**The health divide in different settings: do policies matter? A comparative study of Ghana and England**

<table>
<thead>
<tr>
<th>Journal:</th>
<th><em>International Journal of Health Services</em></th>
</tr>
</thead>
<tbody>
<tr>
<td>Manuscript ID</td>
<td>IJHS-19-0139.R1</td>
</tr>
<tr>
<td>Manuscript Type:</td>
<td>Original Article</td>
</tr>
<tr>
<td>Keywords:</td>
<td>Health inequities, Ghana, England, Public policies, Commission on Social Determinants of Health, Colonialism, Deindustrialization</td>
</tr>
<tr>
<td>Abstract:</td>
<td>Informed by the theoretical perspective of the political economy of health and in the context of the recommendations of World Health Organization’s Commission on Social Determinants of Health, this paper examines the political explanations of geographical health inequities in two extremely different settings; Ghana and England. Based on the ‘north-south health divide’ in the two countries, the paper finds that whilst the drivers of health inequities in both countries are policy driven, historically situated contextual factors (colonialism in the case of Ghana and deindustrialization in the case of England) offer explanations for health inequities in both countries. We conclude by discussing the importance of paying attention to structural factors like colonialism for understanding contemporary health inequities in formerly colonized countries such as Ghana.</td>
</tr>
</tbody>
</table>

[https://mc.manuscriptcentral.com/ijhs](https://mc.manuscriptcentral.com/ijhs)
1. Introduction
The problem of health inequalities and inequities (unfair health differences) has been widely documented both within and among countries. In 2008, the World Health Organization’s Commission on Social Determinants of Health (CSDH) published three broad goals for tackling health inequities: to improve the daily living conditions of people; to tackle the inequitable distribution of money, power and resources; and to monitor and measure health inequities to help assess the impacts of policies and programs targeted at reducing health inequities.\textsuperscript{1} A decade after this publication, social and health inequities continue to persist globally.\textsuperscript{2} An interesting question is whether the drivers of health inequities in countries with varied historical and political contexts differ significantly. For example, how different (or similar) are the drivers of Ghana’s or Nigeria’s ‘north-south health divide’\textsuperscript{3} from those of England’s ‘north-south health divide’ or Germany’s former ‘east-west health divide’?\textsuperscript{4} Additionally, if the causes and explanations of health inequities in such varied contexts differ significantly, how might policy makers in these varied settings respond appropriately to the WHO’s recommendations? This paper is aimed at exploring the political explanations of health inequities in two very different countries, Ghana and England, in order to compare and contrast the political drivers of health inequities in both countries. After providing a brief account of the theoretical perspective of the political economy of health which
informs this work, we explore and compare the drivers of England’s and Ghana’s north-south divide in health, trying to offer some insight on the policy-driven nature of health inequities in the two settings.

1.1 Rationale and basis for comparison

The choice of comparing radically different cases (a method of case selection referred to in comparative policy research as the ‘least-likely’ method\(^5,6\)) offers an excellent opportunity for theory building\(^7\) and for understanding whether a given relationship (e.g. between political choices/public policy and health inequities) continues to exist when radically different cases are compared. We have therefore chosen to focus our comparison on Ghana and England because of the significant differences in the contexts of both countries and also because of the ‘north-south divide’ that affects both countries. A country like Ghana has a colonial past which might be important for tackling social determinants of health in a way that might not be the case for England. Our review, therefore, uses highly different settings to examine some major factors important for understanding contemporary health inequities.

1.2 The political economy of health

Varied accounts exist for explaining how and why health inequities occur. These range from individual differences\(^8\) to differences in the organization of societies.\(^9,10\) The political economy of health approach presents politics as an
explanation for population level health inequities. According to this body of research, the entire organization of a society affects health inequities. For example, highly unequal societies have more health inequities.\textsuperscript{11} From the political economy perspective, the distribution of power, the level of economic and social rights and political and economic relationships among societies, together determine the level of health inequities and vulnerability to societal risks that lead to poor health among population groups.\textsuperscript{12,13}

According to the existing literature in this field, there are three main approaches for explaining the relationships between politics and health inequities; the welfare regime approach, the politics approach and the individual policy approach.\textsuperscript{14} In the welfare regime approach, various welfare state models (e.g. Liberal, Corporatist and Social Democratic)\textsuperscript{15} are compared to investigate their impact on health.\textsuperscript{16} The taxonomies above are mostly based on countries in Europe, North America and Australia -often excluding other regions of the world.\textsuperscript{17} The second approach-the politics approach- examines the relationship between various political arrangements, ideologies (e.g. neoliberalization), institutions (e.g. political parties) or processes (e.g. democratization) and health.\textsuperscript{14} The final approach examines how specific public policies and political choices relate to health and health inequities.\textsuperscript{14} Our study draws on the last two approaches as Ghana is not categorized under any of the welfare state regimes.
2. The English Health divide

