CHAPTER ONE

1.0 Introduction.

Decentralization is based on the idea that, smaller organizations properly structured and steered are inherently more agile and accountable than larger organizations. Max Weber, the turn-of-the-twentieth-century German sociologist who first brought the good attributes of bureaucratic model of management to light and concluded that "bureaucracy was inevitable to human institution still yearned for the fruit of decentralization". He asserted that, the only alternative to bureaucracy is to return to small scale organization" (Weber 1947). Given the strength of this, it is not amazing that national and regional policy makers in many countries across the globe have introduced decentralization strategies. In the restructuring process, institutions particularly the Health Sector now incorporate an extraordinary range and variety of decentralized operating and managerial arrangements, thus the creation of Budget Management Centres(BMC's).

1.1 Background to the study

Decentralization is the transfer of authority and responsibility for public functions from the central government to subordinate or quasi-independent governmental organizations. It is the gradual process of transferring power and resources from the central government to the lower levels of government such as regions, provinces, municipalities and Districts.

Collins and Green (1994), Mills (1994), argues that Decentralization means different characteristics to different writers. Most writers relate the characteristics of decentralization to that of Privatization to be the same. For instance, Collins and Green, (1994) contended that, decentralization encompasses the transfer of authority, functions and resources from the centre to the periphery and privatization involves transfer from public sector to the private sector.

Wasem, (1997) also confirms what Collins and Green asserted above. According to Wasem, several health sector reforms which have been branded 'decentralization' should not have been applicable. For example, the shift of acute services from Hospitals to Home

Care has been termed decentralization. It must be clear that since this reform is devoid of shift in the structure of power or authority, it may not have been appropriate to use the term 'decentralization'.

The health sector in Ghana is decentralized from the Ministry of Health (MOH), to its agencies which are the service organizations and the regulatory bodies to ensure adequate health care at the grass root.

This decentralization was as a result of the Health Sector Reform. This reform was explained as the "sustained purposeful change to improve the efficiency, equity and effectiveness of the health sector". The reform involved numerous fundamental changes in which services were financed, organized and delivered. The three key elements of the reform were fiscal reform, the introduction of market mechanisms and decentralization (Larbi, 1995).

Decentralization of the Health Care Delivery (D.H.C.D) has being embraced worldwide. Worldwide trend towards the health development agenda does not consider top-down approach rather concentrate on community involvement and motivation. This has empowered local governments and local populations to request for adequate resources and decision making power to chart their own development agenda.

Many countries have realized that centralization of the planning and allocation of resources lead to limited flow of resources to the peripheral levels with most of the resources being consumed. Government(s) aims at decentralizing to improve upon public-sector/local government administration and Performance, thus becoming less bureaucratic organizational management.

Perhaps government also realized that centrally administered programs do not always provide for effective programs delivery at the local level, as they do not take into account local needs and characteristics.

1.2 Problem statement

Since the 1980's both developing and developed countries have been embarking on public sector management reforms. The reforms developed earlier in developing countries which were aimed at shaping a public administration that could lead to national development was inherited from the colonial rule.

In Ghana, the Health Sector Reforms popularly known as the Medium Term Health Strategy of 1995 aimed at improving access to basic services, quality of care and efficiency as well as strengthening links with other sectors. One of the major components of the Health Sector Reforms was decentralization. Various institutions have implemented decentralization in one form or the other through devolution, delegation etc. Komfo Anokye Teaching hospital implemented decentralization in the form of Directorates system. Here Directorates have Management Teams which see to the daily administration of the Directorates. The Management Teams have authority to take decisions, prepare and manage their approved budget and expenditure as well as staffing requirements through their Program of Works (PoW).

Collins and Green(1994) put forward that, "the level of implementation of Health Care Decentralization in an institution depends on a number of indicators such as; the right of Directorates to generate their own income, the authority of Directorates to allocate resources, the authority to set targets and see to achieving them, the number and type of decisions taken by the Directorates, the degree of independence of Directorates from the Chief Executive Officer (CEO) as self managed Directorates, the number of hierarchical levels in the organogram, the degree of delegations etc".

Aas(1997) also asserted that, "decentralization in hospitals does not only involve decisions on daily production matters but also budgeting, goal achievement, efficient use of resources, compliance with laws, implementation of quality assurance programmes, departmental planning, administration of personnel, purchase of resources up to certain cost level and contracting with internal and external providers of services"

The indicators above outlined by both Collins and Green (1994) and Aas(1997) will be used to assess the existence and level of decentralization of Health Care Delivery at KATH.

KATH implemented decentralization of Health Care Delivery in the form of Directorates which were decentralized five (5) years ago. There has not being much research to establish the existence of these indicators above. Even though KATH is one of the autonomous Hospitals in Ghana and the Directorates system well implemented and functioning, the level of the implementation of decentralization of health care delivery is still unknown.

One would ask, what does decentralization in the Health Care Delivery at KATH entails? How was decentralization implemented in KATH? What benefits/challenges have been derived from Decentralization of Health Care Delivery? This research was therefore to ascertain the level of implementation of Health Care Decentralization at KATH.

1.3 Rationale for the study

Health Care Delivery is about giving hope when people need it most. Just as the efficiency of the Health Sector is vital to individual, it is as well vital to society. The Health Sector helps people to lead their lives, underpins governance, the economy and all social structures. There is no more important public service in Ghana than Health. You only have to go to a hospital to be reminded of its urgency and capacity to change lives. The achievement of a successful Health Care delivery system can be attributed to the extent of decentralization in the health sector which brings Health Care to the door steps of the masses.

KATH as a teaching hospital impacts knowledge in various fields to its medical students and other Health Care Professionals. Researching into decentralization in the Health sector will be a source of information for both the trainers and trainees. The research work will also be used as a basis for further research work as it may give the level, strengths and weaknesses of decentralization as practised by the management of KATH. It will give Management the opportunity to reflect on some issues that may crop up in the research. Not all trainees will end up working at KATH, most of them will be found

working at other parts of the country and the preparation of this document will be beneficial to them. This document will also discuss the policy implication of decentralization at KATH as regards to the operations of the Directorates.

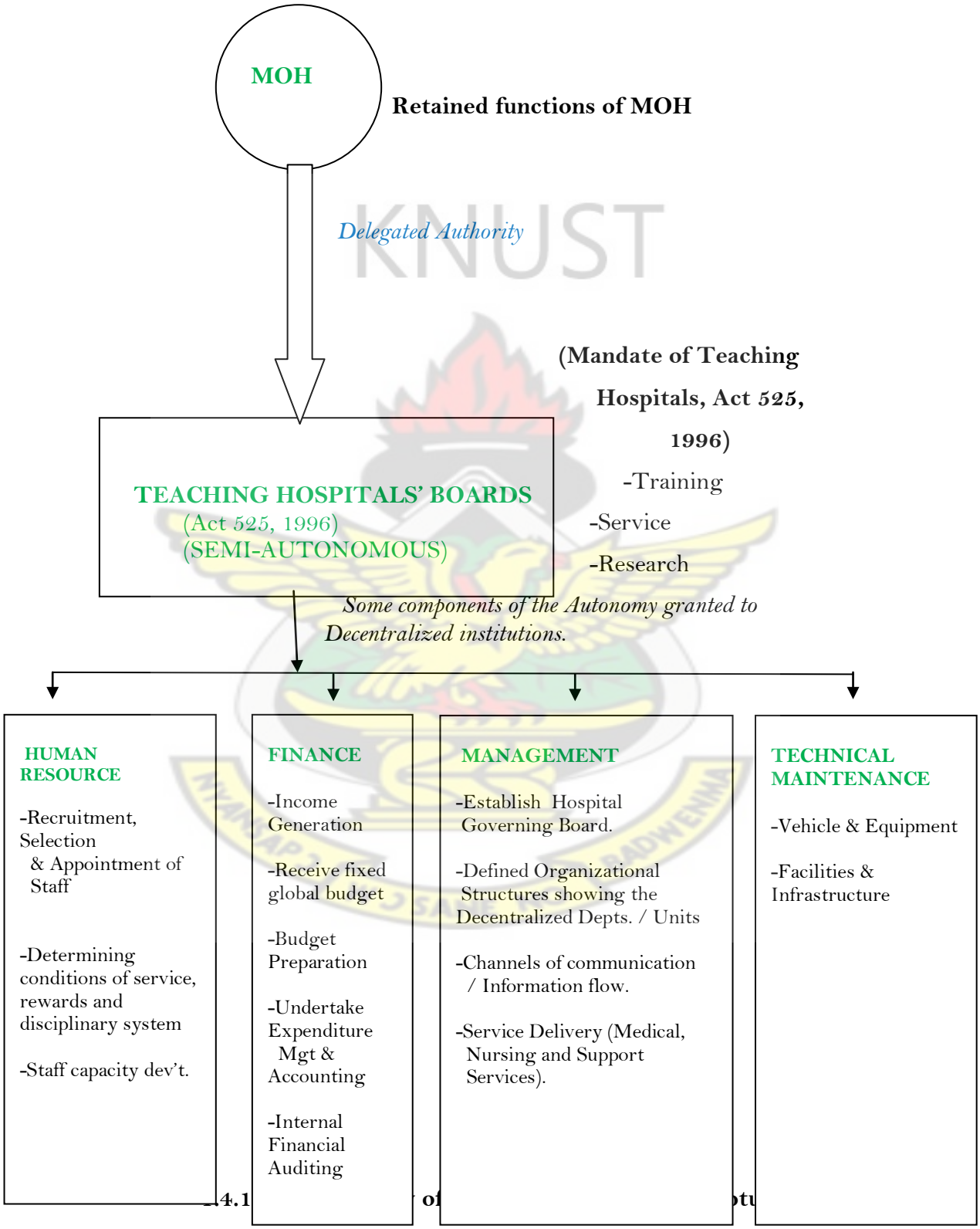
In conclusion, numerous studies have reported both positive and negative effects of decentralization of Health Care delivery. Among the positive impact of decentralization are; the capacity of Health Care decentralization to improve efficiency, a more patient-oriented system and enhanced cost-consciousness(Bergman 1998); stimulation of broader change regarding work organization and working time(Arrow Smith and Sisson 2002; and better implementation of Health Care strategies based on needs(Jervis and Plowden 2003).

Others also disagree with the scholars above, cited inequity to be the most frequent negative impact of Health Care Decentralization (Collins and Green 1994; Koivusalo 1999; Jommi and Fattore 2003). The outcome of this study will give an idea of how these assertions pertain to KATH.

1.4 Conceptual framework

There is decentralization in an institution, if the Directorates/Departments/Units have authority in the management of Human Resources, Finance and Service Organization as shown below.

Fig 1:



4.1 of tu

Framework

The components of the framework which was used in this study are reviewed below with the aim of providing a broader view of the components under the study and how they relate to the subject matter under consideration in this research.

1.4.2 Retained functions of MOH after delegation

The Ministry of Health has retained the responsibility for the stewardship of the entire Health Sector by ensuring equity and efficiency in the sector activities. It exercises this function by providing over all policy directions, institutional development, co-ordinating the activities of agencies, partners and stakeholders involved in health and ensuring performance and accountability within the sector. The MOH co-ordinate planning, resource development and the overall monitoring and evaluation of the Health Sector performance (MOH, POW 2008). The range of autonomy granted to the Semi-autonomous bodies cover; Governance, General Management, Financial Management and Human Resource Management.

As a regulatory mechanism, Semi-autonomous bodies are still subject to the following:
A// Continued to be owned by the public.
B// Operate within national policies & strategies.
C// Conduct and performance are subject to regulation.
D// Continue to receive Government funds.

1.4.3 Delegated Authority granted to the established Teaching Hospital Boards.

Teaching Hospitals Boards were established under the Hospitals Administration Law, 1988(P. N. D. C. L 209). This was strengthened by the GHS and Teaching Hospitals Act, Act 525 of 1996. Article 35/2 of this Act mandates the Hospital Boards to undertake the following;

- Determine the policy of Teaching Hospitals which shall be within the general policies of government on health.
- Ensure sound financial management of the hospitals fund

- Monitor and improve the quality of care at the Hospital.
- Assess periodically, the adequacy of the resources including personnel, physical facilities and finances of the hospital
- Ensure the implementation of the policies, plans and programmes by the appropriate Units at the Teaching Hospitals.
- Appoint staff and determine their remuneration and benefits.

According to Mcpake (1996), the autonomy granted by the MOH to the Hospital Boards include budgetary discretion, implementing cost recovery measures, setting pay scales and the right to hire and fire staff without prior Ministry approval.

In a confirmatory remarks, Weinberg, J.,(1993), asserted that, autonomy granted to the Hospital Boards include improving and monitoring the quality of care, appointing and evaluating the hospital staff, assess periodically the adequacy of the hospital resources, recommend fees levels, provide safeguards and be the trustees of the facilities and equipment of the hospital.

The hospital management reports to the Hospital Board and is supposed to run services within the financial limit set by the global budget and income generation (Cassels, A. 1992). The Hospital Board also report directly to the Minister of Finance and not even answerable to the Director General (MOH, 1991).

1.4.4 Mandate of Teaching Hospitals

According to GHS and Teaching Hospitals Act, Act 525 of 1996, the Teaching hospitals are mandated to undertake the following;

- Provide advanced clinical health service to support the health services.
- To serve as training ground for under graduates and post graduate training in the medical profession.
- To undertake research into health issues of people in the Country.

Based upon these mandates, Teaching Hospitals are granted some degree of autonomy, have discretion in exercising some managerial functions discussed below.

1.4.5 Some components of Autonomy granted to Autonomous Institutions.

The **delegation** of semi-autonomy to the Teaching Hospital Boards represent a change from direct to indirect form of management control. By this authority granted, semi autonomous Bodies have the right to undertake the following;

- **Human Resource:** In human resource management, semi- autonomous bodies determine their own staff establishment, recruiting, selection, appointment, determining conditions of service, rewards and institute disciplinary system (Collin and Green, 1999).

- **Financial Management:** In financial management, semi-autonomous organizations possess the right to formulate and submit its own budget to central government for approval, receive a fixed global budget, obtain grants and loans, raise its own income(through user fees, billing, health insurance) and be responsible for its own internal financial management. A decentralized organization may also be free to submit plans for capital development (Collins and Green 1999, Mcpake, 1996).

- **Management:** Under management, autonomous institutions have an established hospital governing Boards (ACT, 525, 1996). There is the defined organizational structure showing clearly the decentralized Units. Channels of communication as well as information flow are also highlighted. Management decisions in terms of internal policy formulation and implementation are highly decentralized. Again Service deliveries are patterned on the basis of Administration, Finance, Medical Services, Nursing Services and Support Services (Ramesh, 1996).

- **Procurement:** Semi-autonomous organizations run their own tendering processes to award contract for works, goods or consultancy. They also put up internal mechanism to manage logistic storage, inflows and outflows (Collins and Green, 1999).

