FROM QUEUES TO DIGITAL CARE PLATFORMS

What stakeholders said about Ghana’s digital health transition

A short public-facing brief based on workshop discussions with health-system stakeholders in Ghana.

At a glance

Digital health is broader than telehealth

Stakeholders described a mixed ecosystem that includes records, district and hospital systems, e-pharmacy, referral pathways, phone-based consultations, telemedicine, and even video- or social-media communication.

The real question is quality of use

Participants repeatedly shifted the conversation away from simple adoption. What matters is whether digital tools improve coordination, follow-up, data capture, and service flow without adding burden to staff.

Exclusion is about more than connectivity

Older adults, poorer and less educated groups, people in remote areas, persons with disabilities, and those with mental health needs may face barriers related to trust, confidence, awareness, privacy, and scams.

Routine data can be useful - with caution

Stakeholders supported the use of service indicators, but they also warned about missing data, inconsistent definitions, uneven digital maturity, and the need for governance and metadata from the outset.

Why this matters

The workshop did not simply endorse digitalisation in the abstract. It pushed the project toward a more grounded question: how digital care works in everyday practice, who benefits, who is left behind, how staff are affected, and what service data can realistically show over time.

1. A broader view of digital care

Participants consistently argued that digital health in Ghana should not be reduced to a single platform or a single delivery model. In practice, digital care sits across multiple

systems and touchpoints. That point matters because a narrow telehealth lens would miss how care is actually organised on the ground.

- Examples mentioned in discussion included health information systems, hospital and district data systems, electronic records, e-pharmacy, telemedicine, referral systems, phone-based consultations, and video- or social-media communication.
- For the next phase, the proposal will be stronger if it defines “digital care platforms” broadly enough to capture this wider ecosystem rather than one intervention type.

2. Usable systems, not extra burden

In Session 1, the discussion moved quickly beyond the question of whether healthcare professionals use digital tools. The stronger concern was whether those tools genuinely help people do their work well. Stakeholders described good use as use that supports coordination, referrals, follow-up, data capture, and service organisation, while saving time for both staff and patients.

- Poorly integrated systems were linked to documentation burden, interruptions, scheduling difficulties, and the strain of working across parallel paper and digital processes.
- Participants also highlighted workforce outcomes that matter for policy and planning: burnout, technostress, job satisfaction, presenteeism, work meaningfulness, and perceived quality of care.
- A practical caution came through clearly: if the project uses repeated surveys across waves, they will need to be short, focused, and feasible for busy professionals.

3. Inclusion has to go beyond access

Session 2 reinforced that equity and exclusion should be central, not peripheral, to the project. Participants identified several groups who may be at greater risk of being left behind as digital pathways expand, including older adults, poorer groups, less educated populations, people living in remote areas, persons with disabilities, and people with mental health needs.

- But access to a device or the internet is only one part of the story. Low awareness, low confidence, uncertainty about where to seek help, trust concerns, privacy concerns, and fear of scams were all described as real barriers.
- Participants also emphasised that exclusion can happen at multiple points in the pathway: identifying the right contact point, registering, following up, or moving between digital and in-person services.

One especially valuable insight was the need to include people who tried to use digital care and failed - or who chose not to use it at all. Stakeholders saw this group as essential for understanding how exclusion really happens in practice, not just how it is imagined in policy.

4. Routine data can inform service performance - but readiness varies

In Session 3, stakeholders were generally supportive of using routine service indicators to understand hospital performance. At the same time, they were careful and realistic about the limits of those data. The message was not ‘do not use routine data’; it was ‘use it carefully, and build around its weaknesses from the start’.

- Suggested indicators included outpatient volume, total service volume, new and repeat clients, waiting time or waiting proxies, referrals, remote contacts where recorded, complaints, errors, and medication supply tracking.
- Participants repeatedly raised concerns about missing data, inconsistent definitions, changing reporting fields, and uneven transitions from paper systems to digital systems.
- Hospitals may also differ in digital maturity, governance structures, and levels of routine data access, which makes comparability a major challenge.

Bottom line

Stakeholders broadly supported the project’s direction, but they also sharpened its focus. The next phase should move beyond asking whether digital care exists and instead examine how different platforms are used in practice, who benefits, who is excluded, how staff are affected, and what service performance data can reliably show over time.

That shift makes the proposal more realistic, more policy-relevant, and more useful for service planning in Ghana.