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Livelihood Strategies and Performance of Ghana's Health and Education Sectors: Exploring the Connections

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Abstract
The public sector in Africa is riddled with widespread ineffectiveness. Although some countries have implemented various reform programmes with the support of international development agencies, the results so far have been disappointing. One reason for the failure is that the policies have focussed more on achieving macroeconomic stability than making the organisations effective. This article explores a fundamental problem of the policies—the need to focus on the human component of organisational performance. Using education and health organisations in Ghana as examples, the article advances a hypothesis that the livelihood strategies of public sector employees and the performance of their organisations are interconnected. Specifically, it is argued that as public sector employees have become more dependent on multiple sources of income, they have developed multiple social identities, which influence the culture of their organisations. The organisational culture may have encouraged employee effectiveness in some cases, but for most organisations, it has resulted in practices that perpetuate inefficiency and poor performance. To be successful, public sector reform policies must therefore involve deliberate efforts to change organisational cultures. Copyright © 2005 John Wiley & Sons, Ltd.

Keywords
Ghana;employee livelihood strategies;public sector performance;organisational culture

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ABSTRACT

Public service institutions in Africa are riddled with widespread inefficiency. Although institutional reform has recently attracted attention in the international community, the connection between employees' involvement in multiple economic activities and institutional performance has remained unexplored. This paper explores the fluid relationship between multiple livelihood strategies and inefficiency in public institutions. It argues that one's job and profession are important in the creation of their social identity and the collective social identities of employees of an institution define its culture, including the norms and expectations of the workplace. The study demonstrates that multiple livelihood strategies of education and health sector employees in Ghana have led to multiple social identities, making it difficult to maintain the professional identity necessary for the effective running of public institutions.

1. Introduction

The quality of food you give to a labourer determines

how well he works on your farm. (An Akan Proverb)

"Institutional capacity-building" is now a growth industry in international development. Institutional reform is seen as critical to the development of African countries undergoing International Monetary Fund (IMF) and the World Bank-supported neoliberal economic reforms (World Bank, 2001a). The interest in institutions draws, in part, from the experiences of the East Asian "tigers" where efficient public institutions are credited for the region's phenomenal economic development (Wade, 1990; Amsden, 1989). It also draws from Africa's own experience, where widespread inefficient public institutions are blamed for the persistent decline in the region's economy (Stein, 1994; 1995). But like many other clichés that have appeared in the development lexicon, institutional reform has nebulous meaning in common parlance and denotes radically different things to different people depending on their ideological predispositions (Wade, 1996). Neoliberals propose a reduction in the role of the state in the economy as a solution to the widespread inefficiency in situations with weak states such as Africa (World Bank, 1993). While critics welcome the renewed interest in public institutions, they charge that the poor performance of the public sector is due in part to lack of resources and thus tight fiscal policies supported by neoliberals will only stifle development (Tendler, 1997; Colclough and Manor, 1991). While the debate over

institutional reform rages on, it is now obvious that after many years of experimentations with neoliberal prescriptions, African countries are yet to reap the benefits promised by the architects of the policy.

The neoliberal economic policies that have held sway in Africa for over to two decades have been subjected to intense scrutiny and many of the limitations have been pointed out (Konadu-Agyeman, 2001; Carmody, 2001; Stein and Nissanke, 1999). The persistent inefficiency in public institutions despite efforts to reform has baffled many and led to a flurry of explanations.[1] The purpose of this paper is not to assess neoliberal economic policies but to focus on public institutions and explore one issue that has largely been ignored in that discussion: *the human component of institutional performance*. Using education and health institutions in Ghana as examples, I advance a hypothesis that the livelihood strategies of employees and the performance of public institutions are interconnected, and this linkage might help explain the inefficiency in the public sector. The hypothesis is based on three related questions. First, what are the impacts of Ghana's economic policies on the livelihood strategies of education and health employees? Second, what has been the performance of the health and education sector since the introduction of the reforms policies? Third, is there a relationship between the livelihood strategies of employees and the functioning of public institutions?

The data for the study are drawn from a fieldwork conducted between 1995 and 1996 in Wenchi and Techiman in the Brong Ahafo Region of Ghana (Figure 1)[2] and supplemented with information from the 1991-92 Ghana Living Standards Survey (GLSS). Interviews were also conducted with officials at Ministries of Health and Education at the national and district levels. In addition, heads of selected public and private institutions, employees and service users in Wenchi and Techiman were interviewed using structured questionnaires and focus group discussions. Although many of the empirical data for this paper comes from the two towns, the findings have broader implication since public institutions in other parts of the country and Africa face similar problems.

[Insert Figure 1]

The remainder of the paper is divided into six sections. Section two explores the relationship between neoliberal economic reforms and public institutions at the conceptual level. Section three examines the nature and origins of the livelihood strategies of salaried employees in Ghana. Section four probes the connections between reform policies, livelihood strategies and the quality of education and the health services. Section five advances a hypothesis that links multiple livelihood strategies and the performance of Ghana's health and education sectors.

Section six develops a framework for exploring the connection between livelihood strategies and institutional performance. Section seven is the conclusion.

2. Neoliberal Economic Reforms and Public Sector Service Institutions

After dismissing public institutions for sometime, public sector reform has now become an essential component of the World Bank's structural adjustment programs (SAPs). The initial articulation of the SAPs centered on "getting prices right" and reducing the role of the state in the economy (World Bank, 1981). Eight years later, the World Bank began to acknowledge the importance of public institutions and embraced the concept of "good governance" (World Bank, 1989). In 1993, after an internal debate between Japanese and Anglo-American trained technocrats over the role of public institutions in the economic successes of the newly industrialized countries, the World Bank issued the *East Asian Miracle Report* (World Bank, 1993). The report, described by Wade (1996) as "paradigm maintenance", partially admitted the centrality of the state, but maintained the basic tenets of the neoliberal framework. The 1997 report, *The State in a Changing World* also illustrates the difficulties and the contradictions of "paradigm maintenance" precisely because, as Moore (1999:63) argues, "hegemonic attempts to neutralize ideological challenges do result in slight changes to the paradigmatic fundamentals". Although the 1997 report recognizes the role of the state in doing things that the market cannot, it insists that states must match capability and role (World Bank, 1997). In other words, the World Bank admits that the "state" is critical to development, but since states in Africa lack effective capabilities, they must stick to the principles of *laisser faire.* No wonder that institutional reform in Africa has been defined narrowly and couched in neoliberal terms with concepts such as cost-recovery and privatization dominating the discourse.

According to the World Bank, before the introduction of SAPs in the early 1980s, the pricing systems for publicly provided educational and health services in many African countries were driven by the desire to increase accessibility through government subsidies. The approach led to widespread inefficiency in the use of resources, under-investment in public services, misallocation of resources within sectors, and inability to ration services according to need (World Bank, 1981). Low prices of the majority of services meant that the most costly services (e.g. higher education or specialized health care) were subsidized heavily. Inequity in access to education occurred because the high personal costs of education made it more accessible to those in the higher income groups who were

able to out-compete others for limited spaces in schools. Similarly, inequities in health delivery occurred because subsidized services were usually located in urban areas and were inaccessible to the rural population (Jimenez, 1987). Thus, subsidies on public services mostly benefited the rich urban residents more than the rural poor. The task of SAPs was therefore to eliminate subsidies and level the playing field for the rich and the poor.

To increase efficiency in public institutions and reduce inequity in access to public services, the World Bank recommended a series of policies. One such policy is cost recovery. With regard to the provision of education, it is argued that since the benefits of higher education flow directly to the student, cost recovery will help bring the social and private costs and social returns together and increase access to educational facilities (World Bank, 1988). In the case of health services, a distinction is made between curative and primary health care. It is alleged that since most curative services are not characterized by externalities and there is excess demand for them (Jimenez, 1987), governments should capitalize on people's willingness to pay to generate revenue from beneficiaries through user fees (Shaw and Griffin, 1995). In addition to the cost recovery measures, countries were encouraged to implement a variety of cost reduction measures, including retrenchment, rationalization of the use of labor, and wage-restraint policies. Workforce restructuring through retrenchment and rationalization are seen as necessary for public institutions, since they are characterized by inappropriate skill mixes and staffing ratios that make them uneconomically large (Davis, 1991). Wage-restraint policy is needed to cut down costs since wages form a significant part of the cost of providing services. In fact, the World Bank blamed high employee salaries for escalating education bills in Africa:

> "The principal factor behind high unit costs is high teacher salaries, which typically make up 75 to 90 percent of total recurrent costs in education … even at the primary level, salaries are high in relation to per capita income … the salary weight is so high because *all* modern sector salaries are high relative to average incomes (emphasis in original, World Bank, 1981:32).[3]

Recently, the World Bank appears to favor privatization over cost recovery in the provision of health and education (World Bank, 2001b). Over all, however, public sector reform in Africa seems to emphasize the need to cut government expenditure and reduce the role of the state. However the narrow focus on efficiency and cost-cutting have shifted attention from the basic needs of public service sector employees, demoralized them in the process, and created a working environment that favors low productivity and hinders efforts of institutional capacity-building.

