Health Sector Reform and Deployment, Training and Motivation of Human Resources towards Equity in Health Care : Issues and Concerns in Ghana.

Dr Delanyo Dovlo

Director, Human Resources Development Division,
Ministry of Health, P.O. Box M44, Accra, Republic of Ghana.

Abstract

Ghana, a low income developing country, is undergoing health sector reforms aimed at achieving greater equity of access to services, improved efficiencies in resource utilization, development of wider linkages with communities and other partners, as well as improved quality of health services.

These reforms have strong influences on, and are influenced by, issues of human resources development, deployment and motivation. Some of the human resources issues debated under the reforms include issues of distribution of personnel, reprofiling of staff types and skill mixes including delegation of some essential skills. Issues of gender influence on staff distribution, as well as social and geographical factors, affect human resources deployment to meet the health sector reform goals.

Health workers in Ghana have severe distribution differentials in terms of geography as well as between tertiary and primary care sites. Efforts at redress include developing multi-purpose health workers, delegation of certain life saving skills to midwives, schemes to improve personnel administration systems and provision of new incentive mechanisms.

Keywords : Health Sector Reform, Human Resources Development, Equity, Access, Reprofiling of Human Resources.

Introduction.

Ghana, originally known as the Gold Coast, was a British colony for approximately one hundred years before independence in 1957. British rule brought modern or western health systems into the country. The country's health systems at the time are described as focusing on hospital based clinical care; initially served expatriate Civil Servants and merchants and most facilities were concentrated in port towns and areas with commercial activities; and focus on sanitation activities in towns and cities[(1)].

The health sector, after the immediate post-independence period, started addressing issues of equity in health care by expanding the availability of hospitals and health centres to cover much more of the countryside. However these facilities were still not equitably distributed[(1)]. This action also coincided with the introduction of new cadres of health care workers such as Medical Assistants (or Health Centre Superintendents), Technical Officers and Field Technicians for Diseases Control and Surveillance.

By the mid 1980s, like other sub-Saharan African countries, frequent coups d'etat and changes in government and economic decline had contributed to severe reductions in the resources available for health care. This, it is noted by the World Bank, resulted in poor service conditions for health workers and a rapid decline in morale[(2)].

Primary Health Care Policy and Strategy papers were produced in 1979. It moved towards developing district health teams and district based health service systems in order to refocus priorities towards basic clinical and prevention oriented services[(1)].

In 1985, the government of Ghana introduced user fees into the health services marking a significant shift in health policy towards cost recovery, decentralization of management and rationalization of services. A report in a World Bank publication[(2)] indicated an estimated 50,000 surplus staff in the Ghana Public Sector. In the government

health sector, it was estimated that out of a total of 38,000 staff in 1987, some 22,000 were non-technical or unskilled staff and 8,000 of these were redundant labour[3]. A number of mainly unskilled staff were redeployed with the aim of improving the proportion of trained health workers providing services. Staffing levels in the health services were reduced from approximately 38,000 to 27,000 over a five year period.

In the early 1990s Ghana began taking a series of actions towards restructuring its health sector, including developing a Basic Minimum Package of Services; refocusing the emphasis on PHC including Reproductive Health; decentralizing greater management and financial responsibility to Districts; de-linking of Health Service Delivery from the Civil Service; and reviewing the MOH's organisational structure to reflect a shift from vertically systems to a more functional horizontal system.

In 1995 the President of Ghana unveiled a policy document for taking Ghana into a "Middle Income Country" bracket. This document is called "Ghana: Vision 2020"[4]. The Health Sector produced a five year medium term Health Policy and Strategies[5] derived from "Ghana: Vision 2020" that outlined the following objectives:

1) Efficient utilization of all resources allocated for health.
2) Access and equity are key factors in this policy.
3) Improve the standards and quality of services and personnel who deliver them.
4) Increase the empowerment of people and their communities.
5) New and improved organizational and institutional arrangements including increased decentralized authority for health service delivery to an executing agency outside the Civil Service.

In 1996, a detailed programme of work[6] was produced aimed at implementing the medium term health strategies. The development of human resources management strategies formed an important component of the strategic framework and programme of work.

In October 1996, Parliament passed into law the "Ghana Health Services and Teaching Hospitals (1996) Act"-Act 525[7]. This law provided legal backing to the underlying institutional changes in the reforms.

This paper attempts to answer the following questions:

1) What is the distribution of staff in terms of gross numbers, of trained qualified personnel, e.g., doctors, nurses.

