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Article

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ACCOUNTING, CORPORATE GOVERNANCE & BUSINESS ETHICS | RESEARCH ARTICLE

Accountability and transparency: Is this possible in hospital governance?

Patience Aseweh Abor¹ and Carlos Kokuvi Tetteh^{2*}

Abstract: Health institutions in developing countries need to be transparent and accountable to attain universal health coverage and effective institutions as mandated by Sustainable Development Goals (SDG) 3 (*target 3.8*) and SDG 16 (*target 16.6*), respectively. This study seeks to achieve two objectives: 1) to examine financial, performance, and political or democratic accountability at the teaching hospitals in Ghana toward achieving good hospital governance; 2) to examine event and process transparency practices in the teaching hospitals. A comparative case methodology was employed with data from structured questionnaires administered to hospital administrators. The study revealed only one of the four teaching hospitals under study is accountable in terms of financial, political/democratic, and performance accountability. Also, the same teaching hospital was found to practice both process and event transparency, establishing the correspondence between accountability and transparency. The study concludes that most of the teaching hospitals in Ghana have challenges with accountability and transparency at varying intensities. Thus, efforts to ensure accountability and transparency are recommended for quality healthcare delivery and good hospital governance.

Subjects: Governance; Performance Theory; Health & Society

Keywords: accountability; transparency; hospital governance; teaching hospital; Ghana

1. Introduction

The United Nations, in its quest to ensure universal health coverage, recognizes the need for accountability and transparency, non-discrimination and inclusive participation, in ensuring effective curtailment of corruption (United Nations General Assembly Human Rights Council, 2015; United Nations Office of the High Commissioner for Human Rights, 2018). Accountability and transparency practices have emerged as essential tools for addressing both development problems and democratic deficits in the past two decades (Kim, 2018). According to Dubnick and Yang (2011), institutions must be responsible as they exist to fulfill key and essential activities that are depended on by both individuals and the state. Both the state and individuals depend on the effective and efficient performance of organizational tasks that comprise service delivery such as education, health, security, justice, etc. (Mandefro et al., 2011, as cited in; Mcloughlin, 2015).

According to Tisé (2010), accountability is the process of holding people responsible. According to Fox (2007), transparency is seen as a necessary but insufficient condition for accountability and

the prevention of corruption. From the viewpoint of Schnackenberg and Tomlinson (2016), transparency requires that individuals are fully informed about how and why policy decisions are made. Understanding how decisions are taken necessitates knowledge of the procedures that are followed as well as the criteria that policymakers use in making decisions. Accountability and transparency remain one of the most important aspects of corporate governance because they ensure management does not engage in unethical or illegal behaviour as their actions may always be scrutinized (Meijer, 2014). According to Gaventa and McGee (2013), transparency improves control as well as behaviour, thereby supporting effective accountability for performance outcomes. When corporate governance practices like accountability and transparency are highly implemented within an organization, the entity is more likely to produce higher results.

As suggested by the World Health Organisation (2019), quality care, efficiency, responsive service, and fairness are all expected across all hospitals, considering that healthcare activities make a significant contribution to a nation's socio-economic growth. These expectations pose significant challenges not just for healthcare providers but for boards of directors of hospitals, who are expected to have appropriate governance structures, processes, and policies, as well as well-defined accountability (Atela, 2013). Accountability and transparency have become increasingly important as the scale and scope of healthcare bureaucracies present in both the public and private sectors give healthcare actors considerable power over people's lives and well-being.

Ghana has enhanced its financial accountability framework through the introduction and revision of various laws, including the Financial Administration Act, Financial Administration Regulations, Procurement Act, Internal Audit Agency Act, and Audit Service Act. Simultaneously, significant improvements have been made in its public finance management systems (CTAP, 2022). The government has adopted the Medium-Term Expenditure Framework (MTEF) as its budget preparation system, categorizing budget expenditures into administrative and economic functions. Regarding expenditure control, internal audit procedures have been strengthened with the establishment of an independent internal audit agency (CTAP, 2022). Moreover, the government has replaced the core accounting system with the computerized Budget and Expenditure Management System, while the payroll system has transitioned to the Integrated Personnel and Payroll Data System. Government funding allocated to the healthcare sector in Ghana follows a meticulous process, like the withdrawal of healthcare expenses. Regular internal and external audits play a crucial role in ensuring the responsible and efficient utilization of healthcare resources, aligning with the overarching objectives of the health sector (CTAP, 2022).

Do the teaching hospitals in Ghana engage in financial, political/democratic, and performance accountability? Is event and process transparency implemented in the teaching hospitals in Ghana? By providing evidence of financial, political, and performance accountability procedures in Ghana's teaching hospitals, this study is expected to contribute to the body of knowledge on good hospital governance. The study seeks to achieve these two objectives; 1) to examine financial, performance, and political or democratic accountability at the teaching hospitals in Ghana; 2) to examine event and process transparency practices in the teaching hospitals. This study's focus is on health sector accountability and transparency, which is lacking in the literature on developing countries and relevant for Ghana.