Health inequities exist in England at various geographical levels ranging from regional down to the neighborhood level. Although the concept of a ‘north-south health divide’ is an oversimplification, we use it as an entry point for our research for analytical purposes. Different ways to ‘divide’ the north and south of England have been proposed (the Humber-Mersey line, the southern limit of the ‘seven-county north’ the Lowry line and the Severn-Wash line) but, for the purposes of this study, by north we mean the three northernmost regions (North East, North West and Yorkshire and Humber) and by south, the rest of the country. Comparing health indicators in the north to the rest of the country reveals several inequities. For example, a girl born in Richmond (in the south) can expect to live 15 years longer than another in Manchester (in the north). These differences in life outcomes occur across multiple indicators. In the sections that follow, we describe major public policies and political choices that are critical for understanding the north-south health divide.

Table 1 about here
2.1 Thatcherism and the advent of neoliberalization

Politics in Britain over the past century has seen significant shifts on the role of the state in the provision of welfare services, from maximum to limited intervention.\textsuperscript{19–21} After the second world war, there was general consensus in England on the need to provide various social benefits for employment, sickness and pensions for citizens.\textsuperscript{19} The 1980s however saw a significant shift from such ideas to the embracing of neoliberalization- the idea that markets should determine ‘all forms of human interaction’.\textsuperscript{22(p.13)} Whilst a comprehensive analysis of the concept of neoliberalization is beyond the scope of this study, it is worth noting how different authors have interpreted the term.\textsuperscript{23} Wacquant\textsuperscript{24} for example, distinguishes two different approaches to interpreting neoliberalization; one in the narrow sense of hegemonic market rule (‘the triadic combination of deregulation, privatization and the withdrawal of the state from many areas of provision’\textsuperscript{24(p. 69)}) and the other as an overly broad approach that relies on the Foucauldian idea of governmentality (shifting from a narrow economic view to a broader ideology affecting the overall action and conduct of society ‘according to principles of competition, efficiency and utility’\textsuperscript{24 (p 70)}). Ward and England\textsuperscript{25} have also emphasized five key aspects of neoliberalization; clarifying firstly that neoliberalization is a process (as opposed to a static single ‘neoliberalism’) and that is has four key dimensions (It is at the same time 1. An ideology 2. A set of
policies/programs. 3. An institutional form and 4 a way of conceptualizing normative ideas of individual responsibility). In whatever way neoliberalization is conceptualized, its advent in England contributed significantly to the north-south health divide. For the purposes of this study, we draw on the narrower economic approach where neoliberalization tends ‘to advocate a tightly delimited role for the state in regulating economic activity. As a result, it is an agenda that promotes not just the withdrawal of the state from market regulation, but the establishment of market-friendly mechanisms and incentives to organize a wide range of economic, social and political activity’.23 (p 172)

Britain in the 1980s was characterized by monetarist policies of tight money supply, financial deregulation, trade liberalization, privatization of public goods and services and a stifling of the trade unions; put simply, it “re-cast the relationship between labor and capital and between the state, society and the individual”.20(p. 11) These policies became known as Thatcherism, after Margaret Thatcher, the prime minister of Britain at the time. Although Thatcherism itself did not include the privatization of the National Health Service (which had been established under the ideas of the post-war consensus), it put in a place a climate that favored the ensuing privatization of aspects of the NHS by subsequent governments.20,26
The neoliberal turn in England had important impacts on population health and health inequities across the country. The job losses associated with Thatcherism, primarily through deindustrialization disproportionately affected the north of England. The retrenchment of the welfare state disproportionately affected unemployed northerners and attempts to resist such policies received harsh responses with documented instances of brutal and violent subjugation of trade unions (mandated to protect wage levels and working conditions) in Liverpool in the north of England. These have laid a solid foundation for the economic/employment insecurity and the “low-pay no-pay” cycle that has come to characterize employment in former industrial regions in the North East of England.

2.2 Deindustrialization and the creation of a London-centric economy

Closely related to the point above are the distinct effects of deindustrialization. Deindustrialization over the past three decades has occurred mainly in Old Industrial Regions (OIR) located in northern England. Deindustrialization, primarily a Thatcherite legacy initially aimed at creating a competitive service-based economy that encourages labor and capital mobility with a global outlook had a significant effect on the north. It caused manufacturing employment to fall from 8.9 million to 2.9 million within the last half century. In the coal industry -mostly based in the north of England, Scotland and Wales - 500,000 job losses
have occurred, with these falling on former industrial areas in the north whilst leaving much of the south and the rural north untouched. Although the decline in manufacturing jobs is not unique to England or the United Kingdom, the scale of deindustrialization in the UK has gone further than most other advanced economies. Over 3 million jobs were lost between 1973 and 2007 in UK compared to 0.798 million, 1.631 million, 2.04 million, 1.994 million and 0.72 million in Italy, France, Germany, USA and Japan respectively. It is important to state that job losses in England did occur in the south as well, nevertheless, the economic rejuvenation that occurred in places such as London and the Southeast simultaneously with deindustrialization, did offset such job losses in a manner that did not occur in the north.

