A Critical Review of No Bed Syndrome in Ghana: Emergency Care Failures, Accountability, and Policy Imperatives

[1]Barnabas Kwame Yeboah, PhD, [2]Mohammed Ali, PhD, [3]Elizabeth Asor Mensah, [4]Mohammed Damata Yakubu

[1]Director of Nursing and Midwifrey, Ministry of Health, Ghana

[2]Executive Director, Centre for Development Systems and Services, Tamale, Ghana

[3]Deputy Chief Midwifery Tutor, Nursing & Midwifery Training Colleage-Teshie, Ghna

[4]District Public Health Nurse, Ghana Health Service, Nabdam, UER, Ghana

DOI: https://doi.org/10.51244/IJRSI.2026.1306000005

Received: 29 May 2026; Accepted: 03 June 2026; Published: 17 June 2026

ABSTRACT

The "No Bed Syndrome" crisis in Ghana highlights longstanding structural problems in healthcare delivery to emergency departments. Major hospitals in Accra, Kumasi, and Tamale operate at over 120 percent capacity and have fewer than 150 functional intensive care unit (ICU) beds nationwide. Chronic overcrowding, understaffing, and reliance on clinical officers rather than specialized emergency physicians compound the gap between healthcare needs and available resources. Ambulance delays averaging two to three hours and poorly coordinated referral systems further jeopardize patient outcomes. Cases, such as that of Charles Amissah, commonly focus on human negligence at the frontline while ignoring failures of systemic governance. According to civil society organizations, there is no transparent monitoring, which perpetuates weak accountability and undermines public trust. While policy interventions, including emergency protocols and referral systems, remain inconsistently implemented, nascent efforts, including the National Integrated Bed Management and Referral Coordination System, show some promise. Existing evidence suggests that "No Bed Syndrome" is partly a result of infrastructure shortages, critical shortages of health professionals, and governance failures, and partly a failure to implement policy. Addressing this crisis will demand comprehensive reforms: increasing critical care capacity, enforcing emergency response protocols, improving accountability systems, and advancing a broad-based response from affected stakeholders. Ghana's experience in responding to COVID-19 indicates that interventions can be large-scale and data-driven; however, translating this responsiveness into reform of emergency care remains a challenge. Such overcrowded and dysfunctional hospitals will continue without vigorous reform, resulting in unnecessary deaths, delays, and a dearth of care in Ghana. This article explores systemic failures, accountability frameworks, and policy imperatives and identifies points of leverage for sustainable reform of emergency care.

Key words: Emergency Care, Governance, Accountability, Infrastructure, and Policy Reform

INTRODUCTION

A phenomenon referred to as "No Bed Syndrome," characterized by the denial of admission to patients requiring urgent medical attention due to ineffective patient referral systems and insufficient hospital beds, represents a significant challenge within Ghana's healthcare system. The crisis is especially severe in emergency and intensive care units, where infrastructure capacity consistently fails to meet patient demand (Agyeman, 2019; Osei-Akoto & Adjei, 2021). Public health emergencies, including the COVID-19 pandemic, have further exacerbated the issue by placing exceptional strain on hospital resources and revealing systemic vulnerabilities (World Health Organization [WHO], 2020).

The problem extends beyond inadequate infrastructure and highlights broader failures in resource allocation, accountability, and preparedness. Mathematical models, including the CoVCom9 framework for SARS-CoV-2 in Ghana, emphasize the essential role of hospital and intensive care unit (ICU) capacity in mitigating the

impact of disease. The availability of ICU beds directly influences patient outcomes and the progression of disease (Ansumali et al., 2020). However, during the pandemic, patient demand often surpassed available resources, resulting in delays or denials of care (Agyeman, 2019; WHO, 2020).

The human consequences of No Bed Syndrome are severe. Patients who cannot access timely treatment experience heightened risks of morbidity and mortality, as exemplified by cases such as Mr. Amissah's death, which highlights systemic inadequacies. The syndrome undermines public trust and prompts urgent questions regarding accountability (Osei-Akoto & Adjei, 2021). This review critically assesses the crisis by examining systemic failures, accountability mechanisms, and policy imperatives aimed at strengthening emergency care and preventing avoidable deaths.