1.4.6 How delegated authority relates to decentralization.

Decentralization is the spread of power from higher to lower levels in a hierarchy. Decentralization in hospitals may be accomplished through decentralization to departments, divisionalization and delegation of tasks. Delegation of authority is therefore one of the medium through which decentralization is enhanced.

However, for the purpose of this research work, the researcher aims at looking at the Human resource, Finance and Management of decentralized organizations with KATH as the case study.

1.5 Research Questions

1. How is Health Care Service organized at KATH?
2. What is the extent of decentralization of Health Care Delivery at KATH?
3. Has the Decentralization aided efficient and effective management of resources in the Health Care Delivery at KATH?
4. What are the barriers to decentralization of Health Care Delivery at KATH?
5. What recommendations can be made to improve the Decentralization of Health Care Delivery at KATH?

1.6 General Objectives

To assess the decentralization of Health Care Service Delivery at KATH.

1.7 Specific Objectives

1. To describe the Service Organization at KATH.
2. To assess Decentralization of Health Care Delivery at KATH.
3. To assess if the Decentralization of Health Care Delivery has resulted in efficient management of resources at KATH.
4. To identify the barriers to effective Decentralization of Health Care Delivery at KATH.
5. To make recommendations for improving upon the Decentralization of Health Care system at KATH.

1.8. Profile of study area

The city of Kumasi was founded in the 1680's by King Osei Tutu I to serve as the Capital of the Asante State (KMA Medium Term Plan 2006-2009). Given its strategic location and political dominance, Kumasi as a matter of course, developed into a major commercial centre with all major trade routes converging on it.

With time the city began to expand and grow thereby making it second only to Accra in terms of land area, population size, social life and economic activity. Its strategic location has also endowed it with the status of the principal transport terminal and has assured its pivotal role in the vast and profitable distribution of goods in the country and beyond.

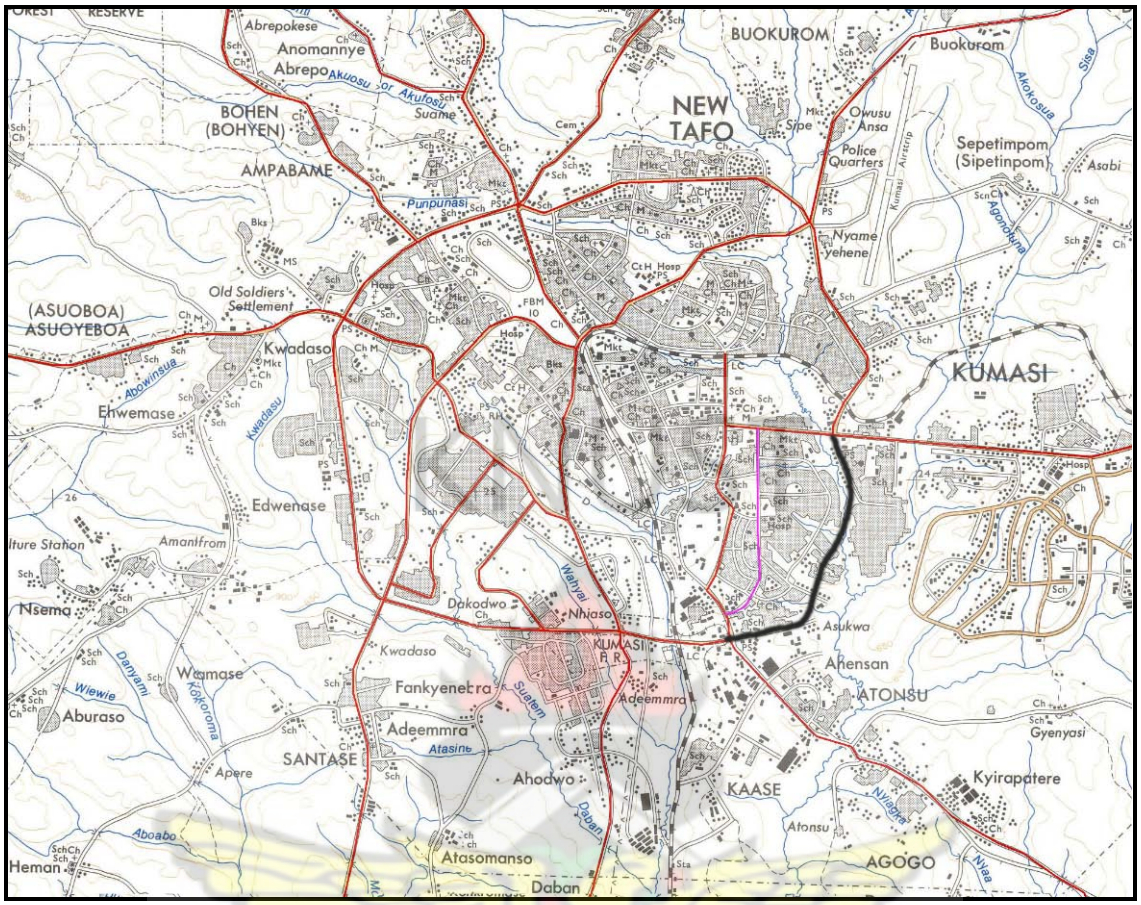
It's beautiful layout and greenery has accorded it the accolade of being the "Garden City of West Africa". From the three communities of Adum, Krobo and Bompata, it has grown in a concentric form to cover an area of approximately ten (10) kilometers in radius. The direction of growth was originally along the arterial roads due to the accessibility they offered resulting in a radial pattern of development. The city is a rapidly growing one with an annual growth rate of 5.47 per cent (KMA Medium Term Plan 2006-2009). It encompasses about 90 suburbs, many of which were absorbed into it as a result of the process of growth and physical expansion. The 2000 Population Census kept the population at 1,170,270. It was however projected to 1,610,867 in 2006 and has further been projected to be 1,889,934 by 2009.

1.8.1 Location and Size

Kumasi is located in the transitional forest zone and is about 270km north of the national capital, Accra. It is between latitude 6.35° – 6.40° and longitude 1.30° – 1.35°, an elevation which ranges between 250–300 metres above sea level with an area of about 254 square kilometres. The unique centrality of the city as a traversing point from all parts of the country makes it a special place for many to migrate to.

Map 1: Map showing some parts of Kumasi Metropolitan Area where KATH is

located.



1.8.2 Climate

The Metropolis falls within the wet sub-equatorial type. The average minimum temperature is about 21.5°c and a maximum average temperature of 30.7°c. The average humidity is about 84.16 per cent. The moderate temperature and humidity and the double maxima rainfall regime (214.3mm in June and 165.2mm in September) have a direct effect on population growth and the environment as it has precipitated the influx of people from every part of the country and beyond its frontiers to the metropolis.

1.8.3 Vegetation

The city falls within the moist semi-deciduous South-East Ecological Zone. Predominant species of trees found are Ceiba, Triplochlon, Celtis with Exotic Species. The rich soil has promoted agriculture in the periphery. A patch of vegetation reserve within the city has led to the development of the Kumasi Zoological Gardens, adjacent to the Ghana National Cultural Centre and opposite the Kejetia Lorry Terminal. This has served as a centre of

tourist attraction. In addition to its scenic beauty as a tourist centre its other objectives include education, preservation of wildlife, leisure and amusement. Apart from the zoological gardens, there are other patches of vegetation cover scattered over the peri-urban areas of the metropolis. However, the rapid spate of urbanization has caused the depletion of most of these nature reserves.

1.8.4 Relief and Drainage

The Kumasi Metropolis lies within the plateau of the South–West physical region which ranges from 250-300 metres above sea level. The topography is undulating. The city is traversed by major rivers and streams, which include the Subin, Wiwi, Sisai, Owabi, Aboabo, Nsuben among others. However, biotic activity in terms of estate development, encroachment and indiscriminate waste disposal practices have impacted negatively on the drainage system and have consequently brought these water bodies to the brink of extinction.

Agriculture in the metropolis has seen a dramatic change in the last two decades due to rapid urbanization. The demand for residential, industrial and commercial land uses has become much greater than that of agricultural land use. Following this, it has been estimated that about 80% of the arable lands have been displaced by the construction of houses and other physical infrastructure.

It has been estimated that the metropolis has 12,000 hectares of irrigable lands consisting of swampy and marshy areas (Metropolitan Agriculture Directorate). Agricultural land use in the metropolis has been consigned to crop farming in the peri-urban communities (eg. Takyiman, Parkoso, Apeadu, Kokoben etc) and along the banks and valleys of rivers/streams. Vegetables, both traditional and exotic, are more widely cultivated than traditional food crops. As it is the case, vegetable cultivation increases with greater urbanization of communities. The main locations for vegetable cultivation are Gyinyasi, KNUST, Manhyia, Georgia and Asokore Mampong.

1.8.5 Health

The Ghana Health Service provides Clinical and Public Health Services through hospitals and clinics and static and outreach stations (Public and Private). Kumasi Metro is endowed with many Hospitals, Clinics, Maternity Homes and Outreach Stations and therefore accessibility to services in terms of distance is good. There are 15 Private Laboratories in addition to the Laboratories in the various hospitals.

The table below shows the distribution of Health Facilities, Private Laboratory service and outreach stations in Kumasi.

Table 1: Health Institutions per Sub-Metro Health Areas

Sub-Metro	Gov't Hospital	Quasi Gov't Hospitals Clinics	Mission Hospitals Clinic	Private Hospital	Private Clinics	Mat. Home	Homeo-Pathic Clinic	Private Labs	Outreach Stations
Asokwa	1	1	1	14	22	18	3	1	47
Bantama	1	0	1	15	16	12	0	7	36
Manhyia North	1	0	1	5	10	16	13	2	41
Manhyia South	1	0	0	7	8	6	4	2	25
Subin	2	3	0	3	11	3	0	3	20
Total	6	4	3	44	67	55	20	15	169

1.9 Profile of KATH

Komfo Anokye Teaching Hospital (KATH) is located in Kumasi. The location of the 1000 bed KATH, the road network of the country and commercial nature of Kumasi make the hospital accessible to all the areas that share boundaries with Ashanti Region and others that are further away. History has it that, in the 1940's there were two hospitals located on the hill over-looking Batama Township designated African and European Hospitals. As their names implied, the African side treated Africans while the European side treated Europeans officials and their families. By 1952, the need to construct a new hospital to cater for the fast increasing population in Kumasi and therefore Ashanti-Region arose.

The European Hospital was therefore transferred to the Kwadaso military quarters to make way for new project. In 1954/55, a new hospital complex was completed and named the Kumasi Central Hospital. The name was later changed to the Komfo Anokye Teaching Hospital in honour memory of the Powerful and legendary fetish priest, Komfo Anokye. The hospital became a Teaching Hospital in 1975 for the training of Medical Students in collaboration with the School of Medical Sciences of Kwame Nkrumah University of Science and Technology (2006 KATH Report).

1.9.1 Vision of KATH

To become a medical centre of excellence offering clinical and non-clinical services of the highest quality standards comparable to any inter-culture standards, within 5 years.

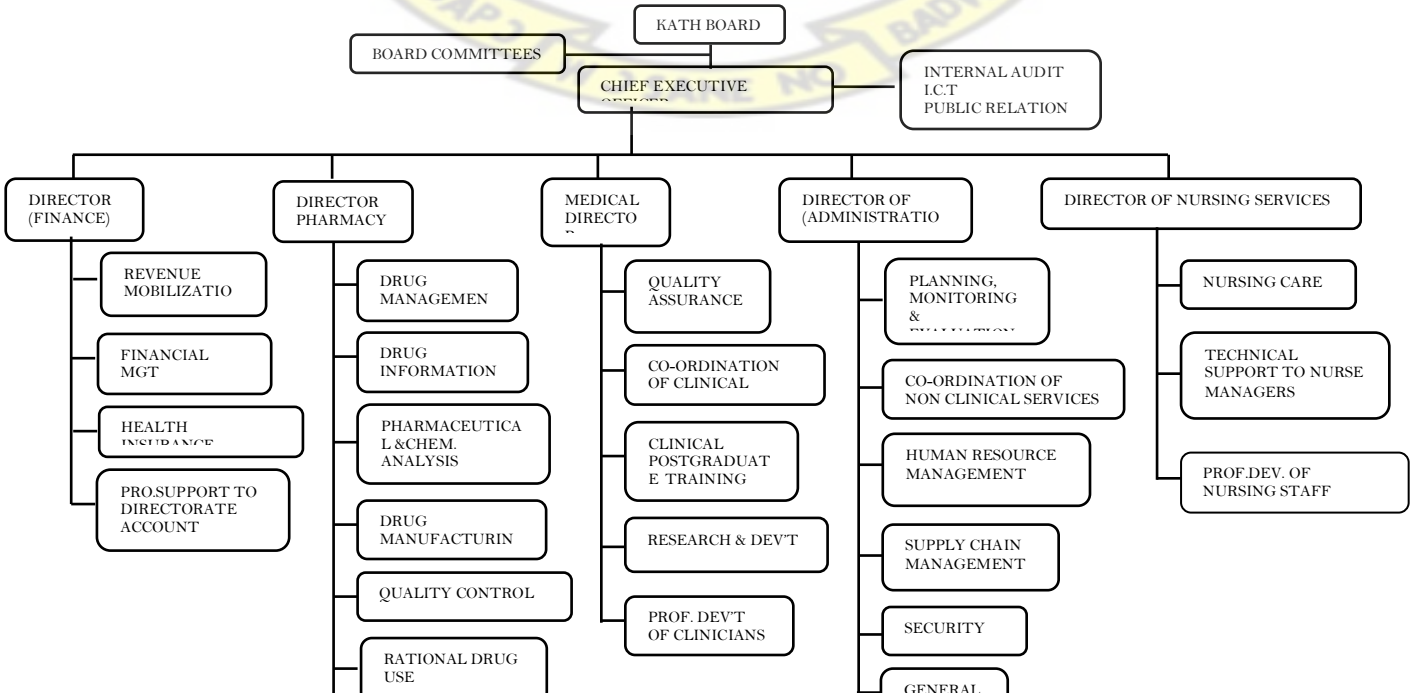
1.9.2 Mission of KATH

To provide quality services to meet the needs and expectations of all its clients. This will be achieved through well-motivated and committed staff applying best practice and innovation.

1.9.3 Decentralized structures at KATH

Principally, KATH has five (5) broad decentralized structures headed by Directors. A number of decentralized institutions are under each of the Directors as shown below:

Fig 2: Organogram of KATH



Source: 2006 Annual Performance Report of KATH.

1.9.4 Service Organization

The service organization of KATH is segregated along the pattern of diseases, sex, age etc. Based upon the above, there are 12 Directorates of which 10 are clinical and 2 are non clinical. The organograms of a typical clinical and non Clinical Directorates are shown below.

