The Capacity Project and Ghana Ministry of Health

Assessment of the Additional Duties Hours Allowance (ADHA) Scheme: Final Report

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Table of Contents

Acronyms

ADHA	Additional Duty Hours Allowance
GHS	Ghana Health Service
GMA	Ghana Medical Association
GOG	Government of Ghana
HCW	Health Care Worker
HR	Human Resources
MOH	Ministry of Health
MOU	Memorandum of Understanding

Executive Summary

The Ghanaian health system faces a number of major challenges in the recruitment, deployment and retention of health care workers (HCWs). Significant among these is the decision by many young, newly trained professionals to migrate due to a number of reasons, including seeking more attractive work and living conditions abroad. Migration patterns of HCWs over recent years show that Ghana has a relatively high migration rate compared to other African countries, particularly among doctors and nurses. Sixty percent of doctors from the country's main medical school emigrated between 1986 and 1995 (Dovlo and Martineau, 2004). Requests for verification of nurses' qualifications to work abroad showed annual figures almost double the replacement rates from training institutions. Human resources for health are also poorly distributed, being one of the ingredients of an increasing inequality among the country's regions and between urban and rural settings. For those HCWs who stay, the incentives for higher productivity and location in remote areas are also low.

In 1998, partly in response to these factors as well as industrial agitation from the Ghana Medical Association (GMA) and health worker unions, the Government of Ghana (GOG) introduced the Additional Duty Hours Allowance (ADHA). (Agitation is a term used by GOG officials, HCWs and health sector unions to describe the industrial relations environment and activities that occurred as part of the ADHA.) The original purpose of the ADHA scheme was to compensate doctors for hours worked beyond the standard 40 hours per week or 160 hours per month. Initially the allowance was only paid to doctors. Significantly, in 1999 the Nurses Association agitated for and was included in the ADHA. The inability of the GOG to "toe the line" in face of industrial action led to a cascading effect in which virtually all public health staff, including the teaching hospitals and faith-based organizations, were included in the ADHA scheme. Consequently, the ADHA budget soared from 3.7 billion cedis in 1998, to 7 billion in 1999 to over 800 billion cedis in 2005. In addition to the ADHA scheme the GOG also negotiated other programs, such as car and housing loan schemes, for rural-based professionals (Dovlo and Martineau, 2004).

Even though the ADHA scheme arose from industrial action between the GOG and HCW unions, the significant increases to income levels that resulted would seem a powerful intervention to positively affect HCW recruitment, deployment and retention. To explore this question and examine the consequences of the scheme, the Capacity Project partnered with the Ghana Health Service (GHS) to undertake a comprehensive study of the ADHA scheme. The study investigated how the scheme impacted a number of human resources (HR) factors associated with health worker recruitment, deployment, retention and performance—specifically, how the significantly higher income levels resulting from the ADHA scheme influenced job satisfaction, motivation, workplace climate and the relationship between clinical and administrative staff, as well as productivity. The study provides a detailed chronology of the ADHA scheme and explores lessons learned from the way in which the GOG implemented and administered the scheme.

The study team relied primarily on the perspectives of different stakeholder groups to complete the data collection and assessment portions of the study. This included focus groups with HCWs as well as interviews with representatives of the GMA and health sector unions. The study team had intended to augment this qualitative data with quantitative data collected from the Ministry of Health (MOH) and GHS. Because it proved unexpectedly difficult to locate and obtain these data, the study team was unable to include complete quantitative data as part of the study findings. This has limited the scope of the report, particularly in regard to the GOG perspective, macro-level impacts of ADHA on retention of HCWs and on the longer-term financial sustainability of the

wage increases. Despite this limitation, the study provides a compelling insight into the scheme's conception, implementation and impact.

Any attempt to describe or view the scheme as a planned retention or broader HR strategy fails to recognize the industrial relations environment from within which the scheme emerged. This is perhaps best captured in the description of the ADHA scheme as "born in crisis and generally managed as crises" (Sagoe, 2004). While HR managers of the MOH and GHS would have liked to shape ADHA as an HR strategy, the events on the ground determined and ultimately shaped its implementation and management.

The complex environment in which the scheme was conceived is reflected in how different stakeholders within the health sector interpreted and viewed the rationale for the scheme. For example, the GOG and GMA viewed it as a negotiated settlement for higher wages for doctors. Nurses, on the other hand, viewed it as recognition for the difficult and under-resourced settings in which they worked. Interestingly, lower-cadre heath workers were most likely to describe the scheme as an HR strategy designed to stem the brain drain of doctors and motivate HCWs.

The study findings are mixed in regard to the impact on heath worker retention. Because income levels are an important element of job satisfaction, the study team expected a positive impact on HCW retention due to the higher incomes resulting from ADHA. While there was some evidence that the ADHA initially stemmed the exodus of doctors, this trend was not maintained. The higher salaries did attract health workers back to the health sector who had retired or moved to another sector, particularly in the case of nurses. The number of applications submitted to HCW training institutions also increased.

In regard to job satisfaction, the positive impacts from the initial implementation were slowly eroded by inequities, inconsistencies and some abuses in the scheme's application at the regional and facility levels. Relationships between different cadres, particularly doctors and nurses, were also damaged due to the perceived proportionality of payments in favor of doctors. ADHA's impact on staff motivation, workplace climate and performance mirrored that of job satisfaction and staff motivation, and was less than expected.