2) Does the distribution of health staff enhance equity, accessibility and affordability?

3) How does the current health reform process and its human resources policies and strategies address issues of access, equity, and affordability of health services?

Methods and Sources of Information

This paper is a descriptive review and analysis, using data collected from annual "**manpower budget hearings**" and data from the Ghana Civil Service "**Integrated Personnel and Payroll Database**". Various human resources and health reform policy discussion documents prepared to support implementation of the Health Sector medium term strategy were also reviewed.

The "**manpower hearings**" are conducted annually in each region and involve determining for each Budget and Management Centre (BMC)[a] the following information:

1) The number of staff in the various staff categories currently at post.
2) The number of staff on the payroll of the BMC[b].

3) New staff requirements for [a] new facilities or extensions to existing facilities, [b] changes in workload, [c] staff loss from retirements, etc.
4) Staff who exceed service requirements and establishment levels.

The Integrated Personnel and Payroll Database (IPPD) is the national database on all public sector staff. It provides some of the gross staff location summaries.

The analysis were performed using data on staff employed **in the Government Sector only**. The data excludes the NGO/Christian and "Private for profit" health sector which has approximately another 5,000 personnel. The "Private for Profit" and Industrial health services are rather smaller numbers and are restricted largely to the three main urban centres which contain approximately 90% of all private medical practice[(1)].

Results and Discussion

1. General Situation

Ghana is a low income developing country located in sub-Saharan Africa. It had a population estimated at 16 million in 1993 with an annual growth rate of 3.0%[(8)]. GDP was estimated at US$400 per capita in 1991[(8)]. It was only in the late 1980s that positive GDP growth rates were again recorded, ranging from 3% to 5% per annum[(9)]. Infant mortality rate (IMR), which was 133 per 1000 live births at independence in 1957, was more recently estimated at 66 per 1000 live births. Maternal Mortality Rate is estimated at between 250 - 400 per 100,000 live births. Per capita expenditure on health was estimated at $6.4 in 1996, but is expected to grow to about US$9 per annum by 2001[(9)]. Studies show that these health and economic indicators vary widely within the country[(1)]. It is a fact that the four northernmost regions and rural areas in general, have worse health indicators than the south and the cities[c].

The Ghana Government Health Sector had a total of 29,645 staff of various professions and categories on payroll[(10)] as of April 1996 (Tables 1 and 2).

Ghana's current health sector reform objectives were predicated on the summation of the country's health services situation as follows:

1) Health facilities are mal-distributed with more access toward the south of the country, and in the cities. On average, some 40% of Ghanaians live more than 15 kilometres away from even the most basic health services[(5)].
2) The budget for health was distributed toward tertiary clinical care *(25% of recurrent expenditures went to 2 teaching hospitals 35% went to the districts and primary care, whilst the national levels retained about 40%).*

---

[a]The BMC is the basic management unit in the health services with a single manager and budget, currently the MOH has approximately 220 BMC.

[b]Sometimes the payroll does not match the number of staff at post due to transfers, study leaves, seconded staff and improper placement of names.

[C]In spite of a growing urban and peri-urban slums

Table 1. Ministry of Health's workers by categories, April 1996

	Number by Payroll		Total	Average Salary (GH C)	Estimated Salary (GH C)
	Male	Female			
Medical Doctors	879	178	1,057	3,939,511	4,164,062,935
Medical Assistants	195	147	342	2,890,154	988,432,668
(Sub Total)	(1,074)	(325)	(1,399)		
Dentists	25	17	42	3,927,503	164,955,126
Other trained Oral Health Personnel	5	4	9	1,514,418	13,629,762
(Sub Total)	(30)	(21)	(51)		
Pharmacist	143	49	192	3,134,236	601,773,312
Dispensing Technician	175	16	191	2,951,174	563,674,234
(Sub Total)	(318)	(65)	(383)		
General Nurses & Midwives	726	5,002	5,728	2,646,072	15,156,700,416
Enrolled Nurses	451	4,131	4,582	1,436,756	6,583,215,992
Comm. Health Nurses	0	2,291	2,291	1,436,756	3,291,607,996
(Sub Total)	(1,177)	(11,424)	(12,601)		
Technical Officer (X' Ray)	382	94	476	2,890,154	1,375,713,304
Technical Officers (Lab.)	134	11	145	2,463,010	357,136,450
Technical Officers (Nutr)	29	55	84	2,463,010	197,107,344
Technical Officers (CDC)	220	25	245	2,463,010	603,437,450
Field Technicians (CDC)	199	30	229	1,397,925	320,124,825
(Sub Total)	(964)	(215)	(1,179)		
Health Services Administrator	51	4	55	2,951,174	162,314,570
General Administrators	4	3	7	4,293,626	30,055,382
(Sub Total)	(55)	(7)	(62)		
Physiotherapists	6	12	18	2,951,174	53,121,132
Technologists(Lab)	29	4	33	2,951,174	97,388,742
Scientific Officer	15	9	24	2,951,174	70,828,176
(Sub Total)	(50)	(25)	(75)		
Other Public Health Personnel(Lep. Mal. etc.)	105	83	188	2,463,010	463,045,880
Environmental Health	1,440	316	1,756	2,463,010	4,325,045,560
Drivers	443	0	443	1,203,768	533,269,224
Others	6,494	5,014	11,508	1,203,768	13,852,962,144
TOTAL	12,152	17,493	29,645	-	53,969,602,624