The economic shifts that began during the era of Thatcherism created an economy with visible winners and losers. The ‘big bang’ deregulation of the 1980s and simultaneous public expenditure and investments in banking, finance and service industries- mostly located in the south (London) - led to southern growth that did not happen in the north. By 2022, the UK’s Trade Union Congress (TUC) projects that the United Kingdom will become more unequal, with London and the South East alone accounting for 40% of GDP compared to 2.9% of GDP in the North East. Such economic variations are partly explained by the weakening of northern industries. More recent data showing the North East in particular as the
“zero hours contract capital of the UK” gives further credence to the fact that the region may not have recovered from the economic policies of the 1980s. Policies of northern neglect became so entrenched that a former Governor of the Bank of England (in)famously stated that “northern unemployment is an acceptable price to pay for curbing southern inflation”.35 (p.47) The creation of this kind of economy has important implications for the distribution of health inequities in England -see Table 2.

2.3 Contemporary Austerity Measures

In more recent times, an important and widely investigated area of study relates to the impact of austerity- “drastic but selective expenditure cuts” - on health.22(p.69) Following the 2008 global financial crisis, several countries have pursued austerity as a means to economic recovery with disastrous public health consequences such as in Greece where public expenditures on health were cut by up to forty percent.36 Between 1921 and 2010, different levels of austerity have been pursued in England, with the post 2010 cuts described as the toughest in recent memory.37,38 The cuts have had a distinct geography disproportionately falling on the poorest local authorities mostly found in the north of England. In Blackpool in the North West for example, every working age adult was projected to lose £720 per year beginning from 2016 compared to £130 in Hart in the South East due to differential cuts in social programs and differential distribution of
claimants nationally. A comparison of the fifty most affected and ten least affected districts revealed a north-south divide in favor of the south (although some rural areas in the north of England similar to London and the South East were fairly insulated from these cuts). A useful summary of the welfare reforms can be found elsewhere. Understanding the relevance of these cuts for the north-south health divide requires an understanding of the geography of welfare recipients in England which shows that many recipients of various benefits in England live in the north.

The implications of these public policies and political choices for north-south health inequities is that the policies engender and entrench inequities. Similar but slightly different is the issue of government spending which also disadvantages the north. Government expenditure in various sectors -including transportation- shows lower spending in the north compared to the south. Such spending differentials adversely affect the northern economy and leads to a migration of the ‘best and brightest’ from north to south. A summary of the key implications of these public policies and political choices on north-south health inequities are shown in table 2. In the sections that follow we describe the major
political factors driving geographical health inequities in a radically different setting- Ghana.

3. The Ghanaian Health Divide
The past three decades have seen remarkable improvements in various health outcomes in Ghana. These improvements have however not been experienced similarly across Ghana’s ten regions (for example, child mortality rates were twice as high in Ghana’s north as its south in 2003), with the three northern regions (Northern, Upper East and Upper West regions) lagging behind the rest of the country.

Health improvements are also increasingly threatened by the rise in non-communicable diseases driven by epidemiological and nutritional transitions although some social interventions such as Ghana’s National Health Insurance Scheme (NHIS) have had a positive impact on health. Table 3 shows that for various health outcomes except for HIV, the north consistently performs worse than the south.

Table 3 about here

As we did previously for England, in the sections that follow, we explore some of the public policies and political choices that are relevant for understanding Ghana’s north-south health divide. Explaining social inequities in Ghana can be contentious. Indeed, some have emphasized unfavorable climatic conditions as a
sufficient explanation for inequities although some literature exists to dispel such “bad geography arguments”.55(pp 28-31)

3.1 From colonialization to Structural Adjustment Policies (SAPs)

European settler colonialism lay a crucial foundation for contemporary socioeconomic differences between the north and south of Ghana.56 Colonial governments did not find northern resources (eg. cotton) useful and thus discouraged- through uneven government investment and malicious competition- the development of such resources. This was aimed at producing a proletariat who would serve as cheap labor to advance the capitalist interests of the colonial economy.57,58 Perhaps the most succinct description of the sentiments and agenda of the colonists towards northern Ghanaians comes from a colonial report describing northerners as:

“[A] n amiable but backward people useful [only] as soldiers, policemen, and laborers in the mines and cocoa farms, in short, to be hewers of wood and drawers of water for their brothers in the colony and Ashanti”.59(p 375)

This sentiment underpinned underinvestment in the north. In vital areas such as education, health and other infrastructure, colonial governments ensured that institutions were set up in the south (where Europeans lived as well) to the detriment of the north.60,61 For example, under governor Guggisberg6il often credited for creating the first national development plan- whilst education in the
south was to be from primary level to the university, education in the north was rigidly controlled and was not to exceed standard three (six years of primary education).\textsuperscript{61(p 257)}

