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Reforming health service delivery at district level in Ghana: the perspective of a district medical officer

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Many countries in sub-Saharan Africa face the problem of organizing health service delivery in a manner that provides adequate quality and coverage of health care to their populations against a background of economic recession and limited resources. In response to these challenges, different governments, including that of Ghana, have been considering or are in the process of implementing varying degrees of reform in the health sector. This paper examines aspects of health services delivery, and trends in utilization and coverage, using routine data over time in the Dangme West district of the Greater Accra region of Ghana, from the perspective of a district health manager. Specific interventions through which health services delivery and utilization at district level could be improved are suggested. Suggestions include raising awareness among care providers and health managers that increased resource availability is only a success in so far as it leads to improvements in coverage, utilization and quality; and developing indicators of performance which assess and reward use of resources at the local level to improve coverage, utilization and quality. Also needed are more flexibility in Central Government regulations for resource allocation and use; integration of service delivery at district level with more decentralized planning to make services better responsive to local needs; changes in basic and inservice training strategies; and exploration of how the public and private sectors can effectively collaborate to achieve maximum coverage and quality of care within available resources.

Introduction

Many countries in sub-Saharan Africa face the problem of providing adequate quality and coverage of health care to their populations against a background of economic recession and limited resources. In response to these challenges, different governments are in the process of implementing, or of considering implementing, health sector reforms (Cassels 1995; Cassels and Janovsky 1996) which ultimately aim to improve quality and coverage of health services as well as efficiency. In Ghana, health sector reforms, popularly known in country as the Medium Term Health Strategy, are aimed at improving access to basic services, quality of care and efficiency, as well as strengthening links with other sectors such as agriculture, education etc, which also impact on the health of people (Government of Ghana 1995, 1996, 1997).

In this paper, aspects of health services delivery and utilization over time in Dangme West district, Ghana, are examined, and ideas for improving health services delivery, quality, coverage and utilization are suggested from the perspective of a district medical officer (DMO).

Dangme West district

Dangme West district of the Greater Accra region of Ghana is located within the Greater Accra region. Although it is typical of rural districts across the country in many respects, such as levels of poverty, lack of telecommunications, good road infrastructure and social services, it is atypical in terms of its distance from the capital city of Ghana, Accra. The proximity to Accra is both an advantage and a disadvantage. It is a disadvantage in that many people who have never been there feel that it must be as well developed and urbanized as the Accra metropolis, and it can get overlooked in rural development issues both within and outside the health sector. The advantage is that to an extent the district is better able to attract trained staff (especially in the district capital, Dodowa, which is closest to Accra) than some of the more remote and inaccessible districts in the country. However, staff are very reluctant to be posted to the more distant parts of the district, and within the Greater Accra region, Dangme East and West districts are regarded as the least desired postings.

Dangme West had an estimated 1997 mid-year population of 103 210 and is divided into four smaller administrative units know as sub-districts, each with an estimated population of 20 000–30 000. Apart from a handful of larger settlements the majority of the population lives in scattered small villages of less than 2000 people, sometimes with very poor road access which gets worse in the rainy season. Pipe borne water and electricity are only available in a few larger communities. The population is generally poor with the main income generation activities being subsistence farming, and fishing along the coast and the Volta river.

In 1997 the public sector health services consisted of four rural health centres[1] with about 10–25 staff each, and five community clinics staffed by 2 to 3 community health nurses each. There were no hospitals or laboratory services. The overall nurse:population ratio was 6:10 000, with one sub-district having only 4:10 000 and the two closest to Accra having

as many as 8:10 000. The private sector consisted of a handful of chemical sellers (lay people licensed by the pharmacy council to sell over-the-counter drugs), two private midwifes, numerous unlicensed drug outlets (predominantly petty traders selling drugs), a few drug peddlers, quack doctors and injectionists. The traditional sector consisted of about 60 MOH trained Traditional Birth Attendants (TBAs) and an unknown number of untrained TBAs, herbalists, bonesetters and spiritualists.

There are no mission facilities in the district, but they exist in two adjoining districts, which are very popular despite the time and travel expenses involved in their use and the higher charges. Reasons community members give for preference of mission facilities include ready availability of drugs, polite efficient staff who do not keep you waiting or insult you, and perceived technical competence and efficiency: 'You can be well insulted at Akuse [a government hospital in the adjoining Yilo Krobo district] by the nurses and small small doctors' but 'The nurses in Battor [a catholic mission hospital in the adjoining North Tonu district] are always busy. The doctors check your condition properly. There is discipline.'

Health financing at district level

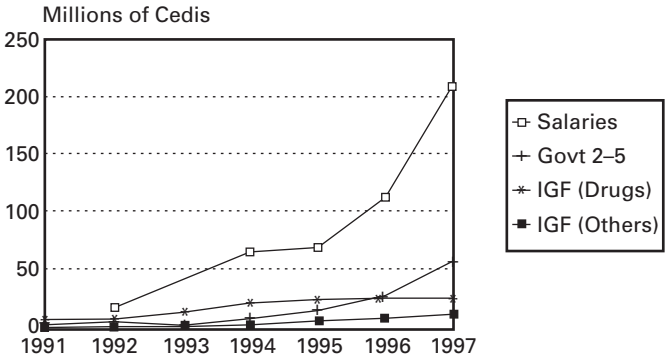
Sources of health financing for district health services in Ghana include internally generated funds (IGF) or user fees, central government allocations, funding from NGOs and other donors, and community contributions in cash or in kind for specific projects.