Source : MoH Manpower Hearing, April 1996

Table 2. Ministry of Health's workers by level of administration, April 1996

Category	Number by Payroll		Total	%	Average Salary (GH ₵)	Estimated Salary (GH ₵)
	Male	Female				
National Level[d]	3,035 (42.35%)	4,131 (57.65%)	7,166	24.16%	1,955,193	14,010,904,673
Regional Level[e]	2,046 (42.29%)	2,792 (57.71%)	4,838	16.31%	1,835,614	8,880,698,781
District Level[f]	4,065 (3.92%)	5,191 (56.08%)	9,256	31.22%	1,779,000	16,466,425,309
Sub-District[g] Level	3,006 35.81%	5,389 64.19%	8,395	28.32%	1,742,221	14,625,941,421
Total	12,152 41.0%	17,493 59.0%	29,645	100.00%	1,820,530	53,969,602,624

Source : MoH Manpower Hearing, April 1996.

3) Substantial duplication of efforts occurred with public, private-for-profit, Mission and NGO facilities, often competing for patients in overlapping catchment areas.
4) Low levels of funding for health services, as well as wastage and inefficient application of available resources to priority services. Moreover, there was a drop in utilization of modern health services especially after user fees were introduced in 1985, which affected the level of cost recovery(1).

In terms of human resources, the health sector in Ghana was described(5) as having **inadequate numbers of rather poorly motivated staff**, who were **inequitably distributed** both in terms of numbers as well as skills. The main human resource concerns are as follows:

1) The actual numbers and the distribution of personnel.
2) The skill mix that is available, including the issue of monopoly of skills by some professions through regulations and legislation.
3) Whether the skills were distributed in the same proportion as the numbers[h].
4) Remuneration, incentives and motivation and how this is reflected by work location and the relative "importance" or priority of the service provided.
5) Supply and requirement for various cadres and skills types.

2. Human Resources Distribution

2.1 North/South Divide in Staff Distribution

The Northern sector of the country has more than 2/5 of the national land mass and 30% of the population. However, it has only 20% of the total health personal. In terms of the "quality" of staff, the three northern regions have 6% of the doctors, or a total of 64 doctors

[d]Central level includes-MOH-HQ, 2 Teaching Hospitals, 3 National Psych. Hospitals.

[e]Regional level includes-Regional HQ, Regional Hospitals and Public Health Labs and Units.

[f]District level includes-District Admin/HQ, District Hospital.

[g]Sub-District level includes-SDH Teams, Health posts, Health centres and clinics.

[h]However, a "skill" may not necessary be equivalent to a specific cadre type and having a skill may not necessarily be acquired from the prescribed formal training programmes of various professions.

for about 4 million people. Approximately 1000 remaining doctors provide services for the 12 million people in southern Ghana. 50% of all doctors are based in the national capital area of Greater Accra Region (in both the Regional Level and in the National Teaching Hospital) which has approximately 12.5% of the population[11]. (Table 3, 4)

Table 3. **Comparison of Regional Populations and Staff Distribution, 1996**.