Most empirical studies examined accountability and transparency in the public sector, especially civil society and the petroleum sector (see Acheampong et al., 2023; Ackah et al., 2020; Van Gyampo, 2016). This study, however, focuses on Ghana's health sector accountability and transparency, specifically the teaching hospitals being the pinnacle of health institutions in Ghana and the health sector being one of the key sectors for growth and development of the Ghanaian economy. Thus, the study seeks to make three contributions to the existing literature. First, the study fills the gap in the literature on accountability and transparency practices at the teaching hospitals in Ghana, as no study on accountability and transparency has focused on the teaching hospital, though a study has been conducted on social accountability in the health sector at the

macro level (see CTAP, 2022). Secondly, the study adds to existing literature on accountability and transparency in developing countries. Thirdly, the study's focus on accountability types (financial, performance, and political or democratic accountability) and transparency types (event and process transparency) is lacking in existing literature in the healthcare sector. Given these three contributions, the study provides evidence for the Ministry of Health to enact policies toward ensuring accountability and transparency in the healthcare sector of Ghana

The remainder of the study is organized as follows: Section 2.0 presents the background, whereas Section 3.0 reviews the theoretical literature, and Section 4.0 presents the empirical literature and hypotheses development. Section 5.0 emphasizes the research design, Section 6.0 presents the empirical results and discussion of the findings, and Section 7.0 provides the summary and conclusion.

2. Background

In Ghana, the apex of the healthcare sector's governance framework is occupied by the Ministry of Health (MOH), which holds oversight over the entire healthcare sector (Abor et al., 2008). The MOH carries out a range of responsibilities, including the formulation of health policies, resource mobilization, monitoring, and regulation of healthcare delivery by various agencies (Ministry of Health, 2023). Additionally, a significant role of the MOH is to craft effective policies that ensure the adequate production of a suitable number and mix of healthcare personnel, the equitable distribution of the healthcare workforce, the adoption of appropriate retention strategies, and the implementation of performance-related reward systems (MOH, 2023). These measures collectively align with the MOH's vision of enhancing the well-being of the people of Ghana.

According to the COVID-19 Transparency & Accountability Project (CTAP) report, research on accountability and transparency (A&T) in the health sector in Ghana is crucial for several reasons (CTAP, 2022). According to the report, A&T plays a pivotal role in shaping healthcare policies, improving service delivery, and ultimately enhancing the overall health outcomes for the Ghanaian population (CTAP, 2022). The CTAP report added that A&T research can shed light on the quality of healthcare services in Ghana and help identify areas where improvements are needed, whether it's in the availability of medicines, the competence of healthcare providers, or the cleanliness of healthcare facilities. The CTAP report also emphasized that research can help determine whether resources allocated to the health sector are being used efficiently and effectively, uncovering instances of misappropriation, corruption, or inefficiencies in the allocation of funds (CTAP, 2022). Thus, A&T can reveal disparities in healthcare access and outcomes among different regions and populations in Ghana. This information is essential for policymakers to ensure that healthcare is distributed equitably, as the study includes four selected teaching hospitals in Ghana that provide tertiary care to most Ghanaians.

Transparency and accountability are essential for building and maintaining public trust in the healthcare system. When citizens can see that healthcare decisions are made fairly and resources are used judiciously, they are more likely to trust and engage with the healthcare system. Research on A&T can evaluate the performance of government agencies responsible for healthcare delivery and assess whether these agencies are meeting their objectives and delivering on their promises to citizens. Ghana faces challenges related to corruption in the health sector. For instance, in the 2006 Global Corruption Report by Transparency International, Ghana's healthcare sector was depicted as afflicted by corruption, revealing instances of bribery and fraudulent activities spanning various aspects of medical services (Nordberg & Vian, 2008; Ofori-Atta & Gadzekpo, 1999). Studies on A&T can help identify corrupt practices, their root causes, and potential solutions to mitigate corruption's impact on healthcare. The findings can inform the formulation of evidence-based policies and strategies to address healthcare challenges by providing policymakers with valuable data to make informed decisions.

Ghana receives significant international funding for its health sector. Accountability and transparency research can help ensure that these funds are used efficiently and following the stipulated

requirements, preventing misuse and potential funding cuts. Research can evaluate the effectiveness of existing accountability mechanisms, such as audits, oversight bodies, and whistle-blower protection programs. This can lead to the strengthening of these mechanisms or the development of new ones. Studying accountability and transparency in healthcare systems globally can provide insights into best practices that Ghana can adopt to improve its healthcare system. Health sector governance plays a crucial role in shaping economic growth, social progress, development, and the achievement of Sustainable Development Goals (SDGs) in low- and middle-income countries (Siddiqi et al., 2009). It involves delegating decision-making authority to governing bodies, with the execution of these decisions overseen by one or more institutions. These systems are designed to ensure accountability and monitor progress (Ciccone et al., 2014). In the context of healthcare services, the implementation process requires the involvement of three key groups: policymakers, service providers, and citizens or clients. Thus, health system governance encompasses the actions and mechanisms used by society to effectively promote and protect the health of its people (Dodgson et al., 2017).

3. Theoretical literature review

Accountability is a governance concept with its roots in the Latin word "*accountare*." Its introduction can be traced back to the early 13th century in the UK, where it was used to provide a list of possessions to the king. In contemporary terms, "accountability" can be succinctly defined as a "social relationship or mechanism that entails a duty to clarify and validate one's actions" (Bovens, 2010). The term "accountability" has been employed interchangeably with a range of concepts, including attributability, blameworthiness, enforceability, liability, obligation, responsibility, responsiveness, and transparency. Prior research has traditionally regarded accountability from the perspectives of normative or virtue concepts (Bovens, 2010), and these viewpoints have exerted an impact on how accountability is defined and conceptualized in both research and practical contexts (de Maillard & Savage, 2022; Khotami, 2017; Williams et al., 2022).

Brinkerhoff's (2004) conceptual model of accountability outlines three types, namely, financial, performance, and political/democratic accountability. Financial accountability ensures proper resource allocation and use through budget or accounting controls and participatory budget processes. Performance accountability examines the degree to which outputs fit with predetermined performance targets. Political/democratic accountability measures how well governments and institutions keep their commitments, act in citizens' best interests, and respond to social requirements (Brinkerhoff, 2004; Ferri & Zan, 2018). For service providers, accountability is based on the quality of care provided to patients (Price et al., 2015). Financial accountability and health system performance accountability are interrelated to some extent. However, financial accountability is largely focused on procedural compliance, whilst performance accountability is particularly concerned with outcomes.

