Investigating the Potential Benefits of Medical Group Practice to the Private Health Care Sector in Ghana

Thesis

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INVESTIGATING THE POTENTIAL BENEFITS OF MEDICAL GROUP PRACTICE TO THE PRIVATE HEALTH CARE SECTOR IN GHANA

By

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DECLARATION

I hereby declare that this thesis is the result of my own original work and that no part of it has been presented for another degree in this university or elsewhere.

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Date: ……

I hereby declare that the preparation and presentation of the thesis were supervised in accordance with the guidelines on supervision of thesis laid down by the Ashesi University College.

Supervisor's Signature: .....

Supervisor's Name: Dr. Esi Ansah

Date: ……..

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ABSTRACT

The aim of the study was to investigate the benefits of medical group practice to the private healthcare sector in Ghana. The 51 respondents of the study consisted of doctors, hospital administrators, and the Director of Private Hospital and Maternity Homes Board. The research instruments used was the semi-structured interview guide consisting of open-ended and close-ended questions. The non-probability sampling technique was applied to select 10 private hospitals in Accra: 40 doctors and 10 hospital administrators; and the Director of Private Hospital and Maternity Homes Board.

The results of the study showed that the main benefits of the medical group practice included flexibility among the physicians, internal referrals, reduction in the startup cost for physicians and reduce the expenses made by patients.

The measures that could be taken to enhance the successful operations of medical group practice in Ghana include education and a well research of the practice done by physicians.

There is, therefore, the need for all stakeholders such as health professionals, civil society organisations, the community and the government to implement these and other measures to enhance the implementation of medical group practice.

Key words: Medical Group Practice, Ghana, Private Health Car

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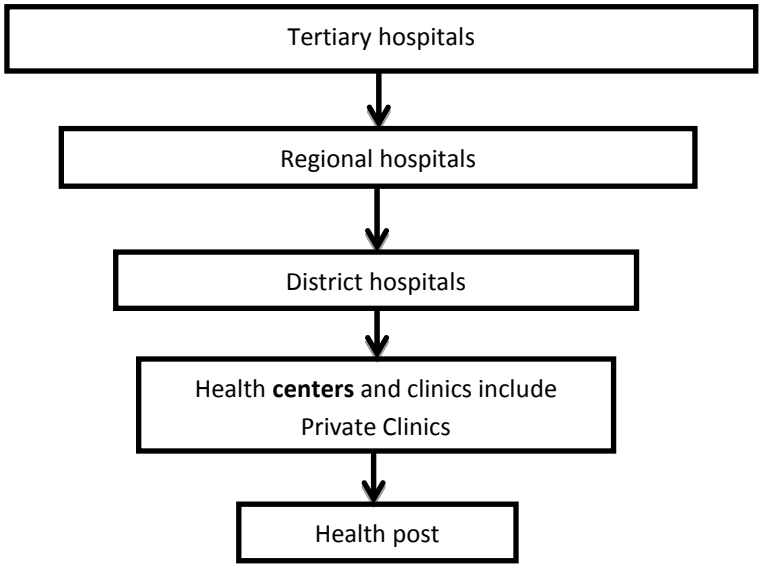
1.0 INTRODUCTION

1.1 Background

Ghana is confronted with a health crisis, driven by the burden of diseases and poverty. This has led to serious challenges to governments in the past and present due to the large role it plays in the health sector. Currently, the government is the largest provider of healthcare controlled by the Ministry of Health and Ghana Health Service**.** The healthcare system in Ghana has five levels of providers. These are (in descending order): tertiary hospitals, regional hospitals, district hospitals, health centers and clinics and health posts which are first level primary care for rural areas. These providers are funded by the government of Ghana, financial credits, Internally Generated Fund (IGF), and Donors-pooled Health Fund (Canagarajah & Ye, 2001).

LEVELS OF HEALTH CARE PROVIDERS (PUBLIC/PRIVATE) IN GHANA



The current healthcare system has proven ineffective in meeting the needs of Ghanaians as many continually die from preventable diseases. The

quality of services available, the geographical access to healthcare facilities, efficiency of service delivery, and availability of adequate resources to finance and sustain health systems, have placed unnecessary barriers to access to healthcare in Ghana. This continuous decline of healthcare has consistently failed to compliment the increasing population growth. As a result, the deteriorating healthcare system has forced the majority of the population to seek alternative healthcare services (Baidoo, 2009).

The private sector is a major player in Ghana's health care system. It is responsible for about 40 per cent of total health care delivery and thus has become the preferred alternative to the Public Healthcare system. The main body that governs the private sector of the health industry in Ghana is the Private Hospitals and Maternity Homes Board (PHMHB), established by Act 1958(No.9) of the Ghanaian constitution. The main providers in the private sector are mission-based providers; consisting ofChristian and Islamichospitals and the private medical and dental practitioners. Hospitals run by religious groups make up 35% of Ghana's Health Care Sector. Private hospitals function as small entities and thus can easily implement any innovations in medical practice compared to government establishments(Baidoo, 2009).

Again, the private healthcare sector in Ghana is made up of diversehealthcare providers ranging from the herbalist to practitioners of orthodox medicine. These healthcare providers also differ in terms of structure, composition, output, and location. For example, the formal private sector, comprising of privately owned medical facilities such as hospitals, clinics, and maternity homes, has emerged largely as a consequence of the

limited coverage of public-sector and charitable healthcare facilities. Currently, over 90 percent of for-profit providers are located where there is market and a higher ability of clients to pay. The formal private health sector provides about 60 percent of all curative health care in Ghana (Obuobi et al, 2009).

As at 2009, there were over 1,000 physicians registered in Ghana, about 700 are engaged in the public sector while around 300 are in the private sector. About 55 percent of private-sector providers are found in the Greater Accra Region. The majority of those surveyed (86 percent) were 45 years old and above while only 7 percent were below the age of 45. In the older group, 46.5 percent were aged 55–64 years and 16.1 percent were 66 years and above. This data shows that private practitioners are an aging population and that few doctors are entering private practice. From this data, it was observed that there were fewer women than men in private practice in Ghana (Obuobi, Pappoe, Ofosu-Amaah& Boni, 2009).

There is also the issue of inadequate access to healthcare in both rural and urban areas. From a financing perspective, health financingfor both the rural and urban areas are inadequate.However, it has beenrecognized and suggested that additional resources should be mobilized to improve care delivery and to extend health care to rural areas to ensure equity (Obuobi, Pappoe, Ofosu-Amaah& Boni, 2009).

Healthcare involves the prevention, care and treatment of diseases and other disorders. It is however important to note that there are many challenges confronting the healthcare sector in Ghana. Some of the challenges include ineffective monitoring and evaluation mechanisms,

improper institutional and professional accountability and inequitable distribution of health professionals. Moving on, this research has identified the need for a new dimension in the healthcare delivery in Ghana and thus proposes the introduction of Medical Group Practice (MGP).

The introduction of medical group practice may be a way of providing good quality healthcare to patients with the prime focus on teamwork from medical practitioners. Medical Group Practice is the provision of health care services by a group of at least three licensed physicians engaged in a formally organised and legally recognised entity; sharing of equipment, facilities, common records and personnel involved in both patient care and business management (American Group Practice Association, 2012).

The concept of medical group practice is relatively new in Ghana. Countries like South Africaand the United States of America have adopted this practice. In the United States where the doctor-patient ratio is very low (1.3 health workers per 1000 persons which is below the United Nation's ratio of 2.5 health workers per 1000 people), the model could be a solution to the inadequate health treatment of the citizenry. In this case, when the doctor to patient ratio is low, it will help the doctors to be able to devote time and attention to the patients which will help in the recovery of the patients (Conway, Gupta & Khajavi, 2007).

Therefore, the private health facilities would be in a better position to implement the MGP model since it is ready to make changes and bring new ideas into the health care sector in the country (Abor, Abekah-Nkrumah& Abor, 2008). Because of the high cost involved in purchasing equipment, it

becomes difficult for the owner of the hospital to purchase all the equipment which will be necessary for operating the hospital.

