

PN-ACC-565

PRIVATE SECTOR HEALTHCARE SERVICES
IN GHANA

**A National Survey
of Private Health Facilities**

Summary of Findings

Private *Initiatives* for Primary Healthcare Project



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Introduction

Private providers play a significant role in meeting Ghana's healthcare needs. However, little is known about the formal private health sector, the range of services it offers, the clients it serves, and the operations and management of the numerous small clinics that provide a significant proportion of care to the country's urban populations. This lack of information hampers the efforts of national health policy planners to assess the current and potential contribution the private sector can make to the achievement of national public health objectives.

In order to better understand the composition of the formal private health sector, the range of services it provides, and how such services are sustained in economically challenging times, the *Initiatives* Project supported a national survey to profile the history, operations, and management of private health facilities in Ghana. Working with the Society of General Medical and Dental Practitioners (SGMDP), a total of 164 physicians in private practice throughout the country were interviewed during the period, December 1994–February 1995. (Details of the survey's implementation, which was managed by Mr. David Stanton, an independent health consultant and Marketing & Social Research Institute Ltd (MSRI) under contract to *Initiatives*, are provided in a methodological note that follows the presentation of survey findings below.)

Survey Findings

Characteristics of the Principal Health Provider

Table 1

Summary of Provider Characteristics

	Count	Col %
Age		
25-34 years	3	1.8
35-44 years	15	9.2
45-54 years	52	31.7
55 years or older	89	54.3
No response	5	3.0
Total	164	100.0
Respondent's Gender		
Male	157	95.7
Female	7	4.3
Total	164	100.0
Post Grad Medical Training		
Yes	157	95.7
No	7	4.3
Total	164	100.0
Additional Management Training		
Yes	25	15.3
No	138	84.7
Total	163	100.0

The majority of providers interviewed were male, over forty five years of age and had been in practice for an average of 25 years. They had been practicing in their current private setting for an average of 13 years. The period from 1977 to 1982 was the timeframe during which most practices were established. Since 1990, a much smaller number of private practices have been established. This finding, in light of the ages of the respondents, suggests that fewer new doctors are entering private practice. Changes in government policies within the last five years restricting the creation of private medical practices, changes in lending practices by commercial banks making it difficult for young doctors to secure loans to establish private facilities, and the decline in the value of the cedis, all contribute to slowing the growth of the formal private health sector in the country (See Tables 1 & 2).

Of the 167 principal providers surveyed, only 7 were women. An analysis by gender of specific variables related to clinic history, services and operations was conducted, but did not yield any statistically significant results.

More than half of the providers surveyed have had postgraduate medical training. Of these, obstetrics/gynecology (27%), surgery (10.6%), family practice (9.6%), pediatrics (7.4%), and public health or community medicine (7.4%) were the leading specializations.

Table 2

Summary of Provider Characteristics (Continued)

	Mean	Std. Deviation	Valid N
Years Practiced Medicine	25.5	7.8	162
Years Practiced in this Clinic	13.3	6.9	160
Total Hours Per Week Worked	51.8	33.6	159
Patients Seen Per Week	113	84.3	157

The leading reason given by over half (52%) of the providers surveyed for entering private practice was flexibility in working hours and greater personal autonomy. The prospect of greater financial rewards was in a distant second place at 17% (See Table 3). Only 15 percent of the providers surveyed have had training in business administration or health services management.

Establishing a Private Practice

Most clinics were established with mainly personal or family finances (83.5%), although some clinic owners also obtained commercial bank loans (38.0%). No provider received any tax incentives or support subsidies when establishing their facilities, and very few received importation privileges (2.5%) or special access to equipment or supplies (3.1%). Thirty-four percent of providers surveyed said they encountered problems with high interest rates when establishing their clinics (34.0%) and high business taxes (60.0%). Other difficulties confronted by private providers include difficulty accessing the resources necessary to establish the practice (40.0%), price ceilings (15.6%), obtaining drugs and equipment (20.0%) and approval to operate a private clinic (20.0%).