Fig 3: Organogram for Clinical Directorate at KATH

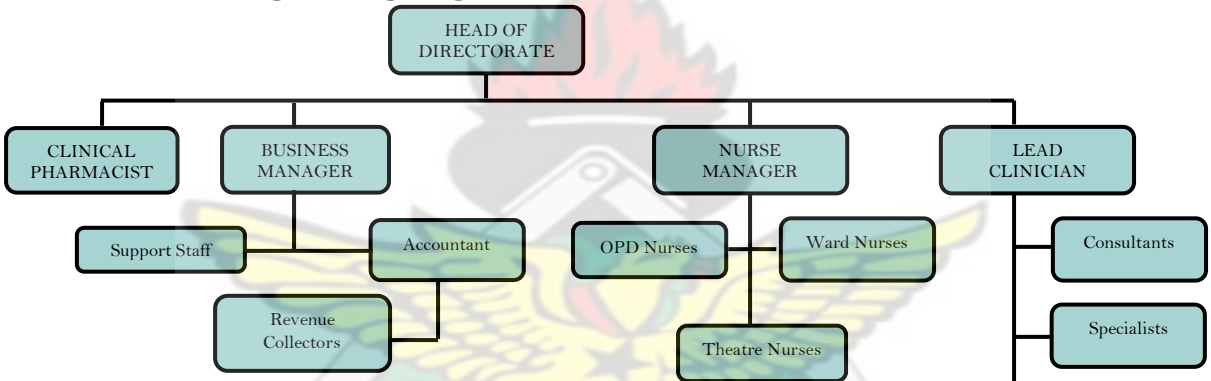
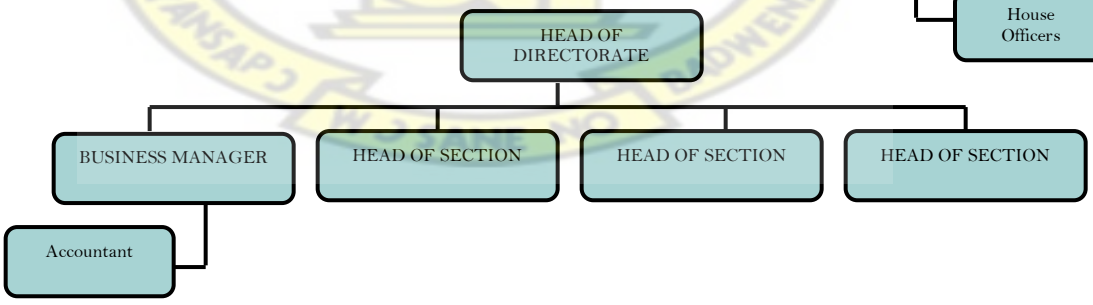


Fig 4: Organogram for Non Clinical Directorate at KATH



Source: KATH composite POW 2008 pg 6

1.10 Organization of Study.

The study is organized into six (6) chapters. Chapter 1 dealt with the Introduction, Problem Statement, and Rationale of study, Conceptual framework, Research questions, General objectives, Specific objectives and Profile of study area.

Chapter 2 contained literature review on decentralization in the areas of Finance, Human Resource and Service Organization (clinical and non clinical).

Chapter 3 dealt with study type and data collection tools and techniques, pre-testing, ethical consideration, confidentiality, study assumptions and research limitations.

The fourth (4th) chapter considered results. The data were put into tables, bar charts and pie charts for easy pictorial and visual understanding etc.

Chapter 5 outlined the discussions of the analysis and major findings of the study whiles Chapter 6 came out with the conclusion of the study and the recommendations to Government, KATH Board, Central Administration and the Directorates.

CHAPTER TWO

2.0 LITERATURE REVIEW

2.1 Introduction

This chapter reviews the relevant works that are published and unpublished on the subject understudy. The relevant literature under study was reviewed under these sub-headings: Service organization, Finance and Human resource.

2.1.1 Management structure of an organization

Nystrom and Starbuck (1981) have defined "structure as the arrangement and interrelationship of component parts and positions in an organization". The

Management structures are an institutional arrangements and mechanisms for mobilizing human, physical, financial and information resources at all levels of the system(Sachedava, 1990, Robbins,1989). The management structure of an organization is therefore the manner in which sub-units are arranged and inter-related. Structure is thus an integral component of the organization. It provides guidelines on; division of work into activities, linkage between different functions, hierarchy, authority structure, authority relationships, coordination with the environment etc. Management Structure in an organization has three components (Robbins, 1989):

- **Complexity,** referring to the degree to which activities within the organization are differentiated. This differentiation has three dimensions:

  - *Horizontal* differentiation refers to the degree of differentiation between Units based on the orientation of members, the nature of tasks they perform and their education and training,

  -*Vertical* differentiation is characterized by the number of hierarchical levels in the organization.

  -*Spatial* differentiation is the degree to which the location of the organization's offices, facilities and personnel are geographically distributed.

- **Formalization** refers to the extent to which jobs within the organization are specialized. The degree of formalization can vary widely between and within organizations.
- **Centralization** refers to the degree to which decision making is concentrated at one point in the organization.

2.1.2. The Organogram of an organization.

According to Leavitt(1962), an "organization is a particular pattern of structure, people, task and technique". Katz et al.(1978) also defined Organization as "a system

which is composed of a set of sub-systems". The organogram is used to show people the intended structure of an organization. Organogram reflects on the power structure of the organization. The organogram is typically in the shape of a pyramid. It shows the person in charge at the top. Below then are the clustered subordinates, usually in progressive smaller order. The organogram is therefore a chart depicting the complete structure of an organisation, or division of an organisation, or a campaign body, including all its committees. It also demonstrates how the various sections of the organisation relate to one another.

2.1.3 Financial Management in an organization

Financial management mean efficient use of economic resources namely capital funds. It is therefore the management of finances of a business in order to achieve financial objectives. Financial management is concerned with the managerial decisions that result in the acquisition and financing of short term and long term credits for the firm (Ramesh, 2007). Two main aspect of financial management are procurement of funds and an effective use of funds to achieve business objectives. Funds can be procured from different sources with different characteristics in terms of potential risk, cost and control.

Sound financial management is essential in all types of organization whether it be profit or non-profit. Financial management is essential in planned economy as well as in a capitalist set up as it involves efficient use of the resources. From time to time, it has been observed that many firms have been liquidated, not because their technologies were obsolete or because their products were not in demand or their labour was not skilled and motivated, but that, there was mismanagement of financial affairs. It is therefore prudent that a sound financial management is cultivated among bureaucrats, administrators, engineers', educationist and the public at large. The main objectives of financial management in any organization are:

- Creation of wealth for the organization.
- Generation of cash.
- Provide a return on investment keeping in mind the risks that the organization is taking and the resources invested.

According to (Ramesh, 2007), the primary elements to the process of decision-making regarding Financial management are; Financial Planning, Financial Control and Financial Investment etc.. Many alternative methods exist for implementing financial management systems and the organization should choose methods appropriate for its particulars scale of operations.

2.1.4 Auditing (internal control standards)

Organizations must provide safeguard for all properties whether cash or other assets and ensure that it's used solely for authorised purposes. Control will be enhanced if the duties of the members of the organization are divided so that, no person handles all aspect of a transaction from beginning to end. Although a complete separation of functions may not be feasible for the organization, some measure of effective control may be abandoned by planning the assignment of duties carefully. (Financial management guide for Non-Profit organization, 2008).

Many of the most effective technique for providing effective financial management are as follows:

- Cash receipt should be recorded immediately and deposited daily.
- Bank account should be reconciled monthly by someone other than the person who signs the cheque.
- A petty cash fund should be entrusted to a single custodian and used for all payments other than those made by cheques.
- Cheque vendors should be issued only in payment of approved invoices and the supporting document should then be cancelled.
- The person who is responsible for the physical custody of an asset should not also have responsibility for keeping the records related to that asset.
- The person who has authority for placing employees on the payroll and establishing wage rate should not be the same person who signs the cheques.

2.2 Operational definition of Decentralization

According to Bossert et tal (2000), "the appropriate mix of central and local management depends upon political, technical and institutional factors, and the real-world cases of this mix are not easily untangled, specify or categorize in neat typologies."

Hospitals are the largest and most complex of health care organizations. In such organizations, responsibility of task needs to be distributed between different levels termed decentralization. Numerous writers have said so much about decentralization over the years. One writer (Bossert et al 2000) asserts that Decentralization deals with the allocation between center and periphery of power, authority and responsibility for political, economic, fiscal and administrative systems. Aas(1997) indicated that, Decentralization is the spread of power from higher to lower levels in a hierarchy.

2.2.1 Objectives of Decentralization.

Decentralization is pursued for technical, political and financial reasons. On the technical side, it is recommended as a means to improve administrative and service delivery effectiveness. Politically, decentralization usually seeks to increase local participation and autonomy, redistribute power and reduce ethnic and regional tensions. On the financial side, decentralization is used as a means of increasing cost efficiency, giving local units greater control over resources and revenues as well as sharpening accountability. In the health sector, where decentralization has been pursued for technical reasons, it has been a major component of performance improvement efforts (Bossert et al, 2000).

2.2.2 Forms of Decentralization

The major standard forms of decentralization are devolution, deconcentration, delegation and privatization (Collins and Green, 1994).

Devolution: This is where the transfer of power from the centre is to constitute regional and local government with their legally recognized autonomy in area of responsibility, resources and decision-making. This means under devolution, hospitals come under the authority of different levels of government although some form of technical and funding relationship may be established with the MOH.

Deconcentration: This is where the centre maintains managerial authority over the periphery/local area while allowing a transfer of decision-making in stipulated areas. This means in deconcentration, the hospital come under the authority of the Ministerial officers at the regional and district level.

Delegation: This represents a change from direct to indirect forms of managerial control. Here, the managerial autonomy is widened but tempered by the requirements and limits of the Central control and regulations. The hospital as a delegated institution within the organizational scope of the Ministry have responsibilities in a number of key areas such as human resource management, financial management, running of tendering processes etc.

Privatization: On the other hand, privatization involves transfer of resources and decision-making from public sector to the private sector.

2.2.3 Determinants of the nature and extent of Autonomy granted to an institution.

The nature and extend of autonomy would depend on the degree to which the government continues to retain control over the various functions of the hospital, particularly important functions such as health policy formulation, the allocation of certain resources(capital funds), control over quality and licensing, regulation of health personnel(selection, recruitment, training, salaries and wages, discipline and discharges), regulation of user fees, allocation of surplus, financial accounts and Book keeping.

2.2.4 Decentralization and Institutional development.

In the health sector, decentralization takes the form of delegation of authority to a number of autonomous agencies and to semi-autonomous Budget Management Centers' (BMC's). In 1996, the Ghana Health Service and Teaching Hospitals Acts gave autonomy to the Ghana Health Service and Teaching Hospitals. The aim of decentralization is to ensure equity, efficiency, quality and financial soundness (MOH 2007 POW).

Decentralization system combines centralized and decentralized components often in complex ways. For instance in Zambia, the Ministry of Health delegated operational authority to a Central Board of Health (CBOH) while retaining policy and regulatory authority for itself. Operational responsibility is further deconcentrated in regional Hospital Boards that can make decisions independently of the CBOH. (Bossert et al, 2000).

The Health Sector in Ghana has decentralized authority to the Service Organizations (Ghana Health Service and Teaching Hospitals) and the Regulatory Bodies (eg Food and Drug Board, Pharmacy Council, Narcotic Control Board etc). Each of these is a Budget Management Center (BMC). It could therefore be noticed that, the GHS and Teaching Hospital are vested with more central authority than the Zambian CBOH. In the same action above, in Philippines, a wide range of policy implementation was devolved to local government authorities whiles the Medical Care Commission manages a National Medical Program and the Department of Health maintains national Public health policy functions.

2.2.5 Levels of the decentralization relating to Hospital Autonomy.

The Government of Ghana (GOG) official document, Medium Term Health Strategy: Towards vision 2020 (Sept. 1995), states that "Teaching Hospitals will be managed as self-governing institutions". The objective is to ensure that managers have the autonomy to allocate resources as efficiently as possible and, at the same time, to ensure that hospital authorities are held accountable for performance of their institutions and the way resources are used (Ramesh et al, 1996).

Autonomy is "the quality or state of being self-governing, especially, the right or power of self-government" and "capable of existing independently" (Ramesh et al, 1996). However, using such "absolute" criteria to define hospital autonomy might, in practice, leave us with a "null set", as no hospital(s) in developing countries, particularly in the public sector, is completely self-governing or is totally independent; at least they are all subject to regulatory constraints in one form or the other. In other words, in practice, hospital autonomy may have to be defined in relative terms. Thus, for example, the term autonomous hospitals are used in the literature to refer to hospitals that are "at least partially self-governing, self-directing, and self-financing" (Ramesh et al, 1996).

The level of decentralization relating to hospital autonomy can be put into two dimensions: the extent of centralization of decision-making (extent of autonomy) and the range of policy and management decisions that are relevant to the hospital, including internal policy formulation and implementation. This means that, an autonomous hospital can exist under Government ownership and private ownership. It is the extent of decentralized decision-making that occurs within the hospital and the extent to which such decision-making is feasible for each of the management functions that are relevant considerations.

In Ghana, decision-making goes through various levels which come together to ensure efficient health sector. Policies and directives move from the National level through the Regional and District levels to the local Community levels.

Resources allocated for the Health Care delivery flow through various levels both national and local governmental bodies before getting to the health facilities. There is legal and institutional frameworks to ensure monitoring, auditing and accounting mechanism to ensure that the intended used of the resource are adhered to.

2.3 Finance

Financial responsibility is important component of decentralization. In many countries, local government or administrative units have the legal authority to impose taxes. However, the tax base is so weak and the dependence on central government subsidies so meager and released untimely.

2.3.1 Objectives of the financial reforms

The objectives of financial reforms were to respond to problems of inefficiency in management procedures which brought up budgets mismanagement and lack of responsiveness to the health needs of local communities. Again, there was the need to ensure equity in resource allocation. The financial reforms therefore aimed to improve allocation efficiency, equity, ensure sustainable financial system as well as appropriate financial information to enhance decision making at all levels in the health system (Bossert et al 2000).

2.3.2 Operational and procedural documentations of the financial reforms

A sector wide strategy expressed in two separate documents; Medium Term Health Strategy (MTHS) and 5year POW(1997-2001) formed the basis of the investments and actions by the MOH. Based on this, a third document; 'Common Arrangement for the implementation of the Medium Term Programme(1997-2001) was developed in December 1996 where planning and budgeting, disbursement, financial control including accounting and auditing, procurement and performance monitoring and evaluation have been categorically spelt out. The three documents have been launched and the signing of Memorandum of understanding (MOU) between the MOH and partners and that marked the beginning of the health fund, the procurement process, joint reviews and meetings (Addai E. et al 2001)

2.3.3 Decentralization and Finance

Financial decentralization can be defined as the division of budget and expenditure among the various levels of government institutions (Saltman and Bankauskeite, 2006). There are a number of controversies in the economic realm about the most effective and efficient way to finance governmental institutions. The most recommended approach is for local bodies to raise fund internally for their own Operations. Collins and Green (1994 pg 14) quoted Oate's Theorem (1972) as contending that, "it will always be more efficient for local government to provide a good within its jurisdictions than for central government

to provide that good across several local authorities". The motive of this is to ensure accountability and local participation. Issues of financial decentralization in Health Care Delivery borders on preparation of budget and expenditure behaviors of health institutions. The introduction of new budget management system designed to maintain financial control throughout government is one of the most important elements of financial decentralization. These incorporate financial planning and control system (International Labour Organization, 1998).

