Decentralisation, decision spaces and human resource management at hospital level

High commitment human resource management approaches used by the management team of Ghana's Cape Coast Central Regional Hospital

Research Report

October 2005

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Abbreviations

ADHA	Additional Duty Hours Allowance
ART	Anti retroviral treatment
C3RH	Cape Coast Central Regional Hospital
CHAG	Christian Health Association of Ghana
CMO	Context-mechanism-outcome
CRHD	Central regional health Directorate
DPF	Donor provided funds
GoG	Government of Ghana
HR	Human resources
HRH	Human resources for health
HRM	Human resource management
HSR	Health sector reforms
IGF	Internally Generated Funds
IPD	In Patient Department
KATH	Komfo Anokye Teaching Hospital, Kumasi
KBTH	Korle-Bu Teaching Hospital, Accra
MOH	Ministry of Health
NGO	Non-governmental organisation
NPM	New Public Management
OPD	Out Patient Department
RDHS	Regional Directorate of Health Services
VRH	Volta Regional Hospital

Preface

This report presents the findings the Cape Coast Central Regional Hospital (C3RH) human resource management study. The first part was carried out in 2004, with a field visit in October by Ernest Denerville and McDamien Dedzo, while the second part was done in 2005, with a field visit by McDamien Dedzo and Bruno Marchal.

The second part of the study started from the findings of the first part and explored in more detail the management approach of the team at C3RH. It introduced the high commitment management (HiCoM) practice concept as a new analytical model and investigated the perceptions of the staff regarding this approach and the conditions under which these HiCoM practices may work. It also allowed to describe the decision spaces in more detail.

This report is an evolution of the first report. Besides minor modifications and updating of data, there have been major changes introduced in the chapters 6, 7 and 8. Shorter summaries are available regarding the stock and flows of health personnel and on the human resource management bundle that is being implemented at C3RH.

Bruno Marchal

December 2005

1 Introduction

Human resources are now generally acknowledged to be the major determinant not only of successful health sector reforms and the performance of health systems in general, but also to achieve the Millennium Development Goals and effectively upscale anti-retroviral treatment programmes. However, in many countries, the health workforce is lingering in a permanent crisis with major problems regarding training and distribution of health personnel, motivation, performance and professional accountability. The impact of the HIV/AIDS pandemic and the brain drain are now compounding this chronic crisis in many countries in sub-Saharan Africa.

The "Health Care for All " Conference (Antwerp, October 2001) emphasised the need for strong health systems and highlighted as the critical factors affecting access to adequate health care the problems of financial affordability of care, deficient mechanisms to ensure quality of care, shortages of competent and motivated health personnel and the failure of disease control programmes to strengthen health care systems (Segall and Gryseels, 2003). These four issues are the basis of the policy supporting research programme[1] *Health Care for All*. The study presented in this report has been carried out within the chapter on *Human resources*.

Regarding the health workforce, the Republic of Ghana currently presents a particularly interesting situation in that its health system has been undergoing important structural changes over the last decade. The far-reaching decentralisation allocated greater autonomy to hospitals, districts and regions. Ghana is also an important sending country in the global "brain drain", which reflects both the country's high medical education standards and a worldwide good reputation of its medical professionals and an inadequate retention capacity of the health system.

While the health care delivery configuration may be different from neighbouring countries, the general situation regarding human resources is quite similar to that of other African countries and equally precarious. However, some health facilities appear to thrive or at least to do remarkably better than others. They seem to be able to attract and retain personnel and to be capable of maintaining good standards of performance in these adverse conditions. Among public health institutions in Ghana, the Cape Coast Central Regional Hospital (C3RH) seems to stand out in its management approaches his for many reasons. It has a well-maintained infrastructure, the staff displays a strong professional attitude and the management team exerts strong and effective leadership. One hypothesis explaining this particular situation could be that the management team of C3RH manages to deal effectively with the internal and external constraints it faces and that its management practices are particularly appropriate, especially those pertaining to human resources, contributing eventually to the relatively high performance standards achieved by this hospital.

As for any manager, hospital managers basically have two major roles that need to be mastered to make the hospital fulfil its roles. First, they need to manage the inner works of the complex organisation that is a hospital. Second, they need to manage the boundary conditions, that is to manage the inter-organisational relationships and the influences and pressures within the environment in which it functions (Glouberman & Mintzberg 2001). In order to explore how at C3RH the hospital management team manages these two key dimensions of hospital management, we conducted a study on the management approach.

In a first part, this report spells out the background, the aim and objectives, the research questions the study seeks to respond to, the study design and the research methods. The second part presents a summary overview of Ghana and in particular the health sector reform process and the consequences for the planning and management of the health workforce. The third part describes the different aspects of the HR management practice at C3RH and a discussion of the decision spaces. Finally, the fourth part presents an analysis and discussion of some major emerging issues.

[1] Beleidsvoorbereidend onderzoek BVO *Health Care for All*.

2 Rationale and background of the study

During a field visit for IMMPACT in April 2004, a visit to the Cape Coast Central Regional Hospital provided a short peek at a facility where the hospital management team apparently manages to retain and motivate its staff in a region with vacancy rates as high as 60% for nursing posts. In Ghana, as in most African countries, the chronic crisis that has been affecting the human resources for health has been putting quite some pressure on the government in general and the health sector in particular. Burning issues such as HIV/AIDS, poverty and the internal and external brain drain are consistently exacerbating this lingering crisis.

The public health literature regarding human resources for health reveals a recent flurry of reports that deal with the crisis of the human resources for health. One stream explores the human resource bottlenecks for the new global health initiatives (Kvale 2002, Chen 2004) and the rapid scaling up of ART and the effects of the pandemic on the health workforce (Cornia et al. 2002, Kober & Van Damme 2004, Huddart et al. 2004, Marchal et al 2004). Another stream focuses on the brain drain (Zurn et al. 2002, Bhorat et al. 2002, Pang et al. 2002, Padarath et al. 2003, Meyer 2003, Patel 2003, Marchal & Kegels 2003, Aiken et al 2004, Buchan & Sochalski 2004, ILO 2004, Martineau et al 2004, Stilwell 2004), while a third stream presents global overviews of the factors that underlie the crisis (Martinez & Martineau 2002, Huddart et al. 2003, Padarath et al. (2003), Brown et al. 2004, Joint Learning Initiative 2004, Narabsimhan et al. 2004, PHR 2004). Often, authors of the latter two streams identify issues such as workplace conditions, remuneration and availability of drugs and equipment as factors affecting the attraction and retention of staff. But frustratingly few experiences of how to manage these problems effectively are documented. If anything, this 'new' attention being given to the health workforce shows that both the world of research and international development has taken up the issue of human resources once again, but it can be argued that the health workforce is again considered a constraint or an obstacle to successful programmes like the 3x5 initiative rather than an essential element of any health system that merits attention in its own right.

In that aspect, this new wave of attention for human resources resembles the literature that focused on the health workforce in the light of the health sector reforms (Gilson & Mills 1995, Paul 1995, Bennett & Miller Franco 1998, Chabot 1998, Mutizwa-Mangiza 1998, Bennett & Miller Franco 1999, Martineau & Buchan 2000, Hernes 2001, PHR 2002, Dussault & Dubois 2003, Kyaddondo et al. 2003, Rigoli & Dussault 2003). Initially, little attention was given to the consequences of health sector reforms for the health workforce, but gradually it became clear that reforms that do not consider the health workers would run into trouble (Johnson 2000). However, most papers remain at a general level of analysis and the 'messy' operational management aspect is conspicuously absent in the discussion. Indeed, in-depth documented knowledge on actual management practices taking place in developing countries is missing, let alone studies on effective and efficient management practices (Buchan 2004).

This study aims at exploring the issues of health workforce management from the operational level and more specifically from the point of view of a hospital management team of a regional hospital. Our analytical framework is based on the model of management of tensions as proposed by Jaffee (2001) and holds that good management basically requires dealing with two 'domains'. The inter-organisational domain includes the interface of the organisation with its environment; and the other organisations and the influences it needs to deal with. The intra-organisational domain covers all aspects of the hospital as an organisation in itself and especially the staff. This perspective is very similar to that presented by Glouberman & Mintzberg (2001).

In this chapter, we will first briefly discuss the process of the health sector reform and its impact on human resource management in general, given the importance of the health sector reform and especially the decentralisation of the health system in Ghana for the inter-organisational domain. In a second part, we'll present the concept of decision spaces in the frame of decentralisation. We will end this chapter by introducing the analytical framework used in this study.

2.1 Health sector reform and the health workforce

The health sector reform in many industrialised countries as well as developing countries took the form of the introduction of concepts of new public management in public service management. This was generally based on the assumption that state-organised services are inherently inefficient and non-effective and often resulting in a low degree of responsiveness to patients and population (Blaauw et al. 2003).

Evidently bureaucratic organisations, the template of organisational structure of many health services in developing countries (Unger et al. 1999), present several types of dysfunction. First, organisations that are structured as bureaucracies may lead to a loss of individual freedom of the staff and impose limits to creativity (Weber 1947). This leads to a tension between the pursuit of organisational effectiveness on one hand, the goal of any organisation, and the individual freedom and margin of creativity on the other hand. It can lead to high degrees of frustration, demotivation and alienation among staff. Merton (1957) similarly found that the obsession of any given well-functioning bureaucracy with compliance with formal rules could undermine the actual effectiveness and efficiency of the organisation through the mechanism of goal displacement. Furthermore, despite its hierarchical and tiered structure that aims at achieving maximum control, the bureaucracy places its staff who work at the interface with the public, the street-level bureaucrats (Lipsky, 1980) in a position that enables them to influence the execution of decisions, organisational strategies and policies to a great extent. Interactions at this interface indeed often shape how patients and citizens experience health care and service delivery. In short, it is not surprising that the very organisational configuration of health systems can inhibit and stifle innovation (Blaise & Kegels 2004).

Without doubt, NPM addressed the right problems: low performance, poor quality of care and of service, limited responsiveness and low utilisation of services. Advocates of health sector reforms indeed argue that the traditional bureaucratic organisation of the health system and the rigid public service rules and procedures impose major hurdles to better manage the performance of both health workers and system. New public management's answer was to introduce performance management systems in which incentive systems were given an important role. It was characterised by a drive for attaining maximal efficiency and cost-effectiveness through down-sizing of the workforce and the introduction of short term contracts, internal competition and privatisation.

However, NPM may itself have been the wrong answer in that it applied a market logic to public services that are essentially non-market activities. Without entering in this complex issue, the emphasis on short-term and measurable results, the transformation of services to 'products', the diminishing commitment to social goals and the introduction of competition at the cost of trust relationships and collaboration has had a serious impact on the organisation and delivery of equitable health services (Baum 2002; see Collins & Green (1994) for a detailed critique of the decentralisation and Wunsch (2001) for a discussion on the tendency of the central level of public systems to resist decentralisation). Not coincidentally, the NHS changed tack with the White Paper 'The New NHS: Modern, Dependable', moving away from the competitive internal market to more collaborative systems based on partnership (Goddard & Marek 1998), although this was at least in part an equally ideological decision of the newly elected Labour government.

Although some of the health sector reforms were thus directly aimed at improving the health workforce performance, the point of departure was the macro-level. Health sector reforms were framed in the concurrent administrative reforms of the governmental bureaucracies. In the initial wave of health sector reforms, some attention was given to assessing and strengthening the human resource planning and development capacity at central level, but the operational aspects of human resource management as experienced at the coal-face, or in this case at the health services itself, was completely overlooked (Wang et al. 2002). Often, elements of reforms that were likely to have an impact on human resource management, such as contracting, were introduced without strong evidence (Atkinson 2002). Also the effect of the decentralisation of the authority to hire and fire and the consequences for equity between regions with different socio-economic conditions and therefore different degrees of attraction to health workers has not been examined thoroughly.

The few studies that did focus on the effects of health sector reforms for the health workforce concentrated on the consequences of decentralisation on the health workers performance and motivation (Mutizwa-Mangiza 1998, Kyaddondo *et al.* 2003, Agyepong et al. 2004). Kipp et al. (2001) indirectly explored HRM issues related to the introduction of user fees in Uganda and the use of part of the revenue for staff incentives, while Green & Collins (2003) explored the tensions that health managers at district level in many countries are facing. Somewhat unsurprisingly, Johnson (2000) showed that decentralisation of certain responsibilities requires sound management capacities at peripheral levels. This is confirmed by a series of case studies carried out by Ssengooba et al. (2002) in Uganda in public and non-for profit hospitals showing that increasing autonomy of hospitals requires a strong management capacity and good reliability.

In short, a review of the literature points out that human resource management has been neglected in the health sector reforms in many countries. In many instances little attention was given to assessing and strengthening the human resource management, planning and development capacity. For Schick (1998) this should have deterred the introduction of NPM, since the preconditions for successful implementation of NPM requires a strong managerial capacity to manage for example the contractual approaches that were introduced in countries like New Zealand and the UK. But also the consequences of reform for the operational human resource management has often been overlooked (Wang et al. 2002). Only recently there has been some acknowledgement of the importance of the health workers and of a minimum management capability for the success of reforms. It can be argued that in many cases of decentralisation, failure may be due to inappropriate design of the reforms due to inadequate consultation (Wang et al. 2002) and insufficient capacity of both health service managers and health boards at district level.

2.2 Defining the decision spaces to better understand the effects of decentralisation

As we mentioned above, one of the underlying assumptions of health sector reform was the low degree of responsiveness allowed to local healthcare managers[2] in the bureaucratically organised public health systems in many developing countries. Bossert (1998) was the first to develop an analytical framework to assess the effectiveness of decentralisation for attaining the health system's objectives by introducing the decision space concept. The author defines the decision space as '*the range of effective choice that is allowed by the central authorities (the principal) to be utilised by the local authorities (the agents)*'. In order to allow a more detailed analysis of which functions are being decentralised and to which extent, the decision space model covers the dimensions of finance, service organisation, human resources, access rules and governance rules. The model has been used to assess the degree of decentralisation in any of the dimensions and to compare processes among countries (Bossert et al 2000, 2002, 2003).

The decision space of healthcare managers is formally defined through legislation and regulations. In the case of Ghana, the cascade of contractual arrangements between the MOH and the GHS on one hand, and within the GHS on the other hand (between GHS and the regions and between the region and the health facilities) will additionally define the formal boundaries of the decision space. However, the *formal* decision space may differ significantly from the *actual* decision space. Bossert mentions that the latter '*may be defined by the lack of enforcement of these formal definitions that allows lower level officials at each level to "bend the rules*" '. Indeed, the healthcare managers can be considered as street-level bureaucrats (Lipsky 1980), who in a decentralised setting may wield even more powers to influence the actual degree and nature of the implementation of the new policies (Atkinson 2002).

[2] It should be noted that we use the word healthcare 'manager' in a broad sense to include all top management staff involved in decision-making and management at the operational health care level, including district medical officers, hospital directors, senior nursing officers and senior administrative officers.

2.3 Calling attention to the process aspects…

In the above sections, mainly policy changes and structural approaches have been presented, usually based on macro-level analyses of the determinants of the health workforce crisis and this has led to changes in the structure of the health system and in the margins of decision spaces of decision makers at the different levels of the health system. As already mentioned, these changes introduced in isolation often miss the ball because the implementation capacity at the operational level has not been taken into account (Johnson 2000, Ssengooba et al. 2002).

At this point, it may be useful to introduce a definition of human resource management (HRM). Reflecting the changing perception of the HRM practice, we use the definition proposed by Johnson (2000), which surpasses the traditional personnel administration role (staffing, workplace policies, compensation and benefits, training and regulatory issues) and includes the following domains. First, HR managers play a support role to the senior management by translating the organisational strategy into appropriate HR policy and practice. Second, they should manage transformation and change. Third, HR managers are responsible for management of the staff contribution, aiming not only at increased employee commitment and competence, but also being concerned about the staff's concerns and problems. In short, HR managers can play an important role in aligning their management practice with the goals and strategies of the organisation to optimise their staff's contribution to the organisational goals. Although in many hospitals in developing countries, including Ghana, there may be few specialist human resource managers, the same roles are (ideally) to be taken up by the general managers or the hospital directors.

In the implementation capacity for such an enlarged role, the management capability of the local teams evidently assumes an important role. This capability is determined by the quality of the management personnel (availability, qualifications and experience) and the management structure that is in place (composition and organisation of the team management, the information system and of the decision making process). However, the less tangible process aspects pertaining to the input of the managers in terms of leadership, personal motivation and vision on one hand and to the actual management practice (the fit between management style and problem/type of staff, management of conflicts, introduction of change, dissemination of innovation) on the other hand is a key ingredient of successful management. While in developing countries health worker motivation and morale has been studied, although not frequently documented, the motivation of the managers hasn't been documented yet, nor has the process aspects of the actual management practice.

