Briefing Paper February 2009

Strengthening Social Protection for Children

reduction of poverty social exclusion strategy security social protection inequality

Social Policies policies Children's Rights

social protection reaching the MDGs

Children, the GPRS and public expenditure in Ghana

Ghana's overarching policy framework for development has been provided by the Ghana Poverty Reduction Strategy (GPRS I) for the period 2003–2005 and the Growth and Poverty Reduction Strategy (GPRS II) for 2006–2009. Children's interests have been well represented in both GPRS I and II and in related sector strategies. However, a UNICEF study (see Box 1) has found that, despite important innovations (notably the National Health Insurance Scheme, the education capitation grant and the LEAP cash transfer programme), further policy development is required to address the financial barriers to access by the poor to health care and education.

The allocation of public expenditure was generally found to match the commitments in the GPRS, although forward projections for health and education expenditure suggest that there is too heavy a reliance on 'internally generated funds', which include fees charged by service delivery facilities and districts and so have worrisome implications from a poverty perspective. Furthermore, spending in the social sectors is imbalanced, with crucial non-salary recurrent inputs crowded out, leading to inefficiencies in service delivery. Improvements made in recent years to the public financial management (PFM) system to ensure better linkages between policy and budgets will therefore need to be continued in order to improve service delivery in health, education, and other services for children.

Box 1. **The study on children, PRSPs and budgets in West and Central Africa**

This is one of eight briefing papers that present the main findings of a study on children, PRSPs and budgets in West and Central Africa. The objective of the study was to deepen understanding of the impact on children of the PRSPs, the evolving fiscal environment and related reforms in public financial management systems and aid modalities in West and Central Africa.

Commissioned by UNICEF's West and Central Africa Regional Office (WCARO) and carried out by Oxford Policy Management (OPM) between November 2007 and February 2009, the study included a regional review and five country case studies on Burkina Faso, Chad, Ghana, Mauritania and Sierra Leone.

The report on Ghana was written by Mickie Schoch, Emily Wylde and Alta Fölscher, with inputs also from Daniel Chachu, Nicholas Adamtey and Sylvester Bagooro of the Integrated Social Development Centre (ISODEC), Accra.

OPM Oxford Policy Management

unicef

Child poverty

Ghana has made significant progress in recent years in meeting the MDG of reducing poverty by half by 2015. Poverty fell from 52% in 1991/92 to 29% in 2005/06 and extreme poverty fell from 37% to 18%. There are, however, worrying geographic disparities, with poverty increasingly concentrated in the northern regions: in 1991/92 these accounted for 30% of the poor, but in 2005/06 for nearly 60%.

With respect to child survival, efforts to reduce under-five mortality had little impact during the 1990s, but there has been encouraging progress since then, with the under-five mortality rate declining from 111 to 80 per 1,000 live births between 2000-2003 and 2004-2008, according to nationally representative Demographic and Health Surveys (DHS). Again, there are large geographical disparities. Malnutrition, which is one of the underlying causes of child mortality, is much higher in the food insecure north.

The largest gains in education were made during the 1990s, with slower improvements since then in the net enrolment rate (NER) in primary education, which is currently 85%. There are significant disparities, with a 20 percentage point gap in the NER between the poorest and the richest quintiles.

Policy response

In general, both GPRS documents and sector strategies have addressed the poverty situation well and set out appropriate strategies and policy measures. Children's issues have been reasonably well covered. However, it is in the translation of these policies and strategies into coherent and prioritised actions, with measurable targets and budgets, that the GPRS documents have had more limited operational value. There has been insufficient detail on how to overcome the barriers to uptake of health care services and education by the poorest.

More specific sector policy is provided through the new health policy and Five Year Programme of Work, both of which are oriented around the High Impact Rapid Delivery (HIRD) approach to accelerate child and maternal survival and the community-based Health Planning and Services Initiative. The policy explicitly recognises the need to address cost barriers to accessing services by the poor and vulnerable and emphasises the centrality of the National Health Insurance Scheme (NHIS), which was set up in 2004 to replace the old 'cash-and-carry' system. In May 2008, the government announced that the scheme would be expanded to cover health care for all children free of charge, irrespective of their parent's enrolment. But, as of mid 2009, this had not yet been implemented and many poor families continue to find the enrolment fees and premium payments too high to afford. Currently about half the population is enrolled in the NHIS.