Table 3

Reasons for entering private practice

	Count	Col %
Work Environment (Flexible Hours)	84	51.8
Financial (It Pays Better)	28	17.3
Dissatisfaction with Ministry of Health	17	10.5
To Help People	10	6.2
Retired from Public Service	10	6.2
No Public Jobs Available	5	3.1
Quality of Clients	5	3.1
Succeeded Father's Practice	3	1.8
Total	162	100.0

Characteristics of the Facilities

Private providers are almost exclusively urban based, with fewer than 2 percent operating in rural areas. Half of the providers (51.9%) own the buildings in which their practices are housed. Most facilities are operated with an average of 10 staff, which includes both medical and clerical personnel, 62.6 percent have inpatient facilities, and 52.4 percent have their own laboratories.

Eighty-two percent of all private practices are 'solo' or single physician practices, and a surprising 18 percent operate in group practices. For many physicians, the desire for autonomy in their work was the main reason for wanting to enter into private practice, and the idea of establishing a group practice runs counter to this idea. Nevertheless, the group practices examined in this study were performing financially as well as the solo practices. Given that the most significant expenditure items in the facilities surveyed was labor and pharmaceuticals, forming group practices may be one way to offset these significant costs by pooling resources, such as staff, and benefiting from economies of scale through bulk drug purchasing. The larger patient volumes and increased cash flows experienced by group practices may act as a safety net for physicians enabling them to survive the economic challenges facing private businesses (See Table 4).

Characteristics of the Clients

Of the practices surveyed, 70.7 percent were classified by the principal provider as *general* or *family* practices. Most clinics see an average of 136 clients per week. According to provider estimates, almost 83 percent of these are women and children.

Approximately 50 percent of all patients were considered "low income" which was defined in terms of the client's profession: those who are employed in a job which typically falls into the C

Table 4

Practice characteristics

	Count	Col %
Scope of practice		
General or Family Practice	116	70.7
Specialist Practice	13	7.9
Combined Specialist and General Practice	35	21.4
Total	164	100.0
Solo or group practice		
Solo Practice	135	82.3
Group Practice	29	17.7
Total	164	100.0
Rent or own clinic location		
Rent	84	51.9
Own	78	48.1
Total	162	100.0
Clinic location		
Urban	134	81.7
Peri urban	27	16.5
Rural	3	1.8
Total	164	100.0
Region where clinic is located		
Greater Accra	86	52.8
Ashanti	41	25.2
Central	13	8.0
Eastern	5	3.0
Volta	5	3.0
Western	13	8.0
Total	163	100.0

Table 5
Summary of practice characteristics, age of practice, staff and hours of operation

	Mean	Std Deviation	Valid N
Years since clinic opened	15	8	155
Number of staff employed in clinic	10	12	162
Hours clinic is open per week	115	60	164

Table 6
Summary of patients seen

	Mean	Std Deviation	Valid N
Number of patients seen per week	136	125	164
Children under 18 yrs per week	56	51	164
Women 18 years and over per week	56	48	164
Men 18 years and over per week	38	43	164
Low income patients per week	71	56	164

& D' income levels - e.g housekeeper, security guard, agricultural worker, fisherman, etc Practices which conducted community based health promotion campaigns (7.3%) saw more low income patients, as did practices with in patient facilities (62.6%)

Referral Networks

All facilities made extensive use of referral networks to receive clients and to send them on for additional care. The most common sources of referrals are employers, schools, and word-of-mouth. Fewer than 25 percent of facilities surveyed received referrals from government hospitals. Conversely, 87 percent of the principal providers interviewed said that they referred patients to public hospitals.

Basic Health Services

Most facilities offer a range of basic health services, including preventive care. The most commonly offered treatments are for malaria (99.4%), gonorrhea (93.9%), and simple diarrhea (98.8%). Other commonly offered services are pelvic examinations (80.5%), antenatal (62.8%) and post partum (59.8%)

care, well baby care (48.2%), and family planning (49.7%). While only 7.3 percent undertook health promotion activities in the community, 75 percent of the facilities offer in-clinic health education (See Table 7).

Nearly 28 percent of the clinics offer childhood immunizations, either on their own or by allowing MOH immunization teams to use their facilities. Significantly more (69.5%) offer tetanus toxoid immunizations.