User fees or internally generated funds (IGF) in Ghana started in 1971 with the hospital fee act. The 1971 fees were very low and aimed to reduce unnecessary use of services rather than to generate revenue. In July 1983 the fees were slightly raised, and in July 1985 a new hospital fee act was passed and the fees were substantially raised, the aim of the Ministry of Health being to recover at least 15% of its total recurrent expenditure. Initially, health centres and clinics were allowed to retain only 25% of their revenue, and hospitals 50%, while the rest was sent to the central Ministry of health and the National Treasury (Waddington and Enyimayew 1989, 1990). In 1990 the law was amended and institutions were allowed to retain 100% of the fees; and a revolving fund for drugs known as Cash and Carry was initiated. Under Cash and Carry, institutions were to recover 100% of the cost of drugs, keep the revenue for drugs separate and use it only to purchase more drugs. The 'Cash and Carry' revolving drug fund currently operates at all facility levels from community clinics to teaching hospitals and successfully recovers 100% of the cost of drugs plus a small overhead (average 10–15% of drug costs in theory but in practice sometimes much more). Apart from fees for drugs, fees have been gradually introduced for other consumables such as OPD cards, gloves, gauze, needles and syringes. In addition there are informal user fees of various shades of legality, such as the 'mother's voluntary contributions' collected by MCH staff to help with transport for outreach which are usually documented and accounted for; and 'under the table fees' which are not documented anywhere and go into the pockets of the staff who collect them.

User fees have been fairly successful in terms of revenue generation, cost recovery and establishment of a revolving drug fund. However, revenue generation and cost recovery have tended to be seen as ends in themselves rather than as means to improving utilization and quality, and user fees have not had as much impact on quality and utilization as they could have. Similar observations have been made elsewhere (Creese 1991). Although financing for drug purchasing is no longer a problem, there continue to be localized shortages of drugs in some institutions, even when the drug in question is available on the market. Minimum stock levels are not observed and drugs are not ordered on time, resulting in artificial shortages while care providers complacently congratulate themselves on having been so successful with cost recovery that they have surpluses in the institutional account.

There are problems in the area of equity with user fees. The clause providing exemption for the poor and treatment of emergencies, whether they are in a position to immediately pay or not, is hardly used and people are sometimes denied the care they need. In part, the non-use of the clause exempting the poor is because the costs of exemption are to be borne by the facility out of the surplus it generates. People are reluctant to watch their surpluses being eroded in a way which brings no obvious benefit to the facility or the workers. There is also extra 'social work' involved in verifying that a person is indeed unable to pay since if just a statement of inability to pay is used, everyone will become 'too poor to pay'.

Central government provides money to districts for recurrent and capital expenditure. Amounts available from central government and internally generated revenue from 1991–1997 in the Dangme West district are shown in Figure 1, which shows that government budgetary allocations to the district as well as IGF have been rising over time. There have been fairly modest rises in per capita dollar terms because of devaluation of the cedi. Per capita expenditure was $0.74 in 1992, and increased to $1.37 in 1997.



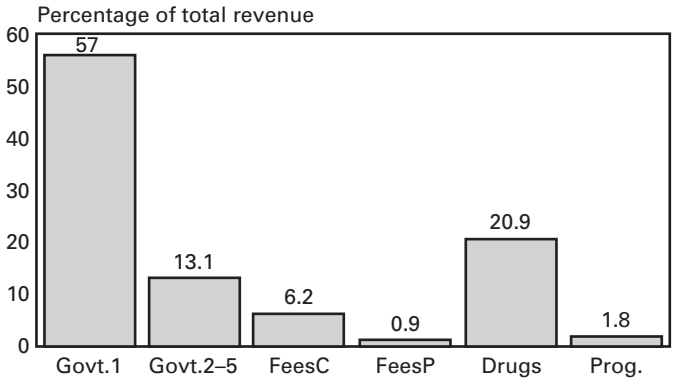
Notes: Govt 2–5 = Government budgetary allocations for recurrent expenditure other than salaries; IGF = internally generated funds (user fees)
Data on salaries for 1991 and 1993 could not be traced on the files
Returns on December IGF for 1991 are missing from the annual report and figures for December were estimated by finding the monthly average IGF from January to November 1991 and assuming it was a fair representation for IGF for December 1991

Figure 1. Revenues for recurrent expenditure: Dangme West, 1991–1997

Part of the increase in staff salaries over time, shown in Figure 1, is related to the transfer of more staff to the district as well as central government salary increases. The progressive increase in non-drug IGF is related to the increasing inclusion of non-drug medical supplies such as gloves, gauze, syringes and needles in the cash and carry system.

It is difficult to keep track of donor and NGO funds since some are allocated vertically and others are used to implement projects directly at the community level; the District health administration is sometimes not aware of the existence of some of these sources or how much is involved. Donor and NGO funds have therefore been left out of Figure 1 because the incompleteness of the data may lead to confusion in evaluating trends. Figure 2 shows the different sources of revenue for the year 1995 and gives an idea of the relative proportions of the different sources of financing. Donor money for that year which was passed through the district health administration, and thus the amounts were known, have been included. This amount cannot be assumed to represent all the donor money which came to the district in cash or in kind that year.

Initially, central government provisions for capital expenditure passed through the sector ministries, and allocation and use was centralized. However, since 1995, as another step towards decentralization, it has been passed through district assemblies as a block fund for all sectors, known as the district assemblies common fund. For Dangme West in 1995, the total was C374 625 000 (US$ 261 609.64) (Kpabitey 1996). The proportion of this fund used on health-related capital projects in each district depends on the priorities of the district assembly and the lobbying power of the district health directorate. However some funding may be sent from the centre with specific instructions to be used for a particular capital project, e.g. World Bank funds for building offices for District Health Management teams (about 90 000 000 cedis). Revenue generated locally by the district assembly is very small; in Dangme West in 1995 the amounts were C126 824 300 [US$88 564.45] actually collected and C44 483 600 [US$31 042.29] in outstanding debts (Kpabitey 1996). The assembly has thus to date not been able to provide significant local funding for the health sector. Communities sometimes contribute to capital projects which meet their felt needs, usually community clinics or staff accommodation, providing locally available materials and labour.



