

# TOWARDS A PRO POOR AGENDA

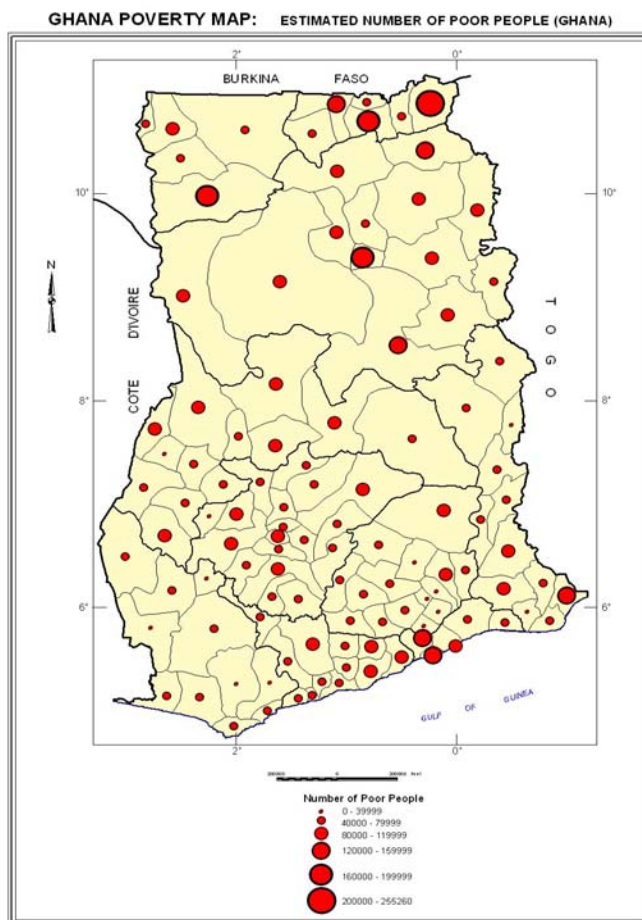
## SERVICE UTILIZATION, OUTCOME AND RESOURCE USE IN POOR AND NON POOR DISTRICTS

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The PoW's overall goal is to bridge the inequalities gap and the strategies put in place aim at reducing geographical disparities and addressing diseases that affect mostly the poor. The analysis of these disparities is very important in the context of the overall efforts at reducing poverty in Ghana. According to the Ghana Living Standards Survey, there was a decline in poverty levels from 51.7% in 1992 to 39.5% in 1999, with three regions (Upper East, Northern and Central Regions) showing opposite trends of increase in poverty. Though the Upper West region saw a decline in poverty, it was slight, with 84% of the population falling below the poverty line and 68% below the extremely poor line. Thus the three Northern regions continue to have poverty levels well above the national average. It is important to note that aggregate regional data hides disparities within regions. The widespread recognition of these intra-regional differences has led to the further disaggregation of national statistical data, leading to the identification of the poorest districts around the country; as a result, 55 districts have been considered especially deprived. The figure below shows the Ghana Poverty Map.

In the framework of the Ghana Poverty Reduction Strategy (GPRS), the achievements of the current PoW need to be assessed not only in terms of average levels for the country as a whole, but also in terms of reductions of inequalities across geographical areas as well as socioeconomic groups. For this reason, the comparative analysis of the differentials in disease profile and service use across the selected districts is presented

in this section. Among the twenty selected districts, seven (Mfantseman, Nzema East, West Gonja, West Mamprusi, Builsa, Lawra and Wa) were included in the list of the "most deprived districts".

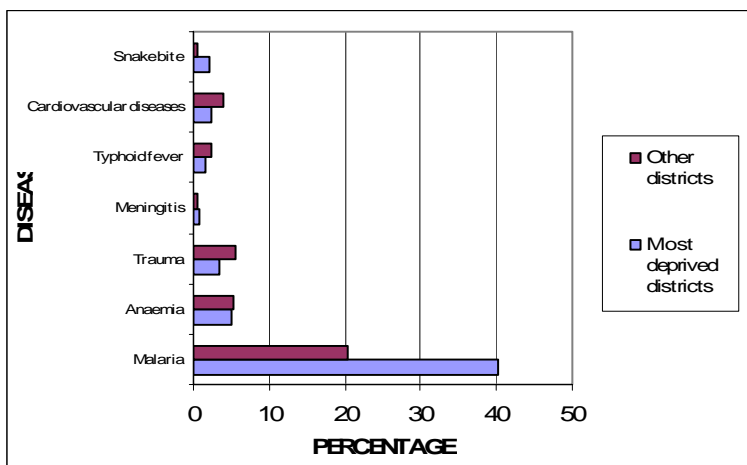


*Ghana poverty map (2004)*

### Uptake of services and outcome: The differential patterns between the most deprived districts and the other districts

The figure below illustrates the different patterns of admission for selected diseases, with malaria accounting for a much higher percentage (40.1%) of the total admissions in the

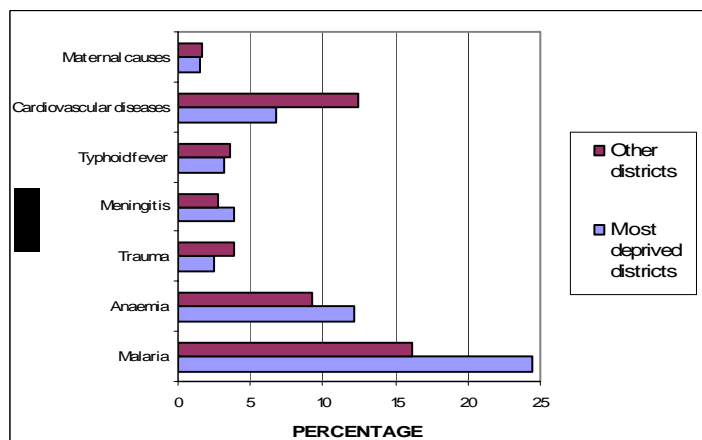
most deprived districts with respect to the other districts (20.5%). Conversely, cardiovascular conditions (including cerebrovascular accident, hypertension and all types of cardiopathy) and trauma (including injuries, road traffic accidents, fractures, burns and poisoning) showed the opposite pattern, with the non-deprived districts showing a higher percentage of admissions (4.1% and 5.5%, respectively) than the most deprived districts (2.3% and 3.5%). As may be expected, admissions for snakebites were more frequent in the most deprived districts (2.1%) than in the other districts (0.5%), while other conditions (such as anaemia and meningitis) did not show any significant pattern.