Factors that influence decision-makers at local level can be categorised in external motivators that include the pressure exerted by staff, the community and local politicians or by the incentives and sanctions defined by the institutional arrangements (Similar to the social capital approach, Putnam 1993) and in internal motivators (personal values and vision, including personal ideological conviction, religious beliefs, etc.). But also structural factors like the organisational configuration (the health system bureaucracy (Blaise & Kegels 2004) and organisational culture (including public service ethics, professionalism and organisational survival reflexes) may influence the actual practice of decision makers.

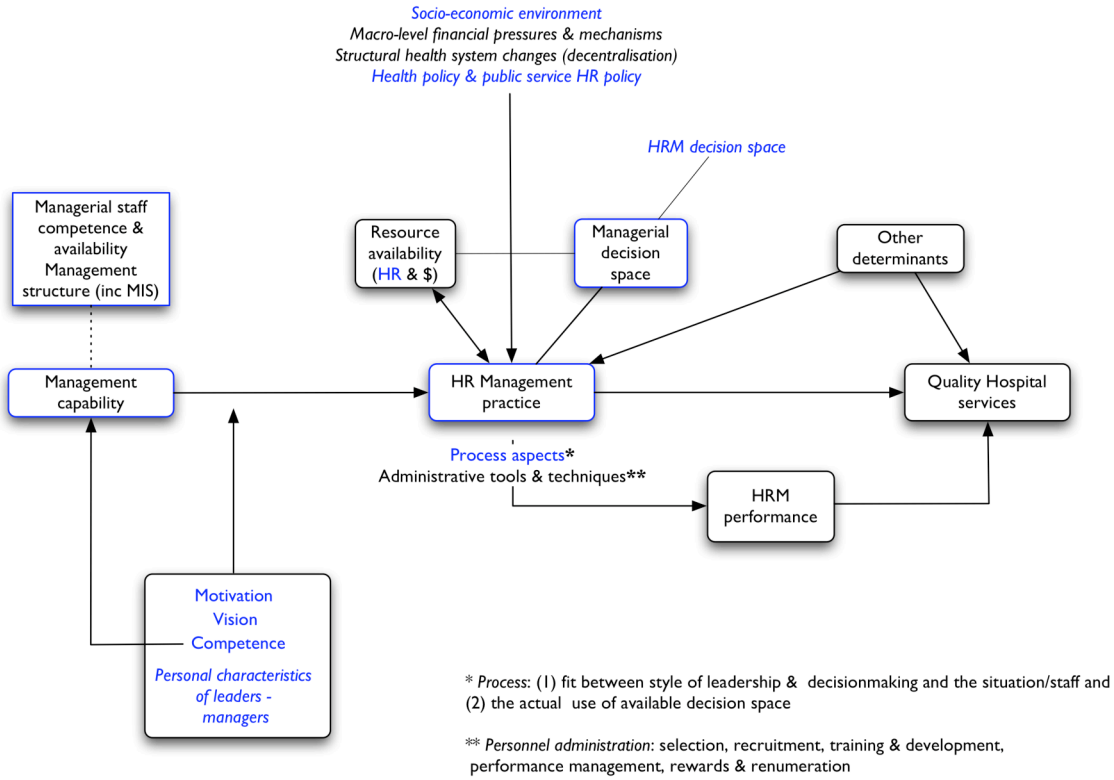
These different dimensions are captured by the conceptual model we used to describe and analyse what shapes the actual behaviour of decision makers and/or managers at the regional hospital in Cape Coast (Figure 1).

2.4 This study in short

Our starting point as summarised in Figure 1 holds that many other factors apart from the organisational structure of the health system and the decision spaces at each level influence the behaviour of health care managers or hospital directors. The mere existence of a clearly defined and well-respected decision space se does not guarantee good management practices nor innovative ideas and practices to be applied. The existing margins of freedom need to be exploited skilfully,

requiring, first, a minimum of management capability and, second, appropriate processes to be put in place (leadership, management style, etc).

Figure 1 – The analytical framework used in this study



3 Objectives and research methodology

3.1 Aim and objectives

This study aims at contributing to a better understanding of the determinants of the decision space of healthcare managers of public sector institutions in resource-constrained countries and of the methods and approaches they deploy to manage their health workforce.

More specifically, this study aims at describing the actual HR management practice at C3RH and to explore the factors that shape it. In other words, it aims, first, at clarifying the actual decision space of the hospital management team regarding human resource management, second, to explore both formal and other factors that shape the actual management practice and finally, to describe which methods are used and developed to manage the hospital staff.

These objectives can be translated into the following research questions:

1. Which management approach is being used by the management team to manage the health workers at C3RH?
2. Which factors determine the decision space of a hospital management team at regional level regarding HRM?
3. How does the hospital management team exploit the available decision spaces?

Logically, the next question would be: How does the actual HRM practice of the hospital management team contribute to a better health workforce performance? While this is a relevant and valid question, due to limited time and resources, this study excluded a detailed exploration of these factors. While therefore causal links between decision spaces, management capability and patient outcomes have not been explored nor studied, we will present a brief description of the performance of the C3RH.

3.2 The research strategy and methodology

3.2.1 Choice and justification of the research strategy

Since this study essentially aims at better understanding the HR management approach utilised by the hospital management team in the specific context of the C3RH, a case study design is most appropriate. Indeed, this design allows exploring a "*phenomenon within its real-life context, especially when the boundaries between phenomenon and context are not clearly evident*" ((Yin, 2003), p. 13). The interactions between the decision space of health managers, the resource availability, staff characteristics and external, environmental factors on one hand and the actual decision-making process regarding HR management on the other hand are multiple and complex, Only a case study offers the frame of analysis that can encompass both the different (contextual and internal) elements and the interaction between them. Furthermore, this design allows a holistic in-depth investigation of these issues as they happen in their natural setting, whereby different sources of information and data collection methods can be used concurrently (Denscombe, 2003), p. 30-31).

We aim to develop this case study within the realistic evaluation paradigm (Pawson & Tilley 1997), for whom the true question is not what works, but rather what works how, for whom, in which conditions and why. This seems a better approach to assess interventions in the field of health care organisation, which is essentially a complex field, than the single-minded focus of the more classical research methods, such as (community) randomised control trials, which aim at effacing all biases and context factors in order to examine the effect of the intervention in isolation. The interventions examined in this study are in essence intervening in complex health systems. Decentralisation changes fundamental rules of the game in an apparently simple way (give hospital managers a larger margin of freedom and they will be more responsive), but it can be safely assumed that the effect of

structural re-arrangements may have unintended and unforeseeable consequences, which in part depend on local contexts at operational level. To obtain a better understanding of such interventions that fundamentally change institutional arrangements (such as health sector reforms and decentralisation) or of the importance of the management style and vision of a hospital management team, it is essential to capture the relevant context elements that may (or may not) have an influence on the interventions being studied. The CMO configuration proposed by Pawson & Tilley lends itself as a quite attractive analytical model, for such studies. In their CMO configuration, the Mechanism M may (or may not) lead to an Outcome O in a given context C. This case study starts from a theory (represented by our conceptual model) that can be considered to be a CMO configuration that states which elements need to be present in the context in order for good management to occur at a regional hospital. In order to examine how far this model can withstand an application to the reality of the Cape Coast Central Regional Hospital, the study presented by this report has been carried out. The realistic evaluation paradigm offers a rigorous manner to transcend the limits of a single case study by explicitly referring to a mid-range theory that bridges the different cases. Indeed, at the end of this study, the original CMO configuration can be adapted in the light of the study findings and will be the departure point of another study.

3.2.2 Selection of Cape Coast Central Regional Hospital as the case

C3RH was chosen as the case to investigate the research questions because of its apparently 'extreme' position, both on the national Ghanaian level and internationally. In Ghana, the hospital has been selected several times as the best hospital in the country, potentially a testimony to the way it has been managed in recent years. Also, when we compare the C3RH with similar institutions in neighbouring countries, the hospital seems to stick out both in terms of hospital performance as regarding HR management performance.

3.2.3 Timing and activities

This research project was carried out between September and December 2004. It started with a preparation phase during which the literature reviews were carried out and the research protocol designed. A two-weeks field visit was carried out at the end of the month of October, in which two of the authors participated, the third one being immobilised by a sports accident. Afterwards, the analysis and the drafting of the research report was done, to which all three authors participated. Papers for publication in peer-reviewed journals are being drafted.

3.2.4 Research and data collection methods

The study is essentially descriptive in nature and allows for a closer investigation of issues that emerge as important. The research protocol included the use of both qualitative and quantitative methods in order to disentangle and describe the relations and links between the various factors that may influence the human resource management practice. These include:

- Semi-structured one-to-one and group interviews with key informants to obtain information about issues such as the management vision, the decision-making processes, stakeholders perceptions, etc.

  Informants include the hospital management team members, heads of units and some staff (mainly nurses), the regional medical director and a key HR researcher in Accra. Field notes (taken during/after the interviews) and tape recordings document the interviews.

- Participant observation to assess the process of decision-making during management meetings and to obtain information regarding the ward management and clinical activities.

  Activities of the following informants were observed: the hospital director, members of the hospital management team and nurses of specific wards.

- A document review to obtain both quantitative and qualitative background information regarding Cape Coast Central Regional Hospital. A specific focus was on hospital records pertaining to the management process (minutes of meetings, etc) and annual reports and staffing reports. Government documents reviewed include the major policy papers on health sector reform and human resources of the last fifteen years and HR statistics. Finally, some key documents pertaining to other regional hospitals were reviewed in order to allow for some comparison.
- Preceding the field visist, a literature review was carried out on the subjects of health sector reform and decentralisation, human resource management in the public health sector and also regarding the health system in Ghana. A literature review on specific human resource management topics, like magnet hospitals, decision spaces, decentralisation and motivation was done.

The comparison of information obtained through these different methods on the same specific topics allows findings to be corroborated (or rejected), thereby increasing the validity of the data (Denscombe 2003, p. 132). The involvement of a senior Ghanaian healthcare manager-researcher has contributed to triangulation of findings obtained from observations, interviews and discussions and document reviews. It should be noted that being a senior health manager working in another region, he personally did not carry out any interview at the hospital to avoid an interviewer effect.

4 General background on Ghana and the health sector reform

In this section, we will first briefly introduce the main features of Ghana and the Central region. In a second step, the evolution of the health sector reforms will be discussed as well as the health workforce situation in Ghana. The reforms that affect the health workforce will then be presented and finally, we'll introduce the institutional factors that shape the margin of freedom of healthcare managers.

4.1 An introduction to Ghana

The Republic of Ghana is a low-income developing country located in West Africa and has a total land area of 238537 square kilometres. It is bordered by French-speaking countries, on the east by the Republic of Togo, Burkina Faso to the north and northwest and on the west by Ivory Coast. The Gulf of Guinea lies to the south and stretches across the 560 kilometres of the country's coastline. The climate of Ghana is tropical with two distinct rainy seasons in the south of the country and one rainy season in the north.

Ghana gained independence from British colonial rule on March 6th 1957 and became a republic on July 1st 1960. The population of Ghana is 18.9 million inhabitants (Ghana Statistical Service, Population and Household Census 2000) with an average growth rate of 2.7%. Life expectancy at birth is 55.4 years for males and 59.6 years for females. The sex ratio has reduced slightly over thirty years from 98.5 males per 100 females in 1970 to 97.9 in 2000. The population is made up of several ethnic groups. The Akans constitute the largest ethnic group (49%) followed by the Mole-Dagbon (17%), Ewe (13%), and Ga/Dangme (8%). Various smaller ethnic groups also abound in the country. Ghana is divided into ten administrative regions, Western, Central, Eastern, Volta, Greater-Accra, Ashanti, Brong-Ahafo, Northern, Upper East and Upper West. The regions are further divided into 110 districts to ensure efficient administration at the local levels.

Agriculture, mining, logging and retail trade are the most important areas of economic activity. Agriculture is the main sector and employs about 50% of the workforce. The leading exports of

the economy are cocoa, gold and timber. Tourism is an important foreign exchange earner. Remittances from relatives working outside the country also constitute an important revenue source in the economy.

4.2 The Central Region

The Central Region occupies an area of 9826 square kilometre, which is about 6.6% of the land area of Ghana (Figure 2).

It has an estimated population of 1.696.357 (projected from 2000 census) and an annual population growth rate of 2,1%. The Central Region is the second most densely populated region in the country with a population density of about 169 persons per-square kilometre. Over 60 percent (63%) of the region is rural. The female to male ratio is about 100 to 92. According to the Ghana Poverty Reduction Strategy document, the Central Region is one of the four poorest regions in the country with 48% of the population classified as poor and 32% as extremely poor. Table 1 below shows the various district profiles.

Figure 2 - The map of Central region, Ghana

According to the Ghana Demographic and Health Survey of 2003, the infant mortality for the Central Region is estimated at 50 per 1000 live births whilst the under-five mortality is 90 per 1000 live births. Compared to the Ghana Demographic and Health Survey of 1998, the infant mortality rate and the under-five mortality rate were 83.8 and 142.1 per 1000 live births respectively. The Maternal Mortality Rate is 5 per 100000 live births.

Table 1 - District, size, population and capitals (Source: 2003 Annual Report: Central Regional Health Directorate, Ghana)

District	Area (sq. km)	2003 Population projection	District Capital
Assin	2300	209096	Assin Foso
Agona	540	169181	Swedru
Abura/Asebu Kwamankese	380	95889	Abura Dunkwa
Asikuma Odoben Brakwa	850	95146	Asikuma
Ajumako Enyan Essiam	480	97881	Ajumako
Awutu Effutu Senya	780	180907	Winneba
Cape Coast	122	125704	Cape Coast
Gomoa	1022	207323	Apam
Komenda Edina Eguafo Abrem	391	119670	Elmina
Mfantsiman	510	162689	Saltpond
Twifo Hemang Lower Denkyira	1370	117451	Twifo Praso
Upper Denkyira	1000	115420	Dunkwa-on-Offin
Central Region	9826	1696357	

Generally, there are two rainy seasons in the region. The peak of the major season is in June. The vegetation is divided into dry coastal savannah stretching about 15 km inland and a tropical rain forest with various forest reserve areas.

The people of the region are mostly Fantis, with fair groups of Akans and Guans, but the towns have significant presence of different tribes form other parts of the country. The major economic activity is agriculture. Small-scale manufacturing also takes place in food-processing, ceramic wares, as well as the salt and soap industry. The region is also endowed with historic monuments like castles and forts that attract lots of tourists to the region.

The region has 9 government hospitals, 1 quasi government hospital, 4 mission hospitals and 39 government health centres. There are 813 pre-schools and nurseries, 1207 primary schools, 856 junior secondary schools, 47 senior secondary schools, 2 technical schools and 172 vocational institutions. There are two universities and one polytechnic.

Over eighty percent (84.2%) of the regional population has access to portable drinking water i.e. pipe-borne (50.5%), tanker service (4.8%) boreholes fitted with pumps or hand dug wells (28.8%) (2000 census). The rest depend on flowing streams and ponds for domestic use. About 11,8% of the total population has access to modern toilet facilities i.e. WC and KVIP (Kumasi Ventilation Improved Pit latrine). In all, 18% have access to any toilet facility (2000 census).

There are good roads linking the region to major cities in other regions. However, the interior sections are sometimes inaccessible in the rainy season because of the bad terrain. Most district capitals are linked with radio communication (2-way) and/or telephone services.

4.3 Health sector reform and decentralisation

Ghana's long-term vision for growth and development was captured in the document "'GHANA VISION 2020" (First Step: 1996-2000) which sets the scene for decentralised planning. The district is the main implementation unit that prepares annualised plans for development purposes. The Medium Term Health Strategy and the first 5-Year Programme of Work documents, which are the main policy documents that directed the Health Sector Reform in Ghana, were derived essentially from the document GHANA VISION 2020.

Health sector reform started in Ghana within an environment of instability in the early 1980s at a time when national governance was in disarray, there was a severe economic crisis and human

development efforts were at a standstill. *Health sector decentralisation* was initiated at a time when decision-making at central level (MOH) was seen to be thwarted by bureaucracy and delays with the result that programme implementation was slow and health care service delivery was inefficient and of low quality. Also at the peripheral level, decision-making capacity was considered low.