Notes: For reasons explained in the text, donor and NGO money is not included apart from money sent by programmes which was passed through the district health administration
Govt. 1 = Salaries; Govt. 2–5 = Other recurrent; FeesC = Clinical fees; FeesP = MCH Outreach fees; Prog. = Vertical Programme funds

Figure 2. Revenues for recurrent expenditure: sources and percentage of total revenue, Dangme West, 1995

Decentralization

Under the Medium Term Health Strategy, the main mechanism envisaged for change is the creation of a Ghana Health Service, distinct from the general civil service and from the central Ministry of Health, which becomes mainly a policy-making body. The Ghana Health Service is an executing agency responsible for running a decentralized health service with the aim of providing access to basic services for all Ghanaians as close as possible to where they live and work (MOH 1996, 1997). The passage of the Ghana Health Service and Teaching Hospitals Act (Republic of Ghana Act 525, 1996) by parliament means that for the health sector, decentralization no longer involves devolution of responsibility for district health services to the district assembly, as envisaged under the Local Government Act of 1993 (Republic of Ghana Act 462) and the very similar preceding PNDC law 207. Until the passage of the Ghana Health Service Act in December 1996, the implementation of the Local Government Act had taken the form of deconcentration, with a gradual transfer of power within sector ministries such as health, education, agriculture etc. from the centre to the periphery, rather than the envisaged devolution. The passage of the Ghana Health Service Act is thus, in a way, an endorsement of an already existing trend within the system.

A still unsolved problem with decentralization at the district level is that vertical allegiance within line ministries is stronger than horizontal allegiance at the district level to the assembly. This, plus the slow progress of decentralization, has meant that one of the objectives of decentralization, intersectoral collaboration, with the potential to solve some of the wider problems leading to the poor health status of Ghanaians, remains weak.

Over the years, there have been several areas of gradual power transfer within the Ministry of Health from the centre to periphery. Capacity building through increasing the competence of District Health Management Teams (DHMT) using a variety of short-term management training, as well as more formal public health training (predominantly MPH training for DMOs), started in the late 1970s and gained momentum in the 1980s and 1990s. Another area of power transfer has been granting the district medical officer direct control over some of the government's budgetary allocation for recurrent expenditure since 1991. Trends in government allocations for recurrent expenditure over time have already been presented (Figure 1). Previously, the Government budgetary allocations within each item were sub-allocated between the vertical divisions, namely maternal and child health, diseases control, nutrition, and environmental health. An improvement in recent years, which is part of financial reform to increase flexibility, has been a

replacement of this method of sub-allocation with one where the money is sent to the district under two headings – money to run the district health administration and money to run sub-district health services. This allows the freedom to make decisions within the district as to which programmes or activities a particular block of money is to be used for, and promotes better integration.

Despite these improvements, there is still rather limited flexibility for financial decision-making at the district level. Preventive health service delivery suffers most from this weakness. Staff salaries, the biggest expenditure category (Figure 2) are centralized; the district has no say in the hiring or firing of staff or on how much of the budget is to go on salaries. The next biggest source of revenue and expenditure is drugs. However, to protect the revolving drug fund, this capital can understandably not be touched but must be used to replenish drug stocks. Government budget allocations for recurrent expenditure, though no longer sub-itemized by vertical division, are still itemized by expenditure category and cannot be shifted between items. Since the allocations to each item usually have no bearing on estimates submitted by the district, this can be a problem. Fees for clinical services other than drugs currently offer a relative amount of flexibility in use. However, as already mentioned, institutions are sometimes reluctant to use their internally generated revenue; and in cases where they do use it, curative care has been the priority use.

Working with the private sector

This is an area where there has been no reform to date. Until the recent interest in collaboration between private and public sectors in health care delivery, the private sector has been largely ignored if not frowned upon by public planners and care providers. There has been little interaction between the two sectors and there is a tendency for some mutual mistrust, even where the private sector is legal and licensed. In urban areas the private sector is fairly well developed, with licensed practitioners such as doctors, nurses, pharmacists and trained lay sellers of over-the-counter drugs known as chemical sellers. In rural areas, however, it consists predominantly of unlicensed and untrained practitioners such as petty traders selling drugs, drug peddlers, quacks and injectionists, with a handful of trained and licensed practitioners such as chemical sellers and midwives in the towns and larger communities. Use of private sector services, especially drug outlets, for purchasing drugs or consultation is a common treatment action. In both urban and rural areas there are no effective mechanisms for quality control, regulation and consumer protection. This kind of scenario has been described in other developing countries (Igun 1987; van der Geest 1987; Haak 1988; Hardon 1987; Greenhalgh 1987; Wolfers 1987; Melrose 1993).

Given the inability of the public sector to provide complete coverage, plus the widespread use of, and sometimes client preference, for the private sector, and the current general political and policy climate which is in favour of privatization, partnership between the two sectors, some form of regulation and simultaneous quality control of both, are necessary if quality and coverage is to improve. Public and private sectors are interdependent whether they willingly acknowledge it or not. Alubo's (1993) study of drug poisoning and deaths in Nigeria is a tragic example of the effects of an unregulated private sector and the interdependent nature of the problems of quality control and regulation in private and public sector.

Civil service reforms

Civil service reforms which have affected the district have been the waves of retrenchment of staff and the partial freeze on employment which started in 1986 and formally ended in 1997. The civil service before redeployment had been growing at an average annual rate of 14%, which was about five times higher than the projected annual rate. Wages, productivity and staff morale were all low (Government of Ghana, undated; Sofo F 1994). Redeployment was a central government response to these issues. The objectives of the redeployment programme relevant to district health service delivery were to remove all surplus or under-employed labour from the civil and education services and keep their size at economically viable levels; and to enable government to pay improved remuneration to workers who remained in these services (from savings to be made from staff reduction) and thereby boost morale (Government of Ghana, undated). Over the four year period 1987 to 1990, a total of 44 838 persons were redeployed. The majority (25%) were from the Greater Accra region (Government of Ghana, undated).