The analyses carried out by the Government of Ghana and other stakeholders over the years have suggested that the major challenges faced by Ghana's private health system are related to limited health care coverage and severefinancing problems.

1.2 Problem Statement

In Ghana, a hospital may be set up as a sole proprietorship, where one person owns and manages it. However, this form of business is set up by one person who runs and manages the organisation with a group of people as employees. The risk involved in sole proprietorship is very high. This is because the owner will be held accountable for any losses for the business. For instance,insetting-up a private hospital which is run by anindividual, the owner will have to use personal funds or resources to keep the company running. However, it can make the owner run out of personal funds. Secondly, since the owner of the hospital provides the initial funds for the set up, it becomes difficult to generate additional capital for the upkeep of the hospital. Lastly, there is lack of continuity because if the owner becomes deceased or incapacitated, there will be no one with the requisite knowledge and skills to continue running the hospital (LaMance, 2012).

MGP is a model which involves partnership with a group of physicians of different specialties or same specialties. This has an advantage over the sole proprietorship form of business set up. The cost of setting up MGP is shared among the physicians and paid accordingly for by the success of the

hospital. The hospital will always be in active because it was set up by a group of doctors and the different doctors will also contribute ideas to making the hospital progress. Furthermore, if a physician should be deceased, it will not affect the business since the remaining partners will continue to run the business. Lastly, all the physicians will be held accountable for any losses or violations that occur. However, they will always work hard in sustaining the hospital. In lieu of this, this study proposes to use partnership in the private sector rather than sole proprietorship in healthcare delivery.

1.3 Objectives of the study

The main objective is:

i. To determine how beneficial medical group practice can be to the private health care sector.

1.4 Research questions

There is the need to investigate the benefits of medical group practice.

i. How beneficial is medical group practice to the private healthcare sector in Ghana?

1.5 Research relevance

This research on MGP will help the people working in the Health Sector to know more about the practice. Thedirector of Private Hospital and Maternity Homes Board and Hospital Administrators will know the benefits that will be derived from this study. Doctors are going to find out the advantages that can be derived from practicing it.

I. Information will be beneficial to medical practitioners.

II. It will contribute to literature on medical group practice in Ghana and add to already existing information.

III. If implemented, it will be useful to patients in terms of cost reduction and delivering quality of service.

1.6 Outline of Dissertation

The study will be divided into five chapters. The first chapter will discuss the introduction of the topic stating the objectives, research questions, problem statement, relevance of the study and the theoretical framework. The second chapter will examine existing literature examining the benefits of medical group practice to the private health care sector. The third chapter which is the methodology will focus on methods used to gather data, the sampling techniques, and the type of data. The findings and discussions which is the fourth chapterwill present the findings of the primary data collected in relation to the objectives of the research. The findings and discussions will form the basis for recommendations and conclusions of the study.

The last chapter which is chapter five will discuss the implications and limitations of the findings. This chapter will also include a summary conclusion of the important findings that explain the research problem.

2.0 LITERATURE REVIEW

2.1 Background of Medical Group Practice

Medical Group Practice is the provision of healthcare services by a group of at least three licensed physicians engaged in a formally organised and legally recognised entity; sharing equipment, facilities, common records and personnel involved in both patient care and business management (America Group Practice Association, 2012).

This model has helped shaped the delivery, quality and patient expectations of healthcare in countries like United States of America, South Africa etc. The first medical group was formed in 1870 by the Homestake Mining Company in South Dakota to serve its employees. It was a practice that was formed to help cure employees of Homestake Mining Company of their ailments and also gave the patients a lot of care and attention. They believed that when employees have sound mind, they will be able to give their best in whatever they do. One other reason for the setting up of MGP by the company was that the mining area was far from town which meant that access to health care for its employees was time relatively expensive considering the time it took employees to get attention and also the cost incurred by the company.

In the United States, forty-three percent of final-year medical residents prefer positions in a group practice and 4 percent hoping to go into solo practice. The number of group practices grew from 300 in 1932 to

16,500 in 1990 and to more than 37,000 in 2003 and the number of good practice keeps increasing over the years (MGMA-ACMPE, 2013)

2.2 Types of Medical Group Practice

Large group and small group

Medical practitioners have the option of choosing the scale of the MGP they form which can either be small or large. The small group consists of member's numbering 3-9 physicians. The moderate group size consists of 10-20 physicians whereas over 20 physicians are considered to be the large group.

Group practice, especially large multispecialty group practice, can improve the quality of health care, decrease cost, and provide a professionally desirable working environment for physicians. Moreover, since medical care has become increasingly complex and expensive, the awareness of medical errors and the possibilities for using organised processes to improve quality healthcare have grown and, the growth of managed care appeared to create new reasons for physicians to practice in groups, especially large groups (Kohn, Corringan, Donalson, 2000; Robinson, 1999).

Single-specialty group and multispecialty group

According to Grumbach (2002), it is believed that small single-specialty groups can gain negotiating leverage with health insurance plans which will be used to benefit patients who cannot afford to pay their bills. While there is coordination between primary care and specialties in multispecialty groups there will be greater understanding and quality of work will be delivered to patients who seek for health care in the hospital. Benefits

to physicians and patients can be reaped from a single-specialty group and a multispecialty group. This is because there will be contribution and commitments by the physicians which will help them provide quality health care to patients and in return will attract patients to the hospital (Grumbach, 2002).

Since it is a hospital, their aim will be to provide quality health care to patients. However, they will concentrate on curing patients and also think of how to make money to sustain the business. In this case, they will consider taking insurance from patients so that they are able to afford quality health care (Casalino, Devers, Lake, Reed & Stoddard, 2002).

It appears that health insurance plans and large private and public purchasers of health insurance affect the size and specialty composition of medical groups. The type of payment method they use and the relevant emphasis they lay on rewarding negotiating leverage versus rewarding quality will determine the type of specialty the physicians will have to form (Casalino, Devers, Lake, Reed & Stoddard, 2002).

2.3 Concept of an Organisation

When a group of people are involved in the accomplishment of a task in an organization, someone assumes the responsibility of directing and leading the group. An organisationrefers to the structure of relationships among position jobs, which is created to achieve certain goals and control the activities of man with a mechanism (Saini & Singh, 2008). It is also a process of identifying and grouping the work to be performed, specifying the work, defining and delegating the responsibility with authority to the

personnel and establishing interpersonal relationship for the purpose of co-ordination of work, so as to get the work done together effectively, and in accomplishing the objectives of the organisation.

Medical group practice as an organization produces a partnership among medical practitioners. With this form of organisation, the physicians decide on how to run the business in terms of amount of money to be contributed by each physician and who does what aside their practice. However, every hospital has a business model. According to Antony (2012), in every organization, there is a business model to help the company plan to produce, deliver as well as profit from the business. Without a successful business model that will guide a business to make progress, it will remain an imaginary idea that will be thought of without establishing it (Antony, 2012). Therefore, the workers will be able to contribute their services to link together and co-ordinate their efforts to be able to accomplish a common goal. In view of this, the element of a business model that will help them achieve their goals with ease consists of the following:

- **Revenue**: This is a variable that keeps the business in check and keeps the business going. It helps to sustain the business and can be derived from the rate at which customers purchase goods or services which will help bring large sums of revenue to the business.
- **Gross margins**: It is how much of the business' profit is left after its costs have been paid. It is the deduction of costs of goods sold from revenue.

- **Operating model**: This element describes all the expenditures that are made by the business such as payment of salaries to workers and for utilities.
- **Working capital**: Working capital is deducting a firm's liabilities from its assets. Those assets may include client contracts, inventories and fixed assets such as equipment and property; liabilities may include suppliers, salaries and taxes.
- **Investment**: The investment model defines how much cash you must put up before you generate enough businesses to cover operating costs; until those costs are covered, a company is not truly profitable.