The Local Government Act of 1993 envisaged a devolution, whereby the responsibility to manage the district health services would be assigned to the district assembly, the locally elected political authority. In practice, the decentralisation took rather the form of a delegation from the Ministry of Health to the autonomous Ghana Health Service, formalised by the passage of the Ghana Health Service and Teaching Hospitals Act in 1996. The constitution of the Ghana Health Service (GHS) effectively introduced a provider-purchaser split. The Ministry of Health was to take on the roles of policy setting, regulation and accreditation, while the execution of the health policies, including the service delivery, was to become the responsibility of the GHS. It should be noted that as a result, the Ghana Health Service falls outside the general public service (Agyepong 1999).

Through the process of "Strengthening District Health Systems Initiative", a district health system model fashioned around the District Health Management Team was created with de-concentration of decision-making authority and management responsibility between 1986 and 1990. District Health Management Teams have been targeted for capacity strengthening through short courses and MPH training since the 1980s and block funding replaced the prior allocation mechanism of line budgeting in 1995 (Agyepong 1999). In the First 5-Year Programme of Work (1997-2001), the policy dealt with the orientation of secondary and tertiary service delivery to support primary health services and with the development and implementation of a programme to train adequate numbers of new health teams to provide and manage the health services.

In response, the general policy direction was to decentralise the personnel management procedures to the regional and district levels including the authority to hire and fire (recruitment) in accordance with the deconcentration from the central level of the GHS to the district and regional level. The promotion of lower staff cadres was delegated to the regional level together with personnel management and salary administration. The goal of human resource development in the health sector was to produce and retain optimal numbers of appropriately trained health workers, placed and motivated to deliver quality health services in areas where the need is highest. Also contracting of human resources for health and performance-based incentive systems have now been introduced (MOH Ghana 1997). It should be noted that the tight financial regime imposed by the World Bank had led to retrenchment in the public service (mainly of the unskilled labour categories and euphemistically called 'redeployment') and a partial recruitment freeze, which was ended only in 1997 (Agyepong 1999).

4.4 The impact of HSR on the managerial discretion regarding HRH management in Ghana

More autonomy for the hospitals

The health sector reforms and the decentralisation have had a varied impact on hospital management in Ghana. Act 525[3] of 1996 confers autonomy on the *teaching* hospitals but leaves the *regional* hospitals as part of the Ghana Health Service under the Regional Health Services. This status brings the teaching hospital board and chief executive to the same level as the Ghana Health Service council and Director-General in the Ministry of Health. Their increased autonomy combines the ability to hire staff and develop incentive schemes with the traditional roles of teaching hospitals in the production and development of HRH. In contrast, regional hospitals

[3] Parliament of the Republic of Ghana: Ghana Health Service and Teaching Hospitals Act 525, 1996.

cannot hire staff except for the cadre of casual workers, but can and do develop incentive schemes for their health workforce.

The purchaser-provider split

As part of the health sector reform agenda and the sector-wide approach setting, a Common Management Arrangement document for the implementation of the programmes of work for the health sector have been developed. This documents policies and regulations for planning, budgeting and disbursement of funds for the health sector and spells out mechanisms for financial control, performance assessment and monitoring and evaluation of the sector programme of work.

To improve on the efficiency gains in the health sector, the ultimate decision was the purchaser-provider split arrangement in 1996. The Ministry of Health is now the purchaser and the Ghana Health Service and others act as service providers, while the statutory bodies act as regulators of the health sector market. The purchaser-provider split introduced several other players in the health sector with the contracting of service provision within the public sector and between the public and the private sector. The mission institutions provide essentially curative services but also public health services, while the private-for-profit facilities are predominantly offer curative services. The Ghana Health Service undertakes both internal and external contracting of services. Not-for-profit facilities are contracted mainly in locations and service areas where they have a comparative advantage over the public sector. The Ghana Health Service also undertakes the commissioning of service provision at local level to regional and district hospitals through laid down management arrangement procedures.

4.5 The human resource situation in Ghana

In terms of human resources, the health sector in Ghana was described in the mid-90s as suffering from having inadequate numbers of rather poorly motivated staff, who were inequitably distributed both in terms of numbers as well as skills. Main obstacles included an inefficient and centralised personnel management system that discriminated against health staff in rural and deprived areas in terms of early and regular promotion, further post-basic training and in-service training (MOH Ghana, 1995). The main HR concerns were the actual numbers and distribution of personnel, the skill mix, remuneration, incentives and motivation and the brain drain.

Like all other developing countries, the human resources for health in Ghana has remained a constant concern. Table 2 shows the desired ratios as stated in the second 5-year Programme of Work of the Ministry of Health in Ghana by 2006 and the proportions achieved in the period from 1967 to 2003. The Ministry of Health has strategically targeted a doctor per 1000 population ratio of 0.2 by the end of the second 5-year Programme of Work in 2006, but the levels at the end of 2003 are just a third of that expectation. Worryingly, there has been a reduction of one third between 2001 and 2003 and the current level is lower than in 1967.

The current professional nurse stock level is a third of the desired level, while the pharmacist stock level is a tenth of the level desired by 2006. Also for these categories, staff levels are lower than in 1967 as production was outrun by population growth and, more recently, by the brain drain. Ministry of Health data show that between 1993 and 2005, 812 doctors, 542 pharmacists and 2.392 professional nurses left Ghana, while currently Ghana has 2.007 doctors, 12.763 nurses and 1.321 pharmacists (Antwi-Boasiako, 2005). Replacement is unlikely to fill the gap due to inadequate production capacity and foreseeable continuing losses.

Table 2 - Human resources for health: desired ratios and current status in Ghana (Source: MOH Ghana)

Staff Category	Desired by 2006	Actual in 1967	Actual in 2001	Actual in 2003
Doctors per 1000 population	0.20	0.08	0.09	0.06
Professional nurses per 1000 population	1.00	0.40	0.40	0.33
Pharmacists per 1000 population	0.10	0.04	0.07	0.01

Table 3 shows the trend of available human resources for health in the public health sector depicting the continuing loss of personnel to the sector. Despite an increase in 1998, the stock of nurses has been diminishing since 1996 similarly as for the doctors and pharmacists.

Table 3 - Human resource for health in the public sector in absolute numbers, Ghana, 1996-2002 (Source MOH Ghana)

Staff Category	1996	1998	2000	2002
Doctors	1154	1132	1015	964
Nurses (incl. auxiliaries)	14932	15046	13742	11325
Pharmacists	N/A	N/A	230	200

Figure 3 shows the attrition due to brain drain that occurred in Ghana between 1993 and 2003. An increasing trend is noticeable for all three cadres.

Figure 3 - Attrition of health personnel due to brain drain, Ghana 1993-2003 (Source: Antwi-Boasiako, 2005)

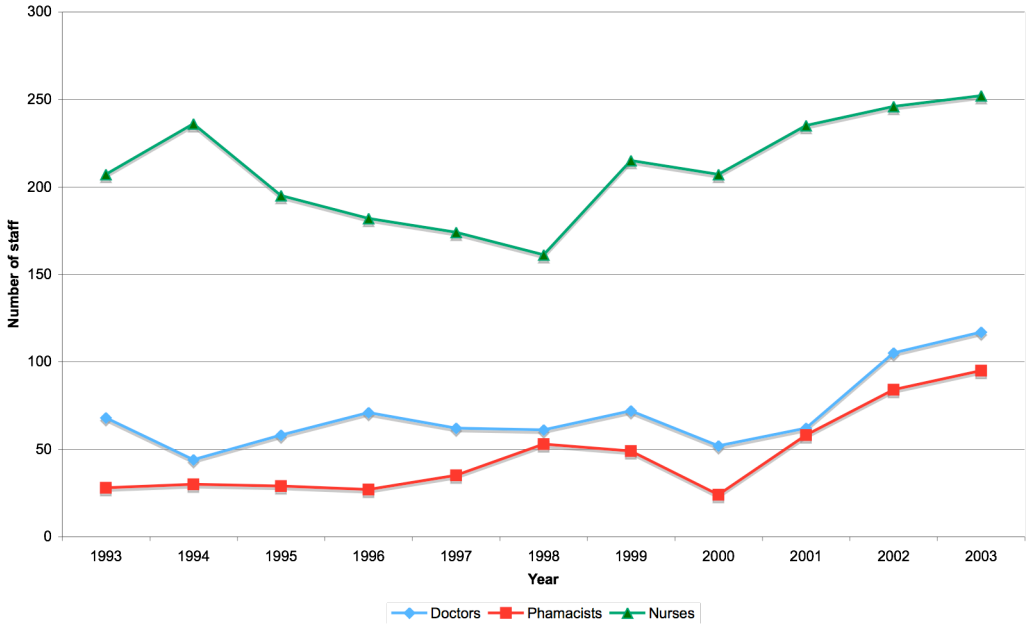


Table 4 shows the available human resource for health in the public and private not-for-profit sector at the end of 2003 and its geographical distribution. As in the case in many countries, the two teaching hospitals (in Accra and Kumasi) are showing heavy concentrations of medical professional personnel. They account for 49,6% of doctors, 12,2% of nurses, 31,4% of pharmacists and 9,6% of other health staff in the public and private not-for-profit health sector.

Geographical disparities are also clear: Northern Ghana representing the three deprived northern regions (Northern Region, Upper West Region & Upper East Region, accounting for 17% of the national population) is under-resourced in terms of human resources for health in both the public and private not-for-profit health sector. The private not-for-profit health sector has comparatively attracted more nurses to Northern Ghana. The total number of doctors in Ghana is estimated at 2007, indicating that slightly less than half are working in the private-for-profit sector (Antwi-Boasiako, 2005).

Table 4 – A comparison of the HRH in the public and private not-for-profit sector, Ghana 2003.

	Ghana Health Service		NGO/CHAG		Teaching hospitals		MOH HQ	National
	Southern Ghana	Northern Ghana	Southern Ghana	Northern Ghana	KBTH	KATH		GHANA
Population (×1.000)	17.049 (83%)	3.535 (17%)						20.584.833 (100%)
Doctors (n)	442	67	33	4	372	204	40	1.162
Pop. per doctor	38.573	52.766	516.651	883.839				17.715
Nurses (inc. aux.) (n)	9.078	1.626	315	455	981	615	21	13.091
Pop. per nurse	1.878	2.174	54.125	7.770				1.572
Pharmacists	136	16	11	0	48	32	12	255
Pop. per pharmacist	125.364	220.960	1.549.953					80.725
Other staff	11.276	2.068	3.897	747	1.304	678	586	20.556
Pop. per other staff	1.512	1.710	4.375	4.733				1.001

Abbreviations: CHAG: Christian Health Association of Ghana; MOH HQ: Ministry of Health Headquarters Staff including Ghana Health Service; KBTH: Korle-Bu Teaching Hospital, Accra; KATH: Komfo Anokye Teaching Hospital, Kumasi.
Note: The two teaching hospitals were excluded from the data for Southern and Northern Ghana

4.6 Current central level interventions affecting health workforce policies in the Ghana Health Service

As described in section 4.3, the health workforce has attracted some attention in the process of health sector reforms. In this section, we will briefly discuss how these three areas of national health policy affect HR management and HR performance in the Ghana Health Service. At present, the priority areas regarding HRH defined by the central level in Ghana are (1) the adequate production of skilled manpower that is adequately trained, (2) to increase the staff retention capacity and (3) to improve the performance monitoring and evaluation.

4.6.1 Adequately trained skilled manpower production

A policy and strategic plan to increase both the number of training institutions for all cadres and the intake into health training institutions in the country has been defined (Antwi-Boasiako, 2005). This is to increase the supply side of the equation and to partly resolve the problem of

the brain drain in the sector. Efforts are also underway to provide health staff to the regional hospitals by accrediting these facilities for the training of medical graduates in houseman job positions and postgraduate positions. These measures are aimed at providing extra doctors and specialists for the regional hospitals. These will augment the effort of employing foreign doctors such as the Cuban Brigade and from other countries such as northern Africa and Eastern Europe. The brain drain is being addressed by several initiatives. Ghanaians working abroad are being targeted through the MIDA project to return for short-term services, while an office has been set up for re-engagement of personnel that left the public service and for non-Ghanaians wishing to work in Ghana.

4.6.2 Staff retention

There are various efforts regarding staff retention currently going on in the Ghana Health Service. Major areas include the provision of saloon cars for health workers on a hire-purchase basis, house ownership schemes and the payment of Additional Duty Hours Allowance to health workers. Other incentives and allowances are paid to health workers in the Ghana Health Service based on location and local circumstances including free housing, free utilities (electricity, water and telephone) and other inducement allowances that aim to compensate public sector doctors for the forgoing a private practice. Differentials are foreseen to increase the attraction of deprived areas (Antwi-Boasiako, 2005). Allowances and conditions also exist and differ in the private and NGO/mission sector of the health service.

The Additional Duty Hour Allowance

Additional Duty Hours Allowance (ADHA) has been paid to health workers from both the public sector and the NGO/mission sector by the government since 1999. Public sector doctors negotiated this allowance and were the initial beneficiaries, but the other health workers joined later. It ranged from 100-200+% of monthly salary for doctors and lesser proportions for other health workers. The rationale is that health workers perform more than the 40 hours per week and need to be paid for the extra hours of work done. Documentation, monitoring and supervision of the actual hours done is unavailable in most circumstances and any system to be developed for this could be cumbersome and costly. Hence, an agreed number of extra hours are allocated per category of staff per month. On average, doctors are paid 200 hours per month as extra hours. Until September 2004, nurses had been paid a varied number of hours depending on location and grade and this had been a source of agitation and several strike actions by nurses. The September 2004 strike led to an agreement to pay the nurses a minimum of 140 hours per nurse per month as extra hours. The other categories of health workers are being allocated extra hours in a process of discussion and negotiation.

4.6.3 Performance monitoring and evaluation

Systems have been developed for institutional and staff performance monitoring and evaluation. Half-year and annual reviews and evaluations of institutional performance in the health sector and staff appraisal systems that monitor and evaluate performance have been introduced. There is also the national awards system that reward good performance on the institutional and individual levels starting from the district awards to the regional awards and finally the national awards. The review exercise and the awards systems lend an air of competitiveness to performance in the health sector at the institutional and individual levels.

At the regional hospital level, institutions are accreditated for housemanship and also for post-graduate medical training. In order to maintain the status of accreditation for the recently introduced National Health Insurance, hospitals will have to improve on the quality of healthcare services provided and maintain their competitiveness in a market situation. These issues are important for hospital management as they need to ensure the availability of equipment and other conditions of service such as accommodation, in-service training opportunities, quality assurance teams etc.

5 A closer look at the Cape Coast Central Regional Hospital

In order for the reader to have a clear picture of the present condition and performance of the C3RH, we present in this chapter information on the performance as a referral hospital that operates not in isolation but within a well-described regional system of public health services. In a second part, this chapter describes the human resource situation of the hospital in terms of current stocks and of dynamic flows of personnel.

5.1 The performance of the Cape Coast Central Regional Hospital

The Central Regional Hospital is the specialist referral hospital for the district hospitals in the region and was commissioned in August 1998. It managed to ensure service in all its departments and units by the year 2001, except for the dialysis unit, which is operational since the end of October. It was the first of three similar regional hospitals built over the last six years in the country. In the discussion of the performance of C3RH, we will whenever appropriate compare findings with those of the Volta Regional Hospital (VRH), one of the two other hospitals constructed together with C3RH and very similar in structure. Volta Regional Hospital opened its OPD services in April 1999 and has a catchment area population of 1.730.442 inhabitants, very similar to that of the C3RH (1.696.357).

If performance is defined as the degree to which objectives are being attained, the hospital's objectives need to be described in a first step. The annual report of C3RH describes its mission as "*to provide quality of care to the public irrespective of their financial, social, ethnic or religious status or background, in line with Ministry of Health policy.*" This mission statement would allow a description of the hospital performance along two dimensions. The first is the system-function of the hospital: how does it carry out the role it is allocated within the health system? Both coverage of the essential hospital functions and its acceptability are important dimensions of this role. A more detailed overview of the hospital services that are currently provided at C3RH and of the accessibility of the services in terms of geographical, financial and psychological access is provided in the annexes.

The second dimension relates to the hospital as an *organisation* that offers specialised care to patients. Aspects assessed include quality of care, clinical (services) management/efficiency, responsiveness, logistical management, resource mobilisation and accountability. This dimension too is discussed in detail in the annex, although a detailed analysis of all aspects of quality of care proved unfeasible in practice. The sections below attempt to summarise the findings regarding the two dimensions.

5.1.1 Synthesis of the systems dimension

Offering specialised care

The Central Regional Hospital is in general taking up its role of a regional referral hospital, but at the same time it attracts some patients from the district hospital in Cape Coast town and the neighbouring districts, as is the case for most regional hospitals in Africa.

