World Health Organization

Human Resources for Health leadership and management: a prototype curricula package

Case studies

Human Resources for Health leadership and management: a prototype curricula package: case studies

(Human Resources for Health leadership and management: a prototype curricula package.
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Contents

Abbreviations

ADHA	additional duty hours allowance
BSc	Bachelor of Science
CHW	community health worker
CU	curricular unit
DDG	Deputy Director-General
DMC	designated microscopy centre
DPI	Department for Planning and Information
EPWP	Extended Public Works Programme
GMA	Ghana Medical Association
HP	health promotion
HRH	human resources for health
HRIS	human resources information system
HWF	health workforce
IMA	Indian Medical Association
MoU	memorandum of understanding
NGO	nongovernmental organization
NHS	National Health Service
NHWA	national health workforce accounts
NHWFS	national health workforce strategy
NQF	National Qualifications Framework
PBF	performance-based financing
PPM	public–private mix
RNTCP	Revised National Tuberculosis Control Programme
SARA	service availability and readiness assessment
SPA	service provision assessment
TB (DOTS)	tuberculosis (directly observed treatment, short-course)
UHC	universal health coverage
WHO	World Health Organization

The role of actors, interests and politics in the implementation of HRH policy: Introduction of the *Additional duty hours allowance in the Republic of Ghana*[1]

Learning objectives

Characterize the role of policy, politics, stakeholder engagement and evidence-informed policy dialogue for shared decision-making.

Tasks and questions

1. Carefully read the case study below and discuss the following questions in your group:
2. What were the key contextual factors that impacted both policy agenda-setting and implementation?
3. Identify the different spheres of human resources for health (HRH) policy that impact on this policy's design and implementation.
4. Identify the most important actors/groups in the case study. How would you characterize:
   a. their leadership style?
   b. the power they hold?
5. Discuss the most important disjunctures between policy intent and implementation and what caused them.
6. Which policy decisions and actions advanced or undermined the agenda for universal health coverage (UHC) and how?
7. Drawing on your own experience, what might have been alternative strategic policy levers and courses of action for policy-makers to generate better outcomes? Consider this question from the perspective of specific policy-makers (national or provincial/state/local) you identify in your discussion.
8. What stakeholder engagements would have been necessary to achieve these alternative strategic policy levers and courses of actions?

Key insights and lessons will be shared and discussed in plenary.

Case narrative

Introduction – Ministry of Defence

In 1998, the 37 military hospitals in Ghana, under the Ministry of Defence, introduced allowances that effectively translated into wage increases for its doctors. The military hospital decision-making is autonomous of the Ministry of Health and the hospitals respond to the Ministry of Defence as part of the Armed Forces. However, while minor allowances can be introduced autonomously, salary rises need the approval of the Ministry of Finance.

[1] Based on: Agyepong IA, Kodua A, Adjei S, Adam T. When 'solutions of yesterday become problems of today': crisis-ridden decision making in a complex adaptive system (CAS)—the Additional Duty Hours Allowance in Ghana. Health Policy Plan. 2012;27(Suppl 4):iv20–31 (http://doi.org/10.1093/heapol/czs083, accessed 14 June 2021).

Historically efforts tended to provide adequate privileges to the military to pre-empt dissent. Officers of the Ministry of Defence – including health workers – are not allowed to go on strike.

Public sector doctors' strike

There had been long-standing discontent among doctors in the public sector, mainly employees of the Ministry of Health, over their extremely low wages. Junior doctors, who on average work longer hours than senior doctors and are unlikely to have their own private clinic, were particularly restless over the issue. Not surprisingly, they were the first to agitate for and initiate industrial action, using the disparity created between the pay of doctors employed by the Ministry of Defence and that of other public sector doctors as a trigger to take action. This action received the backing of their senior colleagues, and the Ghana Medical Association (GMA) declared a nationwide doctors' strike to back their demands for pay reform. The GMA presented the government with three options: salary increases; compensation for work overload; or compensation for long hours worked beyond the standard 40 hours per week in the form of an additional duty hours allowance (ADHA). The GMA had been floating all three ideas for some time as possible solutions to the simmering discontent over conditions of service.

Doctors employed in the public sector represent a large part of health service provision. The thriving licensed private sector is predominantly in the metropolitan and larger urban areas, but not affordable for poorer people. In rural areas, apart from the Christian Health Association of Ghana, the only service delivery options are those provided by the Ministry of Health/Ghana Health Service. The strike therefore effectively brought health service delivery in Ghana to a near standstill. There was a public outcry, with the press and the public generally sympathetic to the doctors, demanding that the government appease them rapidly so that services could be restored.

