THE JAPANESE HEALTH CARE SYSTEM: A TECHNIQUE WORTH EMULATING FOR GHANA

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Abstract: Quality health care has been a vital and indispensable tool for any country that wants to develop and build a healthier wealthier nation. It is so broad from the bottom to the apex coupled with lot of issues, policies and its implementations. Many African nations puts about 50 to 60 percent of its budget into the health and Ghana is no exception, yet developments in the health system turns to be weak, under resourced, localized and scarce. A look at the health care management and systems of some Asian countries like japan, Singapore, Malaysia, and Indonesia shows to be brighter, robust and well structured. This article compares the basic health system of japan to Ghana and how Ghana can learn some basic modalities from the Japanese system to develop the health sector.

Key Words: Health care system, management, ministry of health (MOH), Christian health association of Ghana(CHAG), world health organization(WHO), health systems in transition(HiT), national health insurance scheme(NHIS), national health institute, Ghana health service, Gambare, gross domestic product.

1.0 INTRODUCTION:

A healthcare system is a means of organized social response to the health conditions of the population. It is narrower than a health system and is often described in terms of the levels of healthcare and organisational structure of the Ministry responsible for health in most countries (WHO 2007).

2.0 DISCUSSIONS:

2.1 Brief Description of the Japanese Health Care Management System

Japanese management integrates work with their personal lives. Japanese management sees themselves as company representatives at all times. Thus, during introductions, a manager is introduced by the Japanese company first, followed by the manager's surname.

For example, a Japanese manager working at Honda is introduced as "Honda no Kato-san desu," or Honda's Mr. Kato. Contrast that with the Ghanaian introduction, "this is Dr. Appiah, principal medical officer, Ghana health service." This conceptual difference is culturally engrained and establishes the tone for contrasting management systems in place. The Japanese work ethic has its roots in Confucianism, with an emphasis on respect for work, discipline, and the ability to follow orders. Loyalty to the organization or group is imbedded in Japanese promotion policies. Corporate members expect promotion based on seniority, rather than individual merit, as in the Ghanaian system. On the other hand, Ghanaian health system managers value personal accomplishment for recognition and individual identity. Ghanaian managers are also high in individualism, goal attainment, and future orientation.

2.2 Core Management Practices;

The Japanese consider three core management practices as inherent in their system. These include lifetime employment, seniority wages and promotion, and enterprise unionism. Workers are trained at company expense because of the return on investment of having a lifetime employee. The interdependency of the company and worker negates the need for aggressive labor unions to defend worker rights. Furthermore, this interdependency result in workers competing against other companies, and thus, their self-interest is to improve quality, raise productivity, and accept smaller wages.

Japanese management has the responsibility to create a harmonious environment in which each member of the group effectively contributes to group goals. Japanese feel that the nail that sticks up must be hammered down,

while the Ghanaian system of management believes that the nail that sticks up is most likely to be recognized and promoted. Japanese have a term, *gambare*, which means to persevere, endure, or not give up.

Factory walls are covered with banners touting various gambare slogans and managers often use gambare during a pep talk. However, gambare is an emotional tool that clouds rational thought and minimizes risk management. Gambare makes the Japanese push too hard and fast without evaluating the consequences of their actions. Japanese firms also rotate their management staff every two to three years to expose them to various jobs. While managers learn about different parts of the company, they have insufficient time to develop expertise in each position.

Furthermore, the rotation process lacks a systematic process. For example, a manager might rotate to a subsidiary in a foreign country, and then rotate to a different country, and thus, any benefit gained from learning the language and culture of the first country is lost with rotation. In addition, rotations seem based on need**,** without regard to the value a manager brings to the position. This affects morale and generates an enormous amount of individualism.

2.3 Brief Description of the Ghanaian Health Care System

The system of health care in Ghana is basically the English style; it is 80% English and 20% American. It is like the pyramid with a narrow apex but having a broad base (health care systems management 2011). Multiple factors are almost certainly involved, as they are with differences in health outcomes, and need to be assessed against each other. Medical care may vary because of the health needs of different groups, or the types of care they seek, prefer, or can afford, or because of insurance coverage, provider behavior, or the policies and procedures of hospitals and health systems. Research attention is desirable across multiple dimensions of health care. In addition to the governmental health care system, the church is playing a major role in Ghana. Christian Health Association of Ghana (CHAG) is the umbrella organization that co-ordinates the activities of the Christian health institutions and churches' health programs in Ghana. CHAG is coordinating its programs with the Ministry of Health (MOH) and Ghana Health Service (GHS).

