Decentralization and Health Sector Reform in Ghana: A Former Health Minister's Experience

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Purpose

- The purpose of this presentation is to analyze and share with Public Health practitioners the experiences of a former Health Minister of the Republic of Ghana in reforming the Health Sector.

Sources of Data

- Government documents relating to the decentralization policy of 1989
- The Ghana Health Service and Teaching Hospitals Act, 1996
- Act 525

Sources of Data

- Interviews with selected officials of
  - the Ghana Ministry of Health
  - the Ghana Health Service Council
  - the Ghana Health Service
  - the Ghana School of Public Health
  - the Parliamentary Select Committee on Health
  - stakeholders
  - NGOs, FBOs, CBOs
  - consultants from the London School of Economics
- Secondary data on the subject matter are also used

Methodology

- Descriptive analysis of primary and secondary data supplemented by participant observation.

Learning Objectives

1) Describe the social, political and economic underpinnings of decentralization and health sector policy reforms in Ghana
2) Analyze the decentralization and health sector policy reform strategy.
3) Analyze the socio-political factors that impeded the full implementation of the decentralization and health sector policy reforms

Why Decentralization

- 1978
  - Alma Ata Proclamation of the principles of primary health care (PHC) advocated the need to take services closer to the people, this became a goal for many health services

Why Decentralization

- 1983
  - Formulation of the District Health Policy in Harare, Zimbabwe, to promote coherent health services closer to the people

Why Decentralization

- Recognition of the District Health System as providing the best chances of implementing PHC as enshrined in the Alma Ata Declaration
- The Declaration was incorporated in the 1987 Harare Declaration signed by 22 African countries

Helmut Gorgen, Thomas Kirsch-Woik and Bergis Schmidt-Ehry, The District Health System: Experiences and Prospects in Africa. Manual for Public Health Practitioners, (Eschborn, Germany 2004) p.28

Why Decentralization

- 1990 International Conference on Popular Participation in Arusha, Tanzania, decentralization was listed as one of 10 indicators to be used in assessing progress in popular participation
- The push by IFIs (and some western donors especially the US during the Reagan administration) to get developing countries to implement internal structural adjustment programs - specifically privatization of public enterprises.

Why Decentralization

- 1993
  - Movement for health reform including an emphasis on decentralization, was promoted actively in the World Development Report 1993: Investing in Health

Why Decentralization

- The WHO Publication, Formulating Strategies for Health for All by 2000 identified decentralization of health system structures and management as a key issue for many countries in their achievement of “health for all by the year 2000” and in the development of primary health care.

- Though the discussion of decentralization has for a long time been a key theme in public administration, in the health field, it has been somewhat neglected

- This is why the administrative decentralization exercise in Ghana and its attendant reforms in the health sector is worth studying

Decentralization in Ghana - Background

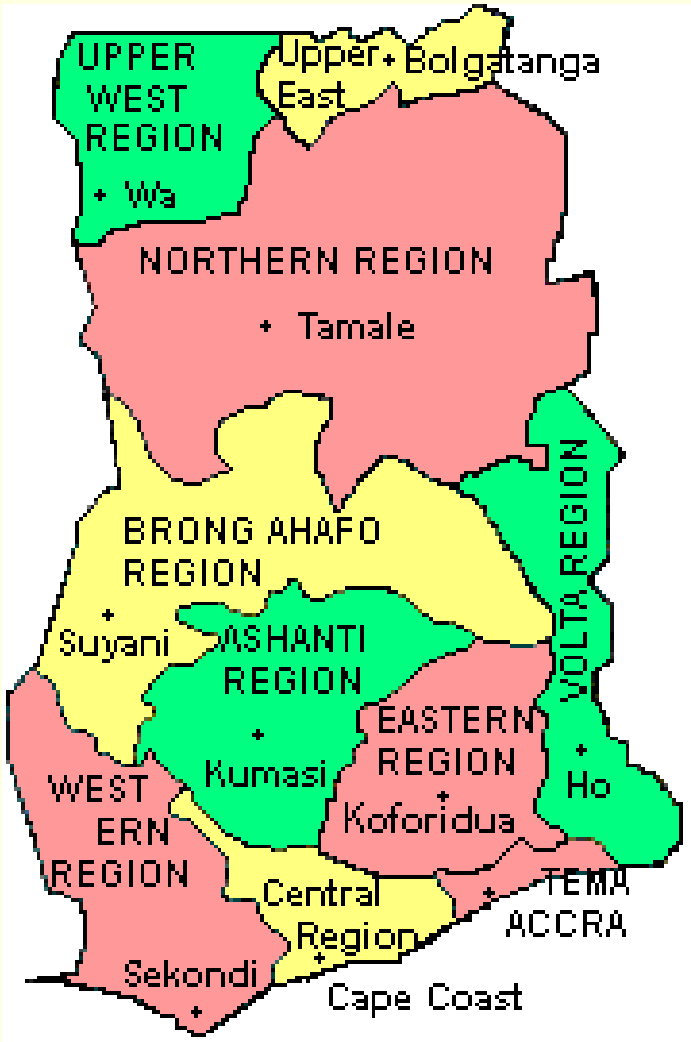
- Traced to period of indirect rule by British colonialists in Ghana, then Gold Coast, in 1878 until 1951 - rule indirectly through chiefs