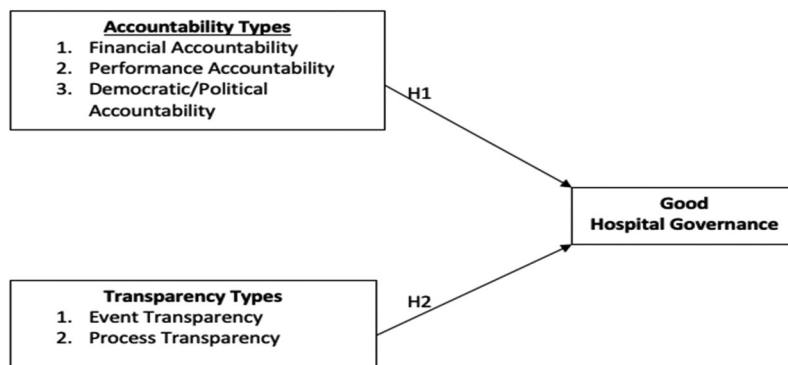
Other types of accountabilities are identified in the literature. These are horizontal, vertical, and diagonal accountability (see Acheampong et al., 2023; Lührmann et al., 2020; Mechkova et al., 2019). These forms of accountability pertain to public sector institutions and governments holding each other accountable on the one hand (horizontal accountability) and, on the other hand, being accountable to the populace (vertical accountability). Diagonal accountability is where the media, civil society organizations, and other non-state actors hold the government accountable (see Lührmann et al., 2020). In addition, our administrative, personal, professional, public, and social accountability (CTAP, 2022; Danhoundo et al., 2018; Ferri & Zan, 2018; Tan & Egan, 2018; Thomann et al., 2018). Public accountability involves street-level bureaucrats such as police officers, social workers, etc. being socially obligated to explain and justify their actions to the general public (Thomann et al., 2018). Tan and Egan (2018) describe administrative accountability as the assessment of managers' and public organizations' performance concerning predefined objectives, standards, and duties. Thomann et al. (2018) propose that professional accountability revolves around the rules, codes of ethics, and standards governing the behaviour and performance of public officials. Danhoundo et al. (2018) argue that social

accountability grants public and civil society organizations formal and informal roles in the governance process while also holding the government accountable across various issues. Lastly, Tan and Egan (2018) assert that self or personal accountability encompasses public officials' self-awareness and their ability to behave and conduct themselves in a manner consistent with their personal moral and ethical values and beliefs. Regardless of the terminology used, scholars concur that accountability is an important aspect of every society, especially democratic ones. Additionally, these studies agree that conflicts between different types of accountabilities can arise and impact the effectiveness of public organizations and managers (Danhoundo et al., 2018; Hussain et al., 2018; Tan & Egan, 2018; Thomann et al., 2018). The COVID-19 Transparency and Accountability Performance Report on Ghana emphasized social accountability (see CTAP, 2022). This current study, however, focuses on financial, political/democratic, and performance accountability, which have been found by Brinkerhoff (2004) to be prevalent in the health sector.

In the case of transparency, according to Heald (2006), experts in public sector management distinguish between two types of transparency: receivers' access to information (event transparency) and accessible, straightforward, and comprehensible administrative processes (process transparency). Transparency in budgeting remains, therefore, an important accountability tool. Heald (2006) argued that transparency is required in four directions (i.e. upward, downward, outward, and inward) by an organization.

In theory, the agency theory together with stakeholder and legitimacy theory in corporate governance is the theoretical basis of this study. The agency relationship in a hospital situation differs from the corporate setting, considering that there are different stakeholders involved in the hospital including patients, medical staff, community care groups, and others (Murphy & O'Donohoe, 2006). According to Tooley and Hooks (2020), organizational accountability discourages abuse of power and prevents manipulation and fraud, hence promoting the legality of establishments that are accountable to the appropriate stakeholders. The stakeholder theory views healthcare institutions as a system with stakeholders that expect management to deliver value through accountability and transparency. The legitimacy theory like the stakeholder theory demands the public healthcare institutions to carry out operations in the interest of the investor (government) to be legitimate. A board of directors in public healthcare institutions acts as an agent accountable to the interest of the central government. Thus, stakeholder, agency, and legitimacy theories are complementary in public healthcare institution systems in realizing good hospital governance. Figure 1 below presents the conceptual framework of accountability and transparency types to achieve good hospital governance in the health sector based on the literature. Thus, good hospital governance (dependent variables) is contingent on well-established financial, performance, and democratic or political accountability as well as event and process transparency (independent variables).

Figure 1. Conceptual framework.



4. Empirical literature review and hypotheses development

Brinkerhoff (2004) empirically explores accountability, defining it based on answerability and sanctions. This exploration distinguishes three types of accountability: financial, performance, and political/democratic. Brinkerhoff (2004) also introduces an analytical framework to map accountability in healthcare, assessing how actors can provide and demand information and enforce oversight and sanctions. Three primary accountability goals are identified: preventing abuse, ensuring adherence to procedures and standards, and enhancing performance and learning. Applying an accountability perspective offers several advantages, including the ability to gain a comprehensive view of healthcare reform, uncover connections among improvement initiatives, and highlight areas needing policy attention. Ultimately, these insights contribute to improved system performance, better service delivery, and informed healthcare policy formulation.