In many ways the story is also one of unintended consequences. An example of this was the tendency for HCWs to transfer to those regions considered more liberal in awarding ADHA payments. As these were often the regions that included large urban centers, the result was to draw health workers away from the rural regions. Also, rather than stemming industrial agitations or pacifying health worker unions, the scheme led to increased strike action in the public health sector. This was due in part to ADHA payments being perceived as salary enhancement or an entitlement rather than payment for overtime hours approved and worked. Action by the government to impose ceilings or delays in payment triggered industrial action by health worker unions. The study also revealed that while higher income allowed some HCWs to increase their standard of living by purchasing a home for the first time, it also created some backlash from within the community. Particularly in the poorest communities, HCWs were seen as *nouveau riche*, and they became targets for higher prices in the marketplace, financial loans and in some cases robbery.

Finally, the study also exposed the critical need to establish the necessary management and regulatory infrastructure in advance of implementing a program on the scale of ADHA. In lieu of official policies and guidelines, regions, districts and even individual facilities fashioned their own.

This not only undermined the scheme's integrity but reduced its effectiveness as an incentive for improved performance and retention of HCWs in Ghana.

In September 2005 the GOG issued a circular officially announcing the disbandment of ADHA in its current form, and the consolidation of ADHA into the base salaries of HCWs. The last ADHA payment was made in December 2005. While industrial agitations continued regarding the terms and arrangements for ADHA consolidation, HCWs in Ghana today enjoy significantly higher base salaries as a result of ADHA.

I. Introduction

1.1 Study Background

There is a chronic shortage of well-trained health care workers (HCWs) globally. This shortage is caused by a range of factors including the migration of health workers to well-developed countries, under-production of the health workforce, inability to pay higher salaries and benefits, inability to sustain other measures to retain health workers in some countries, illness and death and other factors that are uncontrollable (World Health Report, 2006). Ghana has been one of the countries hardest hit by the "brain drain" of health workers to more developed markets such as the UK, US and Canada.

This study derives from a review of retention strategies in Ghana in 2005. Discussions with key stakeholders in the Ghana Health Service (GHS) and Ministry of Health (MOH) at that time highlighted the scope and significance of the Additional Duty Hours Allowance (ADHA) scheme. ADHA was introduced in 1998 as a negotiated settlement to strikes of public sector doctors led by the Ghana Medical Association (GMA) over the issue of long hours and low pay[1]. The original intention was to compensate doctors, particularly junior doctors[2], for working longer hours, but the parameters of the settlement were determined as much by political negotiations as by human resources (HR) planning. From this limited beginning in 1998, the scheme rapidly expanded across all workers in the health sector, and within a few years it had effectively increased the take-home pay of health workers between 75% and 150% depending on cadre and location.

ADHA's evolution and impact can also be considered in the context of supply and demand. The HCWs, particularly clinical staff, had other options for employers both within Ghana and abroad. The MOH and the GHS had no other reasonable options for employees. This fact was repeatedly leveraged by increasingly empowered associations of HCWs to achieve pay increases. One result was that 2006 wages in Ghana were at one of the highest levels in Africa (Ministry of Health, 2007). This has had positive impacts for individuals, but less so for the GHS and MOH. As stated in the draft Independent Review of the Program of Work, "The MOH and health agencies find themselves in a difficult position, with cost pressures (particularly the rising wages, and the pressure for them to rise further), on the one hand, and on the other hand, a resource envelope which is reducing, combined with pressure to improve outputs and outcomes. How can this circle be squared?"

While ADHA was not primarily intended as a retention strategy, it is an important test case that may provide insights for policy-makers and HR managers in other countries. This is a retrospective study that assesses the actual intent, evolution and impact in Ghana.

1.2 Study Purpose

The purpose of this study is to review the evolution of ADHA and assess its impact on HCW satisfaction, retention and performance, as well as its larger consequences for the Government of Ghana (GOG) and the MOH and GHS.

[1] For example, average monthly basic salaries for junior and senior doctors in Ghana in 1999 were $199 and $272 as compared to $1,199 and $2,100 for junior and senior doctors in Malawi that year (Dovlo and Martineau, 2004).
[2] Junior doctors were generally recognized to work far more than standard hours (from interview with Dr. Ken Sagoe, 2006).

The key study questions included the following;

- What were the reasons for the introduction of ADHA, and to what extent was it intended as a human resource strategy?
- What was the process of implementation?
- What were the results or outcomes?
- What were the unintended effects caused by the scheme?
- How did lessons learned from the implementation contribute to policy decisions for salary reforms in the health sector?
- How can lessons learned with ADHA assist other ministries of health strategize for retention and motivation of health workers?

2. Methodology

This study attempted to employ both qualitative and quantitative methods to collect detailed information about the implementation, success and impact of ADHA as well as post-ADHA salary reforms on individuals and institutions.

2.1 Qualitative Methods

1. *Document review* (see Annex A).