2.4 Medical Group Practice Business Model

Heine and Maddox (2009) agreed to the fact that hospitals are the most complex of organisations in any environment. They added that hospitals constantly deal with life and death matters and must, therefore, address "customer" needs of those paying directly for services rendered from customers who are not directly paying for the services they receive. In some cases, the patient/customer is unaware of paying the costs incurred in hospital treatments and procedures. As a matter of fact, they need the help of their insurance companies to help settle the bill. Hospital management reforms continuously improve the level of teamwork, the quality of relationships within teams and communication dynamics amongst organisational teams (Heine & Maddox, 2009). The team work aspect of medical group practice helps the hospital in all areas.

Friesner et al (2009) said the quality of healthcare and patient safety are the common mantra of all primary and secondary health care providers

(Friesner, Neufelder, Raisor, & Bozman, 2009). The purpose and methods of cost analysis which may be applied to hospitals are similar to those which are encountered in most business enterprise. The measurement of costs of products serves two purposes namely: to control the future expenditures for similar products and to compare the costs of the products with the income they produce.

There are different ways of generating revenue in a hospital. These are classified as: (a) board and room, (b) diagnosis and (c) treatment.

Board and room constitute the use of bed, three meals per day and an amount of bedside nursing care. Diagnosis on the other hand constitutes of services of x-ray photography, basal metabolism and laboratory tests. Medical treatment includes the use of facilities such as operating room, physiotherapy and delivery room (Rorem, 2002).

Medical Group Practice however has a way of allocating resources to achieve their goal of sustaining the hospital. Every successful company operates according to an effective business model. By identifying all of its essential parts, executives can understand how the model fulfills a potent value proposition in a profitable way using certain key resources and key processes. Medical Group Practice has a business model like other businesses. There are some elements of business model for medical group practice according to Goodman, Bennet and Odem (1977).

First and foremost, the legal form of the organisation under which the group can provide professional medical services is professional corporation association. This is in a form of partnership because it is a group of

physicians who come together to set the hospital (Goodman, Bennet, & Odem**,** 1977)**.**

Secondly, the policy determination helps in controlling the hospital. Board of directors, executive committee and partners are the ones who control the hospital which is varied by the size of the group. In groups with four or fewer physicians, partners tend to regulate the policy whereas in a group with 5 to 99 physicians, it is controlled by the board of directors. Also, in the groups where there are 100 or more physicians, an executive committee determines policy used (Goodman, Bennet, & Odem, 1977)**.**

The administrator has the opportunity to deliver high quality care to the community through his or her leadership of a health care institution. The administrator works with other trustees to implement policies that will keep the hospitals running smoothing and efficiently (Goodman, Bennet, & Odem, 1977)**.**

The hospital administrator helps to coordinate and motivate departments to work together toward common goal. The administrator must be an expert in health care, business and personnel management and stay abreast of developments in medicine, technology and patient care (Maurer, 2012).

Income can be distributed by using a formula based on productivity.Goodman et al defined productivity in one of three ways: (a) revenue generated, (b) hours worked, or (c) patients seen in the office and at the hospital. Since it is a group practice, income distribution should be

equal unless the capital contributions made varies if it is a multispecialty group, or the income will be distributed according to the specialty and bonus or profit sharing (Goodman, Bennet, & Odem, 1977).

Furthermore, Bronson and Maxwell (2004) included that with medical group practice physicians can include series of one-on-one patient encounters in a group setting during 1 hour 30 minute visit and manage to advise each patient in front of the others. Patients benefit from better access to their physician and significantly increased education, while providers boost their productivity and access without increasing hours. Such group visits are voluntary and for established patients only (Bronson & Maxwell, 2004). The patients sign a bond of confidentiality where no information is leaked outside the group.

2.5 Advantages of Medical Group Practice

Group practices continue to form an effective strategy for meeting the demands of patients. Even though group practices may differ in structure, their members share facilities, personnel and earnings. The creation of a group practice can be looked at as an effective way of offering an integrated menu of health-related services to patients. This puts MGP in a better position to meet demand of patients. It is also known as 'One Stop Shopping' because a patient might receive all the services he or she may need from the group practice especially if it is a multispecialty group practice. Also, because they learn from each other they are able to help in the health care of patients (Practice Central, 2013).

The following below are some advantages of Group Practice:

Pooled capital: Group practices will be able to combine the capital resources of each physician in a way that gives them access to tools that might be cost prohibitive for a solo practitioner, such as start-up funding and electronic medical records.

Risk sharing: Group practices will have a greater flexibility to share the clinical and financial risks associated with business risk with owning and operating the practice.

Combined interest and talents: In some practices, one partner may be interested in overseeing or handling a portion of the business aspects of the practice, while other partners prefer to avoid such role. However, combining the strengths and interests of several practitioners can enhance the satisfaction and productivity of the members of the group and the group as a whole.

Enhanced peer consultation: Group practices offer the opportunity to share clinical and experience with other practitioners. They also provide easier access to coverage when a group member is away from the practice.

Control: Group practices may have a competitive advantage in the marketplace when it comes to referral sources. By offering the one-stop shopping desired by health care payers, multispecialty groups enhance their negotiating position.

2.6 Challenges of Medical Group Practice

Medical Group Practice is a form of private practice that most physicians in the United States will prefer to form rather than a sole proprietorship. This is

as a result of the many benefits it offers even though it comes with its own problems and difficulties. Many healthcare providers are creating their own physician group practices in order to move forward in the health care industry with a better coordination among the physicians. It must however be said that building and running a successful physician group practice has its own challenges. It takes hard work and determination to be able to overcome these challenges (Punke, 2013). Below are some challenges that are faced by group practice physicians.

- **Conflicts** – In group practices there are conflicts when one physician wants to make changes to the business and the other physicians disagree. The physicians must develop skills that will overcome conflicts so that it does not slow down the business. When the group practice is large, it ends up slowing down business because decision-making becomes more driven by policy and bureaucratic rules (eHow Health, 2012).
- **Reputation** - The reputation and practice of other physicians reflect on each individual physician. Being part of a group practice is often *"all for one and one for all"*. Therefore, everyone's capabilities and capacities affect everyone else. If one or two doctors do a poor job, it may change the entire practice's reputation.
- **Loss of Autonomy** - Being part of a team or group means giving up some individuality. Group practices tend to have more rules and formats for standardization. Doctors cannot treat in any manner they choose and they may have constraints on how they can spend money, what tests they may run and other issues (eHow Health, 2012).

2.7 Benefits of Medical Group Practice

2.7.1 Better Delivery of Services

According to Towle (1998), a revolution in health care is occurring as a result of changes in the practice of medicine and in society. These include changing demographics and the pattern of disease; new technologies; changes in health care delivery; increasing consumerism; patient empowerment and autonomy; an emphasis on effectiveness and efficiency; and changing professional roles. These challenges are being faced by the medical profession in the 21st century and to which continuing medical education must respond. The proportion of most rich countries' populations aged 65 and over will have doubled to around 20%-25%. The consequences will be a shift in the need for preventive and curative health care in the direction of chronic health problems of people and a large increase in demand for care of patients. There are greater pressures to reduce increasing healthcare costs (Towle, 1998).

That is why there is the need to use new health technologies such as diagnostic and screening techniques, medical (therapeutic) interventions and techniques for drug delivery, surgical interventions, and information technology and telecommunications. This will help the physicians to help detect the diseases fast and will help them cure the patients as quick as possible. However, not all new technologies will be adopted because of the costs involved. That is the reason why it is advisable to join hands with other practitioners to be able to buy the equipment that will be needed for the curing and detecting of diseases that affect patients (Towle, 1998).

When medical technologies are advanced, it will increase the trend to move health care away from acute hospitals into primary care. With new technologies, much more diagnosis and treatment can be done in the community or at least in daycare settings, with no need for acute hospitals. This has made it clear that there is better delivery of service if all these should be put in place.

Brugha and Zwi (1998) asserted that despite the significant successes in controlling a number of diseases in low and medium income countries, there are some important challenges that remain. One is that large proportion of patients with certain diseases seek care in hospitals that will not be able to give them quality of service. That is why most people ignore going to public hospitals because they feel there is quality of service in the private sector. The available evidence from people suggests that there are serious deficiencies in technical quality. In high income countries there are equipment that helps in the diagnosis of disease and thus help cure patient's health problems at a fast rate which will bring about a healthy country. Moreover, there is the use of technologies that will help diagnose diseases to direct the patients on the medication that is supposed to treat the ailment.