Kaini (2013) found healthcare governance as a framework for improving care quality and accessibility by strengthening accountability and fostering transparency for good healthcare outcomes and shared learning in Nepal. The author found that, by promoting openness and a culture of responsibility, healthcare governance plays a critical role in improving patient experiences. Similarly, Karumba (2018) evaluated the various accountability systems and public administrators' reactions in Kenya's health sector. The study addressed 36 hospital administrators using a case study methodology. A questionnaire was administered through email to collect primary data. The study findings revealed the presence of four accountability mechanisms (Legal, Professional, Political, and Hierarchical), and how they work to ensure hospital administrators are held accountable.

Acheampong et al. (2023) conducted a study on vertical accountability in Ghana, involving interviews with twenty directors from seven state ministries and consultations with ten experts from civil society and academia. Their research revealed key drivers of vertical accountability, such as disclosing financial information, the Right to Information (RTI) Act, merit-based recruitment, record-keeping, performance evaluations, training, and the absence of corruption. However, they also identified impediments like corruption, nepotism, and political apathy, along with resource constraints and weak accountability mechanisms. Overall, the study highlighted the benefits of vertical accountability, including enhanced transparency, resource efficiency, integrity, and trust in governance.

The study adopts the framework of Brinkerhoff (2004) on accountability types, purposes, and health service delivery relevant to the health sector. Based on the Brinkerhoff (2004) framework (see Table 1) and Kaini (2013) argument of the role of accountability in ensuring good hospital governance, we hypothesized that financial, performance, and political/democratic accountability leads to good hospital governance (Hypothesis 1). Also, event and process transparency which interrelates with accountability leads to good hospital governance (Hypothesis 2).

5. Research design

The study employed a case study research design in the analysis. Specifically, the study employed a comparative case methodology by comparing the transparency and accountability practices in the four selected teaching hospitals in Ghana. The use of this explicit comparison method allowed us to transcend the particulars of a single case and instead uncover similarities, shared elements, and distinctions through a methodical process of abstraction (Yin, 2014). This approach provided a unified and comprehensive framework to meet the research objectives. The teaching hospitals were selected because they are mandated by ACT 525 of the constitution to have governing structures or boards (Ministry of Health, 2016) and because they are among the largest hospitals in Ghana. For confidentiality purposes, the selected hospitals were referred to as Hospital A, B, C, and D. Hospital D, though a teaching hospital, had the qualities of a quasi-government institution. There are five traditional and one military teaching hospitals in Ghana namely, Korle-Bu Teaching Hospital (KBTH), Komfo Anokye Teaching Hospital (KATH), Cape Coast Teaching Hospital (CCTH), Ho Teaching Hospital (HTH), Tamale Teaching Hospital (TTH), and 37 Military Hospital (37MH) which is

Table 1. Accountability types, purposes, and health service delivery

Type of Accountability	Examples of healthcare system issues	Primary accountability objectives
Financial	<ul style="list-style-type: none"> • Financial management/budgeting for: <ul style="list-style-type: none"> - Personnel - Operations - Pharmaceuticals/supplies • Specification of fundamental benefit packages • Supervision of contracts 	Dominance of control and assurance. The emphasis is placed on adhering to specified input and procedural guidelines, managing costs effectively, implementing resource-efficient practices, and eradicating waste, fraud, and corruption.
Performance	Distribution of resources essential for efficient system operation Service quality Service provider behaviour Oversight conducted by professional organizations Outsourcing arrangements	Assurance and improvement/learning take precedence. The assurance purpose underscores compliance with legal, regulatory, and policy frameworks, adherence to professional service delivery procedures, norms, and values, as well as maintaining quality of care standards and conducting audits. The improvement/learning objective involves benchmarking, setting standards, managing quality, conducting operations research, and performing monitoring and evaluation (M&E).
Political/ democratic	Equitable or fair service delivery. Openness and clarity. Responsiveness to the public. The trust of service users. Conflict resolution	The focus is on control and assurance objectives. Control encompasses citizen/voter satisfaction, the responsible use of taxpayer funds, addressing market failure, and equitable service distribution, especially to disadvantaged populations. Assurance centers on overseeing principal-agent dynamics, ensuring the availability and dissemination of pertinent information, and upholding quality standards, professional norms, and societal values

Source: Adopted from Brinkerhoff (2004)

a specialized (military) teaching hospital (CTAP, 2022; Ministry of Health, 2022). The four teaching hospitals were selected for analysis based on access to data and responses received from the hospital administrators or Chief Executive Officers during the survey.

Data on transparency and accountability measures were gathered from a structured questionnaire administered to the hospital administrators (managers or CEOs) in the selected teaching hospitals. The survey was undertaken from January to June 2022. The hospital administrators/CEOs were chosen as respondents of the survey because of their knowledge of operations, financial, and decision-making roles in the hospital. The variables of interest are financial, political/democratic, performance accountability, event and process transparency, and good hospital governance. Good hospital governance is operationalized based on the teaching hospital achieving all the accountability and transparency types. Informed consent was received from the teaching hospitals. The questionnaires included general information about the hospital (name, location, year of establishment, the total number of employees, etc.), measures of financial, performance, democratic/political accountability as well as event and process transparency. The responses were coded, presented, and analysed descriptively.