In trying to improve the performance of the health sector and hence efficient Health Care Delivery, Ghana's decentralization policy has had much on the Manpower of health care in terms of how to increase the health services of a particular nature such as Doctors and other paramedical staffs. In several countries, including Zambia, a separate health service agency has been set up to operate as a semi-autonomous government agency, which employs staffs directly. The decentralization of budget management has being reflected in the decentralization of services provision to semi-autonomous hospitals, because the hospitals often consume the largest part of the Health Sector Budget (International Labour Organization 1998).

2.3.4 Sources of Funds to the Health Sector

Financing the health sector in Ghana has undergone a substantial transition as a result of the 5year POW and the Common Management Arrangement. This relate to the amount of resources channeled to the sector and the mechanisms by which funds are given to support the sector as well as how resources are allocated. The funding sources of the operations of the Health sector are Government of Ghana(GoG), Donor Fund and Internally Generated Fund(IGF)

The GoG covers Personnel Emoluments (item 1), Administration (item 2), Service (item 3) and Investment (item 4). The Donor Funds are donations given by the Bilateral and Multilateral institutions to the sector. The Internally Generated Fund covers (Insurance holders and corporate prepayment).

In the health sector, new forms of financing for the health care delivery may involve moving from tax based system to an insurance system due to the establishment of the National Health Insurance Scheme (NHIS). This has brought about new forms of budget management and control between insurance funds and health service providers as well as new systems of payments collection.

2.3.5 The Management of Health Care Funds

The 1995 Medium Term Health Strategy (MTHS) and the subsequent Sector Wide Approach (SWAp) introduced a lot of improvement in the District health financial management system. The financial management reform that followed SWAp shifted management responsibilities to the District level and granted greater control over funds to local Managers. District Health Administrations (DHAs) in the country have, since 1999, been receiving and directly managing funds for non-salary recurrent expenditure under the BMC concept (Asante et al 2006 pp3).

According to Addae et tal (2001), in Ghana, the health policy environment was been characterized in the early 1980's by financial decentralization management development, strengthening of district health system and integrated approach to health delivery. The financing of the Ghana Health Service is tied to the Medium Term Health Strategy and the 5year Programme of Work (5YPoW) and the Common Arrangement for the implementation of the Medium Term Programme (1997-2001) released in December 1996. Sources of funding are based on a combination of health funds, GOG and internally generated funds (IGF) (Addae et al 2001).

The management of Health Care Delivery has continuously been going through experimental approaches all in an attempt to find suitable way of providing the best of care at least cost. The economic and various experiments eventually gave rise to the promulgation of the Ghana Health Service and Teaching Hospitals Act of 1996(Act 525). The Act gave Tertiary Health Services an adequate level of institutional autonomy as Budget and Management Centres. To ensure adequate efficiency, Sub-BMC was created within the tertiary institutions in 1998.

2.4 Human Resource.

Human resource in health care can be defined as the clinical and non clinical staff in charge of public and individual health intervention. The human resources are therefore the stock of all individuals engaged in the promotion, protection or improvement of the health of the population (POW 2007). The most important of the health system inputs, the performance that can be recorded depend largely on the knowledge, skills and motivation of those individuals responsible for delivering health services. The human resource function contributes to making strategic choices about the health care that are essential for developing a national health sector. The (1990) World Health Organization Study group on coordinated health and human resource development emphasized that "human resource have no meaning in isolation but are an instrument for delivering necessary health care"

Decentralization of the health system combined with the Civil Service reform is increasingly prevalent component of the health sector reform. It is however, regrettable that, the implications of decentralization for human resource development in the health sector are mostly neglected. The human resource are the most important component of the health care system in converting available pharmaceutical, medical technology and preventive health information into better health for a nation (Kolehmainen 1998)

Human resource training of health workers take a long time and involve a lot of financial resources. In Ghana, salaries and benefits consume up to three-quarters of the recurrent health budget (POW, 2008). Due to this, human resource issues should command a great deal of attention in any decentralization discussion. The implication of Decentralization for human resources for Health Care Delivery are greatly influenced by numerous factors; the extent of which political/and administrative power is transferred, how the new roles are defined, what skills are available at the local level and what administrative linkages exist between the different management levels and between the Ministry of Health. Human resource and decentralization are closely linked. The ideas of decentralization mostly arise outside the health sector. Local needs are the main issues in many countries that decentralized substantial control over health service to local government. The most important human resource issues that come up as a result of transfer of power to lower management level are; the adequacy of available information on human resources, the complexity of transferring staff, the impact of professional associations, unions and

registration bodies as well as the morale and motivation of health workers(Kolehmainen, 1998).

2.4.1 Adequacy of information as a Pre-requisite for successful Human Resource Decentralization.

Adequacy of information is pre-requisite of successful decentralization. Decisions on human resources will be sound only if they are based on appropriate and timely information (WHO, 1990 Technical Report Series 802). For decentralization to be effective there should be easy access to reliable information. The flow of information is so crucial that, higher level management policy directives to lower level management should be received timely and undistributed whiles feedbacks are also sent to the higher level management in the same way. Basic personnel data should be available at both local and national level for easy co-ordination. It is however regrettable that, in Ghana, and elsewhere, salary data are not reliable, records of staff's position and the individual holding those positions are not clear and out of date(Kolehmainen, 1998). Data on training intakes and output are often incomplete and inaccurate since they come from multiple sources with different schedules of updating and quality control. Reilly(1991), observation of the situation in Papua New Guinea at the time of decentralization was that: "It was not possible to construct complete organizational structures for each health division of every province because of poor records kept at the Department of Health. The section of the Department which dealt with staffing did not know what positions were available in provinces or who filled them. A similar problem was found with duty statement which were out of date and not specific to the tasks to be performed"

2.4.2 The Complications of Human Resource transfer.

The decentralization of human resource to the local level is far more complicated. By transferring human resource to the local level, a lot of activities such as the following will have to be done. These are creating new organizational structures and specifying the linkages, revising job descriptions and reporting relationships, defining new processes for personnel management, deciding how to re-allocate existing staff to new organizational structures, transforming and transferring personnel records and staff etc. (kolehmainen, 1998)

Decentralization therefore calls for major changes in the health care structures and in the jobs that staffs perform. Positions at both national and local require transformation to conform to the new division of power and resources. Existing Organizations may need to be redesigned, revised job descriptions and reporting channels as well as terms and conditions of service. Again, the personnel management process after decentralization must proceed in tendon with the design of organizational structures, salary scales, position levels, recruitment, selection, appointment, performance assessment, staff disciplines etc. will have to be undertaken with some guiding principles from the National level.

2.4.3 The influence of professional associations, union and registration bodies.

Health staff Associations, unions and registration bodies are very powerful force in the design and implementation of decentralized management structures and jobs. According to Kolehmainen (1998), "the issue of labour relations is very much at the forefront in South Africa, where the disparity in conditions of employment between local government, staff and employees of provincial Health Department is a critical issue facing the government in its efforts to institute a unified District based health system that provides care in an equitable manner to all South Africans"

2.4.4 The morale and motivation of Health Staff.

Motivation and morale of health workers are very crucial for the success of decentralization as new structures, roles and responsibilities are defined and staff transfers implemented. A successful decentralization requires that, the new organizational

structures, roles and responsibilities be clearly defined, form a functional whole and be acceptable to the health staff. Kolehmainen(1998), revealed that, a review of decentralization in ten(10) Countries demonstrated that, this area is one of the most problematic for human resources. In the first place, there is unclear definition of organizational structures, roles and responsibilities. Again, roles and responsibilities may conflict with each other. Moreover, the organizational structures and allocation of roles and responsibilities may be disputed.

Much attention has been directed towards the financial and structural reforms to the neglect of the Human resource implications by the implementers of Health Care Decentralization. These reforms and allocation of roles and responsibilities has a relation with the health workforce and its management. Quoting Kolehmainnen (2003), "Re-allocation of roles and responsibilities always affect the health workforce and the way it is managed irrespective of the extent to which health leaders are allowed to shape the decentralized structures and management system"

To improve the performance and productivity of health workers, there is the need to assess staff performance, supervision of employees and respond appropriately to identify performance gap. Managers have to provide the necessary motivation, resources and tools to enhanced high performance and productivity.

Developing countries lack high rate of job performance due to poor living wage for health workers, inadequate drugs, inadequate and poor equipment etc. This inefficiency is also as a result of some health programs being decentralized whiles others remain centralized. Again in most cases, the systems used to appraised staff performance are frequently outdated and poorly understood (Kolehmainen, 2000). Decentralization in the Health care delivery results in considerable new skills, needs and development of human resource initiatives.

In most developing Countries, most institutions do not have staff adequately trained in decentralized organizations to manage human resource affairs. The major duties of the Human resource are recruitment and deployment of staff, salaries administration, benefits and working conditions, staff development, human resource planning and management, legal protection of staff etc.

In Ghana, the Strengthening District Health Systems initiative (SDHS) aimed to improve the Management of decentralized levels. This prepared the platform for successful and stable Health Sector Reform. Human resource is very critical for any health system, but Ghana faces a critical shortage of this essential resource as a result of brain drain, weak management, inadequate production of health professionals and the right mix of skills to deliver Health Care (MOH, Human Resources Crisis, 2005).

2.5 Benefits of decentralization of Health Care Delivery.

Aas(1997), again states that, Decentralized Management reduces cost of Health Care Institutions. Going further, the same author put forward that, decentralization of health care delivery, improves job satisfaction, enhance effective information flow between departments and foster greater perception of work. Aas(1997) quoted Lawson(1991) that, "Decentralization of Health Services in Australia has resulted in improved orientation to priority needs, increased preventive care, better continuity of care and enhanced local interest in the Health Services".

Decentralization of Health Care Delivery make the lower level to learn from their experiences in decision making, their feedback to the Hospital top management may be valuable and the total competence of the Organization may be increased (Aas, 1997).

Bossert et al (2000) enumerated that, "decentralization increases health sector performance, increase service delivery effectiveness, improve efficiency of resource utilization, improve accountability, transparency and legitimacy as well as increasing equity of services by enabling marginalized and poor groups to access health care"

2.6 Limitation of Decentralization of Health Care Delivery

Nonetheless, several limitations may follow decentralization. Firstly, lack of organizational control and co-ordination of divisions. Mechanisms for co-ordination of a decentralized organization may be important. For instance, the formulation of common goals, planning, budgeting, promotion of a common culture, sharing of information, supervision and work standardization (Pascale, 1990).

Another limitation of decentralization of Health Care Delivery is that, competence may deteriorate due to isolation of Directorates.

Thirdly, while too much top control may reduce initiative and creativity, a decentralized organization's ability to release creativity may have limits. Innovations at higher cognitive levels and innovations requiring inputs from different kinds of expertise may require some centralization of intellectual capacity (Pascale, 1990).

Fourthly, the spread of power among several hands may lead to conflicts due to an unclear division of authority and the exercise of personal ambition. In this regard, defense of one's own territory by department heads may be seen.

Fifthly, with greater spread of power within decentralized organizations, the result may be that some Directorates/Units tend to pursue goals other than those of the organization overall.

CHAPTER THREE

3.0 METHODOLOGY

3.1. Study type

The research was a descriptive cross-sectional study involving KATH. Each Directorate has a Management Team which is responsible for all the operations of the Directorate concerned. Cross-sectional study was chosen since it is very cheap, fast and easy to analyze.

3.2. Data collection techniques/tools

The data collection technique was through structured questionnaire administration. The inclusions were Directors, Heads of Directorates, Heads of Units, Business Managers, Nurse Managers and Accountants. All Personnel either than those listed above were excluded. The questionnaire was structured in the same way to ensure that all respondents answer the same questions. It involved both open and close ended questions.

Again secondary sources of data in decentralization of health care delivery both published and unpublished as well as the internet were also used to supplement the field information.

3.3. Sampling size and techniques

A purposive sampling technique was used to select a sample size of sixty-five (65) Subjects. (5) Subjects were selected from each of the 12 Directorates/Units and extra 5 from any other area. Out of this, 60 Questionnaires were retrieved with five (5) questionnaires lost to follow. The Questionnaire recovery was therefore 92.3%.

3.4. Pre-testing

Pre-testing is used to identify potential problems in the proposed study. The Questionnaires were pre-tested at KATH. The original plan of pre-testing at KNUST and Suntreso Hospitals failed as the Subjects in both Hospitals rejected, claiming that the structures in their hospital were entirely different from that of KATH. The way out was to pre-test it at KATH and exclude those subjects who were involved in the pre-testing during the main questionnaire administration.

3.5. Ethical consideration

Ethical Clearance was sought from the Ethical Committee of KATH. After the approval from the Ethical Committee of KATH, Subjects were approached one on one in their Offices and the purposes of the research were explained to them. Those who agreed to be subject were given consent forms to sign and date. Questionnaires were given to them to be answered and dates of collection of answered Questionnaires were fixed. Again, citations were made in document where information was sought.

3.6 Confidentiality

Subjects were assured of confidentiality of information given. Only the research team had access to the information. All interview response sheets were put under lock in a box. Questionnaires were coded in such a way that no identities of Subjects were revealed.

3.7 Data Management and Analysis

The researcher employed biostatisticians to help reviewed answers and developed codes based on the responses. All the data collected was then entered into an excel spreadsheet. All data were post-coded prior to data entry into excel. Twenty percent of the entered questionnaire were randomly selected and were compared to the hardcopy questionnaire to check for data entry errors. The data entry errors were found to be minimal and were corrected. The certified data was analyzed using SPSS version 16.

3.8 Study assumption

It was assumed that all participants would answer their questionnaires on time and give complete and truthful information.

3.9 Limitations of study

- Retrieving Questionnaires from subjects was a major problem due to time constraint and volume of work administrators and other paramedical staffs have to battle with in office. However, through considerable efforts made, 60 out of the 65 questionnaires were retrieved.

- Again, the time period of three months in which the researcher had to complete the research was very short considering the volume of work to be done. However, through sleepness nights the research work was completed within the scheduled time.

- Moreover, financial constraint by the researcher also affected the quick administration of the research work. Time lost was compensated by the point raised above.

- Also, some of the questions were very strict and sensitive such that some responses could have been biased from fear of intimidation from top management. Respondents were assured of confidentiality of responses.

