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EFFECT OF ADMINISTRATIVE DECENTRALISATION IN KORLE-BU TEACHING HOSPITAL ON THE PERFORMANCE OF THE MEDICAL SUB-BUDGET MANAGEMENT CENTRE

BY

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DECLARATION

The author carried out the work in this dissertation alone unless otherwise indicated. Whenever the work of others was included, reference was made to the information. This dissertation has not in its present form or otherwise been submitted to this University for a degree or other qualification.

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DEDICATION

I dedicate this work to the three loves of my life: Veronica, Julita and Kelvin.

ACKNOWLEDGMENT

I will like to thank sincerely Prof. Andrew Anthony Adjei for his immeasurable assistance in this work. Many thanks also to my supervisor Dr. Augustine Adomah-Afari for his unlimited assistance.

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LIST OF ABBREVIATIONS

BMC	Budget Management Centre
CEO	Chief Executive Officer
GHS	Ghana Health Service
HR	Human Resource
IGF	Internally Generated Funds
KATH	Komfo Anokye Teaching Hospital
KBTH	Korle Bu Teaching Hospital
MDGs	Millennium Development Goals
MOH	Ministry of Health
SPH	School of Public Health
WHO	World Health Organization

ABSTRACT

Background

The concept of decentralisation has become a catch word not only within health sector reform strategies, but also in the overall policy and theoretical debates underpinning development. Community participation is a crucial ingredient for the development of responsive health-care systems both in high and low income countries.

Objective(s) The study explored the administrative effects of decentralisation on the Medical sub-Budget Management Centre of the Korle Bu Teaching Hospital.

Methods

An explorative descriptive method (quantitative research) was employed in the study. Questionnaires were used to obtain views from health managers at the various levels in the Hospital. The research assessed performance of the independent variables like governance, finance, human resource and procurement. The quantitative data resulting from the structured questionnaires was analysed using SPSS version 18.00 and a bivariate analysis was done examining the relationships between the independent and the dependent variables.

Results

The results are presented as frequencies and percentages in tables. They are examined section by section, considering human resource issues, financial sustainability, governance challenges, procurement procedure, decentralisation issues and bivariate relationships between the independent and dependent variables analysed.

Conclusion / Recommendations

The study concluded that, based on the descriptive and bivariate analysis from the results and discussions, there was no administrative effect of decentralisation on the Medical sub-BMC of the Korle Bu Teaching Hospital. It is recommended that this study be broadened beyond the scope of managers and unit heads in future studies.

CHAPTER ONE

INTRODUCTION

1.1 Background

The concept of decentralisation has become a catch word not only within health sector reform strategies but also in the overall policy and theoretical debates underpinning the development literature (Munga, Songstad, Blystad, & Mæstad, 2009). However, it is by no means a new concept. Decentralisation reforms gained a special status during the earliest primary health care reforms initiated by the World Health Organization (WHO) following the Alma-Ata Declaration of 1978 (Munga et al., 2009).This declaration emphasised that community participation is a crucial ingredient for the development of responsive health-care systems both in high and low income countries.

A few studies carried out in Tanzania have focused on identifying the type of changes that decentralisation policies have brought about for the management of resources, service provision, and accountability and good governance (Munga et al., 2009). The results highlight both positive and negative effects. On the positive side, aspects such as the increased authority of the district councils to spend user fees to repair health facility infrastructure and purchase drugs has increased the flexibility in planning for health services at the district level. In addition, increased local accountability is another aspect that has been consistently brought up.

On the negative side, the challenges related to unclear and complex local-central relations in terms of managing health sector resources has been highlighted. Little emphasis has been placed on assessing the impact of decentralisation reform on health worker recruitment, and its implications for the distribution of health workers across districts in

the country. In Ghana decentralisation of the health sector has been considered but its implementation has not been smooth. As part of the international restructuring adjustment programs, Ghana started a decentralisation policy in the health sector per an act of parliament, in 1996 (Ghana Health Service and Teaching Hospitals Act 1996, Act.525).

An implementing arm, Ghana Health Service (GHS) of the (MOH) Ministry of Health was created and the district hospitals were integrated into the local government structure. The Teaching Hospitals were given some autonomy, out of which the sub-Budget Management Centre (sub-BMC) concept evolved in the Korle-Bu Teaching Hospital. The impact of decentralisation on one of such sub management budget centres is what this study seeks to examine.

1.2 Statement of the Problem

Low-income countries as well as the World Bank, the World Health Organization (WHO) and many donor agencies are now focused on health systems strengthening in order to improve the health status of populations (World Health Organization 2008). A critical component of the health systems strengthening process is building health care management capacity (World Health Organization 2008). According to the leadership and management strengthening framework of the WHO (World Health Organization 2008), the development of adequate numbers of appropriately trained health managers is an important component of health systems strengthening and achieving the Millennium Development Goals (MDGs).

The management of staff is expected to be decentralised so that local authorities could appoint, develop and discipline their own staff (Marchal, Denerville, Dedzo, Brouwere, &

Kegels, 2005). This is expected to boost morale of the workers than when human resource issues are centralised. In a decentralised environment, unqualified staff are less likely to be recruited and acts of nepotism from the centre could be checked. It is easier and less expensive to conduct a local intake and choose the right people and also monitor their performance. In terms of human resources, the health sector in Ghana was described in the mid-90s as suffering from having inadequate numbers of rather poorly motivated staff, who were inequitably distributed both in terms of numbers as well as skills (Marchal, et al 2005).

Main obstacles included an inefficient and centralised personnel management system that discriminated against health staff in rural and deprived areas in terms of early and regular promotion, further post-basic training and in-service training (Marchal, et al 2005). The main HR concerns were the actual numbers and distribution of personnel, the skill mix, remuneration, incentives and motivation and the brain drain.

The Budgeting for the Korle Bu Teaching Hospital is a top management function . Budget proposals are drawn up by the in-charges of units and departments and these are accompanied by unit reports. The unit reports do not only give an account of achievements, strengths, weaknesses and bottlenecks, but also provide information on possible targets for the upcoming year, the resources needed to attain them and their eventual costs (Marchal, et al 2005). This information is forwarded to a 'budget committee' comprised of representatives of different departments and categories of staff.

Technically guided by financial resource persons such as the chief accountant, the committee's task is to draft a comprehensive hospital budget proposal. After undergoing

analysis by the core management team and receiving the CEO's 'seal of approval', the budget proposal for the upcoming fiscal year is sent to the MOH. This does not encourage financial autonomy. Internally Generated Funds (IGF funds) are disbursed by a 40: 60 ratio. The larger amount goes to the centre and so the sub-BMC is almost always dependent on the centre financially. Central funds hardly get to the units or they come too late and therefore the budget is always thrown overboard.

The governance aspect of a teaching hospital could be discussed from two levels: firstly, the relationship between the Korle Bu Central Administration and the Sub-BMC's, and secondly, the various governance arrangements within the hospital. In general, hierarchical lines are not clearly defined and where they are, these are not adhered to in reality (Marchal, et al 2005). Clear responsibilities are not demarcated. The head of the sub-BMC is an employee of the University of Ghana. Therefore technically he/she owes no allegiance to the CEO of the Korle Bu Teaching Hospital. Simply put, the CEO does not employ him/her, however, the rest of the management team members are employees of the Korle Bu Teaching Hospital. This is a heterogeneous team and they are not likely to achieve much. From the above it is obvious that the head of department will delegate his colleague from the academia to act in his stead when he goes on leave.

Procurement issues for a long time have been centralised, but this has not been helpful. Minor infrastructural repairs are delayed, leading to poor service, which in turn gives services of poor quality. The procurement law permits only a certain ceiling of purchase. At the sub-BMC level the ceiling is placed at five thousand Ghana cedis maximum. The above issues are creating problems for effective management of the sub BMCs under the decentralisation policy within which Korle Bu Teaching Hospital .

