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IN SICKNESS AND IN HEALTH: GLOBALIZATION AND HEALTH CARE DELIVERY IN GHANA

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A poster meant to solicit support for the Global Day of Action Against Debt Crisis (September 26th, 2000) carried the following message: *Rally Against the IMF, Debt, SAP and HIV/AIDS*. Showing the faces of poverty-stricken African children the message went on:

They have been sentenced to death by the banks, drug companies, Western governments, and bodies like the IMF and World Bank. There is a war going on today --of the rich against the poor, of giant firms and their governments partners against humanity.

The message here is very clear: to some globalization or internationalism is evil. It has marginalized the peoples of the developing world and therefore must be resisted. Currently therefore there are several movements in both the developed and the developing world devoted to resisting the macro-economic policies of multilateral agencies (such as the International Monetary Fund, the World Bank and the Group of 7) in the developing world. Indeed globalization has recently evoked wide interest as a far-reaching socio-cultural process. More than merely an economic phenomenon, it has established connections across various communities and cultural traditions. While the benefits of improved information networks and the cornucopoeia of Western civilization have not been lost on many people, the consequences of the significant alterations in the social structure of traditional societies such as those of Ghana have posed problems of existential dimensions. Especially for Africa, the most marginalised but inextricably tied to the globalising economy, the effects of globalization on every sphere of life of her peoples pose critical challenges for national development.

In this paper, I wish to make some passing remarks on the effects of what Nichter (1989) refers to as the "commodification of health"—the tendency by the state to treat health as a commodity which one can buy with money or can obtain through the consumption of medical fixes, medicines. The relationship between money and health is forged by the fact that in contemporary society the most visible resources needed for therapy management are money and pharmaceuticals. The central argument of this paper is that although health is strongly influenced by socio-demographic and cultural variables, generally, the structure of a society's health care system is conditioned among others, by the international context in ways that go far beyond the mere introduction of technological change. It is in this regard that Van der Geest et al. (1990) have advocated for a multilevel perspective in the analysis of health care systems.

To understand the nature, the extent, and the consequences of commodification of health care in Ghana, it is necessary to examine the structure of both the colonial and post-colonial health systems.

The Colonial Health Service

Colonialism, according to Nkrumah (1962) is the policy by which the colonial power binds her colonies to herself by politico-economic ties, which ultimately work to the advantage of the colonialist. The history and development of biomedicine in this country can, therefore, be explained in part by the nature of the political and economic relationship that prevailed between the Gold Coast Colony and Britain. Essentially, the development of the colonial health service may be seen in three major phases. The first phase (1471–1844) was characterised by medical

apartheid whereby white settlers were physically segregated from the local population and given medical coverage. As Simpson observed (1909:13):

The policy has been to provide an European quarter in order that the risk of malaria infection from the insanitary conditions of native houses and from infected natives may be reduced.

Following the signing of the Bond of 1844 between the British and some local chiefs, relative peace was ensured in the colony and this enhanced European commercial and Christian missionary activities in the hinterland. It soon dawned on the Europeans that their health could no longer be guaranteed unless the health needs of the local population were also met. Thus the second phase of the colonial health service was born when health coverage was extended to African domestic servants and those in the colonial civil and military service. Towns with a sizeable European presence were provided with piped water, a drainage system, and other sanitary facilities. In 1868 the first hospital was built at Cape Coast (then the colonial capital) and subsequently rural dispensaries were built in several localities.

However the new medical dispensation did not have an easy beginning. The local people approached it cautiously while utilizing their indigenous healing systems. In an attempt to neutralize the influence of healers and to promote the new health dispensation, in 1878 the Native Customs Regulation Ordinance was passed. This ordinance banned traditional healing and all other indigenous practices, which offended Western sensibilities.

African civil servants were compelled to obtain a certificate of disability from colonial medical officers only. And Christian converts were threatened with ex-communication if found to have consulted traditional healers. The last phase of the colonial health service was born when Asante was defeated in 1901 followed by the annexation of the northern territories. Under the governorship of Gordon Guggisberg there was rapid expansion in the provision of infrastructural facilities. Under his reign, Korle-Bu Hospital was built in 1923 for use by Africans and for research into tropical diseases.

The Colonial medical service was largely curative although in the 1930s a Sanitary Branch was set up to oversee public health. It was also urban-biased and fees were charged. Thus, even at the height of the colonial medical service not more than 10 percent of the population had access to allopathic care. At independence in 1957, Ghana thus inherited the following features of the colonial health care system:

- The principle of cost-sharing
- Largely curative and urban orientation
- Central government as the largest provider of health care
- Subordination of indigenous healing systems to allopathy
- A disadvantaged north in the provision of health and other infrastructural services or facilities.
- With respect to the people, life expectancy was put at 48 years while infectious and parasitic diseases took a heavy toll on the life of children and adults.