Post- Independence Period

- Several different attempts at decentralization by successive governments e.g. 1957, 1961, 1971, 1974,1978
- 1983 the PNDC led by Jerry Rawlings introduced a policy of administrative decentralization of central government ministries alongside the creation of People's Defense Committees (PDCs) in each town and village

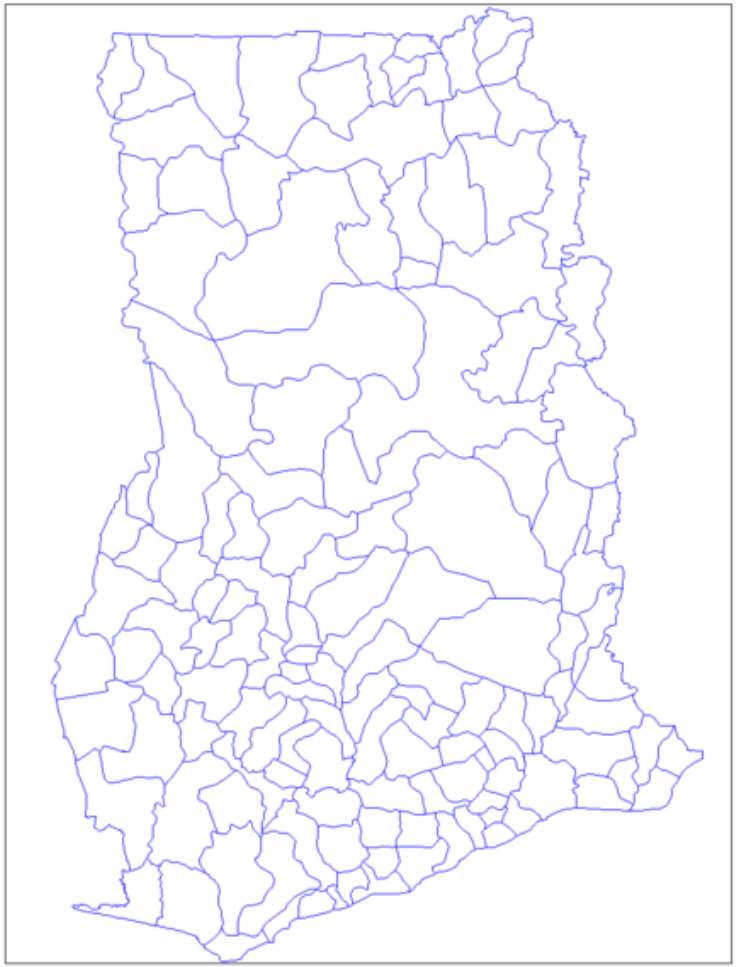
Location of Ghana in Africa

Administrative Regions of Ghana



Creation of District Assemblies

- 1988 Introduction of Local Government Law, PNDC Law 207 created 110 districts within the country's 10 regions with non-partisan District Assembly (DA) elections held in 1988/89 (and subsequently every four years)
  - Three of these are Metropolitan Assemblies (Accra, Kumasi, Shama Ahanta districts) with populations over 250,000.
  - There are also three Municipal Assemblies for areas with populations over 95,000.