2.1 Livelihood concerns: A Missing Component in Ghana's reforms

The need to preserve the tenets of the free market in Africa blinded the World Bank and its supporters to a basic fact about people and institutions: *that people make institutions work and that motivated workers are a sine qua non for institutional efficiency.* Low productivity and inefficiency in public institutions have their origin in the economic crisis that preceded the World Bank's economic reforms. In the pre-reform era, public sector employees were generally underpaid and poorly motivated. As a student in Ghana during the peak of the country's economic crisis in the late 1970s and early 1980s, I saw and experienced first hand, the real cause and nature of institutional decay, especially in the education sector. Local newspapers were filled with stories of teachers, nurses, and even medical doctors who could not depend on their salaries and had to find other sources of income to supplement their earnings. The crisis and poor conditions of service in Ghana coincided with the oil boom in Nigeria; consequently, many professionals and non-professionals left the country for greener pastures in Nigeria. Schools were left without teachers, while those who stayed paid little attention to teaching and concentrated on activities that provided them additional income. The mass exodus of teachers, the lack of interest in teaching among those who continued to stay with the Ghana Education Service (GES) and the increased importance of supplementary sources of income in the household budget during this period, sowed the seeds of educational decline that still bedevils Ghana.

It is important to note that although some of the professionals who left the country returned in 1983 and some even returned to their former employment, they did not return because of improved conditions of service, rather it was the result of forced repatriation. Thus, even though by the mid-1980s, most schools had teachers physically present in classrooms, many remained demoralized because of the poor working conditions. The same explanation is true for other salaried workers such as nurses, doctors, civil servants, etc (UNICEF, 1988). In sum, concern over livelihood is critical to understanding the decline in performance and efficiency in public institutions in the pre-reform era. Consequently, one would expect institutional reform policies to address the livelihood concerns of employees. After all, effective institutions are not created only by good rules and regulations, but also by dedicated and motivated workers who see their personal success and satisfaction as tied to those of their institutions (Grindle, 1997a; Tendler 1997; Samatar, 1999).

However, as this analysis indicates, the concerns of workers as a means of improving public institutions were overshadowed by the need for macroeconomic stability. Thus, instead of devising programs that would be

cognizant of employee needs, SAPs were narrowly defined to coincide with the World Bank's goal of achieving fiscal discipline and cost cutting in an attempt to institute market reforms and reduce the size of the state. As a result, cost-recovery, removal of subsidies and introduction of user fees formed the basis for reforms in the provision of social services. Alternative proposals that included possible increases in government expenditures were ignored.[4] Although the Bank later changed its strategy and introduced the "second generation" reforms, many public institutions remain inefficient because the one-size-fits all approach continued to ignore country-specific institutional aspects of the public institutions (Lienert and Modi, 1997; Nunberg, 1999). Indeed, the policies have not only failed to respond to the livelihood concerns of public sector employees, they have put public employees in a quagmire. The poor working conditions and inadequacy of salaries that characterized public institutions in the pre-reform era have not only continued but the reforms have also introduced new dynamics. On the one hand, the push to reduce government expenditure has meant that salaries and other non-wage benefits are being squeezed. On the other hand, the underpaid and poorly motivated workers are admonished to assume additional responsibility due to employment freezes and to lead efforts at improving efficiency. What is surprising is that the international financial institutions that are championing cost reduction and lower salaries as a way of improving institutional capacity, find it expedient to pay their consultants working in Africa, (Africans and non-Africans alike), salaries comparable to those paid in the industrialized countries, presumably, to motivate them.

In some ways, the contradiction between the livelihood demands of public employees and the expenditure-reduction entailed in neoliberal reform policies is itself evidence of the market's failure to ensure efficient allocation of resources in Africa. The initial assumption was that the low wages would compel some employees to quit their jobs and move to the private sector and the reduction in the size of the public sector would make it possible to pay higher wages. Contrary to the expectations, most salaried workers did not quit their jobs; instead they maintained their jobs while participating in other economic activities to raise additional income. To the teacher, the nurse, or civil servant, a combination of salaried employment with other economic activities is the rational thing to do. The economic calculation of the decision is captured by a phrase frequently heard in discussions with public sector employees in Ghana: "half a loaf is better than none". Despite the low salaries paid to public employees, one can be guaranteed a regular income as well as employment-based benefits. Moreover, public sector employment is associated with high social status and provides useful connections to important people and resources in the

community. But beyond these obvious advantages of public employment, most workers believe, as expressed in the opening Akan proverb, that while a laborer must physically go to the farm to be paid a day's wage, his/her actual productivity in the farm cannot be mandated; it depends on factors such as how the farmer treats the laborer while in the farm. In other words, people could maintain public employment, only go to work when necessary, and be guaranteed of a salary and other employment-related benefits even if their productivity is below expectation.[5] This logic, which underlies multiple livelihood strategies, is not unique to urban Ghanaian workers.

The practice of relying on diversified means of income generation through acquisition of additional jobs has been described as "multiple modes of livelihood strategies' (MML). MML strategy is prevalent in countries undergoing economic reforms and is attributed to job insecurity created by the massive retrenchment as well as the precipitous decline in the value of salaries (Mustapha, 1992; Owusu, 2001). The common practice is for salaried employees to maintain their jobs and at the same time get involved in other economic activities to provide additional income. It is important to note that although involvement in more than one economic activity is not limited to state employees in Africa, the nature of the activities and the effects on public institutions are different from those involved in moonlighting in the developed world (Owusu, 2001). As the case study of health and education sectors in Ghana will show, dependence on multiple economic activities for additional income provides clues for understanding the low morale and the lackadaisical attitude toward work that result in low productivity in public institutions.

3. Multiple Livelihood Strategies in Ghana: Magnitude and Causes

Since April 1983, Ghana has been rigorously implementing World Bank and IMF-supported SAPs, locally termed "Economic Recovery Program" (ERP). The program, which was in response to years of economic mayhem that had engulfed the country, has evolved from the initial objective of reversing economic decline and stagnation to institutional reforms and poverty reduction (Government of Ghana, 1987; 1993). As the longest sustained SAPs program in Africa, the ERP has been the subject of intense scrutiny with no consensus on its impact on the country's development. While the program has been successful in reversing the country's economic decline (Roe and Schneider, 1992; Kapur et al, 1991)[6], its impact on the living conditions of the people is anything but satisfactory.

One of the impacts of the program that is less disputed is the intensification of urban poverty (Jeffries, 1992).

In response to the increasing poverty, many urban residents, including salaried employees, have resorted to multiple livelihood strategies to generate additional income (Owusu, 2001. Table 1 shows MML participation[7] for Ghana as a whole and for Wenchi and Techiman. According to the data, 63.5 percent of salaried employees in Techiman and Wenchi are involved in MML. However, the GLSS data showed that only 17.8 percent of salaried employees are involved in MML. While it is possible that GLSS data may have inadvertently underestimated MML participation, there is no empirical basis for extrapolating the findings from the case studies to the country as a whole. However, the data suggest that such strategies may be becoming widespread.[8] How do we explain the increasing importance of the multiple livelihood strategies among salaried employees in Ghana?

[Insert Table 1]

Participation in multiple livelihood strategies is by no means new or unique to Ghanaians (or Africans). However, the strategy as it is practiced in Ghana is different and its acceptance as a way of life by Ghanaians is quite distinctive (Owusu, 2001). Ghanaian workers, for instance, were involved in multiple economic activities even before the introduction of the ERP in 1983 (Ewusi, 1984; Pellow and Chazan; 1986; Yeboah and Walters, 1997). However there is a striking difference between pre-reform livelihood strategies and the current practice. In the pre-reform era, participants in such strategies comprised mostly the poor and those employed in the so-called informal sector. Current participation in multiple economic activities is not limited to the poor; it also includes a significant proportion of salaried employees. Why?

To a large extent, the proliferation of MML among salaried employees is in response to the neoliberal economic policies with its urban bias assumptions.[9] In the 1960s, public sector employees in Ghana enjoyed a relatively decent standard of living supported almost entirely by salaries (Price, 1975). Even as late as 1974, the minimum wage was sufficient to support the food needs of an average-size urban family (Jamal and Weeks, 1993). However, things began to change in mid-1970s, as a result of the precipitous decline in the economy.[10] In the face of the declining value of salaries, some employees left the country for greener pastures elsewhere while others resorted to farming, with the encouragement from the government. As the economy plunged into deeper crisis in the late 1970s and early 1980s and these strategies proved to be inadequate in supporting urban households, many began to look for other means of income generation, both legal and illegal. Traders resorted to exploitative trading

practices such as hoarding of goods to create shortages, selling goods above the government-controlled prices, and corruption and bribery became rampant. The traders became targets for the military regimes and were subjected to regular attacks and molestation by the military and the police (Robertson, 1983). The criminalization of trade and the negative connotations associated with it discouraged many law-abiding citizens including salaried employees from becoming traders. Those who ventured into trading often did it underground, as majority of Ghanaians. By 1983, when the economic reform policies were introduced, salaries for many employees were still inadequate to support households. However, the criminalization of trade limited their options for generating additional income to either part-time farming or bribery in the work place.