Introduction of ADHA

The government entered into negotiation with the GMA and selected the option of payment of an ADHA, ostensibly to buy time and because the Ministry of Finance felt that given their low numbers, such a payment for doctors only (instead of all categories of health workers) would not make a noticeable difference to the government budget for the year. In addition, it was felt that doctors were indeed working extremely long hours. A memorandum of understanding (MoU) was thus signed between the government and the GMA, to take effect from 1 January 1999, in which it was stated that the ADHA was intended to be "an incentive to compensate for the abnormally poor basic salaries of the medical and dental practitioners in the public sector", and that the agreement was for "160 hours as the average annualized number of hours per month for the payment of the allowance." Since the GMA represents doctors as well as dentists, the arguments were made for both groups and the ADHA was to be calculated on an hourly rate, derived from the salary of the medical or dental practitioner in question. The GMA called off its strike, but with the proviso that if by 1 March 1999 the promised allowances had not been paid, they would resume the industrial action without any warning.

In early February 1999, the Ministry of Health released a memo to all regional directors and other administrative levels containing guidelines for implementing the ADHA policy. The guidelines stated that payment of ADHA was to be done at the facility level with retrospective effect from 1 January 1999. Facilities were to prepare monthly duty rosters for doctors and dentists to ensure 24-hour service. Regional directors of health services and heads of facilities were to monitor implementation arrangements. A review of implementation experiences was planned for May 1999.

Funds for the ADHA were approved and released on 26 February 1999 to all 10 regions and the two teaching hospitals. However, administrative and procedural delays meant that by 1 March ADHA had not been paid. A new cycle of dissatisfaction was thus created, and on 1 March, junior doctors across the country laid down their tools at what they perceived as a breach of the agreement. They resumed work, however, on the appeal and reassurance of the GMA (who had been working with the government to resolve the administrative problems) that the money had been released and payment was about to commence.

Nurses' and other health workers' grievances

The decision to give ADHA to doctors now became the trigger for unintended consequences by further worsening already low nurse satisfaction over their remuneration. Nurses had been watching the doctors strike and its outcome from the sidelines as they also had longstanding grievances over inadequate wages. In April 1999, junior nurses began a strike requesting that nurses also be included in the ADHA. They were supported by the Ghana Registered Nurses Association and the Nurse Anaesthetists Association. A seven-day nationwide strike by nurses ground the health sector to a near halt. The strike ended with an agreement between the government and the nurses unions to include nurses in ADHA payments, also with effect from 1 January 1999. Administrative requirements were introduced requesting that overtime payments be calculated based on duty rosters, authorized by the head of an institution and verified by information from the attendance books.

The decision to include nurses in the ADHA not only created improved nurse satisfaction, but became the trigger for reduced satisfaction and related strike action by other health sector workers. Recognizing that their fragmented nature and small numbers made them ineffective in any negotiation in ADHA payments, the less powerful health worker unions – such as the Government and Hospital Pharmacists Association, the Medical Assistants Association, the Association of Laboratory Scientists and the Association of Health Service Administrators – joined forces with the Ghana Registered Nurses Association. They labelled themselves the "representatives of health workers other than doctors" and demanded that the Ministry of Health include them in the ADHA or else they would strike en masse.

By September 1999, in response to the strikes and agitations, virtually all permanent workers in the health sector were included in the ADHA. The MoU for ADHA between the government and other health worker associations was based on three conditions: payment would be for hours beyond the standard 40 hours per week; timesheets should be kept by each staff member; and these should be verified by management before payment. The MoU was signed on 30 September 1999.

While medical doctors working in teaching hospitals as employees of the Ministry of Health were included in the ADHA, those working as full-time lecturers in medical schools, and thus employees of the Ministry of Education, were not. Doctors teaching in medical schools threatened to stop teaching and go back to practice in the Ministry of Health to improve their salary. In response, an MoU was also signed between the Ministry of Health and medical schools to include them in the ADHA.

High cost of ADHA and payment delays

The expanded ADHA scheme, including almost all permanent staff in the health sector, did not lead to industrial peace despite the fact that ADHA payments were often more than the staff salaries themselves and led to a doubling or more of staff incomes. This was because of repeated delays in payment, leading to further strikes by doctors, nurses and other health workers. As ADHA claims rose steadily, the Ministry of Health introduced regional and institutional financial ceilings on the amount of ADHA to be paid, to limit the rapid growth in costs. This was not completely successful and the ADHA bill continued to rise, with the government continuing to struggle with prompt payment leading to threats of, or actual strikes by health workers. The health sector entered a vicious cycle of payment delay followed by strikes to enforce payment, followed by payment to end strikes and back again. The cycle appeared to have the additional side effect of creating in the mind of health workers and their unions the idea that the only language the government responded to was industrial action rather than dialogue and trust that agreements would be honoured.

The repeated delays in payment of ADHA were attributed by government to the non-submission of the verified time sheets by the respective administrative levels to enable payment. While there were indeed delays in submission of some returns, this did not appear to be the full story as some claims, submitted with full justification, were still not paid on time. It appeared that some, if not all the delays were due to government challenges in meeting the mounting bills. For example, on at least one occasion when a delegation from the GMA came to the Ministry of Health because of ADHA arrears, they were directed to the Minister for Finance, who did not appreciate not being informed of the problem. However, technical staff were told to look carefully at the Ministry of Health budget and identify from where the funds could be taken. Their answer: that year no new capital project could be undertaken.

ADHA management problems within regions and facilities also fuelled discontent and unrest