1.3 Justification of the study

The Board of the Korle Bu Teaching Hospital is the highest decision making body with some, not very clear oversight functions of the Minister of Health (Ghana Health Service and Teaching Hospital Act 1996, Act 525). The Board is appointed by the President of the Republic of Ghana who also decides who chairs it (Ghana Health Service and Teaching Hospital Act1996, Act 525). The Board then puts a management committee in place to run the day to day affairs of the hospital, headed by a Chief Executive Officer. This group superintends over the hospital and run it as a Budget Management Centre (BMC). Since the BMC is very big to handle efficiently, it is decentralised to sub-BMCs for smooth management.

The sub-BMC is headed by a Head of Department who is employed by the University of Ghana. The rest of the management team, composed of the Health Service Administrator, Deputy Director of Nursing Services, Accountant, Pharmacist and sub-BMC Engineer are all employees of the hospital.

The sub-BMC is currently able to raise funds from its clinical activities and other internally generated funds (IGF) to run. Even with this, the unit is expected to share at a ratio of 40:60 per cent. The lager amount goes to the central administration. This arrangement makes financial issues very difficult to manage. We are reminded that very little or no funds come from the centre. Minor infrastructural repairs, small purchases and other petty cash issues are all delayed which leads to poor quality of care.

Human resource issues are all centralised. Staff are recruited at the centre and distributed into the sub-BMCs without any input from the units. This sometimes creates problems like

midwives being posted to the Medical sub-BMC. Other times, staff are posted to a department and they never shows up because they may not be comfortable working there. If personnel issues were decentralised some of the above listed problems may not occur.

1.4 Objectives

1.4. 1 General Objectives

To determine the impact of decentralisation on the Medical sub-BMC of the Korle Bu Teaching Hospital.

1.4.2 Specific Objectives

1. To examine the Human Resource issues within the medical sub- BMC under the decentralisation policy at the Korle Bu Teaching Hospital.
2. To explore the financial state/stability of the medical sub-BMC at the Korle Bu Teaching Hospital.
3. To evaluate the governance challenges faced by management of the medical sub-BMC under the decentralisation policy at the Korle Bu Teaching Hospital.
4. To determine the procurement procedure of the sub-BMC within the decentralisation policy at the Korle Bu Teaching Hospital.

1.5 Research Questions

1 What are the human resource issues within the medical sub-BMC under the decentralisation policy at the Korle Bu Teaching Hospital?

2 What is the financial state/stability of the medical sub-BMC at the Korle Bu Teaching Hospital?

3 What are the governance challenges faced by management of the medical sub-BMC under the decentralisation policy at the Korle Bu Teaching Hospital?

4 What are the procurement procedures of the sub-BMC within the decentralisation policy at the Korle Bu Teaching Hospital?

1.6 Conceptual Framework

The hospital has a Board which is at the helm of affairs. The chairman of this Board and four other members, including a woman, are appointed by the government. The rest are institutional representatives. This Board is then mandated to employ a Chief Administrator or Chief Executive Officer and then an in- house committee is put in place to run the day to day affairs of the hospital. The sub-BMC evolved from this structure because the BMC was too big to run efficiently. This study seeks to look at the variable of the performance of decentralisation through the independent ones like governance, human resource, finance and procurement and also their interplay. This will be considered in terms of function, influence and results.

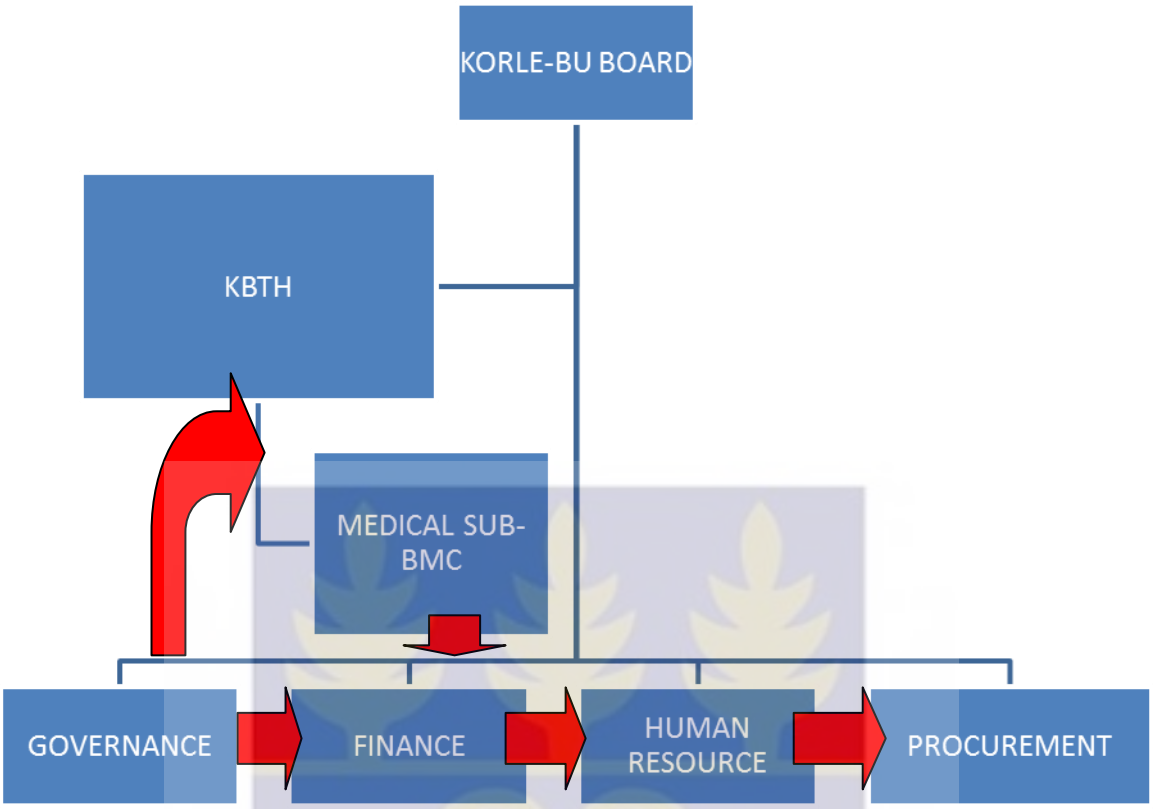

Figure 1: Conceptual framework for decentralisation in the Medical sub-BMC in KBTH.

CHAPTER TWO

LITERATURE REVIEW

2.0 Introduction

This chapter presents a thorough search of research material that sought to solve similar problems. It considers the concept of decentralisation in the first section and subsequently delves into the various classifications of decentralisation, looking at, political, administrative, fiscal and economic or market forms of decentralisation. The effects of decentralisation on finance, governance, human resource and procurement were all examined section by section.

2.1. Concept of Decentralization

It is generally perceived that decentralisation is a process designed to reduce central influence and promote local autonomy (Sumah, 2014). According to Sumah (2014), decentralization is the transfer of decision making from central government bodies to local officials to tailor service provision to the needs of local populations. The focus of the aforementioned conceptualization is overly shadowed by emphasis on meeting the needs of the local populace. In certain jurisdiction of the concept, some emphasis is placed on some attributes deemed to be importantly associated with the concept such as decision making authority, elections, fiscal resources, government and personnel (Sumah 2014).