Post-colonial governments generally followed the trend of northern neglect and underinvestment described earlier. In the era of World Bank and International Monetary Fund (IMF) Structural Adjustment Programs (SAPs)\textsuperscript{iii} (known in Ghana as Economic Recovery Programs (ERPs)) various governments pursued political choices that exacerbated the vulnerability of the north and deepened the north-south divide.\textsuperscript{62,63}

Ghana adopted SAPs between 1983 and 1998 in a desperate attempt to salvage a moribund economy and to escape the economic decline of the 1970s. A profound result of the austerity measures associated with the SAP era cuts in education and health was the disproportionate impact on the north compared to the south.\textsuperscript{63,64}

In this period, government expenditure on health (as a proportion of total expenditure) fell from 10% in 1982 to a paltry 1.3% in 1997.\textsuperscript{65} The introduction of hospital user fees also led to a 25%-50% fall in hospital visits in urban areas in the country and a 45%-80% fall in hospital visits in rural areas.\textsuperscript{63} The paucity of data makes it difficult to know the exact north-south difference in falls in hospital visits. However, given that the northernmost regions were less than 20% ‘urbanized’ compared to about 80% urbanization in the Greater Accra region, with over 20%
urbanization in 5 of the southern regions,\textsuperscript{66} it is reasonable to assume that these drops in hospital visits disproportionately affected the north compared to the south.

Whilst education generally remained free during this period, the cost of “books, furniture and other supplies” kept children in the north and other areas with high deprivation in the country from going to school.\textsuperscript{63}(p. 475) Government spending within the period (in the 1990s for example) was also detrimental to the north, such that whilst the north accounted for 19% of the population, only 11.6% of government spending on education went to the north.\textsuperscript{62}

3.2 Ghana Poverty Reduction Strategy I & Growth and Poverty Reduction Strategy II

After the SAPs came Poverty Reduction Strategies (PRSs). With these programs (which occurred in other low and middle income countries as well), countries typically produced plans to show how International Monetary Fund (IMF) allocations would be used to reduce poverty and the other deleterious impacts of IMF recommended SAPs which had turned out to be nostrums- some have argued that PRSs were simply repackaged SAPs.\textsuperscript{67}

The Ghana Poverty Reduction Strategy (GPRSI) and the Growth and Poverty Reduction Strategy II (GPRSII) were comprehensive poverty reduction strategies in Ghana in the 2000s.\textsuperscript{68,69} These strategies were created to demonstrate how
debt relief from the IMF under the Highly/Heavily Indebted Poor Country (HIPC) initiative would be used to reduce poverty in the country. Whilst the GPRS I, expressly aimed at reducing regional inequities in poverty in the country had stated it would disburse 48% of funds to the north, only 6.8% of these funds were disbursed to the north during actual implementation. Many of the projects aimed at closing the divide never came to fruition. For example, plans under GPRS II to create a rail line to connect the north of Ghana to the south have remained in the eternal political ‘pipeline’, so that whilst the first railway in the country was established in 1901, 118 years later there is no railway in the north of Ghana.

Figure 1 below shows deviations between actual and expected regional expenditure during implementation of HIPC. At the planning stage it was agreed that 48% of funding would go to the three northern regions, 4% to Greater Accra and another 48% for the rest of the south. The reason for the deviations from the earlier poverty criteria stated in the strategy documents was because of a political choice to allocate funds according to metropolitan status which clearly placed the north at a disadvantage as it had (and still has) only one metropolitan assembly in the Northern Region. A more political explanation is the power differential between the northern elite and their counterparts in the south which constrained the northern elite from ensuring that
previous poverty criteria was followed in disbursement.\textsuperscript{71} The allocation of GPRSII did favor the north compared to the south, although in absolute terms the money and resources involved were significantly below the amounts in GPRS I.\textsuperscript{71}

\begin{table}[h]
\centering
\caption{Table 4 about here}
\end{table}

\section*{4 Synthesis of findings}

\subsection*{4.1 Interrogating the north-south divide in health}

As stated in earlier sections, although the north-south divide is a meaningful way to explain substantial geographical health differences within the two countries, it also has some limitations. First, for some diseases, the divide is not so evident (with some diseases actually showing a southern disadvantage). A typical example in Ghana is HIV where rates have been lower in the north compared to the south (see table 2). This is compatible with the political economy perspective described earlier because the factors that drive HIV infection do not only reside with the poor but are very context-specific, depending on several other social characteristics.\textsuperscript{82}

Further, a binary (north-south) way of thinking about health inequities in both countries is challenged by living conditions of some population groups within the supposedly wealthy parts of both countries. A case in point in relation to England was the tragedy of Grenfell tower which is located in the wealthiest borough in London and yet whose casualties lived in unbelievable squalor.\textsuperscript{83} An equally good
example of this in Ghana is that of people in the informal sector in Accra (in the south) most of whom suffer extreme hardship and in some cases forced relocations.\textsuperscript{84}

