service provision and clinical care in the KBTH were segregated. Thus, the units, departments and sub-budget management centres (UDS) were the main service provision points of the hospital. The findings indicated that each sub-budget management centre (Sub-BMC) had a management team made up of a Head of Department, Administrator, Accountant, Head of Nursing Services, Head of Pharmacy and Head of engineering. The structure at the Sub-BMCs was reinforced by a respondent who observed that: "the management structure at the central administration of the hospital is replicated at the units, departments and sub-budget management centres".

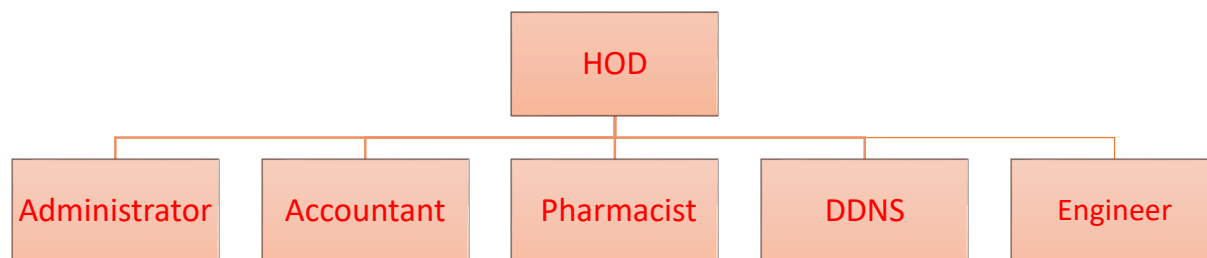
For the purposes of ensuring effective and efficient running of the UDSs, the hospital adopted revenue sharing formula where the Sub-BMCs retained a portion of the revenue they generated to run their department. In this regard, the Sub-BMCs retained 15% of the revenue they generated and 90% of the maintenance fees charged patients and clients (Field work 2019).

Again, the central administration allocated the Sub-BMCs' an operational imprest between Ghc2, 000-Ghc10, 000 depending on their size, service pressure and revenue levels (field work

2019). Moreover, the hospital decentralized procurement powers to the Sub-BMCs, permitting them to spend up to Ghc5, 000 (Field work 2019).

Furthermore, the findings of the study showed that KBTH had a gate keeping policy where patients from the Korle Gonno, Mamprobi, Lartebiokorshie and the Korle Bu enclave were made to report to the Korle Bu Polyclinic as their first point of care when they need medical attention. Upon diagnosis at the polyclinic, patients were referred to the appropriate department in the main hospital. Figure 2 shows the administrative decentralization in KBTH and its leadership structure. It emphasizes that management of the hospital is devolved from the central administration to the sub-budget management centres. Also, figure 3 shows the clinical units in KBTH which serve as the service delivery points of the hospital. It highlights the importance of the seven main departments of the hospital and the Centres of Excellence in the delivery of advanced care.

Figure 2: Organogram of the Sub-Budget Management Centres

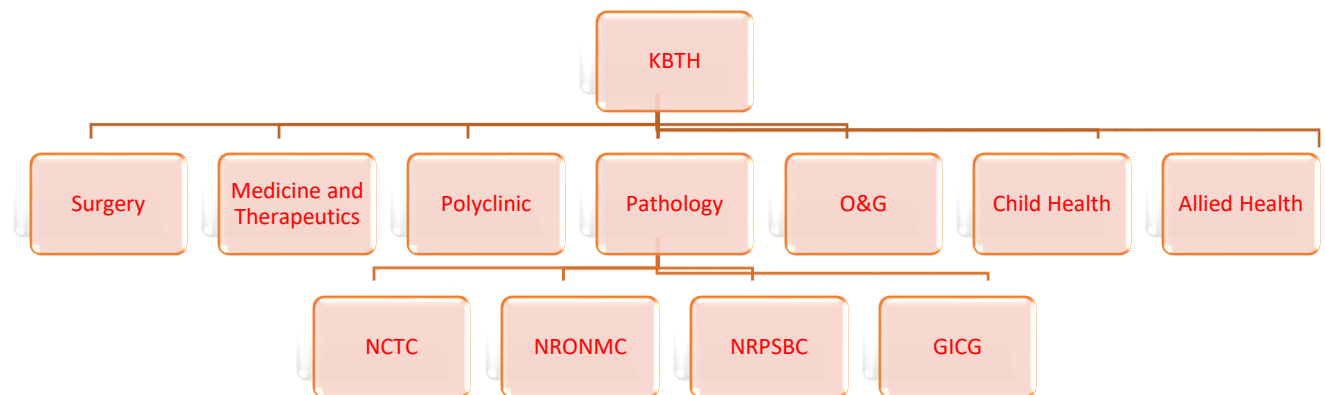


Source: Field work May, 2019

The figure 2 indicates the Sub-BMCs in the KBTH. It revealed a six (6) member leadership team headed by the Head of Department. The Administrator performed supporting role to help the

delivery of services. The Pharmacist and Deputy Head of Nursing assisted the HOD in clinical works whilst the Engineer provided logistical and technical support services needed for operational activities in the Sub-BMC. The Accountant on the other hand, managed the financial resources of the Sub-BMC.

Figure 3: Clinical Organogram of the KBTH



Source: Field work May, 2019

The clinical organogram represents the main institutional set ups used in the delivery of services to clients of the KBTH. It shows that services were rendered through the Departments of Surgery, Medicine and Therapeutics, Child Health, Obstetrics and Gynaecology, NCTC, NRONMC, NRPSBC. Others included the Polyclinic, the Allied Health units, GICG and the Pathology department.

4.13 Accounting for the Successes of the KBTH

The KBTH has come a long way since 1923, making it one of the best hospitals in Africa and the West Africa sub-region. The success story of KBTH can be measured based on the following indices: (i) management autonomy (ii) contribution of members of staff; (iii) commitment of government towards health service delivery; (iv) improvement in condition of service of health service staff; (v) availability of sophisticated equipment and logistics; and (vi) the availability of specialists and consultants.