6. Empirical results and discussion

6.1. General information on the selected teaching hospitals

Hospitals B and D are in the Greater Accra Region of Ghana whereas Hospitals A and C are in the Central and Northern Regions respectively. Hospital B was established in 1923 and is the oldest and largest hospital in the country. Hospital D was established in 1941 as a quasi-government hospital whereas Hospitals A and C were established in 2014 and 1974 respectively. Hospital B had a workforce of about 5000 employees which is the largest in the health sector in Ghana whereas Hospitals C and D had a workforce of about 3000 and 2000 respectively in 2021. However, Hospital A's workforce was about 1792 which was relatively lower than the workforce of the other teaching hospitals. The Medical Directors of Hospitals B, C, and D had a postgraduate degree whereas the Medical Director for Hospital A was a medical specialist. Also, all the Medical Directors in the Hospitals had professional training in medicine and the hospitals have an administrator with a post-graduate degree and Finance officers with a professional qualification. The finance officer in Hospitals A, B, and C had a Chartered Accountant—Ghana qualification, and Hospital D and A Finance Officers had ACCA qualifications. Thus, Hospital A's finance officer had both CA-Ghana and ACCA qualifications. This implies all the hospitals had finance officers with the requisite expertise. All the Hospitals had a board of directors which is a requirement for a teaching hospital in Ghana.

6.2. Financial accountability

The interest of the study is on whether the hospital has records of total expenditure and not the value of expenditure. From Table 2, Hospital A had records of total expenditure from 2017 to 2020. In 2017, Hospital A's total expenditure was approximately US\$ 3.2 million, which increased to approximately US\$ 4.1 million in 2018 and declined to approximately US\$ 3.8 million in 2019 after which it increased to about US\$ 4.3 million in 2020. Hospital C however, had records on total expenditure from 2015 to 2019. Hospital C's total expenditure was approximately US\$ 3.2 million in 2015 and US\$ 3.6 million in 2016 which increased to approximately US\$ 4 million and US\$ 4.1 million in 2017 and 2018 respectively. Total expenditure declined thereafter to approximately US\$ 4 million in 2019. However, Hospitals B and D had no records of total expenditure at the time of the survey. Records of expenditure aid in budgeting and budgets are key in conveying organizational aims and objectives to its stakeholders as noted by Libby and Lindsay (2010). Caamaño-Alegre et al. (2013) consider transparency in budgeting as an important accountability tool and health institutions that have transparent budgets are relatively accountable. Thus, Hospitals B and D are not financially accountable since records of expenditures that aid in budgeting for the next year in operation are virtually non-existent.

Table 2. Total expenditure (2015–2020)

Year	Hospital A	Hospital B	Hospital C	Hospital D	Inter-Bank Exchange rate End Period (December)
2015	N/A	N/A	3,157,894.74	N/A	3.80
2016	N/A	N/A	3,562,945.37	N/A	4.21
2017	3,173,706.79	N/A	4,072,398.19	N/A	4.42
2018	4,136,096.66	N/A	4,149,377.59	N/A	4.82
2019	3,754,272.35	N/A	3,978,3.18	N/A	5.53
2020	4,311,222.41	N/A	N/A	N/A	5.76

Notes: Values are in US Dollar Equivalence of Ghana cedis at the Inter-Bank Exchange rate (Bank of Ghana).
 N/A implies no record from the Hospital.

Based on Brinkerhoff (2004) framework on the health sector A&T framework, Table 3 presents the financial accountability issues in the health sector and what exists in the teaching hospitals.

From Table 3, monies for operations are always approved and the right systems are always put in place to cross-check expenditures on hospital operations in all the teaching hospitals excluding hospital D. Also, pharmaceutical supplies to the facilities are always accounted for and there are standards to check for the veracity of amounts and quantities of pharmaceutical supplies in all the teaching hospitals. From empirical literature, Vian et al. (2017) argued that accountability improves the health system by assuring compliance with standards and procedures. McNeil and Malena (2010) requires an organization to establish credibility among its important stakeholders.

Also, the right standards are followed in accounting for personnel costs and operational expenditure in Hospitals A, B, and D. In the case of Hospital C, the right standards are not always followed in accounting for personnel costs. Even though accountability is regarded as a significant tool that all organizations should incorporate, some studies (see Chan & Rosenbloom, 2010; Gberevbie et al., 2017) have revealed that individuals in leadership roles in addition to some subordinate officers within organizations are extremely reluctant to be accountable and thus avoid accountability. Moreover, there are financial standards that govern the preparation and reporting of financial statements in all the teaching hospitals. Mack and Ryan (2007) consider annual reports as key tools in providing detailed information on the performance and administration of businesses. Information on the financial statements is a key accountability and transparency practice. In Hospital A, financial statements are always reported annually to the public, but this is not the case in Hospitals B, C, and D where financial statements are not reported to the general public. Also, in all the Hospitals, external audits are carried out at least once a year and internal audit departments are present. It can be noted that only Hospital A adheres to all the financial accountability practices or issues. Thus, Hospital A is financially accountable compared to Hospitals B, C, and D.

6.3. Performance accountability

Accountability requires institutions to “account for” their performance in meeting the goals as well as stakeholders’ demands (Friis-Hansen & Ravnkilde, 2013). Shaw (2003) argues that data on the structure, effectiveness, and activities can be employed to establish the link between an organization and its performance. At the time of the survey, Hospital A had nine wards whereas Hospital C had 25 wards. In the case of Hospitals B and D, there were 8 and 20 wards respectively. The number of departments in Hospital B and D are 12 and 13 respectively. In the case of Hospital C, there are over 20 departments and Hospital A has 11 departments. The number of beds in Hospital A was 420 and Hospital D had about 600 beds. Hospital B which is the largest facility in the country had a bed capacity of about 5000 and Hospital C had a bed capacity of about 860 at the time of the survey.