4.2 Differences and Similarities

Looking at similarities and difference in both countries, an important difference in both countries comes from history. The historical explanations of health inequities in Ghana and England differ when one considers colonization and deindustrialization. In the English case, deindustrialization played a crucial role in creating a new sort of economy in which the north was likely to lose- i.e. financialization increased and old industrial areas in the north declined.\textsuperscript{27} In the case of Ghana, colonialization led to a similar north-south divide by creating an economy in which people from the north would necessarily have to be the uneducated proletariat offering cheap labour.\textsuperscript{56,57} In both cases, livelihoods and health of people in the disadvantaged regions were affected with implications for health equity. Whilst the impacts of the two policies have been similar, the policies themselves are different and this is noteworthy.

Several similarities emerged from the review. In England, central government spending on different infrastructure has been significantly lower in the north than in the south. In transportation for example, comparisons of per capita government expenditure indicates that the north of England would have received an extra £59
billion, had the government spent proportionately in northern England as in London or an extra £10 billion if it spent the UK average in the north of England.\textsuperscript{51}

In addition to the lower education spending in the north, the north is underfunded in other sectors. Households in London receive more housing benefits, tax credits and child benefits compared to the north and indeed the rest of the country. They also receive extra ‘benefits in kind’ in per capita terms on bus travel subsidy (£90), rail travel subsidy (£50), housing subsidy (£30) and school meals and healthy start vouchers (£20).\textsuperscript{85} These spending differentials negatively affect the economic potential of the north and also lead to London sucking the “best and brightest” from the north through migration. The policy decisions described can have impacts on various social determinants of health with implications for health equity.

Government underspending has had essentially similar if not the same effects on north-south social and health inequities in Ghana. Spending during GPRS I neglected the north. A similar and perhaps more tragic example of the disproportionately low infrastructural spending, particularly in transportation in the north of Ghana is the 118 years of no rail transport in the north of Ghana as noted earlier.\textsuperscript{70} What these macrosocial defects in policy have meant for the north of Ghana is also very similar to the case of England: The ‘best and brightest’ in northern Ghana move to the south and many professionals such as teachers and
doctors refuse posting to the north mainly because of the poor infrastructural development.\textsuperscript{86,87} Northern schools remain in conditions of disrepair with few teachers, low enrolment rates, high dropout rates and poor performance.\textsuperscript{88} The young men and women who try to escape these unfavorable conditions and move to the south end up in menial jobs which perpetuates the cycle of poverty and health inequity.\textsuperscript{89}

Austerity related policies have also disproportionately affected the northern parts of both countries. Post 2010 austerity measures in England disproportionately impacted the poor with 10\% of the net household income lost among the poorest decile, women, the disabled, larger families and the unemployed compared to everyone else.\textsuperscript{38} The distinct geography of such cuts has meant a disproportionately affected north as noted earlier and this has important implications for health and wellbeing of people in the north.

In the case of Ghana, the SAPs era laid a solid foundation for future austerity in the country.\textsuperscript{64} The cuts of the period had disproportionately negative effects on the north, although more rigorous research needs to be conducted to understand the nature and magnitude of such effects and more importantly the contemporary implications of such effects on health, given current knowledge from life course epidemiology. More recently the government of Ghana has had to implement
more austerity measures in light of a $1 billion loan\textsuperscript{90} although data on the
geography of such cuts is not always available.

The table below provides a summary of the thematic similarities and differences
in terms of explanations of the north-south health divides in both countries.

\begin{table}
\centering
\begin{tabular}{|c|c|c|}
\hline
Thematic Similarity & Country A & Country B \\
\hline
Economic Factors & \textbullet\textbullet\textbullet & \textbullet\textbullet\textbullet \\
\hline
Political Context & \textbullet\textbullet\textbullet & \textbullet\textbullet\textbullet \\
\hline
Healthcare Systems & \textbullet\textbullet\textbullet & \textbullet\textbullet\textbullet \\
\hline
\end{tabular}
\caption{Table 5 about here}
\end{table}

5.0 Discussion

The political economy of health offers an excellent opportunity to think about the
connections between politics and health beyond medical explanations. Although
considerable research has been conducted on politics and health in England and
to explain how politics is implicated in north-south health inequalities in England\textsuperscript{4}
there remains a paucity of research on politics and health in Ghana. The approach
and rationale adopted in our review is similar to Chabrol and colleagues\textsuperscript{91} who use
France and Cameroon to demonstrate the ‘pharmaceuticalization of health
systems’ in the context of austerity policies. Such comparisons of distinct settings
are useful as they show the specific contextually situated and historically relevant
factors necessary for responding to the challenge of health inequities in different
parts of the world. Our review demonstrates the complex relationship between
place and health and the important role of political context in shaping people’s
health and life chances. As demonstrated from our review, whilst there are
challenges with conducting such comparisons, the impacts of government
spending and the differential impacts of austerity policies on people depending on where they live can be quite profound. Our review also shows that whilst public policies (which may not necessarily be health policies) can be manifestly different in different settings, if they are underpinned by a logic of neglect of specific parts of a country, they can increase intra-country health inequities.