4.13.1 Management Autonomy

The flexibility in management and administration emanating from the hospital's agency status was mentioned by eighteen (18) respondents as a major contributory factor for the successes of the KBTH. The elevation of KBTH as an autonomous health organization enabled it to swiftly deal with urgent matters and problems in the performance of its duties. Also, the KBTH status empowered it to introduce innovation and unique ideas to handle their operational challenges. Ten (10) respondents intimated that: "unlike other health organizations, KBTH is freed from the rigid rules of the civil service in responding to their challenges. The management Board and the management team were relatively unconstrained in taking decisions bordering on the hospital's day-today administration and management". Trondal (2014) argued that executive agencies are created as an effort towards resolving specific issues and problems that affect the entire society. The findings of the study support the view of Trondal (2014), as KBTH's autonomous status helped it to handle promptly management problems that negatively impacted clinical service and operational effectiveness.

4.13.2 The Contribution of Members of Staff

The human resource of every organization matters a lot in the attainment of its goals and objectives. The efforts of members of staff in KBTH were identified as a factor accounting for the limited success of the hospital in the performance of its functions such as the provision of advanced clinical and public health service, teaching and training of undergraduate and postgraduate health personnel and the conduct of research to improve health standards and conditions in the country. It was observed during the focus group sessions that: “some of the nurses and doctors are so good and considerate that, as relatives and patients you feel relieved and satisfied”.

4.13.3 Commitment of Government Towards Health Service Delivery

The commitment of successive governments to the provision of healthcare as a social service was mentioned as an important determinant of the success of the KBTH. Government provided the logistical and equipment needs of the hospital and also paid the salaries and allowances of doctors, nurses, pharmacists and the allied health professionals of the hospital. Moreover, government was helpful in the provision of the physical infrastructure and support services for effective and efficient service delivery.

4.13.4 Improvement in Conditions of Service for Health Service Personnel

One critical condition which guaranteed the relative success of the KBTH was the improved working conditions in the health service of Ghana. The salary levels and general working conditions improved tremendously in the health sector in Ghana following the implementation of the Single Spine Salary Structure. KBTH was not an exception. Due to the improved working condition in the MOH, fellows, specialists and consultants from the various colleges of

postgraduate medical education preferred to work in the MOH agencies especially KBTH. A respondent with several years of experience in the CHS and KBTH corroborated this argument by indicating that: “in view of the improved working conditions in the MOH and the stringent policies of the universities on the appointment and promotion of Doctors, Fellows of the Colleges of Postgraduate Medical Education usually choose the MOH, particularly KBTH over the Ministry of Education’s institutions such as the Medical Schools”.

4.13.5 Availability of Sophisticated Equipment and Logistics

The KBTH had the privilege of having some improved and sophisticated medical equipment and facilities in Ghana such as MRI and CT/Scan. The access of KBTH to state-of-the-art technology was due to the strategic nature of the hospital to government’s health policy and programmes. The availability of equipment and facilities attracted patients from all walks of Ghanaian life and those from the West African sub-region. Some respondents in the focus group discussions asserted that: “it is in KBTH that you will find the best equipment and technology to diagnose your precise health need and the right procedure for your cure. From time immemorial, we are always told that if you need the best machines to examine your condition, it is in KBTH you will find it”.

4.13.6 Availability of Specialists and Consultants

KBTH was recognized as the first and leading referral centre in Ghana and one of the best in the West Africa sub-region. The hospital benefited from the doctors trained in Ghana than any health institution in Ghana. The CHS provided an important technical human resource to support the clinical operation of the hospital. The Dental Unit of the SMD operated a significant dental hospital that supported KBTH in the provision of advanced healthcare services. The Dental Unit had many specialists and consultants that offered the best of care. A respondent with a deep

institutional memory and served in senior management positions in both the CHS and KBTH indicated that: “the KBTH receives more than one-third of all doctors trained in the country”.

Furthermore, the Centres of Excellence located in the hospital constituted an important addition to the quality of technical human resource of the hospital. The NCTC, NRONMC and the NRPSBC functioned as specialist units and provided advanced care to patients. Thus, the Centres of Excellence elevated the capacity of the hospital to provide an array of specialized services to patients. It was stated during the group discussions that: “the KBTH is renowned to have the best of doctors and specialists for the treatment of major conditions. Even if you go to the private hospital and your condition goes out of their control, they will transfer you to the KBTH”.

4.14 Challenges of the Korle Bu Teaching Hospital

The KBTH is faced with a number of legal, institutional, regulatory, disciplinary and attitudinal, control and managerial and information technology challenges. .

4.14.1 Legal Challenges

The major legal weakness of the KBTH is the absence of a legislative instrument required for the formal operation of the Ghana Health Service and Teaching Hospitals Act 525, 1996. The absence of the LI was attributed to the seeming lack of interests and political will by government to pass it. Furthermore, Act 525 did not receive adequate publicity from the government and the health service administrators associations and therefore it is highly unknown to many people and interested stakeholders in the healthcare delivery and policy arena. A legal vacuum has thus been created which has been exploited by politicians, board members and the Ministry of Health and government in general. A senior official of the hospital remarked that: “the weaknesses in Act 525 resulted in an amendment process in 2005 but it has not been completed till now due to lack

of commitment and interest on the part of government”. There is no clear procedure and stated level of experience for the appointment of the management team. Similarly, there is no performance management system to guide the performance of senior managers of the hospital. This view is supported by a respondent who argued that: “there is no serious performance targets to regulate the performance of the CEO and the directors to ensure effective and efficient delivery of the hospital’s mandate”.

In addition, Act 525, Section 36(2) imposed a limitation on the ability of the management Board to mobilize private sector funding and investment for the development of the hospital. Thus, section 36 of Act 525 explicitly required the management of the hospital to obtain permission from the Minister responsible for Health before they can enter into contract. Ayee (2001) argued that public sector reforms programmes that were intended to promote effectiveness, efficiency, innovation and quality of care and services failed to yield the needed results due to the absence of bottom-up implementation strategies, lack of political will and motivation.

4.14.2 Institutional Challenges

A respondent who is familiar with Ghana’s health sector executive agencies and the implementation of the executive agency concept in other jurisdictions argued that: “Ghana did not empower the health service executive agencies enough”. The findings showed that there was external interference by the MOH and the central government in the award of contract and suppliers agreement. The imposition of projects on the hospital did not make room for inputs and suggestions by the KBTH board and management for proper maintenance and repairs. A respondent postulated that: “there is undue interference in the management of the hospital through the appointment of directors and the Chief Executive Officer” Another respondent stated that: “both the board and government interfere in the management of the hospital because they know what Korle Bu Teaching Hospital stands for”.