Trade liberalization and the general decriminalization of trade, brought about by the economic reforms, opened new avenues for salaried employees looking for other means of generating income. As a result, trading has become one of the preferred income generating activities for salaried employees (Owusu, 2000). Participation in trading-related activities also increased among public employees partly because the government turned a blind eye to the practice. A possible explanation of the government's lack of response is that the additional income from the practice helped to reduce the harsh impact of the austerity measures and thereby diffused any threat of mass protests – the so-called food riots – associated with such reforms (Walton and Seddon, 1994). In fact, Ghana's experience with earlier neoliberal reforms where austerity measures escalated into urban protest (Hutchful, 1985) and the country's history of labor militancy (Herbst, 1993), give credence to this explanation.

In sum, while failing to reverse the declining salaries, the ERP opened up new avenues for all Ghanaians, including salaried workers to earn additional income. But the proliferation of MML in Ghana must also be viewed in the context of the Jerry Rawlings regime's desire to maintain legitimacy in spite of the harsh economic conditions. It also provides a partial explanation for the near absence of massive urban protests that could have forced the government to abandon the economic reforms altogether. Beyond these obvious advantages of MML, however, there is still the question as to whether such practices benefit society as a whole. One way to answer the question is to investigate the extent to which MML affects the performance of public institutions. We examine the widespread MML's cost to society by focusing on the education and health sectors in Ghana.

4. Case Study of Education[11] and Health Sectors

Although the private sector has always been involved in the provision of education and health services in Ghana, its role has become more important since the introduction of the reforms policies. In addition, the distribution of private schools and health facilities has changed significantly over the period. For instance, in the past, the number of private schools in Ghana was limited and mostly located in the major urban centers. However, since the mid-1980s, the number has not only increased, but also spread beyond the rich urban neighborhoods. Before 1979, there were only eight private pre-tertiary schools in Brong Ahafo Region, but by 1992, the number had increased to 57 with more than half of the new schools being established between 1986 and 1989. A similar trend can also be seen at the national level.[12] In the case of the health sector, the government has historically concentrated its resources in the major urban centers (Oppong and Hodgson, 1994). Non-government entities, especially faith-based groups and private individuals provide health services to many around the country, sometimes with support from the government in the form of subsidies. An understanding of the increase in numbers as well as the geographic spread of private health and education facilities requires some knowledge of transformations that have taken place in the public sector.

Both the education and health sectors experienced severe deterioration as the country plunged into deep economic crisis in the 1970s and early 1980s. Recurrent spending on education, which had averaged about 3.4 percent of GDP in the 1970s, fell to below two percent of GDP in the early 1980s. The health sector also experienced a considerable decline as expenditure per capita declined by more than 77 percent between 1976 and 1982 (UNICEF, 1988). It is in this context that the health and education reforms were introduced. Educational reforms were introduced in 1987 to institute structural and curriculum changes, and find new ways for funding the system (Daddieh, 1995). Specific policies for funding the education sector included changes in budgetary allocation, workforce restructuring, increased community participation and the introduction of user fees. The 1985 Hospital Fees Regulation, which required the MOH to generate at least 15 percent of total recurrent expenditure, represents the government's initial attempt to reform the health sector (Waddington and Enyimayew, 1990). Subsequent reform policies included the introduction of a series of cost-cutting policies including cost recovery, cash and carry system, redeployment of personnel and employment freezes (Penrose, 1995; Foster, 2000).

Health and education sector reforms must be viewed in the context of inadequate salaries and increased

participation in MML by employees (Roenen, 1997; Owusu, 2001). Data from Techiman and Wenchi paint contrasting pictures of the livelihood strategies adopted by health and education sector employees. According to the data (see Table 1):

i) public sector employees are more likely to participate in MML than private sector employees[13];

ii) there are significant differences in MML participation rates among public sector employees; and

iii) GES employees have the highest MML participation rate, while MOH employees are least likely to engage in MML. [14]

There are practical reasons for the difference in MML participation among health and education employees. First, unlike teachers, health workers tend to have irregular work schedules, which do not favor MML participation.[15] Second, unlike teachers, health sector employees have the option of working overtime to generate additional income.[16] Moreover, as will be discussed later, it is often easier for health sector employees to generate additional income through illegal activities and collection of monies from patients, than it is for teachers. Thus, because education sector employees rely on *external sources* for additional income, their activities can be captured by MML statistics; on the contrarily, the activities of health sector employees who rely on *internal sources* of income are not easily captured in MML data. In other words, both health and education sector employees employ multiple livelihood strategies, but the strategies are often different. This suggests that the reform policies have had pervasive effects on the day-to-day operation of health and educational institutions in the country. Health institutions and public schools are constantly exploring ingenious means to increase revenues to supplement declining support from the government. At the same time, they have to deal with poorly motivated employees with increased job responsibilities and service users required to pay for previously free services.

4.1 Quality of Public Services: Education Sector

As noted earlier, there has been a rapid proliferation of private schools in Ghana since the introduction of the educational reform. This is evident in Wenchi and Techiman: as at 1996, the two towns had a total of 17 private schools and most of them were opened within the last 10 years. An explanation of the proliferation of private schools often provided by public school teachers is that private schools have become a façade or a veneer that creates an image of caring and concerned parents. For this public image derived from having their kids in private

schools, parents are willing to pay the extra school fees to send their children to private schools.[17] There is no doubt that private education has become a status symbol, however this explanation does not tell the entire story and contradicts general perception about public education. The truth is that, proliferation of private schools is an indictment on public schools because parents who send their children to private schools do so based on their perception about the quality of education in the two school systems. For these parents, the positive public image is an additional benefit. In fact, some GES officials and public school teachers have their children in private schools.[18] But beyond public perceptions, do the records indicate that private schools provide higher quality education than public schools? An empirical answer to this question is not only useful for education policy regarding equal access but is also central to understanding the linkage between teacher motivation and quality of education in the classroom. After all, the public schools have better resources, more qualified and experienced teachers than private schools[19].

Standardized examination results are useful for comparing the quality of private and public education. Table 2, which presents the Criterion Referenced Tests (CRT) results for the country from 1994 to 1997, shows very poor scores among public schools. The percentage of pupils who achieved "reaching mastery" level within public schools in 1997 is around six percent for English and three percent for Mathematics, while private schools recorded 70 percent and 40 percent respectively. In addition, while the private schools have experienced a steady improvement in performance, public schools have persistently exhibited this low level of education quality over the years. Not only is the percentage of students reaching master level much higher among private than public schools, but also the average scores of private schools are much higher. In addition, there have been steady improvements in mean scores among private schools and limited improvements in public schools. [20]

[Insert Table 2]

Similar trends in examination results are found in Wenchi and Techiman, but some interesting dynamics are revealed by the detailed analysis. Basic Education Certificate Examination (BECE) results for private schools and the best-performing public schools in Wenchi and Techiman for 1994 and 1995 showed *no systematic* difference in the results. Although the private schools performed relatively better in 1994, the 1995 results did not differ significantly from those of public schools.[21] The data show that public schools perform relatively well and the reasons for such performances should be of interest to us. We shall return to the experiences of the better performing

public schools later. But this finding should also be of concern precisely because it suggests that even the best public schools are only as good as (and not better than) private schools despite the differences in the resources. This is the basis of concern regarding public schools and that should be of interest to policy makers.[22]

4.2 Quality of Public Services: Health Sector

Private and faith-based organizations are the main providers of health services in Wenchi and Techiman. The Methodist Church owns Wenchi's main hospital - Wenchi Methodist Hospital (WMH). Similarly, the two main health institutions in Techiman are both faith-based institutions: the Holy Family Hospital (HFH) is operated by the Roman Catholic Mission and the Ahmadiyia Hospital owns the Ahmadiyia Moslem Mission. There are also three private clinics in Wenchi and five hospitals and clinics in Techiman. The WMH and HFH are members of the Christian Health Association of Ghana (CHAG). CHAG-affiliated health facilities are more like "quasi-government institutions" because the government subsidizes their cost of operation in the form of medical and other supplies, provision of personnel, and payment of salaries. Although the government regulates their activities, administrators at CHAG-affiliated institutions have some autonomy in the day-to-day running of the facilities.[23] The Ahmadiyia Hospital, which does not receive any subsidies from the government, enjoys complete autonomy.