The members of CHAG predominately focus on the poorest and vulnerable groups and are therefore often located in the most remote areas of the country. Though, CHAG is one of the only relevant health Non-Governmental Organization (NGO) in the country, CHAG's position in the health sector has deteriorated since the organization faces more other NGO's competing for government resources.

Health Metrics Network, an independent body which undertook a review study of the Ghana health system in April 2005 after two years of implementation, noted that given the low coverage of vital events registration, statistical analysis of the data is necessarily limited (HMN, April 2005).Forty- four percent (44%) of the population is below the age of fifteen while only five percent (5%) is above the age of sixty- five. There are slightly more women (53 per cent) than men (47 per cent) in the overall population.

Life expectancy at birth for a Ghanaian was estimated at 57.7 years: 55 years for males and 59.2 years for females‖ (MOH, undated, p. 8). Infant mortality worsened from sixty-four percent (64%) per 1000 live births in 2003 to 71 in 2006 (US Census Bureau, 2008). Ghana recorded an under-five mortality rate of 111 per 1,000 live births in 2006 (MOH, undated).

Due to their pervasiveness, sanitation related diseases pose a particular problem to the country's health system: The Ghanaian Chronicle reported that 82 per cent of the entire population lacked proper toilet facilities in 2008. The newspaper went on to say that the country's sanitation coverage stood at 10 per cent as at the end of 2006 (Ghanaian Chronicle**,** August 21 2008). Basic sanitation related diseases continue to rise. The national health insurance authorities say 80 per cent of the cases burdened on the scheme are sanitation-related (Public agenda, 1 September 2008). Curable illnesses such as malaria continue to be highly fatal for Ghanaians (see chapter 3.1.; IRIN, 11 August 2008). For a population of a little short of 23.5 million people, there are only 1,439 health care facilities (IRIN, 5 August 2008). A study by van den Boom et al. also states there are only 1,439 health care facilities (IRIN, 5 August 2008). Also, in another study by van den Boom et al. (2004) noted that access to these

facilities remained a problem: Medical facilities were not evenly distributed across the country, with most rural areas lacking basic facilities such as hospitals and clinics as well as doctors and nurses. The study further said that Ghanaians on average live about 16 km from a healthcare facility where they can consult a doctor, but half of the population lives within a 5 km radius. By the same token, the other half cannot consult a doctor within 5 km, which corresponds to a 1 hour walking distance, and one quarter even lives more than 15 km from a facility where a doctor can be consulted. The Government of Ghana embarked on a health sector reform in the early 1990s to improve the accessibility and quality of services. However, the health situation in Ghana is still far from satisfactory. Many people in the country still rely on self-medication (van den Boom et al., October 2004, p. 1, 4, 20, and 21). Projects to raise accessibility, however, are underway: The Minister of Health told Parliament in December 2007 that the Ministry has established 176 health infrastructure projects within a period of five years. This includes 50 Health Centers comprising 22 District Hospitals and 26 Community Health Planning Scheme (CHPS), (Ghana Parliament, 18 December 2007).

The healthcare system in Ghana is organized under four main categories of delivery systems: Public, Private-for-profit, private-not-for-profit and traditional systems.

Though the former three, are mostly associated with healthcare delivery in Ghana, efforts are being made since 1995 to integrate traditional medicine into the orthodox mainstream (Abor; Abekah-Nkrumah; Abor, 2008).The public health care system of Ghana is operated through the National Health Insurance Scheme (NHIS), which permits the operation of three types of insurance schemes, including District-Wide (Public) Mutual Health Insurance schemes in all of the country's 110 districts, private mutual insurance schemes and private commercial insurance schemes. However, only the District-Wide (Public) Mutual Health Insurance schemes are financially supported by the NHIS (Hepnet, 30 June 2007).

The public health system faces a variety of obstacles; among them are shortages of personnel and funding, as well as an unequal distribution of health workers in the country's regions (van den Boom et al., October 2004, p. 4).

The country's most densely populated region, the Western Region, accommodates 10 per cent of the population but only 99 doctors. There are 91 doctors living in the Volta Region and 33 in the Northern Region, compared to 1238 public and private medical as well as dental practitioners in the Great Accra Region (Ghana Home Page, undated; GMA, undated).

