CHAPTER 1

INTRODUCTION

1.1. Background

Ghana like other low-income countries, over the years has achieved a lot of health gains. In general, the health of Ghanaians has been improving since independence in 1957. More infants are surviving, and people are living longer. The number of health facilities and health workers has also increased in leaps and bounds. This reflect the government commitment to improve health for all people living in Ghana regardless of sex, age, ethnic, origin religion political beliefs or socioeconomic standing.

The rapid progress of health care outcomes has led to improvement in burden of both communicable and no-communicable diseases in the face of rapid increase in population, and a change in population structure. Even though, the Ghanaian economy has been declining over the years, it achieved relatively good health care outcomes, which put Ghana above average for Africa.

Ghana is able to achieve this progress in health care using lower expenditure primarily due to health policy focusing on the districts, and sub-districts as targets to achieve greater health gains through decentralization.

Like many nations the two financing questions that tend to dominate health sector reforms are first, the level of financing, and methods for tapping new sources, and second the allocation of funding. While the first is crucial one of the main determinants, the levels of economic growth, is little influenced by health sector policy. The result is that there is relatively little control of overall health sector resources, although the controlling of the public-private miss may be possible. The second question, allocation of resources is much more amendable to medium and even short-run control of health sector planners and policy makers. The question is itself multi-layered and encompasses issues of services to be founded (allocative efficiency), how they are delivered (technical

efficiency) and the method for allocating resources to areas of the country (geographical resource allocation- equity) and individual facilities (provider payments).

1.2. Rational

Despite the considerable achievements made in the health sector routine survey and research suggests that these achievements are not uniform throughout the country. Along side the variation in economic and health status are substantial differences in health sector infrastructure and access to health care facilities (health inequalities) among regions in Ghana. Resources allocations turn to favour areas with existing infrastructure and staffing. A 1989 World Bank health sector review pointed to two main problems with regard to coverage of health services. (i) poor access: the present health system effectively reaches only 65% of the population. (ii) inequality of access, both between urban and rural areas (almost 100% of the urban population being covered, and only about 50% of the rural population) and even more so between regions (rural coverage varies by region from 11% to 100%). (Lavy and Germain 1994).

In Greater Accra region there is one doctor for every 18,400 people. In Upper West the ratio is almost 39,000. Similar differences are apparent in the number of hospital beds and in clinics. In Northern region the average distance to a clinic is more than 12.2 km and in Greater Accra is less than 3.5 km. These observations are linked to the extent that resource flows influence access to service and eventual health status. The emphasis on increasing public spending on primary health care is generally justifies on the basis of that such spending ameliorates the impact of disease on the productive life years of the population (IMF working paper 1999). While there are clearly many determinants of health, targeted resource flow arguably have a substantial part to play in improving health, reducing inequalities and ensuring financial access to services by the poor.

According to a study by Bonsu and Nsowa-Nuamah based on data from the ten year period before the Ghana Demographic and Health Survey 1998, the three northern regions and central region have the highest infant and under five mortality rates. For

example U5DMR ranges from 62 per 1,000 live births in the Greater Accra Region to 171 in the northern region with national average of 110 per 1,000 live birth.

Table 1.1: U5MR by dimension of inequality.

Region	U5MR per 1000	Ratio of UM5R to national average
Western	110	0.99
Central	142	1.29
Greater Accra	62	0.56
Eastern	89	0.81
Voltal	98	0.89
Ashanti	78	0.71
Brong Ahafo	129	1.17
Northern	171	1.55
Upper West	156	1.41
Upper East	155	141

Source Bonsu et al. (2000) Profile of health inequalities in Ghana.

Table 1. 2: Trends in infant and under five mortality rates by regions

Region	IMR' 88	IMR' 93	IMR' 98	U5MR' 88	U5MR' 93	U5MR' 98
WR	77	76	68	151	132	110
CR	138	72	84	209	128	142
GAR	58	58	41	104	100	62
ER	70	56	50	138	93	89
VR	74	78	54	133	116	98
AR	70	65	42	144	98	78
BAR	65	49	77	123	95	129
NR	103	114	70	222	237	171
UWR	-	85	71	-	188	156
UER	-	105	82	-	180	155

Source SDHS 1998

Coupled with the inequalities, the overall resource available from government to the health sector was shrinking in real terms. For ten years (between 1985 and 1995), government allocation to the Ministry of health was approximately $6 per capital

compared to $10 per capital in 1978. Access remains a problem in Ghana after adopting the concept of primary health care for decades. Allocation still favours mostly the rich regions in the south compare to the poor northern regions. This trend turns to deepen the problem of access between urban and rural areas. In addition to difficult access in rural areas especially in the poor regions, other socioeconomic factors combine to produce different health outcome among regions as well as utilization of health care. Routine data from Ministry of Health indicate per capital outpatient attendance of 0.8 in the northern region in 1998, which is one-third of the Greater Accra Region.

Lavy and Germain in 1994 indicated how much improving access to public and private health care could improve or change health care use.

From the table below it is obvious that reducing distance or increasing access to communities would have immediate pay off by dramatically increasing the utilization rate of health facilities. For example halving the mean distance to the nearest public clinic would increase the probability of utilization by 250 percent, from 0.04 to 0.15, and would increase the overall probability of seeking professional care from 0.19 to 0.24 according to the report. The result of the survey present some interesting challenges to the policy-makers and reaffirm the need to hold equity on high in the distribution of health resources. If the objective of providing good health care to all people living in Ghana is to be achieved, and sustain the gains made in the health care system.