As in the case with schools, most private health institutions in Wenchi and Techiman were established after the introduction of the health care reforms. Of the ten private health institutions in the two towns, only three were in operation prior to 1990. Moreover, private health facilities in the study areas have less qualified personnel (most of them rely on nurses' aids rather the registered nurses) and lack sophisticated equipment (e.g. few have laboratories). As a result, they deal with less complicated cases and serious illnesses are referred to the WMH or HFH or other government-owned regional hospitals. Here again, the task is explaining the coincidence between proliferation of private health institutions and the reform policies.

Assessing the quality of health care delivery is a complicated task[24] which would require interviews with patients and follow ups to assess health outcomes. In the absence of such data, hospital attendance can be used as a measure for patient satisfaction and quality of service, particularly in situations where clients have several options, as in the study areas. Table 3 compares hospital attendance at public and private health facilities at the national level. According to the data, the percentage of people who sought public healthcare between 1992 and 1998 decreased by

12.8 percent and more substantially among the poor (by about 24 percent). In contrast, the percentage of people who sought private, modern healthcare increased by 14.8 percent. Considering that fees for private health institutions are significantly higher than in public institutions,[25] we can speculate from the data that while the low hospital attendance by the poor may be due to the introduction of user fees; the same explanation may not hold for the wealthy – it is more likely that they have shifted to the more expensive private institutions. Hospital attendance at HFH and WMH also exhibit a similar pattern. Between 1991 and 1994, the HFH experienced a persistent decline in hospital attendance, averaging about 4 percent. The WMH also experienced over 50 percent drop in attendance between 1993 and 1994.[26]

The impact of user fees on hospital attendance has been documented for Ghana (Waddington and Enyimayew, 1990). Table 3 also confirms that the percentage of people seeking no care increased for all but the richest income groups. However, a study by the Ministry of Health suggests that there may be other important factors accounting for the current decline in attendance at public health institutions. According to the study, patient satisfaction at district public health services dropped from 37 percent in 1997 to only 10 percent in 1999 (MOH, 1999). We can infer from these data that patients who can afford private health care are turning away from public institutions because they are dissatisfied with their services. Unlike the crowded conditions at subsidized hospitals (government and faith – based facilities), patients who go to private health institutions do not have to queue for treatment. A visit to the doctor's office, which could take a few hours in a private health centre, would take the whole day at subsidized institutions. More importantly, medical officers at private clinics are more accessible to patients than those in government and faith-based hospitals; the former work till the last patient is seen and are often available to patients any time; the later may not even be available during normal working hours. Also, some employees at subsidized institutions exhibit unprofessional attitudes in dealing with patients; a practice that would never be tolerated in the private sector.[27] Certainly there are many hard-working nurses and doctors who go beyond the call of duty everyday to save lives and one cannot (and should not) blame them for all that is wrong with publicly-provided health care in Ghana. But as we shall see, a combination of factors beyond the control of employees may explain why it is sometimes impossible even for the dedicated ones to provide the personalized service demanded by patients. This analysis supports Ogoh-Alubo's (1990: 318-319) observation in the context of Nigeria that, "when the introduction of fees is added to the queues and insults for which the public medical care

system is notorious, the growing prominence of private medicine becomes easy to comprehend."

[Insert Table 3]

5. Livelihood Strategies and Public Institutions: A Hypothesis

There are similarities between the experiences in the health and educations sectors. The pre-reform inefficiencies in both sectors could be attributed in part to inadequate infrastructure and supplies as well as low salaries of employees. However due to concerns over macro economic stability, reforms in both sectors cantered mostly on cost-cutting and cost recovery measures. Thus, although supplies are now available in the country (albeit at competitive prices) for schools and hospitals, both sectors are still characterized by widespread inefficiency and the public is compelled to turn to the private sector for these services. The point here is that, while availability of supplies is important for service delivery, that alone cannot be a recipe for revamping public institutions when they are staffed by weary and poorly motivated employees. Below, we explore a hypothesis that connects salaries and non-wage benefits to the performance of public institutions.

Public sector salaries in Ghana do not motivate employees, and health and education sector employees are no exception. But as indicated earlier, low salaries and poorly motivated employees did not start with neoliberal reforms. In fact, the pre-reform inefficiency in the health and education sectors was due, in part to the low morale created by the precipitous decline in real wages and poor conditions of service. For instance, the salary of an experienced teacher in the pre-reform era was just about one-third of what was needed to feed a typical family (Morna, 1989); and it was these poor conditions of service that compelled many teachers to leave the country in the late 1970s and 1980s (Huq, 1989). Thus a critical question for understanding poor performance in public schools is whether teachers' salaries have improved under the educational reform. A trend analysis would have been a better way to examine the changes in the conditions of service for teachers, but lack of data on salaries makes such analysis impossible. Table 4, which presents the monthly salaries of teachers for 1994, indicates that salaries ranged from $34 to $129 depending on qualification and experience. For comparison, a gallon of gas around the same time cost an equivalent of US$2 and a basic lunch of *fufu* and meat at a "chop bar" was approximately US$2! Clearly, the range of salaries would not be enough to support a household and to motivate teachers. As one teacher commented sarcastically, "After pay day, I become another paymaster, albeit, one who cannot pay all the debts." Another complained that: "Under these conditions what can I do? When I am in the classroom, my mind is on what

my children will eat for dinner and not in the class. It is difficult to focus on teaching when you worry about subsistence".[28]

[Insert Table 4]

The situation in the health sector is no different. Health sector employees also experienced a significant decline in real wages in the pre-reform period. Although, salaries in the sector have improved since the introduction of the reforms, they are still below the pre-1970 levels. Retired and old health sector employees in Wenchi and Techiman talked about the "good old days" when salaries provided a decent standard of living and savings. They describe the decline in the value of salaries over time to the current situation where they can barely survive on their incomes.[29]

Salaries have declined, but what about non-wage benefits? In the past, low government salaries were often compensated for by an elaborate system of non-wage benefits (Berg, 1993). While non-wage benefits can motivate employees, it can become a demoralizing force when disbursement is based on non-transparent criteria or when they are not paid at all.[30] For example, on paper, public schools teachers are entitled to a host of benefits including paid-holidays, paid-sick leave, paid-study leave, medical care and paid transportation for official duties. However, reimbursement for expenses such as medical expenses and job-related transportation costs are characterized by frustrating uncertainties and unnecessary bureaucratic processes. Medical expenses are rarely paid, and even when paid, the amount is usually slashed down to "unreasonable" levels. Reimbursement for job-related transportation costs is cumbersome and sometimes not paid at all.[31] As a result, GES officials who are expected to travel across the district to visit schools often do not go and head teachers are also discouraged from attending meetings at the district office. As one supervisor complained:

> I do not have transport so I cannot always visits schools that need my service. I am stuck in the office while schools deteriorate in the rural areas. Claims for T&T (transport & travel) are sometimes denied for no apparent reason. When head teachers are invited to attend meetings in the District Office, it takes forever for their T&T claims to be paid, so the next time that you invite them, they don't want to come.[32]

Dissatisfaction with transportation claims, in an environment where other means of communication, such as telephones, are lacking may have serious effects on public schools, as would be discussed later.

Concerns over non-wage benefits in the health sector are equally widespread, but they take different forms. In the past, both the WMH and HFH rewarded outstanding employees with annual bonuses and end of year benefits.

However, recent financial constraints have compelled them to either reduce their contribution or cut such programs altogether. For instance, annual bonuses and end of service benefits to employees, which comprised 2.6% of total expenses of the HFH in 1992, diminished to 0.4% in 1994. In addition, the Staff Provident Fund, set up by the HFH to provide additional funds to supplement the Pension Scheme was dismantled in 1994 for financial reasons. Although the WMH still had a supplementary pension in 1996, the contribution of the hospital to the fund decreased from 1.7% of total expenses in 1993 to 1.3% in 1994 and further cuts remain imminent.[33] Such cuts in employee benefits significantly affect employee morale and commitment to the job.