The hospital operates an Accident & Emergency unit that recently has been separated from the general out-patient clinic. There are specialist clinics, including an HIV/AIDS clinic, an ophthalmology clinic (with outreach activities), the diabetes clinic (with home visiting) and the asthma clinic. There is also a physiotherapy unit and a Reproductive and Child Health Unit that provides immunisation, family planning and HIV voluntary counselling and testing. In-patient departments include the obstetric & gynaecology unit, paediatric ward, neonatal intensive care unit, make and female surgical ward, female and male medical ward and an intensive care unit.

Additional specialist functions include the neonatal intensive care unit, a blood bank service and a sickle cell clinic. Supervising specialists from Accra run an ENT clinic, dermatology clinic, plastic surgery clinic, orthopaedic clinic and urology clinic. These specialists also carry out operations at C3RH. Diagnostic services include the lab, which is operational 24/24h and the radiology department. Over the last two years all units of which the opening was lagging behind have been opened.

Compared with the Volta Regional Hospital, C3RH lacks a psychiatry unit, but it offers more specialised clinics than VRH.

Utilisation of the out-patient departments

Since 2000, a clear increase in out-patient attendance at C3RH is noticeable (Table 5). In 2003, the average daily OPD visits totalled 218 patients per day, while the annual total amounted to 79.671 patients, of which 31.864 were new cases. In comparison, VRH had a total of 33.504 OPD cases, the number of new cases of which are unspecified (Annual Report VRH 2003).

Table 5 - Outpatient attendance, 2000-2003, C3RH (Source: Annual reports)

Indicator	2000	2001	2002	2003
Outpatient Registrants (New cases)	18338	25751	27708	31864
Total Outpatient Visits	43075	63085	70506	79671
Average Daily OPD Visits	118	172	193	218

Admissions and in-patient data

In 2003, the total admissions at C3RH amounted to 6.593 patients, compared with 3.852 admissions in 2000 (Table 6). In 2003, the admissions accounted for 238.732 in-patient days, with an average daily bed occupancy of 46%. Patients stay for an average length of stay of 5.9 days. In-patient mortality stood at 7.2%. This can be compared with a total number of admissions at VRH of 3.848 in 2003, with a total number of patient days of 31.779, a bed occupancy rate of 87%, probably due to a longer average length of stay[4], and an in-patient mortality of 6,54%. It should be noted that at VRH of the 240 official beds, only 110 are in use.

Table 6 - In-Patient indicators, 2000-2003 (Source: Annual reports C3RH).

Indicator	2000	2001	2002	2003
Total admissions	3852	5372	5563	6593
Total inpatient days	25824	32194	36754	38732
Average daily bed occupancy rate (%)	31	38	44.5	47
Number of beds	226	226	226	226
Average length of stay (ALOS) (days)	6.8	6.2	6.8	5.9
Inpatient mortality rate (%)	7.3	6.8	7.2	7.2

[4] Data for the average length of stay for 2003 are not available, but in 2001 this stood at 11,5 days.

The data of C3RH show a decrease in average length of stay since 2000 and an increasing bed occupancy rate, although the latter remains quite low. The in-patient mortality rate however remained relatively stable over the last 4 years.

Geographical accessibility

The geographical accessibility of the C3RH is difficult to assess with the available data. The main road infrastructure being good doesn't guarantee easy access for people from more remote areas. Specific information regarding geographic origin is not available, but 564 referred patients were received at the Regional Hospital, constituting a very low proportion of all new cases at the OPD departments (1.17%) in 2003. Five % of in-patients were patients referred from other districts. In the same year, fifteen patients were referred from the C3RH to the Korle-Bu University Hospital in Accra, compared to 46 referrals in 2002 and 71 in 2001. The neonatal intensive care unit and the eye clinic are two examples of services that seem effectively to be covering the whole region, with patients being reported to be referred from all districts.

An ambulance service is put in place to go and collect patients at district level on demand. An ambulance is kept stand-by and is in good driveable condition, with good gasoline availability and a communication network is set up in the region.

Permanence

The core services are all permanently operational. The Accident & Emergency department, the maternity, the hospital pharmacy, the out-patient pharmacy, the lab and the operation theatre are all operational throughout the day and night. Ambulance and transport services are stand-by permanently. Furthermore, special opening hours are foreseen for patients that can't attend clinics during regular opening hours. For example, the diabetes clinic opens every 2nd Wednesday between 5 and 7 PM.

Place in the public health system at regional level

While the offer of services is good for a regional hospital, it seems that relatively few patients are referred to the regional hospital (about 5 % of in-patient admissions). This could be due to an ineffective referral system or to good functioning district hospitals. But the hospital is also involved in service delivery the other way around. Clinical outreach activities are organised by several units of the C3RH. The Eye unit for example covers 6 districts with its outreach activities, which are designed to be complementary with the available ophthalmologic services offered at the district-level facilities.

The C3RH also has a role in training of medical and para-medical personnel at the regional level. This is coordinated at regional health directorate level and trainings are organised based on priorities set at this level. On the other hand, students from the Cape Coast university are being trained at the lab of C3RH. Finally, training is also offered to volunteers (for example primary eye care volunteers).

Coordination of the offer of care in the region is being ensured by the regional health directorate and the regular meetings of district medical officers and hospital directors. These meetings seem to be the place were regional priorities are set, difficulties discussed and solutions evaluated. Several examples show that this is the forum where operational problems are being solved. Successful solutions tested and tried in one district or facility are adopted across the region where appropriate.

5.1.2 A synthesis of the hospital performance as an organisation

The second dimension relates to the hospital as an *organisation* that offers specialised care to patients. Specific aspects that ideally should be assessed include quality of care (technical quality and of the interpersonal relationship between providers and patients), clinical (services) management/efficiency, responsiveness to patients, logistical management, resource mobilisation

and accountability. The human resource management aspect of course falls under this heading as well, but this will be discussed in detail in the next sections.

In this section, we present the limited information that could be gathered. It is rather indirect information, as limitations in time and personnel did not allow us to study these aspects in depth. We'll focus mainly on quality of care.

Quality of care

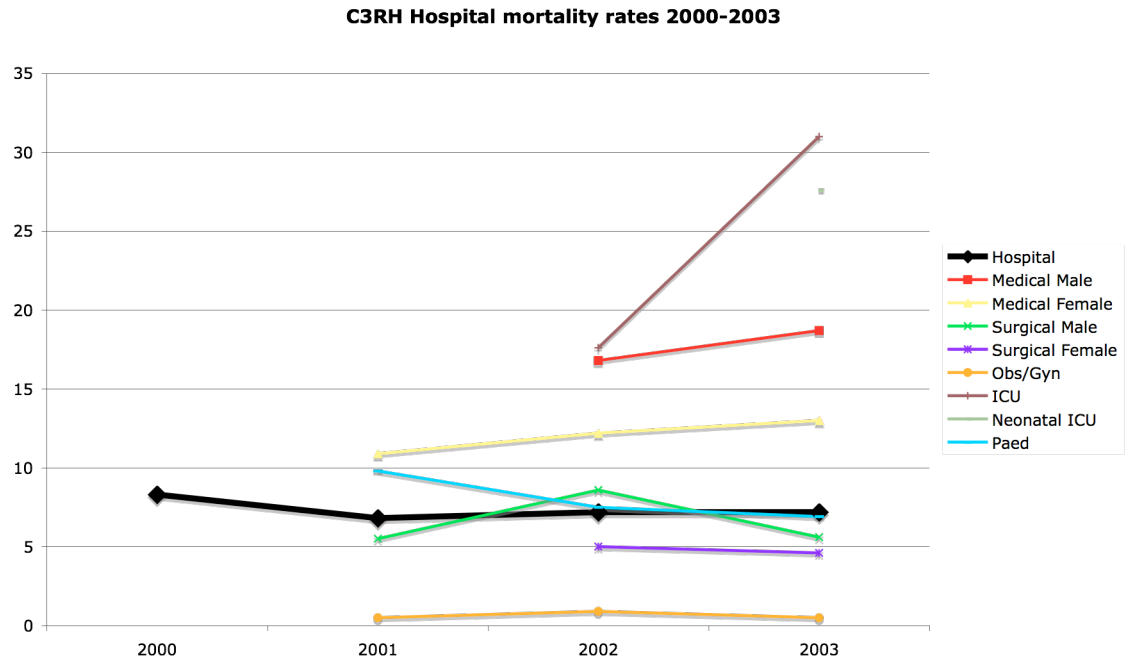
Assessing provider performance, of which quality of care is an essential part, is vulnerable to all the traps of performance measurement, including the risk of giving all the attention to the objectively measurable: indicators then easily become an end in itself and the less tangible aspects risk to be left out of the picture. Ideally therefore, assessment of provider performance uses multiple methods to be valid and reliable (Crossley et al 2002). In reality, often only a compromise can be achieved, whereby the weight assigned to specific attributes should depend on the objective of the assessment (McKinley et al 2001).

Øvretveit (1998) describes a three-tiered approach to assessing quality. The first aspect is *patient quality*, for the measurement of which he discusses three methods. Counting complaints over a given period and categorising them by type of complaint is relatively easy and inexpensive, but has obvious drawbacks. Asking patients to rate service attributes is another method, which incidentally is being used throughout the Ghana Health Service. Identifying critical patient quality features is a variant of the patient satisfaction surveys that focuses on critical incidents. The second aspect of quality of care is the professional quality. Outcomes which can be attributed to the service can be assessed but also the process of care (how well are providers carrying out interventions, treatments and other procedures). The third aspect is the measurement of the management quality, which can be described and broken down into assessing the compliance with 'higher-level' operating requirements and process measures of resource usage and error rates.

Provider quality

The scope of this study and especially the time available on the field resulted in limited data of rather anecdotal and fragmented in nature. Regarding the technical quality of the nursing care, the annual reports of C3RH mention for example the attention that is given to reduce the post-operative infections and bedsores. Of 839 patients admitted in male surgical ward in 2003, no cases of post-operative infections or of bedsores occurred. No bedsores occurred in paediatric ward in 2003 neither. However, data on post-operative infections/total surgical interventions, N of wound infections acquired in hospital, the rate of return to OP theatre for same condition, the rate of complications within X days after major surgery, the rate of emergency re-admissions to hospital within 2 weeks of discharge were unavailable. Other patient outcomes in the sense of intra-hospital mortality rates are being recorded, but cannot be linked to the case mix and are therefore of limited value. The top ten causes of in-patient mortality for 2002 were HIV/AIDS (32), malaria (22), anaemia (19), typhoid fever-sepsis (17), pneumonia (14), liver cirrhosis (14), meningitis (14), cerebro-vascular accidents (13), septicaemia (13), intestinal obstruction (13). The case fatality rate was 3.9% for malaria, 31.7% for AIDS patients, 32% for typhoid sepsis and 48.1% for septicaemia cases, but here too accurate information about severity and stage of the disease is lacking. Figure 4 present the trends of the intra-hospital mortality rates for the period 2000-2003.

Figure 4 - In-Patient mortality rates at C3RH (Source: Annual reports C3RH)



Patient quality

As mentioned, patient satisfaction surveys are now a widespread management tool in the GHS. Patient rating of quality of care, quality of nursing, food, cleanliness and overall satisfaction are assessed through the patient satisfaction surveys. At C3RH, these have been carried out every year since April 2002.

The objectives of the routine client satisfaction assessment survey is to solicit client views about service delivery in the regional hospital, to assess the extent to which matters raised in previous reports have been addressed and to identify and address current problems facing the patients. The surveys are carried out by teachers who are recruited specifically for this task.

For the 2004 survey, 200 clients were interviewed, 100 out-patients and in-patients each. The patients were randomly selected by convenient sampling. Out-patient clients were interviewed after they have been discharged at the dispensary, while in-patients were also interviewed on the day of discharge.

The patient perception regarding the quality of care and of the services at the out-patient clinics is measured though different categories. First regarding waiting times and delays at the various points (at OPD reception, at the triage consultation, for the doctor, for receipt, at the pharmacy and at the lab). Another set of questions focuses on the provider-patient relationship (physical examination, information given, privacy, staff attitude). A third category comprises cost. General aspects are considered as well: cleanliness. Finally patient satisfaction is explored.

Only 2% of interviewees expresses to be dissatisfied with the out-patient care, mainly due to the delays. Staff attitude at the OPD is being reported as very good (38%), good (55%) and poor (7%) in 2003 and very good (53%), good (46%) and poor (1%); showing a clear improvement over the last 2 years. For in-patient care, the dimensions include waiting times and delays, examination by a doctor, serving of drugs, privacy, staff attitude and quality of catering services, cleanliness and general satisfaction. Here too, only 2% of interviewees expressed their dissatisfaction, a rate identical to the results of the 2003 survey. Staff attitude as reported by the

interviewees improved over the last two years. It was reported to be very good (61%), good (27%) and poor (12%) in 2003, and very good (73%), good (26%) and poor (1%).

5.2 The human resource situation at C3RH

The HR management approach can be said to be effective if it manages to attract and retain a sufficient number of health workers and support staff in right skill mix and if it manages to ensure an acceptable degree of productivity/performance. In order to describe the performance of the HR management approach, we will describe two dimensions: the current HR stock, providing a snapshot of the current resources, and the HR flow, which provides dynamic information on trends in time and in- and outflows.

5.2.1 HR stocks

In 2003, the C3RH had a total staff of 352 persons. In this section, we'll focus on the nursing cadre and the doctors, the most problematic groups of professional staff.

The nursing cadre

As for any other health facility in Ghana, the C3RH has been experiencing staffing problems concerning its nursing cadre. We make the distinction between professional nurses, auxiliary nursing staff and other staff, and between the number of staff posted at C3RH and those actually on post. The difference between the two figures is accounted for by staff on long duration training courses.

In the professional nursing cadre, the staffing levels for the nursing officers have been dropping over the last years, the number of staff nurses went up after a dip in 2002 and the number of midwives has fluctuated. Overall numbers, however, increased from 108 staff actually on post to 117 in 2005 (Table 7).

Table 7 - Professional nursing staff levels at C3RH at the end of the second quarter (June), 2001-2005 (source: C3RH Quarterly returns, 2001-2005)

	2001	2002	2003	2004	2005
Nursing Officers					
Principal Nursing Officer	2	3	6	6	8
Snr. Nursing Officer	14	17	10	11	9
Nursing Officer	34	30	21	19	22
Total	50	50	37	36	39
Total actual on post	45	48	34	35	35
Staff nurses					
Senior Staff Nurse	0	14	16	14	5
Staff nurse	37	20	28	28	46
Total	37	34	44	42	51
Total actual on post	31	19	33	31	46
Midwives					
Midwifery Superintendent	0	0	15	17	19
Senior Staff Midwives	5	13	24	21	13
Staff Midwives	21	11	5	2	2
Total	26	24	44	40	34
Total actual on post	26	21	41	39	34
Cuban Nurses	6	6	0	0	2
Total nursing cadre	**119**	**114**	**125**	**118**	**126**
Total actual on post	**108**	**94**	**108**	**105**	**117**

It should be noted that among the Cuban medical personnel, there are a few nurses as well. Also the auxiliary nursing cadre has increased since 2001, but proportionally, it contributes rather little in absolute numbers (Table 8).

In addition, the hospital also disposes of other staff involved in nursing (Table 9). These include rotation nurses from the Nursing and Midwifery training College at Cape Coast and their numbers fluctuate. Ward assistants are relatively few and remain stable in number. Finally, a new category of health aides has been created recently and the first graduates have entered service only in 2005. This cadre is made up of second school graduates who have undergone a six-month training and who assist nurses in their daily activities.

Table 8 - Auxiliary nursing staff levels at C3RH at the end of the second quarter (June), 2001-2005 (source: C3RH Quarterly returns, 2001-2005)

Auxiliary cadre	2001	2002	2003	2004	2005
Supt. Enrolled Nurse	0	0	2	6	9
Principal Enrolled Nurse	1	3	3	2	2
Senior Enrolled Nurse	7	5	7	4	3
Enrolled Nurse	4	4	1	1	1
Comm. Health Nurse	1	1	1	2	2
Total auxiliary staff`	13	13	14	15	17
Actual on post	11	12	12	10	14

Table 9 – Levels of other staff involved in nursing at C3RH at the end of the second quarter (June), 2001-2005 (Source: C3RH Quarterly Returns, 2001-2005)

	2001	2002	2003	2004	2005
Other staff					
Rotation nurses	15	21	9	29	10
Senior Ward Assistant	7	7	7	7	9
Ward Assistant	0	1	1	1	1
Health Aide	0	0	0	0	19
Total Other staff	22	29	17	37	39
Actual on post	22	29	17	37	39

Doctors

For doctors, we will make the distinction between specialists, generalist doctors and housemen.