2. *Central-level interviews with MOH, GHS, GMA and other key stakeholders in the development of ADHA* (see Annex C). The interviews focused on stakeholder views on the reasons for, strengths and weaknesses of the ADHA, and unintended consequences and the subsequent salary reform. While the team included the senior HR manager from the GHS, the MOH HR member was unable to join the team. The role of the MOH HR team member was to lead the collection of data at the central level. The GOG Interview Guide has not been applied to date.

3. *Field study*. The study team conducted focus groups with HCWs at 12 facilities in the Central region of Ghana (see Annex B). The purpose of the assessment was to learn about and document stakeholder perspectives regarding the rationale for ADHA, and assess the extent to which the scheme contributed to motivating and retaining HCWs. The assessment also examined the unintended consequences.

2.2 Quantitative Methods

Annex D lists the types of quantitative data the study team attempted to collect from the central HR functions within the MOH and GHS.

2.3 Time Frame

The study was conducted between mid-March and May 2007.

3. Findings

3.1 ADHA Objectives

A review of MOH and GHS documentation and reports describes the formal objectives of the ADHA as follows:

- To recognize and remunerate health workers for any hours actually performed over and above the approved eight hours a day, 40 hours a week and 160 hours per month work schedule
- To ensure a 24 hours cover at all health delivery points nationwide
- To motivate health workers for higher performance towards provision of improved quality care—thereby helping to restore and sustain public confidence in the public health services delivery.

3.2 ADHA Principles

The ADHA memorandum of understanding (MOU) defines the following as the main principles underlying the ADHA scheme:

- Payment of ADHA shall be made only for work authorized, actually done, properly documented and based on a duty roster, which should be authorized by line Managers and Department heads
- ADHA is neither a salary supplement nor a salary enhancement and therefore shall not be the automatic right of all heath workers
- ADHA shall not be paid to staff on leave or study leave and therefore not offering service.

3.3 ADHA Evolution

By the late 1990s, the GMA had petitioned the GOG over the issue of long hours and low pay for public sector doctors[3]. Their case and motivation was strengthened by significant pay raises awarded to doctors working at the 37th Military Hospital in Accra. This first pay hike at the military hospital was the trickle that would become a flood. Increasing GMA demands were backed up by a long doctors' strike that resulted in the closure of all health facilities in 1998. This had immediate, strongly negative public health and political consequences. It was observed that access to public health services, even a service struggling under large resource constraints, was an essential part of the social contract between the government and the people of Ghana. GMA presented the government with three options for satisfying the striking doctors: 1) salary increases; 2) compensation for work overload; 3) compensation for long hours (ADHA). As noted by Dr. Ken Sagoe (2004), "government considered the introduction of salary increases as impractical against the background of a possible cascading effect on other civil and public health workers." A proposal for quantifying increased workload was not deemed to be rational enough. However, the proposal of compensation based on Additional Duty Hours was viewed as less controversial and was supported by similar examples from the UK where only doctors are paid fixed additional monies in lieu of working beyond the typical 40 hours a week referred to as Units of Medical Time. The government agreed to the proposal because it was less likely to be used by other health workers and other public sectors to demand similar increases. Just before Christmas

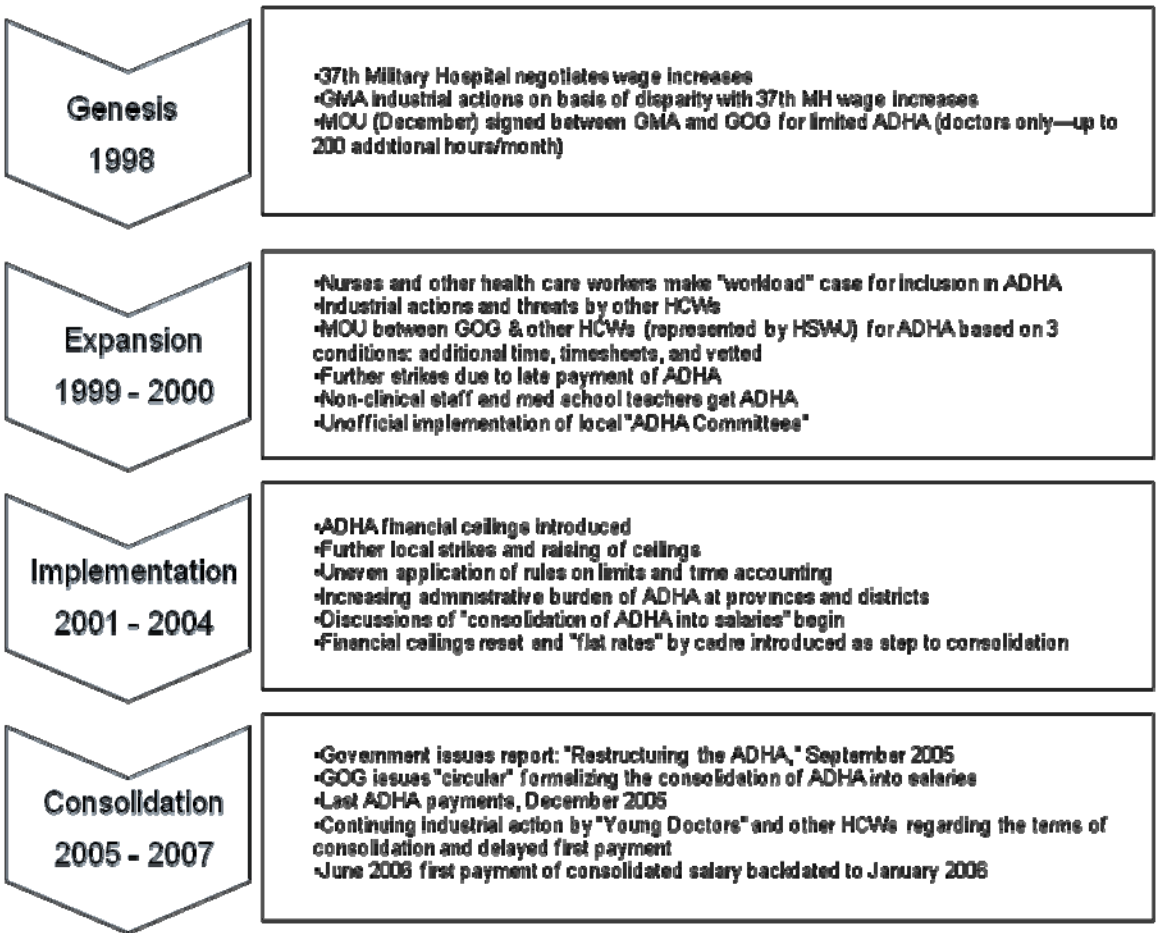
[3] For example, average monthly basic salaries for junior and senior doctors in Ghana in 1999 were $199 and $272, as compared to $1,199 and $2,100 for junior and senior doctors in Malawi that year (Dovlo and Martineau).