What has been the impact of low salaries and discontent over non-wage benefits on the health and education sectors? In the education sector, we could look at the impact at two levels – performance by teachers and supervision by head teachers and GES officials. An evaluation of classroom performance by teachers is a daunting task beyond the scope of this study. Rather we will delve into the possible impact on supervision of teachers – an issue identified by both GES officials and private school proprietors as critical in achieving high quality education. Direct supervision of schools is the responsibility of GES inspectors and head teachers. The head teacher is in charge of the day-to-day running of the school, while GES inspectors are expected to make frequent visits to schools to ensure that head teachers, teachers, as well as students, play their respective roles in the learning process. Over the years however, there has been a complete breakdown in supervision by both GES officials and head teachers. School inspections by GES officials have become infrequent, and even when they do occur, they are devoid of the surprise and the professional elements that make them effective. In fact, visits by GES officials have become nothing more than occasions for social gatherings by teachers and the supervisors. Supervision by head teachers, in most cases, lacks professionalism and has become ineffective over the years, due in part to the meager incentives that come with the responsibility.[34] In 1996, some head teachers received only ¢3,000 (or $1.80) per month as responsibility allowance. In addition, there are elaborate administrative procedures that protect teachers and incapacitate head teachers' role as supervisors. A head teacher summarized the situation:

> The job protection that we enjoy makes it impossible to dismiss a teacher. A teacher may be ineffective, but all I can do is to release him/her to the GES office for re-posting to another school… there are no transparent rules on how head teachers should deal with such individuals to make it a deterrent to others.[35]

It is important to recognize that some public schools have excellent academic records and many are staffed

by committed head teachers and teachers. These schools and individuals are often known in their communities for their effectiveness and professionalism. In fact, one can compile a list of such public schools and teachers just by talking to GES officials and other community members.[36] However, teachers motivated by sheer altruism are few and altruistic head teachers are unpopular among teachers, some of whom would turn down postings to schools headed by such a head teacher.[37] For the majority of employees in the education sector, including GES officials, head teachers, and teachers, low salaries and discontent over non-wage benefits have demoralized them and created an apathetic attitude – supervisors do little to discourage absenteeism among teachers; and teachers come to school when they like and teach how they like. This attitude has become prevalent because as much as teachers still consider salaries important in sustaining households, it is no longer the major source of income. Moreover, the lax supervision makes it easier for education sector employees to be involved in multiple income generating activities. Thus, it is not surprising that the mostly untrained and inexperienced but better supervised and motivated teachers in private schools produce relatively better examination results.

The legal and illegal income generation opportunities pursued by health sector employees may also be attributed in part to the concerns over salaries and non-wage benefits. Employment freeze in government-supported hospitals makes it easier for nurses to work overtime or to convert their annual leaves into money. In 1994, overtime payments to HFH employees amounted to 10 percent of the total expenditure. But probably the most important source of income for health sector employees comes from illegal extortion of monies from desperate patients and their relatives. Some health sector employees collect unauthorized fees; others demand bribes and tips before a service is provided. The story of the goiter woman and my personal experience in one of the regional hospitals attest to the prevalence of such practices, at least in government-supported regional hospitals.

Case I: The Goiter Patient at KATH

In June 1996, a woman with goiter scheduled for an operation at Komfo Anokye Teaching Hospital (KATH), Ghana's second largest health facility, was denied treatment because she was unable to pay the illegal fee demanded by her surgeon. The two major newspapers - *The Daily Graphic* and *The Ghanaian Times* – all carried reports of this incident. The reports attracted the attention of the Minister of Health, who held a press conference and warned against illegal collection of fees in hospitals. The Minister threatened that security personnel would be posted to all health institutions to help stamp out the practice (*Daily Graphic*, June 15th, 1996). In response to the Minister's directive, medical doctors in the hospital adopted a "go-slow" strategy that prompted the hospital management to set up a probe (*Ghanaian Times*, June 17th, 1996). However, the hospital's chief administrator later denied that there had been any deliberate attempts to slow down the activities in the hospital (*Daily Graphic,* June 19th 1996). After

subjecting the poor woman to such publicity, she vanished from the hospital without undergoing the operation (*Ghanaian Times*, June 20th, 1996).

The incident led to the setting up of a committee of inquiry to investigate the collection of unauthorized fees in public health institutions. The committee concluded that the practice is widespread and involves all categories of health personnel as well as non-health personnel. The committee identified three categories of illegal fees. These include fees authorized by hospital management, fees without authorization and unauthorized sales of medical supplies on hospital premises. It noted that inability to pay these fees sometimes leads to unnecessary postponements of diagnosis and treatment. Surgery fees range from ¢25,000 for abortion to as much as ¢600,000 for major surgeries. The consulting room nurse is responsible for collecting "consultation fees" which could range between ¢200 and ¢1,000. At the end of the day, the nurse is accountable to the medical officer and where the medical officer was not in agreement with such collections it was difficult to find nurses to work with. Patients also have to pay fees to non-medical staff for services such as sanitary services, washing of bedding and disposal of placenta (*Daily Graphic,* October 16th, 1996).

Case II: My visit to a regional hospital

In January 1996 I took a patient to one of the regional hospitals and had the opportunity to observe how some health care workers make additional income at their place of work. Below is an excerpt of my journal entry for the day: Everybody that I had to deal with demanded some money. The demands are not like giving tips, since they were made conditional to the provision of service, and at times I had to bargain with the staff person before arriving on an agreed amount. To receive quick treatment and be attended to properly, you have to either know somebody who will take you through the process or be ready to pay bribes. In our case, we had a letter of introduction from a friend in the hospital that referred my patient. I thought the letter would help open doors for us, but I soon realized that it only made paying bribes easier! This is how it went: I gave the letter to the "friend" at the regional hospital (Mr. A.), and he agreed to help us through the process. Despite the long queue at the ticket line, Mr. A. was able to issue a hospital card within minutes and led us to Mr. P. who was responsible for preparing the patient's documents before seeing the medical officer. After taking the temperature, pulse and weight of the patient, he asked for ¢10,000 for the two medical officers who will examine my patient to ensure that he gets better attention. Even after paying the money, we had to wait for close to 3 hours before we were able to see the doctors. When my patient was admitted, the employee who led us to the ward demanded ¢400 and the elevator operator also demanded ¢200. At the ward, we were asked to pay a deposit of ¢40,000 and ¢1,000 ward fees - official receipts were issued for these. As I was leaving the ward, a patient who had been in the hospital for some time advised me to give "something" to the nurse in-charge so my patient would get the necessary attention – the nurse-in-charge was given ¢2,000. On my way out of the hospital, I passed by Mr. A's office to thank him for his help. He asked that I give him ¢15,000 for the surgeons who would operate on my patient: ¢5,000 for the "young doctor" and ¢10,000 for the "senior doctor." At the end of the day, I had paid ¢27,600 in bribes and ¢41,000 in hospital fees.

The above cases illustrate the nature and the magnitude of illegal income generation activities at government hospitals. First, the cases suggest that illegal fee collection at public hospitals is not limited to medical personnel; non-medical personnel are also involved in the process. Second, illegal demands for money before services are provided makes health care inaccessible to the poor. Third, illegal fee-collection has become so

entrenched that attempts to solve the problem without addressing the root causes risks threatening the entire health care delivery system. Finally, public/private comparison of hospital fees must take into consideration the illegal fees in public institutions. The illegal fees in public institutions, preferential treatment of influential people and those willing and able to pay bribes, and the long waiting times in public health institutions are some of the reasons for the increasing popularity of private health care delivery even as private fees remain high.

In summary, despite the similar experiences of the two sectors, there are significant differences in the way that employees in each sector have responded. Education sector employees rely on additional income from MML activities, a practice made necessary by low wages and made possible by the overall laxity of supervision public schools. In the health sector, employees depend more on additional money from within the sector through legal and illegal channels.[38] The difference in the livelihood strategies of employees of the two sectors raises an interesting question of whether institutional characteristics influence the livelihood strategies of employees. In other words, does the institutional setting encourage or discourage employees from pursuing options for additional sources of income?

6. Multiple livelihoods, Social Identity, Organizational Culture and Public Institutions: The search for Connections

How do we make sense of the fact that reforms in the health and education sectors generated different livelihood strategies, yet they all reinforced inefficiency in public institutions? As already indicated, there are several explanations for inefficiency in the public sector, and our purpose is to propose one more hypothesis. So far, we have argued that education and health sector employees rely on multiple sources of income and that the performance of public institutions has continued to decline. The logical step would have been to empirically demonstrate the linkage between employee livelihood strategies and the performance of institutions. But that task is beyond the scope of this paper; rather we merely develop a conceptual argument for hypothesizing the connection between multiple livelihood strategies and the performance of public institutions. The arguments are based on the concepts of multiple social identities and organizational culture (Figure 2).

Bangura (1994) defines multiple social identities as changes in the values of individuals located in multiple work situations. The concept is based on the premise that participation in multiple economic activities alters the

established social identities associated with particular professions and creates multiple social identities that reflect all the different income-generating activities. To be useful for our purpose, the definition must be broadened to include "multiple sources of income" and not just "multiple economic activities". The latter refers to income from economic activities (typically outside the place of employment, as in the case of education sector employees) as well as income from other sources (as in the case of the illegal sources of income for health sector employees), since all do influence one's social identity. In the past, professionals such as teachers, medical officers, nurses, etc., identified with a professional social identity and that made it easier to subscribe to professional regulations and to be loyal to the institution of employment. Professional social identity also made it fairly easy to distinguish between professionals and informal economic agents. However, with the diversification of income sources among many professionals, the characteristics that were central in defining professional identities have disappeared. This is particularly true for professionals who rely on income sources with ethics, values and codes of behavior that are different and often contradictory to what the profession expects of them. Such professionals are more likely to develop multiple social identities that reflect allegiance to the profession as well as their other sources of income. The result is complex identities that often undermine loyalty to the profession and commitment to the organization in which one is employed.

