Human resource mobilisation and management in health systems of Africa: a comparative study of health insurance scheme and health facilities in Ghana

Daniel Dramani Kipo-Sunyehzi

Legon Centre for International Affairs and Diplomacy (LECIAD),
University of Ghana,
P.O. Box LG25, Legon-Accra, Ghana
Email: dkipo-sunyehzi@ug.edu.gh

Abstract: This paper analyses the human resource mobilisation and management in the health systems of Africa. It compares five health organisations from public-private sectors in terms of how they mobilise and manage human resources in the implementation of Ghana's health insurance scheme. It adds to comparative research on HRM practices and organisational culture in a developing world context. It makes two unique contributions: from public-private organisational perspectives and employees/workers and clients perspectives on HR practices to improve workers skills/knowledge and meet clients' health needs. A multi-actor research methodology was adopted with in-depth interviews, focus group discussions, on-site direct observations and documents with a sample size of 107. The results reveal some ironies in public-private organisational behaviour, faith-based, profit-client oriented styles of HRM practices and how such factors affect clients' access to services. It found organisations with more bureaucracies/red tape and professionalism were the least preferred as clients experienced more waiting times.

Keywords: human resource; public-private organisations; health insurance clients; National Health Insurance Scheme; NHIS; Ghana; Africa.

Reference to this paper should be made as follows: Kipo-Sunyehzi, D.D. (2022) 'Human resource mobilisation and management in health systems of Africa: a comparative study of health insurance scheme and health facilities in Ghana', *Int. J. Human Resources Development and Management*, Vol. 22, Nos. 1/2, pp.39–55.

Biographical notes: Daniel Dramani Kipo-Sunyehzi is a Research Fellow at the Legon Centre for International Affairs and Diplomacy (LECIAD), University of Ghana. He coordinates the monthly publication known as 'Conflict Watch' in the Centre. His research areas are Public Administration and Public Policy, Health Policy and Health Systems, Social Policy and Social Welfare, United Nations Sustainable Development Goals/Universal Health Coverage and Foreign Policy and International Politics.

1 Introduction

The research aims to explore how human resources (HRs) affect the health systems in Africa, with specific reference to Ghana's health sector in the implementation of the

National Health Insurance Scheme (NHIS). It aims to identify facilitating and inhibiting factors across countries particularly in Africa. HR mobilisation for health service delivery with an emphasis on the situation of Africa. HR remains a key challenge in the health systems of Africa as most countries are faced with an inadequate supply of health personnel and distribution, low salaries and remunerations, and high attrition to other parts of the world especially the developed countries. These conditions affect healthcare service delivery of chronic diseases like antiretroviral therapy. Also, other HR-related issues in the Southern African region have to do with health personnel productivity and organisational culture-'cultures of service delivery', the inability to retain those trained and HIV infection (Schneider et al., 2006). There is also the problem of brain drain in Africa as a result of globalisation and international migration, as many health professionals migrate to the developed countries (Marchal and Kegels, 2003). Thus, a contributing factor to the decline in health worker-to-population ratios compared to the developed countries.

Liu et al. (2017) examine the supply side of health workers verse the health worker 'needs' in the health systems of several countries particularly the low- and middle-income countries to achieve universal health coverage using the World Health Organisation (WHO) framework. The results of the study predict a higher demand side for health workers for the upper-middle countries than low-income countries. For the health systems of countries to perform very well, there is the need for adequate HR mobilisation at the right time, appropriate number and right incentives to work (Anand and Bärnighausen, 2012; Liu et al., 2017; Caniëls and Hatak, 2019; Luo et al., 2020).

Several studies identified challenges in the mobilisation of HRs for healthcare services in low-and middle-income countries. These challenges are multifaceted and cut across countries in the African continent and other low-and middle-countries ranging from HR supply shortages to health services availability, accessibility, acceptability, needs-based, inequitable distribution of professional health workers and the highly centralised personnel management systems of these countries. These challenges affect the quality of health services and their health systems move towards achieving universal health coverage (Dovlo, 2007; Scheil-Adlung, 2013; Cometto and Witter, 2013; WHO, 2016; Kipo-Sunyehzi et al., 2019; Cometto et al., 2020).

Health systems everywhere depend on HR (health workforce) and the health workforce is of strategic importance to countries health systems in the fight against diseases-international disease control plans (Marchal and Kegels, 2003). Thus, there is an increasing demand for health workers globally to meet the health needs of many countries teeming population, to support the ageing, to meet the changing epidemiology, and take advantage of new technologies or medical advancements (WHO, 2016). The increasing attention is not only on HR mobilisation but the ability to keep the health workforce with an emphasis on work performance (achieving the desired outcome). Several studies show the need to improve the performance of health workers specifically on 'what works, in what circumstances or contexts (Kowalski and Loretto, 2017).

The calls for strong foundations for national health systems after the outbreak of Ebola in West African neighbouring states (Liberia, Sierra Leone and Guinea) in early-mid 2014 has been timely. As the need to strengthen the health systems of low-and middle-income countries which appeared to be weak, coupled with a low health workforce. Research shows the three countries are among the 'world's weakest health systems in terms of 'severe shortage of health workers' in the context of international thresholds for medical doctors, nurses and midwives [Gostin and Friedman, (2015),

p.1903]. There are shortages of 223 recommended by WHO and 345 recommended by the International Labour Organization per 100,000 population. Thus, Liberia, Sierra Leone and Guinea have 'one-fifth to less than one-tenth' of the international recommendations (Gostin and Friedman, 2015). The three countries health force shortages or deficits are not much different from many other low-and middle-countries. Also, the current coronavirus (COVID-19) pandemic shows how unprepared most health systems are and the urgency for countries to put more measures in their health systems, for healthcare services and to boast a health workforce (WHO, 2019, 2020). HR mobilisation in this research is about the ability to recruit the right health workers for a country health system for the delivery of healthcare services at health facilities to the people.