Despite these limitations, the quality of the research were not compromised as the researcher made all efforts and brought the effects of these limitations to the barest minimum.

CHAPTER FOUR

4.0 RESULTS

4.1 Introduction

The results of the study are presented in this chapter. It is shown in tables, graphs and organized based on the objectives of the study. A narrative summarizing the presentation is given as per the objectives of the study.

Out of the 60 respondents, 57 gave information on years of services of which 66% had served for at least 5 years and the rest, 34% above five years. The mean years of services in KATH were 5.14$\pm$ 3.83, and a modal age of 5. The minimum age of service was 1 year and the maximum, 17 years. All the respondents were in management positions made up of Directors, Heads of Directorates, Heads of Units, Business Managers, Accountants and Nurse Managers.

4.2 Service Organization

4.2.1 Management Structure of KATH

The management structure of KATH is in the form of two tier system. The first tier is made up of the governance of the Hospital. This is the Hospital Board, CEO, the Directors and the government appointed persons. The second tier is the operational level. This comprises of the Directorate/Unit Management Teams which are accountable to the Hospital top Management through their Heads of Directorates and Heads of Units.

The hospital is organized into ten (10) clinical and two (2) non clinical Directorates headed by Directorate Heads. Authority is decentralized from the Hospital top Management to the Units at the operational levels.

4.2.2 Respondents impression about current Organogram of KATH

About 70% of the respondents were impressed about the current organogram of KATH. This was because; the organogram eliminates a lot of bureaucracies and makes the operational levels efficient. The organogram eliminates role conflict as it shows clear demarcation of functions. The 30% of respondents who were not impressed about the current organogram based their arguments on the following:

- There should be separation of Internal Audit from the supervision of the entity spending officer.
- The organogram only shows chain of functions and does not show the chain of command.
- The organogram does not show positions or status but the functional units.
- The organogram does not show the span of control at KATH. The span of control by definition is the number of subordinates a supervisor/Director can control directly.

4.2.3 The relation between the Hospital top Management and the Directorates/Units Management Teams at KATH.

Structurally, there exists a vertical relationship between the Hospital top Management and Directorate Management Teams. In terms of Decision-making, the Hospital top Management takes strategic decisions. These are long term goals and are decentralized to the Directorates to undertake the operational and tactical decisions through their POW's for administration of the Directorates. The Directorates Management Team therefore take directives and approval for intended decisions to be implemented from the Hospital top Management through their Heads of Directorates.

4.2.4 The management of Suppliers at KATH

4.2.4.1 External Supplier

The logistics of KATH are received from outside suppliers, central medical stores (CMS), donations. Inspection Teams consisting of the Store Officer, Internal Auditor and representative from the Directorate/Unit where the items are going check the quantity against order and sign way bill and invoices. The Auditor checks product against specification. The Store Officer checks the expiring date, packaging, quantity and compare with the sample and writing of Store Receipt Advice (SRA).

4.2.4.2 Internal Supplier

Internally, logistics/suppliers are also sourced from an internal supplier (eg Pharmacy manufacturing unit).A representative from the beneficiary Directorate checks the quantity of the items. They also check the quality against the sample. This is done by visual inspection or by laboratory analysis. The logistics depending on its nature are stored on racks, shelves, in refrigerators, in containers, air condition rooms (drugs) etc.

In controlling of stocks, maximum, re-order and minimum levels are set and based on these, the stores submit indent to the Procurement Unit which indicates economic order quantity (EOQ) on time to avoid stock outs.

Distribution of stocks items are withdrawn or issued to the user Directorate based on properly written and endorsed requisition. The requisition must be signed by the in-

charge of the Unit, endorsed by the Stores Superintendent and as well signed by the Stores Officer.

Material handling at KATH is mainly manual. However, the store has two pallets which are used in handling stocks items. When it becomes necessary, the Unit hire forklift from commercial/private organizations.

Clerical administration of stores operations are done in stores ledgers, tally cards, issue vouchers and receipt note books. The main methods of stock valuations used are market/current prices and Last in First out (LIFO). Stock taking methods are perpetual and annual stock taking which is mandatory comprising a team from Accounts and Internal Audit.

4.2.4.3 Directorates level

At the Directorate level, management of suppliers takes the form of capturing their logistical needs in their budgets. When this is approved, the Supply Chain Management Unit (SCMU) purchase and store them with regards to stocked item such as gauze, plasters, medicine, infusions etc. In terms of non stocked item such as investment items (computers, equipment etc.) the SCMU purchase them when the need arises. The Directorates request for the logistics as and when the need arises by writing to either Chief Executive or Director of Administration(DOA) for approval. When it is approved, the store superintendent authorizes the release of the items while the stores officer issue out the items.

4.2.5 Financial Management at KATH

Financial Management at KATH involves five (5) major areas which are:

- Cash Management
- Inventory Management
- Management of Account receivable(Debtors)
- Management of Account payable(Creditors)

- Other areas include Budgeting, Training and Education as well as documentation.

The cash management deals with how inflows and outflows of cash are managed. The cash inflows are connected with cash revenue to the Hospital in the form of sale of drugs, rendering services to patients' such as surgical services, sale of tender documents, sale of car stickers etc. All monies connected with the sale of activities to the public are registered here.

The management of inflow of cash is very important because improper management of it will make the Organization to be cash strapped. The management of cash to the Manager is of utmost importance as cash is said to be the life blood of all organizations as cash is used to procure resources, maintenance of equipments etc.

In the management of cash at KATH, the following measures are put in place:

Step 1: All revenue collection points and revenue leaking points have been identified. Appropriate and Competent personnel have been assigned to each point.

Step 2: There is frequent rotation of Revenue Officers from one collection point to the other.

Step 3: Again, there is organization of seminars and training to update the knowledge and skills of Revenue Collectors.

Step 4: There is also segregation of duties involving checks and balances such as: collection of cash, sending cash to Bank, recording of the pay in slip in cash book.

The management of cash outflows takes the form of Authorization and Approval. All expenditures or payments have to be authorized and approved. All payments exceeding 25 Ghana Cedis have to be approved by the Director of Administration or the CEO.

The second means of managing the cash outflows at KATH is the Existence of Internal Audit Unit. The Audit Unit pre-audits all expenses before they are paid. All expenditures must be captured and documented for further checks.

The third means of Cash management is the Account Renewable. This deals with those organizations who do not allow their staff to pay their hospital bills by themselves. Here the organization concerned pays the accumulated bills within time periods such as quarterly, yearly etc.

4.2.6 The implementation of decentralization at KATH

Decentralization was implemented at KATH based on Directorates system along the pattern of age, sex, diseases etc.

4.2.7 Opinions and perceptions of the effect of decentralization on Service Organization

Table 2: Decentralization and Bureaucracy

In your opinion, has the Directorate system Decentralized the Hospital to reduce bureaucracy? If YES/NO, *Please assign reason(s) for your response*.		
Response	*Frequency*	*%*
(YES) Decentralization has reduced bureaucracy	46	76.7
(NO) Decentralization has not reduced bureaucracy	13	21.7
Cannot tell	1	1.6
Total	60	100%

All the 60 respondents indicated that the decentralization system in KATH was organized based on the Directorate/Unit system. In their opinion, (76.7%) said the decentralization in the hospital had reduced bureaucracy. (21.7%) came out that, the decentralization system at KATH has actually not been able to reduce bureaucracy at the Hospital. However, about (1.6%) could not tell whether bureaucracy has reduced or not.

4.2.8(A) Reason(s) for Decentralization reducing Bureaucracy at KATH

The 76.7% respondents admitting decentralization reducing bureaucracy argues that, some decisions are taken and implemented at the operational levels. The Directorates prepare their own Budgets, POW, Procurement plans etc. When these are approved by the Hospital top Management, the Directorates implement them.

4.2.8(B) Reason(s) for Decentralization not Reducing Bureaucracy at KATH

Others as seen above, don't admit that decentralization has reduced bureaucracy due to the fact that, some critical functions are still centralized and has to go through some bureaucratic process (eg logistics, human resource, procurement etc)

Table: 3 Decentralization and Decision–making at KATH

In your opinion, do you perceive you have delegated authority in decision-making? If YES/NO, please give reasons.		
Response	*Frequency*	*%*
(YES) Decentralization has resulted in high delegated authority in decision making at KATH	39	65.0
(NO) Decentralization has not resulted in high delegated authority in decision making KATH.	20	33.0
Cannot tell	1	1.7
TOTAL	60	100

About (65%) of the respondents perceived that, the implementation of the decentralization process at KATH had given them delegated authority for decision-making in matters concerning their Directorates. The Directorate Management Team hold monthly meeting to take decisions, they implement their Budget etc. One-third (33.0%) also indicated the contrary, citing the seeking of approval for some major decisions especially with respect to funds. However, about 1.7% could not make their judgment.

Table 4: Decentralization and Performance of staff

In your opinion, has Decentralization of Health Care Delivery enhanced staff performance? ***Please give reason(s)***		
Response	*Frequency*	*%*
(YES) Decentralization has enhanced staff performance.	53	88.3

(NO) Decentralization has not enhanced staff performance.	7	11.7
Cannot tell	-	-
TOTAL	60	100

From the respondents above, it could be seen that about 53 out of the 60 respondents confirmed that, staff performance at KATH has been enhanced by the decentralization of health care delivery. This is because appraisal of staff takes place at the Directorates, some decisions are taken quickly at the Directorates and Management Teams relate closely to their staff. Again about 11.7% of the respondents however do not see any enhancement in the performances of staff as the Directorates still has to seek approval on some issues which needed prompt attention.

Table 5: Decentralization and Authority to undertake investment project in the Directorates at KATH.

Do you have the authority to undertake any investment project in your Directorate? If YES how do you do so? If No why?		
Response	***Frequency***	***%***
(YES) Decentralization has given authority to undertake investment projects in the Directorates	13	21.7
(NO) Decentralization has not given authority to undertake investment projects in the Directorates	46	76.7
Cannot tell	1	1.6
TOTAL	60	100

About 76.7% said they had no authority to undertake investment activity at the Directorate. However, about 21.7% of the respondents admitted that, they have the authority to undertake investment projects whiles (1.6%) could not tell as detailed in the table above.

4.2.9 How the Directorates/Units undertake their investment Projects

Flowing from the table 5 above, the 21.7% of respondents who admitted having the authority to undertake investment projects stated that, Investment projects are put in the

POW of the Directorates and captured in their Budgets. When they are approved by top management, Procurement Unit is tasked to act on the purchases and other contract processes and finally contract documents are signed between the Hospital top Management and the contractor for execution of task. By initiating the action and defending it for approval gives them that authority. The 76.7% stated that once investment projects are centrally executed by the Hospital top Management it limits their authority.

4.2.10 Contribution of Directorates/Units to Recruitment of staff

The Directorates undertake Human Resource Planning. They as well budget for the Human resource. Based upon the above, the Directorates identify staff needs and submit requisition for recruitment. Upon approval by the Hospital top Management, the Human Resource Unit makes the selection and the Directorate is represented at the interview.

Table 6: Decentralization and effective channels of communication at KATH.

Do you perceive effective channels of communication among Directorates as well as central management? Please state reason.		
Response	***Frequency***	***%***
(YES). There are effective channels of communication at the Hospital.	51	85.0
(NO) There are effective no channels of communication at the Hospital.	9	15.0
Cannot tell	-	-
TOTAL	60	100

Communication plays very vital role in the set up of all organizations. It is therefore one of the life wires for the growth of all organizations. Flowing from above, it is remarkable to notice that, about (85.0%) of respondents clearly see that Decentralization of Health Care Delivery has brought about effective channels of communication among Directorates and between Directorates and Hospital top Management. There is constant inflow and outflow of memos among Directorates and between Directorates and Hospital top Management. All these information dissemination are registered for follow ups and references.

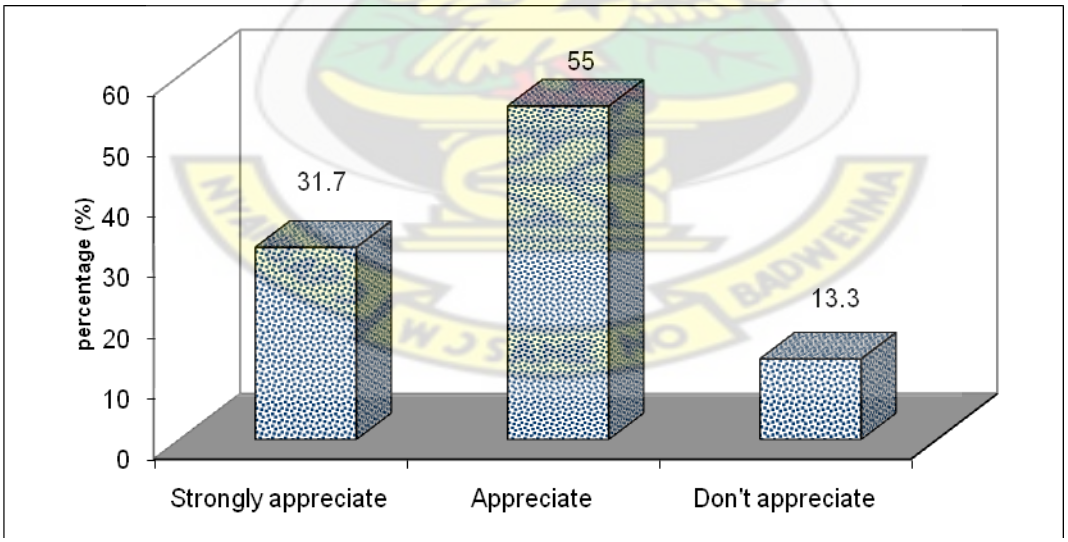
4.2.11 Appreciation of the level of implementation of Decentralization at KATH

Table 7: Appreciation of Decentralization at KATH

Do you appreciate the level of Decentralization of Health Care Delivery at KATH?		
Response	*Frequency*	*%*
(YES). I strongly appreciate Decentralization of Health Care Delivery at KATH.	19	31.7
(YES) I appreciate Decentralization of Health Care Delivery at KATH.	33	55.0
(NO) I don't appreciate Decentralization of Health Care delivery at KATH	8	13.3
(NO) I strongly don't appreciate Decentralization of Health Care Delivery at KATH	-	-
TOTAL	60	100

As shown above, 55% of the respondents appreciate the extent of decentralization at KATH, 31.7% strongly appreciate and 13.3% don't appreciate. This implies that, 86.7% at least appreciate the decentralization system at KATH. The above table is represented graphically on the figure below.

Figure 5: Level of appreciation of the level of decentralization at KATH



4.3 Decentralization and Human Resource Control at KATH.

Table 8: Decentralization and Authority to Hire and Fire staff at the Directorates.

Does the management of your Directorate/Unit have the Authority over hiring and firing of Staff? If YES/NO why?

