CHAPTER 5

CONCLUSIONS AND RECOMMENDATION

5.1. Conclusion

a. Resources flow

From the above analysis the following conclusions can be made on the trend of resource flow into the health sector from 1997 to 2001.

The proportions of government total health expenditure on health increase in the first three years (1997 to 1999) and declined in the last two year (2000 to 2001.

Per capital expenditure on health remain low under the programme of work compare to the early 1980s. This is a reflection on the total national expenditure on health. In absolute terms there was an increase in the total health budget, but it did not increase in real terms. The low per capital health under the programme of work attests to this.

. The programme allocated more budget to regions than other agencies of Ministry of Health. In each year of the programme, regional BMCs got more than half of the total national health budget. Regional BMCs got 66.75, 58.94, 71.82, 69.57 and 63.79 percent of the total national health budget from 1997 to 2001 respectively. Regional BMCs constitute the main service organ of the Ministry of Health. It share of large proportion of the national health budget is to support the government policy of improving access and quality of care through the concept of primary health.

b. Allocative equity

Using the weighted population to analyze equity of budget allocation in terms of health needs, the following can be concluded. The results of tables 4.2, 4.3, 4.4 and 4.5 indicated that there were inequities in allocations of health budget from 1997 to 2001. The so-called poor and deprived regions Northern, Upper East and central with the exception of Upper West were mostly under provided. Upper West seems to have been benefited from the programme. It relatively lost, is not significant under most of the allocation options compare to other poor and deprived regions. Wealthy regions got more than their expected needs. The most affluent region, Greater Accra was over provided more than all regions in all allocation options. This could be due to its high manpower position. Line item 1 (personal emolument) is allocated on the basis of a region's manpower strength based on civil service scales.

Regions with relatively large population and area suffered inequity under the proramme. Ashanti and northern regions are good examples. By all standards northern region should have been the most resourced region in all the allocation options, but it suffered the reverse. Ashanti region is considered as an average region but it suffered under provision throughout the programme. It could be concluded that it large population over relatively large area put it in the vulnerable regions under the programme with regards to resource distribution inequalities.

c. Gini coefficient

The Gini coefficients derived from allocation based on all options revealed relatively fair allocation of health resources between 1997 to 2001, but requires more improvement as none of them gave the gold standard i.e. zero Gini coefficients. A close look at all Gini coefficients (see figure 4.1) suggested that poverty based allocation options gave the best Gini coefficients (0.189, 0.154, 0.277, 0.172 and 0.089) and may relatively lead to equity. It can be concluded that authorities seemed to have allocated health budget according to poverty level so as to enhance equity. This under scores government commitment to

poverty reduction in recent years. Eventhough, poverty gave the best Gini coefficients, it did not achieve the gold standard of zero, which suggests that, to achieve health budget equity more needs to be done. Distance (a proxy of cost) on the hand, produced the worse Gini coefficients (0.238, 0.207, 0.236, 0.236 and 0.306) quite far from zero and therefore seemed to have had little consideration in health budget allocation from 1997 to 2001, eventhough it is important. U5MR did have some influence but not much to have lead to equity. Comparatively, it has better Gini coefficients (0.201, 0.247, 0.219, 0.178and 0.240) than distance and equal allocation among poverty, U5MR and distance. The programme's allocation method of equal allocation among U5MR, poverty and distance did not achieve allocation gold standard of zero Gini coefficients. Its coefficients are not too different from distance. This implies that authorities did not give equal weights to all criteria as planed. It can be said from the above that there is more room for improvement as far as equity gold standard of zero Gini coefficient is concern.

According to Bonsu et al 2000, ranking household expenditure according to their expenditure per head, a proxy for income based on Ghana Living Standard Survey data of 1988 – 89 to compute infant and child mortality rates found out that, surprisingly, the gap between the U5MR for the poorest (155 / 1000) and the non-poor quintile (130 / 1000) is not as wide as expected. This suggests that there is not a strong relationship between poverty and U5MR. Allocating health budget on basis of poverty may not necessary reduce U5MR or cost nor improve allocative equity, eventhough the ultimate goal is to improve health outcome.

It implies that health budgets were poorly allocated by emphasizing on poverty other than distance and health outcomes to achieve equity. This is because all allocation factors are relatively independent and important since there is not strong relationship among them. It can be concluded that the plan budget allocation criteria were not adhered to the later. The programme therefore, could not effectively shift resources from the rich regions to the poor and deprived areas to improve equity. Allocation may have been influence by other factors other than U5MR, distance and poverty. Factors such as external pressure on investment may account for the level of inequity.

5. 2. Recommendation

Using weighted population (needs) to evaluate inequalities in budget allocation, it is evident that the programme of work did not achieve allocative equity. Poor and deprived regions got less budget to improve access to services and promote equity in general. Promoting equity, by allocating more budget to the poor rural and under -served regions would also serve to channel resources to the poor and improve access which in the end may improve health outcomes.

It is suggested that, to shift resources to the poor and deprived areas to achieved equity in health budget allocations, health authorities should emphasis more or equally on health outcomes (proxy U5MR) and distance and not only on poverty as the case now. This calls for adherence to the programme's initial allocation method of equal distribution among the allocation measures. Placing equal emphasis on poverty, health outcome and distances would favour the poor regions by increasing their share of health budget and ultimately improve equity.

However, to improve and sustained equity, it is further recommended that, detail studies should be conducted into the various budget line items (personal emolument, administration, service and investment) separately to determine the cause of the inequality and come out with the appropriate weights for the allocation criteria. And more health indicators such as mortality and morbidity, population by age, cohorts and gender should be considered in future studies.

Achieving equity in health budget means shifting resource, this has a significant implication wealth considering carefully. While some regions would lose from the need allocation formula others would gain. This is a real case in the phase of shrinking resources to the health sector as a result of national economic doldrums. Resources shift should not be so sudden. Regions loosing funds should be given time to adjust their facilities, policies and strategies to accommodate the change. It is equally important for gaining regions to develop structures and develop systems to absorb and use the

additional resources effectively. Most international literature supports a gradual transition. In UK the RAWP formula took more than ten years to bring change (Flagship Module 7). One way of introducing gradual shift is allocate real budget to under provided regions in proportion to annual target. While regions above targets receives no additional funding.

More efforts should be gathered to mobilise more resources into the health sector to help arrest the shrinking resources flow in the sector. Perusing aggressive move to attract more resources from the HIPIC funds to the health sector may contribute substantially to health resources and quicken the pace of the resource shift.

In addition to resource shift it is recommended that Ministry of Health should strengthen it intersectorial relationship with other agencies e.g. District Assemblies and communities and playing a leading advocacy role especially in non-health areas directly related to health.

5.3. Limitation

The study attempted to use the current allocation measures of Ministry of health to access allocative inequalities of health resources across regions in Ghana from 1997 to 2001. This study is not completed without limitation.

The study time was too short to have obtained comprehensive data on all the variable used in resources allocation. Besides, the data was not available year by year on the entire variables used in the equation. For example 1998 U5MR was used as the standard U5MRfor all the years. Further with the exception of 2000 all regional population were projected based on 19988 census due to long absence of national census.

The population need equation used the study did not break down population into sex and cohorts.