[Insert Figure 2]

In every organization, there are written as well as unwritten rules and expectations which define the culture of the organization. While all individual organizations in a particular sector may have similar written rules and expectations, the unwritten ones tend to vary from one organization to another depending on the social identities of the employees. Thus employees' social identities influences the unwritten codes of conduct and behavior of organization, including practices that are acceptable and those that are unacceptable; practices for which one can be rewarded and those that will cause a reprimand; practices which one can get away with and those that will not be tolerated. An umbrella term for these unwritten codes is "organizational culture" and is defined as "a shared set of norms and behavioral expectations characterizing a corporate identity … [including] the extent to which such beliefs and standards of behavior are shared by individuals within an organization and the extent to which such factors are attributed to the organization itself" (Grindle, 1997b:482) These shared norms and expectations of an organization also shape employee orientation toward work and determine the extent to which they direct their attention towards

achieving the goals of the organization. Like all cultures, organizational culture has certain characteristics – it is the product out of the combined social identities of employees of the organization with leadership playing a critical role. However, once the culture becomes entrenched in an organization, it influences the behavior of employees, both old and new, and in the process perpetuates itself. Organizational cultures may also *shared*; they are *learned*; they are *adaptive* and most importantly, they are *dynamic*. Thus, if we have a better understanding of the culture of a particular institution, including how it is created, sustained, and transmitted, it would be possible to design policies to change the culture and transform the institutions. We can illustrate this with Ghana's health and education sectors.

As already indicated, participation in multiple economic activities in Ghana is partly a product of pre-reform economic crisis that shifted professional and organizational priorities from the core responsibility of efficient provision of services to concerns over daily survival issues. As this shift became the norm among employees, enforcement of the codes of ethics in public institutions and among professional groups was grossly undermined. The health and education sector reforms did not only fail to reverse the erosion of professional ethics among public employees, but it also created an environment that encouraged participation multiple livelihood strategies (whether legal or illegal) and turned it into "the way of doing things" and an integral part of the cultures of many public institutions.

The culture of public organizations that supports MML and encourages inefficiency is shared by most employees. In most cases, employees of an institution tend to share similar views on the need for additional income, appropriate means of generating such income, and the impact the activities on the institution. Among education sector employees, participation in multiple economic activities is seen as the norm and the general feeling among many is that there is nothing wrong with the practice. In fact, some officials and head teachers would readily allow teachers to use school land for private farming; ask school children to work in the teachers' farms; or even arrange for a substitute to replace a colleague who is absent because of private business commitment.[39] The GES has no explicit policy that prevents its employees from involvement in other economic activities (except organizing vacation and evening classes by teachers), but the availability of institutional support for those who need it is certain to encourage among the employees.

Similar observations can be made with regard to health institutions. The culture in government hospitals encourages extortion of money from patients. As in the case of GES, when top officials who are supposed to enforce

the rules and regulations of the organization are themselves involved in illegal collection of fees, they lose the moral authority to enforce rules and things begin to break down. For instance, when medical doctors require nurses to collect monies from patients before service is provided; other medical staff (nurses, pharmacists, and laboratory technicians) and non-medical staff (such as ticket officers, cleaners, elevator operators, etc.) could the same with impunity. Presumably, patients also understand and do not challenge the practice because it allows them to circumvent the queues, insults, and nonchalance that are associated with public health institutions.

Organizational cultures are however not monolithic; they are adaptive and vary from sector to sector as well as from an organization to another. On the whole, the culture of public schools is different from the culture of public health institutions. But more importantly, there are significant differences among public schools and among government-supported health institutions. In the health sector, some employees capitalize on the vulnerability of patients and families in their desperate search for treatment and the social perceptions of medical practice to extort monies from patients. Although employees in health facilities owned by religious organization are also involved in such practices, it is not as prevalent or as blatant as in public hospitals. Instead, employees rely more on incomes from overtime and sales of annual leave.[40] In addition, administrators support and sometimes encourage employees to pursue legal options for generating additional income outside the institutions. An official at a mission hospital explained that:

> I know employees who sell things in the market, those with kiosks in front of their homes where they sell things, and those who farm on the hospital's undeveloped land. But I also know that the workers cannot live on the salary alone. I cannot stop them from making a few cedis legally after work. I wish I could do more to help. As a hospital policy, however, we try to discourage our employees from working in another hospital.[41]

Similar observations can be made with regard to the educational institutions.

For an organizational culture to become entrenched, new and old employees must learn and adopt the culture. In situations where participation in multiple economic activities is common, it is often difficult for other employees to resist the lure of participation and focus on the goals of the organization. There may be altruistic head teachers who enforce strict discipline, ensure regular school attendance by teachers and are known among their peers for producing superior academic records. But such hardworking and committed head teachers can be frustrated by those who resist such efforts and the GES's unwillingness and/or inability to support them. New teachers can easily become involved in the practice. In fact, some new teachers choose the profession because of the flexibility in

pursuing private economic interests.[42]

The good news is that organizational culture is dynamic and not static and it may be possible to influence the direction of cultural change in the institution through deliberate policies, practices and personnel changes. We have already pointed that salaries and non-salaried benefits that guarantee a decent living is critical in creating productive organizational culture. Moreover, effective leadership and good supervision can help create a positive culture that encourages efficiency, as in the case of the public schools with impressive academic records. These are examples of how to change organizational cultures of public institutions and put them back on the path to greater efficiency. But more research is needed to empirically explore the relationship between livelihood strategies and the performance of public institutions and to identify the key ingredients that make some public institutions perform better, and apply the lessons to the others.

7. Conclusion

For better or worse, public employment in many African countries has changed significantly in the past three decades, and the rate of change has accelerated over the last twenty years. The concern is not about change per se, it is about why public institutions all over Africa are changing for the worst. Many explanations of why the public sector in Africa is inefficient have already been given. The hypothesis proposed here explores a connection between employee livelihood strategies and the performance of public institutions. It is based on the fact that public sector employees in Africa are no longer the overpaid and pampered class chastised by urban bias theorists; an image still held by some in the international development community. Most of them find it extremely difficult to make ends meet, using only their salaries. Declining wages, increasing cost of living, the need to survive, and lack of motivation may have created a situation where the only change that has occurred is the change for the worse. But at the same time, it may be overly simplistic to assume that all public employees who participate in multiple income generating activities (both legally and illegally) are driven solely by the need to "survive". This analysis suggests that, the organizational culture of public institutions have become more accommodating to such practices. It also suggests that since organizational cultures are dynamic, it may be possible to influence the direction of cultural change through a deliberate policy. There is certainly the need for further studies to explore the causal linkages between livelihood strategies and the performance of public institutions, but if we accept the hypothesis advanced

here, then one has to be skeptical of reforms policies that ignore the survival concerns of employees as well as shock therapies that assume that higher salaries would lead to higher productivity in the public sector. What may be needed is a comprehensive and concerted long term effort that combines transparent reward system rewards with policies and programs aimed at changing the cultures of public institutions. So far, neither SAPs nor the second generation reform seems to address these needs.