Distribution of the percentage of admissions for selected diseases by type of district (Ghana, 2003).

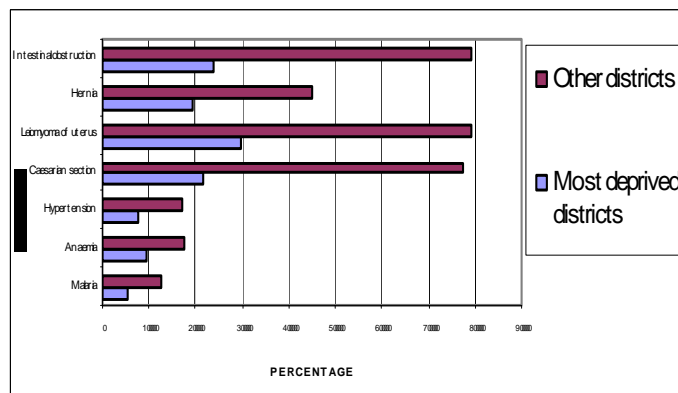
Different patterns of mortality were also observed, with malaria and anaemia accounting for a higher Proportional Mortality Rate in the most deprived districts (PMR=24.5% and 12.2%, respectively) than in the other districts (PMR=16.1% and 9.3%), as illustrated in the figure below. While meningitis accounted for a higher PMR in the most deprived districts (PMR=3.8%), the differences in PMRs were minimal for typhoid fever and maternal causes of death. Conversely, cardiovascular

diseases and trauma accounted for higher PMRs in the non-deprived districts (PMR=12.4% and 3.9%) than in the most deprived districts (PMR=6.8% and 2.5%).



Distribution of the Proportional Mortality Rate for selected diseases by type of district (Ghana, 2003).

A wide variation in user fees was also observed, with the lowest fees being consistently paid in the most deprived districts. Fees paid for surgical conditions, for example, were less than half of those paid in the other districts, with the widest differentials being found for Cesarean section (¢214,486 in the most deprived districts against ¢774,425 in the other districts) and intestinal obstruction (¢240,288 in the most deprived districts against ¢793,907 in the other districts).



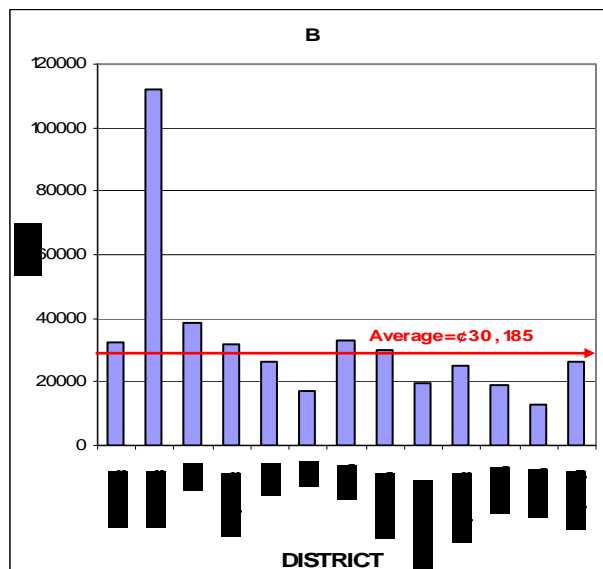
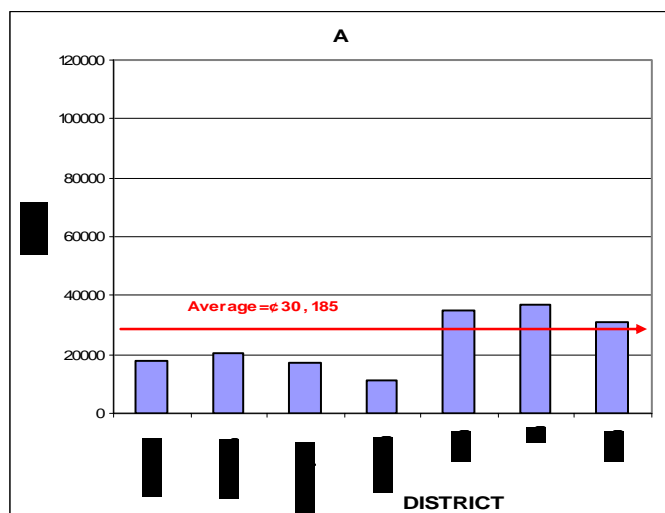
Distribution of user fees for selected diseases by type of district (Ghana, 2003).

Since wide variations were found across geographical areas, the analysis of patterns of service availability, utilization and coverage in the twenty selected districts is presented for comparative purposes.