Rondinelli (1981) sees decentralization as a process of transfer of authority for public functions from a country's central government to sub-national levels of government or autonomous institutions. This posits that the concept is based on the type of responsibility devolved and by the level of autonomy granted to local authorities. A common taxonomy classifies decentralization by three categories of responsibilities: political, administrative

and fiscal (Hutchinson & LaFond, 2004). An extension to this categorization is the addition of market decentralization proposed by Egbenya (2009). He states that, decentralization can be in the form of political, administrative, fiscal and market decentralization. Market decentralization accounts for the direction of public enterprise decentralization in the form of privatization and deregulation. These have been explained below.

2.1.1 Political Decentralization

Political decentralization involves providing citizens or their representatives with additional public decision making power, in particular through democratic process (World Bank, 2000). The rational and principal assumption of political decentralization is that decisions made with greater participation will be better informed and more relevant to diverse interest in society than those made by national political authorities. The reality however provides some level of variance because though political decentralization has this assumption, the process of selecting representatives, personal disposition and interest will determine the level to which they will represent the interest of their constituents.(World Bank, 2000).

2.1.2 Administrative Decentralization

Administrative decentralization deals with the transfer of the responsibility for planning, financing and management of certain public functions from central agencies to field units of government agencies, subordinate units or levels of government (Rondinelli, 1999). This form of decentralization is particularly common in the provision and management of social services to the populace such as health. Administrative decentralization is made up

of four sub-categories namely: de concentration, devolution, delegation and privatization (Rondinelli, 1999).

2.1.3 Fiscal Decentralization

Fiscal decentralization refers to devolving to local levels government control over financial resources either in terms of expenditure, assignments or revenue generation (Hutchinson & LaFond, 2004). It is the situation in which decision about expenditure of revenues raised locally or transferred from central government is done by the local authority. Various shades of prerogatives may exist from its most limited forms to complete autonomous prerogative. (Hutchinson & LaFond, 2004).

2.1.4 Economic or Market Decentralization

This is the form of decentralization where there is a shift from public to private sector. Particular shades of economic decentralization are deregulation and privatization (Mill, 1994). Privatization is the transfer of responsibility from government to private entities designed so that market-style efficiency gains can be generated through higher levels of autonomy and decision making responsibilities (Mill, 1994).

Assessing the various concepts proffered by the various researchers, the impression is that these categories are distinct and mutually exclusive. It also provides the doubtful grounds that there are clear states of the attainment of one category of decentralization or the other. Also from the available literature, a contradiction occurs in conceptualizing the typologies of decentralization While some scholars view privatization and deregulation as a sub-category of administrative decentralization, others view it as co-terminus with market or economic decentralization (Mill, 1994).

2.2 Effects of Decentralization

The experimentation of decentralization has yielded mixed results from the assessment conducted by several researchers across countries. Some clear areas for which data was available are the impact it had on finance, human resource, community participation, equity and access to health care. Some comparative analysis is contained in the following (Bossert & Beauvais 2002).

2.2.1 Finance

With respect to financial discretion, a comparative country study realized varying results. In Ghana, financial discretion as a result of decentralization was limited to local level Budget Management Centres (BMC), while expenditure regarding salaries and capital investments were determined centrally (Sumah, 2014). In Uganda, delegated salaries and vertical programme funding through a block allocation system comprised a large percentage of the funding transferred to districts which means that discretion is very limited to approximately 25% of funds in the district annual plans (Hutchinson, 1998). In the Philippines, central transfer system was relatively unburdened with earmarking set aside and other expenditure constraints (Bossert & Beauvais, 2002). A general observation is that, donor funding for vertical programmes which accounted for a greater percentage of funding to district health system in the aforementioned countries comes with limited discretion.

With respect to income sources and fiscal autonomy, despite the increase in proportion of resources spent at the sub-national levels, own-resource revenue was comparatively small and local institutions remained dependent on central transfer in Ghana, Uganda, Zambia and Philippines (Bossert & Beauvais, 2002). In Ghana, user fees accounted for 19% of

MOH expenditure while in Zambia income generated from local level was much less significant than in the case of Ghana. Ugandan own-source revenue amounted to 6.5% of district income while 35% of Philippines health expenditure is associated with own-source revenue (Bossert & Beauvais, 2002).

2.2.2 Governance and Community Participation

The effects of decentralization on governance and community participation are mixed and depend on the module of decentralization implemented (Bossert & Beauvais, 2002). In Ghana, the system provided little or no mechanism for local governance popular participation in health sector decision making. Mensah (1997) provides that, the district health committees had their roles intentionally limited to advising the GHS and was minimal. Zambia had a relatively impressive structure of citizen participation from the facility level to the district level, but these mechanisms had only been implemented to a limited degree (Bossert & Beauvais, 2002). Uganda had more democratic institutions but mechanisms for participation in health sector governance appeared weak. In the Philippines the process did not involve transfer of power to the community but rather devolution from state officials to the mayor Ramiro (2001).

2.2.3 Access

From previous studies with regard to this subject, targeting and health sector programming was moderately decentralized. In most cases performance contracts were used as a mechanism for centrally controlling local health authorities particularly in Ghana and Philippines (Bossert & Beauvais, 2002). The rationale of this control could be to enforce the implementation of local national priorities. The likelihood of exacerbating inequity of existing difference is eminent with central government ceding the responsibility for

redistribution of income from well-off jurisdictions to less-off jurisdictions. Without the appropriate capacity and distribution mechanism at the sub-national level, such fears can be entertained.

2.2.4 Human Resource Management

Studies have revealed that Ghana and Zambia had more centralized system than the devolution case in Uganda and Philippines (Bossert & Beauvais, 2002). The hierarchical system in place centralized decision of hiring, firing, contracting and salaries. In Ghana, particularly with reference to hospitals, autonomy was limited due to the direct control of activities of the hospital by Ministry of Health (MOH)/GHS) (Bossert & Beauvais, 2002). In the case of Uganda and Philippines, devolution accorded the local health authorities some amount of autonomy to hire and fire (Bossert & Beauvais, 2002). Decentralization often requires enhanced skills and abilities of personnel at local levels to implement decentralized functions. However, research has proved a limitation to the process because of lack of adequate capacity and number of decentralized staff.

2.2.5 Quality of Care

The prospects of improving quality through decentralization are mixed with studies of some health systems providing evidence to this assertion. Jeppson and Okuonzi (2000) reported an improvement in curative services at the local level through local upgraded hospitals in Uganda. Hutchinson (2002) also reported a higher utilization of health services in decentralized districts than non-decentralized districts in Tanzania.

Rondinelli (1999) concludes the subject with the admonishing that to attain success, finances should be followed by clear assignment of functions, informed decision making, adherence to local priorities and accountability.

2.2.6 Procurement market exposure

In Iran, the financial and trade off regulation (2007) categorize procurement practices into three; ie, small, medium and large transactions. Decision right is granted to public hospital within the limit of small transaction only. Medium and large transactions are approved by a bid committee. They (Mehdi,2010) argue that with small transactions, it is preferred to buy from public or government recommended suppliers in order to avoid very rigid financial accountability. The bidding processes are considered time consuming and in order to avoid the paper work, suppliers are usually asked to break down bills into smaller units (Mehdi, 2010).

2.3 Chapter Summary

This chapter showed a thorough search of research material that sought to solve similar problems. It examined the concept of decentralisation in the first section and subsequently delves into the various classifications of decentralisation, looking at, political, administrative, fiscal and economic or market forms of decentralisation. The effects of decentralisation on finance, governance, human resource and procurement were all examined section by section.

CHAPTER THREE

METHODS

3.0. Introduction

This chapter examines the methodology of the study, stating the type, location/area, population and technique. In different sections, this chapter considers the sample size determination, states the hypothesis and variables. Data collection instruments/questionnaire design and administration are also considered. This chapter further explains the data analysis, a pilot study, quality control dynamics and the ethical issues.