Region Location	Proportion (%)					
	Population	Doctors	Professional Nurses	Enrolled Nurses	"Other" Staff	Total Staff
Western	9	5	7	8	11	8
Central	9	4	7	9	11	9
Eastern	14	7	10	16	15	13
Greater Accra	12	11	24	15	13	15
Volta	10	5	8	12	15	11
Ashanti	17	5	7	6	9	7
Brong Ahafo*	11	5	4	6	9	6
Northern*	10	2	6	6	8	7
Upper East*	4	2	3	4	5	4
Upper West*	4	2	2	3	4	3
K'B Teaching Hosp.	-	29	15	9	*	9
K'A Teaching Hosp.	-	19	8	6	*	5
MOH/HQ.	-	3	1	0	*	2

*the four northern regions in Ghana

2.2 The Rural/Urban Divide

The district and sub-district levels are used as surrogates for the rural areas. The districts have restricted authority to manage their own affairs, including recruitment of even the lowest cadres of staff who are still centrally recruited. The district level receives 22.8% of the non-wage recurrent budget but has 59.54% of total staff and consumes 57% of the personal emolument budget Table 5[9]. The difference is not substantial as "district level" includes the main cities (e.g., in 1995, out of some 537 doctors at district level country-wide, 111 were in Accra's districts). The ratio of doctors to nurses (of all grades) in Accra was 1:13, but in the northern region it was 1:23, which may be an indicator of rural/urban staff type differentials with a concentration of the better qualified professional staff in urban areas[10] .

Table 4. Regional Workload(OPD Attendance) Levels and Staff Distribution:

Region/ Location	% of OPD all Attendances	%Doctors	% Professional Nurses	% Enrolled Nurses	%Total Staff
Western	9	5	7	8	8
Central	8	4	7	9	9
Eastern	12	7	10	16	13
Greater Accra	15	11	24	15	15
Volta	9	5	8	12	11
Ashanti	11	5	7	6	7
Brong Ahafo*	14	5	4	6	6
Northern*	4	2	6	6	7
Upper East*	4	2	3	4	4
Upper West*	2	2	2	3	3
K'B Teaching Hosp.	6	29	15	9	9
K'A teaching Hosp.	6	19	8	6	5
MOH HQ.	0	3	1	0	2

* The four northern region in Ghana

Table 5. Staff distribution and salaries, 1996.

	National	Regional	District	Sub District	Total
Number	7166	4838	9256	8395	29,645
%	24.17	16.32	31.22	28.32	100
Salary (¢bn)	14.0	8.88	16.5	14.62	54.00
%	25.93	16.44	30.52	27.11	100
% Non-Wage recurrent budget (1996)	HQ-28% TH-31.3%	17%	22.8% (District & S-District)		

2.3 Gender and Staff Distribution

Fifty-nine per-cent of public sector health workers in Ghana are female. An IPPD analysis showed a preponderance of female health workers in Accra and in other urban population centres (Table 6)[12] . This phenomenon probably occurs through a strong cultural pull of marriage[1], and of finding suitable spouses for these well educated female workers.

The male to female ratio inverts in the more rural regions of Brong Ahafo, Northern, Upper East and West Regions. *(At the National HQ a strong male ratio prevails for obviously different reasons)*. However, training of certain cadres such as Midwives, and Public Health Nurses are **statutorily restricted to women**. Even then, only 12.6% of professional nurses and 9.8% of enrolled nurses are male. 17% of all doctors are female,

however at the district level (including Accra), only 14 % are female. These female doctors are mostly based in the districts of Accra.

Table 6. Gender Distribution of all Government Health Staff (From IPPD manpower report-1996) [9]

Region/Location	% Male	% Female	Male : Female ratio
Western	39.4	60.6	0.67 :1
Central	38.6	61.4	0.63 :1
Eastern	35.2	64.8	0.54 :1
Greater Accra	31.2	68.8	0.45 :1
Volta	34.6	65.4	0.53 :1
Ashanti	41.3	58.7	0.69 :1
Brong Ahafo*	43	57	0.75 :1
Northern*	50.7	49.3	1.04 :1
Upper East*	55.5	44.5	1.25 :1
Upper West*	47.0	53.0	0.89 :1
MOH HQ.	64.7	35.3	1.86 :1

* the four northernmost regions in Ghana.

3. Rewards, Incentives and Disincentives.

The civil service pay structure and scheme of service provided for a rigid staff salary and grading system which did not allow for variation in workload and did not recognise work in unpopular jobs such as in deprived and remote districts. Indeed, the centralised and inefficient personnel administration system seemed to discriminate against staff in remote and rural areas with restricted access to the headquarter officers. Persons in the same grade or rank received exactly the same allowances and pay and, for example, had the same level of rent deduction no matter what type of government accommodation occupied (rural areas were usually worse off in terms of modernity of accommodation and amenities).