Hospital A had 380 beds in 2015 and increased the bed capacity to 400 in 2016, maintaining the 400-bed capacity from 2016 to 2019 after which it increased to 420 in 2021. Hospital B has maintained 5000 beds for the past five years since 2015. Hospital C maintained a bed capacity of 430 from 2015 to 2016, after which it doubled up to 860 beds from 2017 to 2019 and was at 860 at the time of the survey. Hospital D on the other hand, had a bed capacity of 500 in 2015, which increased to 550 in 2017 and further increased to 600 in 2018, and currently had 600 beds at the time of the survey. Given the number of beds in the various facilities, Hospital B and C had an occupancy rate of 70 percent and 60 percent respectively, whereas Hospital A had an occupancy rate of 55.5 percent. In the case of Hospital D, the occupancy rate averaged 90 percent monthly. The number of inpatients in Hospital C averaged 105,000 whereas, in Hospital A, the average number of inpatients was between 11,016. However, Hospitals B and D did not account for the total number of inpatients admitted to the facility. Out of the over 100,000 inpatients admitted at Hospital C, 78 percent were discharged on average. As argued by Shaw (2003), the performance of

Table 3. Financial accountability comparative measures

Financial Accountability	Hospital A	Hospital B	Hospital C	Hospital D
1. Always accounts for the cost incurred on personnel in terms of salaries and wages and other benefits thereon.	X	X	X	X
2. Monies for operations are always approved, and the right systems are in place to cross-check expenditures on hospital operations.	X	X	X	
3. Pharmaceutical supplies are always accounted for.	X	X	X	X
4. There are standards for checking the veracity of amounts and quantities of pharmaceutical supplies.	X	X	X	X
5. The right standards are followed in accounting for personnel costs.	X	X		X
6. The right standards are followed in accounting for operational expenditure.	X	X		X
7. The right standards are followed in awarding contracts for supplies of pharmaceutical products.	X	X		X
8. There are financial standards that govern the preparation and reporting of financial statements in the hospital.	X	X	X	X
9. Financial statements are always reported annually to the public.	X			
10. Financial statements are always submitted to the Ministry of Health	X			
11. External audits are carried out in the hospital at least once a year.	X	X	X	X
12. The hospital has an internal audit department.	X	X	X	X

Notes: X represents compliance, and space represents non-compliance.

the hospital is determined by its effectiveness in the provision of care, and the number of inpatients discharged is a key determinant of hospital effectiveness and performance.

Based on Brinkerhoff (2004) framework on performance accountability for health service delivery, performance accountability issues in Table 4 are analysed between the four teaching hospitals.

Reports are also published regarding employee job performance to key players in the health sector or the public at large in Hospital A. This was not done in Hospitals B, C, and D. In Hospital A, the head of the internal audit department reports directly to the board. However, the head of the internal audit department does not report directly to the board in the case of Hospitals B, C, and D. Stiglbauer (2010) demands that the board of directors in the organization is responsible for fostering an accountability and transparency culture. Michener and Bersch (2013) attribute

financial auditing and other financial records as key tools in demanding appropriate measures from organizations and applying pressure for better product and performance quality as well as evaluating organizational accountability as argued by Harrison and Sayogo (2014). In both Hospital A and D, health providers always enforce the patient’s rights during healthcare delivery, there is a code of ethics staff adhere to and there is an institution/committee that sees to it that staff adhere strictly to the code of ethics. However, this is not the case in Hospitals B and C.

Moreover, in hospital A, there is someone responsible for ensuring that the committee for ensuring the code of ethics functions properly. Hospitals B, C, and D do not have any individual playing that role. Also, there is adequate representation of the various health professional bodies in hospitals A and D but that is not the case in Hospital B and C. In Hospitals A, C, and D, there are avenues for staff improvement, but Hospital B does not have such avenues. Refreshers and retraining courses are often organized in Hospitals A and D but that is not so in Hospitals B and C. Based on Table 4, we can attest that Hospital A has performance accountability compared to Hospitals B, C, and D.

6.4. Democratic/political accountability

All four teaching Hospitals had a working board of directors as mandated by the law (Acts 525). The Ghana Health Service and Teaching Hospitals Act, 1996 (Act 525) requires the membership of a teaching hospital board to be a maximum of 12 members (MoH, 2016). According to Eeckloo et al. (2004), studies related to corporate governance require the board members of a hospital to be 6–12 members. From Table 5, Hospitals A and C had a 13-membership board whereas Hospitals B and D had 11 and 9 board members excluding the board secretary respectively. It can be noted

Table 4. Performance accountability comparative measures

Performance Accountability	Hospital A	Hospital B	Hospital C	Hospital D
1. Reports are published regarding employee job performance to key players in the health sector or the public at large.	X			
2. Health providers always enforce the patient’s rights during health care delivery.	X			X
3. There is a code of ethics that staff adhere to.	X			X
4. There is an institution/ committee that sees to it that staff adhere strictly to the code of ethics.	X			X
5. There is someone responsible for ensuring that the committee’s code of ethics functions properly.	X			
6. There is adequate representation of the various health professional bodies in the hospital.	X			X
7. The Head of the Internal Audit department reports directly to the board.	X			
8. There are avenues for staff improvement.	X		X	X
9. Refresher and retraining courses are often organized.	X			X

Notes: X represents compliance, and space represents Non-compliance.

Table 5. Board composition

	Hospital A	Hospital B	Hospital C	Hospital D
Management Size	6	8	6	12
Board Size	13	11	13	9
Board Members (Outsource)	12	9	12	6
Female Board Members	4	1	2	3
Board Members (Medical Staff)	9	2	2	3
Board Members (Professionals)	9	1	0	2
Board Members (Degree or Prof. Qualif)	13	10	13	9
Board Members (Law degree)	0	1	0	1
Board Meeting (per year)	4	4	12	4

Source: Survey Dataset, 2021.

that Hospital A and C board members exceed the maximum of 12. Denis (2001) argued that large board membership may hinder effective decision-making and lengthen the processes as well as reduce the commitment level of board members. On the other hand, other studies argue that a large board size offers better performance as diverse expertise provides insight for critical decisions (de Andrés-Alonso et al., 2009). Thus, empirical literature provides a mixed impact of the size of the board on the effectiveness of decision-making.