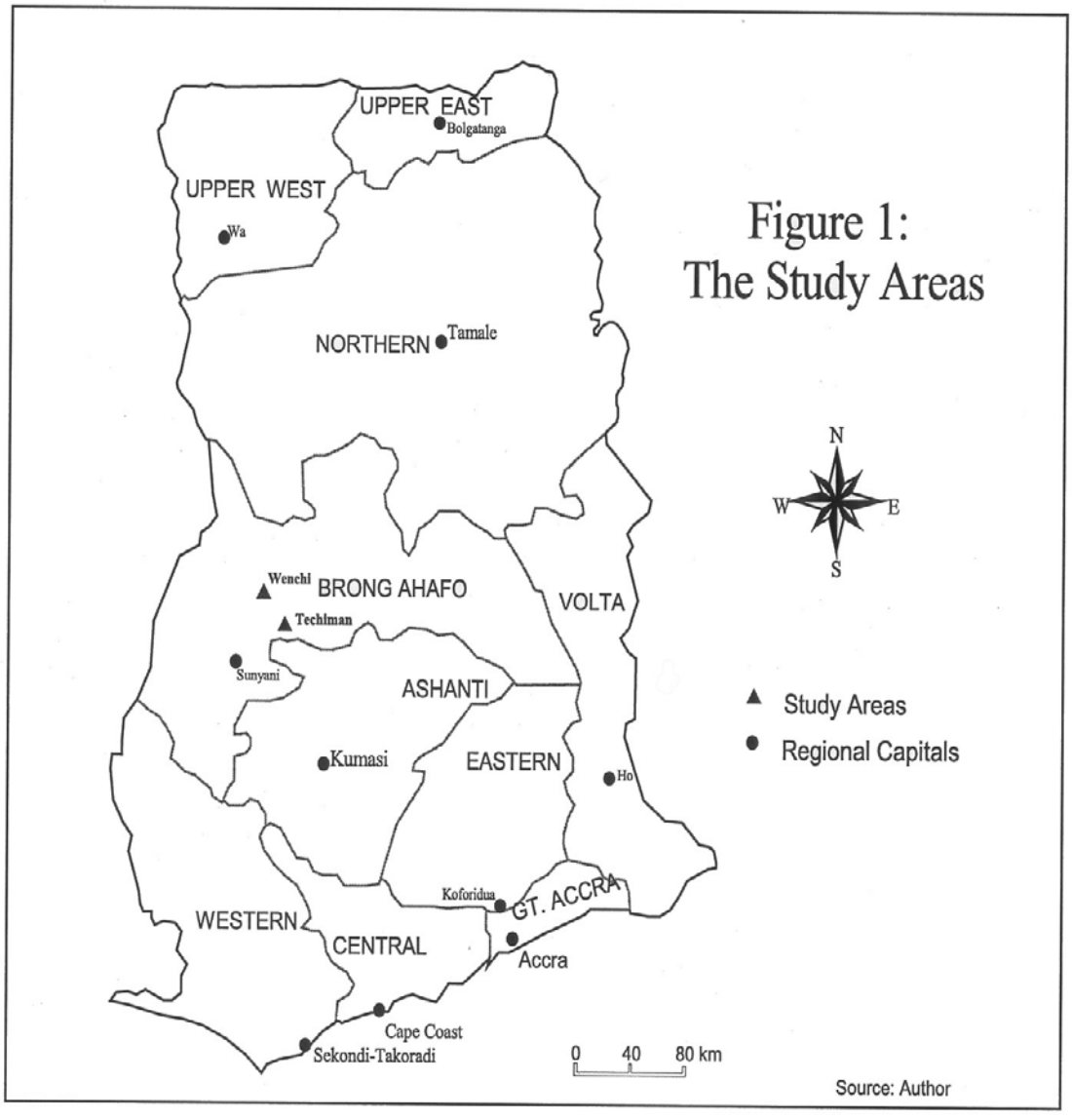

Figure 1:
The Study Areas

Figure 2

Multiple livelihoods, Social Identity and Organizational Culture

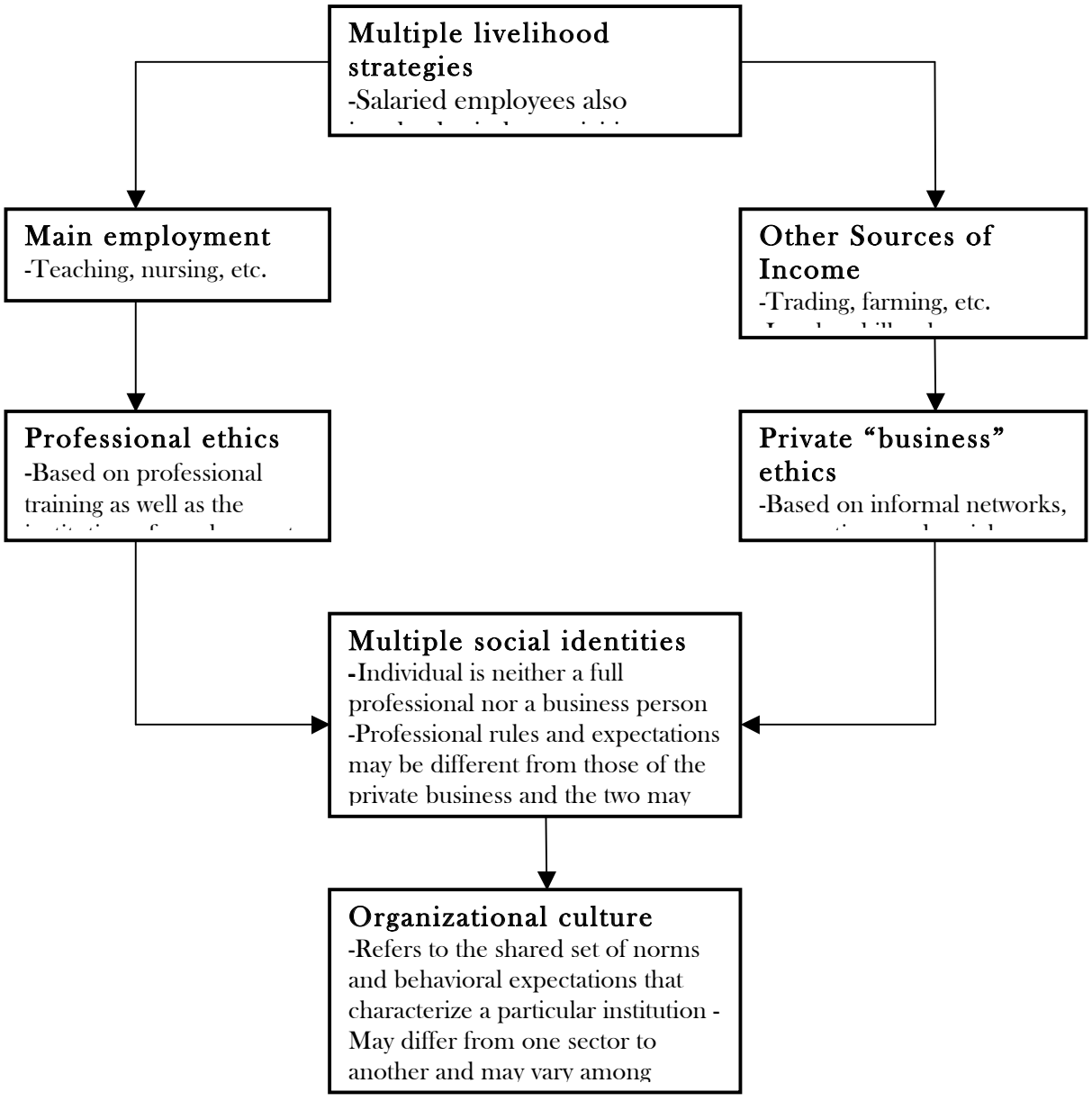

Table 1

MML Participation Rates: Comparison of the case study and GLSS

Category	Case study[1]		GLSS[2]	
	No.	%	No.	%
Total sample	237		4997	
Salaried employees in total sample*	96	40.5	749	15.0
Salaried employees who participate in MML**	61	63.5	133	17.8
Employer		%		%
Government		67.1		21.8
Private		54.5		7.7
Other		50.0		22.2
Type of Public Institution* **		%		
Ghana Education Service		88.0		
Ministry of Health		40.0		
Civil Service		70.6		
Other		53.8		

Notes:

* Percentages are based on total respondents.

** Percentages are based on salaried employees in each case.

*** There were no data on income and type of public institution in the GLSS data.

Sources:

[1] Author's field data (August 1995-August 1996)

[2] Ghana Living Standards Survey (1991-1992)

Table 2

Results of Criterion-referenced Tests, 1994-97

		English			Mathematics		
		1994	1996	1997	1994	1996	1997
Private	Percentage Reaching Mastery	51.4	56.5	68.7	31.7	31.0	40.4
	Mean Score	58.8	61.0	67.4	47.3	47.0	51.7
Public	Percentage Reaching Mastery	3.3	5.5	6.2	1.5	1.8	2.7
	Mean Score	31.0	33.0	33.9	27.7	28.8	29.9

Source: Canagarajah, S. and Ye, X., (2001) "Public Health and Education Spending in Ghana in 1992–98: Issues of Equity and Efficiency" World Bank Working Paper No. 2579, 2001 p.8

Table 3

Treatment Seeking among Self-reported Ill People

Expenditure quintiles	% ill seeking no care			% ill seeking public health care			% ill seeking private modern health care		
	1992	1998	% change (1992-98)	1992	1998	% change (1992-98)	1992	1998	% change (1992-98)
1 – poorest	58.5	63.4	8.3	22.8	17.4	-23.9	14.3	17.4	21.4
2	54.5	64.3	18.0	24.5	18.5	-24.6	15.6	18.5	18.4
3	53.6	59.0	10.1	24.5	23.1	-5.7	17.4	23.1	32.8
4	49.1	52.7	7.4	23.6	23.4	-0.7	20.6	23.4	13.8
5 – richest	43.3	44.0	1.5	27.9	29.4	5.3	23.9	29.4	22.9
Urban	42.6	49.4	16.0	30.5	26.3	-13.7	22.0	26.3	19.6
Rural	54.8	60.4	10.3	22.3	20.3	-9.1	17.6	20.3	15.1
Total	50.8	57.6	13.4	25.0	21.8	-12.8	19.0	21.8	14.8

Source: Canagarajah, S. and Ye, X., (2001) "Public Health and Education Spending in Ghana in 1992–98: Issues of Equity and Efficiency" World Bank Working Paper No. 2579, 2001 pp.38)

Table 4

Median monthly salary of public school teachers, May 1994

Rank	Median monthly salary	US$ Equivalent*
Director	¢137,289.62	129
Assistant Director	¢123,251.51	116
Principal Superintendent	¢109,213.31	103
Senior Superintendent	¢98,791.02	93
Superintendent	¢88,210.13	83
Assistant Superintendent	¢68,841.79	65
Post-Secondary	¢63,549.40	60
Certificate 'A'/Principal Instructor	¢58,256.89	55
General Certificate of Education, (Advanced Level)	¢43,370.93	41
General Certificate of Education (Ordinary Level) and Middle School Leaving Certificate	¢36,001.35	34

Source: Ghana Education Service, Unpublished Records, Accra

*Based on the average exchange rate at the forex bureaus in 1994 (¢1065 to US$).