### Average Expenditures, Service Availability And Service Utilisation

#### Average expenditures per capita

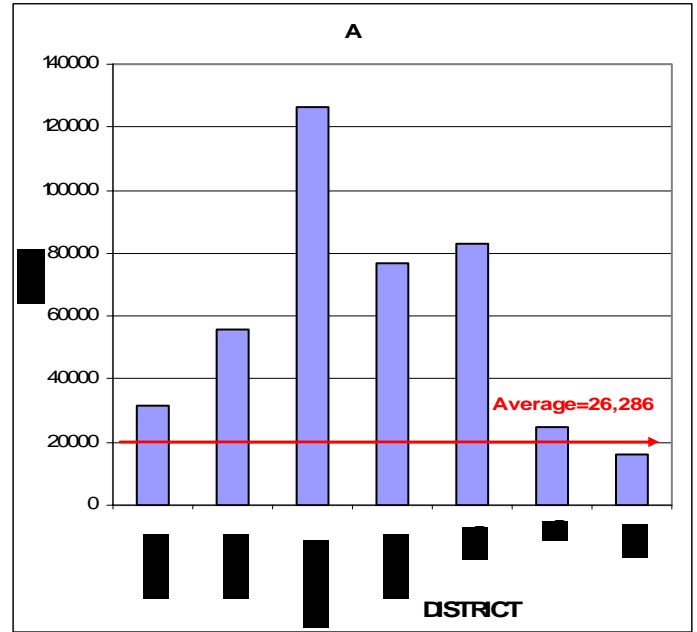
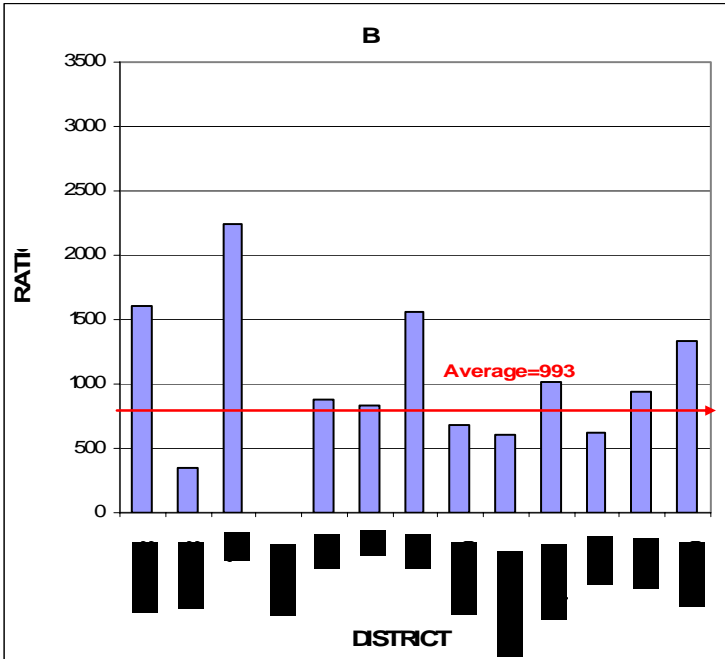
The average expenditure per capita in the twenty districts was ₵30,185.00. It is important to note that, while the full amount of the expenditures for both hospital and non-hospital services are available for the District Health Administration, the District Government Hospitals and the Regional Hospitals, only the expenditures from government subventions were available for the mission hospitals. As a result, the highest expenditures per capita were observed in the districts with both regional and district governmental hospitals, such as in Cape Coast District (₵111,950.00). Conversely, the lowest expenditures per capita were found in districts with a relatively large population and only one mission hospital, such as in West Gonja (₵11,1679) with a population of 153,137 and served by the Damango Hospital, a mission hospital with 142 beds.



Distribution of health expenditures per capita in the most deprived districts (A) and in the other districts (B) (Ghana, 2003).

The expenditure patterns also show that, while a policy of deliberate shift of resources to the most deprived districts exists, spending patterns were not very different from the non deprived districts. Overall spending was also driven by the hospitals and, as shown in the figure below, the presence of large hospitals led to very high per capita spending. The per capita non-hospital spending also showed very little difference between the poor and non-poor districts. To appreciate the situation better it will be important to analyse the data further with respect to budgetary allocations to these districts and to undertake an assessment of the capacity to spend, especially in the deprived districts. However the key observation indicates similar expenditure patterns between the poor and non-poor districts and a continuing trend of very high spending in the clinical sector. Cape Coast district stands out as an outlier with the initial explanation being that the new Regional Hospital and the old hospital continue to function as separate facilities within the same catchment area.

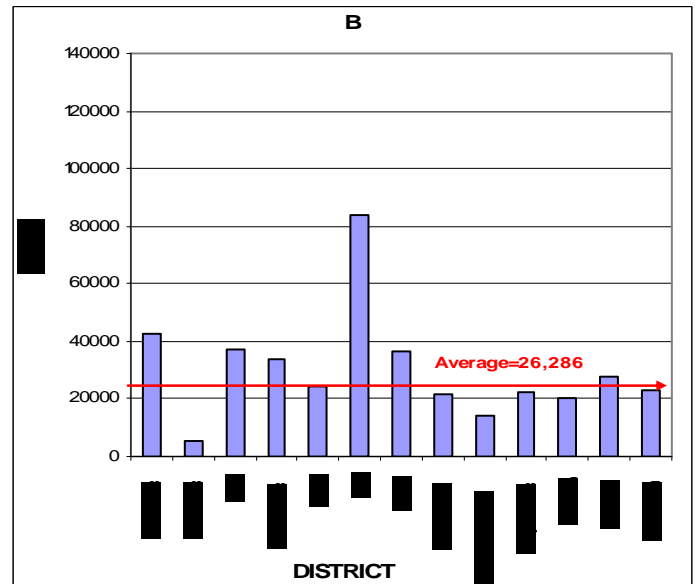




Distribution of population to bed ratio in the most deprived districts (A) and in the other districts (B) (Ghana, 2003).