4. Cultural & Socio-Economic Issues.

Western style health services and western trained health workers inherited after independence are at times unable to meet the needs and requirements of clients. Health workers very often belong to a higher social class than their clients. Attitudinal complaints about staff is thought to contribute significantly to reluctance to use modern health facilities[1].

Rural communities that operate mainly on non-monetary economies have access difficulties, as cash very often is a seasonal commodity. Complaints of unacceptable attitudes of health workers, especially from the rural poor, can only worsen the situation.

5. Availability and Organisation of Skills and Services

Health Services in the past were organised along vertical lines, which created problems for rural dwellers who may need to visit a facility 3-4 times to receive the basic set of services or they may need to see several service providers.

A "**monopoly of skills**" by certain professional groups has contributed to issues of equity and access. Certain life saving procedures, such as IV injections, removal of retained placentae, caesarian sections, etc., are restricted to doctors and specially trained professional staff. Staff trained to work in rural areas such as Medical Assistants, and Enrolled and Community Health Nurses are not provided with some of these essential skills even where help for a patient in an emergency is several hours or even days away. This means that some of the most urgent needs of communities are often not met by the kinds of staff available. Other sub-saharan African countries e.g., Malawi and Tanzania, have trained paramedical staff able to provide urgent surgical interventions. Staff types with such skill "monopolies" are often reluctant to accept postings into deprived areas of the country.

6. Addressing Issues of Equity , Access and Quality: The Agenda for Change in Human Resources Development.

Equity in health care is defined broadly by WHO[13] as the concept that **people's needs should guide the distribution of opportunities for well being**. Buse and Walt[14] also describe equity as "**distribution of burdens and benefits of the health care system**". Efforts at resolving inequity should be aimed at removing unfair disparities and social gaps in health care that are results of geography, ethnicity, socio-economic status, age and gender.

6.1 Deployment/Redistribution of HR: New Issues and Systems

1) **Development of new staffing guides[10]** :

The MOH has undertaken various studies to help link staff placement more closely with workload. Criteria utilized, helps ensure that the staffing levels are guided by the availability nationally of particular staff types and includes the kinds of services offered within each facility. Staffing Norms have been determined and categorised for various types of facilities and institutions in the health sector. For the first time specific work has been done towards creating norms to guide the level of staffing for the two teaching hospitals (which contribute significantly to the staff loss from other levels).

2) **Determination and creation of staff posts for each unit**

The approved norms have now been applied extensively:

(a) to determine more clearly, vacancies in each work location, and

(b) as basis for new staff posting transfers.

This exercise has helped to reveal the location of surpluses and shortfalls in staffing and to gradually begin the delicate process of reversing imbalances through retirement and transfers to needy locations.

3) **Decentralization of Personnel Administration and Salary Management**

To be effective, it is proposed[15] that together with the increasing decentralization of recurrent expenditure to district managers, personnel emoluments would be administered alongside. This will provide opportunities for local managers to use savings made on salary budgets to motivate staff, especially those in deprived areas. It is realised though, that such a

system, in the absence of central rationalization, may worsen existing staff distribution whereby richer urban locations will pay higher salaries and continue to attract the best qualified staff.

4) **System wide Institutional changes influencing Human Resources**

(a) **Increasing proportion of budgets to Districts and PHC services**

The Ghana MOH's medium term programme of work has proposed a shift in the proportion of non-wage operating budget in favour of district level services. A shift is proposed from a current level of 22.8% (1996)of non-wage recurrent budget to 42% in 2001[i] (Table 7). The districts currently hold 57.4% of total national salaries but has 59.5% of the personnel. This is again a possible indication of the "quality" or grades of staff available at the district level. One of the important features of the salary budget shifts will be the holding of budgets for staff recruitment at each level rather than at HQ (Table 8).

Table 7. Proposed Recurrent (non-wage) % Budget Allocation and Resource Shifts - 1996 - 2001[(9)]

	% of non-wage recurrent budget					
Level	**1996**	**1997**	**1998**	**1999**	**2000**	**2001**
Headquarters	28	18	18	17	16	16
Tertiary Institutions	31.3	22	20.5	20	19.5	19
Regional health Services	17	24	24	23.6	23.2	23
District Health Services	22.8	37	37.5	39.4	41.3	42

Table 8. MOH Staff Numbers and Salary Situations for 1997

	National	**Regional**	**District**	**Sub District**	**Total**
Proposals for 1997 Salaries (c bn)	19.4	11.3	14.2	12.3	55.3
%	34	19	25	22	100

Source: MOH health Sector 5 year Programme of Work.