Additionally, we note the paucity of research connecting history (colonialism) and health in settings such as Ghana where the current geography of various socioeconomic inequalities mirrors colonial policies of neglect of certain parts of the country. This calls for more research on the contemporary health relevance of colonialism in Africa, particularly as such research exists in other contexts (such as Canada, USA, New Zealand and Australia), and has shown that colonialism explains some contemporary health inequities.

**6.0 Conclusion**

Our review has revealed a number of issues on the relationships between politics and health in the context of distinct geographic settings. Whilst a north-south health divide exists in both countries, a binary categorization can be problematic because some diseases do not follow a clear divide and some people living in the southern parts of both countries suffer significant health disadvantages too. Uneven government spending and uneven impacts of austerity both demonstrate
the implications of political choices and public policies on health inequities in both countries.

Our review also provides a picture of the complexity of the politics of health: in acting on the recommendations of the WHO’s Commission on Social Determinants of Health, countries need to pay attention to historical context which in many cases underpins contemporary social relations. This focus would allow for a deeper understanding of structural root causes of health inequities and could offer insights on how to better distribute resources within society. Future research could focus on comparing other extremely different settings to investigate difference and similarities between political drivers of health inequities in different countries in order to propose policy interventions for reducing health inequities.

Finally, we note the crucial role of history (colonialism) in explaining health inequities in Ghana and the need for more political economy of health research in African settings with a colonial past.
References


Newcastle Upon Tyne; 2012.


91. Chabrol F, David P-M, Gaelle Krikorian. Rationing hepatitis C treatment in


Endnotes

---

i Data from USA starts from 1979 and data for Japan is from 1973-2006

ii Governor Guggisberg was a British colonial ruler in Ghana and “produced the first 10-year development plan, launched in 1924 to improve health, educational, and economic development across the colony”

iii SAPs were a set of programs that sought to restructure the economies of countries in the developing world or in transition; by mainly advocating cuts in public spending and sale of public assets as means of ensuring economic growth. Ghana was considered a “star pupil” because of its strict adherence to SAP recommendations

iv Local government in Ghana can be Metropolitan (population of over 250,000), Municipal (population of over 95,000) or District (population of 75,000 and above)
Table 1: Key health indicators across the nine administrative regions of England

<table>
<thead>
<tr>
<th>Region</th>
<th>Population (millions)</th>
<th>Life Expectancy at Birth</th>
<th>CVD deaths (&lt;75 years per 100,000)</th>
<th>Cancer deaths (&lt;75 years per 100,000)</th>
<th>Diabetes% (&gt;17 years)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>North</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>North East</td>
<td>2.6</td>
<td>78</td>
<td>81.7</td>
<td>88.8</td>
<td>169.5</td>
</tr>
<tr>
<td>North West</td>
<td>7.1</td>
<td>78</td>
<td>81.8</td>
<td>92.8</td>
<td>159.8</td>
</tr>
<tr>
<td>Yorkshire and Humber</td>
<td>5.3</td>
<td>78.5</td>
<td>82.2</td>
<td>87.3</td>
<td>155.0</td>
</tr>
<tr>
<td><strong>South</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>East Midlands</td>
<td>4.5</td>
<td>79.3</td>
<td>83.0</td>
<td>80.0</td>
<td>143.8</td>
</tr>
<tr>
<td>West Midlands</td>
<td>5.6</td>
<td>78.8</td>
<td>82.8</td>
<td>82.1</td>
<td>147.8</td>
</tr>
<tr>
<td>East of England</td>
<td>5.8</td>
<td>80.1</td>
<td>83.8</td>
<td>70.0</td>
<td>136.0</td>
</tr>
<tr>
<td>South West</td>
<td>5.3</td>
<td>80.1</td>
<td>83.8</td>
<td>80.1</td>
<td>136.5</td>
</tr>
<tr>
<td>London</td>
<td>8.2</td>
<td>80.0</td>
<td>84.1</td>
<td>66.4</td>
<td>134.0</td>
</tr>
<tr>
<td>South West</td>
<td>8.6</td>
<td>80.4</td>
<td>83.9</td>
<td>67.1</td>
<td>134.3</td>
</tr>
<tr>
<td><strong>England</strong></td>
<td>53</td>
<td>79.4</td>
<td>83.1</td>
<td>78.2</td>
<td>144.4</td>
</tr>
</tbody>
</table>

(Adapted from Bambra⁴)
Table 2 Connecting public policies and political choices to health inequities in England