### Population to doctor ratio

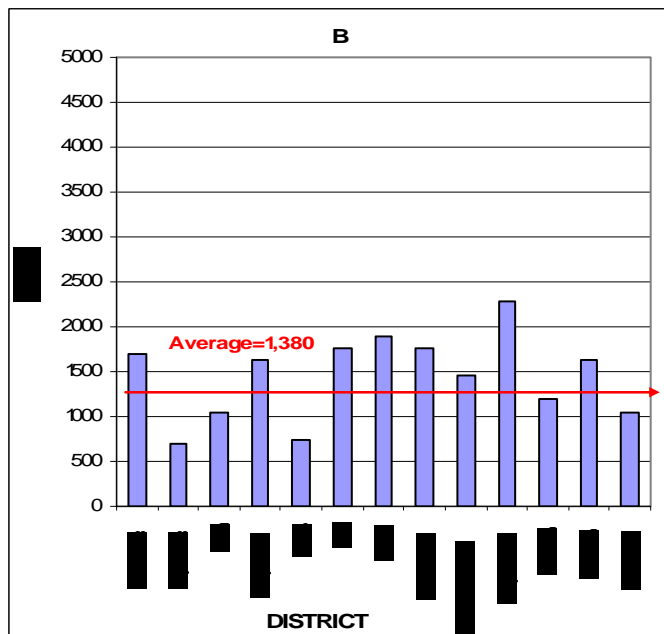
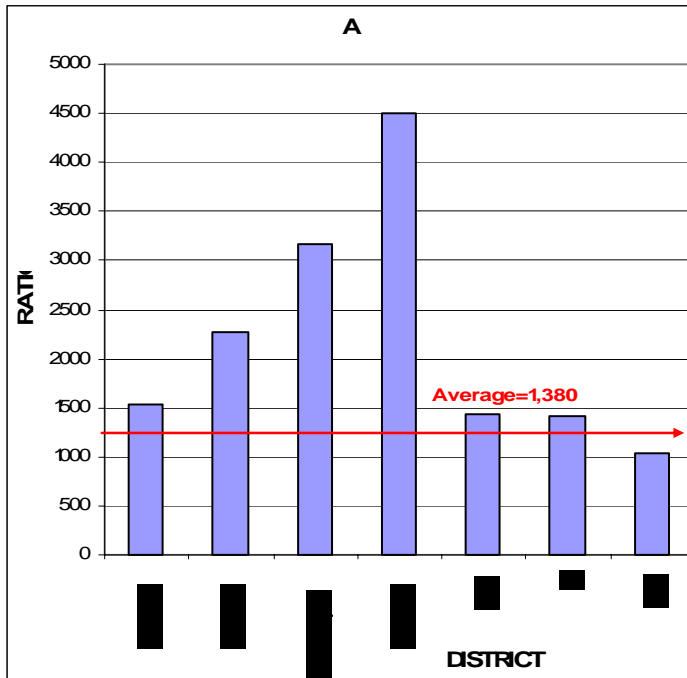
Since both population to bed ratio and population to doctor ratio are the result of the ratio between the size of the population and the availability of health resources, the two indicators showed similar patterns, with the lowest ratio being observed in Cape Coast District (5,644 population per doctor) and the highest in West Mamprusi District (126,425 population per doctor). This is the result of the fact that, while the two districts showed a similar population size (129,811 in Cape Coast District and 126,425 in West Mamprusi District), Cape Coast District had 23 doctors whilst one doctor was posted to the West Mamprusi District, accounting for the wide differences between the two districts.



Distribution of population to doctor ratio in the most deprived districts (A) and in the other districts (B) (Ghana, 2003).

### Population to nurse ratio

As for the population to doctor ratio, Cape Coast District showed the lowest population to nurse ratio (694), whereas West Gonja District showed the highest one, with 4,504 population per nurse, as shown in the figure below.



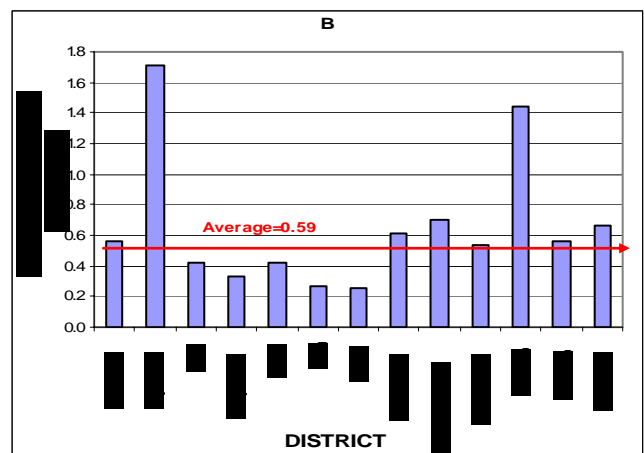
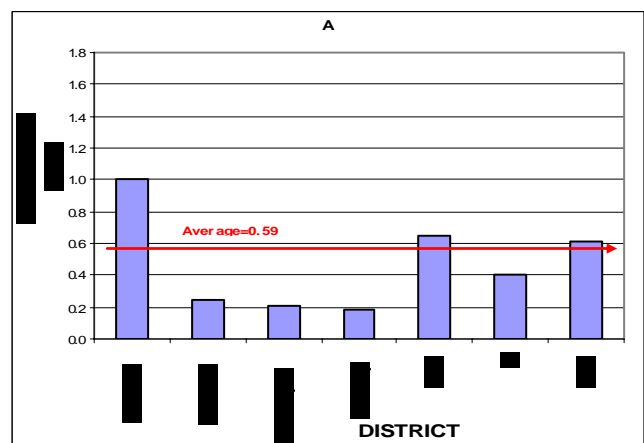
Distribution of population to nurse ratio in the most deprived districts (A) and in the other districts (B) (Ghana, 2003).