(b) **Autonomy of tertiary care institutions and cost recovery approach.**

Currently some 31% of non-wage recurrent costs are absorbed by two teaching hospitals, that in comparison, bear approximately 12% of the total workload. Furthermore, needs of the tertiary hospitals have always assumed a higher national visibility and resources are often diverted to support these hospitals. Staff turnover in teaching hospitals are high possibly due to ease of migration of staff from the country. This leads to a suction of staff from the periphery towards the centre. The creation of Teaching Hospital Boards outside the Ghana Health Service is expected to create greater equilibrium of resources between basic services and tertiary services, avoiding the temptation to shift primary care resources to tertiary care and encouraging application of cost recovery and self

[i]From - Health Sector 5 year Programme of Work, MOH, Ghana, Accra 1996.

financing systems to tertiary care, whist encouraging utilization of less expensive primary and secondary care.

(c) **Establishment of a "Ghana Health Service" independent of the Civil Service.**

The Ghana Health Service and Teaching Hospitals Act[7] was passed by Parliament in October 1996. The Ghana Health Service shall execute services at primary and basic referral levels whilst the teaching hospitals become autonomous institutions with independent decision making boards. This has great potential to support proposals for decentralisation of personnel administration to the district and facility levels. The separation of service delivery functions will enhance efficient utilization of human resources without the constraints of a heavily centralised civil service.

(d) **National health insurance scheme**.

A pilot insurance scheme is being tested in one region. The principles of the proposed national health insurance scheme are based on social solidarity underpinnings. However, this project is threatened by the relatively small proportion of the population in formal and easily verifiable vocations estimated at 10%-12% of the population[1]. The issues of equal or weighted incentives for health workers will need to be clarified as it is clear that demand for services and the level of contributions to the insurance fund is likely to be in favour of urban and tertiary care services. This may further deprive rural areas of staff and funding and intensify the existing inequities.

(e) **Sector based approach to donor investments in health.**

Ghana has agreed to a Sector Investment Approach to the funding of its health services with her donors. This envisages a global planning approach and proposes sector wide plans, targets and joint implementation and monitoring arrangements. It is aimed at reducing fragmentation of services, programmes and even remuneration of staff occasioned by vertical donor projects. It will also encourage a resource based approach to planning and encourages the targeting of resources to the most needy areas. Managers will be assigned at each Budget and Management Centre (BMC).

6.2 Achieving Equity: Issues of Training and Skill Mixes

Whilst the role of auxiliaries and community health workers in achieving greater and quicker coverage with services has been well recognised, the Village Health Worker (Volunteer) system disintegrated under opposition from some professional groups. The concept of Traditional Birth Attendants (TBA) still exists but is also questioned by the national registered midwives association. Since 1991, there has been a move towards reducing the different types of cadres and to reprofile the existing cadres into multi-purpose workers with a broader spectrum of skills.

Some other pre-service training programmes aimed at enhancing equity whilst remaining affordable are as follows:

1) **Male Midwives and Community Health Workers**.
   Discussions have been initiated with various interest groups on the issue of permitting the training of male Midwives and Public Health Nurses. This is expected to enhance retention of such health workers for longer periods in the less urban communities.
2) **Different styles and approaches to specialist training**.
   The Ministry is proposing to redirect the focus of postgraduate medical training that is now perceived as reproducing hospital type specialists rather than providing operational skills geared towards the most common disease problems in the community.
   The aim is to introduce more cost-effective specialisation programmes that focus on practical skills for community level service delivery, with the training duration reduced substantially from an average of 7-8 years to 2-4 years. This has been very successfully implemented with Opthalmologist and Opthalmic Nurse training programmes that have effectively trebled eye care staff in the country and improved the geographical coverage of eye care over a five year period.
3) **Re-profiling: The Multi-purpose or Multi-skilled cadres**.
   New curricula have been drawn for some already existing cadres. For example, Community Health Nurses are now trained with enhanced midwifery skills at the pre-service level to enrich their job content. In 1992-93, the "Life Saving Skills" project[j] in Ghana provided rural midwives with certain skills normally reserved for doctors. These included giving episiotomies, manual removal of retained placentae and, vacuum extractions in delayed second stage. Plans are also afoot to provide post abortion care skills including suction curettage as an additional skill. Supported by a good supervision system, this project has brought skilled care to the most remote midwifery practitioners. The resulting cadre of "Medical Assistants" who staff rural clinics are not really able to make an impact on mortality in their catchment areas due to the need for referral of most emergencies despite the long distances that patients need to travel to receive basic operative care.
4) **Reintroduction of training of clinical care auxiliaries**.
   In 1982, the Ministry of Health decided to enhance the quality of clinical care by abolishing the auxiliary/enrolled nursing cadre. This had an effect on rural health stations mainly staffed by this cadre who are less expensive than professional nurses to train and maintain[n], and are more likely to be retained within the country. Plans are advanced for a new clinical care cadre to be reintroduced. This is to reduce the rapid decline in staffing of clinical services in rural areas.