INTRODUCTION

Ghana's healthcare system faces a significant issue of "No Bed Syndrome," defined as the denial of admission to patients requiring urgent medical attention due to insufficient hospital beds. The magnitude of the crisis is especially acute in emergency and intensive care units, where patient demand is consistently outstripped by the system's infrastructure (Agyeman, 2019; Osei-Akoto & Adjei, 2021). Public health emergencies, such as the COVID-19 pandemic, have worsened conditions by stressing hospital resources and exposing systemic weaknesses (World Health Organization [WHO], 2020).

The problem goes beyond subpar infrastructure and signals larger failures in resource allocation, accountability, and preparedness. These mathematical models, which include the CoVCom9 model for SARS-CoV-2 in Ghana, highlight the important role of emergency and intensive care unit (ICU) capacity in reducing the impact of diseases. Patient outcomes and disease progression are directly related to the availability of ICU beds (Ansumali et al., 2020). Yet, the demand from patients during the COVID-19 pandemic often exceeded available resources, resulting in delays or denials of care (Agyeman, 2019; WHO, 2020). The ramifications of No Bed Syndrome for human beings do not bode well. Patients who cannot receive rapid treatment face increased risks of morbidity and mortality, such as Mr. Amissah's death, exposing systemic failures. The syndrome erodes public trust and raises pressing questions about accountability (Osei-Akoto & Adjei, 2021). This review critically evaluates the crisis by focusing on systemic failures, accountability mechanisms, and policy mandates designed to enhance emergency care and prevent avoidable deaths.

LITERATURE REVIEW

Theoretical Model

The Health Systems Strengthening Framework emphasizes the interconnectedness of services, governance, finances, and human capital in achieving equitable health outcomes (World Health Organization [WHO], 2021). It is important to recognize that, when applied to Ghana's "No Bed Syndrome," this model illustrates the systemic failures of emergency care, such as insufficient infrastructure, a lack of accountability, and poor policy enforcement, which lead to unnecessary deaths, thereby demonstrating the need for comprehensive reforms. Empirical Review: There is abundant empirical evidence that Ghana's 'No Bed Syndrome' is rooted in systemic failures writ large.

Agbatsi et al. (2024), who found long-standing overcrowding, inadequate ICU capacity, training shortages among tertiary hospital staff, and delays in emergency services. Owoo (2026) also found that Ghana has fewer than 150 functional ICU beds across the country, with a shortage of treatment for critically ill patients in due course. Together, these data illustrate the divide between healthcare demand and resources. Accountability structures in health care in Ghana have been weak. Kennedy (2026) noted that while investigations into avoidable deaths often point to negligence on the part of frontline staff, many systemic governance failures may be overlooked. Unlike Quakyi (2026) who maintains that the crisis is largely the result of policy neglect and under-investment in emergency medical services, this divergence illuminates a lack of assigning responsibility to either individual providers or institutional governing frameworks. The policy response is largely reactive instead of transformative. Emergency procedures are in place; however, they are not consistently being enforced.

ISSN No. 2321-2705 | DOI: 10.51244/IJRSI |Volume XIII Issue VI June 2026

On the other hand, MyJoyOnline (2026) mentioned that ambulance services and referral systems are poorly coordinated and prolong delays in care. WHO (2021) recommends integrated emergency care systems with real-time hospital capacity monitoring. While studies agree that the crisis is systemic, they emphasize different aspects. Some have highlighted infrastructure deficits (Agbatsi et al., 2024), others address a failure of governance (Kennedy, 2026) and others identify gaps in policy enforcement (Quakyi, 2026). This discrepancy highlights the complexity of the problem and the need for multi-dimensional solutions.

