

Decentralization in the Ghana Health Service: A Study of the Upper West Region

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Abstract

This study analysed the extent of decentralization in the Ghana Health Service (GHS) and the effect it has on the management of the Service. A retrospective descriptive study method was employed in the study. Questionnaires and interviews were used to obtain views from health managers at the various levels in the GHS. The study used frequencies, percentages, tables and graphs to analyze the results. The study revealed a limited application of decentralization in the GHS. The execution of key management functions were adversely affected by the level of decentralization in the study area. For decentralization in the GHS to yield beneficial outcome or be successful, there is the need for some reforms or preconditions. Without these reforms, the status quo may just persist.

Keywords: Decentralization, Ghana Health Service, Upper West Region

1. Introduction

African countries have undergone waves of decentralisation reforms since their independence. In Africa in general, and Ghana in particular, decentralization is now at the heart of government business and on-going reforms (Alam and Koranteng, 2007).

Reforms in the public health sector in developing countries have been a major policy focus over the last three decades. One such reform in the sphere of governance is decentralization. It is generally conceived as reform towards reducing central control and to promote local autonomy. Rondinelli (1981) conceptualizes decentralization as a process of transfer of authority in public planning, management and decision making from national level to sub-national levels. These reforms are generally aimed at addressing some obstacles and ills of the public systems in which they are applied.

The rationale that has underpinned the application of decentralization by some countries include: responding to local needs and building local capacity, increasing public participation, encouraging intersectoral cooperation, reduce fiscal burden at central level, improve health sector performance and accountability, increased potential to develop new funding mechanisms, improve cost effectiveness, improve autonomy and equity of access to care.

In Ghana, the purpose for decentralization is viewed in several folds. Bossert and Beauvais (2002) in World Development Report (1993) illustrated the rationale as improving allocative efficiency, improving technical efficiency, creating service delivery innovations and improving quality. The rest are transparency, accountability and legitimacy. However, the problem associated with such reforms include: the lack of commitment of the various players to the process, their political nature, the resource requirements to sustain the reform process, institutional capacity and the need for good data as a basis to justify the reform process.

A major area of constraint in the implementation of decentralization in Ghana is the limited transfer of authority from the central agencies to the sub-national structures with its concomitant effect on the management of health systems. This limitation is much more pronounced at the peripheral levels. Therefore, the seeming recentralization at some sub-national levels of GHS poses a great threat towards the achievement of health sector objectives. These constraints may serve as an obstacle to the achievement of health sector objectives.

The objective of the paper is to analyse the extent of decentralization in the Ghana Health Service (GHS) and the effect it has on the management of the Service in the Upper West Region of Ghana.

The rest of the paper is organized as follows: Section 2 is the literature review. Following is the methodology in section 3. The results and discussion is presented in section 4. Lastly section 5 is the conclusion of the study.

2. Literature Review

2.1 Concept of Decentralization

It is generally perceived as a reform process designed to reduce central influence and promote local autonomy. Berman and Bossert (2000) provide a related conceptualization. According to these researchers, decentralization is the transfer of decision making from central government bodies to local officials to tailor service provision to the needs of local populations. The focus of the aforementioned conceptualization is overly shadowed by emphasis on meeting the needs of the local populace. In certain jurisdiction of the concept, some emphasis is placed on some attributes deemed to be importantly associated with the concept such as decision making authority, elections, fiscal resources, government and personnel.

Rondinelli (1981) sees decentralization as a process of transfer of authority for public functions from a country's central government to sub-national levels of government or autonomous institutions. This posits that the concept is based on the type of responsibility devolved and by the level of autonomy granted to local authorities.