The Post-Colonial Situation

A comparative analysis of the mortality and morbidity patterns of colonial and post-colonial Ghana does not present an encouraging picture of the health status of the nation. Generally, while Ghanaians now live longer (58 years) the causes of mortality and morbidity have not been significantly controlled given the huge capital outlay this nation has made and continues to make on health care. The analysis points to a nation in crisis. The following bare facts will contextualize the point:

- Although about 69 percent of the population live in rural communities, only 3 percent of rural households live in communities where there is a doctor; for 36

percent of rural households, a doctor is about 15 km away and for 18 percent a doctor is about 50km away.

- About 70 percent of doctors are located in the Greater Accra Region, which accommodates only 15.8 percent of the national population.
- The Upper West Region has only 9 doctors and until recently, the Upper East Region had no pharmacist.
- Of the 1,600 or more doctors trained by the University of Ghana Medical School only about 360 are still in the system; the rest have voted with their feet. There is 1 doctor to about 40, 000 Ghanaians.
- Our maternal mortality rate is put at 750 per 100,000 live births.
- Our infant/child mortality rate is put at 66 per thousand. There are marked regional variations. In the Northern Region infant mortality is pegged at 114 per 1000 while under 5 mortality is estimated at 237 per 1000.
- General causes of mortality and morbidity are due to preventable parasitic and infectious diseases--malaria, diarrhoeal diseases, guinea worm, bilharzia, cholera, and sexually-transmitted diseases including HIV/AIDs which continue to wreck havoc on the lives of Ghanaians.

Of course, compared to other African countries, we are said to have done better. But why must we compare ourselves to a bad situation? Why have we not made much progress in the area of health care?

For a developing economy, especially, the provisioning of health care is always problematic. Although all agree that health care is a basic need which must be available to all, the practical problems encountered in the implementation of this ideal provide an exercise in morality and political economy. Where resources are limited, it is difficult deciding how best to use them for development. Should they be focused on economic production or social services? Is infrastructure more important than private-sector incentives? Is education more important than health? Such decisions require not only a quantum of wisdom but also the ability to predict accurately the future economic fortunes of the state. In Africa where economic dependency is the norm, policy makers are constantly faced with the task of making choices which are not only economically, socially and morally defensible but also politically expedient.

Response

The response of the post-colonial state to the enormous health burden has been significantly influenced by her fluctuating financial and political health. On Ghana's attainment of political independence in 1957, Dr Nkrumah, the first nationalist leader set the health agenda for the nation when he declared:

We shall measure our progress by the improvement in the health of our people ... The welfare of our people is our chief pride and it is by this that my government will ask to be judged. (Nkrumah 1969: 51)

Thus imbued with socialist and nationalistic fervour and aided by a relatively buoyant economy, social welfare services such as health and education were given priority attention. Indeed in 1961 basic education was made free and compulsory and in the following year health services in public institutions were also made virtually free. Between 1957 and 1963 the number of health centres increased from 10 to 41. However, this policy put a heavy burden on the economy.

Available statistics on central government expenditure for 1963/64 show that of the projected public expenditure of EG 144 million, about 31 percent was earmarked for social services at a

time when cocoa, the nation's main foreign exchange earner, had suffered massive a fall in price on the world market. Thus even though Ghana's cocoa production doubled by over 200 percent from 1956 to 1964/65, this fetched the country a mere increase of 7.7 percent in revenue (Birmingham et al. 1966). International manipulation to cripple the then government was suspected to be at play in this scenario. The resultant financial strain compelled government to impose stricter control on foreign exchange outflow, resulting in the shortage of goods. In the public health institutions, the economic difficulties of the country and the 'dark side' of a free medical service both manifested themselves forcefully; also medicines meant for hospitals found their way into the open market. Mismanagement and pilfering became the norm. As the Konotey-Ahulu Committee Report (Government of Ghana 1970) revealed, Korle-Bu Teaching Hospital alone lost 9,380 linen items including bedsheets, blankets, doctor's coats and hand towels. Besides, an appreciable number of refrigerators, fans, airconditioners and furniture could not be accounted for. In the regions where supervision was even more relaxed, the loss to the state was colossal.