Many staff affected by retrenchment in the district were staff in the common services' unskilled labour categories, such as labourers, ward orderlies etc. Retrenchment has not had any noticeable impact on health financing at district level, which is not surprising given that salaries are centralized. In fact, the visible effects at district level may be negative in that some categories of staff who were retrenched were actually needed as the weedy compounds of some institutions (following the loss of labourers) testify. At national level it has proved hard to disprove or prove gain in the light of the objectives set, in part because of problems with the available data (Sofo 1994). The lack of a direct positive impact of redeployment at district level, or of concrete awareness of a general good achieved at national level, means that there tended to be apathy when requests were made from central levels for names of staff who needed to be redeployed.

A more recent civil service reform has been the decentralization of the pay voucher and the introduction of a computerized, integrated, personnel management and payroll database. Decentralizing the pay voucher has brought to the fore the problem of staff who do not exist or have left the ministry but who are still on the payroll, and made it easier to eliminate them.

Trends in utilization of health services in the district

Using routine health management information system data, utilization and coverage of preventive services over time is illustrated using EPI coverage in children 0–11 months (Figure 3) and antenatal, supervised delivery and family planning coverage for adults (Figure 4). Utilization of basic curative

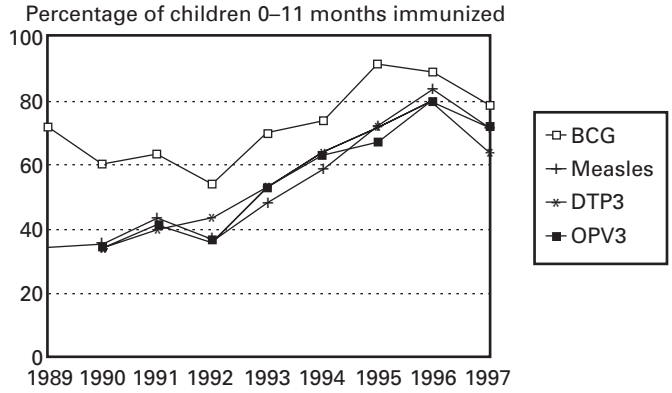
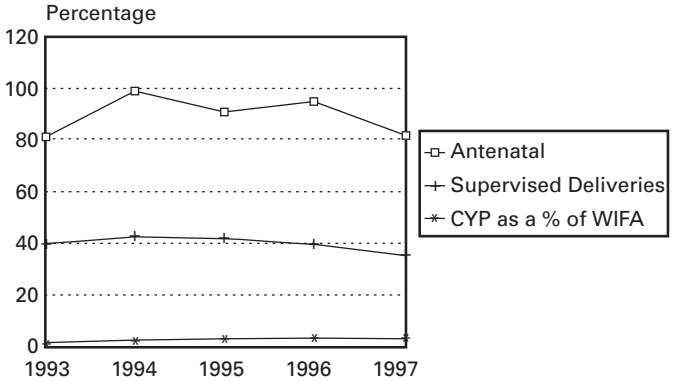


Figure 3. Immunization coverage: Dangme West, 1989–1997



Notes: Antenatal coverage is measured as antenatal registrants * 100 / expected deliveries
Supervised deliveries are expressed as a % of expected deliveries
A couple of years of protection is expressed as a percentage of Women in the Fertile Age (WIFA)

Figure 4. Antenatal, supervised delivery and family planning coverage: Dangme West, 1993–1997

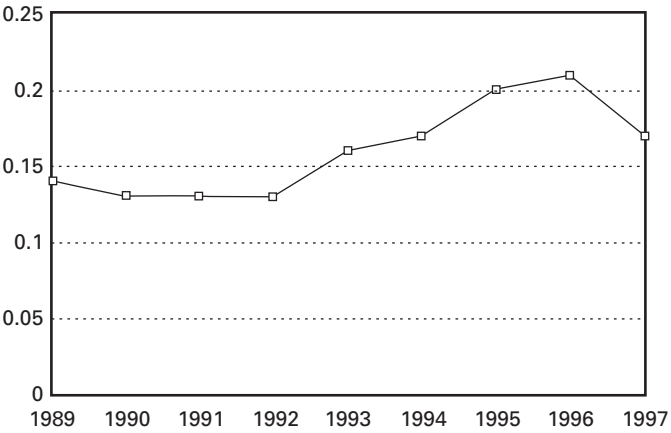


Figure 5. Out-patient attendence per capita; Dangme West, 1989–1997

services is illustrated using out-patient (OPD) coverage (Figure 5). The data are best used by analyzing trends and relative proportions rather than absolute rates since population census data are more than 10 years old.

EPI coverage was very low in 1984 and rose with fluctuations

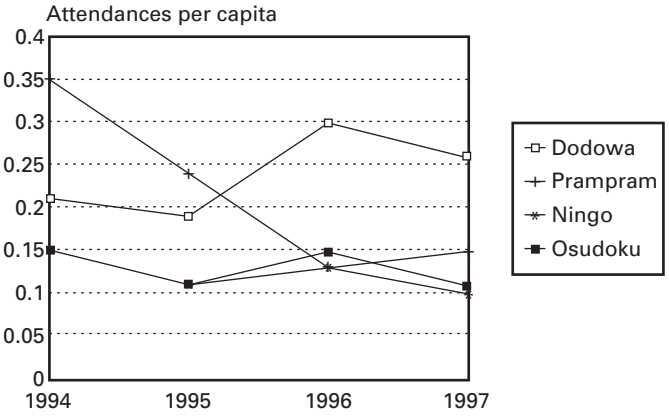


Figure 6. Out-patient attendance per capita by sub-district: Dangme West, 1993–1997

between 1984 and 1990 as a result of the central MOH and external donor driven push, backed with resources, to immunize 80% of children aged 0–11 months by 1990. Mass campaigns led to sudden rises, while pauses by health staff to catch their breath following a particularly taxing effort led to falls. In spite of the intermittent high coverage achieved, the push was negative because it absorbed a large proportion of resources and staff time whilst causing districts to ignore many other problems, including the vital one of developing and strengthening the basic health service. The central push to achieve 80% coverage was released after 1990, and this resulted in some fall in coverage between 1989 and 1992. The extra fall in 1992 was related to staff conflicts in one sub-district which virtually ground outreach services to a halt.