Corruption seems to be another major problem in Ghana's public health care system: In its 2006 Global Corruption report, Transparency International (TI) identified the health sector of Ghana as a corruption prone area with evidence of bribery and fraud across the breadth of medical services. This is said to have emanated from petty thievery and extortion, to massive distortions of health policy and funding, fed by pay offs to officials in the sector (Ghanaian Chronicle, 2 February 2006).

A study carried out in selected rural communities revealed that other factors such as traditional beliefs, social stigma, poverty and illiteracy still stand in the way of proper healthcare delivery. For example, in a study on payment of health insurance conducted in the Kassena Nankana District in Northern Ghana, some of the respondents said that contributing money for illnesses yet to come was not appropriate as that in itself could invite more illnesses. (HRU,May 2005a, p 7). Another study in a district hospital revealed that people with leprosy and tuberculosis defaulted treatments due to social stigma, lack of funds and/or the need to fend for themselves or others (HRU, May 2005b, p. 8).

Primary health care in Ghana is structured to serve the rural and urban population according to priority. The rural areas which are mostly deprived of permanent health infrastructures have been prioritised with programmes such as the Community Health Planning Service (CHPS), which aims to transform clinic- based primary health care and reproductive health services to community-based health services.

Most CHPS workers are mobile and move from community to community to educate community members on preventive practices as well as administer curative services (Ghana CHPS, 2009a). Ghana has embarked on training health workers especially for the need of rural areas. The Kintampo Rural Health Training School

(KRHTS), situated in the middle of the rainforest region of Brong Ahafo, Navrongo Health Research Centre (NHRC) situated farther in the north-east of the country, and others of their kind in other regions of the country train community health workers, nurses and health administrators for deployment into rural areas (Ghana CHPS, 2009a; Ghana CHPS, 2009b).

Secondary and tertiary care is classified as purely curative and offers a range of hospital services, depending on the defined status of the institutions. The secondary and tertiary health care level is sub-divided into several different categories depending on their range of service. A teaching hospital, for example, takes both referral cases and serves as a first point of contact. The military and police hospitals of Ghana serve as tertiary healthcare infrastructures, serving both as first point of contact and referral institutions but do not serve as teaching hospitals. Secondary and tertiary health care delivery in Ghana is mostly an income generating delivery system.

2.4 Basics of the Japanese Health Care Management System

Japan's health system provides universal coverage of the population through health insurance system for employees and their families (60% of the population) and National Health Insurance (NHI) system for the self-employed, retired and unemployed (40%). Annual expenditure is around 8% of gross domestic product (GDP) according to OECD estimates, and the main funding mechanisms are health insurance (50% of total spending), taxation (36%) and out-of-pocket payments (14%). Population health in Japan is among the best in the world, with the longest life expectancy and lowest infant mortality.

The population has aged considerably, with over 21% aged 65 years or older. Recent health system reforms are related in large part to this demographic challenge, such as the introduction of an independent financing system for the oldest-old population cross-subsidized by all health insurers, better integration of preventive services into the insurance system, reforming the methods of paying hospitals and the introduction of a new system of long-term care financed through insurance and administered by municipal governments. The Health Systems in Transition (HiT) profiles are country-based reports that provide a detailed description of a health system and of policy initiatives in progress or under development.

HiTs examine different approaches to the organization, financing and delivery of health services and the role of the main actors in health systems; describe the institutional framework, process, content and implementation of health and health care policies; and highlight challenges and areas that require more in-depth analysis.

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2.5 Who is covered?

Japan operates a universal social health insurance system with more than 3,500 insurers. Employees and their families (60 percent of the population) are required to enroll in the health insurance offered through their employers, and the remaining 40 percent (unemployed, self-employed, and retired) are covered through plans administered by their local municipality or prefecture. All plans cover the same statutory benefit package. Individuals cannot choose their plans. Those who evade enrolling must pay back up to two years of premiums when they re-enter the system (although public assistance will cover them if they are unable to pay this fee). Permanent residents and long-term visitors are also required to obtain coverage; undocumented immigrants are not covered.