Table 1.3. Improved access to health care and predicted probabilities of percent change in health Care Use

	Self-care	Public Facility	Private Facility
Improving Access to Public Health facilities			
Reduce distance by 25%	0.81 (-1.1)	0.06 (41.5)	0.13 (-6.7)
Reduce distance by 50%	0.79 (-2.6)	0.09 (95.9)	0.12 (-14.9)
Reduce distance by 100%	0.76 (-7.2)	0.15 (244.9)	0.09 (-34.8)
Improving Access to Private Health facilities			
Reduce distance by 25%	0.81 (-1.1)	0.04 (-8.0)	0.15 (10.0)
Reduce distance by 50%	0.79 (-3.0)	0.03 (-15.0)	0.17 (20.0)
Reduce distance by 100%	0.77 (-6.0)	0.03 (-28.0)	0.20 (-41.0)
Improving Access to Public Private Health facilities			
Reduce distance by 25%	0.79 (-2.0)	0.06 (32.0)	0.15 (3.0)
Reduce distance by 25%	0.77 (-5.0)	0.08 (72.0)	0.15 (5.0)
Reduce distance by 25%	0,72 (-11.0)	0.13 (182.0)	0.15 (6.0)

Note: The percent changes are given in parentheses. Sources : Lavy and Germain, (1994) p 21, Quality and cost in Health care choice in Developing Countries.

According to Bonsu et al 2001, survey data suggest that, 84 to 86 percent of the rural population in the three Northern Regions compare with 37percent in rural Greater Accra region travel for more than thirty minutes to reach the nearest health facility. In terms of manpower distribution the two teaching hospitals in Accra and Kumasi account for 49 percent of all public employed doctors. Greater Accra Region with about 12 percent of the national population accounts for 42 percent of total public employed doctors and 18percent of (government and mission hospitals) beds. In contrast the northern regions with about 20 percent of the national population accounts for 6 percent of total doctors and 14 percent of hospital beds. The unacceptable inequity in Ghana's health care system underscores the importance of conscious effort on part of both policy –makers and health planners to promote equity in health resources distribution to bridge the gap.

Wagstaff and van Doorslaer (1992) quoting Mooney (1986) and McLach and Maynard (1982) claim that the public attaches greater importance to equity than to efficiency in health care. The pursuance of equity goal by policy-makers in all type of health care system is readily apparent. Despite the public claim and the vigorous pursuance of equity goal by policy makers the big question is what is equity? How should it be defined? And how should it be measured? Answers to these questions leave equity in health care open. It is suggested that sometimes academics and policy-makers agree much less over what they mean by equity than they do over efficiency.

McLachlan and Maynard (1982), for example suggested that …equity, like 'beauty' is in the mind of the beholder. Many other suggestions made include, equal expenditure for equal needs, equal access for equal needs, equal utilization, equal health and so on. The evidence seems to suggest that the egalitarian notion that health care ought to be distributed according to need which command the greatest support among health professionals and the public at large is most favoured, essentially the principles of equal opportunity.

Inequity are inequalities that are judged to be unfair, i.e. both unacceptable and avoidable. Equity in health means that health care resources are allocated according to needs, health services are received according to need, and payment of health service is made according to ability to pay. It implies a commitment to ensuring high standards of real (not only theoretical) access, quality and acceptability in health services for all. (Blas and Hearst 2000) quoting Breavman, 1998 in Health Policy and Planning. Recognizing this, equal access to medical care has always been supported by all political parties and is reflected in the legal framework. As a steep further of the major government health reforms to improving coverage of the population and quality of health care and reduce rural urban dichotomy or otherwise regional gaps the Medium Term Health Strategy (MTHS) was developed.

The Medium Term Health Strategy (MHTS) of Ghana 's health sector based on Government of Ghana Vision 2020 seeks to promote greater equity of access to health care in the country. Adopting the International Conference on Primary Health Care Declaration in 1978, considerable achievements have been made over the years. However, routine survey data suggest that these achievements have not been uniform throughout the country. The drive towards achieving efficiency and equity in health has been revived by Ministry of health's (MoH) 5Year Programme of Work (PoW) 1997-2001 based on the MHTS towards the achievement of government long term vision. The PoW seeks to mobilize more resources, promote equity and ensure efficiency in the health sector. The PoW has ended and therefore it is important to assess the how much the programme's objective is achieved to serve as a guide for policy makers in their next steep.

1. 3. Research questions

1. Did health sector budget increased under the Programme of Work?
2. Were resources distributed equitably under the Programme of Work?

1. 4. General Objectives

The general objective of the study is to assess allocative equity of health budget (resources) to regions under the 5Year Programme of Work.

1. 5. Specific objectives

1. To describe the trend of resource flow into the health sector under the PoW 1997 – 2001.
2. To analysis allocative equity of health budget among region under the PoW

1. 6. Scope

The Programme of Work covers almost all aspects of the Ghana health care system, due to time constrain and unavailability of data the scope of the study is limited to budget allocations across regions under the Programme of Work 1997-2001.

1. 7. Possible benefit

1. The study would contribute to the current restructuring process of resource allocation method.

2. It would service as a partial evaluation of the Five-Year Programme of Work.

3. Provide some guide to the allocation of poverty reduction fund under the Government HIPC initiative programme.