

A time of change: health policy, planning and organization in Ghana

ANDREW CASSELS¹ AND KATJA JANOVSKY²

¹*Department of International Community Health, Liverpool School of Tropical Medicine, UK and*

²*Division of Strengthening of Health Services, World Health Organization, Switzerland*

This paper presents the results of a rapid health sector policy analysis carried out in Ghana in October 1990. Its purpose is to illustrate the dynamics of the policy debate at a time of major change, and to provoke discussion about the practical implications of current policy directions. In addition, it demonstrates the range and nature of issues of concern to decision makers in the Ministry of Health, Ministry of Local Government and National Development Planning Commission. Issues discussed include: the restructuring of the Ministry of Health; resource allocation under decentralization; health planning responsibilities at different levels; the case for an intermediate level of management in a decentralized health system; the relationship between different forms of cost-recovery programme; the future of EPI and; the implications of establishing a national health service. The final section presents some preliminary conclusions concerning the process of organizational change in the health sector resulting from decentralization policies.

Introduction

This paper illustrates the dynamics of the health policy debate in Ghana at a time of major change, and outlines key issues in the sector. The issues reviewed are necessarily selective. They do, however, reflect major areas of concern to senior officials of the Ministry of Health (in Accra and elsewhere), the Ministry of Local Government, the National Development Planning Commission (NDPC) and the donor community. Although the paper addresses issues specific to the Ghanaian context, the underlying themes will be relevant to many countries. They include the effects of decentralization policies, the relationship between central and local government, organizational change within the health sector, and the role of donor agencies.

This document was originally prepared as a position paper for the Ministry of Health in October 1990. A first draft was discussed immediately after completion with key actors. A revised version has subsequently been widely circulated in Ghana and elsewhere. The original text has been slightly modified to make the paper accessible to a wider readership. After a brief introductory section, a series of seven issues is presented. Each issue is preceded by one or more

critical questions, which frame the subsequent discussion.

Background and context

Health sector overview

Despite the considerable progress made in the health sector in Ghana since the economic decline of the early 1980s, many problems remain. Health status indicators show little change, and marked inequalities in mortality rates between different regions and between rural and urban areas persist. It is estimated that only 65% of the population has access to the modern health system, but this figure again disguises gross geographical inequity. Overall utilization of outpatient facilities was estimated at 0.35 attendances per person per year in 1987, less than one third of the rate ten years earlier.¹

The Provisional National Defence Council (PNDC) government has given increasing political prominence to the health sector. Following the early gains of the economic recovery programme, the Ministry of Health (MOH) has received a larger proportion of the government recurrent budget. In 1989, the increase in real terms amounted to 29%, bringing the MOH's

share of overall government recurrent spending to nearly 11%. The real growth of the recurrent budget, however, did not persist in 1990, due to faster than expected rates of inflation.¹ Despite these relatively favourable trends, overall financing for health care remains low, requiring a clear ordering of priorities that is not always reflected in government policy statements.

Along with the political importance of health care has come more intense scrutiny of the Ministry's operations. A high-level health symposium, attended by the Chairman of the Committee of PNDC Secretaries, was held in 1988 to identify key issues and clarify health policy directions.² In early 1989, the PNDC Secretary for Health's policy statement summarized current and planned strategies to improve the performance of the sector. These included efforts (a) to reduce costs; (b) to change the pattern of resource allocation and; (c) to increase financing.³

Strategies for cost reduction have included phasing out the provision of meals by hospitals, reducing the numbers of non-technical staff, implementing an essential drugs policy and improving drug management, and establishing autonomous hospital boards (PNDC Law 209) in an attempt to improve the efficiency of major hospitals.

Changes in resource allocation have been concerned with increasing the proportion of non-salary recurrent costs. Although budget estimates show a trend in the right direction, with salary costs declining to 41% of the total in 1990, actual non-salary disbursements continue to fall far short of the original estimates. It is reported that the share of the recurrent budget devoted to primary health care (PHC) has remained relatively constant (currently about 25%).⁴ Funds for PHC in this sense, however, tend to be defined as those which are not identifiably spent on hospital care. Thus, the hospital sector continues to receive the lion's share of the recurrent budget. The budgetary definition of PHC gives no sense of how the available budget for PHC is actually used.