3.1 Type of study

The study was conducted using an explorative descriptive method: quantitative research. This approach was used because it afforded the researcher the opportunity to solicit appropriate answers in respect of the study objectives. It involved questionnaire administration.

3.2 Study location/Area

The study was conducted at the Korle Bu Teaching Hospital which is close to a 2,000 bed capacity hospital. It is situated in a suburb of the capital Accra, known as Korle Gonor. Specifically the study was carried out in the Medical sub- BMC which is a 222 bed capacity facility. The sub-BMC is composed of, Medical block (134-beds), Chest Clinic (41-beds), Fevers Unit (27-beds), Stroke Unit (20-beds), Renal Unit which performs only day cases for now and the Out Patients Department, (OPD).

3.3 Study population

The study was conducted at the KBTH which is made up of a Teaching Hospital Board at its apex. The study population included:

1. Core management members who are:
   - The Chief Executive Officer
   - Director of Administration
   - Director of Medical Affairs
   - Director of Pharmacy
   - Director of Nursing
   - Hospital Engineer

2. Representatives of clinical staff are made up of four clinical heads of departments:
   - Head of Surgery
   - Head of Obstetrics and Gynaecology
   - Head of Child Health Department
   - Head of Radiology

3. Representatives of the Local Health Service Workers Union comprises of mainly three members of the executive:
   - The Chairman
   - The Secretary
   - The Treasurer

These comprise the House Committee of the Teaching Hospital. This committee helps the CEO to run the day to day affairs of the hospital.

The sub-BMC management is composed of six (6) core members and eighteen (18) unit heads.

3.4 Sampling Technique

Purposive sampling was used to select the members of the House Committee, the sub-BMC core management members and the unit heads. Purposive sampling was adopted for the selection of research participants since it is a form of non-probability sampling in which decisions concerning the individuals to be included in the sample are taken by the researcher, based upon a variety of criteria which may include specialist knowledge of the research issue, or capacity and willingness to participate in the research (Oliver, 2006). Other researchers argue that purposive sampling can be used with a number of techniques in data gathering (Godambe, 1982; Tongco, 2007). Topp, Barker and Degenhardt (2004) applied this strategy to draw from a wide cross-section of users and to sample a relatively large number of individuals in their study of ecstasy users. In this current study, this strategy made it possible for heads of the management teams and units to be enlisted in the study.

3.4.1 Sample Size Determination

The study was conducted in the KBTH which is made up of a Teaching Hospital Board at its apex, six (6) core management members, four (4) representatives of clinical staff and three (3) representatives of the local Health Service Workers Union. These comprise the House Committee of the Teaching Hospital. A total of thirteen (13) members were involved in the study. This committee helps the CEO to run the day to day affairs of the hospital. The sub-BMC management is composed of six (6) core members and eighteen (18) unit heads. Applying a formula appropriate for organizational survey research, taking into account a confidence level ($\alpha/2=1.96$) of 95% confidence interval (CI) and a

margin of error of 15% a sample size of 13 House Committee members and 24 sub-BMC core management and unit heads(total =37) was selected for the study.

3.5 Hypothesis

The hypothesis of the study is: Decentralisation has no effect on the Medical sub-BMC.

3.6 Variables

Both dependent and independent variables were used to measure the key issues so as to meet the study objectives.

3.6.1 Dependent Variable

The dependent variable in this case is the performance of the Medical sub-BMC under decentralisation.

3.6.2 Independent Variables

The independent variables in this case are governance, human resource, finance and procurement.

3.7 Data Collection Instruments / Questionnaire Design and Administration

Structured questionnaires were used to elicit response from heads of the various management teams composed of, House Committee members, core sub-BMC management members and their unit heads. The questionnaires weres self-designed. Section A captured the demographic characteristics while Section B captured the variables. The questionnaires were self- administered and later collected by the researcher (see Appendix B).

3.8 Data Analysis

Data analyses for surveys were descriptive, determining proportions and percentages.

The quantitative data resulting from the structured questionnaires was analysed using SPSS version 18.00. Fisher's exact test was used to assess the significance of the relationship (s) between the dependent and independent variables because of the low cell frequencies.

3.9 Pilot Study

The study was piloted in the same hospital at the Department of Obstetrics which is also one of the sub-BMC's. Mistakes and challenges noted were worked at before the substantive study.

3.10 Quality Control

The questionnaires were administered without names as they were coded. The questionnaires brought in by the researcher were checked for any mix ups or mistakes.

3.11 Ethical Considerations/Issues

Clearance was sought from the Ghana Health Service Ethics Review Committees. Permission was further sought from the Hospital administration and the management of the sub-BMC. The purpose of the study was explained to all subjects and was allowed to join wilfully. Issues of non-disclosure and confidentiality were upheld.

There were no personal benefits that were derived by participating in the study. The information that was collected from this research project was kept confidential. Information about the process that was collected from the study was stored in a file which had no name on it, but a number assigned to it. Which number belonged to which name

was not to be disclosed to anyone except the principal investigator. The findings of this study may be reported at meetings or in journals, but subjects names will not be used in the report.

The subjects did not have to take part in this research if they did not want to do so. The subjects may stop participating in the research at any time they wished to, without losing any rights. Participants who willingly took part signed a participant's consent form. (see Appendix A).

3.12 Chapter Summary

The chapter examined the methodology of the study, stating the type, location/area, population and technique. In different sections, this chapter considered the sample size determination, stated the hypothesis and variables.

Data collection instruments/questionnaires, research design and administration of the questionnaires were also considered. This chapter further explained the data analysis, a pilot study, quality control dynamics and the ethical issues.

CHAPTER FOUR

RESULTS

4.0 Introduction

Section one presents results relating to demographic characteristics of respondents. Section two presents results relating to human resource issues. Section three presents results relating to the financial state/stability. Section four presents results relating to governance challenges. Section five present results relating to the procurement procedures within the decentralisation policy. The sixth section presents results relating to the bivariate analysis between the dependent and independent variables

4.1 Demographic Characteristics of Respondents

The 30 consented individuals in this study answered questions pertaining to the Human Resource issues, the financial state/stability, governance challenges, and the procurement procedures within the decentralisation policy. Data collection took place between June and July, 2015, at the Medical Sub-BMC of the Korle Bu Teaching Hospital. Out of the 37 questionnaires distributed, only 30 were returned. This formed a response rate of 81% (30/37 x 100). While male respondents were 8, representing 26.7%, female respondents were 22, representing 73.3%. The results show that there was no participant under age 31 while 4(13.3%) fell between 31-40years. Indeed, 12(40.0%) were between age 41-50 while the majority 14(46.7%) fell between age 51-60years showing that most of them were approaching retiring age. The gender distribution revealed that majority of management and unit heads were females, 22(73.3%) showing that some affirmative action has been archived. 8(26.7%) of management members were males. The participants had various educational and professional backgrounds with most of them finishing tertiary education.

Most management members 29(96.7%) had tertiary level education while 1(3.3%) had secondary education. A breakdown of the management teams and unit heads shows the following: nurses: 12(40.0%) doctors: 9(30.0%) administrators and engineers: 2(6.7%) respectively and a combination of accountants and pharmacist: 5(16.7%). Below is Table 4.1 showing the demographic characteristics of respondents.

Table 4.1: Demographic Characteristics of Respondents

Characteristic	N	%
Age		
31 – 40	4	13.3
41 – 50	13	43.3
51 – 60	13	43.3
Sex		
Female	23	76.7
Male	7	23.3
Educational background		
Secondary	1	3.3
Tertiary	29	96.7
Professional background		
Medical	10	33.3
Nursing	12	40.0
Health services administrator	2	6.7
Others	6	20.0
Total	**30**	**100.0**

4.2 Human Resource Issues.

Considering the autonomy within human resource management in the sub-BMC, the opinions are very interesting. The results show that 29(96.7%) had no authority to appoint staff while 1(3.3%) had authority to appoint staff, also 28(93.3%) had no authority to dismiss staff while 2(6.7%) had authority to dismiss staff.