2.6 What is covered?

Services: The statutory national benefit package covers hospital care, ambulatory care, and approved prescription drugs, and covers most dental care; it does not cover eyeglasses. Since 2000, long-term care has been covered under its own insurance system, administered by local governments. A number of preventive measures are publicly provided to those aged 40 and older, including screening, health education, and counseling. Mental health care is also covered under the statutory benefit package.

Cost-sharing: In 2009, out-of-pocket payments made up 15.8 percent of total health care expenditures. In general, a 30 percent copayment is required for all covered services, all of which are subject to a government-determined universal fee scale. Some employer-based health insurance funds offer reduced cost-sharing.
Safety net: While 30 percent copayments are quite high by international standards, several measures are designed to protect against excessive out-of-pocket payments, particularly for vulnerable populations. Copayment is only 20 percent for young children and 10 percent for those aged 70 or older (30% for those with high incomes). Also, all insurance plans include a monthly out-of-pocket ceiling, usually 80,100 yen (US$1,056), above which only a 1 percent copayment applies. This ceiling varies for low-income (35,400 yen [US$467]) and high-income (150,000 yen [US$1,978]) insurees. Finally, annual out-of-pocket costs between 100,000 and 2 million yen (US$1,319 to $36,370) can be deducted from taxable income.

2.7 How is the health system financed?
Different health insurance schemes cover different portions of the population, based largely on employment status and age, and premium requirements vary by insurance scheme.

2.8 Employment-based insurance:
Employees of large employers, which operate their own insurance programs, contribute between 3 and 10 percent of their income in premiums, while employees of small and medium-sized employers contribute a uniform 9.5 percent to a single health plan (the National Health Insurance Association). Since this overall 8.2 percent of employee income does not sufficiently cover health care costs for that population, the government provides a subsidy amounting to 16.4 percent of the National Health Insurance Association's costs. Government employees are covered by their own system of insurers (known as Mutual Aid Societies), as are some groups of professionals (e.g., doctors in private practice). All provider fees paid by insurers are set centrally and revised every two years, in what has proven to be a very effective cost-containment strategy (see below).
Roughly one-third of health care spending is financed through central and local tax revenue, not earmarked for health spending.
These funds are mainly used, along with insurance-related premiums, to cover the 40 percent of the population not enrolled in employer-based insurance (retired, self-employed, or unemployed) through the Citizens' Health Insurance system, which is administered by the municipalities. Those aged 75 or older are covered under a distinct health insurance system (Late Elder Insurance), administered by coalitions of municipalities within each prefecture and funded through a combination of general tax revenue, pooled contributions from the other insurance schemes, and, to a lesser extent, premiums.

2.9 Out-of-pocket payments:
In 2008, out-of-pocket payments made up 15.8 percent of total health expenditures, stemming mainly from a 30 percent coinsurance charge on all services covered under statutory health insurance (which is limited by monthly out-of-pocket ceilings and other protections as described above).

3.0 PRIVATE HEALTH INSURANCE:

Private insurance is held by a majority of the adult population, with benefits provided mainly in the form of cash, such as a daily amount for hospitalization.

3.1 How is the delivery system organized?
Physicians: In Japan, primary and specialist care are not held apart as distinct disciplines, as they are in other countries; rather, specialists generally operate in community-based clinics, provide many primary care functions, and can be easily accessed without referral.
Very few clinics have a formal scheduling system; rather, patients wait in the waiting room until they can be seen. Outpatient visits are typically very short, yet common in 2009, physician visits per year (13.9 per capita) were more than twice as frequent as the OECD median (6.2) and three times as frequent as in the U.S. (3.9). Virtually all clinics used to dispense medication (which doctors can provide directly to patients), but only a minority do so now. Clinics are mostly physician-led, with nurses playing less of a role in caring for patients than in some other countries, such as the U.S. Outpatient care is also provided at hospitals. After-hours care is usually provided by on-call physicians; there are few emergency departments in Japan. Hospital-based physicians are paid fixed salaries.

3.2 Hospitals:
Approximately 55 percent of hospital beds are in private, nonprofit hospitals. Public hospitals tend to be larger than private. While in general patients are free to self-refer, some large hospitals and academic medical centers charge a fee to patients not referred by a physician. Roughly half of acute-care hospital beds are paid for solely on

a fee-for-service basis, and the other half partially paid for through Diagnosis Procedure Combination (DPC) case mix–based payments.