Attempts to improve health sector financing began as part of the structural adjustment programme. In 1985, the Ministry increased user

fees to a level which for a time generated 15% of overall operating costs.⁵ Users are now charged the full cost of drugs and 100% of all income from fees and drug sales are retained by the Ministry of Health. Under 'cash and carry', a newly designed drug management system, user fees levied at facility level will be used by health personnel to purchase drugs from regional medical stores.⁶

Influences on organizational structure

The structure of the health system in Ghana has been shaped by a number of different influences. Some of these influences are specific to the development of the sector itself, others result from changes in the overall structure and function of the government.

Within the health sector, vertically-organized public health programmes have played a critical role in the development and functioning of the health system in Ghana. Although the technical concerns of these programmes have changed substantially over time - from smallpox, malaria and yaws before independence to EPI, Guinea worm, AIDS and MCH/FP today - their organizational structures have remained largely unchanged. This approach to the provision of public health services has resulted in separate divisions of the Ministry; each controlling its own cadres of staff; each concerned with its own area of intervention. Vertical organizational structures have, necessarily, resulted in the development of separate, vertically-organized management systems: for the transmission of information, for financial management, for transport, for supervision, and for inservice training.

The importance of horizontal links between programmes has, however, been recognized by the Ministry for many years, with the establishment of district health management teams in 1978,⁷ the granting of increasing fiscal autonomy to the regions, and the establishment of central divisions concerned with health planning and human resource development. The policy of strengthening regions and districts particularly, has recently begun to show signs of success. Several regions, helped by the strategic posting of highly motivated medical officers with public health training, have developed strategies for improving health programme co-ordination in their

districts. Although these regions will become an increasingly important force in support of structural change, they are presently working despite the existing vertical organizational structures and management systems.⁸

It is also clear that there are forces within the system which reinforce the organizational status quo. Those controlling strong technical divisions are understandably reluctant to relinquish power. In the short-term, their argument is strengthened by the recognition that loss of control may be accompanied by loss of programme coverage or effectiveness. Donor concerns for accountability of funds, and the forceful international promotion of selected health care interventions favour vertical organizational structures, with their own programme-specific management systems. Even if donors cannot be blamed for establishing vertical programmes, past support from some agencies has helped to reinforce and maintain existing structural divisions.

In parallel with the recent trend for increased decentralization within the health sector, several donors have moved away from supporting vertical programmes. They have instead started to support broader-based programmes by providing funds for PHC in selected districts or for region-wide health care development. Reorganization and strengthening of managerial capacity have been among the main concerns of the World Bank. By making restructuring one of the conditions of the second health and population loan, the Bank has exercised considerable influence over the speed with which the process of reorganization has been moving. Although there has been movement toward organizational change from within the MOH, the most important forces for change result from the larger economic and political environment in which the Ministry operates.

Decentralization

By far the most important influence to which the health sector is having to respond is the PNDC's far-reaching programme for the decentralization of government. The decentralization programme will radically change the role of district health management teams (DHMTs) and promises to decrease the power of regional management. The present restructuring of the MOH and other operating ministries is to facilitate decentraliza-

tion to local government. The legal framework for decentralization has been enacted as local government law, PNDC Law 207.⁹

The first step in the process of decentralization was the re-alignment of boundaries to create 110 districts from the original 68. This was followed in 1988 by the election of district assemblies.¹⁰

The district assembly will become the main planning authority for all sectors. The planning and budgeting unit, as part of the district executive committee, will be responsible for preparing integrated district plans to be formally approved by the elected assembly. It is intended that policy norms, to guide district planning, will be prepared by the National Development Planning Commission. Support to the districts will be provided as an interim measure, not by regional authorities, but by mobile district planning teams. The planning officers, budget officers and other officials, who will eventually become the government-appointed secretariat for local government, are currently being inducted and trained. Estimates vary between 18 months and five years as the period of time required before all the planned district positions will be filled. DHMT members will no longer control separate Ministry of Health funds. They will, however, prepare annual plans for the sector to be submitted to the district executive committee. The Ministry of Local Government states that health personnel will be paid by and report to district-level authorities. At the Ministry of Health, the uniformly held view is that staff will remain MOH employees.