2.2 Typologies of Decentralization

A common taxonomy classifies decentralization by three categories of responsibilities: political, administrative and fiscal (Hutchinson and LaFond, 2004). An extension to this categorization is the addition of market decentralization proposed by Egbenya (2009). He states that, decentralization can be in the form of political, administrative, fiscal and market decentralization. Market decentralization accounts for the direction of public enterprise decentralization in the form of privatization and deregulation

2.2.1 Political Decentralization

Political decentralization involves providing citizens or their representatives with additional public decision making power, in particular through democratic process (World Bank, 2000). The rational and principal assumption of political decentralization is that decisions made with greater participation will be better informed and more relevant to diverse interest in society than those made by national political authorities.

The reality however provides some level of variance because though political decentralization has this assumption, the process of selecting representatives, personal disposition and interest will determine the level to which they will represent the interest of their constituents.

2.2.2 Administrative Decentralization

Administrative decentralization deals with the transfer of the responsibility for planning, financing and management of certain public functions from central agencies to field units of government agencies, subordinate units or levels of government (Rondinelli, 1999). This form of decentralization is particularly common in the provision and management of social services to the populace such as health. Administrative decentralization is made up of four sub-categories namely: deconcentration, devolution, delegation and privatization.

2.2.3 Fiscal Decentralization

Fiscal decentralization refers to devolving to local levels government control over financial resources either in terms of expenditure, assignments or revenue generation (Hutchinson and LaFond, 2004). It is the situation in which decision about expenditure of revenues raised locally or transferred from central government are done by the local authority. Various shades of prerogatives may exist from its most limited forms to complete autonomous prerogative.

2.2.4 Economic or Market Decentralization

This is the form of decentralization where there is a shift from public to private sector. Particular shades of economic decentralization are deregulation and privatization. Privatization is the transfer of responsibility from government to private entities designed so that market-style efficiency gains can be generated through higher levels of autonomy and decision making responsibilities (Mills, 1994).

Assessing the various typologies proffered by the various researchers, the impression is that these categories are distinct and mutually exclusive. It also provides the shaky grounds that there are clear states of the attainment of one category of decentralization or the other.

Also from the available literature, a contradiction occurs in conceptualizing the typologies of decentralization.

While some scholars view privatization and deregulation as a sub-category of administrative decentralization, others view it as co-terminus with market or economic decentralization.

2.3 Effects of Decentralization

The experimentation of decentralization has yielded mixed results from the assessment conducted by several researchers across countries. Some clear areas for which data was available are the impact it had on finance, human resource, community participation, equity and access to health care. Some comparative analysis is contained in the following.

2.3.1 Finance

With respect to financial discretion, a comparative country study realized varying results. In Ghana, financial discretion as a result of decentralization was limited to local level Budget Management Centres (BMC), while expenditure regarding salaries and capital investments are determined centrally (Bossert & Beauvais, 2002). In Uganda, delegated salaries and vertical programme funding through a block allocation system comprised a large percentage of the funding transferred to districts which means that discretion is very limited to approximately 25% of funds in the district annual plans (Hutchinson 1998). In the Philippines, central transfer system was relatively unburdened with earmarking set aside and other expenditure constraints. A general observation is that, donor funding for vertical programmes which accounted for a greater percentage of funding to districts health system in the aforementioned countries comes with limited discretion.

With respect to income sources and fiscal autonomy, despite the increase in proportion of resources spent at the sub-national levels, own-resource revenue was comparatively small and local institutions remained dependent on central transfer in Ghana, Uganda, Zambia and Philippines (Bossert and Beauvais 2002). In Ghana, user fees accounted for 19% of MOH expenditure while in Zambia income generated from local level was much less significant than in the case of Ghana. Ugandan own-source revenue amounted to 6.5% of district income while 35% of Philippines health expenditure is associated to own-source revenue (Bossert and Beauvais 2002).

2.3.2 Governance and Community Participation

The effects of decentralization on governance and community participation are mixed and depend on the module of decentralization implemented. In Ghana, the system provided little or no mechanism for local governance popular participation in health sector decision making. Mensah (1997) provides that, the district health committees had their roles intentionally limited to advising the GHS and was minimal. Zambia had a relative impressive structure of citizen participation from the facility level to the district level, but these mechanisms had only been implemented to a limited degree (Bossert and Beauvais, 2002). Uganda had more democratic institutions but mechanisms for participation in health sector governance appeared weak. In the Philippines the process did not involve transfer of power to the community but rather devolution from state officials to the mayor (Ramiro et al. 2001).