All 30(100%) respondents had no authority to determine staff salaries. As far as issues of promotions were concern, the results revealed that 25(83.3%) had no authority while 5(16.7%) could promote. With demotions, the picture was not too different, 26(86.7%) could not demote anybody while 4(13.3%) could. General improvements within the sub-BMC with the implementation of decentralisation, 21(70.0%) agreed to have noticed some improvement while 9(30.0%) thought there was no improvement.

When on a scale of 0-10, asked to grade the level of improvement, 9(30.0%) respondents graded zero, meaning there was no improvement, 7(23.0%) graded seven and 5(16.0%) graded five. Results are displayed on table 4.2 below

Table 4.2: Human Resource Issues

	N (%)	
	No	Yes
Authority to		
appoint staff	1 (3.3)	29 (96.7)
dismiss staff	2 (6.7)	28 (93.3)
determine staff salaries	0	30 (100.0)
promote staff	4 (13.3)	26 (86.7)
demote staff	3 (10.0)	27 (90.0)
Seen improvement in HR output since sub BMC implementation	22 (73.3)	8 (26.7)
Level of improvement seen in HR output (0=None, 10=Highest)	Mean (SD) = 3.0 (2.3) Median (IQR) = 3.0 (5.0)	

4.3 Financial Sustainability

The financial dynamics did not give any sense of a better autonomy. For the preparation of financial plans and budgets, 17(56.7%) did not prepare them while 13(43.3%) did. Indeed, 21(70.0%) of the participants said bank accounts were not operated while 9(30.0%) said they were operated. They were not signatories to accounts 26(86.7%) while 4(13.3%) said they were. In fact, 18(60.0%) did not determine expenditure while 12(40%) did. As to whether sources of finance had improved since the inception of decentralisation, 20(66.7%) said it had while 10(33.3%) thought it had not. The 19 (63.3%) respondents who graded zero on a scale of 0-10 are of the opinion that there had been no improvement in financial issues since the implementation of the decentralization policy. Results are shown in table 4.3 below.

Table 4.3: Financial Sustainability

	N (%)	
	No	Yes
Prepare financial plans and budgets	12 (40.0)	18 (60.0)
Operate bank accounts	9 (30.0)	21 (70.0)
Signatory to accounts	4 (13.3)	26 (86.7)
Determine expenditure	11 (36.7)	19 (63.3)
Seen improvement in sources of finance since sub BMC implementation	9 (30.0)	21 (70.0)
Level of improvement seen in sources of finance (0=None, 10=Highest)	Mean (SD) = 1.9 (2.8) Median (IQR) = 0 (5.0)	

4.4 Governance Challenges

Result on issues of governance revealed that 27(90.0%) of participants were of the knowledge that various committees are formed to help run the hospital while 3(10.0%) did not know. The committees, according to 19(63.3%) are in existence while 11(36.7%) say they are not. As to whether they function, 15(50.0%) attest to their functioning while the other half say they do not. Moreover, 16(53.3%) participants think that, there has been

some improvement in governance while 14(46.7%) think differently. On a scale of 0-10, 13(43.3%) are of the opinion that there is no improvement in governance issues since the implementation of decentralization. Results are indicated in Table 4.4.below.

Table 4.4: Governance Challenges

	N (%)	
	No	Yes
Hospital must set up committees to help run it	28 (93.3)	2 (6.7)
Committees are in existence	19 (63.3)	11 (36.7)
Committees functioning	14 (46.7)	16 (53.3)
Seen improvement in governance since sub BMC implementation	16 (53.3)	14 (46.7)
Level of improvement seen in governance (0=None, 10=Highest)	Mean (SD) = 2.6 (2.6) Median (IQR) = 3.0 (5.0)	

4.5 Procurement Procedures

The issues on procurement within the sub-BMC concept are quite new. While 25(83.5%) participants knew of the concept, 5(16.7%) do not know. As 21(70.0%) admit to following the process 9(30.0%) do not. For instance 24(80.0%) concede that it is a cumbersome process while 6(20.0%) do not think so. Again, 19(63.3%) understand the process while 11(36.7%) does not. As 14(46.7%) see some improvement in the process, 16(53.3%) does not. In addition 16(53.3%) think that there has been no improvement in procurement processes since decentralization when asked to grade on a scale of 0-10. Results are portrayed in Table4.5 below.

Table 4.5: Procurement Procedure

	N (%)	
	No	Yes
Know of procurement process	25 (83.3)	5 (16.7)
Follow procurement processes	20 (66.7)	10 (33.3)
Procurement processes cumbersome	24 (80.0)	6 (20.0)
Understand procurement processes	19 (63.3)	11 (36.7)
Seen improvement in procurement processes since sub BMC implementation	13 (43.3)	17 (56.7)
Level of improvement seen in procurement (0=None, 10=Highest)	Mean (SD) = 2.3 (2.9) Median (IQR) = 0 (5.0)	

4.6 Concept of Decentralisation

The concept of decentralisation has been around for a while and in this study, 29(96.7%) attested to have heard about it while 1(3.3%) have not. Whilst 22(73.3%) agree that it is being practiced, 8(26.7%) think otherwise. Again 23(76.7%) prefer that the process of decentralisation continues while 7(23.3%) do not. Half of the participants in this study think that their colleagues understand the concept while the other half thinks differently. As 20(66.7%) are of the opinion that the concept has brought some general improvement in their work ,10(33.3%) do not think so. Additionally, 10(33.3%) are of the opinion that there has been no improvement since decentralization when asked to grade on a scale of 0-10. Results are outlined in Table 4.6 below.

Table 4.6: Concept of Decentralisation

	N (%)	
	No	Yes
Ever heard of decentralization	29 (96.7)	1 (3.3)
Decentralization in practice	21 (70.0)	9 (30.0)
Prefer decentralization to centralization	22 (73.3)	8 (26.7)
Think workmates understand decentralization	15 (50.0)	15 (50.0)
Seen improvement in decentralized output since sub BMC implementation	19 (63.3)	11 (36.7)
Level of improvement seen in decentralized output(0=None, 10=Highest)	Mean (SD) = 3.5 (3.0) Median (IQR) = 4.0 (6.0)	

Table 4.7: Bivariate Analysis Table (demographic Characteristics/Variables)

Characteristic	No. of respondents	N (%) with high autonomy (≥ midpoint score)					
		HRM	Finance	Governance	Procurement	Decentralization	Overall
Age		*P*=1.000	*P*=1.000	*P*=0.677	*P*=0.288	*P*=0.651	*P*=0.199
31 – 40	4	4 (100.0)	3 (75.0)	1 (25.0)	0	2 (50.0)	1 (25.0)
41 – 50	13	13 (100.0)	9 (69.2)	4 (30.7)	2 (15.4)	4 (30.8)	8 (61.5)
51 – 60	13	12 (92.3)	10 (76.9)	6 (46.2)	5 (38.5)	3 (23.1)	10 (76.9)
Sex		*P*=1.000	P=0.638	*P*=0.372	*P*=1.000	*P*=0.393	*P*=0.372
Female	23	22 (95.7)	16 (69.6)	7 (30.4)	6 (26.1)	8 (34.8)	16 (69.6)
Male	7	7 (100.0)	6 (85.7)	4 (57.1)	1 (14.3)	1 (14.3)	3 (42.9)
Educational background		*P*=1.000	*P*=1.000	*P*=0.367	*P*=1.000	P=1.000	*P*=0.367
Secondary	1	1 (100.0)	1 (100.0)	1 (100.0)	0	0	0
Tertiary	29	28 (96.6)	21 (72.4)	10 (34.5)	7 (24.1)	9 (31.0)	19 (65.5)
Professional background		*P*=1.000	*P*=0.125	*P*=0.220	P=0.849	*P*=0.737	*P*=0.123
Medical	10	10 (100.0)	8 (80.0)	2 (20.0)	2 (20.0)	4 (40.0)	6 (60.0)
Nursing	12	11 (91.7)	10 (83.3)	5 (41.7)	4 (33.3)	4 (33.3)	10 (83.3)
Health services administrator	2	2 (100.0)	0	0	0	0	0
Others	6	6 (100.0)	4 (66.7)	4 (66.7)	1 (16.7)	1 (16.7)	3 (50.0)
Total	30	29 (96.7)	22 (73.3)	11 (36.7)	7 (23.3)	9 (30.0)	19 (63.3)