Another challenging phenomenon in the management of the KBTH is that there was a seeming unwillingness and inability of some patients to pay for services rendered to them. The poor financial condition of these patients resulted in an intervention by the Social Welfare Department of the Hospital. The findings indicated four circumstances under which the Social Welfare Department intervened in the fees and charges of patients. One is where a patient was extremely poor and could not afford to pay. Such patients were given complete waiver. Second is where a patient or a child had been abandoned for long period of time without visit by the family. This category of patients were discharged without paying fees and charges. Third is where a patient could afford to pay but not when he was still in admission. This category of patients were discharged through an instalment payment facility. However, this arrangement required someone with a stable income to serve as a guarantor. Finally, there was a deferred payment plan for patients whose source of income was seasonal and needed time to mobilize money to pay.

Despite the provision of healthcare services to the poor and vulnerable patients, the amount lost to non-payment of fees and charges were not reimbursed by the state. Table 4.38, 4.39 and 4.40 show the different social welfare interventions in the operations of the KBTH. It indicates the exemptions and flexible payment scheme the hospital offered poor patients who attended the hospital. Also, it shows the amount of money KBTH lost through fee waivers and the individual donations towards servicing bills of patients who could not afford to pay their fees and charges.

Table 4.38: Level of Fees Waiver Cases

Year	No of Patients	Amount Waived
2014	28	Ghc14,418.52
2015	14	Ghc10,616.92
2016	10	Ghc11,483.71
2017	25	Ghc24,458.48
2018	20	Ghc26,273.06
Total	97	Ghc87,250.69

Source: KBTH 2018 Report

In table 4.38, it can be seen that from 2014-2018, ninety seven patients had their hospital bills waived by the management of the KBTH. The fees for these patients amounted to a total of Ghc87, 250.69. Impliedly, this amount was lost to the hospital.

Table 4.39: Level of Installment Payments

Year	No of Patients	Installment Payment
2012	320	218,642.2
2013	396	291,431.51
2014	450	480,448.17
2015	557	872,409.71
2016	670	1,474,764.88
2017	582	1,133,973.45
2018	564	1,138,371.34
Total	3,539	Ghc5,610,041.26

Source: KBTH 2018 Report

Table 4.39 represents the installment and deferred payments in the KBTH from the period of 2012-2018. It shows that a total number of 3,539 patients benefitted from a flexible payment scheme in KBTH. The total amount involved in the deferred payment for the period of 2012-2018 was Ghc5, 610,041.26.

Table 4.40: Social Packages and Donations by Philantropists

Year	No of Patients	No of Philantropists	Amount Paid
2014	86	5	Ghc61,313.45
2015	108	6	Ghc89,912.00
2016	86	7	Ghc88,496.4
2017	61	4	Ghc69,133.97
2018	96	8	Ghc79,730.22
Total	437	30	Ghc388,586.04

Source: KBTH 2018 Report

Table 4.40 highlights the number of philanthropists that contributed towards payment of the fees and charges of 437 patients between 2014-2018. It shows that a total of 30 social partners contributed Ghc388, 586.04 to service fees of poor patients.

4.14.3 Regulatory Challenges

The field interviews showed absence of proper coordination between Korle Bu hospital and the clinical units in the CHS. According to a respondent who has worked in both the CHS and the hospital: “the loose arrangement between the college and the hospital creates confusion and tension between the two institutions”. Moreover, the absence of a clear definition on the legal

status and identity of the NCTC, NRONMC and NRPSBC raises defects and anomalies in Act 525 of 1996. As a result, the KBTH was compelled to take up legal obligations of the centres. Meanwhile, the Centres of Excellence asserted independence from the central administration of the hospital. The National Cardiothoracic Centre was said to have absented itself from many activities and workshops of the KBTH. A respondent observed that: “the whole of my career in KBTH, I haven’t seen the Director and senior officials of the NCTC at a fora organized by the KBTH management”. Moreover, the field work indicated limited internal control measures to check the conduct of clinical personnel. Also, the field work identified little or no linkages between the clinical departments regarding patients’ records.

4.14.4 Disciplinary Challenges

The field work uncovered several disciplinary challenges affecting the performance of the mandate of KBTH. The committee to determine misconducts and ethical breaches relating to the senior staff had not been effective and strong enough to institute punitive measures against members of staff who were found culpable for various offences. While management quickly instituted punishment against junior members of staff who were found of unprofessional conduct, the disciplinary committee demonstrated lukewarm posture in dealing with ethical issues involving senior staff.

Moreover, KBTH had several members of staff who owe allegiance to other independent state institutions. The situation made it difficult, if not impossible, for the CEO to discipline or dismiss non-performing members of staff who belonged to other autonomous institutions. A respondent argued that: “some members of staff in the finance directorate, social welfare department and some staff of the centres of excellence are not the employees of the CEO. The CEO is therefore

constrained to institute disciplinary measures against these members of staff when they act against rules and regulations of the KBTH”.

Moreover, the hospital is faced with the challenge of some Doctors, Pharmacists and Nurses opening up their own health facilities. These members of staff refer patients to their own private facilities for thorough medical attention to the detriment of KBTH. Similarly, the whole neighbourhood of the hospital is dominated by private pharmacy shops and laboratory centres which serve the numerous patients that come to KBTH (Field work 2019).

Another big challenge to the management of KBTH is the strong professional unions in the hospital. These associations included the Government Hospitals Pharmacists Association (GHOSPA), Nurses and Midwives Association and the Ghana Medical Association. These are very strong unions that help to ensure professional standards. However, they oppose vehemently disciplinary actions against their members. A respondent asserted that: “the professional associations are strong in Korle Bu and will always not allow the CEO to touch any of their members when he or she goes wrong”. Another respondent who served in management of the hospital posited that: “the various professional bodies like the Medical Association, GHOSPA and the Nurses and Midwives associations always fight the management of the hospital and threaten strike when their members are sanctioned for misconducts, so the management of KBTH is always careful when dealing with them”.

4.14.5 Attitudinal Challenges

The field work identified bad attitude to work as perhaps the most difficult challenges affecting the performance of KBTH. A respondent with many years of private medical practice and solid public service record had this to say: “For me the problem of Korle Bu is attitude. You can make all the best laws and if the people are not willing to abide by them, it won’t work. People must

change their attitude and be willing to make a sacrifice for KBTH”. Furthermore, it emerged from the group discussion that: “nurses and other health personnel at the Child Health Department are so disrespectful that they use open and direct insults on mothers who bring their children to the hospital”. Again, it was observed by ten (10) participants during the focus group session that: “the clinical leaders especially the nurses are so impatient and uncaring that if you bring your patient to KBTH and God is not on your side he will die easily”. Another participant in the group discussion noted that: “we need more education and qualified nurses; nurses are the main care givers before the doctor comes in. The inhumane posture of care givers kill patients all the time in the KBTH”.