One interesting finding was the high number of facilities offering antenatal (62.8%) and post partum care (59.8%), compared to the number of facilities offering deliveries - 34 percent offer normal deliveries and 23 percent offer deliveries by cesarian section. Providers who offered antenatal care, but didn't perform deliveries, were twice as likely to refer patients to midwives. How these linkages are made and maintained is not clear and warrants further investigation.

Clinics that offer childhood and tetanus immunizations, and general and specialized obstetrical/gynecological care, are more likely to offer family planning than those clinics not offering these services.

Family Planning Services

Family planning services are offered in just under one half of the practices surveyed (48.7%). Of the services offered, the most common are family planning consultations (95.1%), provision of oral contraceptives (84.1%) and injectable contraceptives (65.9%), and IUD insertion and removal (82.9% and 81.7% respectively).

Most facilities typically do not stock family planning commodities. The principal exception is oral contraceptives, which are provided in just under one-fifth (18%) of the practices surveyed (See Table 8).

Revenues and Expenses

Nearly 60 percent of facilities surveyed discounted their fees to some clients. For the most part, discounts were given to patients whom the provider perceived as being unable to pay the full fee. The most encouraging finding regarding revenues and expenses was the lack of impact that low income patients (or

patients given discounts and free care) had on revenues and expenses. The study indicated that practices which see more clients for whom services are free also had higher revenues. It is suggested that giving free care creates a positive public perception of the facility, improving utilization.

Approximately the same proportion of private facilities saw retainer clients. In most cases, providers charged retainer clients the same fees as they charged regular clients. This suggests that providers don't use pricing to attract retainer clients, and conversely, employers who contract with these providers don't expect discounts for providing a significant volume of clients. Therefore, it would appear that the main benefit to the private providers of taking retainer clients is the consequent increase in overall patient volume. For the employer, the benefit of contracting with one health care provider for employee health services appears to be the reduction in the companies' administrative burden. The possibility of attracting more retainer clients with competitive pricing policies, and the impact that this has on clinic efficiency and overall financial viability needs to be explored further.

Profitability

Complete data on expenses and revenues were available for only 14 facilities. The high rate of non response is a serious limitation to the conclusions that can be drawn from the study, and makes it impossible to discuss the profitability of clinics with any degree of certainty. One reason for non response was that the providers surveyed did not know the amounts for all categories of expenses and revenues on which they were questioned, suggesting a need for better administrative systems. There is also an understandable reluctance to reveal information that is clearly "proprietary" and typically not shared by private enterprises.

A second issue affecting the ability to comment on the profitability of private facilities is the lack of information regarding the separation of practice and personal finances as well as the income from other business ventures in which the respondents may be engaged. Many practices were started using personal funds, but it is not clear whether the health facility paid back the personal funds used, and is now operating wholly unsubsidized. Second, it was clear that a significant number of providers were engaged in businesses other than their clinics (real estate, pharmacies, etc.). Given that some of the clinics operate on the margin, it is not clear whether or not these other businesses are producing revenues used to offset the losses incurred by an unprofitable practice.

Management Practices

Fifty percent or fewer of the practices surveyed had written mission statements, strategic plans, administrative protocols and procurement policies. Fifty-eight percent had written patient care protocols and written job descriptions for staff (67%).

Marketing does not feature prominently in the management of the practices surveyed. Although one third (34.4%) of the practices have assessed patient satisfaction at least once in the past three years, 10 percent or fewer have undertaken surveys of potential clients in the facility service area, or of services offered by other clinics.

Two management practices - written procurement policies, and market research of either other clinics' service offerings, or patient demands and satisfaction - are associated with facilities with larger expenditures and revenues, provision of services such as childhood immunizations, family planning services, and providing medical care in patient's homes. It is likely that the practices which conducted surveys are actively trying to meet the needs and demands of their clients as well as fill the service gaps not met by other providers. Procurement policies (unlike accounting systems which only document cash flow) attempt to control cash flow. This suggests that planning and management are integral parts of operations with higher revenues, expenses and a wider range of services. However, the lack of revenue and expenditure data makes it impossible to determine what impact these management practices have on profitability.