Regional co-ordinating councils, made up of district secretaries and the presiding members of district assemblies will be, as their name suggests, largely concerned with co-ordination. They will have little real power and will pass aggregated plans on to the centre. Health personnel at regional level may provide technical support to districts, but will have to relinquish their present role as line managers.

Selected issues

Reorganization of the MOH

- What will be the main functions of the central MOH under decentralization?

- What comes first, increased efficiency or clarification of roles under decentralization?
- What will be the most critical skills required at the centre?

The main purpose of the current reorganization, or restructuring, is to enable the MOH to play an effective role in a decentralized, national administration. It has been assumed, by higher levels of government, that the implementation of primary health care has given the Ministry valuable experience in managerial decentralization, and that health is in a position to act as a model for other operating ministries.

At this stage, however, restructuring appears to focus primarily on the implementation of a new organization chart prepared by a management consultant. The stated objective of the exercise is to remove barriers to efficiency. In more practical terms, the aim is to break up the vertical empires that have become securely established over the course of the Ministry's development.

The need for creating a trimmer and more efficient organization at the centre is undeniable. However, if central reorganization becomes an end in itself, it can obscure its ultimate purpose – enabling the centre to guide, support and service the districts. Only if the main functions of the MOH under decentralization are clear, can efficiency have an operational meaning: producing more while spending the same, or producing the same while spending less. The clarification of roles and functions, not just at the centre, needs to precede efforts towards improving efficiency. The problem at present is that the process of central restructuring attempts to define the roles of MOH staff on the basis, not of future responsibilities, but of current functions.

There is, therefore, a need to shift from an exclusive focus on the centre. Indeed, a detailed analysis of the functions of central management should arguably be based on a review of how district health management teams (DHMTs) currently function: a critical assessment of how their role will change after the implementation of the local government law (PNDC Law 207); and a clear idea of what support they will need in order to operate effectively. There is a growing number of former district and now regional staff trained in public health planning and management, who

are in a position to contribute to the debate. To date, however, there is little evidence that implementation of organizational reform is being influenced by their views. The process appears to be more informed by management theory than a detailed understanding of operational realities in the health sector.

Another important point in the context of reorganization concerns the skills and experience needed to perform the major functions of the centre under decentralization. It is possible to distinguish three key functions. These are:

- management of central support services
- development of guidelines and procedures for planning and implementing district health programmes
- health policy formulation and development planning.

Management of central support services will include procurement and supply, maintenance, and personnel management. Once systems have been designed and established, these services are best operated by professional managers and administrators. This is reflected in the current plans for the procurement and supply division, which foresee its operation as an autonomous organization outside the Ministry after a period of three years.

The development of guidelines and procedures for district health managers will serve to maintain operational links between the centre and the district. At this stage, it is not clear how technical support and supervision will be organized. The process of adapting and making guidelines operational, however, is a function that will continue to be performed primarily by the region.

Responsibilities under the third and most central function, health policy formulation and planning, include the development and evaluation of technical strategies; translating service objectives into recommendations for resource allocations; reviewing actual expenditure patterns; developing policy implementation indicators; and monitoring the attainment of health status objectives.

These responsibilities require that senior personnel have expertise in the relevant disciplines (including epidemiology and economics), analytic skills, technical knowledge and operational

experience. This combination is most likely to be found in health professionals with training in health planning and management. The current tendency to emphasize managerial skills, almost to the exclusion of all others – an understandable reaction to the genuine shortage of good health managers – could result in a body of senior personnel who lack the technical knowledge needed to formulate sound policies, and the operational experience to develop plans which can be implemented. The centre needs to understand what *can* be done, if it is to advise on what *should* be done.

Policy implementation and resource allocation under decentralization

- Will district assemblies allocate resources in accordance with stated MOH primary health care policy?
- How can the MOH and the National Development Planning Commission control and monitor policy implementation? What will be the role of the MOH in ensuring policy implementation?

There is a danger that resource allocation in the health sector under decentralized systems will favour facility-based curative care. Increased popular participation, at least initially, may lead to more effective demand for physical facilities, and drugs. Despite their importance to ministries of health and donor agencies, preventive and promotive public health measures may be perceived as less important, and certainly less politically attractive to local administrations.

A common strategy for counter acting this trend has been – despite commitments to decentralization – to earmark funds from the centre (usually from external sources) for specific public health interventions, which might otherwise be neglected in local resource allocation. On closer examination, however, there is little to choose from between this type of intervention and the traditional vertical programmes which, by common consent, are to be phased out.