It is significant to note that, all the 32 participants in the group discussions underscored that healthcare in KBTH is expensive couple with extortion by some clinical personnel. Ten (10) participants in the group session affirmed that: “if you don’t have a lot of money and you come to KBTH, your patient will die off with ease, there is so much extortion of money from relatives of patients. It is painful and hurting to the soul”. Five other participants asserted that: “some clinical leaders including nurses and doctors team up to rob families off their money, they waste your time and charge you huge sums of advance money to be paid when they know they cannot handle the case”. Additionally, the field work noted lack of commitment and loyalty of some staff, who pay more attention to their engagement with private hospitals than KBTH which is their main employer.

4.14.6 Control Challenges

The field work indicated that, the KBTH is bedeviled with the challenge of the general public using the hospital as their primary healthcare provider. There is limited understanding among the general public about the referral system. As a result of this misunderstanding, patients went to

KBTH without referral and expected to be attended to. This problem was attributed to the weak gate keeping system at KBTH that ensured that patients used the Ghana Health Service institutions at the sub-districts, districts and the regions for their primary and secondary health challenges.

The control challenges of KBTH were attributed to its clinical units that provided national and public health services. For instance, the Fevers Unit, Chest Unit, the Institute of Clinical Genetics and the Diabetes Centre had close partnership with other independent public health programmes such as the National Tuberculosis Control Programme, National Aids Control Programme, Disease Control and Surveillance Department of MOH, Malaria Control Programme and the Ghana Aids Commission. As a result of the strong bond and common interests shared by the clinical units in KBTH and the public health programmes, some funds and donations to the units did not pass through the central administration and the Trust Fund Secretariat of KBTH due to fear of diversion and misapplication by the central administration.

The effect of the relationship between the public health units in KBTH and the national public health programmes was that, it made the public health units in KBTH to look more to the national public health programmes administration and, consequently, made them loyal to the public health bodies than their KBTH management. Furthermore, there are a number of autonomous institutions in the KBTH which have little or nothing to do with the hospital administration but makes management and control systems difficult to implement. For instance, there are number of schools and activities in KBTH which belong to the UGCHS and therefore, made it difficult for the KBTH management to do anything to minimize their effect on clients of the hospital.

Also, a sizeable number of 141 personnel in the UGCHS doubled as consultants to the hospital, resulting in the emergence of dual loyalty. First of all, the UGCHS personnel belong to the

University of Ghana and owe their loyalty to the Vice Chancellor through the Deans of their respective schools, making their accountability to KBTH difficult to guarantee. Moreover, the direct appointment of the Directors of the Centres of Excellence by MOH makes it difficult for the KBTH management especially the CEO to supervise and monitor their activities effectively, particularly the NCTC which asserted financial and administrative independence from the hospital. It is significant to note that, the presence of the MOH institutions such as the Nursing and Midwifery Training College, School of Hygiene, Public Health Nurses School, Community Health Nurse School, Ophthalmic Nursing School and the School of Peri-operative and Critical Care Nursing, National Aids Control Programme, Disease Control and Surveillance Department and the National Tuberculosis Control Programmes, etc. makes management and control of the population and human activities difficult for the hospital's management (Field work 2019). Unfortunately, every negative development in any of these institutions are attributed to the KBTH (Field work 2019). A respondent with many years of experience in the MOH and the KBTH affirmed that: "in Korle Bu, anything negative is directed to the hospital authorities, people forget that MOH institutions are also located here".

4.14.7 Managerial Challenges

In view of the facilitating role of the KBTH towards the training of health personnel, its facilities and equipment come under severe pressure and damage due to the increasing number of students been admitted by the respective schools. In addition, the management of the CHS and its constituent schools do not contribute to the maintenance of the hospital equipment and facilities. A respondent argued that: "part of the students fees must be allocated to the hospital to service the cost of maintaining its laboratories, equipment and facilities". The KBTH is also faced with the challenge of not having a strategic plan to guide the implementation of its mandate. A senior

official of the hospital pointed out that: “KBTH does not have a strategic plan except a temporal operational outcome framework. Even though there was an attempt to develop one, it was truncated after the supervising CEO was booted out in 2017”.

4.14.8 Information Technology Challenges

The field work revealed that the KBTH had challenges in the use of information and communication technology to aid delivery of services. Significantly, the software KBTH was using did not centralize the records of patients in the various departments of the hospital. In other words, the major departments in the hospital ran separate softwares, making it difficult to track patients’ clinical records easily in the hospital. Thus, there was a duplication of information management and records of patients by the various clinical units.

4.15 Enhancing the Effectiveness and Efficiency of Korle Bu Teaching Hospital

4.15.1 Amendment of the Legal Framework

The amendment of Act 525 and the passing of an LI to operationalize the Act are crucial to smoothen the implementation of the Act and give true meaning to health service executive agency in Ghana.

The executive agency concept was recommended as a policy prescription for the inefficiencies, ineffectiveness and poor quality of customer care in the services provided by public sector organizations. Nevertheless, the executive agency concept in Ghana’s health sector has been fraught with challenges which require attention. A respondent with an extensive knowledge about the workings of health sector executive agencies in the global arena argued that: “Korle Bu’s success was inevitable, even though it could have succeeded better”.

Another respondent observed that: “governance is key in the hospital’s management”. The Board’s composition needs to be reviewed in order to strengthen its supervisory and oversight

responsibility over management and operational matters. The current Board is dominated by the management team members including the Chief Executive Officer and the Directors of Administration, Finance, Medical Affairs, Pharmacy and Nursing services. This practice blurs the distinction between governance and management in the hospital. The Board members must be individuals with extensive and relevant corporate experience for the effective and efficient running of the hospital. A former Board member with rich private sector management experience had this to say: “the problem of the Korle Bu Teaching Hospital is leadership, there must be a constitutional authority to appoint qualified management team, including the Chief Executive Officer, directors and the board members’’. For the purpose of enhancing sound corporate governance culture in the teaching hospitals, the Director of Administration should be the only director on the Board in addition to the CEO and designated as the secretary to the Board.

Similarly, the limitations imposed on the governing Board by Act 525 needs to be expunged to allow the Board free room to operate. Section 36 (2) of Act 525 which requires the approval of the Minister of Health before a contract can be entered into by the hospital governing Board must be removed to give true meaning to the executive agency concept in the teaching hospitals.