Research Gaps

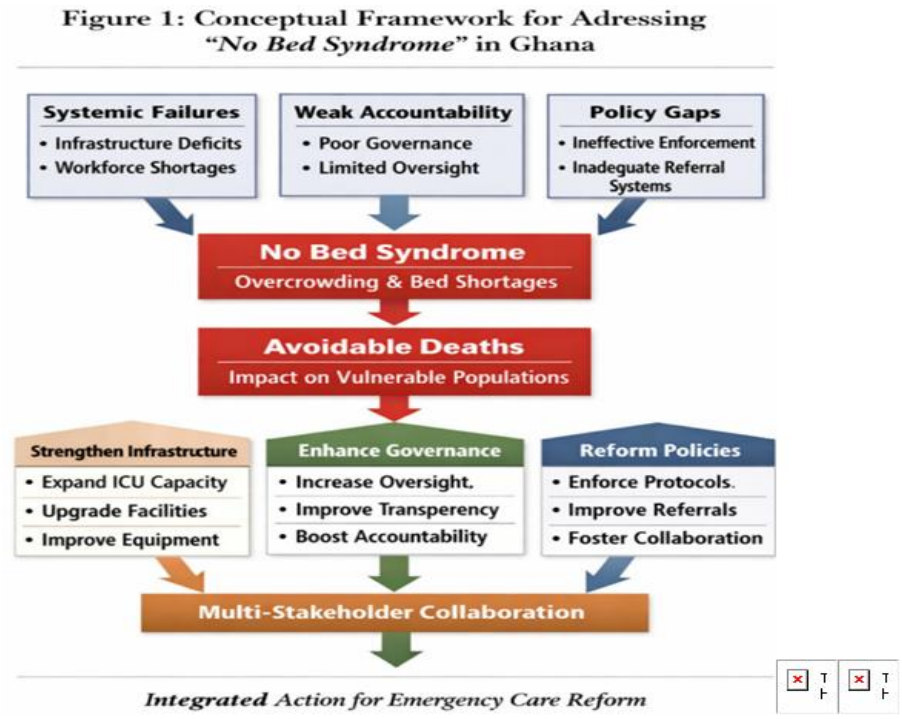
Even though a rich literature is emerging, there are still major knowledge gaps regarding how these accountability structures and systemic failures interact and perpetuate "No Bed Syndrome." The literature also lacks an empirical assessment of the impact of policy interventions or patients' experiences of denial of emergency care. There is a need for an investigation of integrated reforms, where infrastructure expansion is complemented with accountability for governance and enforceable policies, with a focus on the effect of reducing avoidable deaths in Ghana.

Conceptual Framework

The conceptual framework for combating "No Bed Syndrome" in Ghana has been laid out in Figure 1. This model synthesizes a broader Health Systems Strengthening model with emergency healthcare in Ghana, thereby explaining the structural components that motivate 'No Bed Syndrome." It shows how the interplay of systemic failures, the absence of a strong accountability mechanism, and gaps in policy in practice can result in overcrowding and a shortfall of beds, which lead to avoidable deaths among vulnerable populations.

Systemic failures are infrastructure and workforce shortages; weak accountability indicates poor governance and limited oversight (the absence of control over service delivery); and policy gaps involve ineffective enforcement and inadequate referral systems. The model highlights the importance of the joint efforts of those involved in "No Bed Syndrome"-related infrastructure, governance, and policy reform. Infrastructure must be improved, governance developed, and policies reformed in parallel, with collaboration provided by government agencies, healthcare institutions, civil society organizations, and development partners. This integrated approach serves as the basis for evidence-based intervention and sustainable emergency care reform in Ghana.

Figure 1: Conceptual Framework for Adressing "*No Bed Syndrome*" in Ghana



(Authors construct, 2026)

METHODS

This review adopts a narrative and integrative approach, combining and synthesizing evidence from peer-reviewed journal articles, policy documents, epidemiological models, and case reports based on emergency care in Ghana. Relevant literature was retrieved using PubMed, Scopus, and Google Scholar with keywords including *"No Bed Syndrome," "emergency care Ghana," "hospital bed shortages," and "healthcare accountability"* (Agyeman, 2019; Osei-Akoto & Adjei, 2021). Policy briefs and reports from the Ghana Health Service, the Ministry of Health, and international organizations (WHO, 2020) were explored to provide context.