In this article, Brugha and Zwi(1998) agree with Towle(1998) that better quality of service will be complete when physicians are able to diagnose patients with the medical equipment that will help them treat the patients as soon as possible. So when hospital owners are not able to buy a sole proprietorship hospital do not have the necessary equipment to use, it slows down the hospital. This is because they will have to be transferring patients to other hospitals which the hospital might end up losing their

clients. In this case, when the hospital is a group practice, it is easier to be able to afford the necessary equipment which will help them serve their clients well. This is due to the fact that in a group practice, members of the group contribute to buying the items needed (Brugha & Zwi, 1998).

2.7.2 Flexibility

Health policy makers and health service managers are also recognising that the current structure of the health workforce is not suitable for 21st century healthcare delivery. Most countries have a problem of workforce shortages, however, the small workforce that they have also seek for greener pastures outside their countries. Although the headline problem is usually couched in terms of workforce supply, there is a problem in flexibility of the workforce (Duckett, 2005).

The focus on workforce flexibilityis associated withthespecialization of the health workforce. Specialisation which was seen to be associated with higher quality, is now seen as possibly detracting from continuity of care and hence may have a harmful impact on quality, especially in the context of the increased of chronic diseases in the health sector. The benefits of specialisation should not be lost, however, the current roles for health professionals are perceived to be inefficient. This is because more staffs are employed than would be required in an efficient organisation of roles, or staff at higher pay classifications being used to perform tasks which could be performed by staff at lower pay levels.

The inflexibility of contemporary workforce structure also inhibits service delivery because of shortages of staff to perform key roles. Policy

attention is therefore being directed towards strategies about workforce substitution and to develop skills that is to make it easy for existing health professionals to acquire additional skills to enable them to perform additional tasks. The importance of addressing workforce flexibility and the associated issue of workforce substitution cannot be underestimated. Particularly the requirements of future workforce need to make some assumptions about the mix of tasks that will be performed in the future by the health professionals. If the tasks undertaken by a medical practitioner are expanded, then more of them will be required (Duckett, 2005).

One strategy to encourage flexibility in the workforce would be to increase the range of items which do not require personal provision. These flexibility arrangements should be accompanied by educational reforms to facilitate up skilling and reskilling of health professionals. In this regard, increased graduate entry programs for health professionals, whereby graduates from other disciplines are able to undertake shortened courses to gain professional recognition, should be encouraged. Shortened courses for professionals to acquire some of the key skills beyond their normal range should also be developed (e.g. nurses to be trained in foot care) (Duckett, 2005).

According to Brooks et al (2003) there needs to be much greater flexibility of entry for qualified overseas specialists whose training can be demonstrated in a country. Another solution may be to have very senior recruits provided with “clinical mentors” for a period of time. Problems with the medical workforce cannot be viewed in isolation from the other healthcare professions, where shortages are also a challenge. In conjunction

with other members of the healthcare workforce, the role and work practices of junior doctors need to be addressed. In particular, many doctors spend significant time on "non-medical" duties that could be better completed by other staff (Brooks, Lapsley, & Butt, 2003).

These two articles discussed how flexibility is associated to medical practitioners. Flexibility as it sounds can be referred in several ways. It can be the medical practitioners being able to go on their normal errands and also know that there are people to take care of the hospital.

2.7.3 Internal Referrals

According to Forrest, et al(2000), when specialty referrals are made, primary care physicians must coordinate service delivery across settings, multiple providers and time to maintain a seamless continuum of care. Coordination involves the documentation of patient care activities, communication and the integration of service delivery into a medical home. Breakdowns in coordination hold the potential for missed or delayed diagnoses and treatment. Integrated referral care with primary care is a complex and time consuming process. The success of primary care physician's coordination efforts depends on tasks that health care providers perform (Forrest, et al., 2000). It is proposed that 3 coordination events involved in the referral process are:

1) The referring physicians communicates reasons for the referral and relevant patient information to the specialist
2) The specialist completes the referral by communicating findings to the referring physician

3) The referring physician, specialist and the patients negotiate continue care arrangements. Assisting patients in navigating the increasingly complex health care system by scheduling the consultation appointment has become another important coordination role for primary care physicians.

A stated in the third coordination process, the referring physician, specialist and the patients negotiate continue care arrangements which includes stating of prices or allowing the patient's insurance companies to pay. On the other hand, it makes healthcare very expensive for the patients. But in Medical Group Practice, whenever there is referral within the hospital, so far as the patient has been registered as a member the patient will not have to pay to see another doctor.

2.7.4 Learning from each other

Group practice learning has been common where the opportunities have existed. The services of the American Group Practice Association (AMGA), helps assist its member groups in improving the delivery of quality health care through self and shared learning activities (Casanova, Jones, & Lin, 2012). AMGA's member services assists in enhancing performance in quality, patient health, care coordination, and improved outcomes at lower costs. These services include educational conferences at the national and regional level. As part of its mission to improve members' evidence-based standards for delivering quality care, AMGA has been a pioneer in the measurement and sharing of health outcomes and other data for clinical and service quality improvement.

This effort is based upon AMGA's philosophy of "Learning from the Best; Learning from Each Other," a theme carried throughout all AMGA activities that provide venues for self- and exchanged learning. AMGA has been at the forefront in developing tools for continuously improving the quality of care provided by medical groups, and thereby improving the overall health status of patients served by these organisations. The organisation has developed and continuously refined various collaborative research and learning projects and benchmarking programs for their members.

The objective of sharing successful processes and solutions is to motivate and inspire other members to redesign their care processes to accelerate the quality improvement cycle and better meet the needs of their patients (Casanova, Jones, & Lin, 2012).

Generally, doctors within an MGP benefit from learning from each other in the normal course of their work as long as they work in a group or are closely associated with one another.

2.7.5 Less Expensive for patients

Healthcare is changing more rapidly than in any other time in recent history. One of the greatest challenges facing health care today is increasing costs. This affects every domain of healthcare including the number of uninsured, accessibility, quality and continuity, and consumer confidence in the health care system. With this, physicians accept the need to contain costs playing a role in controlling costs and consider cost-effectiveness an appropriate criterion in individual treatment decisions. While some physicians

believe it is their duty to offer patients all treatment options (including high-cost and low-benefit interventions), others believe this should be balanced with duty to use health care resources optimally (Zack, et al., 2001).

The rising cost of healthcare today can be attributed to the development and the demand for expensive medical technologies to diagnose diseases. This is true in cases where certain medical interventions diagnostic procedures, pharmaceuticals and treatments provide care at a very high cost (Zack, et al., 2001).

Healthcare forces providers to pay greater attention to quality and efficiency, with an emphasis on using the latest technologies as support. Healthcare personnel must include strategies to improve care quality, safety and efficiency as they prepare. Organizations are seeking to improve the healthcare delivery system so that they can treat patients at a cheaper price.

Medical groups already realize that increased patient volume requires more than simply adding staff. It means leveraging technology to improve care quality, access, effectiveness, efficiency and safety, which will result in delivering better service care at lower costs. When they are able to leverage cost and treat everyone as such, they will be able to achieve their aim by providing quality of service at lower cost. For instance if a patient is transferred to see a specialist in the same group practice, the person will not have to incur any cost because he or she is already registered in the group hospital.

2.7.6 Understanding and Collaboration

In current Medical and Nursing literature, various federal and provincial policy statements, and several task force reports have emphasized the need for healthcare reform to include interdisciplinary teams working in "collaboration" to provide integrated healthcare. According to Way et al (2000), collaboration is a concept that has come of age. Whether in the healthcare area, or in the global context, the players are urged to pull together to add to each one's individual part to learn from one another. Collaboration has potential to involve the client, energize the professional and integrate the healthcare system.