Staffing patterns do not reflect health needs, and may contribute to the explanation of the hospital performance and quality of care. From the data in the selected districts, the staffing patterns showed that the most deprived districts were more disadvantaged, with a population to doctor ratio of 36,783

(against 23,639 in other districts) and a population to nurse ratio of 1,791 (against 1,266 in other districts).

### Outpatient (OPD) attendance per capita

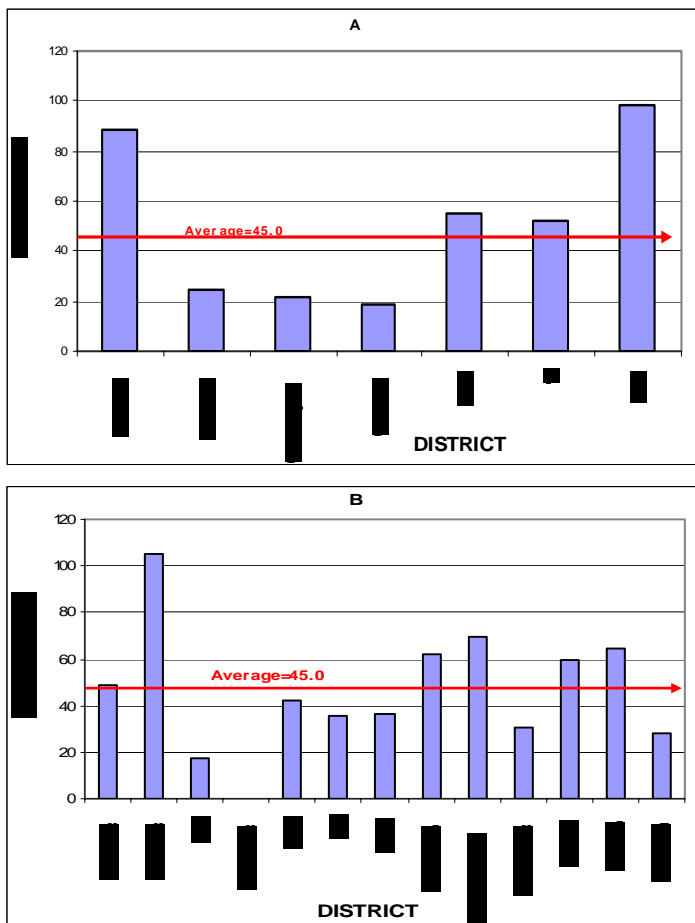
Outpatient attendance per capita is an important indicator of use of outpatient services, reflecting the interaction between demand and supply of outpatient care. Wide differences were observed across the twenty selected districts, ranging between 0.2 visit per capita in West Gonja, West Mamprusi and Mfantseman Districts (all included in the list of “most deprived districts”) and 1.7 in Cape Coast District, as shown in the figure below.



Distribution of outpatient attendance per capita in the most deprived districts (A) and in the other districts (B) (Ghana, 2003).

## Hospital admission rate

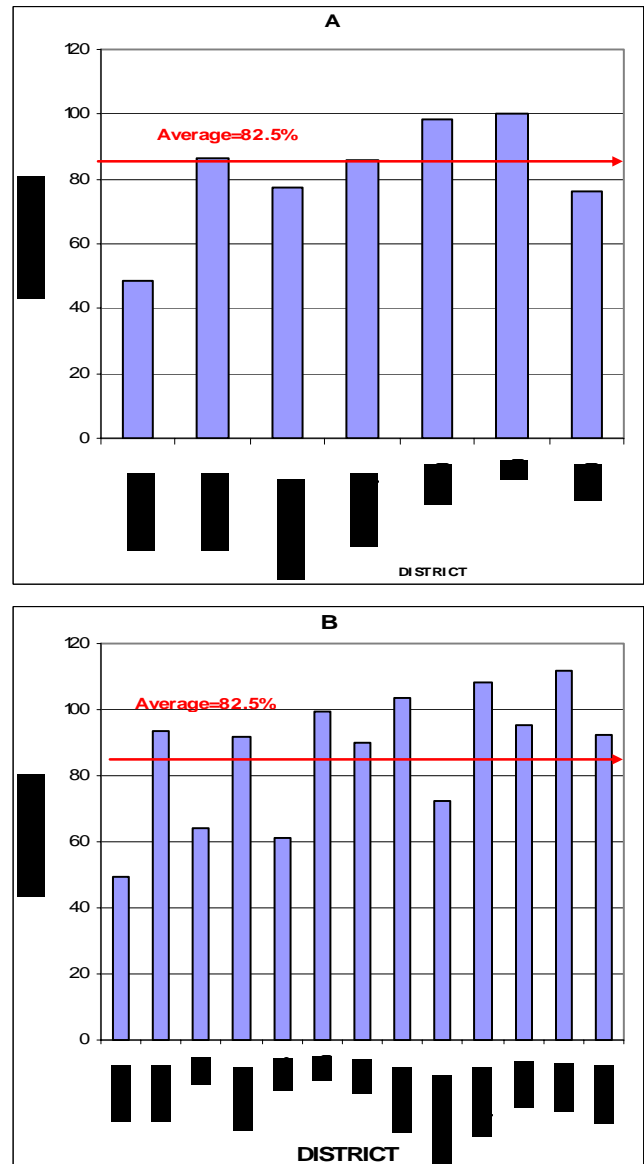
Hospital admission rate indicates the use of inpatient hospital services, reflecting the interaction between demand and supply of inpatient services. Large differences were observed across the twenty selected districts, ranging between 17.1 per 1,000 in Tema District and 105.1 per 1,000 in Cape Coast District, as illustrated in the figure below. Large population and the presence of non-reporting private facilities accounted for the low admission rate in Tema District. The admission rate was not calculated in Dangme East District because the district hospital was still under construction in 2003.