Following the overthrow of the First Republic some cost sharing was introduced by the Second Republican Government. This policy continued into the Third Republic. However, during the 1980s the continued effect of the world-wide recession of the late 1970s continued to be felt. Throughout this 'lost decade' the economy experienced a steady decline. Economic activities stagnated due to lack of raw materials and high operating costs. The production and export of cash crops slumped drastically. Large budgetary deficits and poor fiscal management resulted in high inflation and reduced standards of living for a large segment of the population. Over-valued currency and a fixed exchange rate contributed to decreasing exports and periodic shortage of foreign exchange. Also three years of severe drought and widespread bushfires in the early 1980s resulted in acute food shortages. Added to these problems, in 1983 about one million Ghanaians were expelled from Nigeria, to aggravate the already poor food situation.

For the health sector, the picture was even bleaker; inadequate financial resources had badly affected the supply of drugs and other medical supplies. In some public health centres, so critical was the situation that in patients provided not only their beddings, drugs and food requirements, but also stationery for their medical records. The exodus of professionals from every sector of the economy affected the health sector also (Senah 1989).

The Provisional National Defence Council Government which had overthrown the Third Republican Government was forced to act quickly to save the health sector from imminent collapse, more so when on the assumption of office it had accused the ousted government of "turning the hospitals into transit camps to our graves". In spite of its Marxist rhetoric, the PNDC embarked on a program of economic austerity and structural adjustment supported by the IMF and World Bank. Within this economic programme, user-fees were raise significantly. However in 1992, a total cost recovery policy for drugs (Cash and Carry) was introduced increasing further legal user-fee payment in public institutions. The broad objectives of the (Ministry of Health) MOH cost-sharing policy was to increase revenue from user-fees and to use the revenue to improve the quality and availability of services. It is the expectation that user fees graduated according to poverty level would create incentive for patients to use primary health services and that fees would encourage people to become more responsible for their own health care.

While it is generally accepted that cost-sharing can generate revenue for health services (World Bank 1987; Creese 1991; WHO 1993; Kutzin 1994) debate continues regarding the impact of user fees on health services utilization, health status, quality of care, equity and household welfare. Proponents argue that user fees not only provide revenue but can also improve the quality and scope of services as well as promote efficient revenue utilization by discouraging unnecessary care (Griffin 1988). On the other hand, it is cautioned that user-fees may raise relatively little revenue, may discourage necessary utilization of health services, and may not improve the quality of care (Gilson 1988).

Performance Evaluation

To be fair to the MOH, it may be said that cost-sharing has generated much revenue for the health sector. Expressed as a proportion of government-financed MOH recurrent expenditure, total revenue for user fees averaged 10 percent in the 1990s. In real terms, revenue from user fees grew considerably over the period. However, the largest proportion of user fee revenue comes from drugs charges. This is especially true for smaller health facilities, which do not raise revenue from in patient treatment or diagnostic facilities. It is also apparent that the bulk of revenue comes from a small number of large urban facilities. While it is clear that user-fees generate substantial revenue for the health sector, it is important to consider whether these gains have reflected in the quality of care. While this is difficult to prove one way or the other, there is anecdotal evidence that there is an inverse relationship between user-fee payment and quality of care. Indeed, while the drug supplies in the hospitals have improved considerably, it is evident that patients generally cannot afford the cost of treatment, especially in surgical cases.

While writing this paper, I received an insightful letter from my female postgraduate student who wanted to explain to me why she had failed to present her dissertation chapters. Permit me to quote the relevant portion of her letter:

Actually, I thought I could brave it to the end of the semester but it went out of control and I had to miss a few semester papers to undergo surgery to save my life.

To cut a long story short, I bled for the greater part of last semester due to uterine fibroid. Korle-Bu demanded ₵4.5 million for the surgery but because I could not raise such an amount, I had to contend myself with treatment from a computer herbal clinic at Madina. This did work to some extent ... I was eventually hysterectomised at the Volta Regional Hospital at the cost of ₵2.5 million.

How many ordinary Ghanaians can afford this? Indeed, there are many people who hardly utilize medical facilities both public and private because they cannot afford the cost of services. Korle Bu Hospital has a long list of patients who have absconded due to inability to pay. At the maternity ward, some abscond leaving their babies behind. In the regional hospitals especially, many patients are refused treatment because they cannot make the initial deposit demanded.

Confronted with such scenarios, health officials are quick to argue that there is an exemption policy for the indigent, the aged, the under-five year olds, pregnant women (for antenatal clinic attendance) and for people who are lepromatose or afflicted with contagious diseases such as tuberculosis, HIV/AIDS and sexually transmitted diseases. However, like most policies, these exemptions exist on paper only. In the rural areas most exemption-eligibles do not know about this facility. And even if they know, they are denied the facility because health centres, which operate this policy, are not reimbursed early enough.