Summary

This survey's findings provide a detailed description of the formal private health sector in Ghana. This sector is able to provide a wide range of preventive and curative services to its clients, many of which have low incomes. Growth of the private health sector has been limited by changes in government regulations, prevailing banking practices, and the declining value of the cedi. The future of the private health sector in Ghana will depend, in part, on how well it adapts to these circumstances. To this end, improvements in marketing, business and management practices, will be of great significance.

Table 7

*Summary of Basic Services
Offered by Private Practices*

	Count	Col %
Malaria Treatment		
Yes	163	99.4
No	1	.6
Total	164	100.0
Gonorrhea Treatment		
Yes	154	93.9
No	10	6.1
Total	164	100.0
Simple Diarrhea		
Yes	162	98.8
No	2	1.2
Total	164	100.0
Family Planning Services		
Yes	81	49.7
No	82	50.3
Total	163	100.0
Childhood Immunizations		
Yes	44	26.8
No	120	73.2
Total	164	100.0
Tetanus Toxoid Immunizations		
Yes	114	69.5
No	50	30.5
Total	164	100.0
Pelvic Exam		
Yes	132	80.5
No	32	19.5
Total	164	100.0
Antenatal Care		
Yes	103	62.8
No	61	37.2
Total	164	100.0
Pap Smear		
Yes	48	29.3
No	116	70.7
Total	164	100.0

Table 7
Continued

Maternal Post Partum Care	98	59.8
Yes	66	40.2
No	164	100.0
Total		
Normal Delivery	56	34.4
Yes	107	65.6
No	163	100.0
Total		
C section Delivery	38	23.2
Yes	126	76.8
No	164	100.0
Total		
Specialized Ob/gyn Care	79	48.2
Yes	85	51.8
No	164	100.0
Total		
Well baby Care	79	48.2
Yes	85	51.8
No	164	100.0
Total		
Community based Health Promotion	12	7.3
Yes	152	92.7
No	164	100.0
Total		
Clinic Dispenses Drugs	142	89.3
Yes	17	10.7
No	159	100.0
Total		
Clinic Has Own Lab Facilities	86	52.4
Yes	78	47.6
No	164	100.0
Total		
Clinic Has In patient Facilities	102	62.6
Yes	61	37.4
No	163	100.0
Total		

Table 8

*Summary of Family Planning Services
Offered by Private Practices*

	Count	Col %
Family Planning Consultation		
Yes	77	95.1
No	4	4.9
Total	81	100.0
Provide Diaphragms		
Yes	25	30.5
No	57	69.5
Total	82	100.0
Provide Oral Contraceptives		
Yes	69	84.1
No	13	15.9
Total	82	100.0
Provide Injectable Contraceptives		
Yes	54	65.9
No	28	34.1
Total	82	100.0
IUD Insertion		
Yes	68	82.9
No	14	17.1
Total	82	100.0
IUD Removal		
Yes	67	81.7
No	15	18.3
Total	82	100.0
Norplant Insertion		
Yes	13	15.9
No	69	84.1
Total	82	100.0
Male Sterilization		
Yes	7	8.5
No	75	91.5
Total	82	100.0
Female Sterilization		
Yes	26	31.7
No	56	68.3
Total	82	100.0

Table 9

Prices Charged for Specific Clinical Services Offered

Service	Mean (in cedis)	Std Deviation	Valid N
Registration Fee	1,261	2,436	126
Consultation Fee	5,309	27,875	120
Malaria Treatment	7,164	32,751	113
Gonorrhea	17,484	100,455	95
Simple Diarrhea	4,142	4,713	110
Family Planning Consultation	7,540	12,837	91
Tetanus Toxoid Immunization	2,618	5,110	77
Pelvic Exam	2,893	2,519	76
Pap Smear	1,350	3,865	25
Prenatal Care	3,903	4,317	73
Maternal Post Natal Care	2,574	1,942	59
Normal Delivery	15,027	13,703	46
C Section	131,860	64,322	25
Specialized Ob/gyn	10 018	11 899	41
Well Baby Care	2 496	1 999	47