1998, an MOU was signed by the GOG and GMA allowing ADHA up to 200 additional hours per month.

Somewhat predictably, ADHA did not end with doctors only. By April 1999 the Nurses Association began striking and by September of that year nurses were included. The Nurses Association was immediately followed by the Medical Assistants, the Pharmacists, the Bio-medical Sciences and general Health Service Workers Associations in agitating for, and inclusion in, ADHA. Today virtually all public health staff nationwide, from cleaners and guards up to senior doctors at the teaching hospitals, have benefited from the scheme. The ADHA budget has soared from 3.7 billion cedis in 1998, to 7 billion in 1999 to over 800 billion cedis in 2005.

Figure 1 presents a chronology of the most significant events from the beginning of ADHA in 1998 to the present. The story from start to finish was characterized by industrial actions and negotiations with HCW unions that resulted in GOG concessions and ultimately the consolidation of the increased pay packets under ADHA into salaries. This was the outcome the government had been hoping to prevent in 1998 when it opted for a limited additional hours payment (for doctors only) scheme.

Figure 1: Chronology of ADHA



3.4 ADHA Implementation

ADHA was implemented in the context of industrial actions followed by mediated solution, followed by further industrial actions and negotiated agreements. Strikes and threats of strikes continued even after repeated GOG concessions. The MOH and GHS were constantly on the back foot as they attempted to rationalize and institutionalize the various agreements reached in mediation. ADHA was never expected to be as large or complex as it became, therefore the management practices, monitoring and evaluation were always lagging behind. Managers at each level were, by necessity, reacting to ongoing crises, rather than anticipating and solving problems before they arose. Key constraints to a more efficient implementation included the following:

- Neither the GHS nor the MOH had previously used a time reporting system for documenting hours worked by individuals. ADHA was based on timesheets
- The scheme was never introduced as formal policy. Policies were developed but never officially released
- Influence of associations, particularly the GMA, on how members perceived and performed the rules for ADHA
- No structured or comprehensive approach to communication, education, instruction, training, marketing, etc.
- Inadequate supervision and oversight
- Significant room for regional interpretation—largely based on the loose framework and guidelines established for ADHA—but with both strict and loose interpretations of the process for vetting hours worked
- Mechanisms that did exist gradually eroded as the inequities and discrepancies in the system became known—no reward for following the rules (Central and Volta regions followed the guidelines and managed their budgets effectively).

3.5 Stakeholder Views Toward ADHA

HCWs and government officials interviewed for the study offered somewhat different explanations for what ultimately prompted the GOG to introduce the scheme. From the government's perspective, the ADHA was introduced as a negotiated settlement with the GMA over long-standing grievances and industrial action for higher wages. It was also viewed as a measure to avoid further industrial action by doctors that had not only had crippling effects on health care services but also damaged public confidence in the government's ability to deliver reliable health care services.

For the GMA, the ADHA addressed several issues that had been at the heart of ongoing negotiations and industrial agitations with the government. On one level, it reconciled the pay discrepancy between civil service and military doctors, who had recently been awarded a pay increase. Through the GMA, doctors had also long made the point that the nature of their work (particularly in smaller one-person facilities, where they are essentially on call 24 hours a day, seven days a week) did not lend itself to their being compensated based on a regular 40-hour work week. For the GMA, the ADHA was recognition for the extra hours many doctors worked as a matter of routine and as such was viewed more as salary enhancement or an entitlement than it was payment for overtime.

To a lesser extent, doctors and the GMA described ADHA as an attempt by the GOG to stem the significant exodus of health workers to other countries or the private sector.

