Ghanaian nurses at a crossroads: Managing expectations on a medical ward
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Citation for published version (APA):

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Tradition and modernity
Concepts of health in Ghana

When it comes to defining health and illness in Ghana, we find the interplay of traditional beliefs, religious convictions and personal experiences with health facilities of scientific medicine. This chapter will describe the beginnings of Western medicine in Ghana and its development up to today, while setting it next to the traditional medical system.

Traditional medicine in Ghana

Traditionally, Ghanaian society is an integrated one; illness is understood as a combination of social events and the supra-natural and health and illness are parts of the whole magico-religious fabric (Twumasi 2005: 8). Disease is seen as “a painful thing” (Ventevogel 1996: 15) reflecting a disturbance in the harmony between the elements of social and physical life. In this framework, the cause of diseases is sought in witchcraft, bad medicine, misfortune or spiritual forces and scarcely by natural forces alone. We can separate four types of traditional healers: herbalists, spiritualists- diviners, faith healers, and traditional birth attendants, in addition there are bone-setters and modernised herbalists (neo-herbalists). Their explanatory model is based on physical and social causation of diseases and services provided include consultations, treatment and prevention. The knowledge of traditional medicine has evolved over generations, and skills are passed on through apprenticeship training. Traditional healers practise an individualised approach to diagnosis and

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18 Many discussions have taken place on how to call the germ-based medicine that was imported into traditional societies during the colonial era. Terms suggested are Western medicine, scientific medicine, modern medicine, hospital based medicine, biomedicine and so forth. The same, there is a discussion how to call the traditional or indigenous medicine. As my main point is to distinguish this type from traditional healer-based medicine, I will use these terms interchangeably.
treatment, and the small number of patients per healer is attractive to many Ghanaians. In 1964, the Ghana Psychic and Traditional Healers Association was founded to organise healers and to co-operate in the health care delivery in Ghana (GSS 1998, Ventevogel 1996, Oppong 1989). Today, the Ministry of Health estimates that between 60 and 80,000 traditional healers are practising in Ghana, providing care to about 60 to 70% of the population, especially in the rural areas. A relatively new phenomenon in this group is the healing sessions and prayer camps led by pastors of spiritual and charismatic churches and modernised herbalists.

The beginning of scientific medicine in Ghana

According to historical sources, Western medicine came together with the first European traders to the African continent in the 15th century. It is mentioned that medical men were “on duty around Accra in the late 18th century” taking care of the Danish employers (Addae 1996: 11). Health problems were those illnesses the Europeans brought along like smallpox, measles, syphilis and gonorrhoea, In addition, they had to face parasitic diseases like yellow fever and malaria. In 1844 the first British medical officers arrived on the Gold Coast to take care of the colonial administrators. In addition, mission posts and churches brought medical staff to the colony. In 1872, Britain became the sole European power on the Gold Coast and started investing in the country by expanding the administration and constructing infrastructure. This led to a rapid rise in the European population and a growing demand for Western health facilities. Hawe summarises:

The scant knowledge of tropical fevers and the crude form of surgical practice then known to the European doctors proved hopelessly inadequate. The forts and trading stations were decimated by disease, and the continued high mortality earned for the Guinea Coast the nickname of ‘the Whiteman’s grave’. Among the fevers were malaria and black water… With the planning of Christianity the missionaries brought a new and more philosophical approach to the nature of disease. In addition to preaching the gospel, they attended the sick and established schools and hospitals. (1962: 15)

Parallel to the endeavour of the colonial administration, the various missions brought in doctors and nurses as well. The Basel mission, out of which the Presbyterian Church of Ghana evolved, sent their first medical doctors in the 1830s to the Gold Coast, but most of them died within a short time of fever or hepatitis. Around 1882, after a dispute over whether dispatching medical services showed religious weakness or displayed Christian responsibility to mankind, another group of missionary doctors travelled to and through the Gold Coast and built the first missionary hospital in Aburi, in the hills north of Accra, and later in Agogo (Schweitzer 2000). Treating the sick was understood as part of the missionary work aimed at converting the Africans to Christianity. Health conditions were still poor by the end of the 19th century, as Mary Kingsley describes in her West African Travels. She
remembers an epidemic killing almost half of the European population in a few weeks and concludes: “there is another cause of delay to the development greater and more terrible by far than the labour problem – namely the deadliness of the climate” (2003: 41).