In Ghana, one of the key strategies proposed is education: of politicians, of assembly members, of local leaders, of the people. The objective of this education is to make people alter their perception of development, away from bricks and mortar towards its less tangible but more

sustainable effects. Efforts in this direction are already underway, spearheaded by the Ministry of Local Government. It is too early to tell whether this type of education will be effective in influencing local resource allocation decisions.

Quite apart from efforts to change the attitudes and behaviour of people and local leaders, there is the question of the role of the centre in directing and monitoring policy implementation. District assemblies will be advised to allocate resources within given policy norms. Policy guidelines will be disseminated by the NDPC and by mobile planning teams currently under the Ministry of Local Government, in order to guide the work of the district executive committees. An important task of the new MOH directorate of policy and planning will be to advise the NDPC and other policy-making bodies of appropriate policy norms for health. These norms will need to be translated into guidelines for allocating funds. In order to be able to evaluate whether policy is being implemented and to what effect, the planning directorate will need to monitor resource allocation and expenditure patterns within the district health budget. In addition to financial data, policy implementation indicators will need to include information on management performance, services delivery and utilization, and health status.

Planning revisited

- Given its limited operational responsibility, how can the MOH ensure that the production of plans does not become an end in itself?
- Is the MOH trying to create a planning elite?
- What will be the link between different planning functions at different levels?

The re-emergence of planning as a tool to accelerate development in Ghana is an encouraging development. However, if planning is to become once again a lead strategy, there is a need to look at some of the lessons of the past. The persistent gap between planning and implementation signals that close attention will need to be paid to the conditions required for implementing plans and for achieving development targets. It also argues for setting goals and targets which can be achieved under existing conditions, and sustained in the foreseeable future.

Central planning under decentralization can easily become divorced from implementation reality.

Producing data documents often becomes more important than the frustrating, messy and much less logical process of planning. There is some indication from the current reorganization process that planners may emerge as the elite and implementers as the lesser mortals. Yet, the ultimate performance of the health sector will depend on the implementers and their operational plans. It is imperative that the link between development planning, operational planning (or action planning) and implementation be preserved and strengthened. The current proliferation of different kinds of action plans in Ghana will also need to be addressed to avoid confusion among implementers.

Much will depend on clarifying the functional links between the many different units at different levels in the system, that are intended to have a role in either preparing, reviewing or approving plans. These presently include district health management teams, district planning and budgeting units, regional directors of health, regional co-ordination councils, the MOH planning directorate, the ministerial advisory board, the National Development Planning Commission, the Ministry of Finance and Economic Planning, and the Ministry of Local Government. What, for example, will be the nature of the decisions made at each level? How will the roles of these bodies be co-ordinated? As the first operating ministry to reorganize for decentralization, the Ministry of Health will play a critical role in helping to sort out these questions.

The role of the regions in health care management

- What is the case for an intermediate level of management under decentralization?

Even under decentralization, there is a clear case for an intermediate level of management between the central MOH and the 110 district health management teams (DHMTs). The form that this will take is presently unclear, and requires that careful thought be given to the changing role of the present regions in the lead up to decentralization.

The government's intention to reduce the political and administrative power of the regional level in favour of autonomous districts is clear and unequivocal. Some of the changes

leading to the new system can be made relatively quickly. Budgetary control can be passed completely to the district level. Staff management responsibility can be transferred to the district authorities from the MOH. However, districts throughout the country are at different stages of readiness to take on a more independent role. The Ministry of Local Government itself points out that decentralization requires that the willingness of the centre to let go of power be matched by the ability of districts to take over. It explicitly recognizes that there will be an interim period leading up to full decentralization; until the administrative capacity required to manage autonomous districts is in place.

The role of the region in the management of the health system has already begun to change from one of traditional line management. The most developed regions are starting to pass on an increasing proportion of the budget to the districts; thereby encouraging and building on the increased capabilities of DHMTs. Regions are becoming more conscious of their role as a source of technical advice and support, recognizing the need to 'prove their worth to the districts'. They have a key role in developing functioning management and support systems (for supplies, transport, information and so on) for use in all districts. They can also act as a buffer protecting districts from conflicting central demands. Most critically, a well-run regional health management team is in a position to know which districts require the most support, and which can be further encouraged to run their own affairs. Regional budgetary control allows those districts able to spend their allocated funds increasing independence, whilst retaining resources at the regional level to support the less able districts.