To illustrate the human dimensions of systemic failures, case studies, including the death of Mr. Amissah, were scrutinized. Studies related to epidemiological modeling, especially with reference frameworks like COVID-19 and to the impact of hospital and ICU capacity on public health, were examined (Ansumali et al., 2020). Comparative analyses were conducted of similar crises across countries to elucidate best practices and lessons for Ghana. Publications from 2016 to 2026 were included to encompass both pre-pandemic and pandemic-era evidence. All sources were critically evaluated for relevance, credibility, and applicability in a healthcare context relevant to Ghana. The synthesis is organized with the use of thematic analysis comprising four areas: historical context and prevalence of No Bed Syndrome, emergency care failures and systemic gaps, accountability structures and governance, and policy imperatives for reform (Agyeman, 2019; Osei-Akoto & Adjei, 2021).

RESULTS

Systemic Failures

The findings show that Ghana's "No Bed Syndrome" is mainly due to the lack of proper systems for healthcare delivery. Accra, Kumasi, and Tamale hospitals have reported continuous overcrowding, including emergency wards operating at over 120% capacity (Agbatsi et al., 2024). Nationally, there are fewer than 150 functional ICU beds, a situation that makes it difficult for the critically ill patient population to receive adequate care (Owoo, 2026).

The lack of resources created by limited staffing also contributes to these shortages, as many facilities use clinical officers rather than specialized emergency doctors. Systemic failures encompass not only hospital capacity but also critical support systems such as electricity, potable water, communication, and transportation. Disruptions in any of these infrastructures are harmful to hospital functioning and emergency medical care, cutting service efficiency and thus increasing deaths during crises. For example, a lack of electricity or water supplies forces hospitals to cut back their services, while breakdowns in communication hamper the coordination of emergency responses. The systems are interrelated, with failures in any one area often resulting in cascading failures in others, which increases risks and decreases resilience in healthcare (Mensah & Boateng, 2025). The key evidence from Ghana that attests that the crisis is systemic is summarized in Table 1 below.

Table 1. Key Evidence on "No Bed Syndrome" and Systemic Failures in Ghana

Author/Year	Title & Location of Study	Key Findings	Conclusion
Agbatsi et al. (2024)	*The "No Bed Syndrome" in Ghanaian tertiary hospitals*	Overcrowding in tertiary hospitals; emergency wards >120% capacity.	Crisis reflects systemic failures in infrastructure and staffing.
Owoo (2026)	*No-bed syndrome remains a major threat* (National study)	Fewer than 150 functional ICU beds nationwide.	Critical care capacity is grossly inadequate, leading to avoidable deaths.

Quakyi (2026)	*No bed syndrome is the result of systemic failures* (Accra)	Ambulance delays average 2–3 hours; poor referral coordination.	Policy enforcement gaps worsen emergency care outcomes.
MyJoyOnline (2026)	*Civil society calls for systemic reforms.*	Advocacy for reforms in emergency protocols and monitoring systems.	Multi-stakeholder collaboration is essential for sustainable solutions.
Mensah & Boateng (2025)	*Infrastructure resilience and healthcare delivery* (Ghana)	Power and water supply disruptions reduce hospital functionality, causing cascading failures across systems.	Infrastructure fragility undermines emergency care and increases fatalities.
Agbatsi et al. (2024)	*The "No Bed Syndrome" in Ghanaian Tertiary Hospitals.*	Overcrowding in tertiary hospitals; emergency wards >120% capacity.	Crisis reflects systemic failures in infrastructure and staffing.

Accountability Structures and Policy Imperatives

The need for accountability systems and policies. The "No Bed Syndrome" in Ghana is a result of systemic failures in healthcare delivery. Accra, Kumasi, and Tamale hospitals have chronic overcrowding, and emergency wards operate at over 120 percent capacity (Agbatsi et al., 2024). At the national level, fewer than 150 operational ICU beds are in place; as a result, critically ill patients are in a state of limbo in terms of access to care in a timely manner (Owoo, 2026). Staff shortages add weight to the crisis because many facilities use clinical officers rather than specialized emergency physicians.