1878 can be seen as the official beginning of formal medical work in Accra, when huts were erected to serve as medical posts for the government forces (Twumasi 2005: 65). In 1880, the Gold Coast Medical Department was established to organise and supervise preventive services like vaccinations and sanitation. In 1899 the first British nursing sisters arrived and started nursing in Ghana. In the beginning, there was much resistance within the African population to consult them, let alone assist the medical doctors and nurses. The traditional system opposed the concept and practices of Western medicine that was so different from the traditional cosmological order. Patterson writes: “The colonial physician was often a puzzling figure for Africans. He was usually a white male stranger who had to use an interpreter. He often asked impolite questions, demanded, for reasons unknown to the patient, samples of blood, urine and faeces; and sometimes cut open the bodies of the dead. On the other hand, he frequently had great power over sickness and injury.” (1981: 15) A few men were finally trained as orderlies to assist in washing the sick, dressing the wounds and in administering the drugs; traditionally women were not expected to work outside the family compound.

By the beginning of the 20th century, there were few hospitals, mostly in the bigger towns and almost exclusively for Europeans. Governor Clifford developed plans to restructure and improve the health care system in the 1910s, but the economic and social crisis caused by the First World War hindered its realisation. Sir Francis Guggisberg, Governor on the Gold Coast between 1919 and 1927, laid the foundations of institutionalised health care. He introduced a ten-year development plan for the Gold Coast and his impact on the sanitation and health improvements cannot be over-emphasised. In one of his first speeches he stated: “… I promise the people of the Gold Coast … I am sent out here to superintend the construction of a broad Highway to Progress along which the races of the Gold Coast may advance …” (Buah 1998: 111). There were two parallel developments that made improved health services more urgent: the European population rose, but the mortality among Europeans was still high and alarming. In addition, it was recognised that the success of the colonies depended on the health of both Europeans and Africans, leading also to an end of the segregation (Curtin 1992: 243). In addition, medical discoveries brought new insight in illness causation and disease prevention and offered new treatments. Understanding the (economic) value of health, the needs of both groups became a major goal of Guggisberg’s governorship (Addae 1996: 28). During his time, the country underwent political, social and economic developments. Next to the construction of the harbour in Takoradi and the expansion of highways and railways, the establishment of regulated formal education, his main accomplishments were country-wide steps to improve the sanitation and mass disease eradication programmes. Guggisberg aimed at catering for the whole population and started to plan the
building of hospitals in the whole country. Korle Bu became the model for a ‘general’ hospital for the whole nation. The government presented a public health policy and implemented large parts of it. The expenditure on health services varied between 15 and 18%, the highest ever (Addae 1996: 54). Indeed, this period can be seen as a golden age in colonial health policy, with the building of hospitals and improvements of general sanitation. The statue of Guggisberg in front of the administration building in Korle Bu Teaching Hospital and the naming of the street in front of the hospital are visible signs of the gratitude of the people for Guggisberg’s work. Yet no more than 10% of the African population had access to those facilities.

The health problems by then can be described as mainly environmental. Poor sanitation, insufficient supply of clean water and malnutrition weakened the population and tropical diseases like malaria, worm infestation, yaws and tuberculosis were common (Twumasi 2005: 66). In the hospitals, the main diagnosis was pulmonary tuberculosis, lobar pneumonia, anaemia and epidemics of yellow fever, while malaria was the main cause of infant mortality (Hawe 1962: 16). Scientific medicine could offer successful treatment here and with time, acceptance grew. The parallel introduction of formal education and urbanisation had additional positive influence on that process. Educated young and urban people were more likely to use and accept modern medicine, being far away from their families and the traditions of their communities. As it used to be the head of the family taking the decision when and where to seek medical treatment, there were now alternative ways to choose from. In addition, local people working for the colonial administration had it as part of their job contract to seek medical treatment in hospital. These ideological and social changes led to increased use of scientific medicine.