Creation of District Assemblies

- Based on the success of the DA elections, the decentralization exercise was extended to lower levels with the creation of 1,800 urban/ zonal/ town councils and 16,000 unit committees
- The 10 regions are administered by Regional Coordinating Councils (RCCs)

Objectives of Decentralization

I. Devolution of political and state power in order to promote participatory democracy through local level institutions

II. Devolution of administration, development planning and implementation of the District Assemblies (local government unit)

Objectives of Decentralization

III. Introduction of an effective system of fiscal decentralization that would ensure the transfer of adequate financial resources from Central Government to local government with sufficient autonomy to allocate and utilize the provision of socio-economic services through composite budgeting

Objectives of Decentralization

IV. Declaration of management of public-private partnership in investments, provision of services and economic development programs of the districts through the creation of an enabling environment that promotes the private sector as the engine of growth and development at the local level.

National Decentralization Action Plan, NDAP: Towards a Sector-wide Approach for Decentralization Implementation in Ghana (2003-05; Decentralization Secretariat, Accra Ministry of Local Government and Rural Development September 2003, 3)

Typologies of Decentralization

- Public Administration Approach delineates four typologies of decentralization:
  - Deconcentration is defined as shifting power from the central offices to peripheral offices of the same administrative structure (e.g. Ministry of Health and its district offices).
  - Delegation shifts responsibility and authority to semi-autonomous agencies (e.g. a Board of Health, a separate regulatory commission or an accreditation commission).

Typologies of Decentralization (cont'd)

- Devolution shifts responsibility and authority from the central offices of the Ministry of Health to separate administrative structures still within the public administration (e.g. local governments of provinces, states, municipalities).
- Privatization transfers responsibility and authority, and in some cases ownership, to private providers, usually with a contract to define what is expected in exchange for public funding (e.g. the conversion of public hospitals to private ownership, contracting out specific services).

(Bossert, Decentralization and Reproductive Health)

Theoretical Framework

- Decision Space Approach-
  - Based on principal agent theory developed by economists and used primarily to examine choices made by managers of private corporations
  - Used recently by sociologists, economists, etc. to analyze the relationship between provider and patient
    - The ministry of health in this case is the principal while the local authorities serve as agents

Principal - Agent Relationship Between the MOH, GHS, and THB

MINISTRY OF HEALTH

Represented by the Minister and Directors responsible for policy development and monitoring, and technical advisory services

3 EXECUTING AGENCIES of the MOH

Ghana Health Service (Primary & Secondary Care), Two Teaching Hospitals and Boards (Tertiary Care)

Other MOH AGENCIES

Professional Regulation Boards (medical, dental, nursing and midwifrey, pharmacy), The Food and Drugs Board, the Private Hospitals, Maternity Homes Board, The National Public Health Reference Laboratory, National Psychiatric and Leporacy Hospitals

Conceptualization of the Ghana Case

Two competing concepts:

I. Devolution of major political and administrative responsibilities from central government to District Assemblies

II. Administrative and technical de-concentration as expected to be practiced by the Ministry of Health

Objectives of The Health Sector Reforms

- To raise the efficiency of service delivery
- To provide effective interventions
- To develop linkages with all partners and providers
- To improve equity of access to health services
- To improve quality of care

Decentralization of Health Sector

Initial creation of:

- 10 Regional Health Administrations
- 110 District Health Administrations and sub-districts

Ghana Health Service & Teaching Hospitals Act

- Passage of Ghana Health Service and Teaching Hospitals Act, 1996 (Act 525)
  - Established the Ghana Health Service as an implementer of approved national policies for health delivery in the country
  - Teaching hospital boards to oversee the management of teaching hospitals in the country.
  - Teaching hospitals are responsible for tertiary care.

The Ghana Health Service

- The Health Service to be governed by a Health Service Council consisting of:
  - A chairperson
  - The Director General of the Service
  - A representative of -
    - the MOH
    - Ministry of Finance
    - Ministry of Education
    - Ministry of Local Government
    - Health Workers Union of the Trades Unions Congress (TUC)
  - Five other persons who by their knowledge and experience can contribute to the work of the Council
    - At least two of these persons should be women

Service at The Regional Levels - 10 Regional Health Administrations

- The Act provided for Regional Health Committees (RCCs) in each of the 10 regions.
- Appointments to these committees to be made by the Ghana Health Service Council in consultation with the Regional Minister