4.15.2 Introduction of Performance Management Contract and Clarify Job Descriptions

The introduction of the performance contracting in the form of target setting, monitoring and reporting is imperative. The job, qualifications and experience of the CEO should be clearly spelt out. The clarification should also include the qualifications and expectations of the directors of the various directorates and the procedure for their appointment. The current arrangement allows the Board especially the chairperson, the opportunity to manipulate the appointment of senior officials of the hospital in favour of his preferred people.

Moreover, the KBTH needs a corporate plan to guide the processes towards the achievement of its mandate under the Act 525. The corporate plan must outline clearly the vision, and mission of the hospital and the strategies for achieving them.

4.15.3 Split of Korle Bu Teaching Hospital into Group of Hospitals

The KBTH is a huge and complex institution which needs reform to enhance the delivery of effective and efficient clinical care. Accordingly, KBTH needs to be broken into different hospitals to be known as Korle Bu Group of Hospitals and administered by an entirely independent management teams with the CEO at the apex of the structure. For instance, Toronto in Canada and New York in the United States of America have a specialized and separate hospitals such as the Children Hospital, Women Hospital, and Men's Hospital dealing with different health issues (Field work 2019). A respondent with extensive knowledge of the UK's National Health Service suggested that: "we can split the hospital to become the Korle Bu Group of Hospitals with subsidiary hospitals to be known as Children Hospital, Surgical Hospital, Maternity or Women Hospital and Medical Hospital". Furthermore, the Korle Bu Polyclinic should be upgraded to a general hospital status equivalent to a regional hospital to be able to deal with emergency issues before referral to a specific department in the main hospital for attention. The management team in the sub-budget management centres is a replica of the structure at the central administration which is capable of managing a fully decentralized KBTH structure.

4.15.4 Improvement in Information and Communication Technology

The introduction of an improved information and communication technology to the hospital's operation and management will improve its performance. The digitization must be linked to the admission wards, polyclinic, pharmacies, and the main departments of the hospital such as the Child Health, Obstetrics and Gynaecology, Surgery and Medical and Therapeutics and all other

service delivery points. A respondent who is involved in the application and operation of information and communication technology in KBTH had this to say: “the KBTH at the moment does not have a centralized software that is connected to all the departments. We are hoping to introduce a central database that will be accessible to all clinical departments such as the polyclinic, child health, accident and emergency centre, surgery, obstetrics and gynaecology etc”. This is expected to reduce human involvement and interference in the payment of fees and charges. Additionally, a complete digitization of KBTH will eliminate the frustration clients go through in paying fees at different cost centres.

4.16 Conclusion

This chapter has shown that even though the KBTH was created along the executive agency model, it is not operating in a manner consistent with the model. The hospital management enjoys limited autonomy in its broad mandate contrary to the provision of the Ghana Health Service and Teaching Hospitals Act 525, 1996 which attempted to promote managerialism in the hospital’s operations. This notwithstanding, the KBTH has provided advanced clinical care, teaching and training in medical and para-clinical areas, conducted community and technical outreaches and trained local health personnel to manage health emergencies.

The fortunes of the KBTH can be turned around if the legal framework is reviewed, the appointment of the CEO depoliticized, linkages with both internal and external organizations clarified and strengthened while performance management and ICT are introduced. In addition, behavioural and attitudinal changes are needed from all the stakeholders.

CHAPTER FIVE

SUMMARY, RECOMMENDATIONS AND CONCLUSION

5.0 Introduction

This chapter summarizes the main findings of the study, draws conclusion and makes recommendations to improve the performance of the KBTH. The findings were based on the qualitative interviews and focus group discussions held with senior managers of the hospital, former directors, former board members, and leaders of the Korle Bu Hospital Senior Staff Association, executives of the Korle Bu Health Service Workers Union and clients and patients of the KBTH. Furthermore, the findings of the study were generated by addressing the following: i. assessing the contribution of the KBTH towards the provision of advanced health service, ii. examining the factors that have contributed to either the success or failure of the KBTH since its elevation to the status of the executive agency, and iii. identifying the ways to make KBTH more functional and effective to deliver on its mandate as an autonomous health agency.

5.1 Summary of Findings

The study focuses on the contribution of the KBTH as an executive agency to the delivery of advanced health service. It found that the KBTH provides advanced clinical service to patients. The KBTH is the leading hospital in Ghana and serves as a referral agency for the Ghana Health Service institutions as well as providing advanced and specialized healthcare through the three main centres of excellence located in the hospital.

In addition, the study confirms the KBTH's status as an autonomous executive agency, which is guaranteed under the Ghana Health Service and Teaching Hospitals Act 525, 1996. Consequently, it is functionally and structurally disaggregated from the main public

administration of the state, with a governing board and management team that have been granted autonomy to determine many issues such as administration, finance, budget, human resource and daily operations. However, the findings from the field suggest that the absence of a legislative instrument to guide the operation of the Act 525, 1996 has undermined the board and management's ability to decide firmly on major policies and problems affecting the KBTH.

Moreover, the CHS and its constituent schools provide important technical and consultancy services to the KBTH for the fulfillment of its mandate. All the clinical units and personnel in the CHS offer clinical care and conduct research using samples and cases from the hospital. The CHS is also involved in the training of undergraduate and postgraduate health personnel. Thus, the CHS constitutes the main human resource basket of the hospital.

5.2 Recommendations

Several recommendations can be made to help improve the quality of care and services provided by the KBTH. These can be grouped into the following:

5.2.1 Setting up of an Executive Wing of the KBTH

The establishment of the executive wing concept otherwise known as private school will position the KBTH to offer suitable and sound environment for providing superior healthcare to the middle class in Ghana. This system will enhance KBTH's effectiveness, efficiency and responsiveness to clients' needs. The private school system in hospital management is the practice of setting up executive departments that cater for the health needs of the middle class including business executives, industry leaders and political elites. This approach has the capacity to help KBTH attract important personalities who often travel outside Ghana for healthcare and also provide accommodation for their caretakers throughout their period of admission. For example, the Abuja National Hospital in Nigeria has an executive wing that

caters for the health needs of senior officials of the state, business and industry leaders and the middle class in general (Field work 2019). Similarly, the Kenyatta National Hospital in Nairobi, Kenya has an executive wing to care for the important personalities and corporate leaders in the country (Field work 2019).