2.3.3 Access

From previous studies with regard to this subject, targeting and health sector programming was moderately decentralized. In most cases performance contracts were used as a mechanism for centrally controlling local health authorities particularly in Ghana and Philippines (Bossert and Beauvais, 2002). The rationale of this control could be to enforce the implementation of local national priorities. The likelihood of exacerbating inequity of existing difference is eminent with central government ceding the responsibility for redistribution of income from well-off jurisdictions to less-off jurisdictions. Without the appropriate capacity and distribution mechanism at the sub-national level, such fears can be entertained.

2.3.4 Equity

A study which examined the effects of decentralization on aspects of equity, such as equity of access, utilization of health service or service outcomes realized that, there was more equitable access to care due to increasing budget allocation to districts and more direct control of spending decisions (Agyepong, 1999). In Zambia, the reverse of the above situation was realized. The experience in Uganda is that, the greater fiscal autonomy provided for by decentralization increased utilization of health service for both public and private goods (Hutchinson et al, 2002).

2.3.5 Human Resource Management

Studies have revealed that Ghana and Zambia had more centralized system than the devolution case in Uganda and Philippines. The hierarchical system in place centralized decision of hiring, firing, contracting and salaries. In Ghana, particularly with reference to hospitals, autonomy was limited due to the direct control of activities of the hospital by Ministry of Health (MOH)/GHS (Bossert and Beauvais, 2002). In the case of Uganda and Philippines, devolution accorded the local health authorities some amount of autonomy to hire and fire (Bossert and Beauvais, 2002). Decentralization often requires enhanced skills and abilities of personnel at local levels to implement decentralized functions. However, research has proved a limitation to the process because of lack of adequate capacity and number of decentralized staff.

2.3.6 Quality of Care

The prospects of improving quality through decentralization are mixed with studies of some health systems providing evidence to this assertion. Jeppson and Okuonzi (2000) reported an improvement in curative services at the local level through local upgraded hospitals in Uganda. Hutchinson et al (2002) also reported a higher utilization of health services in decentralized districts than non-decentralized districts in Tanzania.

Rondinelli (1999) concludes the subject with the admonishing that to attain success, finances should be followed by clear assignment of functions, informed decision making, adherence to local priorities and accountability.

3. Materials and Methods

3.1 Research Design

A retrospective descriptive case study method was employed in conducting the study. This approach was used because it affords the researcher the opportunity to solicit appropriate answers in respect of the study objectives. It involved questionnaire application and in-depth interviews. A review of vital secondary data was conducted to provide necessary documentary evidence for the data obtained from the interviews and questionnaires.

3.2 Study Population

The study was conducted in the Upper West Region (UWR) of Ghana which is made up of a Regional Health Administration (RHA) at its apex, eleven (11) District Health Administrations, sixty-five (65) sub-districts and One Hundred and Sixty-Six (166) Community-based Health Planning and Services (CHPS) zones. This forms a four-layer administrative structure of the health service in the region. The study also included the six hospitals in the region. Managers/Heads of such institutions therefore formed the study subjects.

3.3 Sampling Technique

Purposive sampling was used to target the heads of the regional health administration, the eleven district health administrations and six hospitals. This made sure that heads of all such institutions were enlisted in the study. Applying a formula appropriate for organizational survey research, taking into account a confidence level($z_{\alpha/2} = 1.96$) of 95% and a margin of error of 5% a sample size of 50 sub-districts and 96 CHPS zones were selected for the study.

3.4 Data Collection Instruments

Questionnaires were used to elicit response from heads of the District Health Administrations, Hospitals, Sub Districts and CHPS zones. An interview guide was used to obtain responses from the Regional Health Administration. The quantitative data resulting from the structured questionnaires was analyzed using SPSS version 17.00.