If all budgetary power is transferred to the districts, DHMTs at different stages of development are still likely to require assistance, either in obtaining their fair share of the district budget, or in developing the capacity to spend their allocation. The production, adaptation and updating of guidelines, procedures and protocols (the 'software' – using computer terminology – of good management systems) is not a one-off process. It cannot, therefore, be wholly a central function. To be effective, it has to be linked with support and supervision, and an up-to-date knowledge of operational conditions. The need for

district staff to receive technical support in their work will remain unchanged. There are, therefore, a number of critical district support functions that will be needed in the decentralized system. The crucial question is, how they will be fulfilled? There are a limited number of options.

Mobile planning teams are seen as an interim measure prior to the establishment of fully-functioning district planning and budgeting units. Although they are currently operating on a regional basis, it is stressed that they are not regional teams and that theirs is not to embrace a regional function. In any case, the planning teams do not, and are not intended to have, the sector-specific expertise required to assist DHMTs.

The central MOH will not be able to provide the required support and supervision. Even if it were considered possible to carry out management functions in relation to 110 autonomous units from a base in Accra, an explicit aim of the reorganization is to reduce the management role of the centre – except as it relates to central services. Certainly, there is no indication in current plans for units at the centre with geographical responsibilities.

Thus, it could be argued – on managerial grounds in contrast to political ones – that an intermediate level would need to be created if it did not already exist. After full decentralization, the regional role is to be co-ordination, advice and technical support. In the interim, as an arm of the centre and as an ally of the district, the regional health team will still perform a managerial role, albeit with lessened formal powers. Its authority will need to be increasingly based on the quality of its technical advice and support, and less on the power of the budget and control of manpower. Herein lies the new challenge for the region.

Drug management, recurrent cost financing and community involvement

- If the 'cash and carry' system successfully addresses the first two, and the effective functioning of district assemblies the third, what is the role of the Bamako Initiative?
- Is the pilot project approach still needed in Ghana?

Between the 'cash and carry' system and the Bamako Initiative, three critical issues are being addressed: increasing the level of recurrent cost financing for health care; improving the efficiency of the drug logistic system; and fostering public involvement in the provision of health care.

By linking user fees to drug purchase, the 'cash and carry' system guarantees that the cost of drugs, a significant item of recurrent expenditure, will continue to be covered, even if drug prices and service utilization increase. If health workers at facility level are responsible for ordering and paying for their drugs, they are likely to be more concerned that the supply system is responsive to their needs. 'Cash and carry' will, therefore, generate a demand for a more efficient logistic system. It is also argued that user fees will be more acceptable, if they are seen by the community to result directly in service improvements. The 'cash and carry' system has been a major concern of the World Bank, and government approval of the scheme is a condition of the second health and population project. It is to be a nationwide programme, and implementation has already begun in Greater Accra and in Volta region.

The Bamako Initiative set out to address similar concerns but places greater emphasis on community involvement.¹¹ The original intention was that fees charged cover not only the cost of drug repurchase, but also provide extra funds to the community, which could be used to contribute to the salary costs of community-level workers. However, given the need for a national system of drug pricing and the obvious advantages of developing a single uniform national programme, a compromise has been reached. In Volta region, where the 'cash and carry' system has already begun, the Bamako Initiative pilot district will operate in precisely the same way as the other districts in the region. Drugs are supplied to health centres, health posts and hospitals, and fees are levied at the standard national rate. The only difference at this stage is that UNICEF (United Nations Children's Fund) supplies its drugs free of charge.

The original plan to extend the Bamako Initiative to the so-called Level-A community workers, and finance their salaries as well as selected community development activities from drug

income, may still proceed in the five pilot districts. However, the feasibility of such schemes beyond the pilot stage has been questioned. Also, the need for donor-sponsored community involvement is less obvious at a time when the country is embarking on a process of stimulating popular participation by increasing the powers of representative local government.