Coverage of EPI has been rising following the 1992 fall due to increasing effort and confidence as well as commitment within the district to planning within a decentralized system to achieve specific targets. Each year the district and sub-district health teams get together to evaluate progress and replan strategies to move closer to 80% as part of an integrated process within the context of strengthening the basic health system. The slight falls in 1997 are in part due to a problem with vehicle management in one of the more difficult to access areas.

Antenatal, supervised delivery and family planning coverage have more or less remained static. In part this is because these areas have not received the same concentrated attention from the district health directorate and sub-district health teams as immunization. To an extent they have been regarded as a 'Maternal and Child Health divisional affair'. EPI benefited from the pre-1990 push to achieve 80% coverage in that it was pushed onto the general agenda rather than regarded as a particular divisional programme.

Figure 5 shows that OPD utilization per capita remains very low in spite of some increases since 1992. Part of the increase from 1995 onward is attributable to the opening of a health centre in a hitherto unserved sub-district, as well as the opening of three more community clinics staffed by community health nurses. The importance of the human factor is shown in Figure 6 which shows OPD utilization by sub-district. The dramatic fall in Prampram sub-district, which used

to have the highest utilization rates, is related to the transfer of a popular medical assistant and his replacement by one who had personal problems which severely affected his relationship with his clients. The beginning of a rise is related to the change of this officer.

Health service delivery problems from the provider's perspective

From the provider perspective, the current pattern of a few large health centres with many staff is not the appropriate service provision strategy for a population that lives in scattered small villages with poor road access and no proper public transport system. It is true that proximity to health services does not necessarily guarantee use (Malison et al. 1987), however it does influence utilization to an extent, as our slight rise in OPD utilization in recent years shows. Nurse:population ratios can influence coverage. However, the relationship between staff numbers and coverage is not simple since the pattern of staff distribution and availability of resources for service provision also affects the effectiveness of service delivery. There are difficulties in transferring staff to rural areas as many do not want to live in isolated areas. Staffing problems are not just to do with numbers of staff and distribution, but also skills, competence and orientation. Many staff still have stronger allegiance to vertical divisions and their targets rather than integrated service delivery to a given population. Some of these attitudes are reinforced by the old command structure in the Ministry of Health, remnants of which still linger on despite decentralization, where each unit directly controls its staff members right down to the lowest level of the health system.

Currently in-service training is the main strategy used to deal with problems of staff technical competence. The form it is taking is centralized, short-term, predominantly 'classroom' training organized from regional or national level. The decision as to what kind of training to organize and who to train may be driven by availability of funds from different programmes, e.g. Malaria, EPI, TB etc., to run particular training. Some staff in the district who need training may be left out because the funds are not enough to cover 'everybody'. Fragmentation of training for different areas, as well as leaving out some staff who need the new skills and information, does not help to create good integration at the district level. The training often may not have much impact on service delivery in the district since provision is not made for supervision, reinforcement and implementation. Moreover, training usually introduces new or improved approaches that may require more resources, and they are usually not forthcoming.

There is also the whole neglected area of the motivation and morale of health workers. It is unlikely that adequate quality and coverage of health services can be achieved without well-motivated staff with a high morale. Al Hussein et al. (1992) describe the nurses' perspective on factors leading to poor nursing care in government institutions in the Central region of Ghana. Issues raised by the nurses include being required to perform tasks below their level of training, e.g. professional nurses cleaning wards; or conversely, being required to perform tasks above their level of training, e.g. auxiliary nurses doing suturing and setting up intravenous infusions. These problems were related to staff shortages. Other concerns raised were working environment factors such as inadequate equipment and supplies, lack of effective supervision, lack of co-operation from other health team members, poor service conditions such as lack of continuing education, promotion, and grossly inadequate allowances, as well as conflict in nurse to nurse inter-relationships arising from differences in education and status of nurses.

Barriers to health service utilization from a patient perspective

Qualitatively, there is a lot of expressed client dissatisfaction. Factors identified as influencing client perceptions of quality of care in Ghana (Dovlo et al. 1992; Haran et al. 1993; Kumekpor and Richardson 1992; Odoi-Agyarko et al. 1992) are similar to those described from other countries (Maime et al. 1992; Thaddeus and Maime 1994; Jaffre and Prual 1994). They include accessibility, distance, ease of getting there, convenience, costs, humanness, technical competence, information provision to clients, bureaucratic arrangements and efficiency, physical facilities, continuity of care, outcome of care and availability of drugs, supplies and essential equipment.

Some specific issues leading to client dissatisfaction in the Ghanaian context include the equity problem under cash and carry which creates 'unavailability' for the poor. There is also the continued problem, previously discussed, of clients being asked to buy some of their drugs outside the institution. This causes inconvenience and a financial strain on people since it may entail travel outside the community. Some patients even suspect that the public sector workers may be in league with the private drug sellers, making sure patients buy drugs privately so the public workers can get a percentage of the profits – otherwise why should you run short of a drug that is readily available on the market?

