Reorienting health care in Africa – can the élite believe in equity?

Ellen Einterz

Those who have advantages try to hold on to them, but in doing so they often work to the disadvantage of everyone, including themselves. Health workers can play a key role in correcting some of the misconceptions about health produced by a combination of élitism and the unscrupulous marketing of health products.

Monsieur le Préfet, stiff shoulder bars broadening his khaki-clad frame, rolled up in his black Peugeot 504, stepped out and marched into the crowded hospital waiting room where scores of sick men, women and children had been sitting since early morning. Had he thought about it, he would have realized that they had trekked many miles over rough roads, leaving at home other children and chores, their herds and kitchens and fields, and that they had waited patiently for their turn to be served. When Monsieur le Préfet marched past them, looking at no one, they squinted at him and shrugged at one another. Without knocking, he entered the doctor’s office. The patient he displaced was asked to wait outside. Monsieur le Préfet complained to the doctor about a headache and a backache and the doctor questioned him and examined him and prescribed medicine for him to buy at the hospital pharmacy. Having thanked the doctor, Monsieur le Préfet left the room, marched past the waiting crowd and arrived at the pharmacy where he took his medicines, assuring the clerk, whose evaluation he writes every year, that he would send payment “tomorrow”. When asked by a visitor how he managed to be served so quickly – and without paying – Monsieur le Préfet responded, “It is my right.”

The push for decentralized, community control – reorientation – of primary health care in Africa is a push for an equitable distribution of rights (1). Advocates of reorientation hold that the poor, the illiterate and the villager have as much right to basic health care as the rich, the educated and the city dweller, and that need, not power or position, determines priority (2).

The goodness of this goal is not automatically accepted by those whose positions presently command privilege – those, that is, who benefit from the status quo and have the power either to effect change or to impede it (3). The élite – that small slice of society composed of a community’s educated achievers – are a disproportionately influential force in most
African cultures today. If reorientation is to succeed, the élite must be convinced that equitable health care is desirable, for at the moment few are likely to readily acknowledge its benefits. Obstacles to reorientation occur in the areas of essential drug programmes, decentralization, and emphasis on preventive health care.

**Essential drugs and the role of health professionals**

Unrestricted access to medication is the norm in Africa, and self-medication with powerful drugs is common (4). Historically, the limited availability of trained medical personnel meant that everyone with a modicum of education acquired some knowledge of drugs and became accustomed to using it, however imperfectly. The use of newer or more sophisticated drugs - antibiotics rather than analgesics, injections rather than pills, perfusions rather than injections - became a sort of status symbol, a sign of higher education or prestige. A teacher arrives at the health centre with a bag full of self-prescribed penicillin injections, and without explaining his problem or seeking advice, he asks the nurse to administer them. Feeling sluggish, a police officer buys a perfusion set and half a litre of 5% dextrose at the pharmacy and calls a nurse to his house to start a pick-me-up perfusion. An accounts officer keeps a cupboardful of medicinal syrups for her two-year-old. Whenever he falls sick she gives him a spoonful of antibiotic, a spoonful of analgesic, a spoonful of chloroquine and a spoonful of an antidiarrhoeal agent, and she repeats the treatment two or three times a day until the child appears to be better.

Advertisements for medicines in Africa are as ubiquitous and as strident as advertisements for beer and cigarettes, and the literate are bombarded by all of them. To be influenced by such publicity is to demonstrate one's literacy. To demand advertised medicines - brand name drugs in appealing packaging, injections, perfusions, elixirs - is to demonstrate one's sophistication. Switching to generic medicines is considered downgrading. Essential drugs programmes, possibly appropriate for the poor, are considered restrictive and insulting to the better off (5).

Professional health workers, themselves part of the élite, typically do not choose their profession. They succeed in school to a certain point, and then when either their money runs out or their examination results prevent further advancement they apply for training or employment wherever they can find it. If training to be a soldier happens to be the opportunity of the moment, the young man will train to be a soldier. If it is to be a teacher, he will become a teacher. If it is to be a nurse, he will become a nurse. The essential task is to secure a job, a salary, and if possible a means of milking the job to supplement the salary with earnings on the side (6). There is little concern for aptitude or vocation. A sense of vocation may develop during training, but this is almost impossible to maintain once the new nurse enters the working world beside older colleagues who do not pretend that "motivation" means anything but "money" (7). He takes his place among the élite and is rapidly confronted with the classical doctor's dilemma, in which blatant quackery can pay more handsomely than good practice. Nurses and doctors in an unregulated setting have much to gain by promoting expensive, bogus treatments for real or imagined diseases.
Power and decentralization

Loyalty to one’s fellow élite is imperative (3). Where paths to power are tortuous, where the enforcement of laws and regulations follows a set of other unwritten rules, and where merit is as likely to provoke enmity as advancement, professional survival demands that favour should be accorded to others of one’s class. “He may one day be my boss.” “Tomorrow she may be able to open a door for me.” “He will return the favour.” Thus a doctor may make a house call to an administrative authority with an earache but not to a sick villager who cannot walk. Occasional donations through government structures of drugs or medical supplies are more likely to be distributed among civil servants than among the poor. The élite are more likely to gain direct access to a physician while others are steered first to a nurse and may never see a doctor (3). The bestowing of privilege on the privileged – necessarily at the expense of service to the poor – strengthens the power of the giver.