2 Human resource management in organisations: 'model of culture-fit'

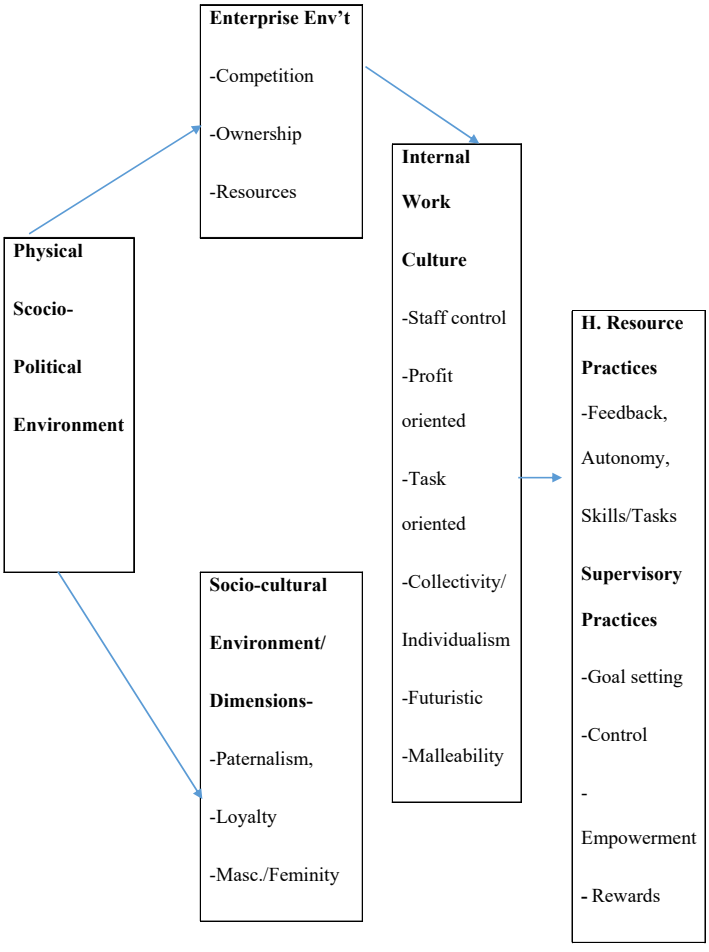
This paper examines 'organisational culture' (Hofstede et al., 1990) and how it affects HR practices, management styles in the low-and middle-income countries context of Ghana. It also looks at how organisational culture affects the implementation of Ghana's health insurance scheme. Thus, to get the right employees, at the right time and for the right position, with some motivations, commitment to work towards organisational goals, mission and visions are crucial for this study. Organisations are only focused on the mobilisation of the right HRs through a rigorous and competitive recruitment process. But are concerned with efficient management of HRs towards their organisational goals and to achieve 'competitive advantages' (Luo et al., 2020). Some studies on human resource management (HRM) and practice literature emphasise employability, motivation, retention and health which are crucial factors (Adzei and Atinga, 2012; De Vos and van der Heijden, 2015; Ybema et al., 2020).

There have been many studies in HRM on public sector organisations, as the public sector is seen as the sector with the largest employer. Also, public sector organisations have a very large workforce from health to other sectors in many countries. Thus, more studies on public sector organisations. The public sector organisation is typically based on their public ownership, funding and authority that is with political leadership as key stakeholders. Public organisations operate largely for public good or value for people/citizens (Perry and Rainey, 1988; Christensen et al., 2007; Van Wart, 2017; Kipo-Sunyehzi, 2019). Private sector organisations, on the other hand, operate with the motive to maximise profit and to promote their shareholders' interests. Studies suggest public organisations HR practices are more transparent and accountable to the public especially on public spending of money or funds compared with private organisations. Also, public organisations HR practices are subject to more institutionalisation-participatory and involve collective bargaining on incentives (Christensen et al., 2007; Knies et al., 2018).

Several studies show the HRM practices in private organisations are quick, less bureaucratic, and create room for innovations. The public sector organisations are faced with excessive red tape, lateness, managerial autonomy, the bureaucratisation of promotions, training, performance appraisals rules and procedures among others and HRM link between employee attitudes and behaviours and performance (Bozeman, 1993; Knies et al., 2018; Kipo-Sunyehzi, 2019).

There may be some 'organisational tensions' within and or outside between or among employees at the organisational and individual levels. The tensions may be based on different qualifications (certificate, diploma or degree holders), based on contracts (temporary or permanent/tenured), professions (trained and or untrained personnel), and superior-subordinate relationships in HRM theory, method and practice in organisations (Fudge, 2006; Kinnie and Swart, 2020). These work conditions affect employees' performance and commitment, likewise, the type of cross-boundary workings, all have implications for employees. In this study, public-private organisations HRM systems, methods and practices are crucial.

Figure 1 Analytical framework (model of culture-fit) (see online version for colours)



Source: Modified from Aycan et al. (1999, p.503)

2.1 Model of culture-fit

Aycan et al. (2000) look at culture as a key factor in organisation behaviour, performance and HRM practices and techniques in different socio-cultural environments. The 'model

of culture-fit' is used to explain how different cultures influence or impact HRM practices in organisations. Internal and external cultures of organisations are important. They affect HRM practices, managerial styles and the socio-political context in which the organisations operate or function in a country. Proponents of model of culture-fit (Kanungo et al., 1999) argue that organisations are influenced by socio-cultural values/environments and the enterprise environment and these two factors affect the internal work culture of organisations, which in turn influence managerial practices or HRM practices. This model of culture-fit has relevance in developed and developing countries contexts due to the differences in their socio-cultural values (Kanungo and Jaeger, 1990; Mendonca and Kanungo, 1994; Kanungo and Aycan, 1998; Kanungo et al., 1999; Aycan et al., 1999, 2000). The model of culture fit is relevant to this study, as the study looks at how public and private organisational culture (beliefs, values, missions, visions) affect HRM practices in healthcare service provision in a developing world context of Ghana.

The dependent variable is health insurance clients access to health services and the independent variable is the HR endowment of health facilities (health organisations) and the health insurance office.