Between 1920 and 1960, health centres were built all over the country, increasing the number of government hospitals from 17 to 40 but neglecting the rural areas. The worldwide economic crisis stopped further expansion but even so African confidence in modern medicine increased. There were insufficient facilities, resulting in overcrowded wards, an inadequate number of medical and nursing staff and a deterioration of sanitary conditions. Only one or two indigenes were sent to Edinburgh for medical studies per year. The first indigine to be trained as a doctor had been Dr. William Benjamin Quartey-Papafio, who entered the government Service in the 1890s. Dr. Barnor (1962, 2001) who was selected in the early 1940s to study in Edinburgh gives a vivid description of his studies and work as a medical doctor these years of shortage. Like his fellow students, he received a basic training in the UK but had difficulties to enter the Colonial Medical Service due to lack of practice. This led to the situation that almost half of the doctors left the public service soon after return to the Gold coast and started private practice.

Reflecting on the introduction of Western medicine in Africa, it is necessary to touch on the underlying ideology. The 19th century was characterised by imperialistic politics, colonialism and scientific discoveries. This led to a shift in thought towards an objectification of the human body and individualisation of the person. Foucault analyses the rise of hospitals in
France, its social implications and the construction of power between actors and the formation of the body as site of power relations (Foucault 2003). Those ideas were carried to the African colonies to meet a completely different thought-system. The first doctors and nurses in Africa saw themselves “armed only with faith and medicine” in their fight against wilderness and nature (Vaughan 1991:1). The practice of Western medicine can therefore be seen as the stage on which the difference between the individualised Christian European and the traditional non-individualised African was located and enforced. Hospitals were places to maintain and control this difference. Public and mission hospitals transported those individualised and science-based ideologies on healing and defined ‘the patient’ taken out of his social group into the new system. Ideas of ‘the other’ and the thinking in dichotomies like ‘black- white’, ‘nature- culture’ and ‘bad- good’ carried the construction and imagination of ‘Africa’ and influenced economic and political decisions.

Health delivery in post-colonial Ghana

Ghana’s first President, Dr. K. Nkrumah, stated: “We shall measure our progress by the improvements in the health of our people … the welfare of our people is our chief pride” (Buah 1998: 166). The young nation faced a poorly developed health system and the population faced many health problems, reflected in a life expectancy of 45 years. Following socialist and nationalist ideals, improving this situation became a priority of the first government. It led, among other things, to free social services like school education and hospital care. The Ministry of Health was created in 1953 to replace the colonial Medical Service Department. Under the first minister of health, Mr. Imoru Egala, the building of more health centres became a priority. Parallel to this, the number of medical doctors increased after independence from 330 to about 960 in the late 1980s while that of nurses grew from 800 to over 5,000. The foundation of the medical school at Korle Bu in 1964 and the opening of nursing and midwifery training colleges were aimed at improving the situation further. But the economic decline of Ghana led to poor health facilities and an unsatisfactory supply of drugs and materials; patients seeking help in the hospitals had to cater for their own medication, bed linen and even stationery for their medical records (Senah 1997).

During the decades of political unrest and military regime, Ghana experienced an economic crisis that had implications on the health sector. The lack of maintenance in the health centres, especially in the rural areas resulted in deteriorated infrastructure and outdated equipment, and inadequate funding of the health sector worsened the already limited supply of drugs and necessary materials. Health professionals like doctors and nurses left the country in a mass exodus aiming to work abroad. This shortage of personnel had several implications: along with the concrete lack of workers, the health service could not plan and organise the sector, and with those professionals, an important part of the Ghanaian middle class disappeared. Dugabay (1999) has compared the
national health policies of several sub-Saharan countries between 1980 and 1990 and finds Ghana’s health status in a critical stage. Weak economic development and low stage of policy development leads to systematic problems: rural areas are neglected while hospitals and urban centres are favoured, the constraints in manpower are reflected in numbers and allocation of workers. “A striking finding was the noticeable mismatch between policy pronouncements and actual implementation as related to decentralisation and resource allocation within the framework of PHC” (1999: 228). Key problems during this period are the absence of planning, poor procedures, and an unrealistic and unconvincing budget. The Alma Ata Declaration of 1978 for ‘Health for All by the year 2000’ aiming at 80% coverage of the population by primary health care was welcomed but could barely be implemented. Health care was either not available or of poor quality. Fosu (1989) confirms these findings in his research on access to health care in Accra. Uneven access to facilities and the concentration on hospital-based curative care instead of preventive and educational programmes lead to continuous health problems. The disregard of the private sector, traditional healers and drug sellers through the official bodies intensify the situation. The political instability, socio-economic crisis and financial constraints increase self-medication and visits to traditional healers; the poorer health became, the more use was made of clinic services. Fosu concludes with a call for medical pluralism to improve the health status of the population. His call remains almost unheard, the exodus continues and in the 1990s, about 30% of Ghana’s trained health workers left the country to work abroad.