Nurses based their case for inclusion on the excessive workload they experienced in understaffed health facilities. Furthermore, they emphasized that the delivery of quality health services was dependant on effective teamwork and that awarding ADHA to doctors only was not only a discriminatory labor practice, but would ultimately undermine teamwork and therefore service quality. As a result, nurses tended to describe their inclusions and that of other HCWs not only as reconciliation of an unfair labor practice, but also as recognition by the government of the chronic staff shortages within the health system.

3.6 ADHA Impacts

The study team assessed the HR impact of the ADHA scheme across a range of areas. These have been grouped as follows:

- *Retention*. The exodus or "brain drain" of health workers as well as internal attrition rates for HCWs, leaving the health sector for private sector employment or other government positions. Retention studies reveal a strong correlation between job satisfaction levels and the intent of health workers to leave the health sector. As the perceived equity in compensation is a major factor in determining job satisfaction, it was envisioned that the ADHA scheme would have a positive impact on retention levels.

- *Health care workers*. The specific areas assessed included impact on income levels, job satisfaction, motivation and performance levels, relationship between HCWs and workers in other sectors as well as within the broader community.

- *Workplace*. This category explored the impact on relationships between HCWs, specifically doctors and nurses, as well as hospital administrators, the MOH and GHS.

ADHA and Retention

The scale and impact of the brain drain of Ghanaian-trained health workers, particularly among doctors and nurses, has been described as a "crisis" in the public health sector. Figures from the GHS indicate that up to 70% of all Ghanaian-trained doctors leave the country within three years of graduation. With the production of 150 per year, Ghana could have added 1,050 doctors in the seven years ending in 2006, but instead there has been no increase.

Findings regarding the impact of ADHA on the emigration or brain drain of doctors are mixed and inconclusive. For example, the December 2004 MOH ADHA Task Team Report concluded that the "committee was unable to document any reduction on the attrition rates of health professionals from the country as a result of ADHA." GMA sources cited in the 2006 Budget Ceilings and Health in Ghana Report however, maintain that the ADHA slowed down the emigration of health workers. It states that the number of newly trained doctors leaving the country fell from 70% to 50% following introduction of ADHA. It also states that "nationally the trend in the doctor to population ratio showed some improvement during the period 2001 and 2003." The report concludes by stating that these positive trends were not maintained and that in fact data show a "slight worsening in the overall situation." Overall, the data collected through study as well as anecdotal evidence suggest the ADHA had a slight impact on stemming the brain drain of health workers—at least in the short term. Interviews with doctors and GMA officials also pointed to an improved relationship between the GMA and GOG, following introduction of ADHA—which may also have contributed to a short-term reduction in decisions of health workers to emigrate.

The impact of ADHA on internal attrition rates and movement of HCWs is also complex. On one level the payment of ADHA to nurses and other HCWs increased the perceived attractiveness of working in the public health sector—at least from a monetary perspective. GHS officials cited an increase in the number of applications for positions in nursing schools, as well as interest from workers who had previously left the health sector to return. A situation was also described in which workers moved from other parts of the civil service in pursuit of the relatively higher wages in the health sector. Examples were also cited in which health workers moved from Nigeria to Ghana to secure ADHA.

While the ADHA increased the level of interest in and applications to nursing schools, this did not directly translate into a significant increase in the actual number of HCWs in the system. This was due in part to a largely constant number of spaces in these training institutions, despite the increased level of interest in joining the health sector.

An interesting phenomenon was also described in which differences in the way the ADHA was administered and paid to workers within different regions also caused the internal and unplanned movement of health workers. This became most apparent after ceilings were first imposed in 2001. The government introduced these ceilings to stem the escalating cost and impose a level of budgetary control over health sector salary costs. However, because these ceilings were based on the average payment across the most recent two to three months, those regions that had carefully controlled their payments had lower ceilings set than those that allocated the ADHA across all health workers, independent of the actual hours worked. Those regions that were unable to use internally generated funds to top up their budgets to meet actual claims were required to cut payments across the board. As a result, imbalances emerged between regions in the amount of payments received by similar cadres of HCWs. This had the unintended consequence of health workers requesting to be transferred to those regions providing higher ADHA payments.

ADHA and Job Satisfaction

Results of interviews with HCWs point to a mostly positive relationship between ADHA and job satisfaction—at least initially. Most HCWs interviewed felt that prior to the scheme they were significantly underpaid, particularly in light of their workload, chronic staff shortages and the important role health workers play in their communities' well-being.

Several factors seem to account for the finding that the scheme's positive impact on job satisfaction was not sustained. First and perhaps most notably was that health workers viewed the additional income as only beginning to address a long-standing deficiency in wages of health workers. This resulted in ADHA being viewed as an entitlement or supplement rather than an incentive or recognition for extra hours worked. This directly counters a stated principle of the scheme that it is neither a salary supplement nor a salary enhancement and therefore shall not be the automatic right of all heath workers.

Secondly, abuses and inconsistencies in how ADHA was calculated and paid became a strong source of animosity among cadres, particularly between doctors and nurses. Instead of improving workplace climate, dissatisfaction and mistrust grew between health workers, and the scheme became a trigger for industrial action by health unions.