4. Results and Discussion

4.1 Basic Characteristics of Respondents

Out of the 164 respondents, 75(45.7%) were males while 89(54.3%) were females. The above scenario is contrary to the popular assertion that management positions are usually the reserve of males. Figure 1 is a depiction of the gender of the respondents.

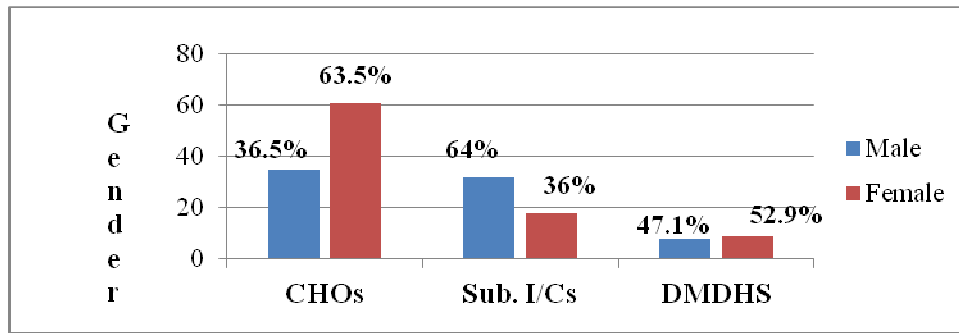


Figure 1: Gender of Respondents
 Source: Authors' Construct, 2013

With regard to the profession of respondents, an observable feature is that, medical doctors dominated as heads of hospitals thus Medical/District Directors of Health Services (DMDHS), Sub District(S/D) In-charges were mostly midwives and community health nurses were the dominant category among Community Health Officers (CHOs). The least qualification of the respondents was a certificate in community health nursing and varied to as much as Post graduate degrees.

4.2 Level of Management Autonomy In Human Resource Management

4.2.1 Management Authority to Appoint/Dismiss or Determine Staff Salaries

The results from the study indicate that, besides the Regional Director of Health Service (RDHS) who has limited authority to appoint staff, no other level in the service has authority to appoint staff. This authority was observed to be functional and not an initiating authority but also limited to category D & E (Staff who require no qualification to join the service eg. Orderlies and cleaners). Even with such categories the RDHS requires financial clearance and approval from the Ministry of Finance and Economic Planning (MOFEP) through the MOH. Much in the same way, managers at the various levels do not have authority to appoint or dismiss established staff. The role of managers is limited to making recommendations to national level for whatever action is required.

On the subject of authority to determine the payment or non-payment of staff salaries, the responses point to inadequate or lack of authority. These views are contained in figure 2.