Collaboration is certainly about positive working relationships amongst professionals, it is muchmore. Collaboration is a way of working, organizing, and operating within a practice group or network in amanner that effectively utilizes the provider resources to deliver comprehensive primary healthcare in acost-efficient manner to best meet the needs of the specific practice population. Successful collaborationbenefits patients, providers and the healthcare setting, as illustrated by providers experienced in collaboration. Collaborative relationships are based on provider equality. This brings understanding between the providers because it is based on equality. Equality brings about understanding because everyone is equal in the group. One of the challenges of Medical Group Practice, talks about conflicts in group practices. This explains why when one physician wants to make changes to the business and the other physicians disagree, it will bring about conflict. However, Way et al (2000) disproves that facts and says in group practices there is understanding and collaboration so therefore they will try and develop ideas to help solve a problem.

In summary, collaborative practice involves working relationships and ways of working that fully utilizes and respects the contribution of all providers involved (Way, Jones, & Busing, 2000).

To address the problems that face global health, an increase in money and drugs, although positive, is insufficient. Far more important is the need to strengthen the health-care workforce in communities, districts, and nations to address the health challenges and to use the resources and interventions for effective care and management of systems (Narasimhan, 2004).

3.0 METHODOLOGY

3.1 Research methods

Exploratory research investigates a situation which helps provides insight to the study. The focus is on gaining insights and familiarity for the investigation. Exploratory research is a methodological approach that is primarily concerned with discovery and generating or building theory (Davies, 2012).

This method of research is best for this paper since it aims atinvestigating the benefits of the group practice to the private health sector in the country.The data gathering method for this paper was qualitative research method.Qualitative research method aims at gathering an in-depth understanding of human-behavior and the reasons that govern such behavior. The qualitative method investigates the 'why' and the 'how' of a decision making. Hence, smaller samples are more often needed to gather information rather than large samples (Al-Busaidi, 2008). It does this by gathering data in the form of spoken or written language. The data sources of qualitative research are having interviews with the participant, group discussions and observations. The data are usually transformed into written text for analytic use (Polkinghorne, 2005).

Qualitative data was used suitable for the purpose of this study. This is because the research is based on opinion of respondentsregarding medical group practice as being beneficial to the private health care sector. Secondly, the paper aimed at answering a 'how' question based on the variables of information.

Data was gathered from both primary and secondary sources. The primary data was useful for finding out the benefits of medical group practice in Ghana since there is not much scholarly information about it in the country. Data gathering from primary sources was first-hand information on the opinions about the topic from the respondents. Primary data was gathered through interview.

The secondary data was gathered on the meaning of medical group practice as well as identifying the theories on MGP. The secondary data was gathered online from articles on group medical practice, scholarly journals, and group practice websites.

Operationalisation

Medical Group Practice: Medical group practice in this context refers to a form of private health sector where it involves a group practice of doctors to help each other in terms of costs, flexibility of work and generation of revenue for the hospital. It is not known practice in Ghana.

Private Health Care Sector: Private Health care in this context is a common practice in the hospital set-up in Ghana. It is normally owned by one person who ends up putting all his or her resources in to the practice.

Investigating benefits: Investigating benefits seeks to find out the benefit of group practice in Ghana.

3.3.Sampling strategy

3.3.1 Description of sample

In gathering primary data, three categories of people were chosen: doctors, administrators of hospitals and a director of Private Hospital and Maternity Homes Board.

The doctors were selected based on the issues raised.Some of which includes revenue generation, shared cost and flexibility. This is because before the doctor comes into terms with other doctors to work together, there must be an agreement which is to accept to be part of the contract.

The administrator handles all the everyday affairs of the hospital (human resource, financials and any capital investments). He or she is in charge of what goes on in the hospital.

Lastly the director of Private Hospital and Maternity Homes Board is the overall boss of private hospitals in the country and can decide to add or take out some processes in Private Hospitals.

3.3.2 Sampling method

The purpose of sampling was to improve the quality of findings by ensuring that the units studied are representative of the broader population. Purposive sampling was used in selecting the sample. Purposive sampling which is known as judgmentalor subjectivesampling is a type of non-probability sampling technique. Non-probability sampling focuses on

sampling techniques where the units that are investigated are based on the researcher's judgments.

Therefore, in this method of sampling the researcher selects the people to be included in the sample. Purposive sampling is useful in identifying individuals who are likely to give detailed information concerning the research topic. It was used in selecting the hospitals that are going to be part of the sample for the study. The research method is appropriate for this study because the study aims to get an in-depth understanding of the study(Laerd Dissertation, 2012).

3.3.3 Sampling size

The sample size was made up of doctors, hospital administrators and the director of Private Hospital and Maternity Homes Board.The sample size of 46(from10 hospitals)was used. Four branches of medicine were sampled from each hospital in addition to the hospital administrator. These branches are:

- General practitioners
- Gynecologists
- Pediatricians
- Surgeons

One doctor from each of the categories were sampled in every hospital excluding the hospital administrator who brought the sample size of each hospital to five. In addition, the Director of the Board of the Private Hospitals and Maternity Homes Board (PHMHB) was interviewed to get views on the research topic.

This study was focused on the doctors of Private Hospitals because they are the main focus of the study. This was due to the fact that they were able to tell the difference between Medical Group Practice and a sole proprietorship.

3.4. Data collection method

The information for this study showed the benefits of MGP to the Private Health Sector in the country. It explained the theory that was proposed that the benefits of MGP are beneficial to physicians as well as to the patients. Therefore, the data gathered will be togive information relating to the better private hospital practice in the country.

3.4.1 Primary data

This paper made use of analysis in gathering primary data. The data that was gathered was the knowledge the respondents have about Medical Group Practice. Interviews were conducted because they generally take more time and result in detailed answers. It is helped get the attention of the respondents since it was a one-on-one interview.

The interview was structured such that it was at the convenience of the interviewees. In addition, considering the experiences and the knowledge gained from working and learning of the respondents, they will be in a better position to offer relevant answers.

3.4.2 Interview

The interviews conducted were semi-structured format. A semi-structured interview is a qualitative method of inquiry that combines pre-determined set of open questions with opportunity for the interviewer to explore particular themes.

A semi-structured interview does not limit respondents to a set of pre-determined answers. It allows respondents to discuss and raise issues that may not have been considered (Evaluation Toolbox, 2012). In relation to what has been mentioned a semi-structured interview was conducted to allow additional information that were not included in the questions but will be helpful for the study.

The questions used for the interview were open and closed ended.Open-ended questions are meant to gather more information through elaboration and explanation whereas closed-ended questions are asked to verify and confirm, usually producing only simple and specific answers (Exforsys Incorporation, 2009). Closed-ended questions are used because they target a specific answer or information. The study will need to clarify the benefits of MGP to the Private Health Care Sector in the country.

3.4.3 Secondary data

Secondary data was collected from academic journals, websites in general and websites for hospitals. The purpose of the secondary data was to support the data that were received from the primary data. Some of the sources that were relevant secondary data were online websites of foreign hospitals that practice Group Practice.

The information collected from secondary data helped know the reasons for MGP been preferred in countries that are practicing it. It gave more information about how the challenges are overcome.

3.5 Data collection procedure

The following steps below shows how the data was collected.

Step 1: Identify the needed information.

Step 2: Selecting the sample

Units of analysis: Private Hospitals and Private Hospital and Maternity Homes Board

Sample size: 10 hospitals; Doctors, Hospital Administrators and the Director of Private Hospital and Maternity Homes Board

Sample method: Purposive sampling

Step 3: Preparing of interview guide questions

Step 4: Conducting interview

The hospitals were visited to know when it was suitable for the interview to take place.

The selected hospitals were visited and an interview was conducted with the doctors and hospital administrators.

3.6 Data analysis

Qualitative data was collected from the interview sessions. Descriptive analysis was employed to interpret the information that was acquired during the data gathering stage.

3.7 Limitations of the of the study

The limitations of the study are:

- Time constraints in interviewing
- Availability to talk to doctors

4.0 ANALYSIS AND DISCUSSION OF RESULTS

4.1 Introduction

The earlier chapters dealt with the background of the study, problem statement, importance of the study, the literature review, the methodology and its limitations. The information from this chapter will allow us to reveal the various benefits of Medical Group Practice to the Private Health Care Delivery as revealed by doctors in the country. Responses were received from doctors, hospital administrators and the registrar of Private Hospital and Maternity Homes Board.