Method: For each area of autonomy (i.e. HRM, finance, etc.), scores were assigned to the individual factors by giving a score of '0' to no autonomy/practice and '1' if the respondent had some autonomy. These were then summed and split into two groups using the median for each area as the cut-off point. The overall score was computed similarly with the totals for each area of autonomy.

Interpretation: Most of the demographic groups individually and totally had high HRM autonomy compared to finance which saw varying levels of autonomy with 41 – 50 year olds having the least (69.2%) among the ages. Male respondents also had more financial autonomy (85.7%) compared to their female counterparts even though there were only 7 males. There was only 1 respondent with secondary education as the highest level therefore it would be inappropriate to compare the various areas of autonomy by educational level. The only 2 health service administrators also had high autonomy only when it came to human resource management. There were varying levels of autonomy by the other areas and overall which can be discussed further.

Note: None of these categorical differences in the table were statistically significant though when subjected to Fisher's exact tests (as seen from the P-values). This could be due to the low numbers. Therefore there is no need for regression analysis.

Interpretation: Most of the demographic groups individually and totally had high HRM autonomy compared to finance which saw varying levels of autonomy with 41 – 50 year olds having the least (69.2%) among the ages. Male respondents also had more financial autonomy (85.7%) compared to their female counterparts even though there were only 7 males. There was only 1 respondent with secondary education as the highest level therefore it would be inappropriate to compare the various areas of autonomy by educational level. The only 2 health service administrators also had high autonomy only when it came to human resource management. There were varying levels of autonomy by the other areas and overall which can be discussed further.

Note: None of these categorical differences were statistically significant though when subjected to Fisher's exact tests. This could be due to the low numbers. Therefore there is no need for regression analysis.

Table 4.8: Weighted Bivariate Analysis Table (demographic Characteristics/Variables)

Characteristic	No. of Respondents	Average % levels of autonomy (0=Lowest, 100=Highest)					
		HRM	Finance	Governance	Procurement	Decentralization	Overall
Age							
31 – 40	4	80.0	68.8	16.7	6.3	37.5	45.0
41 – 50	13	100.0	67.3	28.2	17.3	30.8	52.3
51 – 60	13	90.8	73.1	41.0	42.3	21.2	56.2
Sex							
Female	23	93.9	71.7	29.0	30.4	26.1	53.5
Male	7	91.4	64.3	42.9	14.3	32.1	51.4
Educational background							
Secondary	1	60.0	75.0	66.7	0	25.0	45.0
Tertiary	29	94.5	69.8	31.0	27.6	27.6	53.3
Professional background							
Medical	10	94.0	72.5	23.3	25.0	35.0	53.5
Nursing	12	93.3	81.3	36.1	37.5	22.9	57.1
Health services admin.	2	90.0	12.5	0	12.5	25.0	32.5
Others	6	93.3	62.5	50.0	12.5	25.0	50.8
Total	30	93.3	34.4	32.2	26.7	27.5	53.0

Method: For each area of autonomy(i.e. HRM, finance, etc.), the scores assigned to the individual factors in the previous table are weighted as percentages (0-100%) based on each area's scale and the averages computed for each demographic category. These average levels of autonomy can then be used to support observations made in the previous table.

4.7 Chapter Summary

This chapter in section one presented results relating to demographic characteristics of respondents. The second section presented results relating to human resource issues, while section three presented results relating to the financial state/stability. Furthermore, section four presented results relating to governance challenges. In deed section five presented results relating to the procurement procedures within the decentralisation policy. The sixth section presented results relating to the bivariate analysis between the dependent and independent variables.

CHAPTER FIVE

DISCUSSION OF FINDINGS

5.0 Introduction

This chapter seeks to discuss the findings of the results found from the study. The variables will be considered thematically, section after section comprising human resource issues, financial sustainability, governance challenges and procurement procedures. Deductions will then be made as to how the variables influence the concept of decentralisation and its administrative effect on the Medical sub-BMC of the Korle Bu Teaching Hospital. The bivariate analysis will tail the discussion.

Some scholars argue that, the logic of decentralization is based on an intrinsically powerful idea (Saltman & Bankauskaite, 2006). It is, simply stated, that smaller organizations, properly structured and steered, are inherently more agile and accountable than are larger organizations (Saltman & Bankauskaite, 2006).They further hold the opinion that in a world where large organizations control wide swaths of both public and private sector activity, the possibility of establishing more locally operated, locally responsible institutions, holds out great attraction. Even Max Weber, the turn-of-the-twentieth-century German sociologist who first formulated the key attributes of the bureaucratic model, and who himself reluctantly concluded that bureaucracy was inevitable in human organization, still yearned for the fruits of decentralization. "The only alternative to bureaucracy," he wrote, "is a return to small-scale organization" (Weber 1947). Given the strength of this idea, it is not surprising that national and regional policy-makers in many countries across Europe have introduced decentralization strategies (Saltman & Bankauskaite, 2006). In a restructuring process that has accelerated since the Second World War, the institutional landscape – particularly in the health sector – now

incorporates an extraordinary range and variety of decentralized operating and managerial arrangements (Saltman & Bankauskaite, 2006). It is precisely this broad range and scope of decentralization however which make analysis of this concept difficult. The single, seemingly simple character of decentralization, when probed more deeply, opens up into a broad array of concepts, objectives, and consequences. Far from being a unitary, clearly defined concept, decentralization breaks apart into a kaleidoscope of different, sometimes contradictory definitions, each hallowed in its own theoretical and, often, practical context.

5.1 Human Resource Issues.

Human resource issues are still largely centralized since power and authority have not been passed on to the periphery holistically. Most of the Managers at the periphery do not appoint, dismiss nor even demote. A little over half, ie 70% of the participants however think that some general improvement has been achieved on the inception of decentralisation but when asked to grade the improvements on a scale of 0-10, 9(30%) participants graded zero, meaning there was no improvement at all, indeed, seven respondents graded 7 representing 23% and meaning they noticed some improvement while five subjects found themselves in the middle. They graded five representing 16% meaning they also noticed some improvement. Vrangbak (2004) opines that recruitment of human resource input becomes more efficient as decentralized knowledge can be utilized to hire the right persons. Staff may be more motivated in smaller units where they feel that they can have a real impact. This study demonstrated this opinion in a rather mild way, considering the statistics.

5.2 Financial Sustainability

Financial issues did not show much difference. A little over half 70% of the participants did not prepare financial plans nor budgets and did not even know about the operation of bank accounts, neither were they signatories where accounts exist. This again reveals that financial power was still at the centre. According to (Saltman 2004) decentralization improves control and accountability, staff motivation, coordination across units, patient flow and resource. Utilization Decentralization creates opportunities for local adjustment and experimentation with organizational solutions that may spread to other units though systematized learning processes. This was not all together the case in this study. Furthermore in many countries, accountability for health service provision has been decentralized, but decisions on the regulatory framework of competition, economic policies and trade in services are made more at national than the periphery. Mills,(2000).