Distribution of hospital admission rate in the most deprived districts (A) and in the other districts (B) (Ghana, 2003).

## Antenatal coverage

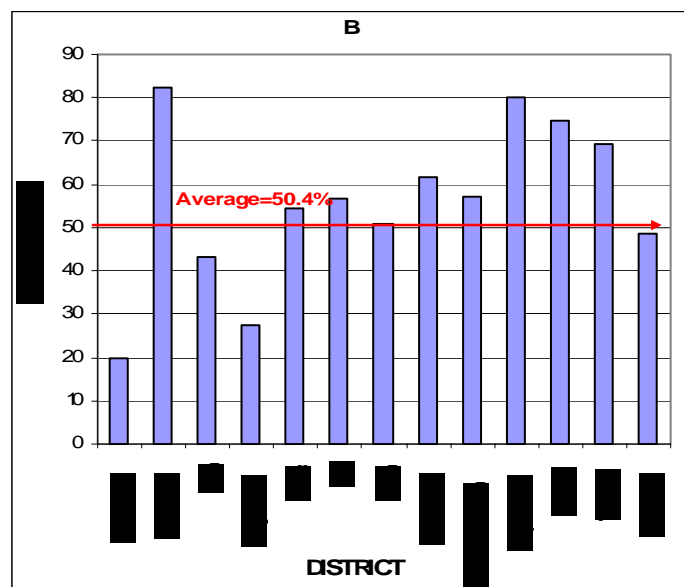
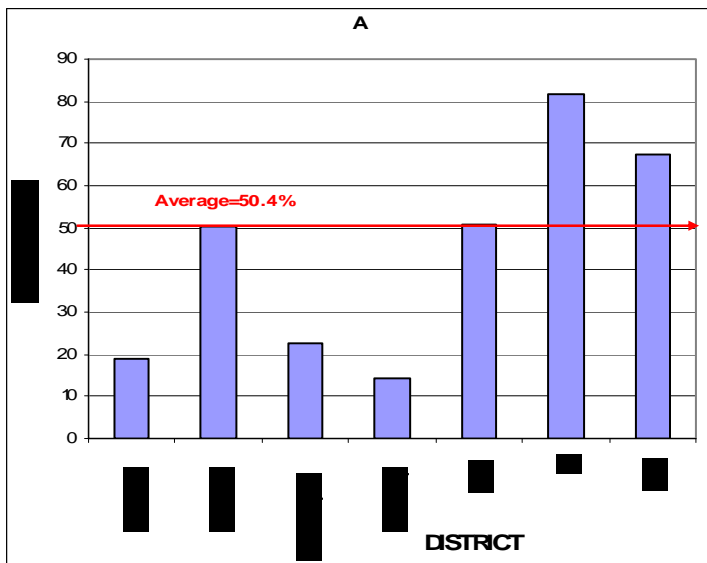
Different patterns in antenatal coverage were observed across the most deprived districts, with Nzema East District showing the lowest percentage (48.4%), and Builsa and Wa Districts showing among the highest coverages (about 99%).



Distribution of antenatal coverage in the most deprived districts (A) and in the other districts (B) (Ghana, 2003).

## Percentage of supervised deliveries

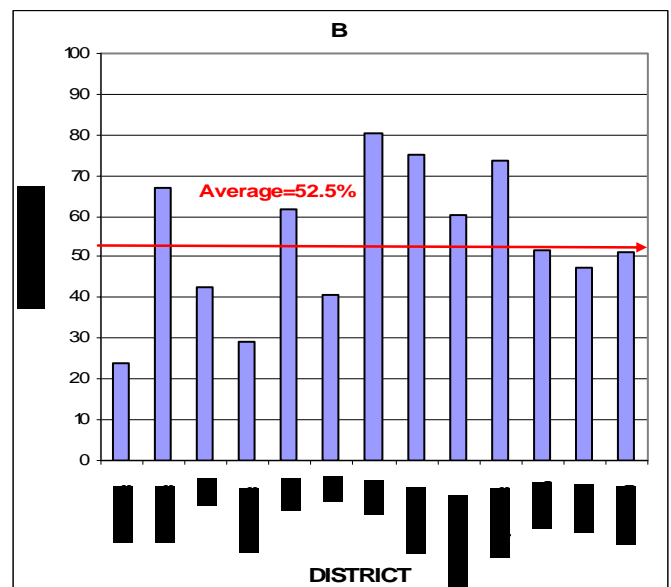
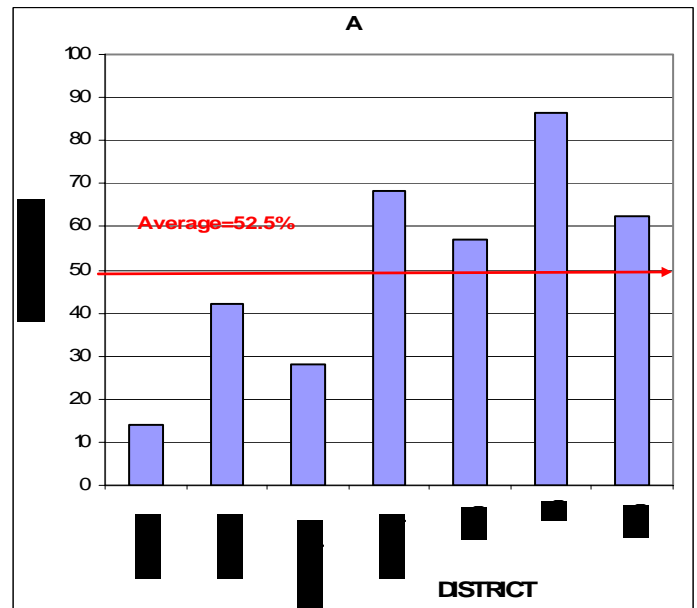
Wide differences in percentage of supervised deliveries were observed across deprived districts, with West Gonja and Nzema East showing the lowest percentages (14.1% and 18.8%), while Wa District ranked second (after Cape Coast District), with 81.6% of supervised deliveries.