3 HRM in Ghana's health system and NHIS

Studies suggest that the HR strength of the NHISs appeared to be inadequate in Ghana. As such, health insurance clients have to spend many hours at the scheme offices seeking services such as registrations and or renewals of membership of NHIS (Alfers, 2013; Kipo-Sunyehzi, 2019). Other studies look at HRM in organisations in developing countries including Ghana on factors that affect HRM practices. 'National culture' is one such factor that affects HRM practices in Ghanaian organisations-public and private with the interplay of 'historico-political' issues/factors-British colonial administration system to a current democratic dispensation. In this era, the organisations adopt HRM practices that make them compete with others in production, service provision and for clients. Also, the two 'external environmental factors' that affect HRM practices are government dominance in the economic and political arenas and national socio-cultural issues/factors-traditions (Debrah, 2003; Akuoko, 2008). The health systems of countries with centralised, and or decentralised management systems, their resource allocation system also influence HRM practices, styles, healthcare services quality, efficiency, staff initiatives, innovations and participation in decision-making among others (Asante and Zwi, 2009; Sakyi et al., 2011; Sumah and Baatiema, 2019).

Some previous studies examined staff perceptions of quality healthcare services, staff actions and behaviours and how these factors affect clients' access to healthcare services in Ghana. Also, some issues related to staff management styles, administrative decisions, motivations, retention, reimbursement, information dissemination, staff performance appraisals among others in health and NHIS in Ghana (Adzei and Atinga, 2012; Alhassan et al., 2016; Kotoh et al., 2018; Kipo-Sunyehzi et al., 2019). These issues/factors are analysed in this study such as the health system, in-service training, supervision, management types, and organisational culture.

4 Methods

This research took place in the African context of Ghana, it involved public-private organisations in the implementation of NHIS. It took 12 months of fieldwork in three phases, first in 2012, send in 2013 and it ended in October 2014. The healthcare facilities are termed health organisations. It involved five health organisations (two hospitals, two clinics and a health insurance office- district and regional). These cases were selected based on their direct involvement in the implementation of NHIS from the start of the policy and the diverse health services provision to health insurance clients-accreditation and renewals profiles (NHIA, 2014). Secondly, the organisations have diverse work cultures and this study looks at how such diverse organisational cultures affect their HR mobilisation and management practices from two actor perspectives-staff and clients. Thus, the study adopted a comparative case study approach. Organisations in such a competitive environment will adopt various strategies that help them to operate, survive and attract more clients to their services. As stated in the literature the private organisations are profit maximisers while their public counterparts seek public interests and good. Hence how public-private organisations orient their staff towards clients and how clients perceive the staff of the public-private organisations are crucial in this study.

This study adopted a comparative case study approach and draws insights from Greenstein and Polsby (1975, p.8) where the researcher used five cases (organisations) and report and interpret 'numerous measures on the same variables of different 'individuals'. The 'individuals' may be persons or collectivities. The focus is on individuals and organisations in this study. Also, the comparative case study approach draws insights from George and Bennett (2005, p.182) work which posits that the 'relationship between independent and dependent variables' and the causal process that connect the two variables. In this regard, the researcher looks at how HRs mobilisation and management strategies in public-private organisations affect the implementation of NHIS (policy) in terms of health insurance clients' access to health services (out-patient, in-patient, diagnostics, pharmacies, eye-nose-throat among other services). This implies this study involves a 'single case' (Yin, 2014) which is the NHIS with 'multiple cases' (five implementing organisations). Hence, this study adopts a 'multiple case study approach' and examines similarities and differences across the five cases [Yin, (2009), pp.138–140]. Yin opines that case study research involves the use of 'multiple sources of evidence' [Yin, (2014), pp.16–17]. This researcher uses multiple sources of data to converge in a triangulating fashion. The study case study protocol is presented in Table 1.

Table 1 Case study protocol

1	The study sites and persons (the scope of the study)
2	The design of research questions (for staff and clients)
3	The design of data collection instruments (in-depth interview guide, focus group guide)
4	Identification and selection of appropriate study participants (staff and clients)
5	Three-phase fieldwork (Preliminary-2012, Main fieldwork, 2013, Last phase 2014)
6	Data analysis (transcription, coding, thematic analysis, peer debriefing, editing, description)
7	Comparability of cases (similarities and differences in HRM practices, styles, behaviours)
8	Data saturation level, dissemination (report, articles, book chapters developments)

4.1 Study participants

The study participants were purposively selected based on their positions and knowledge of the study research questions through the 'purposive sampling method' in a comparative fashion as in previous studies (Flyvbjerg, 2006; Bryman, 2012; Yin, 2009, 2014; Haddock-Millar et al., 2016). The researcher also used the cluster sampling method to involve all categories of health insurance clients per NHIS laws (GoG, 2003, 2004, 2012). The snowball sampling method was also utilised to reach out to other participants. Two categories of participants were involved (staff and clients). The study participants were interviewed through face-to-face, focus group discussions (FGDs), documents review and direct observations at organisations and an office. Four FGDs took place in health facilities (organisations) that involved only clients but could not organise FGDs with staff due to time constraints. Three other FGDs took place at the community level (home setting) with health insurance clients. The in-depth interviews and FGDs participants are given in Table 2.

Table 2 Interview participants

Cases	*Categories of participants*	*Number*
Public health organisations	Directors, managers, administrators and other staff	20
Private health organisations	Directors, Proprietors, Administrators and other staff	17
Health insurance clients	Contributors, premium payees and exempt groups	70
Total participants		*107*

4.2 Data analysis

Data gathered from each case (organisations) were analysed along with major themes and sub-themes and analysed thematically. Also, along with occurring patterns and for their similarities and differences. The document sources (secondary) were matched with the interview sources, interviews records (face-face, FGDs) were transcribed, handwritten field notes and on-site direct observations notes typed out, with translations (reliability) and towards triangulation of data sources. Some validity strategies like 'member checking, peer debriefings' were done from one phase to another. Coding and some ethical issues like participants voluntary participation, privacy, confidentiality were strictly adhered to in the study (Bryman, 2012; Yin, 2014). The two main research questions for the study include:

1 How do HRs affect the implementation of NHIS in Ghana?

2 What are the differences in HRs between public and private health facilities?

5 Findings

5.1 The HR situation in Ghana's health system

The workforce of Ghana Health Service (GHS) stands at 68,132 which constitutes 66% in Ghana and the remaining for the other units. It indicates a 6.6% increase over 2015 [GHS

Annual Report, (2016), p.16]. Despite the increased health force of GHS, there are still challenges in the recruitment and retention of health staff in both the public and private sectors of Ghana's health system. The brain drain continues to be a key factor in the health systems of most African states in healthcare service delivery. It involves the migration of health professionals to developed countries after training in Africa. Ghana as a developing country also has the challenge of how to retain skilled HRs especially those in the health sector with particular reference to medical doctors due to 'medical brain drain'. Ghana has one of the 'highest brain drain rates in sub-Saharan Africa' and this poses a serious threat to Ghana's health system [Gibson and McKenzie, (2012), p.6]. Ghana lost 60% of medical doctors in the 1980s and about 600–700 Ghanaian medical physicians are practising in the USA alone, which constitutes about one-quarter of Ghana's doctors [Kana, (2009), p.8]. There is also 'economic consequences' (loss of resources) due to migration, with 'increased mortality' (loss of lives) in low and middle-income countries-LMIC due to inadequate doctors/physicians (Saluja et al., 2020).

Even though the number of doctors per population (clients) in Ghana has improved slightly from 2008 onward at the national, yet there are still a lot of shortages of health staff particularly medical doctors. Fieldwork records and interview responses with some health officials suggest that the increasing number of medical schools is a key factor in the improved doctor-to-population ratio. However, there are still challenges on the efficient resource allocation, dealing with 'equity' in the distribution of medical staff across Ghana especially medical doctors among others. This was how a Director, Research and Development Division in Accra Ghana commented:

> "The health force has improved tremendously in Ghana, there are several new medical schools in addition to those at the University of Ghana and Kwame Nkrumah University of Science and Technology. Besides, the government is also trying hard to improve the working conditions of doctors to curb migration to other countries. But there is still the challenge of getting the doctors to rural districts. There are several incentives for them but their willingness to remain there is a challenge. Remember, other health staff, are included."

At the regional level (Northern Region), the region also experienced a slight increase in several medical doctors posted there from 2008 onwards. This situation was due to the efforts of the Regional Health Directorate of GHS and Chief Executive Officer (CEO) of the Tamale Teaching Hospital (TTH) to attract more doctors to the hospital. The increase was not limited to only medical doctors but included other health staff. A senior HR official at the regional health directorate said this on health force in the region:

> "The number of health staff posted to the Northern Region has improved and some of the workers accepted postings to the various districts. Also, the new teaching hospital and the University for Development Studies School of Medicine and Health Sciences contributed to more doctors in the region."

Besides interviews, some information was obtained from official documents sources. The doctor-to-population ratio at national (Ghana) and regional (Northern Region) are presented in Table 3.

The HR situation in the Northern Region from Table 3 is not good in terms of doctor-to-population ratio with national. The Daily Graphic (2014) front-page publication captioned 'hospitals cry for help: in three northern regions'. The medical personnel in the three regions are ageing and getting close to retirement. The publication argued that the

HR capacity in northern Ghana remains a big challenge due to the refusal of some medical doctors to accept posting there. On variations across regions, Ministry of Health (MoH) records support that all the ten regions of Ghana except the Greater Accra and Ashanti regions are below the 'national average' of less than 10, 000 one doctor-to-population from 2013 to 2017 [MoH, (2018), p.30]. The national average of one doctor to less than 10,000 (1: < 10,000) is still far from the World Health Organization (WHO) standard of one doctor to 1000 population (1:1,000) (WHO Report, 2020).

Table 3 Doctor-to-population (clients) ratio for national and regional levels

Year	*National level (Ghana)*		*Regional (Northern Region)*	
	Medical doctors	*Doctor: population ratio*	*Medical doctors*	*Doctor: population ratio*
2008	1,855	1: 13,074	33	1 : 70,744
2009	2,033	1: 11,929	46	1 : 50,751
2010	2,325	1: 10,423	134	1 : 18,257
2011	2,477	1: 10,209	117	1 : 21,801
2012	2,477	1: 10,209	117	1 : 21,801
2013	2,730	1: 9,749	131	1 : 20,685
2014	3,016	1: 9,043	117	1 : 23,759
2015	3,263	1: 8,808	208	1 : 18,380
2016	3,365	1: 8,481	216	1 : 13,419
2017	4,016	1: 7,374	269	1 : 11,130

Source: Ghana Health Service (2008–2016) and Ghana Health Service (2017–2018)

At the district level, the researcher examined the staff strength and capacity of the five cases (Health Insurance Office and the four health organisations (health facilities) and how their HR endowment affect the implementation process of the NHIS and the outputs in terms of health insurance subscribers' access to healthcare services at the local level in Ghana. The five cases are presented in two ways: the office and health facilities.

5.2 HRs at health insurance office

The researcher poses the question for NHIS officials: how does the HR of TMMHIS affect the implementation of NHIS? The officials of the Tamale Metropolitan Mutual Health Insurance Scheme (TMMHIS) indicated the HR base has improved over the past years in meeting the teeming numbers of health insurance clients (beneficiaries). The officials in the health insurance office attributed the increased staff strength to the 'temporary staff' like National Service Scheme (NSS) personnel, National Youth and Employment Programme (NYEP) interns, and some industrial attaches. The increased numbers in the health insurance office (TMMHIS) affected the implementation of NHIS at the local positively.

The results show that the increased numbers helped in registration, renewal processes. It also helped in the collection of annual premiums from health insurance clients, distribution of ID cards, communities outreach programmes and in-service training for

service providers. The temporary staff has been engaged in other duties which have given the permanent staff more time to organise in-service training for service providers on tariffs, claims management, computer programmes and monitor revenue collectors among others to improve skills of service providers in the delivery of healthcare services to health insurance clients (beneficiaries). Some interview findings further revealed that the increased staff strength in the permanent staff helped in the efficient monitoring of service providers (hospitals, clinics and others). This was how TMMHIS officials commented on a HR on the implementation of NHIS.