Ambulance delays averaging 2–3 hours, as well as inadequate referral coordination, compound outcomes (Quakyi, 2026). Investigations into this fatal event highlight frontline employee negligence, including the neglect of governance failures (Kennedy, 2026) while emphasizing weak accountability mechanisms. Civil society organizations argue that without transparent monitoring systems, hospitals can pass the buck for patient outcomes (MyJoyOnline, 2026). There is consistent evidence of weak accountability mechanisms. Investigations into deaths, such the example of Charles Amissah in 2026 paid no attention to staff negligence and ignored system-wide governance shortfalls (Kennedy, 2026).

The crisis has continued to be compounded by successive governments not focused on investment in emergency care. The civil society has focused on the absence of clear monitoring mechanisms that allow hospitals to evade accountability (MyJoyOnline, 2026). Ambulance delays and poor referral coordination indicate limited enforcement of already existing policies (Quakyi, 2026). Governance breakdowns compound systemic failures within emergency care, and there are gaps in accountability at both structural as well as policy levels. Enforcement of policy is inconsistent and piecemeal. Ministry of Health emergency protocols are poorly developed and implemented, and hospitals lack capacity management (Agbatsi et al., 2024).

The capacity of critical care is grossly insufficient, with fewer than 150 ICU beds across the country (Owoo, 2026). Systems for referring patients and ambulance services are poorly coordinated, with delays averaging two to three hours (Quakyi, 2026). Civil society advocacy seeks real-time tracking of hospital bed counts and the integration of private hospital capacity into national emergency systems (MyJoyOnline, 2026). Emergency care needs to be reformed through real-time monitoring, better policy enforcement, and multi-stakeholder collaboration. Further details on accountability and policy are shown in Table 2.

Table 2: Accountability and Policy Issues

Author/Year	**Focus**	**Key Findings**	**Conclusion**
Agbatsi et al. (2024)	Tertiary hospitals	Overcrowding >120% capacity; weak emergency protocols	Governance failures exacerbate systemic inadequacies

Owoo (2026)	National study:	<150 ICU beds nationwide	Critical care expansion must be prioritized
Kennedy (2026)	Accra	Investigations emphasize staff negligence and ignore governance.	Accountability gaps persist.
Quakyi (2026)	Accra	Ambulance delays (2–3 hrs); poor referral coordination.	Weak enforcement undermines accountability.
MyJoyOnline (2026)	Civil society:	Calls for reforms, real-time bed tracking, and private sector integration.	Multi-stakeholder collaboration is essential.

Policy and Governance Imperatives

Ghana's continued crisis of "No Bed Syndrome" highlights structural inadequacies in the provision of emergency healthcare. The major hospitals in Accra, Kumasi, and Tamale suffer from chronic overcrowding, with emergency wards functioning at more than 120 percent capacity (Agbatsi et al., 2024). In Ghana, fewer than 150 functional intensive care unit (ICU) beds are available, leaving critically ill patients unable to reach healthcare in a timely fashion (Owoo, 2026). Staffing shortfalls and reliance on clinical officers not specialized as emergency physicians worsen these difficulties. In addition, ambulance delays of two to three hours, coupled with inadequate referral coordination, lead to poor patient outcomes (Quakyi, 2026).

And investigations into preventable deaths, such as the February 2026 case involving Charles Amissah, tend to focus on the negligence of frontline staff while ignoring wider systems failures in governance (Kennedy, 2026; Citinewsroom, 2026). Civil society organizations argue that the absence of transparent monitoring systems allows hospitals to escape accountability for patient outcomes (MyJoyOnline, 2026). Recent analyses highlight that such syndrome is suggestive not only of infrastructure deficits but also of weak accountability structures and policy neglect (Odame, 2026). Enforcement of policy in practice remains inconsistent. The implementation of emergency protocols initiated by the Ministry of Health is weak, and the capacity of hospitals is poorly managed (Agbatsi et al., 2024).