The purpose of this chapter is to analyze and discuss the findings of this study. It presents the data that was obtained from the study in response to the specific research objectives and questions that were outlined in the first chapter. This section presents a qualitative analysis of the data which represents the findings of the interviews.

4.1.1 Hospital Profiles

On the whole, ten hospitals were chosen for the study. These hospitals were chosen as the sample size to represent the population. Hospitals were selected from Spintex, Tema, Nungua, Sakumono, Teshie Nungua and North Kaneshie.

This was done in order not to receive biased responses. This is because if the selection should have been done in one particular locality, the responses may

be skewed. The hospitals are Prima Health Services, Rophi Hospital, Raphal Health Centre, Port Medical Centre, Trust Hospital, Family Health, Christian Medical Centre, Sakumono Community Hospital, Cocoa Clinic and Holy Trinity Hospital. All the hospitals have different categories of medical Practitioners. The responses were from four categories of medical practitioners and the hospital administrator namely; General Practitioner, Surgeon, Pediatrician and Gynecology.

The registrar of Private Hospital and Maternity Homes Board was also interviewed. Private Hospitals and Maternity Homes Board is the governing body of Private Hospitals and Maternity Homes. They also help in registering hospitals during set up.

This study set out to find out about the benefits derived from Medical Group Practice. The following were revealed by the study:

4.2 Challenges of Private Hospital

Private Health Care delivery in Ghana is faced by major challenges that hinder their performance and growth. Whenever a Private Hospital is established, some major challenges have affected their service delivery, performance and growth. The major challenges facing Private Hospitals were identified from the research as:

- High Start Up Cost
- High cost of Capital/Borrowing cost
- Low consumer repayment

4.2.1 High Startup Cost

Hospitals generally require large startup capital. Thenature of the business is capital intensive. Key equipment required for diagnostic purposes are sometimes prohibitively expensive for a small private firm. They are however required if one is to give quality service to clients. Due to the expensive nature of these equipments and its lack thereof in private hospitals, patients are sometimes referred to other hospitals for treatment. This means more cost in the form of consultation fees at the new hospital and also inconvenience. This lack of care in one central location can sometimes lead to death of patients.

To ensure one has all these equipment present in a private firm, a large initial cash outlay is required. This will usually have to come from personal savings or from borrowings. Since it is difficult to usually have personal savings huge enough to start projects of this nature, most people will resort to the bank for lending. Our banking system is Ghana, is not flexible enough to give people access to huge sums of money required for these purposes and thus one has to scale down the size of the hospital and sometimes lead to the unavailability of some vital tools and equipment required for optimal operation.

4.2.2 High cost of Capital

One option for the startup businessman is to acquire loan from the banks. Loans do not come cheap and most often one has to go through complex processes to access them. A loan process can take months from

start to completion. Sometimes, people are required to bring large collaterals in the form of landed properties. This makes it difficult for people to access them. When one is able to provide these, the interest payable on the loan is prohibitive. Ghana currently has one of the highest loan interests in the world. Thus profits of the business will be spent in servicing the loan interest repayments and thus restricting the growth of the firm. It also does not allow one to take such initiatives since one cannot reap the benefits of their investments until the loan debt is settled which could take years.

4.2.3 Consumer Repayment is low

Due to the high cost of initial startup with its attendant high interest payments (borrowed funds), the charge for services rendered at the hospitals becomes too high. Some patients may default on payments and lead to the business becoming cash trapped to carry out essential expansion.

4.3 Answering the Research Question

In answering the objective of this study, the benefits derived from practicing Medical Group Practice will be outlined and discussed. The question for this study is "How beneficial is medical group practice to the private healthcare sector in Ghana?"

4.3.1 Definition of Medical Group Practice

The American Group Practice Association(2012) defined MGP as the provision of healthcare services by a group of at least three licensed physicians engaged in a formally organised and legally recognised entity; sharing equipment, facilities, common records and personnel involved in both patient care and business management. With reference to the respondents,

the definition to the practice tends to be good. They describe this to be a combination of resources from physicians to set up a hospital to be able to provide quality health care to their clients and at affordable prices.According to the response from the registrar of Private Hospital and Maternity Homes Board, it is a good practice because of the shared costs among the physicians. In effect this definition of MGP explains what is done within the hospital when it is set up.

The respondents believed that there are certain benefits that are gained from the MGP and as such overcomes the disadvantages of Private Health Care. The benefits of MGP mentioned during the interviews of medical practitioners are as follows:

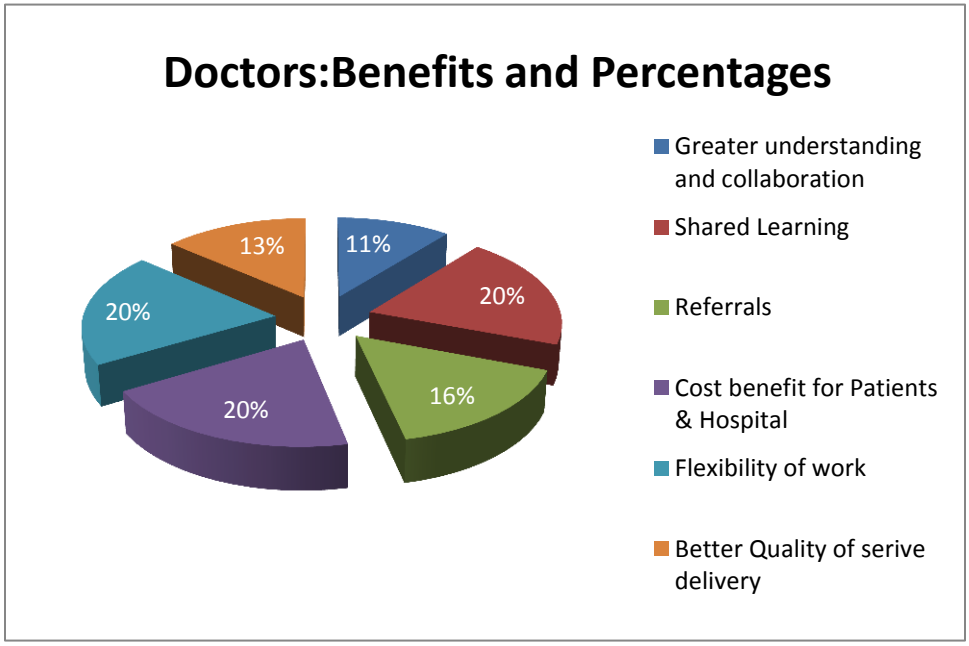
4.3.2 Benefits by Doctors

This is a table representation of the benefits mentioned by the medical practitioners

Table 1

DOCTORS		
BENEFITS	Frequency	% of Frequency
Greater understanding and collaboration	19	11
Shared Learning	35	20
Referrals	28	16
Cost benefit for Patients & Hospital	35	20
Flexibility of work	35	20
Better Quality of serive delivery	24	14

Chart 1: This is a pie chart representation of the benefits in the table.