Table 10

Mean Monthly Expenses by Type of Expense

	Mean (in cedis)	Std Deviation	Valid N
Expense	327,602	1,114,527	73
Rent	960,166	2,034,983	110
Labor	498,062	1,030,450	52
Equipment	442,995	1,076,281	68
Supplies	860,744	1,200,890	99
Pharmaceuticals	135,227	363,375	111
Utilities	252,001	559,252	63

Table 11

Mean Monthly Revenues by Source of Revenue

Source	Mean (in cedis)	Std Deviation	Valid N
Total Revenue	2,726,551	5,672,848	76
Revenue from Patients	1,873,302	2,947,855	63
Revenue from Retainer Contracts	1,888,484	4,766,176	50
Other Sources of Revenue	3,427,239	4,109,572	6

Table 12

Management Systems in Place

	Count	Col %
Filing System for Medical Records		
Yes	159	97.5
No	4	2.5
Total	163	1000
Written Procurement Policies		
Yes	161	98.2
No	3	1.8
Total	164	1000
Inventory Control System		
Yes	159	97.0
No	5	3.0
Total	164	1000
Accounting/Bookkeeping System		
Yes	97	59.1
No	67	40.9
Total	164	1000
Personnel Policies and Procedures		
Yes	83	50.0
No	81	50.0
Total	164	1000
Analysis of Patient Data		
Yes	127	77.4
No	37	22.6
Total	164	1000

Table 13

Summary of Management Practices

	Count	Col %
Written Mission Statement		
Yes	58	36 0
No	103	64 0
Total	161	100 0
Written Strategic Plan		
Yes	81	50 3
No	80	49 7
Total	161	100 0
Written Administrative Protocols		
Yes	68	42 0
No	94	58 0
Total	162	100 0
Written Patient Care Protocols		
Yes	93	57 8
No	68	42 2
Total	161	100 0
Written Job Descriptions		
Yes	108	66 7
No	54	33 3
Total	162	100 0
Market Surveys of Patient Demands		
Yes	17	10 6
No	144	89 4
Total	161	100 0
Surveys of Competitor's Services		
Yes	12	7 4
No	150	92 6
Total	162	100 0
Survey of Patient Satisfaction		
Yes	56	34 4
No	107	65 6
Total	163	100 0
Major Expansion Project in Last 3 Years		
Yes	70	43 2
No	92	56 8
Total	162	100 0

Methodology

Purpose

The purpose of this study was to collect data on the history, operations and management of private health facilities in Ghana in an effort to better understand the composition of the formal private health sector, the range of services offered in their facilities, and to offer some insight into how such facilities sustain their operations in economically challenging times. The study also examined the business development and management strategies used by these facilities in order to better understand why some clinics perform better than others.

The specific areas examined were

- 1 Characteristics of the principal health provider
- 2 Clinic history and management
- 3 Patients and services offered
- 4 Clinic staff
- 5 Revenues, expenses and fees for services
- 6 Costs of drugs and supplies
- 7 Laboratory services
- 8 Equipment and supplies
- 9 Observation of the facility infrastructure

Survey Design & Management

Management

Marketing and Social Research Institute, Ltd (MSRI), a Ghanaian firm headquartered in Accra, and Mr David Stanton, an independent health consultant, managed the survey under contract to the *Initiatives* Project. MSRI and Mr Stanton had successfully implemented a survey of private physicians for the purpose of assessing their role in the diagnosis and treatment of sexually transmitted diseases.¹

Sample

The study was designed as a census of all members of the SGMDP who were physicians. The most current membership list identified 279 members. After excluding dentists, providers who were no longer at the given addresses, and providers who had died, a total of 241 doctors were identified for inclusion in the study. Of these, 164 were interviewed, yielding a sample of 68 percent. The majority of the facilities were located in the Greater Accra and Ashanti regions, the remaining facilities were located in the Central, Eastern, Volta, and Western Regions. No facilities were located in the Northern region of the country. The regional distribution of the 164 doctors interviewed was very similar to the distribution of the 241 doctors identified.