Having been required to adapt the Bamako Initiative in line with government plans, UNICEF is now proposing to support intensive 'community-based PHC' in one district of each region. The intention is to broaden what was originally conceived as a strategy to support PHC. Therefore, the districts selected include those involved in the Bamako experiment. The case against pilot projects hardly bears repeating, and it is ironic that it is now ten years since the original districts (one in each region) were selected by the health planning unit as pilots for primary health care.¹² In Ghana, as elsewhere, there is no shortage of interesting small-scale projects that have never been implemented on a national scale, not least because the level of effort and the input of external resources could not be sustained or extended with local resources. In the face of the widely held view in Ghana that more modest efforts on a national scale are preferable to pilot projects, the notion of a new set of district-level PHC experiments in 1990 seems somewhat misplaced.

After 1990: the politics of EPI

- Whose priorities are being served by the current acceleration of programme implementation?
- To what extent do current strategies to boost immunization coverage compromise long-term sustainability?
- How will the MOH react when current levels of donor support start to decline?
- To what extent will reorganization and decentralization prevent future internationally determined health policies from distorting local priorities?

Ghana, in common with most developing countries around the world, has been subject to increasingly intense pressure to achieve immunization coverage targets. Recognizing the importance of a well-run immunization programme, there has been a great deal of discussion among senior managers over the last 2–3 years

about programme strategy. At a meeting of MOH divisional heads and regional directors in mid-1990, a strategy of 'extended outreach' had been agreed. This would not result in 80% coverage, but was judged technically appropriate to Ghana's present situation, and would yield sustainable levels of coverage. In the final quarter of 1990 however, directives were received by the MOH, which indicated that every effort had to be made to achieve 80% coverage by the end of 1990. In most districts, this required that extended outreach be abandoned in favour of mass campaigns.

Even in the strongest regions, the achievement of 80% coverage by the end of the year would only be possible by devoting virtually *all* available resources to this end. Although it is possible to add other activities to EPI, the cost in terms of disruption to other work is considerable. DHMTs are beginning to question whether the advance payment of field allowances started during the present campaign will be maintained after the current enthusiasm for EPI passes. If it is not, what will be the effect on future outreach programmes? It is being recommended that no fees be charged during mass campaigns. DHMTs have expressed concern about the effect of this strategy on static services, for which nominal fees are still charged. It is, of course, arguable whether fees should be charged for immunization, but in Ghana EPI fees constitute a significant proportion of the funds over which DHMTs have complete control. They, therefore, have additional importance to local level managers.¹³

Finally, there is the question as to what extent the emphasis on coverage compromises the need to ensure quality, and to improve public understanding of the purpose and benefits of immunization?

Immunization is a service that the health system will need to provide every year, for as long as immunization-preventable diseases remain prevalent, and the number of children needing immunization will not decrease dramatically in the foreseeable future. The hopes of those convinced about the early eradication of measles, polio and neonatal tetanus notwithstanding; sustainability of immunization programmes is a critical issue, and current strategies would benefit from further examination. Having

promoted the development of ambitious immunization programmes over the course of the last decade, the donor community is now beginning to look to countries to take on an increasing role in the financial support of programmes. To what extent will their priorities be shared by district administrations, who may now have a more influential voice in resource allocation?

Finally, it is often assumed that the propensity of internationally determined priority programmes to dominate the scene is linked with the existence of vertical programmes in the Ministry of Health. The current reorganization aims to dissolve these programmes. This does not mean, however, that donors cannot influence the work of districts by other means, by making available programme-specific vehicles, supplies and equipment, for example, or through local or national political figures.

A national health service for Ghana

- What are the implications of a national health service for the MOH and for local government?

A recurring theme in discussions of structural change in the health sector is the desirability of creating a national health service in Ghana. The organizational form that such a service might take has not been made explicit. Given the different views that were expressed, however, a number of important organizational questions have emerged.

The most widely accepted idea of a national health service is an organizational structure which is financed from public funds, but which takes the executive agency out of the direct control of the civil service. This arrangement would enable managers to run the service free of the restrictions normally associated with civil service traditions, rules and procedures. New management systems and selection procedures, designed to foster initiative and productivity, can be introduced without the need for uniformity with the civil service as a whole.