DPC payments offer per-diem rates that vary depending on diagnosis and procedure, and on how long the patient remains hospitalized. They also include physicians' fees. Hospitals voluntarily elect to receive DPC payments or remain under fee-for-service; DPC rates are multiplied by a hospital-specific coefficient, so as to keep them relatively in line with fee-for-service payments.

Traditionally, hospitals have been used as both a source for acute care and a site for long-term care for the elderly. Other forms of long-term care have since developed, particularly since the introduction of public long-term care insurance in 2000, but it is still common for hospitals to provide long-term care.

3.3 ***Long-term care:***

Long-term care has traditionally been provided by hospitals far more routinely in Japan than in other countries, although directing more patients to nursing home equivalents is a policy focus. Since 2000, all patients aged 65 and older and some disabled between 40 and 64 are covered under the national long-term insurance program, administered by the municipalities. Roughly half of the financing flows through taxation and half through premiums. Premiums vary by municipality and are linked to income (6 different premium levels for age 65 and older; 1 percent of income, up to a ceiling, for age 40 to 64). A 10 percent copayment applies to all covered services, up to an income-related ceiling.

Covered services include institutional care, visiting nursing, rehabilitation, home help, and day services.

3.4 ***Government insurance and financing:***

Roughly one-third of health care spending is financed through central and local tax revenue, not earmarked for health spending. These funds are mainly used, along with insurance-related premiums, to cover the 40 percent of the population not enrolled in employer-based insurance (retired, self-employed, or unemployed) through the Citizens' Health Insurance system, which is administered by the municipalities. Those aged 75 or older are covered under a distinct health insurance system (Late Elder Insurance), administered by coalitions of municipalities within each prefecture and funded through a combination of general tax revenue, pooled contributions from the other insurance schemes, and, to a lesser extent, premiums.

3.5 Mental health:

Japan has the largest number of psychiatric beds per capita in the world, but has been taking some steps in the past decade to move mental health care more into the community. Approximately 80 percent of psychiatric beds are private and nonprofit, and providers are generally paid fee-for-service. Mental health care is covered under national health insurance, along with the standard 30 percent coinsurance; although protections exist that include reduced cost-sharing for patients recently discharged from psychiatric institutions. Suicide prevention is a particular priority at present.

3.6 What are the key nongovernmental entities for system governance?

System governance is largely in the control of the Ministry of Health, Labor and Welfare and regional governments, but some nongovernmental entities still play a role. Perhaps the most significant is the Central Social Insurance Medical Council, made up of ministry-appointed representatives from payer (7 members) and provider (7 members) organizations, public representatives (6 members), and technical experts (10 members). The Central Council's primary function is to approve the biennial revisions to the national fee schedule, which determines prices for all publicly covered health services. Current reforms aim to increase the number of public representatives on the Central Council and make the decision-making process more transparent.

The Japan Council for Quality Health Care (JCQHC), established in 1995, undertakes a number of activities related to improving quality throughout the health system. They include hospital accreditation, creating clinical guidelines, and tracking complaints made to medical safety support centers (see below). The JCQHC does not have any regulatory power to punish poorly performing providers.

3.7 What is being done to ensure quality of care?

There is little in the way of regulation regarding quality improvement. Hospital accreditation in Japan is voluntary, and undertaken largely as an improvement exercise rather than as a way to penalize poor providers; roughly one-third of hospitals are accredited by the JCQHC (described above), which does not disclose names of hospitals that have failed the accreditation process. Hospitals can be sanctioned through reduced reimbursement rates if staffing per bed falls below a certain ratio.

About 300 hospitals voluntarily participate in benchmarking projects and publicly report on quality indicators.

Physicians can proclaim any subspecialty at their discretion without accreditation. Accreditation processes vary by specialty, but often are not rigorous and do not require recertification. Consequently, certain subspecialties such as neurosurgery and orthopedic surgery are far more common than in the U.S.

Every prefecture has a medical safety support center for handling complaints and promoting safety. Since 2004, advanced academic and public hospitals are required to report adverse events, although significant underreporting may occur.

4.0 FINDINGS: Basics of the Ghanaian Health Care Management System

4.1 Who is covered?

Coverage is universal. All those "ordinarily resident" in Ghana especially citizens of Ghana are entitled to health care that is largely free at the point of use. Only treatment in an accident and emergency department and for certain infectious diseases is free to people not "ordinarily resident" such as visitors or illegal immigrants (Ministry of Health 2010a).