---

[j] LSS, is a project by the MOH, Ghana Registered Midwives Association and the American College of Midwives.

6.3 Motivation & Incentives to Encourage Effective Deployment of Human Resources.

To reinforce these institutional changes and ensure motivation in a more visible way, a new scheme and new conditions of service are being designed to implement the Ghana Health Services and Teaching Hospitals Act (Act 525, 1996), i.e.,

1) Removes management responsibility from technical and professional staff and places it into the hands of full time managers.
2) Recognises more clearly the need to compensate staff working in rural and unpopular areas. This will be effected through pay based on workload and also by providing compensation for the lack of social utilities and amenities. It is proposed that rural service of four or more years duration should shorten promotion time and also give early opportunity for specialisation and further training.
3) Common grades and titles and career pathways are proposed which shall allow for all cadres to reach the highest levels of remuneration and to encourage other cadres aside from those in the more recognised and vocal professions.

Other systems being developed are aimed at improving staff morale by decentralising the award of promotions and other benefits making the process less time consuming and more efficient. It is also proposed that savings made from salary budgets in areas where staff are reluctant to accept postings to, are used to provide incentives to staff.

De-linking from the Civil Service is expected to improve pay conditions and benefits beyond what was possible under the Civil Service.

Conclusions

Strengths and Opportunities

The strengths of the changes envisaged are based on availability of a core of well trained and motivated District managers and staff. This is essential for entrusting so much responsibility to a decentralised system. The increasing employment of flexible and less bureaucratic procedures, with transparent resource allocation systems should improve staff confidence in operations of the new health service.

As the figures indicated, clearly the control of resources is being shifted more directly to the operational level, i.e., the district. However it is essential that this should be sustained through active support and supervision from the central and regional levels. Care must be taken that decentralization does not result in decentralised chaos or a multiplication of corruption in which national and centralised systems were sometimes implicated.

Much effort has been spent on gradually building the capacity of district managers to plan, budget, implement and satisfactorily evaluate service targets. The ongoing parallel decentralization of government to local assemblies has also prepared the ground for greater community involvement in health decision making. Coupled with this district capacity building has been the emergence of a critical mass of new cadres of national level policy makers with better analytical and planning capacities and skills to support district level actions.

The Ministry of Health, in support of the medium term health policies has introduced a new in-service training policy which proposes regular and routine training and updates for various categories of health workers.

Vision 2020 and government policy (sometimes linked to elections) has resulted in significant improvements in rural conditions (e.g., improvements in road network, provision of electricity and water) which will assist staff acceptance of postings to such locations.

Weaknesses and Threats:

District capacity to sustain bottom up planning and responsibility for substantial budgetary changes remains critical for retaining political will for sustained decentralization.

Donor sensitivities are also heightened by the Sector investment or "Common basket/pot" approach to funding. This puts greater reporting and analytic responsibilities on managers at all levels.

The professional associations and workers unions remain suspicious of changes that might result in some loss of skill monopolies and these unions are powerful enough to delay or reverse some of the fundamental changes envisaged.

Unpublished preliminary studies indicate a high level of migration of Ghanaian physicians and nurses soon after graduation. **The rates are expected to be as high as 50% - 70% outside the country within 5 years of graduation**. This is a serious issue that threatens the MOH's capacity to implement its health reform and decentralization programme.

Whilst improvements in the economy have occurred, inflation remains high and the stability of the local Cedi (US$1.00 = GH₵2,000) is shaky. Confidence in the economy will be essential to improving service delivery and retaining qualified staff.

Redistribution of staff.