Source: Field Data

Every respondent in this category mentioned various benefits they think would be derived by being in a group practice. However, because almost all the physicians have been practicing for more than 7 years, they displayed high levels of knowledge about the field of study. The benefits mentioned includes less expensive health care for patients and physicians, physicians learning from each other, internal referrals and thus low costs, greater

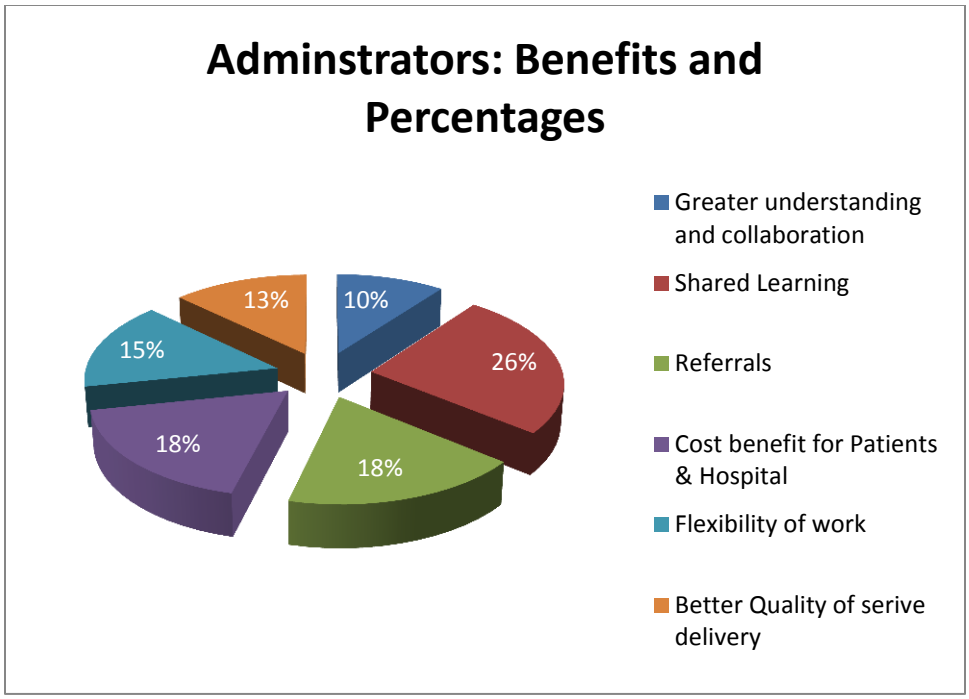
understanding and collaboration, flexibility and better delivery of service. From the data above, 13% respondents believe it allows for better delivery of service, 20% responded to the fact that it is flexible, 20% responded to the its been less expensive to patients and physicians, 16% responded to the advantage of referrals of patients, 20% also responded that the physicians will learn from each other and 11% responded that there is greaterunderstanding and collaboration. The physicians also attested to the fact that it is a good practice but also admit that the difficulty is in the willingness of people to set it up.

4.3.3 Benefits Identified by Administrators

Table 2: This is a table representation of the benefits mentioned by the administrators.

HOSPITAL ADMNISTRATORS		
BENEFITS	**Frequency**	**% of Frequency**
Greater understanding and collaboration	4	10
Shared Learning	10	26
Referrals	7	18
Cost benefit for Patients & Hospital	7	18
Flexibility of work	6	15
Better Quality of serive delivery	5	13

Chart 2: This is a pie chart representation of the benefits in the table of Hospital Administrators.



Source: Field Data

The benefits mentioned by the hospital administrators includes less expensive medical costs for patients and physicians, physicians learn from each other, for internal referrals, greater understanding and collaboration, flexibility and better delivery of service. These were the same as mentioned by the physicians. From the data above, 13% responded to it as beenbetter at delivery of service, 15% responded to the fact that it is flexible, 18% responded to the its been less expensive to patients and physicians, 18% responded to internal referrals of patients, 26% also responded that the physicians will learn from each other and 10% responded that there is greater understanding and collaboration.

4.3.4 Reduced Cost for Starting up the Hospital

Every organisation requiresan initial healthy dose of funds to set up. The amount of money needed to start-up the business is known as capital. 18% of the response from the hospital administrators indicates that MGP reduces cost of setting up. This is also supported by 20% of the physicians. During the interview both respondents including the Registrar of PHMHB mentioned that MGP as a form of private health care is less when setting up. This is due to the shared costs and risks by the people who come together to initiate the process.

In a private-owned hospital because the hospital is started by mostly one person, it becomes expensive to start. However, they end up going for loans from the bank to help them start. The loan process is cumbersome and when granted is paid back with huge amounts interest payments. When this happens, the process ends up adding to the cost of running the hospital and this may in turn transferred to the patients making access very limited to people with enough funds to spend.

In MGP,a larger group of people agree to come together to set up the practice.Therefore, this makes contributing towards the start-up of the hospital cheaper than that of an individual set up. Contributions can take various forms depending on the agreement reached within the group. This could be cash, space or equipment but this ensures that there is no too great strain placed on an individual’s resources.

4.3.5 Better delivery of service

Clients of a hospital always ask for better delivery of service. Clients want to be able to have confidence in wherever they seek health care. However, they rather fall on hospitals that are able to provide services that are affordable to them not necessarily of high quality. 13% of respondents in both groups mentioned there is better delivery of service in a group practice. This comes from having people with all kinds of skill in the hospital. The combination of expertise in various areas of healthcare ensures that the best is given at any point in time. Shared ideas by the various owners will ensure that the best diagnoses are given for conditions. There is also the need to have all the essential equipment that the hospital required in order to function. With the shared responsibility, these are possible and hence allow doctors to give off their best. The level of interest the doctors also have in the success of the hospital allows them to take all the appropriate measures to ensure all hired hands work at the highest level of capability and ethics.

During the interview with the Registrar of PHMHB, it came to light that in order for a hospital or a group practice to be able to deliver better service to their clients, there should be most of the equipment that will be needed in diagnosing the ailment of the patients so that he or she will be treated as such. This response is in agreement to the literature by Towle(1998) and Brugha and Zwi(1998) which says that hospitals with a revolution in health care are occurring as a result of changes in the practice of medicine and in society. These include changing demographics and the pattern of disease; new technologies; changes in health care delivery and an emphasis on effectiveness and efficiency. Also, these challenges are being faced by the medical profession in the 21st century and to which continuing medical

education must respond. The consequences will be a shift in the need for preventive and curative health care in the direction of chronic health problems of people and a large increase in demand for care of patients. There are greater pressures to reduce increasing healthcare costs.

That is why there is the need to use new health technologies such as diagnostic and screening techniques, medical (therapeutic) interventions and techniques for drug delivery, surgical interventions, and information technology and telecommunications. This will help the physicians to help detect the diseases fast and will help them cure the patients as quick as possible.

4.3.6 Flexibility for physicians

Private health care facilities may be owned by an individual orthree or more partners. In private health care delivery the owners employ workers such as nurses, doctors, and administrators to work with. In this form of employment, doctors do not have the required flexibility to conduct other businesses or engage in any other activities outside their scope of work or employment. This is because working hours and other benefits of the employment are dictated by the owner of the business.

However, an MGP allows doctors lot of flexibility. This is especially so when there are more than one specialty in the partnership. This ensures that there is always someone in a specialty to consult in any event thus allowing the rest to schedule other businesses or activities within their working hours knowing well that there is someone to carry out their duties.

According to respondents (15% of Administrators and 20% of doctors) agree that there is great flexibility in a group practice. Respondents intimated that an MGP will give them the opportunity to pursue other areas of interests to them without having to worry about their absence.They also indicated that the larger the group, the higher the level of flexibility one can enjoy in the partnership. According to them, their current jobs limit their ability to do anything outside the normal hours of employment like furthering their education or any other activities that even inure to the benefit of the hospital they currently practice in.

4.3.7 Internal referrals for patients

16% of doctors, 18% of administrators and the registrar of PHMHB mentioned there that there are internal referrals of clients in an MGP. Referrals happen when a patient is transferred from one specialty to the other within the same hospital. One specialty can transfer a patient during consultation to another specialty within the same hospital based on symptoms described.

Internal referrals are beneficial both to the hospital and the patient. To the patient, referral is a way of savings money as the patient will not have to pay another consultation fee to access another specialty. To the hospital, referral allows a patient to choose them as the first choice of healthcare.

According to the respondents, MGP allows for referrals since patients data will be shared among the doctors. Also, since there would be more than

one specialty doctor in the group, a patient will not have to be referred to another hospital for treatment. According to respondents, patients will benefit immensely as their cost of healthcare will be minimized and the quality of healthcare they access will improve dramatically. Respondents also recognized the fact that, the quality of healthcare that will be introduced into the medical system will serve as the bar for other medical institutionsto measure themselves by.

The respondents also indicated that referral system will make the hospital the first choice of medical care as patients will be assured of quality service without worrying about high costs and the confusion of whether their conditions demands another medical facility or not.