Service at The Regional Levels - 10 Regional Health Administrations

Composition

I. Chairperson
II. The Regional Director of Health Service
III. Representative of the Regional Coordinating Council
IV. A senior health professional in the Service in the region

Service at The Regional Levels - 10 Regional Health Administrations

Composition cont'd

V. One representative each from the Muslim and Christian religious groups in the region

VI. A representative of the regional House of Chiefs

VII. Two persons - residents in the region, inclusive of a female, who by virtue of their interest and experience in health matters are capable of contributing to the work of the Regional Health Committee

Service at The District Level - 138 District Health Administrations

- Service at the regional level is duplicated at the district level

Operationalization of The GHS at the National and Regional/District Levels

Ghana Health Service Council

Appointed by President in consultation with the Council of State

Director General of GHS

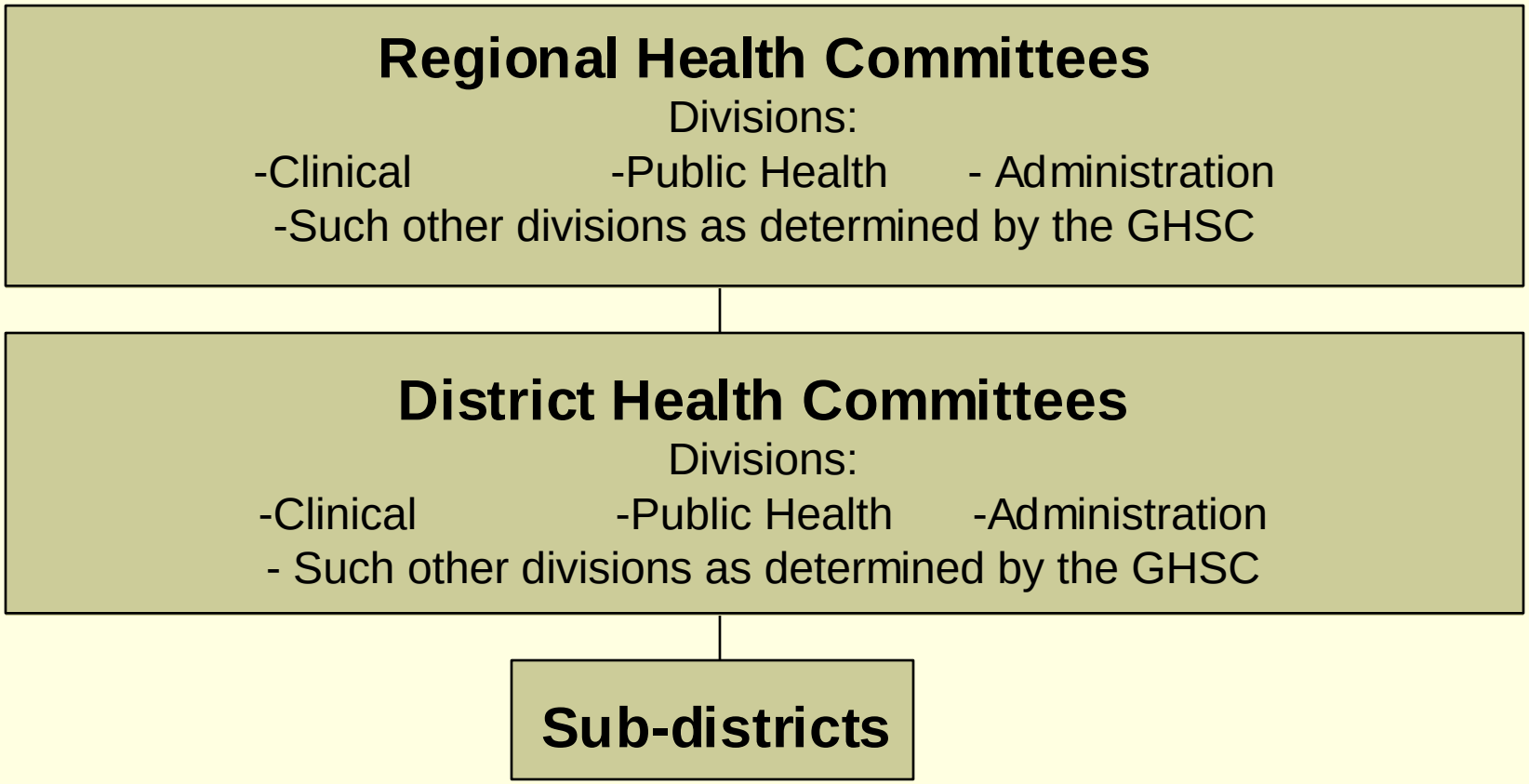
CEO of GHS - appointed by President in accordance with the advice of the GHS Council given in consultation with the Public Services Commission