Despite overall shortages of staff, clearly there are severe maldistributions and the creation of the new service and its decentralised nature is an opportunity to achieve greater distribution of staff according to need. The service can sustain this through decentralised recruitment systems that will advertise vacancies according to the locations where staff are needed and not as part of an ongoing global staff recruitment as previously occurred in the civil service.

Re-profiling:

The multi-purpose community health worker, combining clinical and preventive skills should become an essential and cost effective cadre for service delivery in Ghana. Relaxation of the gender rules that prevent males from belonging to certain cadres also need to be reviewed and action initiated in changing the statutes. Skill delegation and equipping staff based in rural areas to handle a wider spectrum of emergencies should increase the confidence of clients in the services. Multi-skilling can be expected to reduce the number of staff required to provide basic services and encourage efficiency in utilising staff.

Incentives and Motivation:

These factors remain major influences on the management and retention of human resources. The salary differentials between attractive foreign countries, such as the USA and South Africa, and Ghana cannot be easily bridged because of the current economic performance. However substantial non-monetary influences exist. These include increasing local opportunities for specialist and postgraduate training, rewarding staff according to differential workloads, especially for those working in locations that are considered unpopular, and also improving the efficiency with which personnel actions are handled.

Resolving human resources issues will be essential to implementing Ghana's health sector reforms. This will involve strong management capacity as well as complementary service delivery staff. These are non-negotiable factors in meeting the challenge of developing and sustaining a new image for the Ghana Health Services.

References :

1. Kunfaa EY. **Sustainable Rural Health Services through Community-Based Organisations**. Spring Research Series No.16, University of Dortmund. Dortmund: SRING Centre, 1996; p25, 54.
2. The World Bank. **Adjustment in Arfrica: Reforms, Results, and the Road Ahead**. New York: Oxford University Press, 1994; p127.
3. The World Bank. **Better Health in Africa: Experience and Lessons Learned; Development in Practice**. New York: IBRD/World Bank, 1994; p89, 118.
4. Republic of Ghana. Ghana**, Vision 2020 (The First Step:1996-2000)**. Accra.: Assembly Press, 1995.
5. Ministry of Health. **Medium Term Strategic Framework for Health Development in Ghana, 1996 - 2000**. Accra: Ministry of Health, 1995.
6. Republic of Ghana, Ministry of Health. **Health Sector 5 year Programme of Work**. Accra: Ministry of Health, 1996; p3-6.
7. Government of Ghana**. The Ghana Health Service and Teaching Hospitals Act, 1996, Act 525.** Accra: Parliament of the Republic of Ghana, 1996.
8. The World Bank. **World Development Report 1993**, **Investing in Health**. New York: Oxford University Press, 1993.
9. Republic of Ghana, Ministry of Health. **Health Sector 5 year Programme of Work**. Accra: Ministry of Health, 1996; p29-32. (Unpublished Report)
10. Human Resources Development Division: **Manpower Establishment Levels for 1997**. Accra: Ministry of Health, 1996.
11. Human Resource Development Division. **Manpower Position on Payroll - April 1996.** *MOH-Human Resource Bulletin*, 1996; 1:5.
12. Director of MIS, Office of Head of Civil Service. **IPPD Manpower Statistics (MOH)**. Accra: Ministry of Health, 1997. (unpublished report)
13. World Health Organization**. Equity in Health and Health Care: A WHO/SIDA Initiative**. WHO/ARA 96.1. Geneva: World Health Organization, 1996.
14. Buse K, Walt G. Aid Coordination for Health Sector Reform: A conceptual framework for analysis and assessment. *Health Policy and Planning, 1996; 3:173-188.*
15. Ministry of Health, Ghana**. Policies and Principles for Development of Human Resources for Health: 1997 - 2001**. Accra: Ministry of Health, Ghana, 1997.

Other Bibliography.

16. Martinez J, Martineau T. (editors) **Human Resources and Health Sector Reforms. Research and Development Priorities in Developing Countries.** Liverpool: Liverpool School of Tropical Medicine, 1996; p7-11. (mimeograph)
17. Martineau T, Martinez J. **Human Resources in the Health Sector. Guidelines for appraisal and strategic development**. Health and Development Series. Working paper No.1. Brussels: European Commission, January 1997; p15.
18. The World Bank. **World Development Report 1994, Infrastructure for Development, World Development Indicators**. New York: Oxford University Press, 1994; p214.
19. Ministry of Health. **Management Arrangements for Implementation of the medium term programme of work(1997 - 2001)**. Accra: Ministry of Health, 1996.