5.2.2 Competitive and open appointment of the CEO and the Directors

The appointment of the CEO and directors of the KBTH should be based purely on the merit principle and on competitive grounds. The appointment of the CEO, directors and deputy directors should be open to all qualified people for the best and most experienced person to be selected. The current practice where the appointment of deputy directors are reserved for administrators within the KBTH does not promote merit-based appointment and the needed innovation, ideas and experience necessary for the running of the hospital. The Public Service Commission and the hospital Board must develop strong indicators upon which to appoint prospective CEOs and Directors.

5.2.3 Creation of a Unitary Health Service and Organizational Reform

Perhaps one of the major challenges affecting the delivery of efficient and quality of care to patients in the KBTH is the operation of the teaching hospitals as parallel structures to the Ghana Health Service. It must be noted that health is a continuum and as such there must be strong linkages between all institutions involved in health service provision. Thus, the Community-Based Health Planning Services (CHPS), sub-district, district, secondary and tertiary health institutions must work in a coordinated manner to provide effective clinical services to patients. It is worth mentioning that the current policy arrangement where the Ghana Health Service agencies are governed and managed separately from the teaching hospitals do not inure to the benefits of patients. Unlike the health sector executive agency concept practiced in the United Kingdom which unites tertiary hospitals and lower level health institutions, the Ghana Health

Service and Teaching Hospitals Act 525 separates the primary and secondary health institutions from the tertiary ones, making continuous care difficult to be assessed by patients. For example, the teaching hospitals and their Chief Executives in the United Kingdoms are all under the management, control and direction of the Chief Executive Officer of the UK's National Health Service (Field work 2019). This policy arrangement makes continuous care and the referral system seamless for patients at all levels of the health system.

However, the practice is opposite in Ghana. The teaching hospitals and the district and regional hospitals are managed differently under independent governing boards. Consequently, patients bear higher cost in addition to institutional challenges and difficulties in accessing advanced care at the tertiary facilities. Thus, a proper coordination between or integration of the lower level hospitals into the tertiary ones will enhance the referral system and easiness of patients access to higher levels of care.

5.2.4 Institution of performance management system and Strategic Plan

The KBTH governing Board must develop performance management systems to guide and monitor the effectiveness and efficiency of senior managers of the hospital. Equally significant to the effectiveness, efficiency and quality of care and service delivery is the designing of a strategic plan for the hospital. A comprehensive strategic plan must be developed that takes into consideration the three main mandates of the hospital to provide advanced healthcare service to support the ones provided by the lower level hospitals, training and education of undergraduate and postgraduate health personnel and the organization of health research to improve conditions of lives in the country. Moreover, the development and institutionalization of regular performance reviews and quarterly monitoring and evaluation of the clinical departments and the support service units are crucial to enhancing the organizational effectiveness of the KBTH.

5.2.5 Strengthening of KBTH Research Unit

Research into health issues is an important aspect of the mandate of the KBTH. The current Research and Training Unit of the hospital which approves and facilitates research projects and ethical standards must be expanded and resourced to conduct relevant researches to improve professional practice and health outcomes. The hospital must also initiate its own research to enhance the performance of its functions and care.

5.2.6 Harmonization of the Official Relationship Between the CHS and KBTH

The KBTH and the UGCHS are the pivot around which advanced health service is provided. In view of this, the working relationship between these two bodies must be defined and clarified to enhance cooperation and the environment under which services are provided. The harmonization of the relationship could take the form of a memorandum of understanding (MOU) between the KBTH and the UGCHS to formally unite clinical departments in the UGCHS into the hospital's activities. The MOU must address lingering issues such as the appointment of the heads of clinical units in KBTH and the operation of clinical services by the Medical School, the Dental Unit and SBAHS and related revenue sharing formula. Moreover, the role and position of the Provost of the CHS who is the academic and administrative head of the college must be clarified. The amendment of Act 525 must take into recognition the reforms by the University of Ghana which has established the collegiate system. Thus, the Provost must be recognized under the proposed amendment of Act 525 and given a place on the KBTH board.

5.2.7 Harmonization of the Status of the Centres of Excellence

The status and legal identity of the three centres of excellence in relation to the KBTH must be clearly defined. The Ministry of Health must expressly indicate the powers and mandate of the centres of excellence and the relationship with the KBTH central administration. The clarification is needed to help address the seeming lack of cooperation by the centres of

excellence particularly the NCTC. Most of the personnel working in the centres of excellence and their support services are provided by the hospital's central administration but the centres do not report and cooperate with KBTH CEO, making coordination and control systems difficult to enforce. It is revealing to note that even though the centres draw their administrative support and personnel from the main hospital, their revenues and accounts are kept from the knowledge of KBTH's central administration. In view of the location and strategic importance of these centres for advanced healthcare delivery, they must be constituted into separate hospitals as part of the Korle Bu Group of Hospitals under the ultimate responsibility of the KBTH CEO.

5.2.8 Development of Hostel Facility for Clients and Relatives of Patients

Another area of KBTH operations which can generate huge sums of revenue to the hospital is in the building of accommodation facility for families and individuals who patronize the hospital. The KBTH owns large acres of land, a portion of which can be used for this purpose. The Mother's Hostel situated between the Obstetrics and Gynaecology and the Child Health Departments is woefully inadequate for the thousands of patients and their families who attend the hospital daily. A visit to the hospital in the evenings reveals hundreds of people sleeping under trees and corridors. This situation requires urgent attention to secure decent and clean environment for the numerous clients and families who bring their loved ones to the hospital on referral. Relatedly, the hospital management should endeavour to build specific sitting areas for individuals that visit their patients during the day. This investment has a huge potential to raise money for the hospital and uplift the image and responsiveness of KBTH to customers' needs.

5.3 Conclusion

This study has highlighted the contribution of the KBTH to the delivery of advanced health service. Based on the findings of the study, it can be argued that the KBTH operates as an

autonomous agency of the Ministry of Health. The Act 525, 1996 separates the hospital from the main civil bureaucracy and confers autonomy, governing and managerial powers on the Board and management team. These achievements notwithstanding, the hospital is faced with a number of challenges including managerial, control, legal, coordination and regulatory. Others are the lack of commitment and loyalty of critical members of staff to the vision of the hospital and political interference from both the Ministry of Health and other central government agencies. The adoption of the executive wing concept, clarification of the official relationship between the KBTH and the CHS, review of the Act 525 and further devolution of the major Sub-BMCs will position KBTH to deliver effective, efficient and quality advanced health service.