As with the scheme's impact on job satisfaction, its positive impact on staff motivation and performance was also not sustained. Health care managers described it as a useful tool to reward performance, and also an effective measure in enabling them to staff the traditionally hard-to-fill

night shift for nurses. HCWs were reportedly enthusiastic to work additional hours, sometimes to the point where they were reluctant to take their official leave and thereby become ineligible for ADHA.

For the scheme to have had a sustained positive impact on worker motivation and performance, it was critical that it be viewed as an incentive or reward for extra effort. As with the impact on job satisfaction, the ADHA appeared to become less of a motivating factor and effective management tool the more it became viewed as a salary supplement or entitlement for all. As stated by a health worker in Central region, "what was the point of working harder if everyone received the ADHA anyway?" This was particularly the case in those regions or hospitals that were most "generous" with across-the-board allocation to all health workers without strictly applying the duty roster and work actually done and documented.

While not directly investigated during the study, the scheme's impact on HCW productivity was discussed with MOH officials and hospital/facility managers. While inconclusive, there is some indication that it may have negatively impacted productivity levels. For example, members of ADHA committees described situations in which health workers would delay or postpone tasks that could reasonably be accomplished within regular working hours to justify the need to work overtime.

An interesting and somewhat unanticipated study finding concerns how the increased compensation levels impacted community sentiment toward HCWs. For example, health workers describe some resentment and animosity toward them as well as instances of being charged higher prices at the market. This became more explicit and widespread following consolidation of the ADHA into HCW salaries in 2005. Fueled by media reports that exaggerated the size of salary increases, health workers became targets for assault and robbery, and there were instances of house burglary. Several health facilities instructed nurses to change out of their uniforms before going home as a way to reduce the likelihood of such incidents. While it is difficult to gauge the extent or frequency of these events, a clear perception existed within the community that health workers had received a substantial pay raise that exceeded the compensation of workers in other government sectors.

ADHA and the Workplace

The study also explored the impact on relationships among health workers as well as the impact of industrial action associated with ADHA on workplace climate and the dynamic between health workers and hospital managers.

Animosity between doctors and nurses emerged almost immediately following the scheme's introduction in 1998. A principal source of this acrimony was a general perception by nurses that awarding the ADHA only to doctors was not only an unfair labor practice, but also failed to recognize the extra workload the nurses were carrying due to chronic staff shortages in many health facilities.

Even after nurses were brought into the scheme, bitterness remained and, to some extent, intensified. The imposition of ADHA ceilings in 2001 meant there were often situations in which the actual claims from staff exceeded the budget. As a response, some facilities used internally generated funds to make up the difference. Facilities without sufficient internal funds had little choice but to impose across-the-board cuts to payments. Significantly, doctors were not included in these payment reductions. The fact that doctors were also not required to submit claim forms, unlike all other HCWs, only served to further fuel these workplace tensions.

Industrial agitations and the frequent strike action taken by the GMA and nurses unions at different junctures also negatively impacted the workplace climate. In many cases, hospital and facility managers were given little notice of impending strike action and operated in an environment characterized by an "undercurrent of industrial unrest." The relationship between the GOG and different association groups also meant that any delay in payment triggered industrial action almost automatically. As noted in the April 2002 ADHA Review Committee Report, "The threat of strike action and its impact on the health system may have been used to coerce managers to bend the rules concerning the payment of ADHA."

ADHA also imposed an administrative burden on health facilities. It was reported that in many facilities, at least one full-time resource was dedicated to supporting the scheme. At the beginning, the responsibility tended to fall on the accounting or finance function. As difficulties mounted, oversight committees comprised of a cross section of cadres and ancillary staff were formed in an attempt to make the process more transparent and equitable. In lieu of official guidelines and instructions, many of the committees established their own local procedures and methods resulting in a multiplicity of operational guidelines and procedures.

4. Discussion

For both the GOG and GMA, signing the original MOU in 1998 operationalizing the ADHA was intended to bring about positive change in the health sector. For the GOG it bought a cessation to a crippling series of industrial action by the GMA, and for the GMA it was recognition of a long-standing claim for compensation for the extra hours worked by doctors, particularly in "single-man" facilities. The GOG also anticipated being able to prevent the scheme from being expanded to other HCWs and sectors. Had this been the case and if the ADHA was confined to doctors only, the story may well have been a different one. Instead, the inclusion of nurses and, in time, all other health workers, exposed the lack of sufficient planning and management systems to support the scheme. The rapid growth and complexities of the scheme can be seen in the annual final costs, which spiraled from 17 billion cedis in 1999 to 720 billion cedis in 2005.

The expansion across the entire health sector was, in retrospect, virtually impossible to prevent. Much as the GMA leveraged the pay rise at the 37th Medical Hospital, other cadres of HCWs were not likely to miss the lesson of the doctors' strike, or to agree that ADHA was something only doctors deserved. Industrial action by nurses and other HCWs in 1999 would have been difficult to prevent even if the GOG was prepared. Each new industrial action resulted in mediation and concession. While the scheme has been an unprecedented benefit for the incomes of HCWs, it does beg the question as to the consequences for the health status of Ghanaians as a whole. For example, has the increased remuneration produced a commensurate rise in the quality of care? While it may be too early to tell, the basic health indicators in Ghana have remained largely constant over the last ten years.