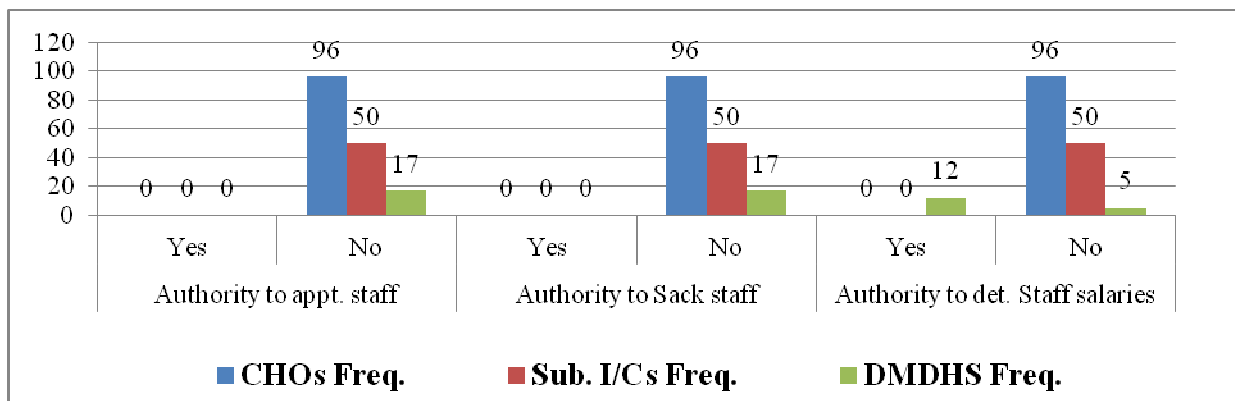


Figure 2: Views on Authority to Appoint, Dismiss or Determine Staff Salary
 Source: Authors' Construct, 2013

4.2.2 Promotion and Demotion

The results are varying depending on the level of management. Again at the last two hierarchies (thus CHPs Zones & SD), the indication is that they have absolutely no role in either promoting or demoting staff under their jurisdiction. A greater portion of respondents at the district/hospital levels indicate they play a role in the promotion of their staff. The results of level of autonomy and discretion with respect to managers' ability to promote or demote are shown in figure 3.

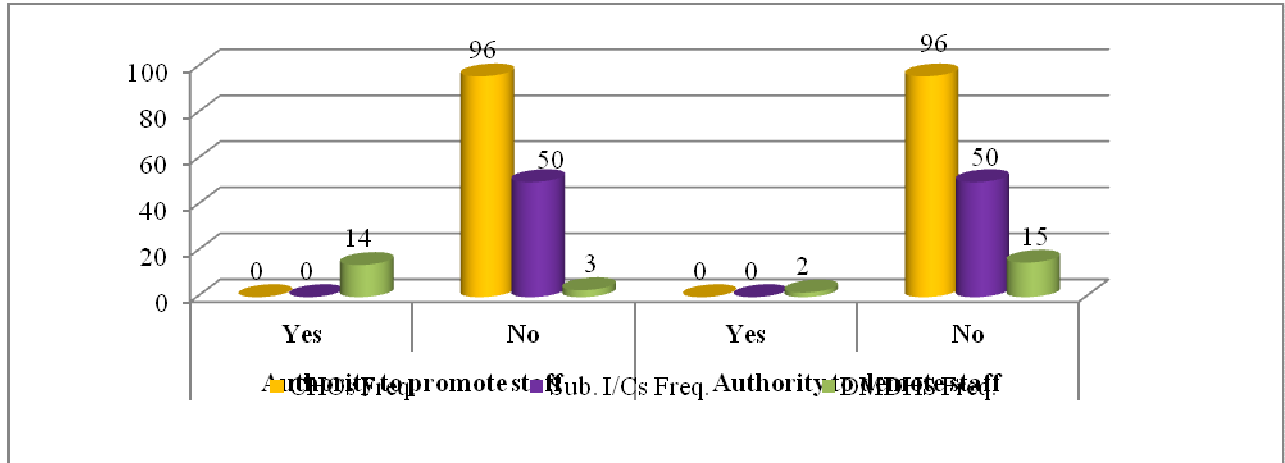


Figure 3: Managements' Authority to Promote or Demote Staff
 Source: Authors' Construct, 2013

Further assessment point to the fact that they either appraise staff under their jurisdiction for promotion or recommend them for promotion. At the regional level the prerogative is limited to category D & E staff. However with regard to other class of staff the RDHS could only recommend promotion or demotion.

4.2.3 Authority to Prepare Plans and Budget

Respondents' views at the level of the District/Hospitals indicate they prepare plans and budgets for their facilities using National/Regional Budget guidelines. Review of relevant documents indicates that the health service uses a planning and budgeting template of national character which is circulated to the various levels of the service. At the level of the SD and CHPs zones, the responses are mixed and vary between districts. It further points out that, the inclusion of such levels in planning and budgeting is not mandatory and at the discretion of the district managers. Figure 4 is a graphical indication of the Authority of CHO's, Sub I/C's and DMDHS to prepare plans and budgets.