> "We work under pressure because of limited numbers some time past but National Service Scheme decision to post more personnel to scheme office has helped us. I must commend NYEP too they are helpful and those on attachment. These students help in managing claims too (I: SO4). Similar opinions were shared by officials (I: SO5, I: SO3, I: SO2)."

However, one unit indicated that they did not feel much of the help of the temporary staff as many were not working directly under the unit. This was what one official said on how HRs affect the implementation of NHIS at the local level (TMMHIS):

> "Yes, there are many NSS personnel and other attaches but many of them are not directly engaged in the accounting related activities. You know this unit is a sensitive one, we don't bring all on board (I: SO1)."

Apart from interviews, the researcher reviewed documents on HR practices or patterns at the health scheme office (TMMHIS). The office consists of a scheme manager, four-line managers (accountant, management information system (MIS), claims and public relation officer). Other permanent staff members include a data entry clerk and a driver. In addition to this permanent staff, there was the temporary staff. The HR data on TMMHIS showed an increased number of permanent staff over the years. The increased number of permanent staff of TMMHIS and the assistance offered by the non-permanent staff helped improve the relationship between TMMHIS and service providers in the implementation of NHIS. The increased HR helped in these areas: fast claims management, more time for visits and more supervision and in-service training among others which improved health insurance clients' access to health services at the scheme office and facilities.

5.3 HRs at health organisations (health facilities)

MoH HR report revealed that 'majority of the highly skilled staff' in Ghana were in the public sector while mission clinics and hospitals staff were 'mostly semi-skilled' with over 50% employees as 'auxiliary and ward assistants'. Also, the private self-finance employed 10% of the workforce with staff mostly in urban areas. The private sector has a 'more number of health facilities' but appeared to have a 'proportionately smaller number of staff' than those in the public sector [MoH, (2007), p.9, 2018].

The study found that the two public health organisations (WH, BC) received staff directly from GHS/MoH (government). The mission hospital (SDAH) received some staff directly from GHS and others through their internal recruitment process while the private clinic (HAC) recruited staff by itself without any financial support from the mission or government. Table 4 shows the staff strength, capacity/size of the four health organisations (healthcare facilities) in the Tamale Metropolis.

Table 4 shows the two categories of staff namely medical and non-medical. By medical staff, this refers to health workers directly involved in the delivery of healthcare services. Data showed the public hospital (WH) has appropriately 70% more medical personnel (184) than a private hospital (SDAH) with 112. While the private hospital had four medical doctors, only two doctors were at the post in the public hospital. In terms of medical or physician assistants, the public hospital had seven against two in a private hospital. Nurses are considered key actors in the delivery of healthcare services. They usually assist medical doctors and medical assistants in both out-patient and in-patient and other healthcare services. Professional nurses (general, midwives, enrolled, community nurses), the public hospital had 147 professional nurses against 54 in a private hospital in the delivery of healthcare services to NHIS beneficiaries/clients. Thus, the public hospital employed almost three times more professional nurses than the private hospital.

Table 4 The staff strength of health organisations (healthcare facilities)

Categories of staff	*Healthcare facilities*			
Medical staff	*WH-public*	*SDAH-private*	*BC-public*	*HAC-private*
Medical doctors	2	4	-	-
Medical/physician assistants	7	2	1	2
Locum doctors	-	4	-	-
Professional nurses	147	54	19	4
Non-professional nurses (ward aides)	9	12	1	3
Nutritionists	-	1	-	-
Medical record keepers	2	10	1	3
Pharmacists/pharmacy technicians	5	3	1	2
Dispensary assistants/attendants	-	8	-	1
Laboratory technicians/assistants	6	4	-	1
Radiographers/X-ray technicians	1	-	-	-
Clinical engineer/optometrist/assistants	-	4	-	-
Anaesthetists/biomedical scientists	5	6	-	1
Total medical staff	*184*	*112*	*23*	*17*
Non-medical staff				
Administrative staff/Administrators	5	14	1	1
Accounts staff/Finance/NHIS officers	12	19	2	3
+Orderlies/cleaners/drivers/casual workers	13	20	8	6
Total non-medical staff	*30*	*53*	*11*	*10*

Source: WH Annual Performance Review, 2013; SDAH Annual Report, 2012; Human Resource Report, 2013; BC Annual Review, 2013; HAC Clinic Annual Performance Review, 2009–2011 *Professional Nurses: general registered, midwives, enrolled, community health and public health

On the provision of specialised healthcare services, the private hospital employed four specialists like a clinical engineer (trainer, adviser), optometrist and assistants (eye care) while these specialists were absent in the public hospital. The public hospital employed a radiographer/x-ray technician for scan (X-ray) services but this specialist was not found in the private hospital to render healthcare services to health insurance clients.

5.4 In-service training and supervision of staff of healthcare facilities

On in-service training for staff, the study found in the private clinic that management met staff regularly to review their healthcare service delivery. The rationale for periodic in-service training was to update staff on tariffs, claims filling, management of folders, prescriptions, injections and diagnoses among others. This was how a senior administrative official in a private health organisation (private clinic) commented on in-service training:

> "Our medical assistant has been providing healthcare services in Tamale for over 20 years, he often shares his experience with new ones and updates on quality services to attract clients" (I: PRC1).

Table 5 Health insurance clients perspectives on Staff HRM practices, actions, styles behaviour

HRM factors	*Public hospital*	*Private hospital*	*Public clinic*	*Private clinic*	*Health insur. office*
Verification of ID cards	More procedures	Less procedures	Less procedures	More procedures	More procedures
Waiting times at facilities	More hours less care	More hours good care	Fewer hours good care	Fewer hours very good C.	More hours less care
Harshness	More harsh words	Less harsh words/hope	Few harsh words	Less harsh words	Few harsh words
Attention for clients	Less attention	More attention	Some attention	More attention	Less attention
Organisations cultures	No profit individualism	Less profit collectivism	No profit mixed	Less profit collectivism	No profit individualism
Organisations supervisions	Less	More	Less	More	Less
Competition	Less	High	Less	More	Less
Staff behaviour	Not so good, not caring	Very good, caring	Mixed, some caring	Very good, caring	Not so good, not caring

Note: Fieldwork data: in-depth interviews, FGDs with health insurance clients/beneficiaries.