In education, key policy documents are the Education Sector Plan and the Government White Paper on Education Reforms. Important new initiatives include the capitation grant, which provides a direct payment to schools at kindergarten, primary and junior secondary levels based on enrolment numbers.

Also noteworthy are the initiatives to strengthen social protection, including the Livelihood Empowerment Against Poverty (LEAP) programme, which provides conditional cash transfers aimed at assisting extremely vulnerable, ultra-poor households to meet their basic needs and access social services. There are also two school feeding programmes.

Aggregate fiscal position

After experiencing a number of years of improving fiscal balances, in part on account of debt relief, Ghana found itself veering off track in 2006-2008. The causes were multiple: transfers to the state-owned electricity generator to mitigate an energy crisis; higher than expected increases in public sector wages; and lower than expected domestic revenue and external grants. As a result, the domestic primary balance turned negative and the overall fiscal deficit worsened, reaching almost 15% of GDP in 2008, putting Ghana in a weak position to absorb the shocks resulting from the global economic crisis. Total expenditure experienced a fall from 33.3% of GDP in 2004 to 30.7% in 2005 but then bounced back in 2006-2008.

Growing reliance on IGF

Following an actual increase of 32% in real terms between 2005 and 2007, domestic revenue was projected to grow at a similar pace between 2008 and 2011. Particularly noteworthy in these projections is the increased reliance on internally generated funds (IGF), which represent fees, charges and other revenue retained by service delivery institutions and by districts. According to the Medium Term Expenditure Framework annexed to the Budget Statement, between 2009 and 2011 IGFs are expected to increase from 6% of spending to 9% overall, but by much more in health and education. This raises concern from an equity perspective as it has not

been clarified how this will be achieved (through an increase in fees?) without compromising stated anti-poverty goals.

Social services have been prioritised in budgets and MTEF projections for 2007 to 2011, with the budget share fairly stable over the period (see Figure 1). However, the credibility of the projections is open to question in the case of the social sectors, since the growth in expenditure depends largely on a projected large increase in IGF, rather than increases in discretionary government revenue and donor financing.

This is especially evident with respect to health spending, which is projected to increase in share of total government expenditure from 14.9% to 17.7% between 2007 and 2011. However, as a share of discretionary expenditure, it will increase only slightly over 2007 levels, after a dip in 2008. Similarly in education, as a share of total expenditure there is a small decline from 30.3% to 27.5%, whereas there is a marked fall as a share of discretionary expenditure from 40.9% to 32.5%. In health, IGF are expected to increase from 9% of total health resources in 2007 to 17% in 2011 and in education a similar increase is expected from 10% to 18%.

Efficiency of spending

A specific concern for the operational efficiency of expenditure is the very low relative share of spending on goods and services in health and education, where expenditure is dominated by salaries for personnel (see Figure 2). Given the importance of spending on critical complementary inputs, such as textbooks, drugs and transport, these patterns are worrying.