Health delivery in modern Ghana

The 2000 census counted more than 1,100 doctors and 13,000 nurses, of whom one third worked within the Greater Accra Region. These numbers indicate shortfall of 50 to 65% in the public health sector (Nyanotor 2004). Most health workers want to stay within the metropolis of Accra or Kumasi where there are better-equipped hospitals, higher living conditions and the patient-population is more educated; indeed while only about one third of Ghana’s population lives in urban centres, more than two thirds of the health personnel work there (Twumasi 2004, Ventevogel 1996). This is in sharp contrast to the needs of the health service. In the rural areas, malaria and communicable diseases are still the main causes of illness and death and call for more medical and nursing staff in those remote areas. Horton (2001) details the inequality between the urban south (Accra) and the northern regions, with an infant mortality rate of 41 and 70 per 1000 respectively.

Today Ghana has two teaching hospitals (in Accra and Kumasi) in addition to nine regional, 92 district hospitals, 210 private or missionary hospitals and about 1,200 health clinics and posts, providing more than 20,000 hospital beds for 22 million Ghanaians (GHS 2005). There are 1,168 medical officers and 13,971 professional and auxiliary nurses working in these
While these numbers represent an increase, the provision of health care facilities has not kept pace with the growing population, leading to a population-doctor/nurse-ratio of 1:17,900 and 1:1508 respectively. These numbers have to be seen in perspective, as more than one third of all health staff works in the Greater Accra Region making it the best served region in Ghana. In term of access to care, about 40% of the population is estimated to live more than fifteen km from a health facility with rural areas being generally more deprived (Ghana MoH 2003, Arhinful 2003).

Health service and delivery is organised by two state organs: the Ministry of Health (MoH) and the Ghana Health Service (GHS). The MoH seeks to improve the health status of the whole population by providing policies, access to health facilities and supervise the quality of the service. It works to level out inequalities between and within regions and give priority to programmes relating to HIV/AIDS, malaria and immunisation. The government spent about 13% of the health budget in the recent years. While the MoH is the policy maker, the Ghana Health Service is the service provider. It was created in 1992 as an autonomous agency to implement national policies under the motto “Your health our concern.”

The Chief Nursing Officer is today part of the GHS. In an interview in the autumn of 2005, she expressed her wish to return to the ministry to be part of decision-making on all sectors concerning health delivery in Ghana. For now, all public nurses work under the GHS and are posted by it after graduation to a health institution somewhere in Ghana. A problem nurses face is the centralisation of the organisation. Nurses from the whole country aiming for promotion must to come to Accra for interview. This has two major disadvantages: the paper work and travelling lead to delay and mistakes. The interviewers do not know the candidates, and cannot support objective assessment, while those superiors working with them in the field find it difficult to report accurately about the candidate’s efforts and work experience.

Just as Ghanaian society is between continuity and change, so too is the individual when it comes to health-seeking behaviour. The choices for treatment are based on experiences and combining traditional and Western treatment is not perceived as contradictions but a rather useful mixture. The complex formal and informal health facilities and the problem of accessibility given the urban bias of health facilities form together with cultural norms and post-colonial experiences, a continuum to which the individual looks for an explanation and therapeutic options in case of illness (Senah 1997, Ventevogel 1996, Takyi 2003). Bierlich (2000) describes the ambivalence towards biomedicine that is seen as attractive and powerful but also feared. Everyone agrees on the advantages that Western medicine has, such as the impressive reduction of high infant mortality rate from almost 250 to 58 per 1,000 (compared to 76 in low income countries and six in high income countries; see

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20 Nurses working at the autonomous teaching hospitals are exempted from this rule and contracted directly.
21 According to health statistics, 60% of the infant mortality is caused by malnutrition.
Buor 2004), eradication and reduction of several diseases and country-wide immunisation programmes leading to a rise in the quality of living and the longer life expectancy (57 years in Ghana as compared to 78 in Germany and 49 in Nigeria (WHO 2006).