4.3.8 Shared learning among doctors

20% of doctors, 26% of administrators believe that an MGP will allow for shared learning among doctors in the same specialty group. They believe that when physicians learn from each other, they acquire more knowledge concerning their field of work. In relation to health care when physicians share knowledge from their practice, they will be able to help the hospital deliver better quality service to their clients.

Group practice learning has been common where the opportunities have existed. The practice will help assist its member groups in improving the delivery of quality health care through self and shared learning activities. The learning from the physicians in the group will help the members assist in enhancing performance in quality, patient health, care coordination, and improved outcomes at lower costs.

4.3.9 Reduces cost for patient care

MGP helps to cut down costs for patients and this is confirmed by 18% of administrators, 20% of doctors who responded to questions. They believe this is possible due to several factors which give cost advantage to an MGP. One of such factors is referral which allows a patient to be referred internally without having to pay any extra cost of consultation. Also, scale allows for acquisition of inputs at a much cheaper costs and also the utilisation of advantages of scale in labour.

Not only does scale help them acquire inputs cheaper but also increased client base means increased income which allows for better remuneration of workforce. Happy workforce will give better quality of service and ensure a continuum of the cycle.

4.3.10 Collaboration and Understanding

A successful MGP requires great collaboration among the partners. MGP requires this in order to take decisions that will inure to the benefit of the hospital. Since decision making is an important part of any business, the level of understanding required in any partnership will have to be high

According to respondents, 11% doctors, 10% administrators and the registrar of PHMHB mentioned that an MGP will increase the collaboration that exists among doctors. Since MGP will have to be formed based on trust, the level of collaboration that will be expected from the partners will be high.

4.3.11 Inhibitors to the practice of MGP in Ghana

According to the respondents, despite the numerous advantages of that an MGP will give in the practice of medical healthcare in Ghana, there are many inhibitors of its practice as well.

According to the respondents, one such inhibitor in Ghana is the poor accounting system that exists in such partnerships. This happens when partners are able to withdraw money from the business funds and apply it to their own means without prior approval. This they fear will lead to misappropriations since a lot of people may be too reliant on the business funds and not treat the business as an entity separate from them.

This means that, partners within an MGP will have a certain level of distrust for each other and this will not be best for the operation of the business.Ideas of everyone will be second guessed and mistrusted leading to long delays in decision making and sometimes the wrong decisions being made due to the mistrust of one member of the partnership.

Also, since this is a new concept in Ghana, respondents believe that the most viable option will be to form a small scale MGP. This means a limitation to the number of people who will form this. Based on the success story, the membership can then be increased. However, this also brings in an added complexity about funding. Since the number of doctors will be small, the initial outlay of cash will also need to be substantial. Due to the difficulty of banks to give borrowing and the interest charges, doctors may not be willing to take that risk of having to borrow from the banks to finance this.

5.0 CONCLUSIONS AND RECOMMENDATIONS

5.1 Introduction

This chapter gives the conclusions and recommendations of the researcher based on the findings discussed in the last chapter. These recommendations when applied has the potential of ensuring the successful formation and operation of an MGP in Ghana to bring more competition and better quality care into the healthcare system on the country.

5.2 Summary

In summary, an MGP practice in Ghana will be one great alternative to the traditional system of healthcare delivery with shared costs being the biggest driver of this form of practice. The relative ease with which this form of practice can be formed compared to the traditional form will ensure that the country has a healthcare system that can absorb the number of patients that want to access healthcare every day.

However, this system lacks exposure and a lot will have to be done on this front to expose doctors to the idea. The recommendations of the researcher will go a long way to bring about the desired change in the sector.

5.3 Recommendations

5.3.1 Education by the Ministry of Health

The Ministry of Health can serve as one channel through which the practice of MGP can gain a foothold into the country. As part of their duties, they may want to take up the challenge of educating doctors to consider

going into an MGP as an alternative of seeking employment in existing hospitals. This will also help to increase the number of hospitalsthat serve the communities within their localitymaking accessibility easier and convenient for the patients. This will encourage doctors who have not considered that form of partnership to start the idea on a small scale and grow it into a successful alternative to the one man private hospital system.

The Ministry of Health can also take it upon itself to have a support division that helps doctors who consider this setup through the legal requirements to business structures where the doctors may not have the required expertise. The support division will also be able to give the required trainings in management and other needed areas to ensure that the right decisions are being made that will benefit the organisation and its client base as well.

5.3.2 Government Support for funding

Due to the high initial cost associated to forming a small scale MGP, doctors who may consider this form of business will require some level of support to acquire funding from the banks. A special fund can be set aside through which the doctors can access as a group to form the partnership. This will ensure shared risks and responsibility.

The government may also partner with the banks to arrange special funding for the initial startup capital of MGP's and offer flexible repayment terms so as to encourage them to take on the risk of this business.

Corporate businesses dealing in medical inputs can also offer hire purchase agreements to people willing to form MGP's so they can acquire the vital

medical equipment that will be required for the startup of the business. Since the equipment required forms the highest cost to any startup in this field, such an agreement will be of immense benefit to the medical field in Ghana.

5.3.3 Strong business structure

To enable an MGP in Ghana to function, the issue of trust within the partnership must be resolved. The most efficient way to resolve this is to ensure strong initial business structure. This can be achieved by ensuring that the agreement forming the MGP has clear rules about the roles and responsibilities of every single partner. Benefits must be stated clearly and penalties for any form of malfeasance must also be made clear. When these rules are in place, the partners can be assured of the safety of their investments and all work will be focused on ways to ensure profitability and the growth of the organisation.

5.4 Conclusion

The study primarily focused on ascertaining the benefits of the practice of MGP in Ghana. This study gathered data from physicians in the practice, hospital administrators and the director of Private Hospital and Maternity Homes Board. The opinions gathered revealed a general acceptance by medical practitioners in the country. There is the belief that, this system is agood alternative to the current private healthcare system practiced in the country.

Respondents agree that this type of medical practice has numerous benefits that inure to the benefit of the practice and to the patients. This will increase the quality of service rendered in the sector.

Despite the advantages mentioned, there is the general lack of willingness on the part of doctors and other healthcare professionals to partake in this form of business. Reasons mentioned range from initial cash outlay, general distrust of other members who may form the partnership and the expected low level of collaboration this may bring among other reasons.

The forgoing are some proposals about how to overcome the mentioned reasons as this form of business has advantages outweighing the disadvantages outlined.

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APPENDIX 1:

INTERVIEW GUIDE

This is a study being carried out by an undergraduate student of the Ashesi University College on medical group practice in private health facilities in Accra. Your responses to the interview questions will only be used for academic purposes and confidentiality is assured.

DOCTORS

WARM-UP QUESTIONS

1. How long have you been in practice?
2. Do you work in more than one hospital?

MAIN QUESTIONS

3. Have you heard of Medical Group Practice?
4. What comes to mind when you hear of it? Are there other names for it?
5. Do you know of any hospital practicing it?
6. What do you think will be some of the benefit of owning a health facility with other doctors?
7. What do you think will be some of the benefit of working with other doctors?

HOSPITAL ADMINSTRATORS

WARM-UP QUESTIONS

1. What are your duties as a hospital administrator?

MAIN QUESTIONS

2. Who owns the hospital? Is it one person or more than one?
3. Have you heard of Medical Group Practice?
4. What is Medical Group Practice?
5. Do you know of any hospital practicing it in Ghana?
6. Will you like to work as an administrator with a group of doctors?
7. What do you think are the benefits that can be derived from Medical Group Practice?

PRIVATE HOSPITAL AND MATERNITY HOMES BOARD

WARM-UP QUESTIONS

1. What are your duties as the head of the board?

MAIN QUESTIONS

2. How many types of health institutions do we have in Ghana?
3. What are some of the challenges of operating a Private-Owned Hospital?
4. Have you heard of Medical Group Practice?
5. What comes to mind when you hear of it? Are there other names for it?
6. Do you know of any hospital practicing it in Ghana?
7. What do you think are the benefits that can be derived from Medical Group Practice?