The Ghanaian specialists have been fluctuating in number, but have been in the 'minority' since 2001 (Table 10). Indeed, in order to fill the deficits in the specialist cadre, the management team at C3RH has sought to recruit expatriate doctors. Gradually, the number of Egyptian specialists has increased to five in 2005, while the Bulgarian surgeon has been at the hospital since four years now. This recruitment on contractual basis allows to redress the skill mix and to have specialists in all major domains (obs/gyne, surgery, internal medicine, paediatrics, ophthalmology and maxillofacial surgery).

Also the Cuban doctors provide a major boost to the numbers, but the hospital has little freedom in selection of skill mix, as the distribution of the Cuban medical personnel is decided at national level.

It should be noted that specialists from the Korle Bu University Hospital in Accra provide additional consultations and perform also specialised operations during their supervision visits in the fields of ENT, dermatology, plastic surgery, orthopaedics and urology.

Table 10 - Evolution of number and skill mix of doctors at C3RH, 2001-2004 (source: Annual reports C3RH)

	2001	2002	2003	2004	2005
Specialists					
Ghanaian	7	3	3	5	5
Cuban	7	5	4	4	7
Bulgarian	2	1	1	1	1
Egyptian	0	1	2	3	5
Total	16	10	10	13	18
Generalists					
Ghanaian	8	9	12	4	11
Cuban	0	0	6	0	0
Bulgarian	0	1	1	0	0
Total	8	10	19	4	11
Total doctors	24	20	29	17	29
Total doctors on post	N/A	N/A	24	N/A	27
Housemen					1

Regarding the generalists, the picture is unstable in the sense that the numbers of both Ghanaian and Cuban doctors vary substantially from year to year. The number of medical students carrying out their housemanship is expected to increase with the accreditation of the hospital for obstetrics/gynaecology and surgery. A record of 19 doctors have applied for a post or housemanship at C3RH at the end of October 2005.

5.2.2 HR flows

Turn-over

Relatively few staff are leaving the Cape Coast Central Regional Hospital and most do so on transfer or because they go for further training. The year 2005 was exceptional in that 18 staff embers were on transfer out. No staff have been laid off since 2001. At 1 or 2 per year, the number of retired staff is very low. It should be noted that no nurses left the GHS for abroad at C3RH, in contrast to the Volta RH, where in 2003 five nurses left 'for greener pastures'. In 2003 and 2005, 2 staff members at C3RH left their post without explanation. In 2005, 7 staff members took leave without pay.

Training and development

The management team at C3RH has consistently put an emphasis on staff training and development (Table 11). In 2002, there was a sharp reduction in the budget allocation and therefore the number of staff trained, but since then the budget has been increasing again. For the nursing cadre, a specific post of training coordinator has been created, responsible for in-service training and identification of staff members training needs and opportunities.

Table 11 - Number of staff trained and training budgets, C3RH, 2000-2004 (source: Annual reports C3RH)

	2004	2003	2002	2001	2000
No of staff trained in-service	300	263	110	340	170
Amount spent on training (in Cedi)	50 000 000	25 834 000	12 804 000	44 000 000	10 000 000

6 The HR management practice

In this chapter, we set out to describe the actual management practice at C3RH, focusing specifically on the human resource management aspect (an answer to our first research question). The standard functions of human resource administration and management carried out at C3RH include workforce planning, staff selection & recruitment, training and development, rewards and remuneration policy and disciplinary actions. These routine responsibilities are taken up by the Administrator Non-medical who heads the HR department. Our point of departure is that while good execution of the standard functions is essential for a correct management, the more intangible aspects of the human resource practice may be key to good performance of the health workers. In this chapter, we will describe some issues that struck us during the field visit and in the analysis of the findings. These closely interrelated key dimensions of the human resource practice at C3RH are trust in leadership, open access to information for staff and patients, decentralised decision-making and staff motivation schemes.

6.1 Communicating and sharing information

A striking feature observed at C3RH is the affluence and availability of information that flows in various directions, contributing to better communication between management and staff, between different units, and also between users and staff. Several communication channels have been put in place by the quadripartite team in order to keep communications at an optimal level, starting from the point of view that this contributes to enhance staff satisfaction and eventually hospital performance.

Bridging communication gaps at different levels of staff management

Communications between staff and management can be considered at four levels at Cape Coast:

- At **individual level,** supervisees and direct supervisors meet on an almost daily basis and may or may not engage in discussions regarding the tasks to be carried out. Whether communications are one-way or two-way will depend on factors such as management style and the nature of the task at hand. At C3RH, the widely adopted manner of discussion and of the delegation style usually yield two-way communication, which also seems to facilitate the yearly employee evaluation process[5].
- At **unit level**, monthly staff meetings are held to share information, assess achievements and shortfalls, and discuss unit-specific issues. During such meetings, the staff may be given feedback of decisions and activities carried out by the hospital management team and obtain a better insight in activities pertaining to related departments. Given the strong coordination within the nursing cadre, information to and fro the nursing administrator flows freely.
- Monthly **hospital management committee meetings,** in which all wards and departments are represented by their in-charge, deal with strategic choices and are supposed to be the main decision-making forum.
- At the **institutional level,** the quarterly staff *Durbar* epitomises the exercise of staff participation at C3RH. The durbar is a general assembly presided by the core management team and attended by all hospital workers of all categories. It is organised in a ceremonious manner[6], but as confirmed by observation, this does not stop staff

[5] Performance of each employee is evaluated by his immediate supervisor according to a GHS standard evaluation framework.

[6] A whole ritual : Commence with prayer, then a comprehensive agenda with minutes of last durbar, matters arising, issues of the day and other matters

members of any category to take an active part in discussions. During the durbar, the core management team is to give an account of activities that have taken place during the past three months, and it also helps maintain the discussions on track. In some instances, debates may get vocal but mutual respect is the rule. In the durbar that we observed in September 2004, animated discussions led to some important decisions being made. At one point, all participants were asked to vote on a decision regarding the staff welfare fund for which the contributions are collected at national level. The welfare committee will eventually use the official minutes of the durbar as evidence that the staff agreed unanimously to increase their monthly contributions. It was observed that sensitive issues for which investigation by the management was called for were not shunned and publicly debated.

All staff and managers interviewed tend to agree that the durbar as specifically designed as a staff interface is pivotal: it contributes to create stronger cohesion and a sense of belonging among hospital staff. According to the hospital director, it is the only moment one can fairly assess the state of the collective workforce motivation. For the staff, it is a unique opportunity for their voices to be heard especially when they have grievances.

Besides these meetings and committees, information directed to the staff is distributed throughout the hospital through postings of the agenda and minutes of the diverse meetings. Staff satisfaction surveys are carried out as well as a means to collect opinions, comments and suggestions of staff in an anonymous manner. Finally, the annual report is another channel of information to both the outside world and the staff of the hospital.

Informing the patients

The relative high openness regarding information applies as well to the flows to patients. Informing the patients aims at increasing transparency and accountability in the first place. However, it also serves to increase efficiency of the nursing staff. According to the director, providing relevant, simple and accurate information to hospital users can contribute significantly to reducing the staff workload, as this would reduce the demands for information from the patients and visitors. Various channels are put in place:

- A public address audio system on which tapes are played in English and local Fanti language provide information on services, schedules, fees, exemptions, and even who to see in case of grievances.
- Besides promotional posters, information with simple graphs regarding patient satisfaction surveys are posted so everyone can view the results. Doctors' and nurses' schedules are clearly displayed in all wards so at all time everyone knows who is on duty and where. Even schedules for management and special committee meetings are posted at places open to patients. A suggestion box is also clearly displayed and apparently sometimes used.
- More recently, the superintendent proposed the creation of a new position that would reinforce this patient information system: an information desk officer. The incumbent[7] is responsible for answering patients' questions (reception function), but also for obtaining and organising the information to be disseminated to the patients and at the same time provide feedback to the staff. She is directly supervised by the nurse in-charge of OPD, but the range of the patient information system goes far beyond this unit.

The effects and benefits of this enhanced patient information system on reducing the staff workload have not been measured, but at C3RH, there is a general sense of relief among staff. It

7 Presently the position is held by a young lady who was among many candidates responding to a public advertisement. She underwent a serious recruiting process through a 'representative committee' specifically created for this occasion. The Medical Director played no active role in the actual recruitment although he proposed the creation of the post which is not foreseen by the GHS.

is considered that this has reduced the occurrence of quarrels between hospital employees and users. One can assume that it has also helped save time spent on redirecting patients or having to give them explanations. It may also help reduce waiting times for patients who get annoyed or frustrated and take it out on the hospital staff.

We would assume that the open access to information should in principle make the patients and their relatives better informed about the way the hospital is run and how funds are used and that this would need to be complemented by an effective mechanism for patients to express their voice. However, we didn't have the time to dig into this question that may represent an indirect mechanism to exert user or community pressure on the hospital management.

6.2 Decentralised decision-making

When referring to overall managerial approaches being employed at C3RH, all hospital management team members who were interviewed used the same wording: '*Decentralised participative management*'. This phrase has a double meaning. First, the different units or divisions enjoy a certain level of autonomy in terms of decision-making and specific objective setting for what regards their specific unit or department. Second, the management team at C3RH seems to aim at developing a democratising decision-making structure that fosters active participation of the key actors at all levels in decision-making that affects the hospital as a whole.

While the domains that are of essential importance to the mission and the performance of the hospital are under the direct authority of the director and the quadripartite team, the units are still consulted or asked to prepare proposals regarding these issues. Decisions regarding budgeting for example will ultimately be taken by the quadripartite team, but all units and wards propose budgets to the hospital management team and these seem to be taken seriously. Similarly, this deliberate policy delegates considerable decision-making authority over a number of domains, including the sensitive Additional Duty Hours Allowance and matters regarding supplies and purchases, to staff committees.

The configuration of decision-making at the level of the units and wards mimics quite fairly that of the hospital as a whole. We will describe the housekeeping unit as an example of how this type of management works, as well as the decision-making process at ward level.

The housekeeping unit

The housekeeping unit is one of four comprising the support service department, which is under the supervision of the non-medical administrator. The unit is headed by an environmental health officer and its main purpose is to carry out all sanitation duties within the hospital and its immediate vicinity. With the help of an assistant, he oversees a roster of approximately 70 workers belonging to three different categories: the porters, the hospital orderlies and the compound orderlies. Those who are formally appointed enjoy the same nominal status except for a ranking related to seniority and granted by an official centralised promotion process. One can find in the wards senior orderlies or senior porters who carry out the same tasks as those who have not yet been promoted. This acknowledgement of seniority is usually accompanied by a raise in salary and should be made automatically every three years, pending recommendation of the workers' immediate supervisor.

Most members of the housekeeping workforce at C3RH have received at least primary education. Upon their appointment at the unit, they meet with the head of unit and his assistant who assign them to tasks according to need or abilities after discussions over the job. Then, the newly appointed worker undergoes a period of orientation in order to get acquainted to the tasks and his co-workers who participate in his/her initial training. Each worker is provided with standard guidelines in regard to his specific tasks. These instructions are accompanied by explanatory information in order to help them understand the rationale and importance of some recommended measures such as hand washing and disposal of sharps.

Hospital orderlies and porters fall under the direct supervision of the nurse on-duty of the wards to which they have been designed. The formal hierarchy is usually respected in that if there is a problem pertaining to 'housekeeping' duties, the parties involved know that it will be reported to the head of that unit. This calls for actual horizontal integration to be achieved in order to keep channels of communication and liaison devices at optimal level. Beside for routine cleaning, the hospital orderlies may be asked by the nurse to assist in some exceptional cleaning tasks. The porters need to communicate properly with the catering service or the laundry in order to maintain adequate coordination between these different services. Porters and orderlies reporting late to work or shirking their responsibilities can be a hindrance to flow of service provision and eventually impact on quality of care.

The picture that emerges in case of the housekeeping department is one where there is a cascading delegation of authority. The housekeeping unit is quite autonomous and reports directly to the top management, but in practice, the reasons for unplanned contact are two-fold: 1) when the units inputs are required for budgeting and planning and 2) when lapses are perceived by management.

Communication with other levels of the organisation occurs through three other scheduled meetings: 1) the general staff quarterly durbar, 2) the head of department monthly meetings and 3) the quality assurance committee. Although hierarchical lines are clearly defined, this should not prevent an employee to have access to the medical superintendent if they feel the need to consult him. If a decision is to be taken however the proper channels will be used.

The management at ward level

In managing their nurses and their cadre of orderlies, our observations and interviews show that the heads-of-unit use techniques quite similar to those utilised by the Medical superintendent and his team:

- Providing firm, but accessible leadership that is supportive and fairly democratic.
- Providing access to information through monthly unit meetings that are held for activity review, general discussions regarding tasks, working conditions and shortcomings. All staff members have a voice and suggestions proposed for solutions are usually taken into account and further explored.
- Continuous monitoring of working conditions and essential supplies and training needs assessment. In the latter case, there is consultation with the in-service training coordinator. Further education is strongly encouraged for all levels of staff.
- Active efforts to bring employees to value their job and to boost their confidence.
- Allowing workers to take initiatives that may have a positive bearing on the individual and overall unit performance. The workers of some units have for example created a staff welfare fund that they manage through a committee: monthly contributions to provide assistance in case of bereavement or other personal circumstances that require finances.
- Delegating of functions to staff members. Within the wards, upholding discipline of the orderlies is a responsibility of the orderlies disciplinary committee, the purpose of which is to keep offenders from tarnishing the unit's reputation and distorting their performance under the credo '*We are a centre of excellence*'. This committee actually does not apply any disciplinary measure, but first summons the person at fault for a 'query' and maybe another if results are not conclusive. In case the employee fails to comply to the 'code of good conduct' by continuing to be late, absent or rude for instance, the committee recommends sanctions that may include suspension without pay or relocation. We have an example of a hospital orderly who was 'demoted' to the rank of compound orderly by recommendation of the committee. Considering his long history of absenteeism, he was facing dismissal, but the committee took into account

special circumstances that kept him from properly carrying out his previous duties. He was quite happy to be sent to work outside.

These points are supported by the comments and answers given by nurses who were interviewed.

6.3 Staff motivation schemes

The hospital management is employing several techniques to boost and maintain staff morale and motivation and to keep employees' minds focused on the job despite strong factors that can pull them off track.

Financial incentives

All staff members interviewed agree that their official salary does not allow them to make ends meet. They are all in favour of schemes whereby hard work and good productivity would be better recognised through financial incentives. There is a perpetual debate on this particular topic in the literature and those in favour of financial top-ups argue that this is the way to go because the health worker's problems do not fundamentally reside at the health system (the hospital in this case) but are linked to a money-driven environment. However, the C3RH top management does not favour financial incentives too strongly, arguing that they may contribute to distort not only vocational or professional aspects of healthcare provision, but also to alienate the health workers, the performance of whom may become dependant of this 'token of appreciation'.

In spite of the official discourse of the management team that states that financial incentives are not used, the top managers when confronted with the acute shortage following the massive departure of the expatriates have resorted to the pro-active proposal of financial incentives to key-staff in order to forestall possible disruption of services. By 'pro-actively' we mean that management did not wait for irrational demands to come out amidst a foreseeable collapse. Making the first move in such a situation allowed to appear to be in control for a while, to remain within budgetary capacities and to create some breathing space in order to look for solutions during the crisis.

As already discussed above, the additional duty hours allowance allocation (ADHA) has become an automatic topping up mechanism not only for doctors, but for all cadres in the Ghana Health Service. While correcting at least partly for the inadequate salaries, we wouldn't consider this to be an incentive as such, as it has become an automatic top up independent of any performance measurement or assessment.

Non-financial incentives

While financial incentives are not in the official toolbox of the management team, it pays quite some attention to the non-financial incentives.

For some *essential* staff members (mainly doctors[8]), non-financial incentives were instituted during the acute crisis: 3 meals a day when on-duty, phone cards, transport or fuel allowance. Three medical officers interviewed said they were quite happy with the efforts made by the hospital to support them in facing the pressure and extra burden of the workload. These gestures by management were considered as being a clear recognition of their work. At the same time, other categories of personnel, like the nurses and lab technicians who share this burden with the doctors are quite less satisfied, as they are not even given a snack or a drink during their extra working hours.