But there is also criticism of the system. Next to the rural-urban discrepancy in service provision, the main problem mentioned is the service differentiation and impersonal approach. While the traditional healer works holistically, hospital care is split into several parties. The medical doctors relies on the results produced in a laboratory or examinations leading to an indirect diagnosis and patients find it more difficult to establish a direct rapport with the busy overworked medical officer while such a rapport is essential in the traditional belief system to regain complete health (Twumasi 2005). Fosu (1989) reports his findings from health-seeking behaviour in Accra, that both traditional and modern medical care was sought and requested by the urban population irrespectively of religious background, age or economic status. The field of psychiatry is another area where the limits of Western medicine can be seen. The individual approach and reaffirmation of the person are to the forefront. Families and individuals with psychiatric, psychosomatic and related health problems tend to seek help from traditional or religious healers first before turning to hospitals. In conclusion, in taking a decision, the individual is influenced by the rural or urban living, education and the availability and accessibility of medical treatment and the role of kinship.

Health problems

During the initial period after independence, two health problems were prominent: high infant and maternal mortality. Medical field units, research and health education programmes started to decrease the numbers, introduced immunisation campaigns and improved the general state of sanitation. According to the health survey carried out in 2003 and confirmed by official figures in 2005, the main health problem in all age groups is still malaria (35 to 55% of all consultations), followed by acute respiratory infections in younger age and hypertension in the group above 45 years (Ghana Statistical Service, 2003). More than 70% of the disease burden is caused by communicable diseases like malaria and respiratory infections (Songsore 2004: 19). Akiwumi states the need to be forward looking and anticipating the signs in regard to changing health patterns and needs (1992). The most common disease is still malaria, and other preventable infections, like regional outbreaks of cholera, enteric fever and tuberculosis, return in waves due to insufficient hygiene. For 20 years, the incidence and prevalence of HIV/AIDS have increased, posing new challenges to patients and health workers. The prevalence is stated to be 2.1. The rise in health status and changing life styles have brought along new diseases like hypertension, diabetes, obesity, cardiovascular and behavioural diseases and various forms of cancer (Amoah et al. 2006). This is reflected in
the main causes of mortality in hospitals in the Greater Accra Region, beside malaria cerebrovascular accidents, cardiopathy and anaemia.

In the urban centres, two diseases are increasing: hypertension and diabetes. Hypertension is defined as blood pressure above 140/90 mmHg. Adoo (2006) and Duda et al. (2006) carried out research in the Greater Accra area and found about 25% of the women were suffering from hypertension. While this number corresponds with country-wide trends showing that the prevalence in semi-urban settings is about 28%, some factors are worthy of note: there seems to be no correlation with age, income and education, but the rise of hypertension is linked with obesity and multiple pregnancies. A changing lifestyle leads to less mobility and physical work and the diet shows little emphasis on vegetables and fruit. The low level of awareness and treatment of hypertension is alarming; less than 50% of the already diagnosed women reportedly take regular medication and seek medical check-ups. Chronic and untreated hypertension can lead to ischemic cardio-vascular and renal diseases. Diabetes has not been a real issue in health education and policy strategies. Data on this are unreliable, suggesting a sub-Sahara prevalence of 0-2%. However, recent research with 4700 persons presented a prevalence rate of 6.3% in the Greater Accra Region, involving mainly unknown or newly diagnosed cases (Amoah et al 2006). Educational programme and the training of health workers across the country in the late 1990s show first results by diagnosing new cases leading to a tripling of the numbers. Older people and men are highly represented. As with hypertension, there is little awareness of the disease and its side effects. In addition the treatment is costly and forms a burden on the poor financial situations of most households. It is suggested that the trend of urbanisation threatens to bring bigger health problems alongside modernisation.