The Ghana Health Service and Teaching Hospitals (Amendment) Bill, 2019 requires the members of the teaching hospital board to be separate from the management team to ensure good hospital governance. Mwenja and Lewis (2009) argue that the board expedites the strategic drive of a Not-for-Profit Organization and plays a crucial role in determining the long-term existence of the organization. Brown (2005) identified the board as a resource to the organization and provides the expertise for the long-term survival of the organization. Out of the 13 member boards of Hospitals A and C, 12 are outsiders from the Hospital. In the case of Hospitals B and D, nine and six respective board members were outsiders or did not work at the hospital. This implies that all the teaching hospital boards have members who are in the management team of the hospital, and this may hinder their effective role in the board as board members are required to direct the relationship between the organization and the diverse stakeholders for the long-term existence of the organization (Rehli & Jager, 2011).

Board gender diversity has been identified as imperative in determining the performance of institutions in ensuring accountability and transparency (Abor, 2017; Barako & Brown, 2008). Hospitals with more gender diversity have been identified to ensure good corporate governance (Abor, 2017; Post & Byron, 2015). The female composition of the board at the time of the survey showed one female member on the board of Hospital B, two in Hospital C, three in Hospital D, and four in Hospital A. Hospitals A and C may have a relatively larger number of females members in the board or otherwise, more gender-diverse since they both have a relatively larger board size.

Hospitals B and C both had two medical staff who served as board members at the time of the survey. On the other hand, three board members from Hospital D were medical staff of the hospital. In the case of Hospital, A, nine of the board members were medical staff of the Hospital. This indicates Hospital A, had a majority of the board members serving as medical staff in the Hospital. In the case of the number of board members who are medical professionals

outside the Hospital, Hospital A had nine board members in that capacity, whereas Hospital B and D had one and two board members respectively who operate as medical professionals outside the Hospital. Hospital C, however, had no board member in this capacity. Act 525 Amendment Bill, 2019 suggests all members of the board must be outsiders of the management team or must not be staff of the teaching hospital to ensure good hospital governance. Good corporate governance demands board members to be separate from the management team of the institution. Thus, this implies that teaching hospitals have board members who are equally in the management team, and this inhibits good hospital governance in the teaching hospitals.

All the board members have a degree or professional qualification. However, Hospitals B and D had one member of the board with a law degree whereas Hospitals A and C did not have a board member with a law degree. Act 525 Amendment Bill, 2019 requires a legal practitioner with at least ten years in good standing at the Bar to be a member of the board. Also, in all the teaching hospitals surveyed, the Chief Executive Officer or the medical director is not a chairman of the board of directors. This conforms to the requirement of the Ghana Health Service and Teaching Hospitals Act, 1996 (Act 525) which requires a chairperson who is not an employee of the hospital (MoH, 2016). Subsection (1) under Section 38 of Act 525, requires a board of a teaching hospital to meet at least once a month which implies a minimum of 12 meetings in a year.

From the survey, there is variation in the frequency of board meetings in the hospitals. Hospitals A, B, and D have board meetings four times a year whereas Hospital C had board meetings 12 times a year. It can be noted that the frequency of board meetings may establish the authority of the board in the Hospital. A board that meets several times acts more as the governing body of the Hospital than a board with relatively few meetings in a year. It can be established that a high frequency of board meetings may result in a consolidation of the tasks performed by the board and the execution of its mandate (Endacott et al., 2013). Hospitals A and D had a board performance evaluation policy whereas Hospitals B and C had no evaluation policy. Also, Hospitals A and B both had a subcommittee for Audit whereas Hospitals C and D had a subcommittee on finance and quality improvement respectively.

From Brinkerhoff (2004) framework of political/democratic accountability in health service delivery, the following (see Table 6) political/democratic accountability issues are comparatively analysed.

From Table 6, in hospitals A, B, and C, the board is always responsible for the oversight role in the formation of hospital objectives. However, this is not the case in Hospital D. In all the hospitals, the CEO/Medical Director is always responsible for the oversight role in the implementation of hospital objectives. Also, hospital administrators in Hospitals A and D are held accountable for their actions at the end of the year but in the case of hospitals B and C, the administrators are not held accountable. In the case of Hospital A, the oversight committee has representatives from the government but Hospitals B, C, and D have no government representative in the oversight committee. Moreover, the hospital objectives are always consistent with the ruling government's aspirations for the health sector in Hospitals A, C, and D but not the case in Hospital B. From Table 6, it can be noted that Hospital A is politically/democratically accountable compared to Hospital B, C and D.

6.5. Event transparency

From Brinkerhoff (2004) accountability framework, political/democratic accountability overlaps with transparency. Event transparency involves ease of accessing information. From Table 7, there are appropriate channels for resolving differences between the cabinet i.e. Minister of Health, and the directors of the hospital regarding courses of action and objectives in hospitals A, B, and C but not so in Hospital D., This may be attributed to the special case of hospital D as a quasi-government institution responsible to the Chief of Defence Staff. Periodic reports are furnished to the government regarding general hospital conditions in all the hospitals. Also, in all hospitals, there are laws, rules, or standards that govern how the hospital should be run.