Another client problem is the perceived competence of the provider. People want to see a 'doctor' not necessarily in terms of a degree per se, but in terms of competence to make a diagnosis, give appropriate therapy and achieve prompt recovery without complications. There is some mistrust of the skills of lower level workers, and conflicts may arise between patient perceptions of quality and providers' technical knowledge, as the village health worker programme showed. Village health workers were trained by the District Health Management team for four to six weeks, supplied with drugs and supervised by the sub-district health team. They were limited to the use of 10–12 over-the-counter drugs and not trained or allowed to give injections. Remuneration was to be from their user fees as well as community contributions. To date, most community clinics staffed by village health workers are struggling to stay financially viable or have collapsed, partly because of the low utilization rates and revenue. An internal evaluation in 1992 (Agyepong and Marfo) showed that community members were not using the clinics because they felt the quality of care was not up to the standard they wanted and the training of the village health worker was inadequate since they could not perform functions that nurses can and which they valued, such as giving

injections. Clinics which are still doing well financially, and have relatively high attendance rates, are those in an area where the supervising sub-district staff have observed and lodged a complaint that the village health workers are 'undertaking additional "curative care" activities for which they have not been trained'.

Clients also want to see an upgrading of the diagnostic competence of sub-district level facilities, commonly expressed as wanting laboratories, X-rays etc. Personal characteristics of the provider are important, as shown by the earlier example of a fall in utilization at one centre following the transfer of a popular medical assistant and replacement with one whose conduct was unacceptable. This is similar to the findings from a study in Zaire (Hadad and Fournier 1995) where it was observed that 'A drop in utilization follows the appointment of a nurse who is competent, but whose conduct is highly offensive' and 'The appointment of a relatively competent nurse whose strength lies in interpersonal relationships has a positive influence on the activity of a centre'.

Suggestions for change

Decentralization, increases in the government budgetary allocations to districts and granting more direct control of spending decisions to districts are changes in the health sector which have had some positive impact on service delivery. The impact of user fees has been mixed. Any improvements in utilization, quality and coverage are slight and give no reason for complacency, but rather suggest that more needs to be done. Possible ways ahead are discussed below under two broad classifications: increasing the efficiency of use of available human and material resources, and finding more resources.

Increasing efficiency of resource use

There are several expenditure choices which can be made in a country or district, and differing levels of efficiency will be achieved depending on the choices made.

Provider perceptions of cost recovery aims

If maximum efficiency is to be achieved in the use of resources, service providers must move from seeing cost recovery and improved resource availability as ends in themselves to seeing them as a means to improving utilization, coverage and quality. Using the case mentioned earlier of essential drugs for example, perhaps if a system was worked out of penalizing institutions which run short of essential drugs or do not maintain minimum stock levels, despite having adequate cash in the drug revolving account, and rewards were given for institutions which used their money to ensure good drug management, the message would gradually sink in that surpluses in the bank are not an end in themselves. An example of a penalty could be a fine to be paid by the institution, either to the regional or district medical stores, each time a monitoring visit from the DHMT showed there was a problem of drug shortages and failure to maintain minimum stock levels. Conversely, a 'best spender' award, involving not just a shield or medal but significant cash prizes for staff in facilities using internally generated funds to increase utilization, quality and or coverage, could help to encourage staff to make more use of internally generated funds for the purposes for which they were designed.

Why/what am I paid

If jobs and remuneration in the civil service were more linked to achievements in utilization, coverage and quality, and not automatically guaranteed once a person entered the service, there would perhaps be more achievements to record. The Ghana health service needs to consider this issue. The private sector sometimes succeeds better than the public sector because the financial rewards in terms of profits are very much related to ability to attract and satisfy clients. Currently, in the public sector, regardless of the quality of your output and the satisfaction or otherwise of your clients, your pay packet comes at the end of the month. Generally, the worst you can expect for bad or incompetent work and/or behaviour is a transfer to another station. Similarly, no matter how hard you work or how excellent your output, your pay remains the same – and that same is barely adequate for the basic necessities of life in terms of food, clothing and shelter.

It is hardly surprising if the attitude of many staff to their work is indifferent at best and negative at worst. Perhaps substantial rewards, such as a fifty or hundred percent salary rise for all staff in a high performing facility for the next year with a renewal if their performance continues, or significant cash awards (bonuses) at the end of the year for hard working staff, could create better motivation among staff. Alongside such a positive reward system could be a negative reward system such as salary decreases for very poor work. However, if such reward systems are to be used, they must be accompanied by well laid out, tested and unprejudiced guidelines for assessing who benefits, which are based on long-term assessment by immediate supervisors rather than a day visit by a 'monitoring team' from regional or national level. Such out of context monitoring visits can create spurious assessments and actually act as a disincentive. Day visits can, however, be a useful verification of a continuous assessment report.

Polyvalent staff

Developing better links and co-ordination of curative and preventive service delivery at the district and sub-district level through negotiation, dialogue and reorientation of staff perceptions of their jobs could help in getting some of the more 'flexible' user fees used for preventive care, without clinical service providers feeling that they are funding an activity which is none of their business. Related to this is the need to reduce 'staff specialization' at sub-district level and below, so that staff provide integrated service rather than programme delivery. As previously mentioned staff still tend to perceive themselves and their tasks by division rather than as a team trying to improve quality, coverage and utilization of services at district level. Delivery of a basic package of health services requires well-distributed and trained staff based at the community level who have an integrated rather than a divisional or programme perspective; not an oversupply of specialized staff. Staffing of rural health centres needs to be trimmed down to a few slightly more specialized staff to deal

with referrals from the community level, to provide support and supervision of service delivery, and for reporting and feedback to and from the community level.

Though MOH Ghana is currently exploring how to redesign the basic training of some categories of health staff to achieve this effect, the process is very slow and the need is here and now. Staff already in the system can be retrained and re-oriented while we wait for the multi-purpose community health worker to materialize. If the current patterns continue, only people who live in communities in which health centres and posts are located will continue to have effective access to primary health services on a regular basis, while the rest have access only once a month or so with the few staff who go on outreach.