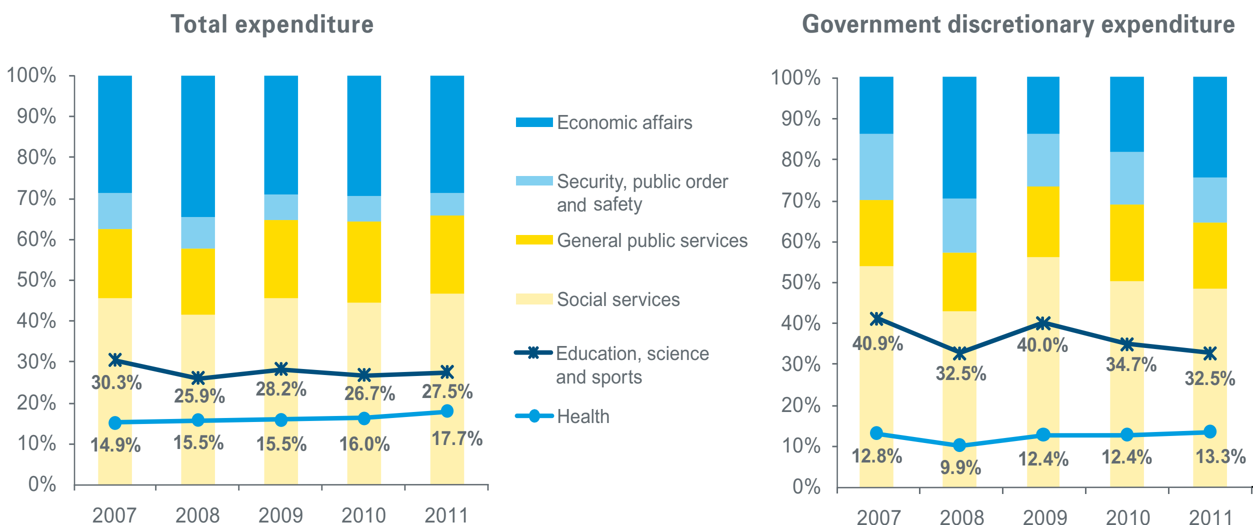
Health

Table 1 shows the distribution of expenditure allocated to district health administration, district hospitals and sub-district services in the budgets for district services and regions for 2006-2008. It shows a projected reallocation of spending, particularly from the Central, Northern, Upper East, Upper West and Western regions to the Greater Accra region, reinforcing historical disparities.

Disaggregated historical budget data are sparse. However, it is possible to examine past changes in staffing of doctors by region in order to get a sense of whether there has been a reallocation of resources to underserved areas. In fact, the opposite has happened. Between 2001 and 2006, the regions with the most favourable initial doctor/population ratios were those that received the largest increases in the number of doctors. By contrast, the poorer regions received the smallest increases, with the northern region receiving no new doctors despite having the lowest doctor/population ratio.

These inequities may also be inefficient. Anecdotal evidence suggests that there are severe imbalances in resources in

Figure 1. Distribution of spending across sectors, 2007-2011



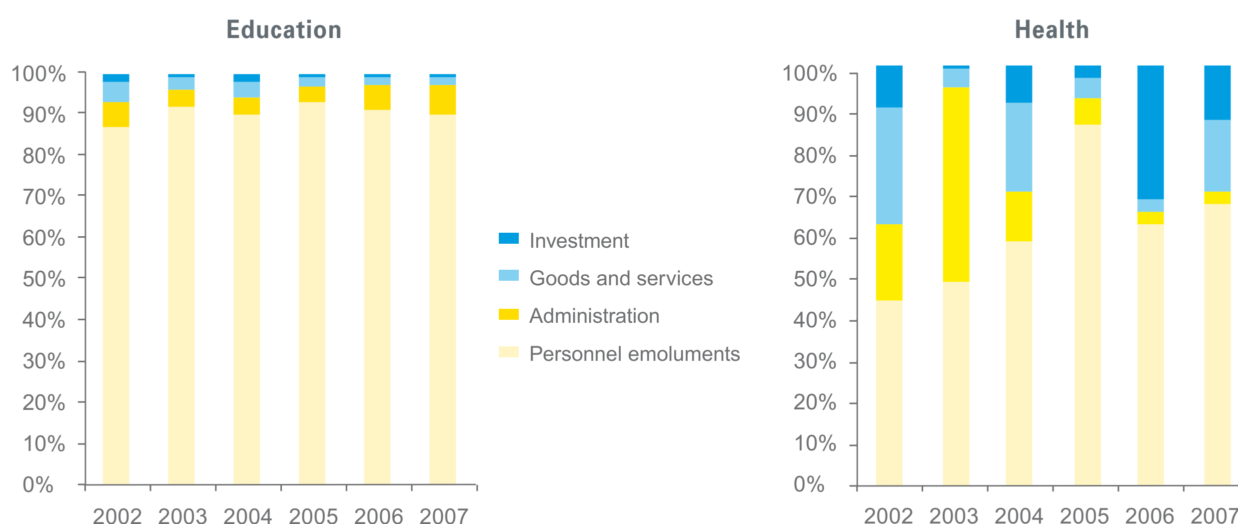
Source: Authors' calculations based on Ministry of Finance and Economic Development, Budget Statements 2007, 2008 and 2009.