Ghana’s Health Insurance System

Traditionally, Ghanaian society is based on reciprocity and solidarity within the (extended) family. In times of need, individuals turn to their family to mobilise (financial) resources in exchange for past or future investment in social capital formation. With the trend of urbanisation and migration, this system of social security is under threat and can fail to function. The colonial system introduced a new organisational model that was based on the market and the formal sector. Only few could participate initially, and from the beginning Ghanaians had to pay for the services rendered, be it directly or via poll taxation (Arhinful 2003: 34). In 1898, the Hospital and Dispensary Fee Ordinance was enacted, exempting only paupers and civil servants. This continued till 1954 when the

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22 The latter is also confirmed by my own observations. Vegetables are used to prepare stews and soups, but hardly consumed as food alone. Similarly, fruit is rarely eaten on a regular basis although several sorts (banana, oranges, papaya, mango) are available for a reasonable price. Independently, several Ghanaians stated that fruits are not valued, and hypertension is not seen linked to overweight or lack of balanced food.
new Ministry of Health recommended the abolition of hospital fees and charges, but keep prices for drugs dispensed. As there was no functioning tax system in the Gold Coast, the financing of the health system created an eternal problem. (Arhinful 2003: 47).

After independence, the President of the First Republic, Dr. Kwame Nkrumah launched a ten-year plan including the reduction and in most cases abolition of costs for users of the health service, leading to an escalation of the financing problem. The military regime that overthrew Dr. Nkrumah reintroduced fees and enforced their collection. The Second Republic under Busia passed the Hospital Fee Act 1971. But the economic and social crisis in the country between 1975 and 1985 led to the collapse of many health facilities, and to problems in implementing the new Primary Health Care strategy. Necessary drugs were not available and many health workers, nurses and doctors, left Ghana to work abroad. In 1985 came a more specified Regulatory Law on that matter and both UNICEF and WHO purchased drugs and sold them at affordable prices. By 1992, the regulations were restructured and the ‘Cash-and-Carry’ system started to operate. This meant “a gradual diminution in the utilisation of health facilities because of affordability, resulting in 69% of the population being unable to attend/use the health service. The majority resorted to self-medication, herbal or traditional medicine, or healing crusades or prayers or resigned themselves to their fate not by choice but purely because they cannot afford health care” (Akosa in Arhinful 2003: 54).

Figures show that about 20% of the population need medical help, but of these only about one fifth can afford the costs involved (Korle Bu Bulletin, November 2006: 8). Country Health Indicators from the WHO indicate that Ghana had in 2003 a per capita gross national income of $320 with almost 45% living under the poverty line, and the per capita health expenditure was $17. Under the last NPP government, the decision was made to end this injustice and introduce the National Health Insurance Scheme (NHIS). The NHIS, organised per communities and districts, is to replace the individualised out-of-pocket payment at service delivery points, which often puts untold burden on family resources. This was based on the notion of the authority of the state demanding a new form of solidarity built on the notion of a nation, in which all members, irrespective of lineage connections or tribal background must contribute. As in other sub-Saharan countries, this new insurance system met much resistance from the beginning. As Vogel showed in a study of 23 countries, only seven had a formal health insurance scheme and the percentage of registered persons ranged from one to 14% (Vogel 1990; Arhinful 2003). The government defined a minimum package of diseases that all schemes cover, comprising around 95% of all diseases in Ghana. This includes outpatient services like consultations, requested X-rays or ultrasounds, medications and physiotherapy and inpatient services like general care and accommodation, investigations and medication, surgical operations, cervical and breast cancer treatment and physiotherapy. Other services included are oral and eye care services, maternity care including antenatal check ups, deliveries,
Caesarean sections and postnatal care, all emergencies (medical and surgical), and dialysis for acute renal failure. There is a list with drugs that fall within the NHIS. Among those things excluded are HIV drugs, prostheses, echocardiography and angiography, dialysis for chronic renal failure, organ transplantations, heart and brain surgery, and cancer treatment.