The failure to adequately plan for implementation and to anticipate the different aspects of ADHA is an important lesson from the study. As outlined in Volume 1 of the Restructuring the ADHA Report 2005, "no clear criteria were provided for who should be included in the scheme." Secondly, there were no effective mechanisms in place to monitor working hours and determine the number of overtime hours. Inadequate education or provision of official guidelines also left the scheme open to local interpretation, resulting in significant inconsistencies in how it was applied both within and between regions.

To an extent, this information void was utilized by the GMA and other health association groups and unions to influence their members' behavior and orientation toward ADHA. For example, the GMA instructed that their members were not required to complete duty rosters or submit claim forms.

The need for comprehensive procedures and quality control mechanisms was even greater given that the ADHA was implemented in a largely centralized HR management system. While the MOH and GHS had devolved some management responsibilities to Budget Management Centers within each region, responsibility for the majority of HR tasks remain centralized. The ability to ensure the proper administration of ADHA from the central level is heavily dependant on the facility administrators, district and regional managers adhering to clear processes for claiming, authorizing and allocating ADHA payments. This and other factors not only created a crisis situation in how the ADHA was administered, but also how it impacted HCWs and the health system overall.

While ADHA appeared to have some positive impacts on health worker motivation and performance, these positive impacts tended to quickly dissipate as the perceived inequities, industrial agitations and disquiet toward the scheme grew. Despite attempts by the MOH and GHS to articulate the scheme as compensation for overtime hours worked, the majority of health workers viewed it as salary enhancement and therefore an entitlement or component of base salary. This view significantly reduced its effectiveness as an incentive or management tool to motivate and reward workers. Once it became institutionalized as a fixed addition to income, often paid whether overtime hours were worked or not, it ceased being a performance based incentive scheme. Extending the AHDA to all sector staff, rather than restricting it to those cadres in short supply or who genuinely worked longer hours, tended to reinforce the "salary enhancement" view.

While some evidence exists that the ADHA slowed down the emigration rate of health workers, particularly during the period of 2001–2003, the general consensus is that the scheme had a negligible impact on attrition levels.

The conclusion that the extra compensation received by health workers failed to positively impact attrition rates can perhaps be better understood by looking at the scheme's impact on job satisfaction. It is generally accepted that job satisfaction is a strong predictor of a worker's intention or decision to leave his or her job. While ADHA increased the take-home pay of workers (in many cases significantly), it was not integrated as part of a comprehensive retention strategy that addressed other determinants of job satisfaction. Most notable among these is quality of the relationship between worker and supervisor, a manageable workload and a job or work climate that is stimulating and fun. Based on the findings of this and other studies, it is reasonable to argue that these factors were negatively impacted. The numerous AHDA reviews commissioned by the GHS, for example, were undertaken as an attempt to address the "state of seething unrest" in the health system. This state of unrest was characterized by animosity between doctors and nurses over the allocation of compensation, industrial action between association groups and the GOG as well as the introduction of ADHA ceilings in 2001. These and other factors combined to create increasing dissatisfaction among various health worker groups, and ultimately negated the positive impacts anticipated from increasing the compensation of HCWs.

The study also spotlights the critical need for strong management systems to underpin human resources for health schemes and programs—particularly those implemented on a national,

sector-wide level. Sufficient time must be invested up front to establish the processes, procedures, systems and capabilities necessary to support, control and manage these programs.

The study calls into question the appropriateness of schemes like the ADHA for those cadres not routinely required to work overtime. Compensation schemes need to consider and be tailored to the nature of each cadre's employment. While the ADHA was an appropriate scheme to reward doctors for the extra hours they often were required to work, nurses and other health workers tend to work a standard shift schedule. Further study is clearly required in the area of designing compensation and incentive schemes for specific health cadres.

Finally, the study also reinforces the importance of documenting and investigating programs like ADHA. Many initiatives are being undertaken by governments and ministries of health in developing countries to strengthen their health systems and sectors. While these initiatives and programs often start out with clearly articulated goals, their implementation often reveals the rule of "unintended consequences." It is important therefore to document the impacts of these programs and to uncover the root causes of these unintended consequences. Once confirmed and documented, these findings can be shared with other health sector officials and development partners and used in the planning, implementation and management of subsequent programs.

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Annex B: In-Depth Interview Guide for Senior MOH/GHS Personnel and Managers

GHS/MOH/Capacity Project
Assessment of Additional Duty Hours Allowance and Workforce Motivation and Retention

Draft
In-Depth Interview Guide for
Key Informants: Senior MOH/GHS Staff
(Retired and in Post), Managers at District Level

Consent Form

The Ministry of Health and Ghana Health Services (GHS) is collaborating with the Capacity Project to conduct an assessment of the Additional Duty Hours Allowance (ADHA) scheme, which was implemented from 1999 to 2005.

We anticipate this interview will take about 30 minutes to complete. Our plan is to sit with you and complete the questionnaire as we go through it. When complete, your anonymous questionnaire will be inserted in an envelope and stored to protect your identity. We aim to interview Senior MOH/GHS staff at central and district level who took part in one way or the other with planning and/or implementation of ADHA. For this reason we will talk with officers in post, as well as those who have retired. Our data collection should be complete at the end of April and it will take us until June to compile our reports.