Deputy Director General

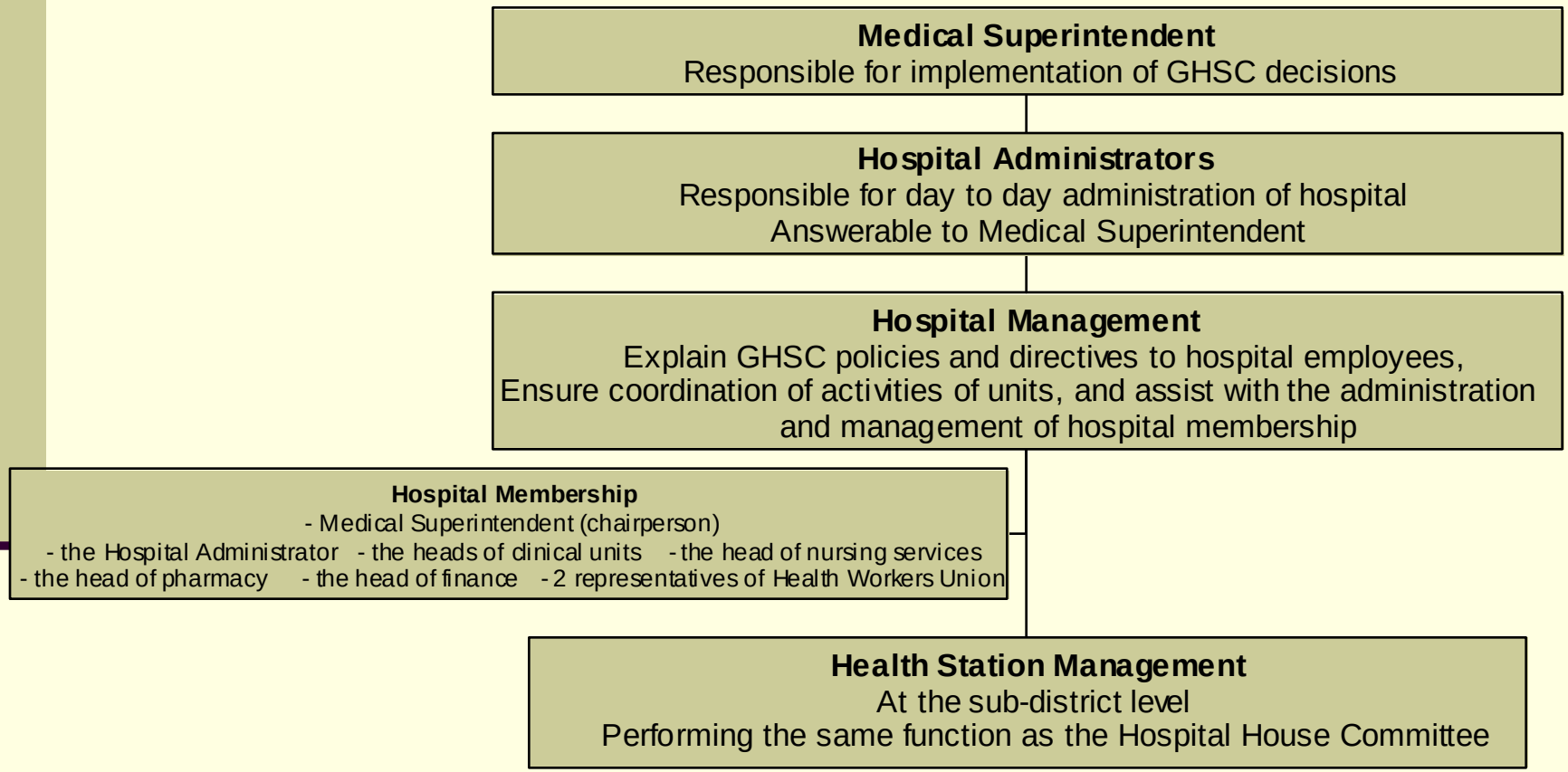
Directors of Division

-Health Administration & Support Services Division
-Policy, Planning, Monitoring & Evaluation -Public Health Division
-Institutional Care Division -Supplies, Stores, and Drug Management
-Human Resource Development/ Finance