5.3 Governance Challenges

Governance issues offered about the same trend of events. Majority knew of the existence of various committees to help run the hospital, however half (50%) of the participants were of the opinion that these committees were not functional while the other half (50%) thought they were. A little over half 70% of the participants saw no improvement in governance issues with the inception of the decentralisation policy. The political discussion of process-related benefits of decentralization can be traced back to Adam Smith and John Stuart Mill (Pollitt 2005). Mill makes a particularly strong argument in his *Principles of Political Economy* of 1848. He argues that decentralized democratic structures could provide essential breeding grounds for active and informed participation as well as a countervailing force against central bureaucracy (Mill 2004). Participatory decision processes within decentralized units are thus seen as a value in their own right

and as a way for citizens to become knowledgeable and active in political issues generally (Peters & Wright 1998; Baldersheim & Rose 2000; Mill 2004).

5.4 Procurement Procedure

Procurement processes, although quite a new concept, the results showed that 83% of the participants thought they knew about them and half 50% considered them cumbersome but relatively functional. On a final note we return to Enthoven (2000) who points out that reforms which may look good on paper tend to be hampered by lack of political space, lack of sufficient data, lack of motivation and the general inability of the health care sector to escape the "harsh realities of the market". Decentralization is defined as transfer of power, but not all powers are always transferred. Thus local authorities may be in charge of the purchasing of a set of services that is decided by detailed national health policy, or they may themselves freely decide what type of services are to be provided. Also, while purchasing power is decentralized, capacity decisions may remain the responsibility of central authorities.

5.5 Decentralisation Issues

The decentralized concept was known to majority of the participants and in their opinion it was sparingly being practiced but they thought the process must be given time to evolve and grow. The main disadvantages of decentralization according to organization theory are: (1) the risk of sub-optimality as decentralized entities focus on their own performance rather than the entire organization; (2) lack of coordinated steering impulses; (3) inappropriate diversity in practices and standards especially in personnel management; and (4) reduced comparability and predictability at the system level (Jacobsen & Thorsvik

2002). In terms of health services, spreading decision capacity to several decentralized units may create problems in coordination across these units.

Based on a public administration perspective, decentralisation could be considered as the transfer of formal responsibility and power to make decisions regarding the management, production, distribution and or financing of health services usually from the centre to the periphery.

In this study, transfer of formal responsibility and power to make decisions was not at play since power was still centralised, there was no shift in formal accountability and decision making structures from the centre to the periphery. What seemed obvious however was a horizontal level of decentralisation based on not necessarily transferring authority to the periphery but more on functional principles. Responsibility is linked to decision making and should be understood as formal responsibilities for making decisions.

Power is linked to the scope for decision making, ie the range of decisions one can take, including the degree of discretion and the importance in terms of impact on producers and consumers of health services, (Bossert 1998).

. This study catalogues the multiple dilemmas involved in attempting to assess both the structure and function of decentralization in health care systems. After first reviewing the complexities involved in defining and measuring decentralization, it explores the multi-faceted political and financial contradictions that inhere within decentralization. Subsequently, the study looks at key questions about the ability of decentralization to achieve the outcomes that have been attributed to it.

Despite the number of theoretical frameworks for decentralization, few measure the scope and extent of decentralization. Rondinelli's frequently applied public administration framework, for example, does not measure degree of decentralization. Since decentralization and centralization represent two ends of a single continuum, the question of degree is an important one. Bossert's (1998) concept of decision space integrates both horizontal and vertical decentralization and is intended to measure the degree of decentralization. This approach, however, does not consider decentralization as a process. The lack of analytic criteria is a key reason for difficulty in determining the outcome of decentralization.

The challenges involve identifying dependent and independent variables and then demonstrating the appropriate associations between them. It is difficult to quantify dimensions such as responsibility, autonomy, power and accountability. The process of identifying independent variables is equally complex. The most common independent variables for decentralization have been fiscal ones, such as local spending as a proportion of national spending. However, fiscal indicators can often be misleading measures of power and authority. It is worth noting that in considering the bivariate analysis in this study, none of these categorical differences observed were statistically significant when subjected to Fisher's exact test.

5.6 Chapter Summary

This chapter discussed the findings of the results found from the study. The variables were considered thematically, section after section comprising human resource issues, financial sustainability, governance challenges and procurement procedures. Deductions were then made as to how the variables influence the concept of decentralisation and its

administrative effect on the Medical sub-BMC of the Korle Bu Teaching Hospital. The bivariate analysis tailed the discussion.

CHAPTER SIX

SUMMARY, CONCLUSIONS AND RECOMMENDATIONS

6.0 Introduction

This chapter presents a summary of the study, conclusions and recommendations. It further speaks to the limitations and direction for future research.

6.1 Summary of the study

The general objective of the study was to determine the impact of decentralisation on the Medical sub-BMC of the Korle Bu Teaching Hospital while the specific ones were to examine the Human Resource issues, the financial state/stability, governance challenges faced by management and the procurement procedure in the same institution. The study was conducted using an explorative, descriptive (quantitative) method. The study site was the Korle Bu Teaching Hospital and the study population was thirty-seven while the sampling technique was purposive. . Questionnaires were used to elicit response from heads of the various management teams composed of, House Committee members, core sub-BMC management members and their unit heads. Data analysis for surveys questionnaires were descriptive, determining proportions and percentages. Fisher's exact test was used to determine the significance of the relationship between the dependent and independent variables. The quantitative data resulting from the structured questionnaires was analysed using SPSS version 18.00. The main conclusions in relation to the objectives of the study have been presented below.

6.2 Conclusion

This study looked at the administrative effect of decentralization on the performance of the Medical sub-BMC at the KBTH. The conclusions reported herein indicate that there has

been no administrative effect of decentralisation on the performance of the Medical sub-BMC of the Korle Bu Teaching Hospital. This agrees with the hypothesis tested based on the descriptive and bivariate analysis done. The key conclusions are reported below.

6.2.1 Human Resource Issues

The study concludes that the hierarchical system as far as human resource is concern was in place and centralized. The decisions of hiring, firing, contracting and determination of salaries were all centralized. It is argued that decentralization often requires enhanced skills and abilities of personnel at local levels to implement decentralized functions. However this study shows from the demographic combinations and the bivariate relationships that there was a limitation of the process because of lack of adequate capacity of various managers.

6.2.2 Financial Sustainability

The literature argues that decentralisation is usually designed to allow peripheral health institutions to operate a revenue – generating commercial system and to exercise higher management authority, aiming to reduce central subsides by improving cost recovery rates. This study however, concludes that this could not be achieved completely, since a little over half of the participants did not prepare financial plans and budgets and had no direct say in disbursement of funds. Financial discretion as a result of decentralisation is limited to the Budget Management Centres, while expenditure regarding salaries and capital investments are determined centrally. With respect to income sources and fiscal autonomy, own resource revenue is comparatively small and local institutions remain dependent on central transfer.

6.2.3 Governance Challenges

The effect of decentralization on governance are mixed and depend on the module of decentralization implemented. In this case the system provides little or no mechanism for local governance participation and limits the periphery to advisory roles.

6.2.4 Procurement Procedure

The study argues that procurement processes are still considered fairly new but decision rights are granted to peripheral institutions within the limit of small transactions only. Medium and large transactions are approved by bid committees. It is argued that with small transactions, the preference is to buy from public recommended suppliers in order to avoid very rigid financial accountability. The bidding processes are considered time consuming and involve a lot of paper work.