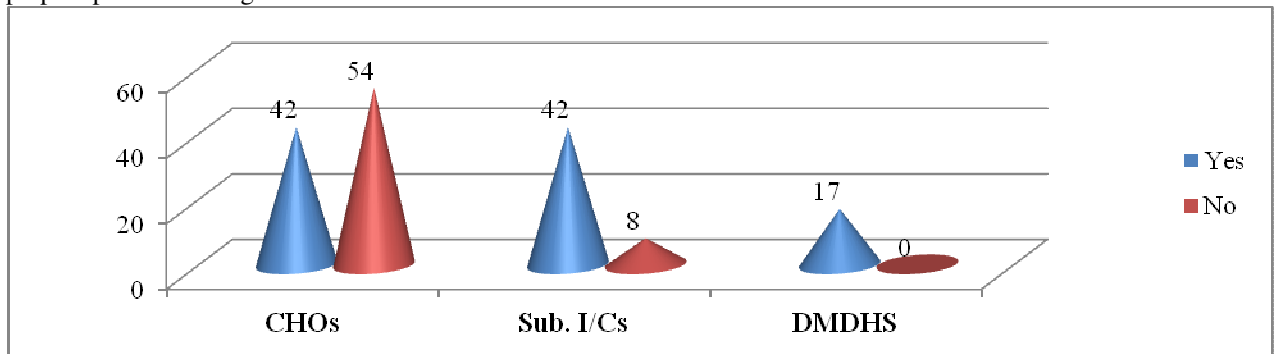


Figure 4: Views on Management's Authority to Prepare Annual Plans & Budgets
 Source: Authors' Construct, 2013

However, relevant literature indicates that, at levels where there is direct provision of service, the major source of revenue is internally generated funds. Conversely the other levels of the service are financed by subventions from the MOH. Other sources are donor funding and Local Authorities.

4.2.4 Account Operation and Signatory to Accounts

Seventeen, 17(100%), of respondents at the level of the district /hospitals operate accounts with managers being signatories to the accounts. Out of the 50 SD I/C's, 48(96%) have accounts in operation but 42(92%) of the total SD In-charges are signatories to the accounts. The contrast is however glaring when 85(88.5%) of the CHO's responding to the question indicate they do not operate accounts. With regard to signatories to the accounts, 88(91.7%) are not signatories to the accounts. This further suggests that out of the 11% who operate accounts for their zones almost all of them are signatories to the accounts they operate. Table 5 is a summary of their responses across the spectrum.

Table 5: Views on Existence of Bank Accounts and Signatories to the Accounts

		CHOs		SD. I/Cs		D/MDHS	
		Freq	%	Freq	%	Freq	%
Operation of own account	Yes	11	11.5	48.0	96	17	100
	No	85	88.5	2.0	4	0	0
Signatories to account	Yes	8	8.3	48.0	96	17	100
	No	88	91.7	2.0	4	0	0

Source: Authors' Construct, 2013

4.2.5 Determination of Expenditure & Authority to Expend Funds

At the regional level some level of financial leverage with regard to GOG allocation exists. However with regard to program funding or organizations which provide some intervention in health care, the authority to determine expenditure or expend such funds is limited.

At the other levels of the District/Hospital, the reports are mixed. However one clear indication is that financial autonomy diminishes as one moves from the level of the regional health directorate towards the CHPS Zones. The research also reveals that such autonomy is not absolute. Each level makes recourse to higher management hierarchy for approval or advice. Views of respondents on this matter are shown in figure 6.