[8] Only 7 doctors worked at C3RH during August-September 2004. The 2 Ob/Gyn. specialists are involved in a rotation scheme with the district hospitals, according to an arrangement between C3RH and the regional directorate

On the other hand, some blanket measures aiming at providing incentives to all cadres of staff have been instituted. There have been attempts to introduce transportation allowances for all staff, but they have not been continued for a number of reasons: a) the staff are too many for the Internally Generated Funds to sustain this expenditure. Besides, there is already a mini-bus allocated to staff transportation. However, it seems that those employees who manage to properly articulate their need and justify additional transportation fare succeed more easily in obtaining it. A special staff cafeteria has been created that is subsidised by the hospital and where most of the staff, including the expatriates, have their meals. About 70% of the present staff (all categories) enjoy subsidised accommodation in the vicinity of the hospital. The rent is collected at the central level of the Ghana Health Service by direct wage deduction. There is an accommodation committee at the hospital with a composition similar to that of the many other issue-related staff-run committees. Its role is to see to it that housing is dealt with fairly and that the people who need accommodation are provided when possible. Although the premises are quite exiguous, there is a long waiting list of people who aspire to this kind of accommodation. It is considered by the staff as an incentive to stay working at Cape Coast but as with a number of other issues, the top management doesn't intervene in its direct management.

These measures are quite similar to the efforts undertaken at the VRH, differing mainly in the intensity and scope, which is higher at C3RH.

Rewards

All heads of units are encouraged to identify best workers to be recommended for monthly or annual rewards (*Best Nurse*, *Best Orderly*, *Best paramedical staff* member, etc.). The recipients usually get money or gifts such as television sets. At institutional level, we should also mention the annual 'Best hospital of Ghana Award', which C3RH has won in 2003.

6.4 Performance management

A strong culture of management by objectives visibly pervades the whole Ghana Health Service. Regular target setting and evaluation is carried out by the core hospital management team and the findings are reported as such in the Annual Report. This focus on management-by-objectives is not restricted to the quadri-partite team, however, but is also prevalent at the department and unit level. This approach is focusing on continuous quality improvement as a main managerial concern and relegates the assessment of individual staff members to the annual staff appraisal, which is taken into account in the promotion procedure. Promotion is a rather regulated process or a fixed pathway with a number of distinctive steps, including an interview in Accra, that should guarantee progression in salary scales, but promotion is in theory not automatic. It is however difficult to assess how far the system has not become a bureaucratic procedure whereby merely carrying out each step leads to confirmation.

Performance of staff and units is also the subject of the quality assurance programme. The Quality Assurance Committee aims at coordinating all care activities in the hospital and organises clinical conferences, mortality meetings and maternal death audits. It also carries out the annual patient satisfaction and staff satisfaction surveys. The staff durbars are used as a channel to elicit the staff's views on the hospital performance. It is however not clear in how far these activities lead to better patient outcomes and to better organisation of service delivery.

6.5 Trusted leadership

At Cape Coast Central Regional Hospital, conversations with the hospital director, other core management team members and the staff in general showed that the management team shares a common approach to leadership and that they realise that the style of leadership they display can be a strong motivating factor.

The vision on leadership of the key actors seems an important factor. According to the director, the best way to demonstrate leadership and elicit trust and respect from staff is to set sound examples: "coming to work on time, keeping one's word, acknowledging one's limitations and mistakes, avoiding conflicts of interest, recognizing achievements, listening to others and being respectful". According to him, if the leader has a clear view and understanding of actual working conditions of the staff, this can make him responsive to their needs not only as hospital employees, but also as whole individuals and team players. Furthermore, once the leadership is established and a trusted relationship is developed, management is more likely to have the upper hand when it comes to abating tension or resolving conflicts.

At C3RH, a striking importance attached to the element of trust emerges from the interviews and the discussions. It seems that among nurses, the deliberate approach of the quadripartite team to inspire trust has indeed been effective. All nurses interviewed stress the importance of confidence and trust in the nursing administrator and the core management team in general.

We had the opportunity to observe a manifestation of this trust in the leadership during the September nurses strike for an increase in ADHA allocation. Even though the nursing manager was on leave during that period, the entire nursing body at the hospital had agreed not to enter the strike under her advice. Other arguments that were given was that their reputation would be at stake and that they could in no way afford to have patients die due to lack of care. Out of the 14 nurses interviewed, including the acting nursing manager, 13 stated clearly that their decision was in no way coerced, but based on the *wise* advice or unwillingness of their leader to participate in the strike. The only nurse who did not share this opinion argued that most nurses continued to work out of fear rather than respect and conviction because they all knew that the reasons for that particular strike were legitimate and 'founded'. This interviewee may have a point. The nurses following the judgment of the nursing administrator can indeed also be interpreted as an easy exit from the dilemma of having to decide between supporting their peers and their duty towards the patients as part of their professional conscience by shedding all responsibility to their 'leader', instead of actually sharing it.

6.6 Synthesis

What emerges from the observations, interviews and discussions is that the management style(s) used at C3RH are quite complex. Because is rather a hybrid than one homogeneous approach, it seems to reach a good fit with the problems at hand and the type of staff involved. This multi-faceted approach is rooted in a conscious choice of the top management team and thus well-shared and applied in a rather coherent fashion by all top managers.

7 A description of the decision spaces available at regional hospital level

Our second study question is: *Which factors determine the decision space of a hospital management team at regional level regarding HRM*? This chapter will present a detailed description of the decision spaces at regional hospital level and the factors that define it. It proposes first our analytical model and then proceeds by analysing the formal dimensions of the decision space available to regional hospital directors and their management team. In a final part, we explore how the formal decision space is actually exploited through two specific cases.

7.1 The analytical model

The concept of managerial decision space was proposed by Bossert (2000) to allow a more detailed description of the decentralisation policies that have been introduced in a number of countries. His model first implies a decentralisation policy that aims at allowing effective autonomy to peripheral components of an organisational system, such as the health system. However, good and responsive management will depend of other factors than instituting appropriate margins of freedom for local healthcare managers. According to our analytical model, the performance of managers will not only depend on the defining political context and the resulting administrative and structural reorganisations, but also on resource availability and managerial capabilities at the periphery (See Figure 1).

Our field study at C3RH shows that the formal degree of freedom offered to the hospital managers may under certain given conditions appear to take different forms. In fact, the process of decentralisation in Ghana is on-going and not all components of autonomy have yet attained the same level of 'progress', thus making the decision space resemble a complex 'patchwork' of opportunities and constraints rather than a clear-cut full autonomy granted in all major domains. For instance, regional hospitals are allowed to retain and manage the totality of funds generated (wide financial management margins), but it takes no formal part in the selection and recruitment process of professional staff (narrow HR management margins).

Table 12 summarises the basic background information regarding the decentralisation as discussed in section 4.3.

Table 12 – The decentralisation of the health sector in Ghana

Basic type of decentralisation	Delegation of health service delivery function to autonomous Ghana Health Service (GHS), Deconcentration towards peripheral levels of the GHS
Year initiated	1996 (establishment of the GHS and the Teaching Hospital Act)
Levels	10 Regional Health Directorates, 110 health district administrations.
Special features	GHS is overseen by the National Governing Council and retains relative centralised control over the different levels of authority within the health system

In order to describe the decision space as it exists at the level of C3RH, we used a conceptual framework developed by Govindaraj & Chawla (1996), in which decision space is viewed under four main dimensions: governance, general management, financial management and human resource management. Bossert and Beauvais (2002) came up with a similar framework, using five dimensions: finance, service organisation, human resources, access rules and governance rules. Although the wording is different, the approach is the same. It eventually leads to the construction of a 'decision map' from a matrix like the one shown below and this can eventually be used as a tool for comparison of decision space in different systems and contexts.

Formal versus actual decision spaces

Where Bossert's framework focuses largely on the formal decision spaces[9], we'll make a clear distinction between what is presented as the formal decision space and the actual managerial decision space. The former, laid out by the central authorities, is essentially shaped by the current political orientation of the public sector reforms at large. The latter, which in reality can be considered as an 'operational decision space', is first determined by the ability or motivation of the intermediate or peripheral agent to reconcile their personal managerial capability with the official decision space. This implies that the manager not only has certain personal attributes such as a clear vision, leadership skills, the requisite know-how and a willingness to innovate, but that there are also associates and allies he can rely on.

Table 13 - Matrix for decision space assessment (Adapted from Govindaraj & Chawla, 1996)

	Range of Choice		
Functions	Narrow	Moderate	Wide
Governance			
General management			
Financial management			
Human resource management			

7.2 The management decision space: formal and informal dimensions

7.2.1 Governance

We will discuss the governance aspect at two levels: first, the relationship between the Regional Health Directorate and the Regional Hospital, and second, the various governance arrangements within the hospital.

Intra-health system governance

Under the decentralised system in the Ghana Health Service, the ***Hospital Director*** (Medical Superintendent) of the Central Regional Hospital at Cape Coast is responsible to the ***Regional Director*** of Health Services in the Central Region of Ghana. The Hospital Director (Medical Superintendent) is appointed by the Ghana Health Service Governing Council. The relationship ofbetween tC3RH and the Region should be seen within the cascade of contractual agreements in the GHS between all levels of the system. However, while a contract exists between the GHS and the Region, at the end of 2005, there was not yet a contract signed between the Region and the C3RH, or the district hospitals.

In general, hierarchical lines are clearly defined and these are adhered to in reality. Clear responsibilities are demarcated. The relation between regional director and hospital director is therefore instrumental in laying down the formal range of choice. Although all decisions that imply change or some level of departure from national norms need prior approval by the regional director in order to be implemented, innovation occurs through a dynamic process of discussion and negotiations between both parties. For example, at hospital level, new working arrangements that delegate tasks to auxiliary workers can be tested. These will be discussed at regional level and taken up in all other facilities if deemed worthwhile.

[9] As we mentioned in the Introduction, Bossert (2000) initially distinguished the formal from the actual decision space, but his later model focused on the formally defined decision space.

Besides formal rules and relationships, our observations at Cape Coast show that this particular relationship, strengthened by previous professional relations, mutual respect and understanding, contributes to widening the scope of the formal 'decision space'. In contrast to some neighbouring countries, there is a far less strong feeling of a rigid bureaucracy in the GHS.

Intra-hospital governance

Regarding governance within the hospital, our study shows that at C3RH, some particular arrangements exist, which, we'll argue, are contributing to the staff commitment. Several levels of decision-making exist within the hospital. We'll describe the main elements: the management teams (quadri-partite team and hospital management team), the advisory board, the issue-related committees, the unit meetings and the staff durbar. Whereas most of these decisionmaking bodies are instituted and operating according to central regulations, they have been tweaked at C3RH with the clear aim of improving transparency and particpation of various cadres in decisionmaking.

The core management teams

At C3RH, the day-to-day management is carried out by a core management team called the **'quadripartite committee'** because of its four-member composition. It is comprised of the Hospital Director, the Nursing Manager, the non-medical Administrator and the Chief Accountant (Business Manager). This is a significant deviation from the standard core management team in that the chief accountant replaces the Medical Administrator. The main reasons stated for this structural arrangement are that it allows the Medical administrator (a doctor)[10] more freedom and time to attend to care delivery and it enables the management team to keep more closely informed of the financial state of the facility.

Besides daily interactions, this managerial committee meets formally on a weekly basis for planning and evaluation purposes. Members of this team also have the responsibility to disseminate information throughout their respective services. In that regard the Medical Director works closely with the Administrator Medical and acts as his 'representative' at the quadripartite level.

The **Hospital Management Team** consists of the quadri-partite team members and the pharmacist-in charge. In theory, the HMT sets out the main lines for the daily management of the hospital. In practice, the quadri-partite team is quite influential, but it seems that a good balance is found between the executive team (Quadri-partite Team) and the strategic management level (HMT).

The **Heads of Units meeting,** which consists of a much broader group of people representing all the functional units is the main forum of information exchange.

Advisory board

By law (Act 525), any regional hospital should have an **advisory board** of which the Medical Superintendent and the administrator non-medical are members. In its present state, the board at Cape Coast, which is comprised of seven community 'counselors', plays a purely consultative role on general issues pertaining to hospital management and specific policies. No approval by this board is needed to carry out decisions made by the Hospital Management Team. Decentralisation policy implementers have inexplicitly restrained community involvement at this level thus allowing the hospital management team to enjoy a fairly large margin of freedom.

In practice, the board is perceived as a council of elders or opinion leaders who are supposedly representative of the community. Its members are co-opted with some consideration given to representativity (gender, religion, ethnic origin). At Cape Coast this arrangement seems credible

[10] This was done in a context of acute and severe shortage of medical doctors. In fact the medical administrator was relieved of 'administrative' duties to devote his time to clinical activities. Since the arrangement seemed to work, the new structure has been maintained although it does not appear on the official organogram.

and accepted because it is considered to favour transparency, dialogue and trust. Our interviews and informal contacts with different stakeholders indeed show us that all parties involved are quite satisfied with this. First, the law is complied with, as the board has been constituted. Second, the board members are quite happy to serve and enjoy the prestige of being representatives of their community, despite their limited 'powers'. As for the hospital management, having such a committee is always useful in that its members are respected in the community and enjoy a wide audience. On the other hand, the top managers seem to take the board's advice into consideration in decision-making. In short, although the ultimate decision rests on the shoulders of the director, the participation of the board in reaching the decision is actual. '*It's helpful and necessary because it reduces tension*' (a member of the core management team).

Efforts toward transparent governance have been made by providing channels through which the community (patients/users) can express its needs and grievances. This voice of the community is not limited to the C3RH advisory board (where one could actually question the representation of the common people). Within the hospital, patient satisfaction surveys and suggestion boxes, the results of which are publicly posted and disseminated, are more accessible channels. The Regional Directorate of Health Services also monitors the trends in community perception through other groups and a wider 'people's committee' representing all districts. This is based on the rationale that the people need to be consulted and informed at all times in terms of actions to be taken on their behalf if one contemplates effectively favourable and sustainable outcomes.

Issue-related committees

Several committees have been created to deal with specific aspects of hospital management (the Internally Generated Funds committee (see below), the procurement committee, ADHA committee, etc.). Their role is to support top management by independently analysing the issues they have been delegated to deal with and proposing a way forward. The ADHA committee for instance should meet at the beginning of every month to determine the amount to be allocated to each individual employee based on a set of predetermined criteria. The Hospital director only verifies that no ceiling has been surpassed in terms of 'overtime' allowed per category. The same is true for other committees like 'procurement' where the decision to purchase and spend a given amount is made by the committee without anything being directly imposed by the top management.

Unit meetings

At Cape Coast, each unit organises unit meetings at least once a month. For operational care delivery units, meetings may be more frequent. At these ward conferences, unit-related issues are discussed with all staff of the unit in question.

Budgets and annual plans are discussed and drafted during these meetings. Disciplinary problems can be decided upon at this level, too. Furthermore, outside staff are called in case of specific problems in order to analyse and solve the issue. Our interviews indicate clearly that this mechanism of coordination between operational units and support departments is considered as crucial by all parties involved. Also quadripartite team members are invited to these meetings and actually attend. Also here, this interaction between operational unit staff and management is considered by all as a very effective communication channel, which allows good exchange of information and transmission of problems and priorities to the top management. It is considered as bringing down the barriers.

It should be noted that the unit heads are members of the Unit Head meeting, which represents another complementary interface with between the operational and management level of the hospital.

The staff durbar

While staff representation at management level has become an integral part of hospital organisational culture within the GHS, it is taken one step further at C3RH through the ***staff***

durbars, which are held every quarter. This is a general assembly of hospital staff that is open to all employees, irrespective of category, rank in hierarchy or employment status. At the durbar, the management team presents the achievements, the problems and the financial accounts of the last quarter. Then any issue pertaining to the hospital can be raised by staff members and these are openly discussed. Examination of the minutes and the interviews indicate that grievances and demands from the staff are expressed and that at times the management is openly criticised.

Direct observation at a staff durbar during the field visit in October 2004, interviews with staff and the detailed minutes of past such meetings lead us to assume that this special 'gathering' is a management tool of utmost importance, not only regarding human resources management, but perhaps even more for transparency and fairness of decisions of the quadripartite team. The fact that information regarding all aspects of hospital management, including revenue collection, expenditure and debts, flows freely considerably contributes to this.

As already mentioned, between the quarterly durbars, information dissemination and feedback mechanisms are routinely managed through the monthly unit meetings. This allows all categories of staff to know beforehand what to expect from the durbars and results in a smooth process even when highly sensitive issues are addressed.

A synthesis

At C3RH, the standard procedures regarding the governance structures are implemented according to the GHS regulations, but especially the set-up of the internal governance structures and the actual decision-making power of each of these structures sets the hospital apart from other hospitals. This results in an actual delegation of power from the top-level of management to the lower levels for a substantive range of issues. Only the Board can be considered to be 'toothless', which somehow surprisingly to us does not seem to be considered a problem at Cape Coast.