A national health service, in this sense, would clearly differentiate between the role of a civil service ministry responsible for overall policy decisions, and the organization set up to plan and manage a service, guided by those policies. The ministry would continue its role in com-

peting for the sector's share of the national budget, and an executive board or equivalent, would be responsible for ensuring the most effective use of those funds. In this regard, the MOH's key function would be providing clear guidance to the executive concerning trade-offs between objectives of equity and efficiency in the conduct of its operations. The organizational structure of a national service can be more or less decentralized. Current policy tends to favour the political needs of local government at the expense of the managerial requirements of the health system. This would not be the case under a national health service, where managerial requirements would be the main determinants of the roles and responsibilities of different levels.

If such a system were introduced in Ghana, the question arises as to how such a service, and its employees, would relate to the district assemblies and their secretariats. If the purpose of a national health service is to establish a more effective structure for health planning and management, how does this fit with plans for local government control over all development activities? If a national health service depends for its effectiveness on becoming a separate employer, how does this square with the intention to transfer staff management responsibilities to the district authorities?

Conclusions

The aim of the original position paper was to provoke further thinking, particularly within the MOH, about the practical implications of current policy directions and intended structural change. Although many of the issues were being discussed *within* the different organizations involved, there was little dialogue *between* agencies, or between staff at different levels. One of the consequences of producing this paper was that discussion was stimulated in Ghana.

Although the paper is about a particular time in a particular country, many of the underlying themes – notably the difficulty of linking policy development to politically realistic organizational change – remain constant despite changing circumstances. Also, the issues confronting the health sector in Ghana today, are the very same ones that many other countries are currently facing.

It is important to realize that these issues must all be addressed, not sequentially but simultaneously. Ministries of health do not have the luxury of focusing on single issues. This paper can, therefore, also serve to call attention to the wide ranging and complex nature of the concerns and responses with which countries must grapple.

A number of preliminary conclusions emerge from the review of current issues in Ghana:

- 1 The purpose of restructuring operating ministries is to enable them to function appropriately in relation to a decentralized government administration. In the MOH, however, two completely separate debates are taking place. Restructuring of the MOH is of primary concern to HQ staff, and is in danger of being seen as an end in itself. Changes in the power and function of local government, on the other hand, are of more concern to regional and district staff, who have to deal directly with elected representatives. There is an urgent need to promote discussion between HQ and field levels of the organization.
- 2 Pressure on the MOH to complete the process of restructuring is growing. What will indicate completion, beyond the formal acceptance of the new organizational chart and the appointment of individual staff to key positions in it, is less clear. It is probable that the fundamental and politically sensitive changes in the budgetary system, which will result in a real shift of power to district assemblies, will not keep pace with central restructuring. If this is so, there must be a risk that a restructured MOH will continue to function in its usual centralized fashion.
- 3 The risk that resource allocation in the health sector under decentralization will favour facility-based curative care cannot be over-emphasized. This stands in stark contrast to the traditional assertion that PHC implementation will improve significantly under decentralization.

Apart from efforts to 'educate' politicians, there is an important role for the National Development Planning Commission in col-

laboration with the MOH to develop a system for monitoring policy implementation in districts. Such a monitoring system would need to be linked with some authority to redirect the allocation of funds by district assemblies. Alternatively, a system of central grants to redress serious inconsistencies between local priorities and central policy would need to be instituted.

- 4 Regions play a critical role in the support of districts. The question of how regions can effectively perform this important managerial function under decentralization without the power of the budget, needs to be carefully reviewed. If there is to be a long transition period (as is widely anticipated), an interim solution will be required. Notwithstanding the political objectives of decentralization, efforts need to be made to clarify the managerial role regional directors of health and their teams can and should play both in the interim period, and under full decentralization.
- 5 Further progress in decentralization will depend on the resolution of several complex organizational and political issues, about which the different key actors hold conflicting views. These include decisions about the extent of budgetary powers to be invested in the district; the role of central government agencies in providing support to local government; and the responsibility of local government in relation to the employment of staff of operating ministries. Although these issues are unlikely to be resolved quickly, they all have vitally important implications for the provision of health care in the future. If the MOH plays no part in the debate, then changes will continue to be imposed by other levels of government. To be an effective participant, the MOH needs to review its own priorities critically, in terms of the types of service it can afford to provide; the quality and coverage it aims to achieve; and the structures and systems required to support and monitor progress.
- 6 Increasingly, donors in Ghana are concerned less with single projects and more with broad-based sectoral and institutional development for health. For agencies to be

actively involved in the policy dialogue with government is clearly preferable to a continuing insistence on implementing pre-determined programmatic agendas. However, it is equally important that donors, whose financial power gives them considerable clout, are aware of the practical implications of changes they recommend, and the capacity of systems and individuals to implement those changes.