Response	*Frequency*	*%*
(YES). The management of the Directorates/Units have the authority over Hiring and Firing of Staff.	24	40.0
(NO) The management of the Directorates/Units have no authority over Hiring and Firing of Staff.	35	58.3
Cannot tell	1	1.7
TOTAL	60	100

Over half (58.3%) of the Managers, indicated that in the management of human resources, the Directorates in the Hospital cannot hire and fire staff. Their arguments were that, the human resource need is based on top management approval. Aside, the Human Resource Unit is tasked with that responsibility. About 40% indicated otherwise that, based upon their recommendations, a person may be employed or deployed, the Directorates gives the requirements of the staff needed, the Directorates is represented during interview for recruitment etc. and that makes them to have that authority.

Table 9: Decentralization and resource allocation at KATH

Do the Directorates have control over resource allocation in the Directorates? If YES/NO please state reasons.		
Response	*Frequency*	*%*
(YES). The management of the Directorates/Units have control over resource allocation.	34	56.7
(NO) The management of the Directorates/Units have no control over resource allocation.	26	43.3
Cannot tell	-	-
TOTAL	60	100

As far as control of resources is concerned, 56.7% of the respondents said they had control over resources allocation in their Directorates. This is because, the Directorates prepares and implement their approved Budget. Again, the Directorates have the right to re-prioritize activities based on emergency and 43.3% asserted they do not have that control with approval seeking as the major reason.

Table 10: Decentralization and Authority to Discipline Staff.

Does the management of your Directorate/Unit have the Authority to

discipline their staff? If YES in what ways and if NO why?		
Response	*Frequency*	*%*
(YES). The management of the Directorates/Units have the Authority to discipline their staff.	50	83.3
(NO) The management of the Directorates/Units have no Authority to discipline their staff.	10	16.7
Cannot tell	-	-
TOTAL	60	100

Over eighty percent (83.3%) have the authority to discipline their staff at the Directorate level for various offences. Disciplinary measures include giving queries, summoning staff to appear before Directorate Management Team, reporting to Hospital top Management etc.

Table 11: Decentralization and Authority to undertake training activities (capacity Building)

Do the Directorates/Units have the authority to undertake training activities (Capacity Building) for their Staff?		
Response	*Frequency*	*%*
(YES). The management of the Directorates/Units have the Authority to undertake training activities (Capacity Building) for their Staff	55	91.7
(NO) The management of the Directorates/Units have no Authority to undertake training activities (Capacity Building) for their Staff.	5	8.3
Cannot tell	-	-
TOTAL	60	100

Offering training to staff is one of the motivational strategies in an organizational development. In relation to staff training provision at KATH, about 91.7% had authority to undertake staff training in their Directorates.

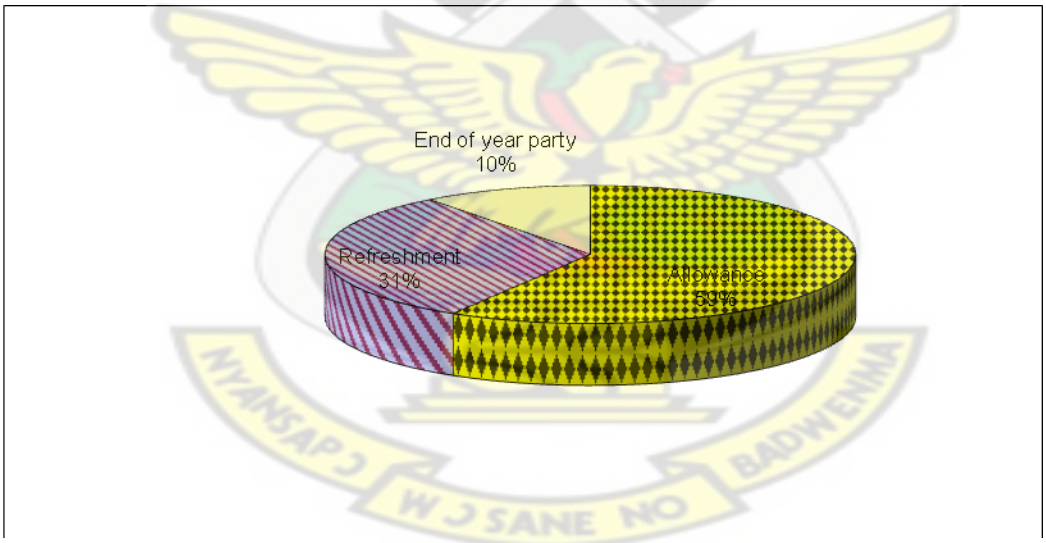
Table 12: Decentralization and motivation of staff

Are there incentives systems in place by the Directorates to motivate staff? If Yes, in what ways? If No why?		
Response	**Frequency**	**%**

(YES). There are incentive systems in place to motivate staff.	29	48.3
(NO) There are no incentive systems in place to motivate staff.	31	51.7
Cannot tell	-	-
TOTAL	60	100

About 51.7% of the respondents indicated that, there were no incentives systems in place to motivate staff at their Directorates. They contended that, the Hospital rather motivate staff by offering free transportation to the staff on some approved routes to some limited distances. However, about 48.3% of them admitted incentives systems are strongly in place to motivate their staff. Among the various incentives systems to motivate staff are shown below:

Figure 6: Forms of incentives at KATH



The forms of incentives identified were allowance as enumerated by (59%) of the respondents, refreshment (31%) and end of year party (10%) as pictorially presented above.

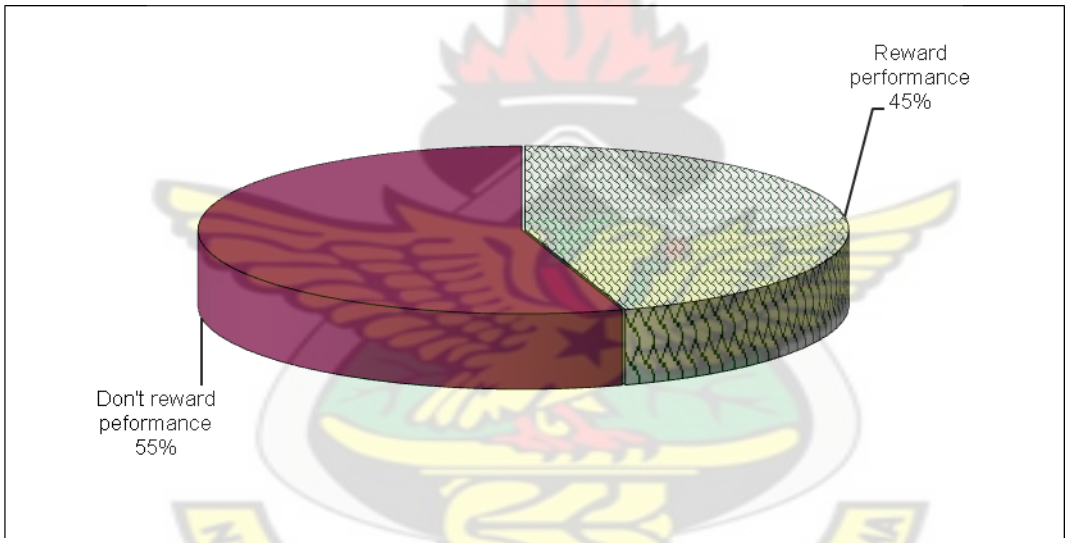
Table 13: Decentralization and rewarding exceptional performance of staff.

Is exceptional performance rewarded in the Hospital?

Response	*Frequency*	*%*
(YES). Exceptional performance of staff is rewarded.	27	45
(NO) Exceptional performance of staff is not rewarded.	33	55
Cannot tell	-	-
TOTAL	60	100

Rewarding exceptional performances of staff in the hospital is a great motivator. About (45%) of the Managers agree to the fact that, exceptional performances of staff are rewarded at KATH. On the contrary, (55%), of the respondents have never seen any exceptional performance of staff been rewarded at the Hospital. The above table is represented graphically overleaf.

Figure 7: Rewarding performance



4.4 Decentralization of Health Care Delivery and Finance

Financial decentralization aimed at ensuring smooth operations of organizations so as not to be cash trap. Cash flow is the major life wire of every organization. The natures of financial decentralization at KATH in relation to Directorates authority are given by respondents below:

Table 14: Decentralization and Directorates control over Budget and Expenditure.

Do Directorates have authority over Budget and Expenditure? Please

explain your answer.		
Response	***Frequency***	***%***
(YES). Directorates have authority over Budget and Expenditure at KATH?	44	73.3
(NO) Directorates have no authority over Budget and Expenditure at KATH?	16	26.7
Cannot tell	-	-
TOTAL	60	100

The (73%) of the Managers indicated that they had authority over budgeting and spending in their Directorates. This is because; it is the Directorate that prepares and implements their Budget. However, 16(26.7%) of them seem not to have authority over their Budget and Expenditure at the Directorates. The major reason given was that, all Budgets prepared are subject to top management approval.

Table 15: Decentralization and Directorates access to financial resources for day to day operations.

Do you have easy access to financial resources for day to day operations? If YES/NO please explain.		
Response	***Frequency***	***%***
(YES). Directorates have easy access to financial resources for day to day operations	43	71.7
(NO) Directorates do not have easy access to financial resources for day to day operations	17	28.3
Cannot tell	-	-
TOTAL	60	100

As high as (71.7%) of the respondents had easy access to financial resources to run the day to day operations of their Directorates due to the Decentralization of the Health Care Delivery. This is due to the fact that all Directorates have imprest which is recouped after exhaustion. On the contrary, 28.3% indicated otherwise with the reason being that, recouping goes through a lot of processes and financial spending are also given a ceiling.

Table 16: Decentralization and Auditing of Directorates Activities

Are there systems in place to Audit Directorates activities? **If YES in what ways?** **If NO why**?		
Response	***Frequency***	***%***

(YES). There are systems in place to audit Directorates activities at KATH.	60	100
(NO) There are no systems in place to audit Directorates activities at KATH.	-	-
Cannot tell	-	-
TOTAL	60	100

It is remarkable to hear that, there is (100%) systems in place in auditing of financial transactions of the Directorates at KATH as indicated above. All payments not exceeding 25 Ghana cedis are authorized by the Business Manager and all payments exceeding 25 Ghana cedis are authorized by either the DOA or the CEO. Again all payments are captured by the Audit Unit and all receipts are cross checked.

Table 17: Decentralization and Hospital top management financial control over Directorates.

Does the Hospital's top management exercise any financial control over Directorates?		
Response	***Frequency***	***%***
(YES) The Hospital's top Management exercise financial control over Directorates at KATH.	58	96.7
(NO) The Hospital's top Management does not exercise financial control over Directorates at KATH.	2	3.3
Cannot tell	-	-
TOTAL	60	100

(Over ninety percent (96.7%) claimed that top Management of the Hospital exercise financial control over the Directorate's financial activities. The nature of the controls is further stated below.

Table 18: How the Hospital top management exercises financial control over Directorates.

If yes, how do they exercise that control?		
Response	***Frequency***	***%***
Directorates Budgets are subject to approval	57	95
Directorates day to day financial transactions are subject to	3	5

approval by Hospital top Management		
Others	-	-
TOTAL	60	100

According to the respondents as seen above, top management exercising financial control over Directorates reflects in approval of Directorates Budgets submitted (95.0%) and approving of day-to-day spending exceeding 25 Ghana cedis(5%).

Table 19: Decentralization and Central Administration's ceiling on Directorate Budget.

Does the Central Administration place limitation on the Directorates Budget?		
Response	*Frequency*	*%*
(YES) The Central Administration places limitations over Directorates Budget at KATH.	58	96.7
(NO) The Central Administration do not place limitations over Directorates Budget at KATH	2	3.3
Cannot tell	-	-
TOTAL	60	100

Ninety six percent (96.7%) said that top Management limits Directorates' Budgets through the use of the annual ceiling. About 3.3% do not see any ceilings been imposed on the Budgets of the Directorates.

Table 20: Systems put in place to check financial misconduct Directorates at KATH.

Are there systems in place to check financial misconduct of Directorates? **If YES in what ways?** **If NO why?**		
Response	*Frequency*	*%*
(YES). Systems are in place to check financial misconduct of Directorates at KATH	60	100
(NO) Systems are not in place to check financial misconduct of Directorates at KATH	-	-
Cannot tell	-	-

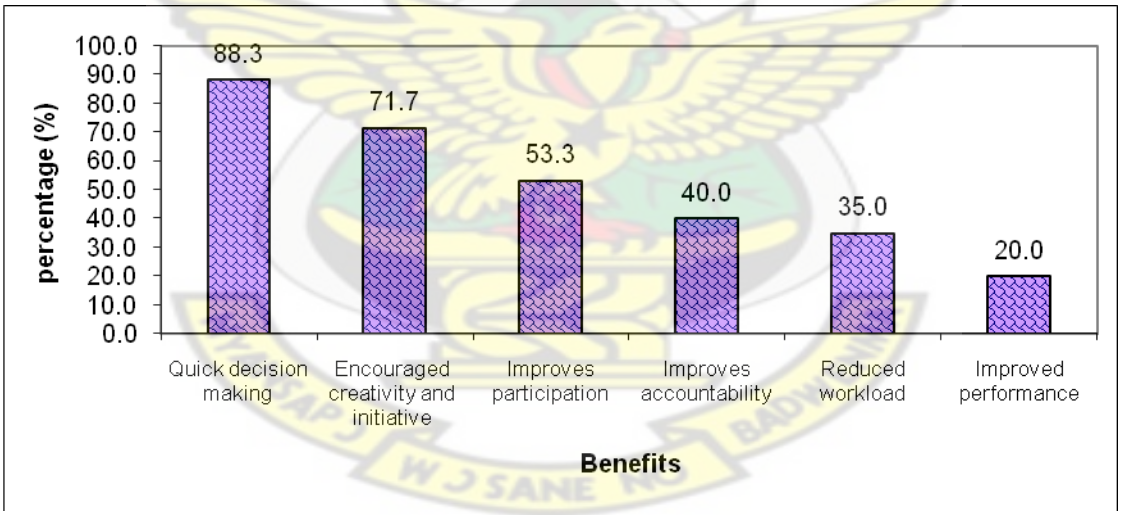
TOTAL	60	100

The entire respondents agreed that, the top management at KATH has put in place systems to check financial misconduct at the Directorates which are the sub-Budget Management Centers' (BMC's). These are the institutionalization of spending limits of Directorates, the activities of the Audit Unit and the strict adherence to only items captured in the Budget.

4.5 Benefits of the decentralization system at KATH

Decentralization of Health Care Delivery has been of great benefit to KATH. Among the benefits enumerated include quick decision- making, encouraging creativity and initiative, improving staff participation etc. as shown graphically below.