<table>
<thead>
<tr>
<th>Policy</th>
<th>Political economy explanation of north-south divide</th>
</tr>
</thead>
<tbody>
<tr>
<td>Thatcherism and neoliberalization</td>
<td>Increased privatization of the NHS following Thatcherism led to outsourcing of services such as cleaning to private companies.(^{20}) Currently the private sector has a more pronounced presence in the provision of health services with important implications for health services delivery.(^{22}) Privatization efforts led to reduced service quality with evidence of overpricing of supplies.(^{22}) The north-south relevance of these changes to the NHS is that any negative effects on health likely fall more heavily on the north because people in the north have the lowest levels of private medical insurance thus no buffer against a failing NHS.(^{40,41})</td>
</tr>
<tr>
<td>Deindustrialization &amp; The London Centric Economy</td>
<td>Deindustrialization is implicated in the rise in unemployment which affects health through material and psychosocial pathways. Large numbers of people in the north are employed on ‘zero-hours contracts’-contracts that do not guarantee a minimum number of working hours a week.(^{34}) This has resulted in a rise in material deprivation and stress which can be associated with cardiovascular disease, unhealthy behaviors, musculoskeletal disorders and physical and mental disorders.(^{22,42}) These negative health outcomes extend to the families of the unemployed as well, as there is evidence of an increased likelihood of death among the wives of unemployed men.(^{43}) The primary relevance of this for the north-south divide is that the precarious employment and unemployment associated with deindustrialization has fallen more heavily on the north thus exacerbating the north’s vulnerability to the poor health outcomes above. The London centric English and UK economy means a southern concentration of wealth, with people in the South East earning up to 25% more than those in the Midlands.(^{44}) Since incomes often determine people’s diet, housing and other living conditions and by extension health,(^{45}) it stands to reason that these income differences would have a deleterious effect on the health of low earning northerners. For example, dietary differences exist between regions, with poorer diets, lower physical activity and higher obesity found in the north.(^{46}) Such poor nutritional ‘choices’ are likely explained by limitations of income.</td>
</tr>
<tr>
<td>Contemporary (Post-2010) Austerity</td>
<td>The large proportion of benefits claimants are concentrated in the north, thus the cuts to these benefits affect northerners the most.(^{19}) The connections between these cuts and health is that it takes away income that could be used for food or housing. The rise in food banks use in England generally (but particularly in the north) shows the implications of cuts on health via food security.(^{47}) Additionally, suicides, mainly out of desperation from unemployment and loss of benefits increased after the financial crisis, although the increases were higher (12.4/100,000 in north west) in the north than the south (8.7/100,000 in London).(^{48}) The possible causal relationship between these suicides and austerity via unemployment can be seen in the fact that as unemployment recovered in 2009 the suicides fell, and rose again with the post 2010 austerity reforms.(^{48}) This suggests a possible dose-response effect. Furthermore, anti-depressant prescriptions also increased in the north as compared to the south as depression rates increased following austerity.(^{48}) Finally, recent cuts occurred in NHS spending for services related to the elderly and children according to Maynard(^{50}) and these have an uneven geographical impact (see private medical insurance point above).</td>
</tr>
</tbody>
</table>
Table 3 Regional inequalities in key health outcomes across Ghana’s 10 region

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>North¹</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Upper West (U/W)</td>
<td>4.23</td>
<td>0.76</td>
<td>4.7</td>
<td>76.6</td>
<td>54.3</td>
<td>31</td>
<td>26</td>
<td>1.6</td>
</tr>
<tr>
<td>Upper East (U/E)</td>
<td>1.05</td>
<td>0.62</td>
<td>2.6</td>
<td>73.8</td>
<td>64.0</td>
<td>25</td>
<td>24</td>
<td>2.5</td>
</tr>
<tr>
<td>Northern (N/R)</td>
<td>2.48</td>
<td>0.94</td>
<td>3.4</td>
<td>82.1</td>
<td>46.0</td>
<td>36</td>
<td>20</td>
<td>1.7</td>
</tr>
<tr>
<td>South</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Brong Ahafo (B/A)</td>
<td>2.31</td>
<td>0.30</td>
<td>2.0</td>
<td>62.5</td>
<td>38.0</td>
<td>25</td>
<td>28</td>
<td>2.7</td>
</tr>
<tr>
<td>Ashanti (A/R)</td>
<td>4.78</td>
<td>0.20</td>
<td>1.8</td>
<td>53.7</td>
<td>63.0</td>
<td>27</td>
<td>20</td>
<td>2.6</td>
</tr>
<tr>
<td>Western (W/R)</td>
<td>2.38</td>
<td>0.35</td>
<td>3.0</td>
<td>64.6</td>
<td>40.0</td>
<td>27</td>
<td>15</td>
<td>2.5</td>
</tr>
<tr>
<td>Central (C/R)</td>
<td>2.2</td>
<td>1.39</td>
<td>1.9</td>
<td>70.2</td>
<td>48.0</td>
<td>34</td>
<td>19</td>
<td>1.8</td>
</tr>
<tr>
<td>Eastern (E/R)</td>
<td>2.63</td>
<td>0.26</td>
<td>0.8</td>
<td>66.1</td>
<td>43.0</td>
<td>38</td>
<td>17</td>
<td>2.6</td>
</tr>
<tr>
<td>Volta (V/R)</td>
<td>2.12</td>
<td>0.57</td>
<td>2.4</td>
<td>69.9</td>
<td>42.0</td>
<td>27</td>
<td>5</td>
<td>2.7</td>
</tr>
<tr>
<td>Greater Accra (G/R)</td>
<td>4.01</td>
<td>0.61</td>
<td>1.3</td>
<td>59.6</td>
<td>37.0</td>
<td>14</td>
<td>12</td>
<td>2.4</td>
</tr>
<tr>
<td>Ghana²</td>
<td>24.66</td>
<td>0.53</td>
<td>2.2</td>
<td>65.7</td>
<td>41</td>
<td>28</td>
<td>20</td>
<td></td>
</tr>
</tbody>
</table>