Other staff confirmed such training often takes place at their usual less busy periods of the day in order not to distract healthcare service delivery. One in-service training session was observed at the private clinic. The researcher was told the training focused more on drugs and health insurance claims management. Both interview findings from staff and direct on-site observations revealed that facilities that have more staff to handle these services: NHIS card verification, collection and distribution of beneficiaries' folders at registrar were able to speed up the processes involved in clients accessing healthcare services at health organisations (health facilities). Short in-service training was common

in the private clinic while in-service training with more duration at the public clinic. This was revealed by staff, as such training is often organised outside the facility. Another difference in HRM practice found was that there was more supervision of staff in the private clinic than in the public clinic. There was more visibility of the senior administrative officer at the various sub-units.

Between the two bigger health organisations (hospitals), it was found in the public hospital that the supervision of staff was left with sub-units heads. Hence, the researcher noted the key roles of matron and senior nurses at wards in supervising nurses in healthcare service delivery. Similar supervisory structures were found at the private hospital. The noticeable difference was in terms of autonomy to carry out decisions in healthcare service delivery, the public officials had more autonomy than their private counterparts, while short training and supervisions were more in the private health organisations than in public health organisations. The general views expressed by health insurance clients on how HRM practices, styles, actions, behaviour, organisational culture among others that they consider to affect their access to health services are presented in Table 5.

6 Discussion

The evidence obtained from the field (interviews and official documents) show an improved situation (increased pattern, in Table 3). This is partly attributed to the desire of medical doctors to stay and work in Ghana and is partly associated with the increasing numbers of medical schools across Ghana. Only two regions of Ghana have achieved the national average or target of 1: < 10,000 population (MoH, 2018). Ghana's HR situation at the international level, the evidence show Ghana is far from meeting the WHO desirable doctor–population ratio is 1:1,000 (WHO Report, 2020, WHO, 2019, 2020).

In terms of health organisations ability to recruit qualified and professional staff in Ghana, the results show that the private/mission health facilities rely more on ward assistants. The study findings also confirm the perception that private health facilities employ more non-professional and unlicensed staff. This may also give credence to persistent accusations from the Ghana Registered Nurses Association that some private health organisations/facilities, particularly private clinics recruit 'unlicensed' or 'un-registered nurses'. This calls for Ghana Nurses and Midwives Council to sanction such health facilities or report their activities to their regulatory body -Private Hospitals and Maternity Homes Board (PHMHB). The current regulatory body is Health Facilities Regulatory Agency (HeFRA) from 2011.

On mobilisation of resources (human), the study findings show that public health organisations had more staff than their private counterparts. Despite the relatively less staff in private health organisations, the private staff exhibited more positive HRM practices, behaviour than the public. The evidence shows inadequate HR strength in Ghana and worse in Northern Ghana. The findings are consistent with previous studies (Asante and Zwi, 2009; Alfers, 2013; Kipo-Sunyehzi, 2019).

Based on the views of clients, the private health organisations staff appeared to be more clients oriented, task-oriented and profit-oriented than their public counterparts. The private hospital had a unique organisational culture of loyalty, commitment (paternalism) and faith-oriented which instil some 'hope for clients' on recovery over illnesses. The public health organisations staff have more autonomy in decision making than those in

private. These findings or empirical observations concur with previous studies or works (Kanungo and Jaeger, 1990; Mendonca and Kanungo, 1994; Kanungo and Aycan, 1998; Aycan et al., 1999).

7 Conclusions, implications and limitations

This study concludes that HRM practices like in-service training, fair treatment of staff, good management styles and skills are key facilitating factors, as they have a positive effect on the implementation of the NHIS (health policy). The study findings imply that implementing organisations of policies need good HRM practices, organisation culture, adequate and well-motivated staff to achieve organisations visions/missions. For the HRM practitioners, the findings imply that good practices, the right staff orientations and regular training of staff are necessary for health service delivery. The study has a geographical limitation and that future research needs to be across regions and countries for a broader perspective on the comparability of HR issues.

References

Adzei, F.A. and Atinga, R.A. (2012) 'Motivation and retention of health workers in Ghana's district hospitals', *Journal of Health Organization and Management*, Vol. 26, No. 4, pp.467–485, doi.org/10.1108/14777261211251535.

Akuoko, K.O. (2008) 'Traditional values, socio-cultural factors and human resource management practices in public sector organisations in Ghana', *Journal of Science and Technology (Ghana)*, Vol. 28, No. 3, pp.58–69, DOI: 10.4314/just.v28i3.33108.

Alfers, L. (2013) 'The Ghana national health insurance scheme: barriers to access for informal workers', *Women in Informal Employment Globalizing and Organizing Working Paper*, Vol. 30, pp.1–22.

Alhassan, R.K., Nketiah-Amponsah, E., Spieker, N., Arhinful, D.K. and de Wit, T.F.R. (2016) 'Perspectives of frontline health workers on Ghana's National Health Insurance Scheme before and after community engagement interventions', *BMC Health Services Research*, Vol. 16, No. 1, p.192, doi.org/10.1186/s12913-016-1438-y.

Anand, S. and Bärnighausen, T. (2012) 'Health workers at the core of the health system: framework and research issues', *Health Policy*, Vol. 105, pp.185–191.

Asante, A.D. and Zwi, A.B. (2009) 'Factors influencing resource allocation decisions and equity in the health system of Ghana', *Public Health*, Vol. 123, No. 5, pp.371–377, doi.org/10.1016/j.puhe.2009.02.006.

Aycan, Z., Kanungo, R., Mendonca, M., Yu, K., Deller, J., Stahl, G. and Kurshid, A. (2000) 'Impact of culture on human resource management practices: a 10-country comparison', *Applied Psychology*, Vol. 49, No. 1, pp.192–221, doi.org/10.1111/1464-0597.00010.