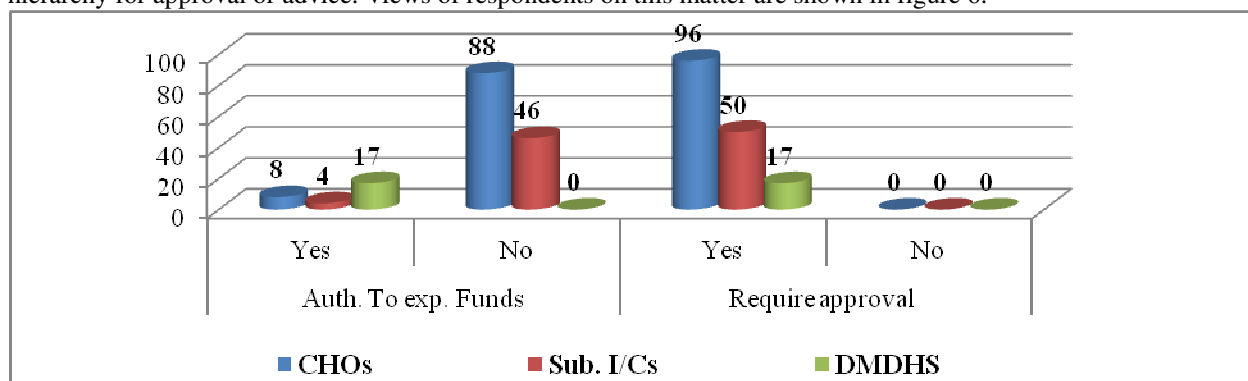


Figure 6: Managements' Authority to Expend Funds

Source: Authors' Construct, 2013

4.3 Governance and Community Participation

The view of the RDHS was that, the committee existed with the community duly represented. However with respect to functionality, he posited that *'they are not functional, as a matter of fact it is no more a legal entity because they all have time'*. The responses of the other levels of management are contained in Figure 4.6

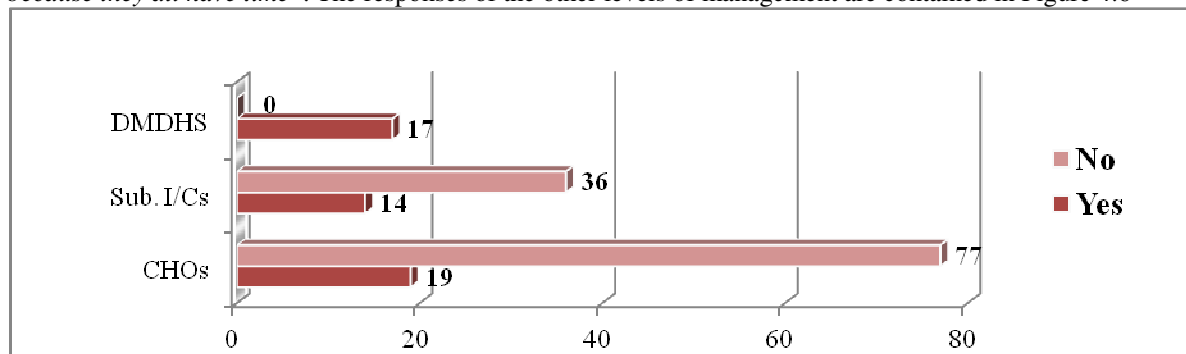


Figure 4.6: Managements' View on Existence of Health Committees/Boards

Source: Authors' Construct, 2013

As a way of representing the communities' interest in management, the high level of non existence of these committees is indicative of the subordinating interest of the community in management. The reasons offered by respondents for the non-existence of these committees vary. They range from lack of commitment of members,

transfers to a high level of non response. This could be interpreted to mean lack of action on the part of the managers to get these committees established and made functional.

5. Conclusion

The study established that, the practice of decentralization in the management of GHS was quite limited. This is corroborated by the centralized management of key management functions such as planning and budgeting; management of human resources; financial management and governance; and community participation. The execution of key management functions were adversely affected by the level of decentralization in the study area. Decentralization as articulated by Hutchinson and Lafond (2004) is not a cure in itself to all ills of a poorly functional health sector. For decentralization to yield beneficial outcome or be successful at the level of the study there is the need for some reforms or preconditions. Without these reforms, the status quo may just persist. The study however lacks an encompassing set of indicators to assess the effect of this limited decentralization on health sector performance and therefore recommends further research in this area.

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