All data are from the Demographic and Health Surveys.¹ Calculations for the north and south are the authors’ own calculations made by simply finding the average of the rates for all regions in the north or south.

² These are actual national averages and are not calculated by the author.
Table 4 Connecting public policies and political choices to health inequities in
Ghana

<table>
<thead>
<tr>
<th>Policy</th>
<th>Political economy explanations of the north-south divide in health</th>
</tr>
</thead>
<tbody>
<tr>
<td>Colonial Legacies</td>
<td>The colonial legacy of building infrastructure only in areas inhabited by Europeans led to very little infrastructural development in the health and educational sectors in the north.(^72) Currently the north has no mental health institution and the lowest number of hospital beds when compared to other regions in the south.(^73) Doctor to population ratios are generally higher in the north (as high as 1 doctor to 36,000 in Upper West region) than the south (about 1 doctor to 2,744 in Greater Accra region) albeit with significant regional variations.(^73) The impact of colonialism has greatly influenced the distribution of power especially since the north has generally ended up with very low levels of education and high levels of illiteracy.(^74) The limiting of educational opportunities in the north means that the less educated people from the north have lower incomes which could potentially limit their ability to access health services since health is not free at the point of use. The current national health insurance scheme however provides some financial protection to people in lower income quintiles.(^75) The disproportionately lower numbers of health institutions and health professionals could also affect health inequities through the unavailability of certain health services and the extra costs associated with travel to health facilities.(^76)</td>
</tr>
<tr>
<td>SAPs</td>
<td>Studies on the impact of Structural Adjustment Programs on health and health seeking behavior have concluded that SAPs caused people to rely on self-medication as the cost of drugs became prohibitively expensive.(^77) For example, close to the end of the period of adjustment, the cost of drugs for treating fever was about 60% of total treatment costs.(^78) Although some of these studies were not necessarily based in the north, the impact was likely higher up north as the north was poorer at the time of the studies (and still is). The distribution of health facilities and health personnel in Ghana from 1992-1998 disproportionately favored the south over the north which was characteristic of the lower levels of investment in the north during this era.(^79) Apart from health services provision, other important factors shape the distribution of health outcomes. Social determinants of health such as income were affected during SAPs as investments were largely in cocoa in the south to the detriment of the north.(^80) With declining spending in education in the north as well as the shifting of various costs to parents, a higher burden was pushed on rural and northern parents who had to pay more for their wards’ schooling.(^63)</td>
</tr>
<tr>
<td>PRSs</td>
<td>The low levels of funding to the north especially during GPRSI has health equity implications because funds from the GPRS were used to build facilities such as toilets(^55) and thus an underfunding of the northern regions during this period could have affected the availability of such facilities. The availability of sanitary facilities has critical implications for the incidence of conditions such as cholera. Evidence from the sixth round of the Ghana Living Standards Survey (GLSS 6) suggests that the north continues to lag behind in terms of the availability of toilets.(^81)</td>
</tr>
<tr>
<td>Theme</td>
<td>Ghana</td>
</tr>
<tr>
<td>---------------------------</td>
<td>--------------------------------------------</td>
</tr>
<tr>
<td>Uneven government spending</td>
<td>No railway in north, underspending during GPRS</td>
</tr>
<tr>
<td>Uneven impact of austerity</td>
<td>Greater impact of SAPs</td>
</tr>
<tr>
<td>Historical explanation</td>
<td>Colonialism</td>
</tr>
</tbody>
</table>
Figure 1: Deviations between actual and expected regional Highly Indebted Poor Country (HIPC) expenditures 2003-2005

(Source: Based on data from Abdulai. Bars to the right denote over disbursement of funds to a region relative to the planned spending. All three northern regions received much less than promised. (See table 3 for names of regions)