Figure 8: Percentage distribution of benefits of decentralization in KATH



4.6 Limitations of Decentralization of Health Care Delivery at KATH

The implementation Decentralization of Health Care Delivery at KATH has numerous set backs. The major limitations are stated below:

Table 21: Limitation of decentralization at KATH

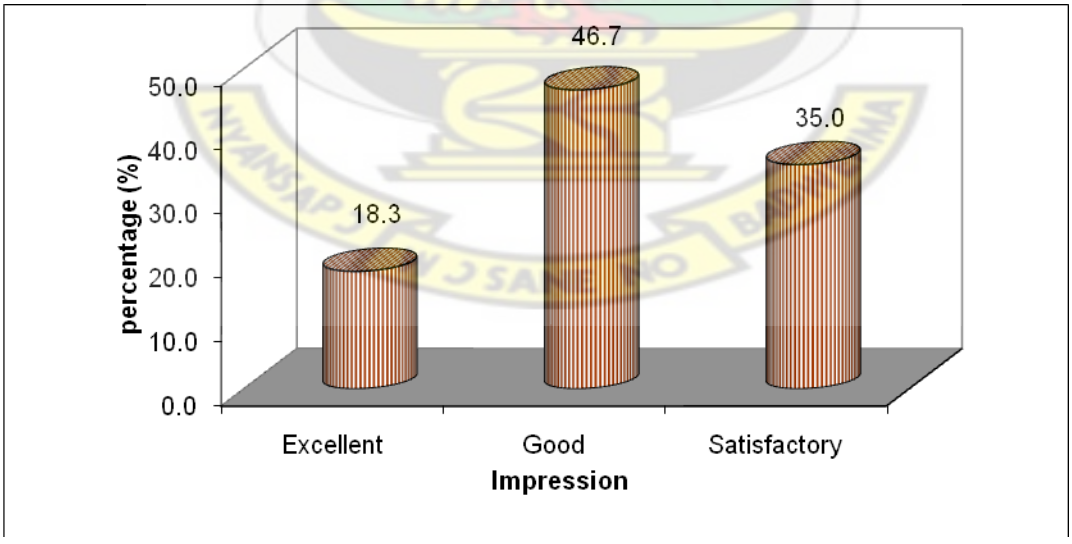
What are the major limitations of Decentralization of Health Care Delivery at KATH?		
Response	**Frequency**	**%**
Inequality in imprest to Directorates	10	16.6
Limited Authority at the Directorate level(Decision- making)	15	25.0
25 Ghana cedis spending limit at the Directorate too small	25	41.6
Disparities in allowances to Directorates	3	5.0
Poor information flow	7	11.6
TOTAL	60	100

The financial spending limit of 25 GH cedis (41.6%) and perceived limited authority at the Directorate level (25.0%) were the major problems identified to be associated with the decentralization system at KATH. Other problems were inequality in imprest disbursement to the Directorates (16.6%), Disparity in allowances (5.0%), and poor information flow (11.6%)

4.7 Impressions about the decentralization system at KATH.

Respondents commented on the decentralization system at KATH based on the categories of excellent, Good and Satisfactory as shown graphically below:

Figure 9: Impression about decentralization done at KATH



Over forty percent (46.7%) of the respondents had the impression that decentralization at the hospital was good, whiles others perceived it as excellent (18.3%) and (35.0%) of the respondents judging it to be satisfactory.

4.8 Level of Decentralization of Health Care Delivery at KATH

Table 22: Perceived level of implementation of decentralization of health Care delivery at KATH

How will you rate the implementation of Decentralization of Health Care Delivery at KATH?		
Response	*Frequency*	*%*
BELOW 50%	10	17
Between 51-69%	26	43
Over 70%	24	40
TOTAL	60	100

About 43% of respondents indicated that the level of decentralization at KATH was between 51- 69%, below 50% was represented by 17% of the respondents and 70% and above level was indicated by 40% of the respondents as shown above. In effect, about 83% of the respondents commented that Decentralization of Health Care Delivery has come of age at KATH with implementation level of above 51%.

CHAPTER FIVE

5.0 DISCUSSIONS AND MAJOR FINDINGS

5.1 Introduction

This chapter compares the data generated out of the questionnaire with the objectives and what the literature review outlined. The chapter tries to ascertain whether the objectives have been addressed depending upon the responses in chapter four (4).

5.2 Description of the Service Organization at KATH

5.2.1 The Management structure of KATH

The mean years of service at KATH are between 5.14 -+ 3.83. The implication is that, many of the respondents were in the service before the introduction of Decentralization of Health Care Delivery at KATH. This means that, based upon their experiences of the before decentralization and after decentralization at KATH, whatever responses they give is a true reflection of the nature of decentralization at KATH.

KATH has been decentralized into Directorates based on the pattern of sex, diseases, age etc. Strategic decisions are taken by the top management of KATH (Hospital Board, CEO and the five (5) Directors. Decentralization manifest at KATH where Directorates/Unit Management Teams are tasked to take operational and tactical decisions with the Heads of Departments and Units accountable to the top management. This vertical structure

ensures authority, responsibility and accountability of Directorates. The implications of this are as follows:

- That authority emanates from top to down in the form of directives, guidelines, request etc. Whiles the reverse is feedbacks for actions taken from bottom to top Management.
- The second implication is that, top level Managers and Directorates Management Teams are held accountable for the actions and inactions of their staff.
- The third implication is that, top level Managers at KATH delegate task to their subordinates and are ready to be held responsible for the outcome.

5.2.2 Impressions about current organogram of KATH

About 70% respondents accepted that, the current organogram of KATH was good based on it showing clear demarcation of functions. However the 30% who objected to this, made remarks of chain of command and span of control not so clear. The implication is that, there is the possibility of multiple issuance of command from different directions to a particular worker. This may result in conflict of reporting.

5.2.3 Financial Management at KATH

The motive of financial reform was to improve allocation efficiency, equity, ensure sustainable financial system as well as appropriate financial information at all levels in the health system (Bossert et al 2000). KATH aimed at applying this dictates by ensuring efficient cash management, effective inventory management and better management of Account receivable and payable. The checking of all revenue leaking points as well as the frequent rotation of revenue officers from one collection point to the other is laudable. The existence of the Internal Audit to pre-audit all financial transactions is also remarkable. The implication of all these is that revenue leaking has been minimized at KATH.

5.3 To assess Decentralization of Health Care Delivery at KATH

5.3.1 Decentralization and Bureaucracy at KATH

One of the expected results of decentralization is to reduce bureaucracy in an organization. The data generated revealed that, 76.7% of respondents affirmed that, decentralization has truly reduced bureaucracy at KATH. The implication is that top management will have ample time to take strategic decisions. Again, Directorate Management Teams frequency of consultations to the Hospital top Management have reduced a bit as they can now take decisions at the Directorate level. This does not mean decision making at the Directorates are unlimited. The Directorates will still have to go through some bureaucracies in areas such as logistics acquisition, recruitment, procurement etc.

5.3.2 Decentralization and Decision-making at KATH

Again, delegation plays a crucial role in Decentralization of Health Care Delivery (Collins and Green 1994). The analysis had an overwhelming 65.0% of delegated authority granted at the Directorates level. The implication of this is that, some decisions can be taken at the Directorate level. Among the numerous decisions that can be taken include execution of Directorate POW and approved Budget, re-prioritization of Directorate activities etc. However, the 33.0% who indicated contrary asserted that, final authority for a decision taken does not rest on them and thus cannot claim they have authority in all decision-making. The best they could do is to set up the frame work and solicit approval from top management more especially in financial transactions exceeding 25 Ghana cedis. The implication is that, delegation is not absolute as the central level still oversees affairs in all Directorates at KATH.

More so, with regards to Job performance, Aas(1997) asserted that, Health Care Decentralization enhances the performance of staff. About 88.3% of the respondents admitted that service performances of staff have improved as a result of the introduction of Health Care Decentralization. Some staff problems are addressed at the Directorate level, Directorates give in-service-training to their staff and the management teams are closely related to their staff thus ensuring effective supervision.

5.3.3 Decentralization and authority to undertake investment

Projects at KATH

About 76.7% of the respondents stated that investment projects are largely done by Hospital top Management. The Directorates only put their investment projects in their POW and budget for it and when approved, notify Central Administration when the time is due for implementation. The implication is that, investment projects are initiated by the Directorates at KATH, but actual execution with regards to contracting processes is the mandate of the Central Administration.

5.3.4 Decentralization and information Flow at KATH

The results showed that, information dissemination at KATH was good. About 85.0% of respondents admitted that vertical information dissemination (top-down and bottom-up) and as well functional (among Directorates and Units) was good. The implication is that, there is quick dissemination of directives and feedbacks at KATH. Decision making is enhanced at all level. There is efficient and effective inter-directorate interaction for smooth administration of the Hospital. According to (WHO 1990, Technical Report Series 802), information flow is of paramount importance to decentralization. It is therefore recommendable that KATH has excelled in information dissemination.

5.3.5 Appreciation of the level of implementation of Decentralization at KATH

With the objective of assessing Decentralization of Health Care Delivery, about 31.7% of the respondents admitted they strongly appreciate the level of implementation of Health Care Decentralization whiles 55% appreciate and 13.3% of respondents not appreciating due to various reasons. In effect, about 86.7% of the respondents appreciated the decentralized system at KATH. This implies that, based upon this, it could be conveniently said that, there is greater staff participation in all deliberations at KATH as one of the motives of decentralization.

5.3.6 Health Care Decentralization and Human Resource Control at KATH

Human resource is an important component of the Health Care Decentralization. In Ghana, salaries and benefits consumed by the human resource take about $^{3}/_{4}$ of the recurrent health budget. Due to this, human resource issues should command a great deal of attention in any decentralization discussions.

About 40.0% the respondents stated once they do human resource planning, the request for staff, give staff qualification requirement, represents the Directorates during recruitment interviews etc. they have the authority to recruit and deploy staff. Despite the fact that, the Directorates do their Human resource planning, prepare POW, budget etc, whatever is been done is subjected to Central Administration's approval. This has made about 58.3% of respondents to indicate that they don't have authority to recruit and deploy staff at the Directorates level. This implies that, the Directorates have some authority in recruitment of staff but not absolute. They further indicated that, to the best of their opinion, recruitment and deployment of staff is initiated by the Directorates and a centralized Unit
(Human Resource Unit) is tasked to undertake the process on behalf of the Directorates. The implication is that, it reduces cost to the hospital and ensures uniformity of recruitment processes as all the Directorates cannot be given a separate Human Resource Unit.

5.4. To find out if Decentralization of Health Care Delivery has resulted in efficient Management of Resources at KATH

5.4.1 Decentralization and resource allocation at KATH

Directorates Control over resources is another crucial aspect of decentralization of Health Care Delivery (Collins and Green 1994). About 56.7% of the respondents indicated that, the Directorates at KATH have control over resource allocation and distribution. This is better as in case of inadequacy of resources, the Directorates can re-prioritize resource allocation in terms of direction of flow and quantity granted.

5.4.2 Decentralization and Authority to discipline staff

Again, 83.3% of the Directorates have the authority to discipline their staff. Regularizing and monitoring the activities of the human work force is very important for the smooth operation of Health Care Decentralization (H.C.D). The implication here are that, the Directorates ensure the accountability of its staff in the performance of their duties. Employees undertake their duties in compliance to the status quo of KATH. Directorates ensure that staff identify themselves with the goals and objectives of KATH and comply by the organizational ethics and standard operating procedures (SOP).

5.4.3 Decentralization and Authority to undertake Training activities at the Directorates

Training programmes which serves as a constant development of the skills of the human resource is of utmost importance for the successful operationalization of Decentralization of Health Care Delivery. Despite the fact that the Directorates have no control over recruitment and deployment of staff, they have massive authority in developing their human resource through training (91.7%). Once the Directorates know their staff training needs and address them, the output of the Directorates are going to be high and more efficient as constant training upgrade the skills of the staff

.

5.4.4 Decentralization and motivation of staff at KATH

With respect to incentives and motivation, (Kolehmainen, 1998) revealed that, this area is one of the most problematic in Health Care Decentralization. About 51.7% of the respondents echoed that; the Directorates do not give incentives to their staff. Of the 48.3% that give incentives, allowances take the chunk of it (59%). Flowing from the above, 55% of the respondent said, the Directorates do not reward staff for exceptional performances. The implication is that work output may be below expected level due to lack of motivation of staff. Most staff will not have the commitment to make sacrifices for greater output and can easily be poached by other organizations.

5.4.5 Health Care Decentralization and Finance at KATH

5.4.5.1 Decentralization and Directorates control over Budget and Expenditure

By the dictates of the Ghana Health Services and Teaching Hospitals Act, Act 525, 1996, Autonomy was given for the establishment of BMC's. The aim of this directive was to enhance equity, efficiency, quality and financial soundness. KATH established the Sub-BMC's in the Directorates. About 73.3% of the respondents agree that, KATH has not defied this directive and that the Directorates have control over the preparation and implementation of their approved POW and Budget. This means that, the Directorates are both generators of revenue and expenditure execution provided it does not exceed the spending limit of 25 Ghana cedis. The implication of this is that, the Directorates can draw their own budget in line with their POW and in accordance to the Budget ceiling outlined by the Hospital top Management. Due to the issues discussed above, the Directorates have about 71.7% easy access to financial resources for day to day administration of the Directorates. The end result of this is that, there will be smooth implementation of the policies at the Directorate level.

5.4.5.2 Decentralization and Auditing activities at KATH

To ensure good financial use, all the Managers admitted there is 100% auditing of the activities of Directorates by the Hospital top Management. Revenue generated payments are audited and recorded. Authorizations are given for all payment exceeding 25 Ghana cedis. All receipts are cross checked. This means that, there is both financial soundness and accuracy in the revenue generation and expenditure at KATH. The Audit Unit pre-audits all financial transactions to ensure conformity to financial norms in the Hospital.

Again, the Hospital top Management exercise about 96.7% of financial control over the Directorates through approving Directorates Budget, approving day to day financial transactions exceeding 25 Ghana cedis etc. Flowing from above, it could be seen that, the top Management are very much concerned about the financial transactions of Directorates thus forestalling any financial misconduct. The respondents put forward that, the major means of exercising that financial control was by subjecting the Directorates budget to approval (95.0%) and that Directorates budgets are followed. There is also 100% systems put in place to check financial misconduct of the Directorates by the activities of the Internal Audit Unit.

5.4.5.3 The level of appreciation of Decentralization at KATH

To ascertain the level of appreciation of decentralization at KATH, 55% of respondents appreciate, 31.7% strongly appreciate and 18.3% came out clearly that, H.C.D is excellent. To further confirm the assertion above, another aspect of the questionnaire was used to reinforce. Here 46.7% of respondents advocated that H.C.D at KATH was good whiles 35% of them registered satisfactory. In effect about 81.7% of respondents have actually appreciated the level of Decentralization at KATH. This implies that Decentralization of Health Care Delivery at KATH has actually met the expectations of most of the staff.