Sampling Frame

Region	Physicians Identified		Physicians Interviewed	
	Number	Percent	Number	Percent
Greater Accra	141	58.5	86	52.4
Ashanti Region	58	24.1	42	25.6
Central Region	16	6.6	13	7.9
Western	16	6.6	13	7.9
Volta	5	2.1	5	3.0
Eastern	5	2.1	5	3.0
Total	241	100.0	164	100.0

Instrument

The survey instrument was developed by *Initiatives* and was modified by the investigators in Ghana. This enabled the researchers to adapt the instrument to some of the unique aspects of medical practice in the country. One important area that was modified was the section covering the price of immunizations. Questions regarding the cost of vaccines were removed because providers who offer immunizations do not pay for the vaccines which are provided free of charge by the Ministry of Health. In addition to asking providers if they offered childhood vaccines, they were also asked if they provided tetanus toxoid immunizations to women of child bearing age, and if they allowed the Ministry of Health immunization teams to use their facilities during immunization campaigns.

Interviewers

Nineteen interviewers (thirteen men and six women) were recruited to conduct the survey. Interviewers received training for two days before starting data collection. This training focused on interview skills and a thorough review of the instrument to be used.

Field Test

The instrument was field tested on five providers in Accra. From the field test it was learned that some clinics are part of a system of satellites. Therefore, two questions regarding the affiliation of facilities to others were added. It was also learned that drug costs to patients are often included in the cost of treatment, making it difficult for providers to identify the cost of the drug to the patient. Four questions were added regarding the patient's cost of drugs when this cost is included in the treatment fee.

Data Collection and Management

Data collection took place between December 18, 1994 and February 4, 1995. Interviewers scheduled appointments with practices and identified persons within the practice who could answer questions on the subjects covered by the instrument. In most cases the surveys were completed in one visit. However, due to the length of the questionnaire, many providers were unable to complete the interview in one session. In these cases, follow-up interviews were necessary. Interviewers also carried out the observations of the facilities at the time of the interview.

Quality Control

Surveys were inspected by the field supervisors to verify that they were complete and correctly filled out. The interviews were sent back to the provider to resolve any items that were ambiguous. The surveys were then sent to Accra where the supervisor of the project reviewed the questions. Open-ended responses were then coded and the forms were sent to data processing. The data were entered by experienced key punch operators, and reviewed by the head of data management for errors in entry.

Analysis

As this was a descriptive study the focus of the analysis was to produce measures of central tendency to create a 'picture' of the formal private health facilities in Ghana. The results of nominal variables were expressed as raw scores and percentages. Ordinal variables were expressed as median, mean and standard deviation. Box and whisker plots were produced for some ordinal variables to visually represent the range of responses. Where comparisons were made, analysis of the variance, Chi Square or Fishers Exact, were used to test for association between variables of interest. Logistic regression was used to determine the independence of variables associated with certain outcomes. Analysis was performed using SPSS PC, EPI Info, and Logress.

Reference

¹ Stanton, D, Asamoah Odei, E, Asamoah Adu, A, Kittoe, K, Quarcopone, F, Richter, J. *Assessment of Private Sector Sexually Transmitted Disease Diagnosis and Treatment*. Accra, Ghana Marketing and Social Research Institute, 1994

About Initiatives.

Private Initiatives for Primary Healthcare (Initiatives), is a demonstration project funded by USAID and managed by the JSI Research & Training Institute. It was designed to test different models of sustainable private sector basic health service delivery systems, and to support local USAID missions' participation in health sector reform efforts. Focusing on Ghana, Nigeria, Ecuador and Guatemala, *Initiatives* provides technical assistance to support the development of local initiative groups (LIGs), which represent different models of private sector healthcare. Technical assistance is also provided to support the development of local management groups (LMGs), which could serve health care providers as a local source of technical assistance in the long term. Documentation and analysis of the experience of these *Initiatives* supported organizations will yield insights into the prerequisites for financially sustainable private basic health services, and will contribute to our understanding of the conditions necessary to establish, maintain, and expand the availability and accessibility of quality healthcare to low income urban populations.

For a copy of the full report of this survey or for more information about *Initiatives*,
please contact

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