Distribution of supervised deliveries in the most deprived districts (A) and in the other districts (B) (Ghana, 2003).

## Postnatal coverage

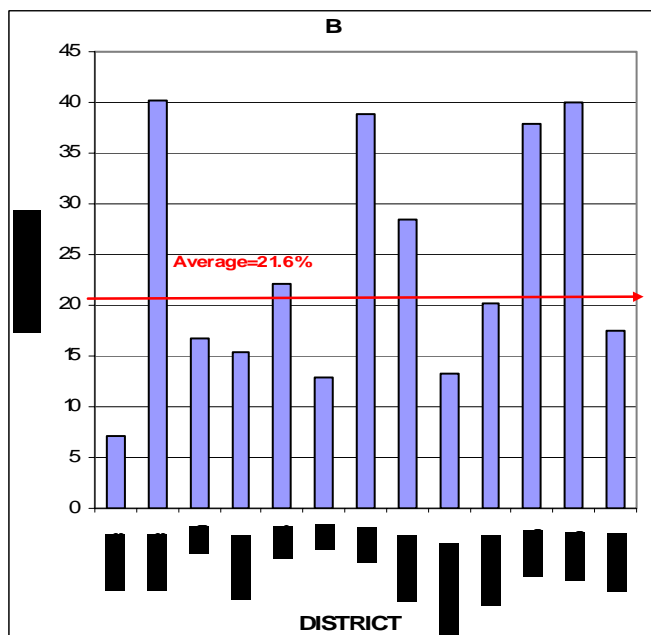
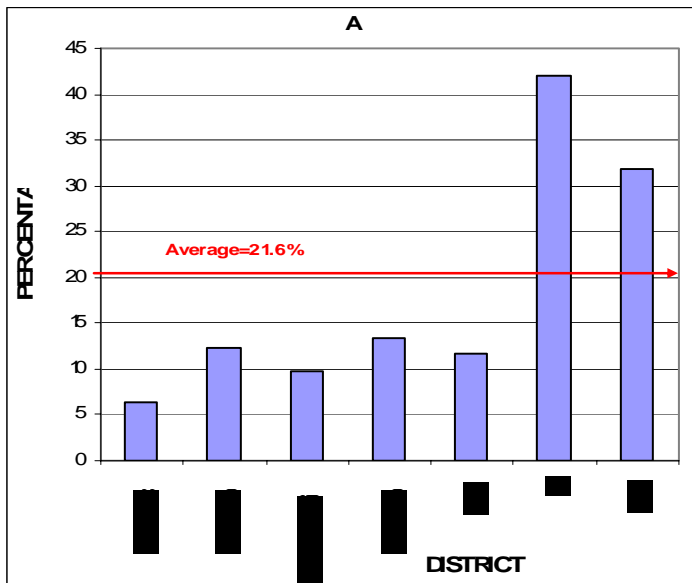
Nzema East and Wa Districts (both included in the list of the most deprived districts) showed the lowest and highest postnatal coverage, with 14.0% and 86.4%, respectively.



Distribution of postnatal coverage in the most deprived districts (A) and in the other districts (B) (Ghana, 2003).

## Percentage of family planning acceptors

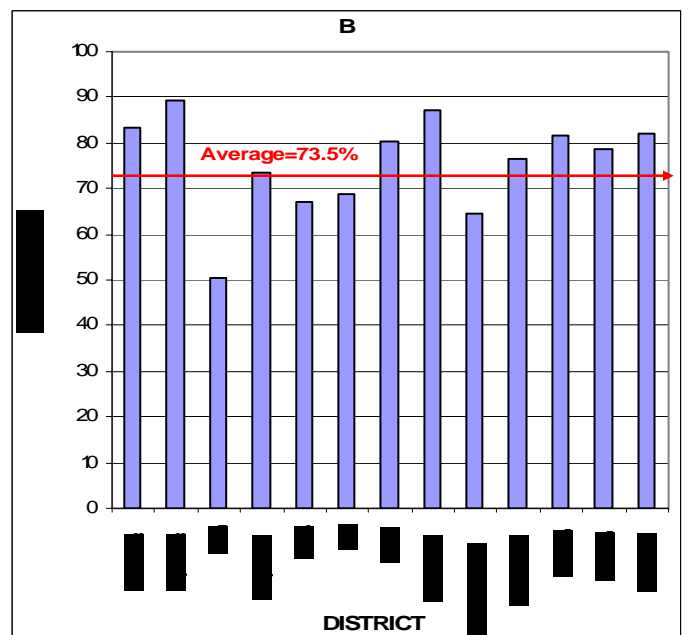
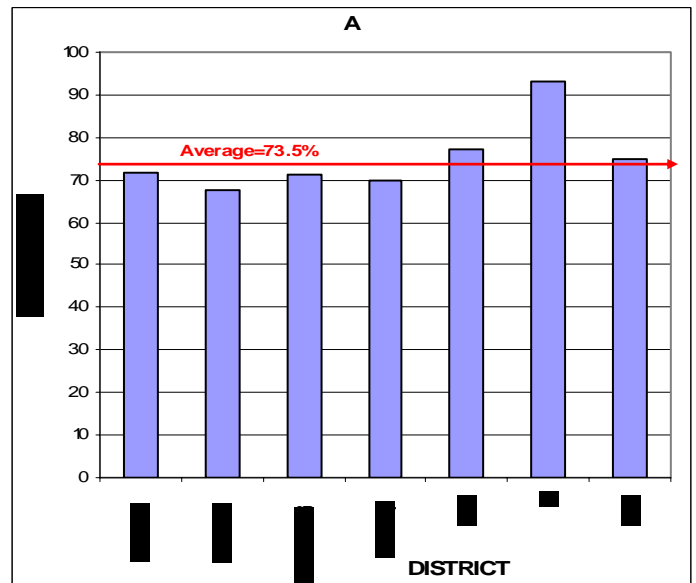
The same patterns were observed for the family planning (FP) services, with Nzema East ranking last and Wa District ranking first in terms of percentage of acceptors (6.4% and 42.0%, respectively).