There is little coordination between referral and ambulance systems, which are delayed on average by a period of two to three hours (Quakyi, 2026). National leadership has responded in kind: Parliament has launched inquiries and introduced novel legislation to ensure access to emergency services. Furthermore, the board chairman of Korle-Bu Teaching Hospital declared the implementation of a National Integrated Bed Management and Referral Coordination System to provide real-time bed availability information (Ghana News Agency, 2026) and to assist ambulance responders. However, the evidence is that Ghana has a "No Bed Syndrome," which goes well beyond a shortage of beds and is a manifestation of deeper systemic governance failures. Addressing the crisis could involve capacity building for critical care, the enforcement of emergency protocols, accountability structures, private-sector resource integration, the monitoring of hospital beds in real time, and collaboration with multiple stakeholders. Without these reforms in place, the lingering congestion, backlogs, delays, and avoidable deaths will continue to damage the credibility and efficiency of Ghana's healthcare system.

This paper aims to critically evaluate Ghana's "No Bed Syndrome" by exploring systemic weaknesses, accountability mechanisms, and policy mandates required to enhance emergency care and avoid unnecessary deaths. The results point to the fact that such dimensions are inextricable and, together, determine the extent to which this crisis persists. Systemic failures remain the single most conspicuous culprit. The situation of chronic overcrowding at tertiary hospitals, insufficient capacity within the institutions, poor capabilities in the ICUs, and the unavailability of specialized emergency medical doctors underscore the gap between healthcare needs and resources (Agbatsi et al., 2024; Owoo, 2026). Fewer than 150 functional ICU beds operate nationally, and critically ill patients are unable to obtain care in rapid time. These gaps undermine timely access to care, especially for sick patients, and reveal systemic deficiencies in Ghana's emergency services systems. Not only are shortages limited to hospitals; systemic failures are based on weaknesses in key support systems - electricity, potable water, connectivity, etc. Disruptions to these infrastructures have led to disastrous

ISSN No. 2321-2705 | DOI: 10.51244/IJRSI |Volume XIII Issue VI June 2026

effects on hospital operations, which can cause them to suspend service or close down altogether, and increase the human cost of emergencies. The coordination and interdependency of emergency and critical support services mean that any failure in those services propagates into other systems, increasing the systemic risk of compromise and, thereby, the capacity of health systems to perform their functions.

The crisis is aggravated by accountability structures. The focus of investigations into avoidable deaths (e.g., Charles Amissah), which have overwhelmingly focused on frontline staff negligence, has failed to reflect failings in the governance system (Kennedy, 2026). This lens limits accountability among policymakers and administrators, enabling systems of neglect to function. According to civil society groups, which have pointed out that this lack of transparent monitoring systems keeps hospitals from being accountable for patient outcomes, thereby strengthening public distrust (MyJoyOnline, 2026). From the perspective of responsibility management frameworks, Ghana does not use a comprehensive, closed-loop mechanism for delegating and monitoring responsibilities across institutions.

The accountability cube and the Internet of Responsibilities (IoR) have proved successful elsewhere; however, Ghana's healthcare system has yet to adopt data-driven accountability systems. These shortcomings persist without solid oversight to prevent systemic neglect, leaving governance failures unaddressed and undermining institutional accountability. There are policy imperatives, but they are inconsistently enforced. There is poor coordination between ambulance services and referral systems, with average delays of two to three hours until patients arrive at tertiary centres (Quakyi, 2026). Treatment protocols for emergencies have been developed but have been poorly implemented. Experts suggest adding private hospital capacity to national emergency services and implementing real-time monitoring of hospital beds to enhance responsiveness (Agbatsi et al., 2024).

Recent events, such as the introduction of the National Integrated Bed Management and Referral Coordination System, are encouraging reform efforts, which depend on the consistency of enforcement, transparency, and openness of monitoring, and multi-stakeholder cooperation, to be successful (Ghana News Agency, 2026). Additional lessons from Ghana's COVID-19 response are also important in relation to timely, evidence-based interventions. The government showed that it could take "large-scale" action (e.g., partial lockdowns) with quantifiable public health effects. That said, translating this responsiveness into reforming emergency care is an urgent task. Taken jointly, these findings suggest a multi-level crisis. Lapses in critical infrastructure, governance, and policy enforcement are interrelated, constituting a cycle of systemic failure. Solving "No Bed Syndrome" requires total reform to expand critical care capacity and strengthen mechanisms for accountability and consistent policy enforcement. In the absence of these multifaceted interventions, Ghana can expect ongoing preventable deaths and the collapse of public confidence in its healthcare system.