6.3 Recommendations

Based on the findings/conclusions of the study, the following are recommended for consideration by health policy makers and practitioners.

1. There is the need for strict policy guide lines to be laid out concerning the inception and implementation of policies in the future.
2. There is the need for managerial training to be instituted before policies are put in place and job descriptions must be known.

6.4 Limitations to the study

The study was beset by the following limitations:

1. The health institution could not provide lots of documents and a vivid chronological institutional memory.

2. Using quantitative research method could not help elicit the perspectives of the respondents as the questionnaires were structured and very rigid.
3. The sample size was small since the study was conducted within one BMC of the entire hospital.

4 The study population did not include members of staff outside the management team members and unit heads to know their views on the effects of decentralisation on their performance as well.

6.5 Direction for further research

Due to the limitations of the study, the following are recommended for consideration by future researchers:

1. Further work should be done on a broader scale and the types of decentralisation or their scope of frameworks determined.
2. Qualitative research method should be applied to explore the perspectives of the management team members and unit head of the effect of decentralisation on their performance.
3. Similar studies should be conducted at a similar teaching hospital (Komfo Anokye Teaching Hospital) to examine and provide some basis for comparison (between KBTH and KATH) on the effects of decentralisation on management performance.
4. Future studies should include members of staff outside the management team members and unit heads to know their views on the effects of decentralisation on their performance as well.

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APPENDICES

Appendix A: Participant Consent Form

Name of Principal Investigator: Foster Gbagbo

Title: Effect of administrative decentralisation in Korle Bu Teaching Hospital on the performance of the Medical Sub-Budget Management Centre.

Purpose of the study:

This study seeks to analyse the administrative effect of decentralisation in the Korle Bu Teaching Hospital on the performance of the Medical sub-BMC. The research hopes to achieve this by assessing performance of the independent variables like, governance, finance, human resource and procurement. An explorative descriptive study method will be employed. Questionnaires and interviews will be used to obtain views from health managers at the various levels in the Hospital.

I……..have been invited to take part in the research ……. I have been told the purpose of this research study is to ; To find out how the process of decentralisation affects the Medical sub-BMC in the Korle Bu Teaching Hospital. I have been told the procedure of the study is; To find answers to the issues raised above, and

a team of researchers will ask a few questions to obtain information. There are no risks, dangers nor discomforts associated with the study.

The information that is collected from this research will be kept confidential. Information about me that will be collected from the study will be stored in a file which will not have my name on it, but a number assigned to it. Which number belongs to which name will not be disclosed to anyone except the principal investigator.

I do not have to take part in this research if I do not wish to do so. I have been told that this proposal has been reviewed by the Ghana Health Service Ethical Review and Clearance Committee. This is a committee whose job is to make sure that research participants are protected from harm. If I have any questions I may ask those now or later. If I wish to ask questions later, I may contact the following:

Hannah Frimpong

ERC Administrator

Tel 0243235225 or 0507041223

I have read the foregoing information, or it has been read to me. I have had the opportunity to ask questions about it and any question that I asked have been answered to my satisfaction. I consent voluntarily to participate as a subject in this study and understand that I have the right to withdraw from the study at any time.

Signed by……

Date……..

Place……

Appendix B: Questionnaire

School of Public Health

College of Health Sciences

University of Ghana

The purpose of this study is to examine the effect of administrative decentralisation of the Korle-Bu Teaching Hospital on the performance of the medical sub-BMC. The findings will help to improve service delivery. Your response and contribution will be used for academic purposes and no disclosure will be made to any third party. However, you are allowed to discontinue this interview at any stage. Thank you.

SECTION A (DEMOGRAPHIC DATA)

1. Age

a. 20-30 ☐ **b. 31-40** ☐ **41-50** ☐ **51-60** ☐

2. Sex

(a) M ☐ **(b) F** ☐

3. Educational background

(a) Primary ☐

(b) Secondary ☐

(c) Tertiary ☐

4. Professional Background

(a) Medical ☐

(b) Nursing ☐

(c) Health Service Administrator ☐

(d) Engineering ☐

(e) Others ☐

SECTION B: Autonomy in Human Resource Management

1. Do you have authority to appoint staff? (a) Yes ☐ **(b) No** ☐

2. Do you have authority to dismiss staff? (a) Yes ☐ **(b) No** ☐

3. Do you have authority to determine staff salaries? (a)Yes ☐ **(b) No** ☐

4. Do you have authority to promote staff ? (a) Yes ☐ **(b) No** ☐

5. Do you have authority to demote staff? (a) Yes ☐ **(b) No** ☐

6. Is there improvement in your output since sub BMC implementation?

(a) Yes ☐ **(b) No** ☐

7. If yes, on a scale from 0 – 10 indicate the improvement as you have seen, where

0 = no improvement and 10 = most improvement.

0 ☐ **1** ☐ **2** ☐ **3** ☐ **4** ☐ **5** ☐ **6** ☐ **7** ☐

8 ☐ **9** ☐ **10** ☐

SECTION C: Autonomy in Finance

1. Do you prepare financial plans and budgets? (a) Yes ☐ (b) No ☐

2. Do you operate bank accounts? (a) Yes ☐ (b) No ☐

3. Are you a signatory to the accounts?(a)Yes ☐ (b) No ☐

4. Do you determine expenditure? (a) Yes ☐ (b) No ☐

5. Is there any improvement in your sources of finance since sub BMC implementation? (a) Yes ☐ (b) No ☐

6. If yes, on a scale from 0-10 indicate the improvement as you have seen, where 0 = no improvement and 10=most improvement.

0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐

8 ☐ 9 ☐ 10 ☐

SECTION D: Autonomy in Governance

1. Do you know that the hospital must set up various committees to help run it?

(a) Yes ☐ (b) No ☐

2. Are they in existence? (a) Yes ☐ (b) No ☐

3. Do they function? (a) Yes ☐ (b) No ☐

4. Is there improvement in governance since sub BMC implementation? (a) Yes ☐ (b) No ☐

5. If yes, on a scale from 0-10 indicate the improvement as you have seen, where 0=no improvement and 10=most improvement.

0 ☐ **1** ☐ **2** ☐ **3** ☐ **4** ☐ **5** ☐ **6** ☐ **7** ☐

8 ☐ **9** ☐ **10** ☐

SECTION E: Autonomy in Procurement

1. Do you know of procurement processes ? (a) Yes ☐ **(b) No** ☐

2. Do you follow them? (a) Yes ☐ **(b) No** ☐

3. Are they cumbersome? (a) Yes ☐ **(b) No** ☐

4. Do you understand them? (a) Yes ☐ **(b) No** ☐

5. Is there improvement in your procurement processes since sub BMC implementation? (a) Yes ☐ **(b) No** ☐

6. If yes, on a scale from 0-10 indicate the improvement as you have seen, where 0=no improvement and 10=most improvement.

0 ☐ **1** ☐ **2** ☐ **3** ☐ **4** ☐ **5** ☐ **6** ☐ **7** ☐

8 ☐ **9** ☐ **10** ☐

SECTION F: Decentralisation

1. Have you heard of decentralisation? (a) Yes ☐ (b) No ☐

2. Is it in practice? (a) Yes ☐ (b) No ☐

3. Do you prefer it to centralisation? (a) Yes ☐ (b) No ☐

4. In your opinion, do those you work with understand it? (a) Yes ☐ (b) No I ☐

5. Is there improvement in your output since sub BMC implementation? (a) Yes ☐ (b) No ☐

6. If yes, on a scale of 0-10 indicate the improvement as you have seen, where 0=no improvement and 10=most improvement.

0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐

8 ☐ 9 ☐ 10 ☐