Distribution of the percentage of FP acceptors in the most deprived districts (A) and in the other districts (B) (Ghana, 2003).

## EPI coverage

All the deprived districts showed a coverage similar to the national average (as Mfantseman, Nzema East, West Gonja, and West Mamprusi Districts) or even higher than the average (as Builsa, Lawra and Wa Districts).



Distribution of EPI coverage in the most deprived districts (A) and in the other districts (B) (Ghana, 2003).

### **Differentials in disease patterns and service coverage: some reflections on the disadvantage among the poor**

The overall disease profile in the most deprived districts shows the overwhelming burden of malaria and seems consistent with the current knowledge of the disease patterns prevalent among the poor. Overall, the Global Burden of Disease study estimates that communicable diseases are much more important for the poor than it is suggested by averages. Non-communicable diseases are correspondingly less important. Globally, among the poorest 20%, communicable diseases cause 59% of deaths, and 64% of DALY (Disability-Adjusted Life Year) loss. By contrast, non-communicable diseases cause 34% of deaths and 44% of DALY loss. The difference between total death and disability among the rich and that actually experienced by the poor is defined as the “poor-rich gap” (poorest 20% to richest 20%). Communicable diseases are by far the most important reason for the existence of the “poor-rich gap” and account for nearly four-fifths (77% for deaths, 79% for DALY loss) of the gap’s size. Non-communicable diseases account for less than one-fifth of the gap (15% for deaths, 9% for DALY loss) and injuries account for around one-tenth of the gap (8% for deaths, 12% for DALY loss).

Resource availability and service delivery show socially marginal and economically deprived groups having the greatest overall need for health care but are least able to obtain it (the so-called “inverse care law”). From this perspective, unequal health care is important because it reinforces poverty, causes social injustice and increases overall rates of morbidity and mortality. In sub-Saharan Africa, on average, the richest 20% of the population receive well over twice as

much financial benefit as the poorest 20% from overall government health service expenditures and the difference is particularly notable with respect to hospital services.

However, large variations in service availability, utilization and coverage were observed across the deprived districts, with epidemiological and socio-economic factors, as well as other factors under the local managerial control, accounting for the observed patterns. In general, hospital beds located in “non-poor” districts and in more urbanized areas tend to be staffed and equipped more intensively. It is logical for hospitals to be located in areas with a high enough concentration of population to keep the relatively large amount of resources (staff, equipment, supplies) occupied. However, resource allocation and distribution appear to be still inequitable. An important challenge in improving the health status of the poor is how to ensure a balance between direct health care and the preventive aspects, especially in the delivery of maternal and child health services, in malaria control and in the provision of safe water and sanitation, given the close relationship between diseases that affect the poor and poor environmental health. Another important challenge is related to the functioning of the referral system. Because of the predominantly urban location of hospitals coupled with largely rural, dispersed populations, it is essential to develop a functional referral system and to ensure the quality of care provided in lower level facilities that serve more widely dispersed populations. Furthermore, efficiency in hospital management is important also for supporting and complementing non-hospital health services. Lower level hospitals can provide substantial primary health care services directly as well as support to non-hospital aspects of primary health care. Referral hospitals can also pro-

vide technical support for lower level services, outreach specialist services and a focus for training of skilled manpower.

Achieving a balance between demand and service provision at each level depends on several factors, including underlying morbidity pattern, health care seeking behavior of the population, availability of the services and their perceived quality, as well as their cost to patient. The principles for setting prices should be that user fees are consistent with ability to pay, linked to the quality of services, and be subsidized for services that have externalities, are public goods, or are merit goods. Exemptions should be granted on equity grounds, or for those services, which provide benefits well beyond the patient, ensuring that access to health care is not hampered for the poor and the vulnerable. A key finding of this analysis is that, while user fees in the most deprived districts are much lower than in the other districts, are still a major obstacle for the access to hospital services for the poor, therefore supporting the implementation of the pre-payment and risk-pooling insurance schemes.

From the available evidence, the strategies for reducing the inequality gap include targeting public sector resources to where they will most reduce the disease burden for the poor and filling gaps in the primary and preventative care system for the poor in order to do this. In particular, four means of directing health resources to the poor are identified:

- Address the burden of disease: ensure that resources address health conditions for which the burden of diseases is high among the poor
- Provide cost-effective services targeting the poor: give priority to basic social services, primary health care, prevention

and basic curative services plus health promotion and essential surgery

- Direct resources to poor areas: provide attention to deprived population in poor rural and peri-urban areas and urban slums
- Direct resources to the poorest households and communities: protect the poorest from cost burden they cannot meet.