Table 6. Political/Democratic accountability comparative measures

Political/Democratic Accountability	Hospital A	Hospital B	Hospital C	Hospital D
1. The board is always responsible for the oversight role in the formation of hospital objectives.	X	X	X	
2. The CEO/Medical Director is always responsible for the oversight role in the implementation of hospital objectives.	X	X	X	X
3. Hospital administrators are held accountable for their actions at year-end	X			X
4. The oversight committee has representatives from the government.	X			
5. Hospital objectives are always consistent with the ruling government's aspirations for the health sector.	X		X	X

Notes: X represents compliance, and space represents Non-compliance.

In hospitals A and C, the hospital administrator furnishes the public with vital information whereas in hospitals B and D, this is not always done. This is relevant because if documents detailing decisions are disclosed to the public, the information is observed as transparent (Florini & Florini, 2007). Thus, if the public easily accesses information from health institutions, it makes it possible to demand organizational responsibility or be transparent and accountable (McGee & Gaventa, 2010). Also, patients are always given a voice of choice when treatment cases vary in Hospitals A and D but not always so in Hospitals B and C. Standards are available to workers to understand the basis of measurement of staff performance in Hospitals A and D, but this is not the case in Hospitals B and Ball (2009) argued that the more open and easier it is for the public to obtain information from the hospital, the more transparent the

Table 7. Event transparency comparative measures

Event Transparency	Hospital A	Hospital B	Hospital C	Hospital D
1. Appropriate channels for resolving differences between the Ministry of Health and the hospital directors	X	X	X	
2. Periodic reports are furnished to the government regarding general hospital conditions	X	X	X	X
3. some laws or standards govern how the hospital should be run	X	X	X	X
4. The hospital administrators furnish the public with vital information	X		X	
5. Patients are always given a voice of choice when treatment cases vary.	X			X
6. Standards are available to workers to understand the basis of measurement of staff performance.	X			X

Notes: X represents compliance, and space represents Non-compliance.

institution. This implies event transparency is evident in all the teaching hospitals. This is confirmed in Bouzarjomehri et al. (2021) where reporting hospital performance to the public was found to improve hospital transparency in Iran.

6.6. Process transparency

Process transparency like event transparency overlaps with political/democratic accountability according to the Brinkerhoff framework on health service delivery. Table 8 presents the process transparency issues and comparative analysis between the four teaching hospitals. In Hospitals A and C, healthcare policies are fair for all classes of citizens and there are no forms of discrimination. This is not so in Hospitals B and D. Also, the right institution (such as the Nursing & Midwifery Council) is always involved in the recruitment of nurses and other staff, and the right criteria are always used in the recruitment of staff in hospitals A and D but not always the case in hospitals B and C. There are outsourced professionals, and they go through work standards and evaluation protocols in hospitals A and D. This is, however, not the case in hospitals B and C per the survey.

Also, Staff are always monitored to ensure that compliance with appropriate professional standards is maintained in Hospitals A and D but not so in Hospitals B and C. There are clear rules for government interference in hospital administration in Hospitals A, C, and D but not so in Hospital B. In Hospitals A and D there is someone responsible for supervising and ensuring that the quality standards are adhered to. This was, however, not evident in Hospitals B and C. Also, appropriate lines of communication are used by management in trying to reach out to the public in all the hospitals. All these measures culminate in process transparency. Rawlins (2008) argues that employee trust and perception of organizational transparency are increased when processes are improved.

Table 8. Process transparency comparative measures				
Process Transparency	Hospital A	Hospital B	Hospital C	Hospital D
1. Health care policies are fair for all classes of citizens or there are no forms of discrimination.	X		X	
2. The right institution is always involved in the recruitment of nurses and other staff in the hospital.	X			X
3. The right criteria are always used in the recruitment of staff.	X			X
4. There are outsourced professionals, and they go through work standards and evaluation protocols.	X			X
5. Staff are always monitored to ensure that compliance with appropriate professional standards is maintained.	X			X
6. There are clear rules for government interference in hospital administration.	X		X	X
7. There is someone responsible for supervising and ensuring that the quality standards, if any, are adhered to.	X			X
8. Appropriate lines of communication are used when trying to reach out to the public	X	X	X	X

Notes: X represents compliance, and space represents Non-compliance.

7. Summary and conclusion

The study finds that financial, performance, and political accountability, as well as event and process transparency practices, are not fully performed in all the teaching hospitals in Ghana. The study also finds hospitals with large management sizes have lower board sizes and lower numbers of board members appointed from outside the institution. Also, hospitals with larger board sizes have a larger number of board members appointed from outside the health institution. A common practice not found in most of teaching hospitals is a record of total expenditures per year. However, some efforts have been made by one of the hospitals to adhere to all the accountability and transparency practices. The study recommends efforts to advance accountability and transparency in the teaching hospitals in Ghana to improve hospital governance and provide quality healthcare in Ghana. Thus, the Government of Ghana and the Ministry of Health have to enact policies to this effect.

As a result of this study, further research may be undertaken on other healthcare providers. The study investigates accountability and transparency in public hospitals, meanwhile, health institutions in Ghana are broadly categorized into private and public hospitals. Thus, further studies may be undertaken in the private sector. An expanded sample size is recommended to make conclusions about the problem of dual accountability from public and private sector viewpoints in this study. The study was limited to the availability of data to undertake rigorous quantitative analysis so further research may employ other techniques to the current study.

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Approval was received from the Ghana Health Service Ethics Review Committee with protocol identification number GHS-ERC 003/12//19

Informed consent

Written Informed consent was provided to the administrators of the selected teaching hospitals before the questionnaire was administered.

Correction

This article has been corrected with minor changes. These changes do not impact the academic content of the article.

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