the northern regions, with many health centres and health posts without staff or equipment, and referred to as 'white elephants'. At the aggregate level, a review in 2007 showed that only 186 of the 2,005 Community based Health Planning and Services (CHPS) compounds, the core service units of the new health strategy, were functional.

Education

By contrast with the health sector, rapid increases in teacher deployment to the northern regions have meant that pupil/teacher ratios have declined significantly, bridging the equity gap substantially, although there is still some way to go in the Upper East Region.

Figure 2. Composition of social sector expenditure by types of input, 2002-2007



Source: Authors calculations based on data from the Ministry of Health and Ministry of Education, Science and Sports.

Table 1. Distribution of allocated regional expenditures in health, 2006-2008 (% of total)

	2006	2007	2008	Share of population
Eastern Region	11.0	10.3	11.1	11.0
Ashanti Region	11.3	8.9	13.6	19.0
Brong Ahafo Region	0.2	0.2	0.1	9.6
Central Region	12.4	10.2	5.2	8.4
Greater Accra Region	4.7	7.5	33.1	15.4
Northern Region	9.1	5.4	2.9	9.6
Upper East Region	3.3	1.2	1.9	4.8
Volta Region	28.5	39.1	25.2	8.6
Western Region	11.2	10.0	6.0	10.2
Upper West Region	8.3	7.1	0.9	3.0
Total	100%	100%	100%	100%

Box 2. **Efficiency implications of the funding mechanisms for districts**

Ghana has embarked on a process of decentralisation as part of wider efforts to enhance good governance. The country is divided into 10 regions, which were further divided in 2006 into 138 districts, a number that has since increased to 178. However, fiscal decentralisation is limited, with District Assembly budgets consisting essentially of funds for capital expenditure, aside from small amounts for basic administrative costs. The financing of District Assemblies typically comes from five sources:

- Government of Ghana grants, which are earmarked grants, e.g. from the Ghana Education Service, that must be used for a specific purpose;
- District Assembly Common Fund (DACF) allocations, which by law currently amount to 7.5% of tax revenue, are only partially managed by the districts and are mainly for capital expenditure projects;
- HIPC Fund resources (from debt relief), which are awarded according to specific criteria, again largely for capital expenditure;
- internally generated funds (IGF), such as property taxes, user fees, licenses and permits, which districts may use for recurrent and capital spending of their own choosing;
- development partners' contributions, which may be used for the specified purposes agreed with donors.

In the case of the DACF, 10% is earmarked for regional coordinating councils, parliamentary constituencies, and monitoring and evaluation. Of the 90% remaining, 41% is deducted at source for specific activities and therefore is not managed directly by the District Assemblies. The largest of these deductions (30%) is for the National Youth Employment Programme. The remaining 59% is free to be allocated by districts, mainly for capital projects.

Districts in poorer regions receive more per capita than those in richer ones. For example, districts in Upper East receive more than twice as much as Greater Accra on a per capita basis. However, poorer districts have less discretion over the use of resources, as they are far more dependent on the DACF and donor grants and have limited scope for raising IGF. Being highly dependent on DACF transfers also causes inefficiency as these resources are more heavily weighted towards capital expenditure than would be optimal. Spending on infrastructure appears not to be accompanied by adequate recurrent resources for maintenance and service delivery.

However, many of the new teachers are unqualified. At national level nearly 40% of teachers do not have the necessary qualifications, but this is higher in the northern regions. Many new teachers in the north are from the National Youth Employment Programme, which allocates youth to serve as teachers in rural areas. However, these teachers are untrained and they are not under the management control of the district education offices, which as a result have no discretion in terms of their allocation or sanctions for non-attendance or non-performance.