In the Northern, Upper East and Upper West regions where poverty is rife and maternal mortality rates are very high, in addition to free antenatal services, delivery has also been made free. This notwithstanding, the expected level of services utilization has not been realized. In my study in these regions, it became obvious that the cash nexus was an important consideration here. As many husbands argued, should there be any complication which would require their pregnant wives staying in the hospital longer than necessary, they would not be in a position to pay. Thus when labour sets in, women ingest *Kalugotim*, a local oxytocic, to speed up labour contraction. This, as reported in the *Daily Graphic* a few months ago has resulted in several cases of ruptured uterus and death.

Perhaps another important reason for the poor utilization of maternal health services is the unpreparedness of sub-district health centres for most obstetric emergencies. All the sub-districts health centres visited in the three northern regions were poorly staffed. And none had complete delivery set and functional autoclaves. We cannot win the war against maternal mortality under these circumstances.

Pharmaceuticalization

The commodification of health care has inadvertently fetishised pharmaceuticals as a critical component of health care delivery in Ghana. The level of drugs supply has become an important barometer for assessing the political stability of our country. This is true in a context where pharmacovigilance is very weak. In our part of the world, cosmopolitan medicines have sold themselves very well. As Bledsoe and Goubaud (1988) have aptly observed, they are as available as Coca-cola. In every therapeutic encounter, the patient expects to receive something—medicines or prescription. For the doctor and patient alike, handing out a drug is a much simpler conclusion to the encounter than recommending a preventive action, which in our poor and insanitary environment could well be more appropriate and even cheaper. The demand for medicines is almost without limit. Any frailty is believed to command a drug. Consequently, the pharmaceutical industry is in good business.

Several researchers have shown how the politics of the industry ensures such a fixation and the consequent harm it does to people, especially in the developing world (Kanji et al. 1992; Melrose 1981; 1982; Silverman et al. 1976). Describing the effects of dependency on drugs, an Indian ayurvedic vaidya has made an analogy between drugs and eye glasses. He observes:

Allopathic medicines are like eye glasses. Once you put them on, your eyes do not improve; they become dim with continued use and you come to depend on them more and more. Eyeglasses are not bad, they are useful for those who grow old. They are a good crutch, but if one does not need a crutch this may be a bad thing. One leans on the crutch and does not strengthen the eye, one takes medicines and does not strengthen the body. One becomes dependent on the medicine bottle. The company becomes strong, the body remains weak. (Nichter 1989: 194-5)

As the *vaidya* has rightly observed, the more medicines we take the weaker the body becomes and the stronger the pharmaceutical industry becomes. In Ghana, drugs are sold literally by any person. And they are used for the wrong conditions, in wrong combinations and with wrong or sub-therapeutic dosages. The extent of the public health hazard posed by this situation has not yet been appreciated by health policy makers because of the dearth of empirical studies on this phenomenon. However, for lack of time, let me quote three instances of how pharmaceuticals have been indigenised and the result of this:

Wolf-Gould et al (1991) wrote:

While working at Korle-Bu Hospital... we learned about a young male patient who was admitted with aplastic anemia. The previous year he had recovered from typhoid after receiving treatment with a course of oral chloramphenicol. He was so impressed with the drug that after discharge, he began to buy chloramphenicol from vendors in town and took two a day to prevent further illness. He developed aplastic anemia ... and died several days after admission.

The *Mirror* of July 18th 1992 reported:

A 20-year old mother of two died shortly after a relation administered to her an enema containing a mixture of Guardian soap, TCP (an antiseptic) and some tablets through the frontal passage in an attempt to abort her two month old pregnancy.

Again the *Mirror* of September 14th 1996 reported:

A 21-year old woman died shortly on admission to hospital after she had drunk a concoction of washing blue, and twelve tablets of chloroquine in an attempt to terminate her pregnancy.

Such stories are often reported in the tabloids as if to entertain readers but they point to serious medical problems in the society.

Conclusion

In the Third World, today, the false sense of security rendered by the prevalence of medicines for health as well as illness has reduced society's impetus to actively mobilize itself for promoting environmental health and sanitation. It is evident that prevention of diseases by social improvements and environmental management is a more promising avenue for enhancing health than merely increasing expenditure on medical technology. Indeed, it is often argued that the principal determinant of health in any society is basically nutritional status and the quality of the environment. In globalizing our health care system this self-evident truth seems to have been forgotten.

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