In most African countries, less than a third of public funds dedicated to health leaves the cities (8). Reorientation of primary health care requires that the huge budgets of urban, institution-based health care be broken up and redistributed to the periphery (5). It further requires that control of these budgets be shared between service staff and local communities and that management of funds be monitored (2). In other words, reorientation requires those in power to slash and scatter their power base. This is not an attractive option to many of those in power. As Zaidi explains, “for international organizations to expect governments to really work for the people is a reflection of their naïveté. These institutions fail to understand and see the forces behind the government and those in power, and thus fail to see the contradictions within” (5). Lack of money is not the problem, and more money is not the solution, although many keepers of the till would argue otherwise. Absurd distribution and poor management of existing resources are the problem, and better distribution and honest management are the solution. The building of a hospital benefits only the builders. Making it work benefits all, but this is by far the harder thing to do.

Preventive care

The élite, by definition set apart by their ability to maintain a higher standard of living for themselves and their families, are accustomed to thinking in terms of private, not public, health. If their children have been vaccinated, they are not concerned about an outbreak of measles. If they have safe drinking-water, they are not likely to be troubled by polluted rivers. Yet emphasis on prevention through public health intervention is a cornerstone of the reorientation philosophy (8).

A preventive approach to health care requires an improvement in the status of women. Recent advances in education for girls have in many cases resulted in a paradoxical decrease in their empowerment. Less trapped within restrictive traditional roles, girls are also more exposed to abuse in schools and the workplace, where they typically hold the lowest-level jobs (9). Although more educated than in the past, they remain grossly undereducated. With rare exceptions they do not participate as equal partners with men in financial control or other decision-making processes.
The challenge to change

Those comfortable with the status quo are naturally resistant to innovation. Health workers and administrators entrenched in an old fortress are adept at maintaining an imposing façade, however well they know that behind it the beams have already fallen. The innovator who suggests a new way of constructing the crumbling walls is rudely turned away by the proud proprietor with the self-evident explanation, “That is not the way we do things here”.

What, then, is to be done?

Members of the health profession must first believe in and then demonstrate their abilities. Basic health care is affordable to all but the very poorest in the poorest countries (10). Essential drugs programmes make sense not only economically but medically. The official with his treasure of perfusions and quinine and vitamin injections checks into a hospital as one would check into a hotel. He does so because he has come to believe somehow that this is the best way to treat a headache and fever. No one has ever tried to tell him – or, better yet, show him, convince him – that ten tablets of chloroquine, at a fiftieth of the cost, constitute a more effective treatment. Nurses and doctors have simply complied with requests to inject, perfuse and prescribe irrationally. Advertisers have succeeded in duping the public and the profession, and both keep going around in circles duping one another. Health workers would do well to remember that in matters of health care, they are called to lead, not follow.

Clinicians must demonstrate that they can fairly reliably distinguish illnesses that require an antibiotic, for example, from those that require an antimalarial, and those that require nothing at all. Parents who stock a home pharmacy and self-prescribe one of everything when they or their children fall sick do so because they believe that is the best care available. Professionals know otherwise, and convincing patients of their knowledge and ability will enhance their own status while making life better for all.

The importance of women’s influence in the health care of families is universally acknowledged (7). Excluding them from decisions concerning health care is like excluding businessmen from decisions concerning the economy. It can be done, but it cannot be done successfully. Those in power must recognize this. Similarly, the benefits of disease prevention and of a strong public health approach to health problems are clear and must be explained, publicized and popularized.

Few élite would choose to stand guard over a propped up façade if they believed the whole building could be built to stand. Reorientation programmes provide the standard blueprint for excellent, affordable primary health care. Flexible enough to permit adaptation to local conditions, the design nevertheless has certain immutable supports: priority according to need, sustainability through community involvement, and development based on regular monitoring and evaluation (8).

Reformers do not seek to reduce the privilege of some but to increase the privilege of many. Only when everyone can say “It is my right”, and realize that this also means “It is my responsibility”, will communities know they have constructed a solid shelter they can trust and maintain with pride.
References


---

**How the poor become poorer**

The most striking observation about the transfer of resources is that, since the early 1980s, most developing countries have been net providers of financial resources to the rest of the world, rather than recipients. ... A surge in the tempo of development will be virtually impossible if the flow of external resources continues to be from the poorer to the richer countries rather than vice versa.

As long as the rate of interest is higher than the growth rate of the resources out of which the debt has to be serviced, debt problems, which hit the developing countries much more seriously, will be inevitable.

---