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"Villagers": Differential treatment in a Ghanaian hospital

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Abstract

Differential treatment of patients by health workers in African medical institutions is acknowledged by patients, health workers and policy-makers alike to be an obstacle in the realization of government objectives of equity in health care. This qualitative study understands the production and legitimization of differential treatment from the perspective of health workers. On the basis of qualitative field material from a hospital in Northern Ghana the relation between socio-cultural, biomedical and bureaucratic aspects of hospital practice is explored through a focus on categorizations of patients. It is concluded that to blame the "bad attitudes" of health workers for differential treatment is not an adequate explanation. It is important to acknowledge that differential treatment can be understood as a form of agency, and is related to the conditions of hospital work and to the professional and social identities of health workers.

Keywords: Health workers; Hospitals; Differential treatment; Patient categories; Bureaucracy; Ghana

Introduction

Complaints about the poor behaviour of health workers in African health care systems have been reported from all over the continent. Despite health workers' perceived role in attracting or repelling patients from health facilities this issue has received little attention in social science research. In political and administrative settings there is a general agreement that health workers suffer from an "attitude problem". This is an assumption that health workers have forgotten or misunderstood or that they deliberately ignore their practical and professional responsibilities. Indeed, all health workers have been made familiar with the professional ethics of health work and ideas of altruism and impartiality during their training, and yet many of them fail to perform accordingly. They provide different services for different patients: they are corrupt, rude, and indifferent to some patients, while others (often family and friends) receive services of a higher standard.

However, the "attitude explanation" has a definite limitation. At a fundamental level it confirms a die-hard assumption that the ideal hospital is an objective and rational institution, and that therapeutic interaction can and must remain unaffected by personal interests and socio-cultural forces such as kinship-based priorities, status negotiations, etc. Consequently, health workers are seen as responsible for bringing undue social priorities and cultural norms into their ideally "culture-free" work place, thereby obstructing institutional and professional aims and codes of behaviour.

However, putting the blame for poor behaviour on the health workers alone blurs the fact that there are other important forces at play in the interaction between staff and patients in health facilities. Serious resource deficiencies, poor working conditions, underpayment, understaffing, etc., are important and obvious catalysts of malpractice, but I will focus on the more subtle relation between patient categories and differential treatment, because it is central to a thorough understanding of hospital practice.

A hospital is a bureaucracy, whose units, hierarchies and roles are defined in relation to a biomedical discourse involving specific categories of actors that sets the stage for their interaction (cf. Turner, 1987). Despite established recognition that an understanding of health care systems must include "health bureaucracies" (Kleinman, 1980, p. 26), the role of the organisational

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layout in health service delivery has largely been overlooked in studies of health care. On the basis of field material from a regional referral hospital in Ghana, I will approach the problem of differential treatment of patients by looking at the interplay between the socio-cultural setting, the biomedical discourse and the bureaucratic organisation of the hospital. I will argue that these three aspects generate similar ways of categorising patients. This categorization contributes to the legitimisation of differential treatment of patients in Ghanaian health care facilities, which therefore is not simply a question of health workers having ignored or misunderstood their institutional role.[1] Differential treatment should rather be understood as a form of agency within a complex institutional setting.

Setting

The material for the analysis was generated in a field study undertaken in 1998 in Northern Ghana among staff and patients in Bolgatanga Regional Hospital.

Ghana is located on the south-central coast of Africa, bordering on Togo, Burkina Faso and Cote d'Ivoire. Following independence from British colonial rule in 1957 the country was in reality divided into two parts. For purposes of production and economic gain the fertile south had been provided with better infrastructure, health and educational facilities than the dry, barren north—an imbalance that still haunts the Northern Ghana today. During the 1970s and 1980s Ghana experienced a steady weakening of the economy, and worsening conditions for trade on the world market. A severe drought and the forced return of expatriate Ghanaians from Nigeria let to a serious famine in 1983 and 1984. In 1983 a Structural Adjustment Programme was launched, which had a stabilizing effect on the economy, but also further burdened the poor as the government gradually divested itself of the provision of social services (Senah, 1997, p. 56). Today, access to health care and education remains a problem, particularly in the rural north, although the coverage and utilization of public health services has increased over the last decade (World Bank, 2003). The three northern regions are inhabited by a third of the total population, but in 1998 held less than 11% of all health facilities and only 7% of government-employed doctors (Jespersen, 1998, p. 94).[2]

The Upper East Region is one of the poorest and least fertile regions in Ghana. Most people rely on subsistence farming for their daily needs and have very limited access to cash. They live in small village communities without electricity, running water or sanitary facilities. The rural poor make up the larger part of patients in Bolgatanga Regional Hospital, which is the main government health facility and referral hospital in the Upper East Region. Outpatient attendance in 1996 reached a total of about 63,000 patients. The hospital runs seven wards with nearly 200 beds, and admissions in 1996 reached approximately 6000 patients for an average stay of almost 4 days. Staff with curative or caring functions includes a dozen doctors, a few medical assistants and more than 100 nurses, including nurses specialized in midwifery, anaesthesia and psychiatry as well student nurses (Bolgatanga Regional Hospital, 1996). The majority of medical officers and assistants employed at Bolgatanga Regional Hospital come from other parts of the country, and most of them do not speak any of the local languages. Many of the nurses, however, are local women educated in a nearby nursing school. The health workers at the hospital consider Northern Ghana to be an unattractive posting for several reasons: A general north/south bias casting the rural north as less developed and more "primitive" than the south, the harshness of the climate, understaffing in health facilities and the lack of hospital resources to provide facilities for staff members (accommodation, etc.). Furthermore, there are very few good schools for the education of their children and only limited opportunities to generate additional income in the form of a shop, a piece of farmland, private consultations, etc.

The working conditions at the hospital reflect the resource deficiencies in the health care system in general. The buildings are deteriorating (parts of the electrical and sewage system are out of order for instance) and equipments are faulty or lacking, making it impossible to carry out even basic hospital procedures.

The most common alternatives to biomedical health care are the herbalists, diviners and traditional birth attendants who are present in most villages and church-based healers who are found mainly in urban settings. The exact distribution and use of these types of treatment has not been recorded, but in 1995 the Ministry of Health (MOH) estimated that about 50%

[1] The analysis of differential treatment would benefit from the inclusion of other issues which are beyond the scope of this article. These issues have been discussed elsewhere and include parameters of patient satisfaction (Andaleeb, 2001; Gilson, Alilio, & Heggenhougen, 1994; Jackson, Chamberlin, & Kroenke, 2001), abuse of patients as professional control (Jewkes, Abrahams, & Mvo, 1998), the impact of health workers' informal economic activities on quality of care (McPake et al., 1999), health worker motivation (Franco, Bennett, & Kanfer, 2002), etc. See also Cohen (1980) and Price (1975) for work on bureaucracies in developing countries, and Lipsky's (1978) instructive book on street-level bureaucracies.

[2] In 1991 the Upper East Region had approximately 1 physician per 55,000 people. The average allocation in Ghana as a whole amounts to 1 physician per 16,673 people (Senah, 1997, p. 58).