7.2.2 Financial Management

Regarding the financial management dimension, we will describe the margins of freedom regarding revenue and expenditure.

Revenue

As for any government facility, C3RH disposes of income from three sources: 1) Government of Ghana allocation (GOG), 2) internally generated funds (IGF), and 3) donor pooled funds (DPF). Clear budget lines spell out the use of allocated funds, although some switching between lines is allowed. The greatest freedom exists for the IGF funds.

The state allocation (GoG) and donor funds (DPF) are sent from the central level to the Regional Directorate. It should be noted that between the Ghana Health Service and the Regional Directorate, there is effectively a purchaser/provider split relationship governed by a contract that specifies the budgetary allocation and the services to be delivered within a specific timeframe. At this moment, further contracts between the Region and the health facilities are not yet signed at Central region. The allocation to the different public facilities operating in the region will mainly depend on an assessment of each facility's budget, case load, case mix, utilisation and prior performance and is based on consultations and negotiations between the regional administration and the facilities.

At C3RH, these two funds combined represented approximately 20% of the hospital's yearly income in 2003 and 25% in 2004. The total combined revenue in 2003 stood at 1,4 billion Cedi and at 2,4 billion Cedi in 2004. This means that 75 to 80 % of the hospital's revenue is generated by hospital services paid for directly by the patients (out-of-pocket).

The hospital increasingly depends on the IGF, as government allocations are being paid irregularly. In 2005, the GoG allocation for clinical service delivery has not been transferred, while the GoG adminstration allocation has been paid out for the 1st and 2nd quarter only.

While the GoG and the DPF funds are provided for ear-marked purposes, the IGF can be used as seen appropriate by the hospital management within certain guiding limits. This includes improving health workforce conditions through hiring of casual workers, subsidising meals or drugs for staff or staff internet facilities. However, at C3RH 55% is plowed back into clinical services, 25% in administration, 5% in investments and 'only' 5% in personnel benefits.

At C3RH, the IGF is managed by a special committee. Like the other committees, it is composed of members from different departments and units. It meets monthly under the guidance of the non-medical Administrator and its main task is to set the fees of hospital services and drugs after analysis of data pertaining to drug availability, affordability and market trends keeping in mind cost recovery before profit. The decision to set a given price for a service is thus not that of a single person but of a group of people representing the entire staff and not only top management. This committee also plays a role in helping the hospital manage and control loss of income associated with exemptions, uncollected fees from staff drug consumption and absconding users. This role, which was not obvious at first, results from the sense of ownership acquired through active participation in management. It is developed to the extent that some employees who are members of finances-related committees actually express risk aversion and feel threatened by increasing exemptions and high abscondance rates. When asked for their opinion on things that needed to be improved at C3RH, 2 out of 3 orderlies interviewed mentioned taking measures to deter absconders and staff who refuse to pay for their consumption of drugs.

Budgeting

The function of budgeting for the hospital is under the responsibility of the top management. Budget proposals are drawn up by the in-charges of units and departments and these are accompanied by unit reports. The units reports do not only give an account of achievements, strengths, weaknesses and bottlenecks, but also provide information on possible targets for the upcoming year, the resources needed to attain them and their eventual costs. This information is forwarded to a 'budget committee' comprised of representatives of different departments and categories of staff. Technically guided by financial resource persons such as the chief accountant, the committee's task is to draft a comprehensive hospital budget proposal. After undergoing analysis by the core management team and receiving the hospital director's 'seal of approval', the budget proposal for the upcoming fiscal year is sent to the CRHD.

Concluding remarks

It could be argued that this delays of GOG funding de facto increases the decision making space of the Hospital Director to a substantial extent. It actually forces the hospital to pay a lot of attention to efficient revenue generation. This may lead to the adoption of a profit-driven management approach, which may lead to reduced financial accessibility. Ensuring financial accessibility seems not a major concern at the C3RH. A contract between the region and the hospital should foresee regulation of (financial) accessibility. Currently, waiving and exemption procedures do exist at C3RH, but may not be sufficient to ensure financial accessibility as many poor patients from the rural districts are likely to face other barriers such as transport that prevents them to reach the regional hospital.

7.2.3 General Management

In terms of general management, the hospital functions under the norms, procedures and recommendations of the Ghana Health Service. Roles and tasks are clearly defined and all members of staff are bound by an employment contract. Manuals for standard operating

procedures regarding all aspects of management are available at the hospital. The package of activities to be offered is also stipulated from above. The role of the top management here is to ensure that everything goes well according to the official programmes and guidelines. However, as we already mentioned above, the management has taken a specific option within the standard operational guidelines. Management is seen as a collective exercise whereby issue-related committees support the managers. The quadripartite committee that handles daily management activities can rely on the much broader Head of Units meeting team comprised of all heads of departments and units. The decentralised and participative managerial strategy allows for resolution of many problems at unit level, thus freeing top management for other purposes. Daily management become routine and the Medical superintendent usually have to intervene only in specific cases as a last resort.

The hospital director is directly accountable for all matters regarding planning, inventory and maintenance of estate. In the case of C3RH, beside the main buildings for OPD, wards and support services, there are the equipment, the vehicles and the housing that is provided to staff. Like other sensitive issues concerning staff, an accommodation committee, meeting monthly, primarily deals with personnel accommodation. The Hospital director therefore stands as the *chief executive officer* who bears the weight of ultimate responsibility for the performance of the facility, not only in terms of organisation per se but also in terms of care delivery.

Our interviews indicate that the scope of responsibilities of a regional hospital director regarding general management (and also financial management) is felt to be quite appropriate at C3RH. Within the boundaries of the procedures and regulations of the GHS, the top management team of the C3RH is able to ensure a sound administration and management of the hospital.

Conclusion

At C3RH, the formal decision space offered by the standard regulations are considered to be fine, but are in fact exploited in the sense that decision making is decentralised to lower levels of the hospital. This approach goes beyond the customary prescribed way of organising management and decision making.

7.2.4 Human resources management

In the framework, the human resource management dimension includes staffing, the recruitment process, remuneration and training.

Staffing: coping with the chronic shortage of human resources

The chronic shortage of human resources for health, compounded by the external and internal 'brain drain', is the major HRM problem faced by the management team.

In the regions, formal hospital staffing in the sense of distribution of personnel among units, services, hospitals and districts falls under the direct responsibility of the Regional Directorate, which maintains a human resource database for all health facilities. This allows determining the shortfall for each staff category and formulating realistic requests that are eventually submitted to the GHS at central level. Since appointment of staff can only be done by the GHS council, the planning capacity of the Regional Directorate of Health Services is considerably limited and this reflects on the hospital. When newly appointed health workers are assigned to the Regional Directorate, the latter determines the intra-regional postings according to priorities of the regional health system. The final staff allocation is based on formal requests and discussions, but in particular cases districts and hospital directors make special requests.

Formal staffing norms exist and have been defined for all cadres in all types of facilities by the central level on the basis of workload and responsibilities of all cadres and time estimated to be required for specific tasks. However, given that they have been not reviewed since 1995-6 and the current shortage of doctors and nurses, the norms are in practice not relevant. Instead, at

facility-level, assessments are made to allow the optimal use and distribution of available health workers. These assessment guide recruitment of staff on short contract and also expatriate staff (See below).

Since mid 2003, the Regional Health Directorate has a human resource manager who has been assigned two basic functions. First, the objective is to make personnel administration more responsive (speeding up transfers, promotions, retirement issues, etc). Staff counselling sessions are organised during which staffs are informed and advised on issues that may affect their career development and retirement. This is appreciated by staff, as they can have most of their employment and benefits issues sorted out in Cape Coast instead of in Accra. Furthermore, induction sessions for all staff arriving at the region provide orientation on the GHS mission and vision and information regarding the procedures, but also provides an introduction to the socio-economic profile of the region. Finally, specific introductions by cadre are organised.

Second, this officer contributes to the development of a HR strategy at the regional level. This strategy includes sponsoring training for specifically deficient cadres and active headhunting by the region at the medical faculties to convince students to come and do their housemanship in Central region.

We must also note the contribution of the 'Cuban Medical Brigade', which is the subject of a political agreement between the governments of Cuba and Ghana. Cuban teams are allocated in function of need to facilities throughout the country. The 2002-03 and 2004-05 teams consist of a mix of specialist doctors, nurses, physiotherapists, etc. Although they make up for a substantial proportion of the doctors at C3RH, the management team has no voice in determining the exact skill mix and numbers. However, compared with other settings where Cuban medical personnel is being deployed, the skill mix they offer at C3RH is usually fairly complementary.

Recruitment

Margins of freedom regarding recruitment are limited. At facility level, health professionals can only be hired on short-term contract-basis and cannot be induced in the public service on local initiative. In practice, this limits the extra-legal benefits package for locally contracted workers. Furthermore, these workers can be only given 2 year-contracts. They receive a grade that is one lower than their previous grade and cannot head units or departments.

On average, two of three 'contract-nurses' are employed by C3RH. Furthermore, the hospital hires a pathologist for the mortuary, and periodically a nurse anaesthetist.

The selection and recruitment of non-professional staff lies within the authority of hospital management. These usually include watchmen, orderlies and health aides. Casual workers are also hired for positions not established within the Ghana Health Service. Data entry secretaries were hired when the computerised information network was set up. These employees under contract with hospital management are paid for from the IGF. Only exceptionally, it is possible to obtain an official appointment for people holding justifiable positions even if these latter are not officially recognised by the GHS personnel category list.

Two strategies are used to increase the number of doctors. First, the hospital management and the regional directorate work closely together to attract medical students doing their *housemanship*. Representatives of the hospital actively scout the medical faculties to try to persuade future housemen to apply for a posting at C3RH. They usually succeed in attracting some housemen. Despite the fact that the hospital has to contend with other facilities that seem to offer better incentives[11], in 2005, nine doctors applied for housemanship in C3RH.

Second, C3RH has been successful to recruit expatriate personnel (Table 10). Health facilities are officially allowed to recruit expatriate personnel in negotiation with the central GHS level.

[11] Training can also be completed at accredited private hospitals

This eventually leads to official employment by the GHS. However, important incentive packages are required to make these posts attractive. At C3RH, this includes offering staff housing, subsidised communication (internet access, cell phone cards) and a top up of the salary.

Within the contours of the formal decision space, the top management of a hospital has thus only limited freedom to attract and recruit staff. As we'll see below, through offering some additional remuneration package, the margins can be pushed a little for certain cadres. Furthermore, there is no flexibility regarding firing staff. At C3RH, the director expressed his frustration of not being able to change the composition of the administrative staff, which in his opinion was staffed badly at the start of the hospital.

Remuneration

The formal remuneration

The GHS council sets the salary scales of all GHS staff and pays out salaries accordingly. The hospital management team has no authority to change whatsoever regarding salaries of GHS staff. As we already mentioned, in terms of salaries paid to *casual workers*, the hospital has a certain amount of leeway and it is able to contract them for sums much lower than the GHS salaries.

Informal remuneration

Some margins of freedom are offered by the discretion in allocation of IGF that is given to facility management teams. C3RH uses between 2,5 and 5,6% of its internally generated funds to this end. This is currently limited to an incentive package for doctors doing night duties at the Accident & Emergency department. Some benefits are provided also to the expatriate doctors and the Cuban medical personnel.

Since 1999, the additional duty hours allowance (ADHA) is topping up the salaries of health workers. The funds are allocated on a monthly basis by the central level of GHS to the Regional Directorate, which in turn transfers the funds to the health facilities pending an official claim report by the facilities. Initially, the ADHA was paid out only to doctors, but under subsequent pressure through strikes, it was extended gradually to all cadres. Where initially, additional working hours were to be determined by the direct supervisors of each individual employee and approved by the heads of units, now fixed ceilings translate in automatic entitlement to ADHA. Doctors are now entitled to 200 hours per month, while the ceiling for an orderly is around 40 hours. In real terms, the ADHA is very substantial, adding on average 250-300% to the salary.

Training

Provision of in-service training is an integral part of the GHS professional development policy. The GoG budget allocation contains limited funds earmarked for training. At C3RH, the in-service training manager assesses training needs and develops training programmes in conjunction with the top management and unit heads. All categories of staff take part in different types of in-service training at C3RH.

Within this national policy, the management team at C3RH allows great flexibility for personal development. Taking advantage of the nearby University of Cape Coast, quite some staff are following diploma or post-graduate training, some of them sponsored by the hospital. Top managers advise staff members on career paths. Doctors have been sent for specialised training while remaining informally committed to the institution, nurses have been encouraged to study to become medical assistants, and orderlies have been given the opportunity to pursue their schooling or to be trained as health aides. The quadri-partite team shows quite some flexibility - and are perhaps simply pragmatic-, allowing staff to attend classes during working hours (on condition that they do what their job requires them to do and that they arrange this among their colleagues).

This proactive professional development policy is seen by the management team as an essential task of a tertiary level hospital, but is also an essential part of their human resource management vision. Training opportunities are also considered as non-financial incentives. While contributing to staff motivation and commitment, as shown by our interviews, this strategy of support to professional development carries risks. Indeed, from our interviews individual requests for higher education that may have purposes beyond the short-term interests of the hospital are not stopped.

Synthesis

Regarding human resource management, the formal margins of freedom are currently limited. However, responsive management is possible to exploiting some formal mechanisms (hiring expatriate professionals, using IGF funds to attract and retain specific cadres) and pushing other limits (e.g. encourage staff to enlist in professional development and allowing them to attend classes during official working hours).

7.2.5 Conclusion

Several factors combine to define the actual decision space used by managers at regional health facilities in Ghana. These are primarily informed by the formal institutional arrangements that specify which degree of decision-making authority in which domain is decentralised and the resulting contractual arrangements. From our study, we conclude that managers may be able to better exploit or even artificially 'inflate' the formal decision space resulting from official arrangements thus creating a wider area of manoeuvrability. Personal connections and networks play a role in this.

The above description can be synthesised in a decision space map. Table 14 presents the map for the C3RH.

Table 14 - Using the 'Decision Map' to compare formal and actual decision space at C3RH (Based on Govindaraj & Chawla, 1996)

	Range of Choice			
Functions		Narrow	Moderate	Large
Governance	Operational hierarchy			
	Hospital board			
	Community involvement			
	Staff participation			
General management	Institutional arrangements			
	Required service package			
	Payment mechanisms			
	Hospital information system			
	Norms and procedures			
Financial management	Revenue			
	Budgeting			
	Expenditure allocation			
	Accounting			
Human resource management	Contracts			
	Salaries			
	Benefit packages			
	Training			

Legend:
Formal decision space :
Functional decision space as observed at C3RH :

Referring to the Bossert & Beauvais and Govindaraj & Chawla decentralisation and decision space frameworks, one can say that in the Ghana health system, actors at all levels of the decentralised health system play the dual role of principal and agent depending on the interface. The decentralisation process is one of compromise, meaning that the health system is constantly the theatre of dynamic negotiations and trade-offs, ensuring some degree of checks and balances. Although some qualify it as 'centralised decentralisation', mainly because there is limited community representation and involvement, well-endowed and motivated managers who exhibit innovative leadership styles are able to use their skills to expand the decision space, fit it to their functional needs and improve their institutional performance.

8 Discussion

8.1 The limits of this study: How representative is C3RH?

Compared with other regional hospitals in Ghana, C3RH is representative in that it faces the same kind of institutional and legal institutional arrangements and other key aspects of the environment as any other regional hospital in Ghana. However, in our opinion, two sets of factors set it apart: first, physical environmental factors and, second, leadership factors.

The fact that the hospital is located in a major town that disposes of an adequate infrastructure in terms of electricity, water, communication, education facilities and roads creates conditions that put it apart from regional hospitals in the other poor regions of Ghana. These conditions combined with the institutional characteristics of C3RH - a tertiary hospital – are likely to increase the attraction exerted by posts in the C3RH compared with district hospitals in the same region, but also with other regional hospitals.

A second major differentiating factor is the leadership, in terms of competence, vision and management approach/style of the management team and the hospital director. While it is difficult to make any comment on the leadership capacities of other regional hospital directors, we feel that this is an aspect that specifically marks the C3RH. If this would then be a factor that differentiates this hospital from others, it is exactly the reason why C3RH was chosen as a case.