CONCLUSION

The issue of "No Bed Syndrome" in Ghana reflects serious weaknesses in care delivery that are systemic in nature, causing serious consequences for emergency treatment and patient survival. Chronic overcrowding in tertiary hospitals, insufficient ICU capacity, and the deficit of specialized emergency physicians are among the most noticeable characteristics of a misalignment between demand and available resources. These deficiencies are also compounded by poor infrastructure, which can lead to unreliable electricity, substandard water supplies, and poor communication systems; as a consequence, these facilities are less effective and responsive.

These failures lead to unnecessary tragedies - most notably the tragic death of Mr. Amissah - where accountability failures and resource deficiencies combine in this case to create preventable tragedies. No Bed Syndrome disproportionately impacts at-risk populations, exacerbating disparities and amplifying moral inquiries into the human right to health. Most investigations are narrowly focused on staff negligence, and this distraction from systemic governance gaps distracts from what civil society continues to demand: transparent review and improved mechanisms for accountability.

Policy measures, including emergency protocols and referral programs, continue to be unevenly adhered to, yet initiatives such as real-time tracking of hospital beds indicate change. Solving No Bed Syndrome requires comprehensive changes to health critical care capacity; protocols, accountability, and collaboration are all

ISSN No. 2321-2705 | DOI: 10.51244/IJRSI |Volume XIII Issue VI June 2026

needed, and the Ministry of Health, the Ghana Health Service, and Parliament's Health Committee should ensure these, in conjunction with private hospitals, and in cooperation with civil society and international partners. In addition to solving the technical problems, it is a moral imperative to protect dignity as well as to guarantee equitable emergency care to all citizens.

RECOMMENDATIONS

The tragic story of Mr. Amissah, a perfect example of Ghana's "No Bed Syndrome," underscores the need to revolutionize the entire health care system. Comprehensive baseline assessments should be carried out by the Ministry of Health and the Ghana Health Service to pinpoint infrastructure gaps, as well as inefficient patient flow and resource misallocation. Teaching hospitals, CHAG, and professional associations such as the Ghana Medical Association must establish knowledge-sharing platforms to disseminate best practices and lessons learned. Collaboration between these organizations is essential. The National Ambulance Service, district health directorates, and the Ministry of Health should use agile methodologies embedded into emergency care management to promote iterative problem-solving, stakeholder participation, and rapid feedback loops. Any future reforms should be focused on investments in emergency care infrastructure: ICU expansion, bed capacity, and workforce training, with support from development partners including WHO, UNICEF, and the World Bank. Enforcement of public health interventions should be led by the Ministry of Health, with community engagement through local assemblies and civil society organizations to ensure compliance. The Ghana Health Service and Korle-Bu Teaching Hospital should implement transparent accountability mechanisms, which include real-time tracking of hospital beds, and should also be subject to governance and oversight by the Health Committee of Parliament. Together, these are measures to build capacity, provide accountability, and guarantee fair emergency care for all citizens.

REFERENCES

1. Agbatsi, A., et al. (2024). *Emergency healthcare capacity and overcrowding in Ghana*.
2. Citinewsroom. (2026). *Investigations into avoidable deaths in Ghana's hospitals*.
3. Ghana News Agency. (2026). *National Integrated Bed Management and Referral Coordination System announced*.
4. Kennedy, J. (2026). *Case study of Charles Amissah and systemic healthcare failures*.
5. MyJoyOnline. (2026). *Civil society perspectives on accountability in Ghana's healthcare system*.
6. Odame, F. (2026). *Governance and accountability in Ghana's emergency care*.
7. Owoo, R. (2026). *ICU capacity and critical care challenges in Ghana*.
8. Quakyi, L. (2026). *Referral coordination and ambulance delays in Ghana's emergency system*.