Selection and training of auxilliary staff

A potential obstacle to the implementation of this strategy of service delivery is the understandable reluctance of health auxilliaries trained for rural areas, who often have a relatively urban background and social and family ties, to work in remote rural communities with poor utilities and social opportunities. The method of selecting candidates for training as health auxilliaries such as community nurses will have to change if we really want to train staff to provide services in rural areas. Currently selection is a predominantly academic competitive process based on performance in aptitude tests; no allowance is made for the question of whether selected candidates will be able to work in rural areas. Since urban schools are usually better that rural ones, most candidates are young unmarried women from relatively urban areas.

A better selection process would be to link selection of candidates to district assemblies where they already live, so that even before they are trained, they are earmarked for particular districts and communities, and after training will not be accepted elsewhere. Quotas of number of nurses to be trained each year would be granted to districts based on population to be served, nurses already present and any other objective indicators of need agreed upon by districts assemblies and the Ministry of Health. Participation and performance in a Village Health Worker programme as a prerequisite to sitting the exam and entering training would help trainees to know what they are in for and to decide before training if this is really the job they want to do.

It would probably also help if training was structured such that some was in the form of field practice or on-the-job training within the rural setting where trainees are destined to work; sometimes, two years away in a relatively urban area can leave you disinclined to return to the village to work there. Developing the rural areas – an intersectoral, local government and central government problem – plus better incentives for staff who work in relatively remote areas will help to resolve some of these problems on a long-term basis.

In-service training strategies

Designing and running more integrated inservice training programmes would be more beneficial to districts than the current single disease or programme training. For example, malaria, diarrhoea and ARI, which tend to be childhood problems, could form one training package, while chronic communicable diseases such as leprosy and TB, which tend to be adult problems, could become another training package, perhaps with other predominantly adult problems such as AIDS and other STD, depending on how practical this is. At the same time, design and funding decisions, such as what categories of staff and how many should be trained, should be better linked to who actually provides the services in the field rather than who is supposed to. In rural areas, a nurse not traditionally recognized as a prescriber may be the only person readily available to attend to a sick child. If a nurse carrying out immunization sees a sick child in an outreach clinic, which is not uncommon, they are in the difficult position. S/he could treat the child (which may have a simple case of ARI or malaria), despite not having the formal training, or s/he could refer the child and mother to a clinic, sometimes miles away over poor roads. Similarly, clinical nurse auxiliaries, who commonly take over the clinic when the trained prescriber is not available, are often not recognized as playing the role of prescribers.

Less inservice training in classrooms (the current pattern) and more on-the-job training using strategies such as structured observation of performance on the job with feedback, peer review and discussion, reminder strategies or combinations of approaches, can be more useful for the acquisition of the skills needed in service delivery. Training programmes need to be driven less by availability of training funds from a division or donor, as currently happens, and more by district needs assessments and integrated plans. It must be mandatory that a portion of training funds is given to implementation and subsequent supervision and reinforcement, or that arrangements are made for these important follow-up activities before training is organized. Currently, there is usually no provision for assisting staff to implement the new approaches that training programmes introduce.

Exemptions

To increase efficiency of resource use in terms of equity, there should be a specific government budgetary allocation for the poor, rather than it being left to institutions to use their surplus. This must be accompanied by clear, non-bureaucratic written guidelines defining those who cannot pay and need exempting as well as checks and balances against abuses of the system which are specific and sensitive and do not end up depriving the genuinely poor or overwhelming the system with spurious poor. Staff of small community-based clinics can handle the social work involved themselves since they are very close to the community. Larger institutions will need to have social workers attached to help deal with some of these issues.

Private sector involvement

Given the virtually non-existent experience, answers need to be sought through exploration, discussion and negotiation with all parties concerned about issues of licensing, quality control, regulation, and avoidance of duplication by the public sector of what the private sector is doing adequately.

Currently different councils license different practitioners, e.g. the Pharmacy Council for chemical sellers and pharmacists. How can licensing procedures be made more sensitive to needs and local circumstances? Would incentives, assistance or lower licensing fees for those wanting to practice in remote rural areas encourage more private practitioners to go into these underserved areas?

Basic and inservice training requirements before licensing need to be clearly defined, as well as the appropriate balance between licensing bodies, District Health Management Teams, local government and the private sector itself in quality assurance. Currently, for example, private maternity homes are supposed to be supervised by the district public health nurse. Should the district pharmacist supervise chemical sellers and private pharmacies? What are the limits of their authority and how clearly defined are they? For unlicensed outlets, such as the petty traders who sell drugs, should some basic training along with a licensing procedure be developed? Many petty traders who sell drugs are illiterate and the community just buys drugs rather than consults them (Amuah et al. 1990); but do we really want to create yet another cadre of 'health auxiliary'? It is probably better to put more effort into health education for individuals, households and communities so they can make better drug use choices.

Since local government has a legislative role at the district level, it should be involved as fully as possible in deciding on issues of regulation and licensing of the private sector. If the community trusts in and uses the services of an injectionist, it can be very difficult to regulate them even with legislation. Communities and their elected representatives at the district assembly therefore need to be sensitised and fully aware so that they understand the need for regulation and can play a full role in quality assurance, e.g. rejecting or protesting against the practices of injectionists and quack doctors.

Generating more resources

Preventive services, at least for now, cannot really be expected to generate enough revenue to be self-financing since any significant charge for services is likely to have an adverse impact on coverage, as experience with curative care has shown (Waddington and Enyimayew 1989, 1990). The proportion of government recurrent expenditure on staff salaries, as compared to operations, is high. However, if further redeployment is carried out, will those left be prepared to take on more work with no extra salary? This is unlikely since people are already using their spare time to find ways of making ends meet. Moreover, since there is little development in the private sector, there is nowhere for those who have been redeployed to go. They simply end up swelling the number of dependants of those still in employment. Ultimately, we cannot escape from the fact that the economic situation of the country has to improve if absolute resource availability for health is to improve.