Is the case then representative for other regional hospitals? In the larger study, of which we report the human resource management part in this paper, we set out to describe and assess the different elements that account for the performance of human resources and we would argue that it is the specific combination of these elements in the actual setting of C3RH that makes this hospital function the way it does. Clearly, not only the socio-economic conditions, but also the interactions between the actors and the other intangible process aspects put a limit on the comparison with similar hospitals in Ghana. As such, it would be foolish to claim that C3RH is representative of all (regional) hospitals in Ghana, but perhaps the issue of external validity is beside the point. The true question in understanding what sets this hospital in a different league is to know how the mechanism (delegation of decision making to lower levels inside the hospital) works (or not) in the given context. Only if we can clarify these interactions and refine our initial analytical framework can we draw lessons on how the approaches used at Cape Coast can be applied in hospitals both in similar and in different geographical and social settings. Ideally, this would be the first of a series of case studies that starts from the analytical framework, which is in essence a middle-range theory that can be refined through repeated cycles of adaptation to new findings from the field.

8.2 Managing a complex organisation situated in a complex environment

Hospitals are complex organisations. Different cadres of staff, each with their own professional ethics, norms and values constitute effectively different sub-cultures within one organisation. Management needs to ensure coordination of these activities and different groups in order to attain an optimal level of integration of the specialised functions of a hospital. It should ensure the effective functioning of the clinical departments (the core functional units), a good support by units such as lab, radiology and pharmacy, an appropriate organisational structure and an appropriate management style. Logically, the latter would be striving at the balance between allowing a certain professional autonomy for nurses and doctors on one hand and reaching the organisational goals (which can in essence be summarised by providing accessible, effective, efficient and equitable care acceptable to all patients) on the other hand.

But hospitals do not exist in a vacuum. The general environment in which the hospital as an organisation functions can be described through categories such as the governance rules and

institutional arrangements (with their consequences for the decision space), the norms of the public sector, the socio-economic conditions of the population it serves, the professional ethics, the general culture, etc. More specifically, the human resource market (production in quantity and quality, availability of personnel, brain drain), the degree of professionalism and of public service ethos are key elements, as are the perception (and respect for the health worker) of the public, their channels of voice and co-management, etc. A second role of the hospital manager is therefore to manage the boundary conditions that have an essential influence on the performance of his workers and thus on the organisation. As a result, good hospital management demands dual competences and strategies, managing the inside (inner context) and managing the outside (the outer context) (Glouberman and Mintzberg, 2001b).

A consequence of the complex nature of a hospital and of its tasks and the subsequent heterogeneous composition of its staff is a huge potential for tensions. At the intra-organisational level, Jaffee's framework of organisational analysis (Jaffee, 2001) sees tensions arise first from the need to differentiate and integrate. A hospital necessarily needs to ensure differentiation of activities (the clinical specialities, nursing, diagnostics, administration, logistics, management), but also to integrate these activities in order to provide care in an effective and efficient manner. A second tension is likely to arise from the human factor of the workforce. Medicine essentially is a human-centred activity, in which the patient-provider relationship is key. This puts a lot of weight not only on the competences and actual behaviour of the health worker, in whose practice interpersonal skills play a key role, but also on managing these health workers so that a humane medicine is practiced. Further complicating the 'human factor' is the need to reconcile individual motives with organisational goals, the core task of any manager.

We argue that the very different functions and tasks of a specific nature – caring and curing of human beings - carried out by composite teams of health and non-health professionals and non-professionals call not only for complex organisations, but also for an adapted management style, in which trust may have an important role to play in managing the tensions that are likely to emerge in such environments.

8.2.1 Trust and regulation of health professionals

Above, we described three key issues that struck us when analysing the observations and interviews: decentralisation of decision-making, its concomitant openness of information and a holistic approach to sustaining motivation of staff. The fourth element of a leadership that is apparently being trusted by the staff may not be there by coincidence, but rather have emerged as the result of the three first characteristics of the management approach.

In the public health literature, trust is mainly framed in provider regulation. Trust is considered an essential component of the patient-provider relationship. (Mechanic and Schlesinger, 1996) state that "*trust refers to the expectations of the public that those who serve them will perform their responsibilities in a technically proficient way (competence), that they will assume responsibility … and that they will make patients' welfare their highest priority (agency)*".

More recently, trust is also identified as a central element in better management of health workers (Gilson, 2003). Organisational trust can be defined as "*the extent to which one is willing to ascribe good intentions to, and have confidence in, the words and actions of other people*" working in the organisation (Cook and Wall, 1980). At hospital-level, trust between health workers and management refers to employees' belief that they will ultimately form the organisation's actions. Blaauw et al. (2003) argue that a socio-cultural perspective on managing health workers that is based on trust would be more appropriate than the classical mechanistic approach that calls for a bureaucratic organisation, or the economic perspective that uses the market mechanisms to coordinate work and workers alike. In their socio-cultural view, social networks are the organising principle, which uses trust and shared values and norms as the main means of coordination. The same organising principle is proposed by Glouberman & Mintzberg (2001a and b). In western countries, the New Public Management movement gradually phased out the

command and control type of management by medical personnel and introduced professional managers in the NHS. However, mistrust between medical personnel and managers emerged all over. Without entering in this complex issue, the tendency to emphasise short-term and measurable results, the transformation of services to 'products', the diminishing commitment to social goals and the introduction of competition at the cost of trust relationships and collaboration had a serious impact on the organisation and delivery of equitable health services (Baum, 2002). Not coincidentally, the NHS changed tack with the White Paper 'The New NHS: Modern, Dependable', moving away from the competitive internal market to more collaborative systems based on partnership and trust (Goddard and Marek, 1998), although this was at least in part an equally ideological decision of the newly elected Labour government.

8.2.2 How does organisational trust work?

Trust has shown to have a positive impact on group cohesion, perceived fairness of decisions, organisational citizenship behaviour and organisational commitment, job satisfaction and organisational effectiveness (Firth-Cozens, 2002, Laschinger et al., 2000). In contrast, withholding information, or creating the impression that this is the case causes mistrust.

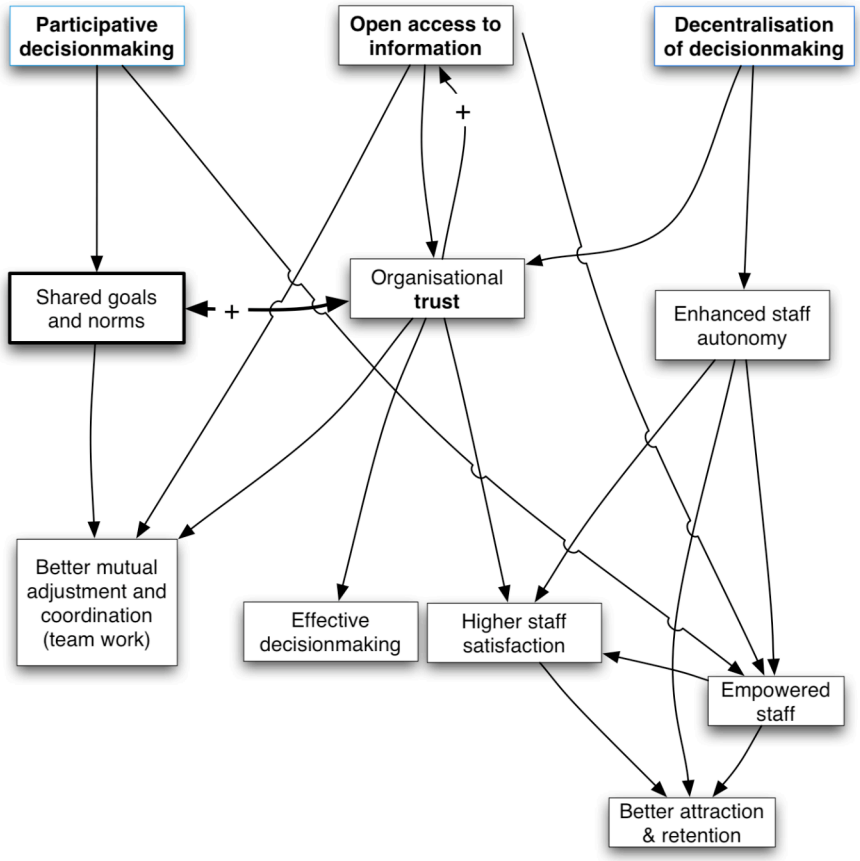
Access to information, participative decision-making and increasing autonomy of professionals by decentralising decision making has been shown to lead to increased organisational trust (Firth-Cozens, 2004). This author summarises the organisational conditions that promote organisational trust as follows:

- Less hierarchy: Flatter organisations allow the distance between workers and managers to be smaller, enhancing trust. Decentralisation of decision-making to frontline workers also contributes.
- Participation of staff in decision-making. Empowerment of nurses has been shown to enhance trust (Laschinger et al., 2000) and Kanter's empowerment theory (Kanter, 1979) has been used to explain the magnet hospital phenomenon (Scott et al., 1999, Laschinger et al., 2003, Laschinger et al., 1997, Hatcher and Laschinger, 1996, Laschinger et al., 2000).
- Openness of communication and effective two-way communication is key to instituting a climate of trust.
- Human resources policies and procedures. The process that underlies the decisions that touch upon human resources (posting, promotion, disciplinary action, remuneration) should be well communicated, consistent and fair (See also (Daniels, 2000) for a discussion of the accountability for reasonableness framework)

Managers play an important role in developing organisational trust by controlling the flow of essential information. Open communication not only favours coordination through mutual adjustment, which is a very effective means of coordination of professionals that are dealing with uncertainty and fast changing states of acutely ill patients, but also empowers staff members (Kanter, 1979). Trust is also determined by the organisational structure, the managerial philosophy and the employees' expectations of reciprocity (Laschinger et al., 2000).

Another means to enhance mutual adjustment is using a strong organisational culture to guide behaviour and practice. Shared valued and norms can be very powerful indeed. However, given the heterogeneous composition of a hospital staff, professional subcultures may be strong and need to be bridged by overarching shared values of caring for the patient (Glouberman and Mintzberg, 2001b). Again, providing open access to key information and ensuring good channels of communications at all levels of the hospital may reinforce the sharing of these values. Besides the formal channels of information, the informal ones are perhaps even more important and for these to flourish, a certain degree of trust is required, which itself is a result of open communication and participative decision-making. What we see emerge is then a virtuous circle or rather a network of self-reinforcing interactions Figure 5.

Figure 5 – Factors influencing organisational trust



8.2.3 A trusted management team does not succeed in fighting the HR crisis?

The data on the stocks and flows may seem to indicate that in Ghana, even a hospital management team that creates an environment of organisational trust and professional autonomy is not succeeding in filling the gaps in its workforce. Indeed, the total professional nursing cadre decreased from 126 in 2002 to 99 in 2004, while the total number of doctors went down from 23 in 2001 to 16 in 2004. However, the fact that no nurses left C3RH for abroad, that no workers have been laid off and that retirements are rare all indicate that the inflow into the hospital's workforce is the problem rather than the outflow. We believe that this reflects the general human resource situation in Ghana, which has experienced a shrinking pool of doctors and nurses willing to stay and work in the country since many years. It is indeed estimated that 60 % of the doctors who graduated in Ghana between 1985 and 1994 left the country to mainly the UK and USA (Dovlo and Nyonator, 1999) and that half of Ghana's doctors work abroad (Teferra, 2000). A second factor is the relative short period during which this management approach has been implemented at C3RH. All in all, these findings suggest that simply putting in place a 'correct' management style does not lead to higher attraction rates if the pool from which can be recruited is ever drying up. Correcting health workforce deficits calls for comprehensive measures that intervene at all levels, including the organisational level. At the latter level, both adequate margins of freedom and sufficient resources are essential conditions for a competent management team to develop appropriate human resource management strategies.

8.2.4 Can this work in other settings?

Organisational trust at hospital level evidently does not merely depend from organisational characteristics, but is influenced by the immediate context and the wider culture and the pressures of society. The above-cited papers focus mainly on developed countries and assume that a number of basic conditions have been met. Good working conditions with an acceptable minimum of drugs, supplies and equipment and a minimum of well-trained staff are key assumptions taken for granted in the cited literature. Perhaps more important elements may be the presence of a relatively strong professional ethics and in public services, a public service ethos. To our knowledge, these presumably important factors are little documented in the health management literature. Our study did not analyse in detail the context elements of professionalism and public service ethics, but from the interviews and observations these two issues seem to emerge as important drivers of staff behaviour that require closer investigation.

A second important point is the relatively high degree of decentralisation in Ghana's public health system. It could be argued that the devolution allowed the passage from a strong hierarchical and bureaucratic model of organising health care (high grid/high group in Douglas grid/group typology) to a low grid/high group situation, which favours and emphasises active participation and negotiation among staff members. Effective decentralisation thus emerges as an important factor.

At this point, our hypothesis is that in order to create an environment in which organisational trust can blossom, first, a certain minimum of norms and goals should be shared. In case of the C3RH, both professional and civil service norms and standards that put the patient first seem well entrenched in the organisational culture of the hospital, but further studies are needed to examine this assumption. Second, participation in management, open communication and negotiation calls for a particular organisational context that allows a minimum of decision spaces at the organisational level.

8.3 The decision space: truly indicating the margins of freedom of a manager?

One can argue that the decision space maps that can be charted on the basis of the conceptual model of decision space indicate the margins of freedom of a hospital manager in dealing with the environment. Two remarks need to be made here. First, as described above, the actual decision space can be quite different from the official, formal one, either because the formal space is deliberately left vaguely defined or because the regulation capacity to enforce correct use is inadequate. Second, and related to the first point, there may be other important factors that shape the actual practice of the managers: voice of the community and/or its representatives, their personal motivation and vision and finally, pressures from within the hospital staff. It can assumed that the degree of professionalism and of public service ethos of the health workers in the public health system could presumably be important determinants of staff behaviour in general and of their position regarding the management of their own facility. The voluntary non-participation of the nursing staff in the national strike, which broke out during our study visit and was directed at increasing remuneration, is a good example of how professional pride and a sense of service to patients motivated nurses to continue caring for their patients.

9 Conclusion

Regarding human resources for health (HRH), Ghana currently presents a particularly interesting situation. On one hand, the far-reaching decentralisation allocated greater autonomy to hospitals, districts and regions, while on the other hand it is also an important sending country in the global "brain drain". This study focused on the Cape Coast Central Regional Hospital, because it is a facility that appears to be able to attract and retain personnel and capable of maintaining good standards of performance in an overall difficult HRH context. It was carried out within the chapter on *Human resources of the BVO Health Care for All.*

The health sector reforms in Ghana allowed a widening of the formal and actual decision space of hospital managers, which have been exploited successfully at Cape Coast regional Hospital. However, many other factors apart from the organisational structure of the health system and the decision spaces at each level influence the behaviour of health care managers or hospital directors. Evidently, the mere existence of a clearly defined and well-respected decision space in se does not guarantee good management practices nor innovative ideas and practices to be applied. The existing margins of freedom need to be exploited skilfully, requiring, first, a minimum of management capability and, second, appropriate processes to be put in place (leadership, management style, etc). At C3RH, the excellent management capacity allows an appropriate management approach to be put in place that seems to contribute to the overall performance of the hospital.

In a sense, the findings of our study are nothing new. At C3RH, the management team (to some extent unconsciously) applies a style and approach that empowers its staff members and allows them to function in a relative autonomously fashion that is well suited to their profession. Enabling information to flow relatively openly, delegation of decision-making to lower intra-hospital levels and a supportive leadership are thus not only a logic answer to the complex organisational structure in which professionals plat a key role, but leads also to empowerment of staff. While we have insufficient evidence to say that this finally leads to better staff performance and a higher retention capacity, the perception of the staff of being empowered and of organisational trust clearly emerged from the interviews. Given the complexity of the forces that define the inflows and outflows of the health workforce on national and even international level, this does not seem to contribute to fill acute gaps in the hospital's workforce. Interventions on the organisational level inherently have a limited impact in the complex domain of human resources for health.

What can be learned from this case? The true question seems to be how to ensure a delegating management practice that pursues the organisational objectives while respecting the minimum of professional autonomy that is required by the professional cadres in bureaucratically organised health systems. The latter are not the settings the most favourable at promoting an open access to information and participative decision-making. At the Cape Coast Hospital, the management team seems not only succeeding at an optimal balance between autonomy for the medical and nursing cadres and the pursuit of the hospital's objectives, but by the same mechanisms also to ensure inspiring trust in its leadership. In other words, within the hospital's bureaucratic general organisation, the health professionals are given room for developing a true professional practice. Our hypothesis is that the conditions for this to happen are favourable in Ghana: at Cape Coast, the degree of professionalism and of public service ethos is sufficiently strong to allow a kind of self-regulation by health professionals.

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