NOTES

[1.] Inefficiency in public institutions in Africa has been attributed to inappropriate institutions (Dia, 1996); corruption (Kiltgaard, 1997); the eroding stock of human capital (Haque and Aziz, 1998), among others.

[2.] Wenchi and Techiman are medium-sized towns in the Brong Ahafo Region of Ghana and are located about 20 miles apart. Techiman has a more diverse economy and is a locus of rapid population growth; Wenchi is a typical town with a relatively slow population growth rate.

[3.] The comparison of salaries with per capita income is problematic since the informal sector is often ignored in official data collection. In addition, in the period preceding 1981 (the statement refers to that period), Africa's budgetary allocations to the social sector, including education, were at their lowest level. Thus, the supposedly high share of salaries in recurrent expenditure may not be a reflection of higher salaries, but an indication of the magnitude of the cut in government allocation to other items on the recurrent budget.

[4.] When SAPs were proposed in the 1980s, there were other competing proposals which were silenced because their proponents lacked the large amounts of money required for their implementation. The alternative proposals included the UNECA's "Africa Alternative Framework to Structural Adjustment Programme for Socio-Economic Recovery and Transformation(UNECA,1989) and the UNICEF's "Adjustment with a Human Face" (Cornia, Jolly, and Stewart, 1987).

[5.] Field notes, August 1996.

[6.] The IMF and the World Bank are happy with Ghana's success. In fact, Ghana is seen as a model of the success of SAPs in Africa (World Bank, 1994).

[7.] MML Participants includes salaried employees who are also involved in other economic activities for the purpose of generating generate additional income.

[8.] The different MML participation rates from the case study and GLSS data are due, in part, to the different objectives of the two surveys. Since the GLSS was not designed specifically to study multiple livelihood strategies, the questionnaires and the interviewers may not have aggressively pursued important leads about multiple employments and may have inadvertently underestimated MML participation. The different estimates might also be due to respondents' unwillingness to talk to "strangers" about supplementary economic activities, for fear of taxes or because the activity is either illegal or is done

"illegally" – this was more of a problem with the GLSS than with the case study. Time may also be a factor explaining the different participation rates. The GLSS was undertaken in 1991-1992 while the fieldwork on which the case study is based took place between 1995 and 1996. Thus, although the case study is not representative of the country, its MML participation rate is probably closer to reality.

[9.] Urban bias thesis attributes the underdevelopment and poverty in the developing world to state diversion of resources from rural to urban areas (Lipton, 1977).

[10.] A series of events that led to the collapse of the Ghanaian economy in the late 1970s, including bad domestic policies, political instability and pressures generated by the global economy (Ninsin, 1987[).]

[11.] The discussion of the education sector is limited to basic education, including primary and junior secondary schools.

[12.] Conversation with officials at the Ministry of Education, Accra October, 1995.

[13.] Although one can argue that the data on MML participation by the type employer is not very conclusive, the data must be put in a context. For instance, while the percentage for the "other" category looks relatively high, it is based on very small number of cases. Also, regarding public sector/private sector employee participation rates, the consistency in the two data sets seems to be more revealing than the relative participation rates.

[14.] Anecdotal evidence suggests that health care employees who are not directly involve in the provision of care and therefore do not have opportunity for overtime (i.e. administrative workers) are more likely to participate in MML.

[15.] A typical school day runs from 8.00 a.m. to 2.00 p.m., Monday to Friday. The regular schedule gives teachers the time to participate in other economic activities. Although the typical working day of medical workers is also eight to nine hours, the working hours could be in the morning, afternoon or evening. In addition, the days off do not always fall on weekends.

[16.] Discussions with the Accountant, Wenchi Methodist Hospital and the Hospital Administrator, Holy Family Hospital

[17.] Focus group discussion with teachers, Techiman, November 1995.

[18.] Field notes, June 1996.

[19.] There are exceptions to this generalization: some private schools have excellent facilities and pay

higher salaries than public schools.

[20.] Other factors may have contributed to the better examination results in private schools. It is possible that admissions to private schools are selective based student's academic records or the socioeconomic background of parents. It is also likely that class sizes in private school may be smaller or teachers teach to exams.

[21.] Unpublished Records, Ghana Education Service, Wenchi and Techiman District offices.

[22.] Ghanaian newspapers are full of articles lamenting the falling standards of public education. See "Our non-English Speaking JSS Graduates" Daily Graphic, July 10th 1997; "A Headmaster's Plea" Editorial Daily Graphic July 4th 1997; and "Task for GES Council" Editorial Daily Graphic, August 27th 1997.

[23.] Despite the relative autonomy of CHAG-affiliated institutions, the government still controls personnel issues including salary. In fact, employees of CHAG-affiliated institutions are considered government employees and the government pays the salaries.

[24.] A distinction must be made between quality of treatment and the general treatment of patients. The former is more difficult to assess because public facilities often cater for patients with serious life-threatening illness than private facilities. The focus here is on the later, including the attitude of nurses and hospital staff towards patients, access to medical personnel, time spent waiting for service, evidence of bribery and corruption, and the perception of fair treatment.

[25.] The fees for private health facilities are generally higher than those of public and quasi-public providers for similar services. In Nigeria, the fees charged by private hospitals can be as high as 100 to 300 percent of those charged by public facilities (Ogoh-Alubo, 1990) although comparable data are not available, anecdotal evidence point to similar fee differential.

[26.] See the 1994 Annual Reports for Holy Family Hospital and Wenchi Methodist Hospital. The unusually large drop in hospital attendance at the WMH was blamed on rumors that an incompetent medical officer at WMH was responsible for several deaths (Discussion with WMH official, November, 1995).

[27.] Discussion with a private medical practitioner, Techiman, December 1995.

[28.] Response to interview questions, June 1996.

[29.] Response to interview questions, June 1996.

[30.] Most private employees do not have many of the non-wage benefits that their counterparts in the public sector have but this often does not seem to have any serious impact on their morale. Non-wage benefits in the public sector are a source of discontent, precisely because it is part and parcel of the contract with the state and employees feel they have the right to demand them. Most private sector employees accept the jobs knowing clearly that they are not entitled to such benefits and therefore they do not expect them. Under such conditions, minor token actions by the proprietors such as free lunch or loan advances can significantly boost employee morale.

[31.] Interview with a Ghana Education Service School Inspector, May 1996.

[32.] Ghana Education Service Inspector, May 1996

[33.] 1994 Annual Reports for Holy Family Hospital and Wenchi Methodist Hospital

[34.] Discussion with a retired teacher, July 1996.

[35.] Public school head teacher, Techiman, March 1996.

[36.] Further studies may be necessary to explain why some schools perform better, but anecdotal evidence suggests that dedicated and altruistic leadership may be the key. As will be shown later, leadership is critical in creating organizational cultures that encourage efficiency.

[37.] Focus group discussion with teachers, Wenchi, December 1996.

[38.] Despite the connections between salaries and productivity, there is not much difference between public and private sector salaries, especially in education and the health sector. This can be attributed to two factors. First, as the only dominant player in the labor market, the government's wage level is the de factor market price for labor. Second, the high unemployment rate in the country makes it possible for the private sector to pay the near-market price for labor while demanding better customer satisfaction from employees. The relatively low wage and better performance in the private sector is made possible through effective supervision.

[39.] Interview with Ghana Education Service official, Wenchi, December 1995.

[40.] Discussion with Wenchi Methodist Hospital and Holy Family Hospital officials, 1996

[41.] Response to interview question, January 1996.

[42.] Focus group discussion with teachers, Techiman, January 1996.

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