Aycan, Z., Kanungo, R.N. and Sinha, J.B. (1999) 'Organizational culture and human resource management practices: the model of culture fit', *Journal of Cross-Cultural Psychology*, Vol. 30, No. 4, pp.501–526, doi.org/10.1177/0022022199030004006.

Bilpeila Sub-District (2012–2013) *Annual Performance Review*, Ghana Health Service (GHS) Tamale.

Bozeman, B. (1993) 'A theory of government 'red tape'', *Journal of Public Administration Research and Theory*, Vol. 3, No. 3, pp.273–304, doi.org/10.1093/oxfordjournals.jpart.a037171.

Bryman, A. (2012) *Social Research Methods*, 4th ed., Oxford University Press, Oxford.

Caniëls, M.C. and Hatak, I. (2019) 'Employee resilience: considering both the social side and the economic side of leader-follower exchanges in conjunction with the dark side of followers' personality', *The International Journal of Human Resource Management*, pp.1–32, doi.org/10.1080/09585192.2019.1695648.

Christensen, T., Lægreid, P., Roness, P.G. and Røvik, K.A. (2007) *Organisation Theory and the Public Sector: Instrument, Culture and Myth*, Routledge, Abingdon.

Cometto, G. and Witter, S. (2013) 'Tackling health workforce challenges to universal health coverage: setting targets and measuring progress', *Bull. World Health Organ*., Vol. 91, pp.881–885, doi.org/10.2471/BLT.13.118810.

Cometto, G., Buchan, J. and Dussault, G. (2020) 'Developing the health workforce for universal health coverage', *Bulletin of the World Health Organization*, Vol. 98, No. 2, p.109, DOI: 10.2471/BLT.19.234138.

Daily Graphic (2014) National Newspaper publication, 5 September, p.3.

De Vos, A. and van der Heijden, B.I.J.M. (Eds.) (2015) *Handbook of Research on Sustainable Careers*, Edward Elgar Publishing, Cheltenham, UK.

Debrah, Y.A. (2003) 'Human resource management in Ghana', in Budhwar, P.S. and Debrah, Y.A. (Eds.): *Human Resource Management in Developing Countries*, pp.190–208, Routledge, London.

Dovlo, D. (2007) 'Migration of nurses from Sub-Saharan Africa: a review of issues and challenges', *Health Services Research*, Vol. 42, No. 3, pp.1373–1388, doi.org/10.1111/j.1475-6773.2007.00712.x.

Flyvbjerg, B. (2006) 'Five misunderstandings about case-study research', *Qualitative Inquiry*, Vol. 12, No. 2, pp.219–245, doi.org/10.1177/1077800405284363

Fudge, J. (2006) 'Fragmenting work and fragmenting organizations: the contract of employment and the scope of labour regulation', *Osgoode Hall Law Journal*, Vol. 44, No. 4, pp.609–648.

George, A.L. and Bennett, A. (2005) *Case Studies and Theory Development in the Social Sciences*, Belfer Center for Science and International Affairs, Cambridge.

Ghana Health Service (2008–2016) *Annual Reports 2008–2016*, Accra, Ghana.

Ghana Health Service (2017–2018) *The Health Sector in Ghana: Facts and Figures 2017*, Accra, Ghana.

Gibson, J., and McKenzie, D. (2012) 'The economic consequences of 'brain drain' of the best and brightest: microeconomic evidence from five countries', *The Economic Journal*, Vol. 122, No. 560, pp.339–375.

Gostin, L.O. and Friedman, E.A. (2015) 'A retrospective and prospective analysis of the West African Ebola virus disease epidemic: robust national health systems at the foundation and an empowered WHO at the apex', *The Lancet*, Vol. 385, No. 9980, pp.1902–1909, doi.org/10.1016/S0140-6736(15)60644-4.

Government of Ghana (GoG) (2003) *National Health Insurance Act. (Act 650)*, GoG, Accra.

Government of Ghana (GoG) (2004) *National Health Insurance Regulations. (L. I.1809)*, GoG, Accra.

Government of Ghana (GoG) (2012) *National Health Insurance Act. (Act 852)*, GoG, Accra.

Greenstein, F.I. and Polsby, N.W. (Eds.) (1975) *Strategies of Inquiry*, Addison-Wesley Publishing Co., California.

Haddock-Millar, J., Sanyal, C. and Müller-Camen, M. (2016) 'Green human resource management: a comparative qualitative case study of a United States multinational corporation', *The International Journal of Human Resource Management*, Vol. 27, No. 2, pp.192–211, doi.org/10.1080/09585192.2015.1052087.

Haj Adams Clinic (HAC) (2012) *Annual Performance Review 2009–2011*, HAC, Tamale.

Hofstede, G., Neuijen, B., Ohayv, D.D. and Sanders, G. (1990) 'Measuring organizational cultures: a qualitative and quantitative study across twenty cases', *Administrative Science Quarterly*, Vol. 35, No. 2, pp.286–316.

Kana, M.A. (2009) 'From brain drain to brain circulation', *Jos Journal of Medicine*, Vol. 4, No. 1, pp.8–10.

Kanungo, R., Aycan, Z. and Sinha, J.B.P. (1999) 'Socio-cultural environment, work culture and HRM practices: the model of culture fit', *Latest Contributions to Cross-Cultural Psychology*, pp.269–286.

Kanungo, R.N. and Aycan, Z. (1998) 'Issue of culture fit in human resource management practices', *Vision*, Vol. 2, No. 1, pp.5–11, doi.org/10.1177/09722629X98002001002.

Kanungo, R.N. and Jaeger, A.M. (1990) 'Introduction: the need for indigenous management in developing countries', in Jaeger, A.M. and Kanungo, R.N. (Eds.): *Management in Developing Countries*, pp.1–23, Routledge, London.

Kinnie, N. and Swart, J. (2020) 'Cross-boundary working: implications for HRM theory, methods, and practice', *Human Resource Management Journal*, Vol. 30, No. 1, pp.86–99, doi.org/10.1111/1748-8583.12239.