Conclusions

Improvement in the quality and the coverage of basic health services at the district level requires a move from vertical to slanted/more horizontal thinking in terms of service delivery, and flexibility of funding at the district level must increase. Programme managers have an understandable nervousness about suggestions like this. A fall in coverage has frequently been observed with a change from vertical to more horizontal organization. In the example of EPI in Dangme West given earlier, there was a fall when the central vertical push to achieve 80% coverage by all means (fair or foul) was removed. However, as this same example showed, changing from vertical to more horizontal thinking did not lead to a long-term fall in coverage. In the medium term, a higher and more stable coverage has been achieved.

A question sometimes asked is 'Well, that is Dangme West, but are all districts in Ghana equally well managed?'. The answer is, some are worse managed and some are better managed. However, what is more important is whether it is possible to achieve a situation where most districts are well-managed enough for high and stable coverage to be achieved and maintained as part of an integrated health care delivery system. The answer is 'Yes, if the Ghana health service is prepared to put in the effort'. Secondly, the suggestion that more integrated approaches are needed at the district level does not mean that there is no room whatsoever for vertical programmes, but rather that vertical programmes should be the exception rather than the rule they currently tend to be, and programme managers should be open to possibilities for integrating and still achieving the desired results.

Opening up to more integrated thinking also means a greater openness to the need to develop the basic health system in developing countries, rather than looking for quick magic bullets to achieve a desired effect whilst the system remains unchanged. Such efforts usually do not endure.

In a way, the difference between the vertical 'quick magic bullet' approach and the slow and unexciting (in terms of quick results) integrated approach can be compared to the difference between arranging temporary lodgings in a hotel for a displaced person as against helping them build a house as a permanent dwelling place. The hotel arrangement is quick, the results are immediately obvious, it is comfortable while it lasts and it achieves the desired effect of providing a place for the person in the short term. Building a house is a slow and tedious business, and can mean a long-term commitment. During the period of construction a temporary shelter for the displaced person is still needed. It can be expensive to build a house, though sometimes the cost may not be much more than the overall cost of the hotel accommodation. However, at the end of the day if you build a house the displaced person is permanently housed. What the developing world needs in terms of assistance for health service delivery is people who will help us build a house which will remain and continue to serve us long after they have gone.

Illustrations aside, for a concrete example of how more integration and horizontal health service delivery at district level could be achieved without necessarily comprising coverage in the long term, the medium term health strategy in Ghana will be used. The suggested health service delivery package in the medium-term strategic framework for Ghana (Republic of

Ghana 1995) has a comprehensive set of services encompassing all the current programmes. Programme managers could sit down with district staff in each region to see how programme goals and objectives can be integrated into the yearly goals and objectives of the districts, and what strategies will be more effective for integrated implementation as well as outcome indicators to measure success or otherwise. The routine Health Management Information system in districts could be strengthened to ensure accurate data collection, analysis, and use in evaluation and planning as well as reporting. With this kind of approach, it would then be possible for programmes to obtain the information they want without having to develop special forms and strategies which sometimes disrupt the development of a strong, basic district health system. Resources could then be provided as part of the districts' financial allocation to help achieve the desired objectives, rather than as programme funds. Annual or even half yearly and quarterly review conferences at sub-district, district and regional levels can be used to assess, evaluate and replan. However, it is not recommended that funds are just pooled and sent to the district without going through prioritization and goal setting, plus agreement on indicators and outcomes, and strengthening of the health information system to monitor performance, if significant impact is to be achieved.

Equally important, time and attention have to be given to building capacity in district health managers and putting resources into making it attractive for good managers to stay at least in some of the more remote hardship district postings. Every country has its Siberia where most people are not particularly keen to go and there are no easy answers to the problem of getting good managers in relatively remote districts. Incentives, however, can be useful. These should be not just differential salary scales, which can be hard to manage, but innovations such as funds to be able to purchase a car of your own or own a house after a certain number of years' service in the more remote districts. The definition of what constitutes a hardship district will have to be carefully and objectively worked out. Equipment and resources to be able to work must be provided and expressed needs promptly dealt with so that staff in such areas do not suffer the additional frustration of no job satisfaction. Especially important is the provision of some form of communication system so that the sense of isolation is reduced, e.g. Motorola if there are no telephone lines. Moreover, staff who opt for such postings must have assurance that they will not be posted and forgotten, and the option to transfer elsewhere after two years service.

It is not advisable to try to force and manipulate staff into accepting such postings against their volition. When that is done they often either go under protest and provide sub-standard service or run away whenever possible and are never at post. If conditions are made attractive enough, some staff will volunteer to go. For example, when an NGO which had put up a clinic in a small rural community in the more remote part of the Dangme West district, where staff do not want to go, offered to double the salary of nurses who would go there, four nurses volunteered rather than the two who were needed. It is therefore not absolutely impossible to get staff to accept certain postings if you are prepared to differentially reward services, depending on an objective assessment and provision of relief for the hardship involved.

Apart from the need for more horizontal thinking and flexibility in funding, services must revolve around communities; the clustering of staff in a few facilities should be replaced by more equitable distribution which is related to settlement patterns. Both pre- and in-service training must be linked to needs, and reinforced with supervision and assistance for implementation; and the management of health service delivery from district down to community level, as well as the routine health management information system, must be strengthened. We also need further research and dialogue to find answers to the question of how to best involve the private sector to obtain good quality and coverage of health services. Last but by no means least, improvements in the general economy would benefit the health sector.

Endnotes

[1] Rural health centres (also called health posts when they are more rudimentary) in Ghana are usually headed by nurse practitioners trained in clinical care and some administration, known as Medical Assistants. They are supported by health auxilliaries providing clinical care, known as enrolled nurses; auxilliaries providing preventive care, known as community health nurses; and other categories of staff such as midwives, communicable disease control officers and environmental health staff. Larger centres may have more professional nursing and other medical related staff such as state registered nurses, public health nurses, and nutrition officers. They also have common services and support staff such as labourers, ward orderlies etc. Total staff complement can be as high as 30 or more.

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Biography

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