4.2 What is covered?

Services: The precise scope of the National Health Insurance Scheme (NHIS) is now defined in statute and regulation. However, in practice it provides or pays for: preventive services, including screening and immunization and vaccination programs; inpatient and outpatient (ambulatory) hospital (specialist) care; physician (general practitioner) services; inpatient and outpatient drugs; dental care; some eye care; mental health care, **BUT NOT** including care for those with learning disabilities; palliative care; some long-term care; withdrawing rehabilitation.

4.3 Cost-sharing:

There are only a few cost-sharing arrangements for publicly covered services, the rest is been subsidized by the government. Drugs prescribed under the NHIS by general practitioners, dentists, Specialists and others are subject to a fixed-rate charge.

4.4 How is the health system financed?

Public expenditure, mainly on the NHIS, accounts for about 84 percent of this (OECD 2011). Around 75 percent of NHIS funding comes from general taxation and 20 percent from national insurance (effectively a payroll tax imposed on all employees), with user charges and other sources of income accounting for about another 3 percent.

4.5 How is the delivery system organized?

Government: Responsibility for health legislation and general policy matters rests with Parliament and the Ministry of Health. The NHIS is currently administered through 10 regional strategic health authorities that are accountable to the government of Ghana. At the local level, commissioners of health care services (currently 152 Primary Care Trusts, or PCTs) contract with providers (hospital trusts, general practitioners [GPs], independent providers for services they judge to be appropriate for their local population.

NHIS is now trying to control around 80 percent of the taxes budget (allocated to them using a risk-adjusted capitation formula).

4.6 Primary care:

Primary care is delivered through general practitioners, nurses, physician assistants and other allied health professionals who have been registered with their professional bodies. Physician assistants are normally the first point of contact for patients who usually do not get the opportunity to see GP's in their communities. The physician assistants also do refer cases beyond them to GP's for special care and later if the GP's cannot deliver the optimum service, they also refer to specialist practitioners.

In some parts of the country walk-in centers offer primary care services, and for these registration is not required.

4.7 Outpatient care: GPs act as gate keepers to hospital specialists but patients are able to choose which hospital department to visit. The NHIS has recently introduced the right to choose a particular primary health care provider, but that is not fully implemented. The majority of outpatient care is carried out in hospitals, although care has increasingly been delivered by hospital specialists in primary care settings and by GPs with intense training in particular conditions.

4.8 Hospitals:

Hospitals are now organized both as NHIS trusts directly responsible to the government or fully private with the cash and carry system. In particular, Foundation Trusts have easier access to capital funding and are able to accumulate surpluses or run (temporary) deficits. Since 2004, a majority of NHIS trusts have become Foundation Trusts.

Both types of hospital contract with PCTs for the provision of services to local populations and are reimbursed for these services at the same nationally determined rates. Public funds have always been used to purchase some hospital care from the private sector but the level has grown in recent years. Beginning in 2003, some routine elective surgery and diagnostic services have been procured for NHIS patients from freestanding treatment centers owned and staffed by private sector.

4.9 Long-term care:

The NHIS pays for some long-term care (i.e., for those with continuing medical or skilled nursing needs), but most long-term care is referred to as adult social care. Public coverage of adult social care is means-tested. Separate government funding is available to people with disabilities according to national eligibility criteria and is not means-tested.

5.0 RECOMMENDATION:

The writer sees health systems in Ghana to be too imitating of the English/British style and this is the time to use our sense of dynamism to consider the Asian style of rapid progression especially the Japanese, Singaporean and Malaysian systems of health system.

There should be re-envisioning, adopting values of the Japanese style which puts the organizational goals and country at the top rather than the managers or health care providers.

6.0 CONCLUSION:

The Ghana health system is improving from good to better, to attain the best level, policy makers should consider the problem based methodology which at the end will put the interest of the populace or individual patients at the top before the mangers. These also make health care providers in the hospitals and clinics also centralize policies and decision in order to safe guard their future and job.

Although the introduction of the National Health Insurance Scheme, (NHIS) in the Ghanaian healthcare management system, these problems, and the perennial situation of people presenting to the health facilities late with easily salvageable and preventable conditions that could have saved them had they reported earlier, have been reduced, and though not completely effaced.

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