The level of implementation of decentralization at KATH was peaked at 70% by 24 respondents (40%). 26 respondents (43%) said, H.C.D at KATH hovers between 51-69% whiles 10 respondents(17%) gave a thumb up for below 50% level of implementation. The implication is that, KATH has made a remarkable head way in decentralization of Health Care Delivery as seen above.

5.4.5.4 Benefits of Decentralization of Health Care Delivery at KATH

Numerous benefits of decentralization of Health Care Delivery were put forward by Bergman 1998, Arrow Smith and Sisson 2002, Jervis and Plowden 2003 as well as Aas, 1997. The benefits of Health Care Decentralization at KATH include quick decision making (88.3%). This goes to confirm that, there is a little bit reduction in work load at KATH.

Not all, about 71.7% pointed out that, H.C.D has encouraged creativity and initiative in Job performances whiles 53.3% has noted H.C.D. has resulted in improved participation of staff. Decisions are taken by the entire Management Team of the Directorates. Monthly Directorates meetings are held and outcome reported to the Hospital top Management. This means that there is consensus building at KATH.

Moreover, H.C.D improving accountability accounted for about 40%. This means that, delegating authority for the performance of task does not mean shedding responsibility

for performed task by the superior officer to the subordinate. The superior officer is still held accountable for the actions and inactions of staff at the Directorate. This therefore ensures effective supervision of subordinates at KATH.

Decentralization improving performances accounts for 35% and 20% respectively at KATH. This confirms that, there has been reduction in bureaucracy and that there is efficient and effective management practices at KATH.

5.5 To identify the barriers to effective decentralization of Health Care Delivery at KATH.

5.5.1 Problems of Decentralization

Once more, numerous limitations of H.C.D were stated by (Collins and Green 1994, Koivusalo 1999, Jommi and fattore 2003). The responses from the Directorates had about five (5) major problems associated with Health Care Decentralization at KATH.

It was noted that (41.6) % of the respondents felt that, the 25 GH cedis spending limit of the Directorates is too small. Any expenditure exceeding that has to be approved by the Hospital top Management. This practice is drawing back the high rate of reduction in bureaucracy at the Hospital top Management has to be consulted frequently for discussions and justifications for some expenditure intended to be made.

In addition, inequalities of imprest disbursement to Directorates accounts for about (16.6%) of the problems associated with the H.C.D. at KATH. It could be noticed that, respondents do not consider the nature of activities undertaken by Directorates but claims once all Directorates are operational, imprest should be distributed equally. Basing upon this, 5.0% of respondents stated that, Disparity in allowances is also a problem in the H.C.D at KATH.

5.6 Major Findings

The following were the major findings of the research work on Decentralization of Health Care Delivery at KATH. The Major findings were based on the Objectives of the research.

5.6.1 Description of Service Organization

- The mean years of service of respondents at KATH were between 3-5years.
- The Management structure at KATH is made up of Hospital Board, CEO, the Directors and the Directorates/Unit Management Teams.
- Top Management at KATH takes strategic decisions while the Directorate management takes the Operational and Tactical decisions.
- About 70% of respondents appreciate the current organogram of KATH. About 30% of respondents felt the organogram does not show chain of command, position status as well as span of control.
- There is vertical relationship between the Hospital top Management and the Directorates(Top-Down and Bottom-Up interaction)
- The Service Organization at KATH is in the Directorate system. The Directorates are formed along the pattern of sex, age, disease pattern etc.

5.6.2 Assessing Decentralization of Health Care Delivery at KATH

- There is greater degree of delegation in the Service Delivery at KATH (65%).
- Decentralization has really improved staff performance as stated by 88.3% of respondents.
- The Management Teams of Directorates have about (71.7%) easy access to financial resources for day to day administration.

- Directorates have controls over their budget and expenditure although top Management has to approve the Budget (73.3%)

- About 76.7% of the respondents agreed that, decentralization has led to reduction in workload of top Management. Hospital top Management is only contacted on issues over and above the jurisdiction of the Directorates Management Team.

- The level of implementation of H.C.D was appreciated by 55% of the respondents.

5.6.3. Decentralization and efficient management of resources

- Strict financial management practices are adhered to at KATH to ensure efficient and effective financial transactions.

- The Audit Unit at KATH has 100% mandate in pre-auditing all financial activities at KATH.

- 76.7% of respondents admitted that Directorates do not have major authority to undertake investment projects. The Directorates initiate the investment projects through the POW and budget for it. But the final approval rest with top Management. This means that. Investment projects implementation at the Hospital is centralized at the top Management level.

- Again, 58.3% of respondents stated that the Directorates do not have authority to recruit and deploy staff. The best the Directorate could do is to recommend for an action to be taken with respect to employment and deployment of staff.

- In terms of logistics, Human Resource and Procurement units at KATH are centralized.

- The Management Team at the Directorates have authority over resources allocation (56.7%) and 91.7% authority over training of their staff.

- Offering incentives to staff does not exist in most Directorates at KATH as confirmed by 51.7% of the respondents. However, the 48.3% that offers incentives in their Directorates indicated allowances to staff take about 59% of their incentives.

- Directorates' budgets are subject to approval by Hospital top Management as there is regular auditing of Directorates activities.

- The major benefit of H.C.D at KATH is quick decision making (88.3%).

5.7 Barriers to effective Decentralization of Health Care Delivery at KATH

- The major problem of D.H.C.D. at KATH is the 25 GH cedis spending limit directive given to the Directorates (41.6%) which is deemed to be very low.

CHAPTER SIX

6.0 CONCLUSION AND RECOMMENDATIONS

6.1 Introduction

This chapter sums up the entire research by outlining the conclusion based on the results, the discussions, the major findings in alignment with the objectives of the research. Recommendations are also made to the Government, Governing Board of KATH, Central Administration of KATH and the Directorates as well.

6.2 Conclusion

In this research, three important components of D.H.C.D at KATH are outlined; Service Organization, Human Resource and Finance. The outcome of the research on D.H.C.D at KATH indicated that, there is smooth operation of decentralization at KATH and positive results of decentralization have been achieved despite the few limitations enumerated.

The results stated clearly that, the management structure at KATH truly depicts a decentralized Organization as confirmed by the organogram. Financial issues at KATH are sound, Directorates even though cannot recruit and deploy staff, can recommend for an action in Human Resource.

Bureaucracy has actually reduced and most decisions are taken at the Directorates level with few being subjected to Hospital top Managements' approval. It must be noted that, for the fact that there is decentralization does not mean total autonomy of Directorates. At least, the operations of the Directorates should be subjected to control by the Hospital top Management as they will be held accountable for any mess ups.

KATH, within five years of D.H.C.D. and achieving between 51-69% level of decentralization implementation is laudable and hope by hard work, by the next five years, greater level of implementation of H.C.D. will be achieved.

The researcher cannot conclude without highlighting other areas of further research such as the impact of Decentralization of Health Care Delivery on Staff performances at KATH.

6.3. Recommendations for improving upon the Decentralization of Health Care Delivery at KATH

Based upon the results and in relation to the objectives, the following are recommended to enhance better decentralization of Health Care Delivery at KATH.

6.3.1 Government

1. The Government should give about 70% of Executive Board members' representation to people who are actively involved in the management of the Teaching Hospital concerned. This is because; being people on the field, accurate and technical decisions can be taken as they already know the situation on the ground.

6.3.2 Governing Board of Directors of KATH

2. It is recommended that, the three tiers Management Structure of KATH below should be strengthened by given clear demarcation of functions more especially between the Directorates and the Units.

   1st tier comprise Hospital top Management, CEO and the Directors

   2nd tier made up of the Directorate Management Team

   3rd tier to be composed to the Units Management Team.

The successful implementation of the above will extend decentralization further down the ladder. This will mean that delegation with the commensurate authority will be granted to the Units for operations.

3. It is recommended that, the Governing Board of KATH should decentralize human resource issues to the Directorates. By this every Directorate will see to its human resource needs, conduct its own recruitment and subject it for approval by the Central Administration.

6.3.3 The Central Administration of KATH

4. It is also recommended that, a position/status oriented organogram of KATH be drawn to show status of Management staff. An employee merely seeing his/her position at very key area in an organization is a motivator and enhanced self actualization and esteem.

5. The 25 GH cedis spending limit directives given the Directorates by the top Management of KATH should be adjusted upwards. This will give some sort of greater autonomy in decision making to the Management Team of the Directorates.

6. The Directorates should be permitted to undertake some form of investment projects by themselves. This can be made possible by permitting the Directorates to hold back some percentage of their budget for investment projects which will be subjected to approval and supervision by the Hospital top Management.

7. The Management of KATH should offer incentives to staff especially for exceptional performance to motivate them. This can take the form of end of year bonuses, best worker award, long service awards etc. This will actually put some sort of competition in work performances as all staff will strive to be recognized. Again this will make most staff resist poaching by other organizations.

8. The top Management of KATH should focus on decentralization in the Directorates as a way of ensuring equity, control, accountability and performance

with more emphasizes on day to day work in the Hospital. For this matter there will be the need for the creation of functional Deputy Directors.

9. The Internal Auditing function should be made independent of the Entity Spending Officer (C.E.O) if possible accountable to the Hospital Board.

10. The Hospital top Management should organize workshops in batches and educate staff on the motives of Decentralization and how it has been applied specifically to KATH.

6.3 .4 Directorates at KATH

11. There is the need for the Directorates to develop inter-directorate policy agenda, greater consciousness and institutional links.

12. All Directorates should be made to operate their own Accounts out of their revenue generated. This Account should however be under the supervision of the Hospital top Management.

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APPENDIX "A"

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APPENDIX "B"

DEPARTMENT OF COMMUNITY HEALTH

SCHOOL OF MEDICAL SCIENCES –KNUST

I am a student of KNUST (School of Medical Sciences, Department of Community Health) conducting a study on the "Decentralization of Health Care Delivery at KATH". This study is in partial fulfillment of a Masters degree in Msc Health Services Planning and Management. Your response to this questionnaire will be used solely for the study and kept confidential. Thank you for your time and efforts.

QUESTIONNAIRE

(Please tick or State as appropriate)

Bio-Data

DIRECTORATE…….. STATUS OF RESPONDENT:

NO. OF YEARS SERVED AT KATH……. Managerial Position? ☐ Yes...1

☐ No…2

SERVICE ORGANIZATION

1. How is the management of KATH structured?

   ……

   ……

   ……

2. Are you impressed about the current Organogram of KATH?

   ☐ Yes…….1 ☐ NO…….2 ☐ Can't Tell

   If YES/NO please give reasons……

   ……

   ……

3. What relations exist between the Hospital Top Management and the Directorates/Units Management Team at KATH?

   ……

   ……

   ……

4. How was decentralization implemented at KATH?

……

5. How do you manage logistics/Suppliers at KATH/Directorates?

……

……

6. How does KATH manage Finance.

……

……

7. In your opinion, has the Directorate system Decentralized the Hospital to reduce Bureaucracy? Ye☐…1 No☐.2 C☐ Tell…….3

Please assign reasons for your response

……..

……

8. In your opinion, do you perceive you have delegated authority in decision making? If YES/NO, please give reasons.

☐ Yes ….1 ☐No ……..2 ☐Can't Tell…….3

9. In your opinion, has the Decentralization of Health Care Delivery enhanced Staff performance?

☐ Yes…….1 ☐ No….2 ☐ cannot tell…3

Please give reason(s)……

……

10. Do you have the authority to undertake any investment project in your Directorate? ☐ Yes……1 ☐ No….2 ☐ Can't Tell…….3

If Yes, How do you do so?.....

If No, why?.....

11. Do you perceive effective channels of Communication among Directorates as well as Central Management? Please state reasons.

☐ Yes……1 ☐ NO…….2 ☐ Cannot tell…..3

12. Do you appreciate the level of Decentralization of Health Care Delivery at KATH?

☐

I strongly appreciate……1

☐ I appreciate……...2

☐ I don't appreciate……..…...3

☐ I strongly don't appreciate……4

HUMAN RESOURCE

13. Does the management of your Directorate/Unit have authority over Hiring, Promotion and Firing of Staff? If YES/NO why?

☐ Yes …1 ☐ No ...2 ☐ Can't Tell

14. What contribution do the Directorates/Units make to recruitment of staff?

…….

…….

15. Do the Directorates have control over resource allocation? If YES/NO please state reason(s)

☐ Yes…….1 ☐ No ……2 ☐ cannot tell…..3

16. Does the management of your Directorate/Unit have the authority to discipline their staff? If YES in what ways and if NO, why?

☐ Yes……1 ☐ No……2 ☐ Can't tell….3

17. Do the Directorates/units have the Authority to undertake Training activities (Capacity Building) for their staff?

☐ Yes… …1 ☐ No …….2 ☐ Can't Tell…3

18. Are there incentives systems in place by the Directorates to motivate staff? If YES in what ways and if NO why?

☐ Yes …..1 ☐ No…….2 ☐ Can't Tell….3

19. If Yes to the above (Q18), please state……..

20. Is exceptional performance rewarded in the Hospital?

☐ ☐ ☐

Yes ….1 No …2 Can't Tell…..3

FINANCE

21. Do Directorates have authority over their Budget and Expenditure? Please explain your answer.

☐ Yes……1 ☐ No…2 ☐ Can't Tell…..3

22. Do you have easy access to financial resources for day to day operations? If YES/NO please explain.

☐ Yes …..1 ☐ No……2 ☐ Can't Tell…..3

23. Are there systems in place to audit Directorates activities?

☐ Yes……1 ☐ No…….2 ☐ Can't Tell…..3

If Yes, in what ways?.....

……*If No why?*.....……

24. Does the Hospital's Top Management exercise any financial control over Directorates?

☐ Yes……1 ☐ No……2 ☐ Can't Tell….3

25. If Yes, How do they exercise that control?

☐ Directorates budgets are subject to approval…….....1

☐ Directorates day to day financial transactions are subject to approval by top Management……..2

☐ Others, Please state……3

26. Does the Central Administration place limitation on the Directorate's Budget?

☐ Yes……1 ☐ No…..2 Can't Tell….3 ☐

27. Are there Systems in place to check financial misconduct of Directorates?

☐ Yes ……1 ☐ No…..2 ☐ Can't Tell…..3

If Yes in what ways?.....

If No why?.....

OTHERS

28. What are the major benefits of Decentralization of Health Care Delivery at KATH?

……

……

……

29. What limitations or problems do you associate with the decentralization of Health Care Delivery at KATH?

……

……

30. What are your recommendations to overcome these limitations?

……

……

……

31. On the whole, what are your impressions about decentralization of Health Care Delivery at KATH?

☐ Excellent…..2 ☐ Good…..2 ☐ Satisfactory……3

32. How will you rate the implementation of Health Care Decentralization at KATH?

☐ Below 50%.....1 ☐ between 51-69%.....2 ☐ Over 71%.....3

THANK YOU.