Underlying PFM weaknesses

The inefficiencies and equity problems highlighted above reflect deeper problems in the public financial management system itself, as well as the form that fiscal decentralization has taken. The sub-optimal mix of inputs is caused by a range of systemic problems, including the funding mechanisms for districts, the weak coordination between budget planning and decisions on salaries, the lack of budget comprehensiveness and reallocations during budget execution.

As Box 2 discusses, the funding mechanisms for districts give these local government bodies very little discretion over the use of resources and tilt expenditure towards capital projects at the expense of recurrent inputs.

Political considerations result in wages and salaries being set outside the framework for medium term budget planning. Although personnel remuneration is by far the largest element in expenditure on both health and education, this is negotiated outside the regular process for medium term spending decisions. Salary agreements tend to exceed the ceilings set in budget appropriations.

Over-spending on salaries in the course of budget execution has been accompanied by under-spending on investment, as well as shifts in expenditure allocations among sectors. These in-year reallocations undermine the reliability of budget estimates and thus the credibility of the budget as an instrument for planning and resource allocation, reducing the incentives for well-costed policy-based budgeting.

The lack of budget comprehensiveness is a further constraint. In the health sector, for example, the fact that revenue from user fees is not incorporated into the budget process undermines the ability to plan and budget in a comprehensive manner. Neither the health basket fund nor the NHIS statutory fund are subject to scrutiny by the Ministry of Finance and Economic Planning or the National Development Planning Commission, making it difficult for these central government bodies to have a comprehensive view of finances in the health sector. This also hampers accountability. This is particularly problematic in the context of the current expansion of the NHIS, as current financing arrangements may be unsustainable.

The situation is further complicated by the fact that central government and local authorities use different budget classification systems, making it impossible to get a consolidated overview of all spending within a sector.

Recommendations

As the government tries to restore overall macro-fiscal sustainability, by reducing the high overall fiscal deficit, while also coping with the shocks resulting from the global economic crisis, it will be important to ensure that expenditure on essential services for children (and poverty reduction expenditures more generally) are maintained.

Up to now, overall levels of spending on health and education appear to have been well prioritised towards children's interests. However, the study has highlighted the need to improve the composition of funding so that there is:

- less reliance on internally generated funds for spending in future, with an emphasis on more secure and more equitable funding from central government resources;
- a better balance between salary spending and expenditure on critical goods and services;
- a stronger effort to overcome historical disparities in service provision, particularly in health.

In order to improve the efficiency and equity of spending, it will therefore be important to continue reforms in the PFM system, so as to strengthen the links between the GPRS, the MTEF and annual budgets, and also improve the system of intergovernmental fiscal transfers, in particular to give district assemblies more discretionary powers in the allocation of the resources they receive from central government.

Given the critical role of the NHIS in expanding financial access to health care envisaged by current policy, the current lack of sustainability of funding flows is alarming. This will only be exacerbated if the programme is successful, with more individuals drawing on an already overstretched system. Progress in this area would help to consolidate the significant advances already made in improving equitable access to services in Ghana and help to accelerate the recent reduction in the still high levels of child and maternal mortality.

UNICEF West and Central Africa Regional Office
wcaro@unicef.org • www.unicef.org/wcaro

with **UNICEF Ghana**
P.O. Box 5051, Accra-North, Ghana
accra@unicef.org

Oxford Policy Management (OPM)
6, St. Aldates Courtyard, St. Aldates,
Oxford OX1 1BN, UK

© UNICEF, 2009. Produced with funds contributed by Swedish International Development Cooperation Agency (Sida)

The findings, interpretations and conclusions expressed in this paper are entirely those of the author(s) and do not necessarily reflect the policies or the views of UNICEF and OPM.

Layout & design: Julie Pudlowski Consulting/ Rita Branco • **Photography:** © UNICEF/WCARO/2009/Pudlowski