



Catastrophic Effects of COVID-19 Health Expenditure Shocks and Multidimensional Poverty in Ghana: What Financing Mechanisms Mattered?

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Background

In Ghana, evidence shows that the COVID-19 pandemic had a significant impact on livelihoods, particularly on people who work in the informal sector. The evidence points out that the pandemic led to significant income and employment losses, which has led to increased poverty and food insecurity. Also, informal workers, a higher proportion of whom are women, faced a higher risk of exposure to the COVID-19 infection and the slew of pandemic response measures, for example, lockdowns and stay-at-home orders, as well as guidelines around social distancing implemented by the government

disproportionately affected people found in the informal sector. People living in urban slums without access to good sanitary facilities were also at a higher risk of infections.

The problem

In Ghana, both direct and in-direct effects of the pandemic on health and health outcomes became prolonged during the second and third waves of the pandemic. Despite seemingly obvious disruption this brought to the health system and health care utilisation, there is paucity of published literature on the effects to household health expenditures among diverse socio-economic groups, including the poor. No known study has examined the magnitude and extent to which these possible payments, if they existed impacted the vulnerable, particularly poor households. Also, several key questions remain answered in the literature. To what extent has COVID-19 impacted on out-of-pocket (OOP) payments as a share of total household expenditures during the pandemic? What are the determinants of COVID-19-related CHEs? How did CHE shocks impact multi-dimensionally poor households and how did they mitigate such shocks? This policy brief answers these questions and examines the policy implications of financing mechanisms and their impact during health emergencies.

Analysis

Using the Ghana Living Standards Survey Round 7 (GLSS 7), and the third wave of the Ghana COVID-19 Households and Jobs Tracker (HJT) data set, this brief provides useful insights to policymakers on catastrophic health expenditures in Ghana, and the financing mechanisms employed by households to mitigate the health expenditure burden during the pandemic. In our analysis, we interact with multidimensional poverty and various financing mechanisms which provide useful insights for policy actions for future health emergencies, particularly for households facing multiple overlapping deprivations in Ghana. The HJT data set is a nationally representative survey covering sampled households from the Ghana Living Standards Survey round 7, across all the 16 regions of Ghana. Using Computer Assisted Telephone-based Interviews (CATI), the survey follows more than 3,000 households from June 2020 (first wave) to September 2020 (second wave), December 2020 (third wave) and finally April 2021 (fourth wave).

In this brief, we employ data for wave 3 of the survey on 2370 households in Ghana. The use of wave 3 only is due to the availability of COVID-19-related health expenditure variables as well as the need for us to take cognizance of the end of the 2020 financial year in December.

Major findings

- On average, 4.2 % of households spent in excess 40% of their total household expenditures on COVID-19-related health expenditures during the COVID-19 pandemic period (2020-2021). On the other hand, 52.2% of Ghanaian households spent more than 5% of total household expenditures on COVID-19-related HEs. This shows a disparity in COVID-19-related health expenditures among households and hence the uneven impact of the pandemic on different households.
- Comparing this to the pre-pandemic period (based on GLSS 7 data), we observe a high difference in the percentage of households making catastrophic payments at a 5% threshold (Akazili et al., 2017)
- Poor households had a higher degree of catastrophic COVID-19 health-related expenditure than non-poor households.
- Households in urban areas expenditures exceeded the 10% threshold compared with rural areas, probably due to differences in cost of living in both regions
- Approximately, 68.7% of households spent in excess of 5% of total non-food expenditures to health and healthcare.
- Non-poor catastrophic households have a lower degree of catastrophe; larger households and households with insurance and those who received some government assistance have lower degrees of catastrophe.
- Government assistance is key in mitigating the degree of catastrophic health expenditure by poor households.
- Remittances from abroad are key in mitigating the degree of catastrophic health expenditure by poor households.

Implications for policy makers - Conclusions and policy recommendations

Conclusion

Our findings highlight a negative welfare consequence of the COVID-19 pandemic on households. We observed 1% difference between the pre-pandemic period (5%) and during the pandemic (4.2%) percentage of households making catastrophic payments. In general, findings show government assistance and remittance were key in moderating the degree of catastrophic pandemic health expenditure of poor households while insurance mitigates the probability of households being catastrophic.

Recommendations

Below, we present some key recommendations for three core areas: health practice, policy and research. These recommendations aim to promote greater equity in health financing, both during health crises and in more routine circumstances.

For practice

- **Increase Accessibility:** Healthcare providers should strive to make treatment more accessible and affordable. This can involve negotiating with pharmaceutical companies for lower drug prices or introducing sliding-scale fees for services.
- **Community Education:** Health practitioners should work with local communities to increase their understanding of available government support, insurance schemes, and how to access these resources.
- **Promotion of Health Insurance:** Healthcare Practice should involve active promotion and facilitation of enrollment in health insurance programs, particularly targeting high-risk groups including multidimensionally poor households.

For policy

- **Strengthening social safety nets:** Given the importance of government assistance and remittances in reducing catastrophic health expenditures, it is critical to reinforce social safety nets. This could include enhancing the availability, accessibility, and effectiveness of public health insurance schemes. Policies to lessen the costs of informal safety nets such as remittances can also be pursued by the government.

Targeted Support for High-Risk Groups: Policies could be implemented to provide targeted support for the most vulnerable households, like those in urban areas, smaller and uninsured households, and those with no access to government assistance or remittances.

- **Cross-sector Collaboration:** Encourage cross-sectoral collaboration to support initiatives that address other social determinants of health like employment, housing, and education, that influence the ability of households to absorb high health costs.

For research

- **In-depth Analysis of Disparities:** Further research could investigate the causes of the disparities observed in CHEs for different households during the pandemic. Understanding these differences can inform more equitable health financing strategies.
- **Impact Evaluation Studies:** Research should be conducted to measure the impact of current and potential policies aimed at reducing catastrophic health expenditures. Understanding what works, for whom, and under what circumstances, is critical to policy improvement.
- **Identifying Long-term Effects of Health Crises:** More research is needed on the long-term effects of such health crises on household expenditure and overall economic status, helping to illuminate the potential long-term societal impacts of pandemics and similar crises on poverty eradication but also on well-being more broadly.

References

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