Kipo-Sunyehzi, D.D. (2019) 'Public-private organizations behaviour: the paradoxes in the implementation of Ghana's health insurance scheme', *Public Organization Review*, pp.1–12, doi.org/10.1007/s11115-019-00461-5.

Kipo-Sunyehzi, D.D., Ayanore, M.A., Dzidzonu, D.K. and AyalsumaYakubu, Y. (2019) 'Ghana's journey towards universal health coverage: the role of the national health insurance scheme', *European Journal of Investigation in Health, Psychology and Education*, Vol. 10, No. 1, pp.94–109, doi.org/10.3390/ejihpe10010009.

Knies, E., Boselie, P., Gould-Williams, J. and Vandenabeele, W. (2018) 'Strategic human resource management and public sector performance: context matters', *The International Journal of Human Resource Management*, pp.1–13, doi.org/10.1080/09585192.2017.1407088.

Kotoh, A.M., Aryeetey, G.C. and Van Der Geest, S. (2018) 'Factors that influence enrolment and retention in Ghana'National Health Insurance Scheme', *International Journal of Health Policy and Management*, Vol. 7, No. 5, p.443, DOI: 10.15171/ijhpm.2017.117.

Kowalski, T.H. and Loretto, W. (2017) 'Well-being and HRM in the changing workplace', *The International Journal of Human Resource Management*, Vol. 28, No. 16, pp.2229–2255, doi.org/10.1080/09585192.2017.1345205.

Liu, J.X., Goryakin, Y., Maeda, A., Bruckner, T. and Scheffler, R. (2017) 'Global health workforce labor market projections for 2030', *Human Resources for Health*, Vol. 15, No. 11, pp.1–12, DOI: 10.1186/s12960-017-0187-2.

Luo, B.N., Sun, T., Lin, C.H., Luo, D., Qin, G. and Pan, J. (2020) 'The human resource architecture model: a twenty-year review and future research directions', *The International Journal of Human Resource Management*, pp.1–38, doi.org/10.1080/09585192.2020.1787486.

Marchal, B. and Kegels, G. (2003) 'Health workforce imbalances in times of globalization: brain drain or professional mobility?', *The International Journal of Health Planning and Management*, Vol. 18, No. S1, pp.S89–S101, doi.org/10.1002/hpm.720.

Mendonca, M. and Kanungo, R.N. (1994) 'Managing human resources: the issue of cultural fit', *Journal of Management Inquiry*, Vol. 3, No. 2, pp.189–205, doi.org/10.1177/105649269432010.

Ministry of Health (MoH) (2007) *Human Resource Policies and Strategies for the Health Sector for 2007–2011*, Accra, Ghana.

Ministry of Health (MoH) (2018) *Holistic Assessment of 2017 Health Sector Programme of Work*, Accra, Ghana.

National Health Insurance Authority (NHIA) (2014) *Accreditation Report – July 2009–December 2013*, NHIA, Accra.

Perry, J.L. and Rainey, H. (1988) 'The public-private distinction in organization theory: a critique and research strategy', *Academy of Management Review*, Vol. 13, pp.182–201, doi.org/10.5465/amr.1988.4306858.

Sakyi, E.K., Awoonor-Williams, J.K. and Adzei, F.A. (2011) 'Barriers to implementing health sector administrative decentralisation in Ghana: a study of the Nkwanta district health management team', *J. Health Organ. Manag.*, Vol. 25, No. 4, pp.400–419, DOI: 10.1108/14777261111155038.

Saluja, S., Rudolfson, N., Massenburg, B.B., Meara, J.G. and Shrime, M.G. (2020) 'The impact of physician migration on mortality in low and middle-income countries: an economic modelling study', *BMJ Global Health*, Vol. 5, No. 1, pp.1–8.

Scheil-Adlung X. (2013) 'Health workforce benchmarks for universal health coverage and sustainable development', *Bulletin of the World Health Organization*; Vol. 91, p.888, doi.org/10.2471/BLT.13.126953.

Schneider, H., Blaauw, D., Gilson, L., Chabikuli, N. and Goudge, J. (2006) 'Health systems and access to antiretroviral drugs for HIV in Southern Africa: service delivery and human resources challenges', *Reproductive Health Matters*, Vol. 14, No. 27, pp.12–23, doi.org/10.1016/S0968-8080(06)27232-X.

Seventh Day Adventist Hospital (SDAH) (2011–2013) *Annual Report*, SDA, Tamale.

Sumah, A.M. and Baatiema, L. (2019) 'Decentralisation and management of human resource for health in the health system of Ghana: a decision space analysis', *International Journal of Health Policy and Management*, Vol. 8, No. 1, pp.28–39, DOI: 10.15171/ijhpm.2018.88.

Van Wart, M. (2017) *Leadership in Public Organizations: An Introduction*, 3rd ed., Routledge, New York.

West Hospital (WH) (2012–2013) *Annual Performance Review*, Ghana Health Service (GHS), Tamale.

WHO Report (2020) [online] https://www.who.int/gho/health_workforce/physicians_density/en/ (accessed 19 August 2020).

World Health Organization (WHO) (2016) 'Health workforce requirements for universal health coverage and the Sustainable Development Goals', *Human Resources for Health Observer Series*, Vol. 17, Geneva.

World Health Organization (WHO) (2019) *World Health Statistics 2019*, Geneva.

World Health Organization (WHO) (2020) *World Health Statistics 2020*, Geneva.

Ybema, J.F., van Vuuren, T. and van Dam, K. (2020) 'HR practices for enhancing sustainable employability: implementation, use, and outcomes', *The International Journal of Human Resource Management*, Vol. 31, No. 7, pp.886–907, doi.org/10.1080/09585192.2017.1387865.

Yin, R.K. (2009) *Case Study Research: Design and Methods*, 4th ed., SAGE Publications, Inc., Thousand Oaks, California.

Yin, R.K. (2014) *Case Study Research: Design and Methods*, 5th ed., Sage Publications, Inc., Thousand Oaks, California.