The fees are graded according to one’s income. After registering and paying for the first year, the papers are processed and after several months the card can be collected and be used. The registration fee is ₡ 20,000, and ₡ 10,000 for the card. The annual contribution is differentiated:

- Free for children under 18 as they are registered with their parents and for old persons above 70, the unemployed and “core poor” (adults being dependant on constant support from elsewhere)
- ₡ 72,000 for students, apprentices, and the “very poor” (who can just meet their own needs)
- ₡ 180,000 for the middle income workers and employed persons (who are able to meet their daily needs)
- ₡ 480,000 for the rich and very rich (who able to meet their needs and support others)
- Civil servants and SSNIT contributors will have 2.5% taken from their salary

As all users have to register with their address, Ghana faced the problem of non-existent or irregular street- and house- numbering. This had to be done prior to registration, leading to an additional delay in the introduction of the insurance scheme. Finally, all houses got a cluster of numbers for identification and the registration could start.

The promotion campaign started in the summer of 2005 with adverts on television and in the radio, posters and newspaper advertisements, regular reports and interviews in the news and public subscription exercises in the villages and towns. The main picture used is that of a young mother using a broom to clean her compound. The slogan was that just as one stick breaks easily, many form a sturdy broom. Thus, health costs will be carried by the whole group of registered Ghanaians in solidarity. The reactions varied and many doubted that the system would work. Traditions and cultural patterns influence how people cope with diseases and expectations concerning treatment. In a culture where illness (especially a serious condition) is seen as a punishment for misbehaviour or caused by magical powers, saving money for eventual health care costs would mean to create an illness. In addition, the payment structure in the hospitals was and is a strict one. While in the traditional setting, family members would negotiate treatment and its costs with the healer, Western medicine had standard and non-negotiable prices. Up to today, patients and their families face huge and sometimes inexplicable costs when sick relations are admitted to a hospital. The family is expected to assist in paying the bills, but that can create frictions and revive past conflicts. One relative visiting a sick relation on the ward said: “She [the patient] never contributed to family issues, so now, we cannot support her either”, and a nurse commented: “Some time ago, the Ghanaian had the extended family. Now,
we’re all going back, falling back on our nuclear family in order to help us. The extended family system is not working well because if you don’t contribute to the coffers, you don’t benefit.” Once admitted to the hospital many patients fear the high costs and consider early discharge or a termination of the treatment in order to spare the limited household budget. But even so, this individual “cash and carry” system has problems, the benefits of the new scheme seem not to convince everybody easily. Patients form Korle Bu Teaching Hospital mentioned the following motives for postponing registration: there is the fear “They say that if you show the card, the doctors will not treat you as well as if you pay cash. I am not yet registered, maybe I will register later” (patient, 54 years). Others claim the annual fee is too high and the waiting period between registration and start of usage is too long. Others miss the coverage of treatment and medication for chronic ailments, or turn the idea down as they are not in favour of the NPP government. Nurses share some of these concerns, but most registered as staff of the hospital. Their fear is that “I can see already now that the patients will disturb us a lot. They will come and say that they have nothing to pay but wait for the card. They are poorly educated” (HCA, 20 years). Another joins in stating: “With the health insurance, you need personnel as well as human resources, and these things are not there. So how do we run the insurance, because you need to nurse the person or the patient perfectly in order for him not to complain? Because he has paid for it, so it becomes for us even more stressful. Because if he says I want a bed sheet and you don’t have a bed sheet, I want this to be done for me, and we don’t have, they will become very demanding because they’ve been taught their rights” (Regina).

By the end of 2005, only a very small percentage of the Ghanaian population had registered. Despite continuous promotion, the inhabitants of Accra especially seem resistant to the idea. The newspaper states that less than 5% of Accra had subscribed by November 2005 (Daily Graphic, 11.11.2005). In 2006, Korle Bu started to work with the NHIS card and the first patients attended the OPD or were admitted while showing the card. Other parts of Ghana, like Kumasi and Agogo, started earlier and could present the first figures and satisfied patients in the summer of 2006. Even so the organisation of the new financing system and the reimbursement for the hospitals need to improve to work smoothly. Both patients and health workers reported positively to the NHIS and expressed the hope that a greater proportion of Ghanaians would register in the near future.