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RESPONDENTS INTERVIEWED

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2. Dr. Henry Holdbrook-Smith – Former Chief Executive Officer of the Korle Bu Teaching Hospital. Interviewed on the 29/03/2019
3. Dr. B.D.R.T. Annan- Former Director of Medical Affairs and former Acting CEO, Korle Bu Teaching Hospital. Interviewed on the 2/04/2019
4. Rev. Professor Andrew Seth Ayettey- Former Board Chairman, Korle Bu Teaching Hospital. Interviewed on the 8/04/2019
5. Professor Aaron Nii Lante Lawson- Former Dean, University of Ghana Medical School and former board member, Korle Bu Teaching Hospital. Interviewed on the 9/04/2019
6. Professor Nii Otu Nartey- Former Chief Executive Officer, Korle Bu Teaching Hospital. Interviewed on the 10/04/2019
7. Mr. Eddie Annan- Former Board Chairman, Korle Bu Teaching Hospital. Interviewed on the 12/04/2019
8. Professor. Samuel Ofosu-Amaah- Former Board Chairman, Korle Bu Teaching Hospital. Interviewed on the 12/04/2019
9. Dr. Augustina Kodua- Lecturer, University of Ghana School of Pharmacy. Interviewed on the 12/04/2019
10. Professor Edwin K. Wiredu- Former Dean, University of Ghana School of Biomedical and Allied Health Sciences. Interviewed on the 17/04/2019
11. Professor Afua Jectey Hesse- Former Director of Medical Affairs, and former Acting CEO, Korle Bu Teaching Hospital. Interviewed on the 17/04/2019 and 24/05/2019

12. Mr. Kambarin Kombian- Deputy Director of Administration, Korle Bu Teaching Hospital and former Secretary to the KBTH board. Interviewed on the 18/04/2019
13. Mr. Christopher Nartey- Former Director of Administration, Korle Bu Teaching Hospital. Interviewed on the 30/04/2019
14. Professor Anthony Mawuli Sallar- Former Board Chairman, Korle Bu Teaching Hospital. Interviewed on the 30/04/2019
15. Rev. Albert Okpoti Botchwey- Former Chief Executive Officer, Korle Bu Teaching Hospital. Interviewed on the 13/05/2019
16. Mr. Egyaboaful Anan-Kakabaah- Former Director of Finance, Korle Bu Teaching Hospital. Interviewed on the 21/05/2019.
17. Professor Kwabena Frimpong-Boateng- Former Chief Executive Officer, Korle Bu Teaching Hospital. Interviewed on the 21/05/2019
18. Professor Agyeman Badu Akosa- former head of Pathology Department, University of Ghana Medical School and former Director General, Ghana Health Service. Interviewed on the 23/05/2019
19. Mrs. Cynthia Boateng- Deputy Director of Administration/Trust Fund Administrator, Korle Bu Teaching Hospital. Interviewed on the 3/06/2019
20. Mr. Charles Ofei-Palm- President, Korle Bu Senior Staff Association. Interviewed on the 3/06/2019
21. Emeritus Professor Richard Berko Biritwum- Department of Community Health, School of Public Health. Interviewed on the 4/06/2019
22. Mr. Nicholas Achaab- Secretary, Korle Bu Health Service Workers Union. Interviewed on the 4/06/2019.

23. Mrs. Mary Amankwah- Women's Wing Leader, Korle Bu Health Services Workers Union. Interviewed on the 4/06/2019.
24. Professor Henry Asare-Anane- Head, Department of Chemical Pathology, School of Biomedical and Allied Health Sciences. Interviewed on the 18/06/2019.
25. Dr. Mrs. Afua Owusua Darkwah Abrahams- Head, Department of Pathology, School of Biomedical and Allied Health Sciences. Interviewed on the 6/06/2019.
26. Miss Bernice Anane Mawuli- Assistant Lecturer, Department of Pathology, School of Biomedical and Allied Health Sciences. Interviewed on the 6/06/2019
27. Dr. Franklin Acheampong- Head, Research and Training unit, Korle Bu Teaching Hospital. Interviewed on the 6/06/2019.
28. Professor Lydia Aziato- Dean, School of Nursing and Midwifery, University of Ghana. Interviewed on the 1/07/2019.
29. Mrs. Georgina Anim- 2nd Vice Chairperson, Korle Bu Health Service Workers Union. Interviewed on the 11/06/2019.
30. Mr. Edwin Kojo Quansah- Administrative Manager, Pharmacy Directorate, Korle Bu Teaching Hospital. Interviewed on the 11/06/2019.
31. Mr. Samuel Ampofo Gyampo- Organizer, Korle Bu Senior Staff Association. Interviewed on the 14/06/2019.
32. Samuel Akotua Atweri – Director, Human Resource, Korle Bu Teaching Hospital. Interviewed on the 14/06/2019.
33. Mr. Kwame Gyamfi- The Legal Officer, Korle Bu Teaching Hospital. Interviewed on the 17/06/2019.
34. Rev. Professor Patrick Ferdinand Ayeh-Kumi- The Provost, College of Health Sciences, University of Ghana. Interviewed on the 18/06/2019.

35. Dr. John Ahenkorah- Head, Department of Anatomy, School of Biomedical and Allied Health Sciences, University of Ghana. Interviewed on the 18/06/2019.
36. Mr. Raphael Abagna- Office Manager, Income Generation and Consultancy Committee, College of Health Sciences, University of Ghana.
37. Professor. Alfred E. Yawson- Head, Department of Community Health, School of Public Health, University of Ghana. Interviewed on the 18/06/2019.
38. Dr. Francis Kwamin- The Vice Dean, School of Medicine and Dentistry, College of Health Sciences, University of Ghana. Interviewed on the 28/06/2019.
39. Dr. Philip Amoo. Head, Public Health Unit, Korle Bu Teaching Hospital. Interviewed on the 28/06/2019.
40. Professor Angela Ofori-Atta- Head, Department of Psychiatry, School of Medicine and Dentistry, University of Ghana. Interviewed on the 1/07/2019
41. Mr. Muniru Alhassan- Director of Administration, Korle Bu Teaching Hospital. Interviewed on the 1/07/2019
42. Mr. David Lamptey- Head, Social Welfare Unit, Korle Bu Teaching Hospital. Interviewed on the 1/07/2019.
43. Mr. Lucas Amewudah- Deputy Director of Finance, Korle Bu Teaching Hospital. Interviewed on the 9/07/2019.
44. Mr. Pius Agbeviadey- Head, Policy Planning, Monitoring and Evaluation Unit, Korle Bu Teaching Hospital. Interviewed on the 9/07/2019.