The purpose of the assessment is to learn about and document stakeholder perspectives regarding the rationale for ADHA, and assess extent to which the scheme contributed to motivating and retaining health care workers. The assessment will also examine the unintended consequences caused by the scheme. The lessons learned will assist Ghana MOH and other ministries plan better for the motivation and retention of health workers.

Some people are concerned that giving a negative report about their perspectives of ADHA may put them at risk. We have attempted to minimize that risk in the following ways: 1) The questionnaire is anonymous; your name is not attached to your responses; 2) If the study team member reads the questions to you and records your spoken answers, this will be done in a private setting where no one can overhear your responses.

If you have any questions, you may also call the Assessment Team Leaders,
_____ at_____ or _____at
_____

_____
Printed name of study staff obtaining consent Signature Date

Part I.

We have a few questions about the position you hold/held and personal characteristics.

1. What is your current job status with the Ministry of Health or the Ghana Health Service?	**Currently employed** _____ **Retired** _____
2. What is your cadre?	**Medical Doctor: please specify type**_____ **Allied health: specify type**_____ **Nursing: specify type** _____ **Pharmacy: type**_____
3. How did you participate in the ADHA e.g. Policy, administrative, ADHA recipient	
4. How many years have you/did you work for the MOH or GHS?	_____**years (and/or** _____ **months)**

Part II.

QUESTIONS:

1. What is your understanding of the reasons which influenced government decision to initiate the ADHA scheme?

2. How effectively was the ADHA implemented, in terms of

   - Policies and procedures

   - Operational Guidelines

   - Reporting and feedback

   - Quality control

   - Training/Education of HCW regarding ADHA

3. How would you describe the impact/outcomes of the ADHA in terms of the following

   HCW Income levels

HCW Motivation

HCW Job Satisfaction

HCW attraction/retention in disadvantaged regions

Relationships between different HCW cadres

HCW and other public sector workers

Relationship between the government and HCW Unions

4. How would you describe the evolution of ADHA into current salary reform policy?

5. What is your opinion regarding the impact or effect of this evolution in terms of HCW motivation and retention?

6. How is this reform being funded and is this funding sustainable

7. How has salary reform in the health sector affected the rest of the public sector?

8. If you were to be involved in policy making for a scheme similar to ADHA, What would you do differently?

Annex C: Interview Guide for Government of Ghana Officials

CAPACITY PROJECT: Ghana ADHA Study

Interview Guide for Govt. of Ghana Officials

I. **Introduction**

The study team met with HCWs and managers in the field, as well as GHS officials and HCW Association leaders regarding ADHA. We have recorded stakeholder opinions regarding the origins, chronology, administration and impacts of ADHA and the subsequent salary consolidation. What is missing from the story is the Government's perspective on the causes, impacts and sustainability of ADHA/consolidation. We believe that only the GOG will be able to provide the balance and the macro-level perspective.

II. **Questions (from the GOG perspective)**

1. What were the principal reasons the GOG agreed to ADHA for the Doctors, and then for all other HCWs?

2. To what degree did GOG conceive, and structure, ADHA as a deliberate HR strategy?

3. How serious were the political stakes for the GOG in resolving the industrial actions of the HCW associations? What might the consequences have been for "holding a hard line" against the demands of the unions?

4. Could it have been possible to "hold the line" on ADHA for doctors working long hours ONLY?

5. What were the biggest challenges for the government in administrating ADHA?

6. What factors ultimately drove the decision to consolidate ADHA into salaries?

7. How has the ADHA experience impacted the GOG relationship with the HCW Associations and unions? Have the unions and associations become more confident?

8. What are the financial implications for the GOG of the consolidated salaries for HCWs? Does this present challenges in terms of sustainability?

9. How likely is it that other public sector workers will also agitate for similar wage increases? How likely is it that they will actually receive these wage increases? And if so,

will the level of increase be driven by negotiated settlements to industrial actions OR by the job evaluation scheme under JEWG?

10. Will the GOG be able to afford and sustain salary increases for other public sector workers?

11. What advice would you give to another country considering the introduction of a scheme like ADHA?

Annex D: Indicators

	Indicator
1.	The number of applications submitted to HCW training institutions—all cadres
2.	The number of people enrolled in HCW training institutions—all cadres
3.	The number of HCW submitting applications for verification of credentials so as to work abroad—all cadres
4.	The variation in remuneration levels by cadre
5.	HCW attrition rates
6.	The level of inter-sector migration (e.g., employees in the education sector seeking to join the health sector—a sample site or cohort will be used to collect and report this indicator)
7.	Growth in the ADHA budget by year—this budgetary figure will be cross-referenced with the HSW salary budget to show the point at which the ADHA budget exceeded the salary budget

The Capacity Project is an innovative global initiative funded by the United States Agency for International Development (USAID). The Capacity Project applies proven and promising approaches to improve the quality and use of priority health care services in developing countries by:

- Improving workforce planning and leadership
- Developing better education and training programs for the workforce
- Strengthening systems to support workforce performance.

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