References

- ¹ World Bank. 1990. *Staff appraisal report*. Second Health and Population Project. Report No 9029-GH. November 16.
- ² Ministry of Health, Government of Ghana. 1988. Issues, problems and priorities of the health system in Ghana. Unpublished background paper prepared by the Ministry of Health for the National Health Symposium, State House, Accra. June 7-8.
- ³ Ministry of Health, Government of Ghana. 1989. Action plan to improve health service delivery in Ghana. Unpublished policy statement prepared by Nana Akuoko Sarpong, PNDC Secretary for Health. 27th February.
- ⁴ World Bank. 1991. Public Expenditure Review 1990. Presented at an informal donor co-ordination meeting, January.
- ⁵ Waddington C and Enyimayew KA. 1990. A price to pay. Part 2: the impact of user charges in the Volta region of Ghana. *International Journal of Health Planning and Management* 5: 287-312.
- ⁶ Drugs cash and carry scheme. 1990. Unpublished Ministry of Health, Government of Ghana document. Cash and carry is strongly identified with the World Bank 2nd Health and Population Project. The system was designed with the help of Bank staff, and approval for its implementation was a conditionality of the IDA credit.
- ⁷ Ministry of Health, Government of Ghana. 1978. A primary health care strategy for Ghana. Unpublished policy paper. August.
- ⁸ Ministry of Health and World Health Organization. 1991. Proceedings of a national meeting on the co-ordination and integration of health programmes and services in Ghana, held at Sogakope, Volta region. 14-16th January. WHO/SHS/DHS 91.2.
- ⁹ Republic of Ghana. 1988. Local Government Law (PNDCL 207). Ghana Publishing Corporation (Printing Division). Accra, Assembly Press.
- ¹⁰ Republic of Ghana. 1987. Creation of district political authority and modalities for district level elections. Ghana Publishing Corporation (Printing Division). Accra, Assembly Press.
- ¹¹ UNICEF. 1988. The Bamako Initiative. Recommendation to the executive board for programme co-operation 1989-1993. E/ICEF/1988/P/L.40. 15 March.
- ¹² Ministry of Health, Government of Ghana. 1982. The health policy of Ghana. Unpublished policy document. April.
- ¹³ Waddington C. Regional health economist, Volta region. Personal communication.

Acknowledgements

We are grateful to the officials of the Ministry of Health, Ministry of Local Government, National Development Planning Commission and the representatives of international and bilateral agencies in Ghana, who shared with us their concerns and views. Special thanks are due to Dr Moses Adibo, Dr Nana Enyimayew, Dr Asamoah-Baah, the Honourable Kwamina Ahwoi and Mr Nicholas Bennett.

This analysis was carried out while the authors were working on the Strengthening District Health Systems Initiative, a Ministry of Health programme supported by the Division of Strengthening Health Services of the World Health Organization, with funding from the Overseas Development Administration, UK.

Biographies

Andrew Cassels is a Senior Lecturer in the Department of International Community Health of the Liverpool School of Tropical Medicine. After graduating in medicine from Cambridge University, he became involved in the management of community health programmes in Nepal, India and Bangladesh. Since joining the Liverpool School, he has been responsible for a three-month course on primary health care management and has carried out numerous consultancies in health policy and management. He holds a masters degree in community health from the London School of Hygiene and Tropical Medicine.

Katja Janovsky currently works with the District Health Systems Group of the Division of Strengthening Health Services at WHO in Geneva. She began her involvement in public health in the Office of International Health Programmes at the Harvard School of Public Health. She worked in East Africa for eight years, first as a health planner in the Ministry of Health in Kenya, and subsequently as Director of Project Management and Health Planning for the African Medical and Research Foundation (AMREF), a regional non-governmental organization. Since joining WHO, she has been supporting various initiatives concerned with health systems development in Africa and Asia. She holds a masters degree and a doctoral degree in administration, planning and social policy from Harvard University.

Correspondence: Dr Katja Janovsky, Division of Strengthening Health Services, World Health Organization, CH 1211 Geneva 27, Switzerland.