Operationalization of The GHS at the National and Regional/District Levels



Internal Management of Hospitals



Teaching Hospital Boards

- Oversee the management and administration of teaching hospitals.
- Membership:
  - Chairperson (not an employee of hospital)
  - The Chief Administrator of the hospital
  - The Dean of the relevant Medical School
  - The Medical Director of Hospital
  - The Director of Administration of the hospital

Teaching Hospital Boards

- Membership cont'd:
  - The Director of Nursing Services
  - The Director of Finance of the hospital
  - The Director of Pharmacy
  - The Dean of the Dental School (where applicable)
  - Three (one should be a woman) other knowledgeable and experienced individuals who can contribute to the work of the Board

Problems of Reform Implementation

- The primary factor to be considered in these discussions is the fact that 2000 was an election year
  - For the first time in its history, an incumbent Ghanaian president would retire and hand over to an elected successor
- This had serious implications for:
  - The creation of the Ghana Health Service
  - Establishment of the Regional/ District Health Committees

Problems of Reform Implementation

- The process of separating the executing agencies from the policy-making MOH caused major difficulties in defining their roles.
- Conceptual differences in the interpretation of the reform policy
  - though Act 525 clearly identified the various divisions to be created in the GHS, there was confusion as to whether or not similar divisions ought to remain in the MOH
  - The most critical of these was the location of the Supplies, Stores and Drug Management - because of its lucrative contracts

Problems of Reform Implementation

- Lobbying and jockeying for positions, especially the top echelons
  - i.e. directorships of the units in the GHS was intense
- The appointment of a Director - General (DG) of the GHS the previous year created winners and losers in the MOH
  - The new DG naturally planned to reward supporters with some of the more prestigious appointments, and punish opponents

Note:

It was the general belief that since the GHS would not be part of the Civil Service, its conditions of service would be far better, than the residual MOH staff.

Problems of Reform Implementation

- Scramble for Logistical support:
  - Space for the GHS- since the bulk of the MOH staff would be shifted to the GHS
  - Allocation of office space, residential accommodation, vehicles and equipment became a major issue
- Sensitive human resource management decisions:
  - Transfer of professional group of staff from the MOH to the GHS
  - Balancing professional competence with political correctness.

Problems of Reform Implementation

- Inadequate managerial and technical capacity to implement policy:
  - The absence of managers and other technical staff to fill positions in the GHS meant the large number of doctors who had long tenure in bureaucratic positions in MOH would remain.
  - The presence of medical doctors in bureaucratic positions as opposed to clinical work in the hospitals is a long standing issue due to the shortage of doctors in the country as a whole.

Problems of Reform Implementation

- Inadequate budgetary allocations:
  - Funding for new offices, equipment, and staff recruitment was a problem
- Confusion in direction of donor support:
  - Where should donor support be directed? The MOH or GHS?

Problems of Reform Implementation

- Personnel and attitudinal problems:
  - Reluctance of top-level bureaucrats to relinquish power and responsibility to regional and district level operatives.
- How to balance the strong feeling of ethnicity with objectivity and neutral competence required of the bureaucratic administrative process

Shortcomings

I. Emphasis on material aspects at the expense of deeper human motivational concerns
II. Failure to address lethargy and apathy
III. Failure to consider the meaning of work and public service in predominately rural society where indigenous social and cultural values are important for understanding work behavior

Shortcomings

IV. Failure to consider:

- Ghanaian society as pre-modern, transitional, pre-capitalist, underdeveloped, and developing; as opposed to urbanized, modernized, industrialized and developed
- However it adopted uncritically bureaucratic and managerial reform models that are better suited for industrialized societies

Shortcomings

- The GHS reform plan had been patterned after the British NHS partly due to the historical relationship between the countries and also due to the influence of consultants from the London School of Economics and DFID which provide a lot of donor support

- The health sector reforms are considered to be “top-down” and elitist.

- Reforms should have made compromises between modernity and localism on one hand and bureaucratic needs and community values on the other.