APPENDIX A:

**INTERVIEW GUIDE FOR OFFICIALS OF THE KORLE BU TEACHING
HOSPITAL**

**ASSESSING THE PERFORMANCE OF AN EXECUTIVE AGENCY IN GHANA: THE
CASE OF THE KORLE BU TEACHING HOSPITAL, 2008-2018**

Dear Respondent,

This is a study being conducted by a Master of Philosophy (MPhil Part II) student of the Department of Political Science, University of Ghana. The information being sought is purely for academic purposes. You are therefore assured that any information and responses provided will be treated with the strictest confidentiality and thus will not be disclosed to any individual, group or organization which might misuse the information. Your name is therefore not required. Thank you for your participation.

1. What are basic services provided by the Korle Bu Teaching Hospital to the people of Ghana and its neighbouring countries?
2. What strategies and approaches are employed by KBTH in the provision of these services?
3. How does KBTH contribute to the delivery of advanced clinical health services to augment those provided by Ghana Health Service?

4. What activities and measures does KBTH undertake to promote teaching and training of health personnel?
5. What does KBTH do to enhance research into conditions of health of the people of Ghana?
6. In what management decision and administrative policy is KBTH able to pursue without the involvement and direction of Ministry of Health and the central government?
7. How does Korle Bu Hospital collaborate with the College of Health Sciences in the provision of health services?
8. What factors account for the success of the Korle Bu Teaching Hospital?
9. What factors are responsible for the failures and challenges of KBTH?
10. How can KBTH be made more effective and efficient in health service delivery;
11. How will you rate the performance of the KBTH in the provision of advanced clinical health services to augment the ones performed by the Ghana Health Service? Excellent; Satisfactory; Unsatisfactory

12. How will you rate the performance of the KBTH in teaching and training of undergraduate and postgraduate students in medicine, nursing, pharmacy, dentistry and other para-clinical and technical disciplines? Excellent; Satisfactory; Unsatisfactory

13. How will you rate the performance of the KBTH in undertaking research into health issues to improve condition of health of the people? Excellent; Satisfactory; Unsatisfactory

APPENDIX B:

**INTERVIEW GUIDE FOR THE OFFICIALS OF THE COLLEGE OF
HEALTH SCIENCES, UNIVERSITY OF GHANA**

**ASSESSING THE PERFORMANCE OF AN EXECUTIVE AGENCY IN GHANA: THE
CASE OF THE KORLE BU TEACHING HOSPITAL, 2008-2018**

Dear Respondent,

This is a study being conducted by a Master of Philosophy (MPhil Part II) student of the Department of Political Science, University of Ghana. The information being sought is purely for academic purposes. You are therefore assured that any information and responses provided will be treated with the strictest confidentiality and thus will not be disclosed to any individual, group or organization which might misuse the information. Your name is therefore not required. Thank you for your participation.

1. What are the key services provided by the Korle Bu Teaching Hospital?
2. How does the College of Health Sciences (CHS) contribute to the delivery of these services?
3. What strategies are used by the College of Health Sciences in the delivery of these services?
4. How does the CHS contribute to the provision of advanced clinical health services to support the ones provided by the Ghana Health Service?

5. What activities and measures does the CHS undertake to promote teaching and training of health personnel?
6. What does the CHS do to promote research into conditions of health of the people of Ghana?
7. What factors are responsible for the success of the Korle Bu Teaching Hospital?
8. What factors account for the failures and challenges of the KBTH?
9. How can KBTH be made more effective and efficient in health service delivery?
10. How will you rate the performance of the KBTH in the provision of advanced clinical health services to augment the ones performed by the Ghana Health Service?
Excellent; Satisfactory; Unsatisfactory
11. How will you rate the performance of the KBTH in teaching and training of undergraduate and postgraduate students in medicine, nursing, pharmacy, dentistry and other para-clinical and technical disciplines? Excellent; Satisfactory; Unsatisfactory

12. How will you rate the performance of the KBTH in undertaking research into health issues to improve condition of health of the people? Excellent; Satisfactory; Unsatisfactory

APPENDIX C:

**INTERVIEW GUIDE FOR THE PATIENTS AND CLIENTS OF THE
KORLE BU TEACHING HOSPITAL**

**ASSESSING THE PERFORMANCE OF AN EXECUTIVE AGENCY IN GHANA: THE
CASE OF THE KORLE BU TEACHING HOSPITAL, 2008-2018**

Dear Respondent,

This is a study being conducted by a Master of Philosophy (MPhil Part II) student of the Department of Political Science, University of Ghana. The information being sought is purely for academic purposes. You are therefore assured that any information and responses provided will be treated with the strictest confidentiality and thus will not be disclosed to any individual, group or organization which might misuse the information. Your name is therefore not required. Thank you for your participation.

1. What services of the Korle Bu Teaching Hospital did you enjoy or access?
2. How well was/were the service(s) provided?
3. Are you happy with the service(s) If yes, why? If no, give reasons
4. What are the three key factors which have made KBTH to deliver its service(s)?

5. What are the three key factors which have undermined the delivery of services by KBTH?
6. How will you rate the performance of the KBTH in the provision of advanced clinical health services to augment the ones performed by the Ghana Health Service? Excellent; Satisfactory; Unsatisfactory



UNIVERSITY OF GHANA

ETHICS COMMITTEE FOR THE HUMANITIES (ECH)

ECH 122/18-19

Ref. No.:

20th June, 2019

Mr. Seth Ponku
Department of Political Science
University of Ghana
Legon.

Dear Mr. Ponku,

ECH 122/18-19: ASSESSING THE PERFORMANCE OF AN EXECUTIVE AGENCY IN GHANA: THE CASE OF KORLE BU TEACHING HOSPITAL, 2008-2016.

This is to advise you that the above reference study has been presented to the Ethics Committee for the Humanities for a full board review and the following actions taken subject to the conditions and explanation provided below:

Expiry Date:	20/06/20
On Agenda for:	Initial submission
Date of Submission:	21/03/19
ECH Action:	Approved
Reporting:	Bi-Annually

Please accept my congratulations.

Yours Sincerely,

Prof. C. Charles Mate-Kole.
ECH Vice Chair



Cc: Prof. Joseph R. A. Ayee, Department of Political Science, University of Ghana.
Dr. Abdulai Kuyini Mohammed, Department of Political Science, University of Ghana.

COLLEGE OF HUMANITIES