SNI® SURGICAL NEUROLOGY INTERNATIONAL

OPEN ACCESS
For entire Editorial Board visit : http://www.surgicalneurologyint.com
Editor:
James I. Ausman, MD, PhD
University of California, Los Angeles, CA, USA

Editorial

Access to health care in sub-Saharan Africa

Gilbert Dechambenoit

Department of Neurosurgery, CMCO Côte d'Opale, Route de Desvres, 6236v0 Saint Matin Boulogne, France

E-mail: *Gilbert Dechambenoit - gdechambenoit@neurochirurgie.fr
*Corresponding author

Received: 27 October 16 Accepted: 27 October 16 Published: 23 December 16

The paper describing two cases of extradural hematoma in Nigeria is a subject of concern and requires close examination.[1] It was published in Surgical Neurology International (SNI) despite unfavorable opinion of all reviewers. Objections to its publication mentioned the anecdotal character of the described events, related as a "tragic-comic tale" with a pinch of – doubtless involuntary – cynicism, but without suggestions or solutions to the difficult problems of supplying and opening access to health care for Africans.

The issue raised by the Editor-in-Chief should be considered keeping in mind some substantive points among the complex group of problems characterizing the health situation in Africa, which is – a fact too often forgotten – a vast continent, immensely varied in its people, territories, and history. Any approach to the subject must be based on factual analysis.

James Ausman suggests constructing a liberal, private-sector driven, health care system, while excluding other models of universal health insurance coverage which, in the past, demonstrated their efficiency and produced considerable beneficial results in particular historical periods; for instance, in European societies during the industrial revolution and in the aftermath of the 2nd world war, these models were built with the State playing an essential structuring role. Institutional changes began in the 19th century with the model conceived in Prussia by Otto von Bismarck (1815–1898). Then in 1942, the British scheme sponsored by William Beveridge (1879–1963), in a social context marked by a strong influence of John Maynard Keynes (1883–1946), and in 1945, the program of the French *Conseil National de la Résistance*.

To propose a health care funding scheme solely on the basis of the United States example and experience appears singularly inappropriate. Social, economic, and political contexts as well as conditions in various parts of the world differ greatly from those in America. And there is no unique, immutable, universally applicable financing method or development model in general – the latter still crying for a definition – the less so as our imaginary ONE world is now caught up in a social and digital revolution and, practically everywhere, in search of lost bearings. We are far from the "End of History," as proclaimed by Francis Fukujama in the euphoric aftermath of the fall of the Berlin Wall. The world is continually re-inventing its workings, in a kind of Darwinian struggle for survival. We should, therefore, be pragmatic.

African countries in their present borders are a recent creation; European states, the USA, China, India, and others did not become what they are in just half a century. In Africa, awareness of and adhesion to nationhood are still growing. It is a bit simplistic to view corruption, though an important factor, as the only stumbling block holding up development and improvement. Structural state governance weaknesses are doubtless revealed when such States fail to ensure fully, everywhere, respect for constitution and laws designed to provide justice, social harmony, and equity to all. Inevitably, there are also,

This is an open access article distributed under the terms of the Creative Commons Attribution-NonCommercial-ShareAlike 3.0 License, which allows others to remix, tweak, and build upon the work non-commercially, as long as the author is credited and the new creations are licensed under the identical terms.

Access this article online

Quick Response Code:

Website:
www.surgicalneurologyint.com

DOI:
10.4103/2152-7806.196631

How to cite this article: Dechambenoit G. Access to health care in sub-Saharan Africa. Surg Neurol Int 2016;7:108.
http://surgicalneurologyint.com/Access-to-health-care-in-sub-Saharan-Africa/

© 2016 Surgical Neurology International | Published by Wolters Kluwer - Medknow

in these "young" countries, antagonistic social forces at work, as well as external constraints and pressures arising from great power politics and policies, which exert conflicting pressures on weaker countries. Adding to the disruption are the so-called "laws of the market," though not much has been seen to date of the "invisible hand" brandished by Adam Smith (1723–1790).

A brief historical review of health care funding in Africa

In 1979, at Alma Atta, in the USSR, an international WHO/UNICEF conference gathered for the purpose of achieving "health for all" by 2000, by emphasizing on primary health care which was expected to attain universal coverage at an affordable cost. The project, in part inspired by the Chinese model and involving active participation of the beneficiaries, rested on the concept that major health problems were linked to unhealthy living conditions and unfavorable environments, i.e. parasitic, infectious diseases, and nutritional insufficiencies. Relatively simple health actions/interventions were advocated that would solve, it was thought, the problem. However, the health services provided under this scheme being poor –implementers had been under the illusion that primary health care services would cost very little – those patients who had a little more income preferred to go directly to the hospitals. The result was that the high-spending secondary and tertiary health centers maintained and increased their importance as health providers.

Further, in the interval, population growth continued, government budgets melted, and the costs of health services and goods continued to rise. The combined effects of all this have led to decaying health systems, and at the same time as an increasingly impoverished population turned away from them. The embryonic hospital-centered system has remained, serving mostly urbanized areas, and absorbing 60–70% of the governments' health budgets, with a large proportion going into health personnel expenditures.[2]

Afterwards came the Bamako Initiative (BI) initiated by James Grant, director of UNICEF, and adopted by the 37th Regional Committee of the World Health Organization (WHO) in 1987. This scheme advocated direct resale to users, with a small margin, of generic medicines purchased at a low cost, a mechanism intended to ensure a regular supply of medicines and help cover the operating costs of health centers. Later, the principle of cost recovery was extended to a variety of medical interventions (consultations, hospitalization, etc.). In practical terms, for people, the results of the BI were mixed, which is hardly surprising, given the state of insolvency of the beneficiary population.

Very few African countries have implemented their objective of allocating 15% of their GDP (the Abuja declaration, 2001) to the health sector. When salary and personnel expenditures take up between 60 and 70% of hospital resources, there is little left for other hospital expenditures.[2] To make matters worse, sub-Saharan governments have had to implement the structural adjustment policies recommended by the World Bank and International Monetary Fund (IMF). Its as if the entire system globally functioned on the line that, the poorer the country, the more its inhabitants and people are required to pay for health care out of their individual pockets; the most in need are consequently ignored. The failure of such programs has been demonstrated and condemned by Joseph Stiglitz, Nobel winner in economics (2001), and a former chief economist at the World Bank.[11]

The social and economic tasks confronting African countries are gigantic on several fronts, e.g., infrastructure, health, education, security, etc., and the resources to fund them miserably small. In 2015, the USA's GDP stood at $17.9 trillion; Nigeria's GDP in the same period was $568.51 billion.[10] In wealthy countries, health expenditure per capita is estimated at $3100 on average. In sub-Saharan Africa, average per capita expenditure is $37.[12] The government health budget of a country with a population of 10 million is equivalent to the budget of a regional health center serving 100000 people in a developed country.

Nevertheless, despite meager financial resources, things are moving in the right direction. Thus, a large number of African countries have begun to work at setting up various types of universal medical insurance coverage, such as Senegal, Ghana, Gabon, Cote d'Ivoire, Kenya, and Benin, in an effort to reduce social inequalities. In addition, international solidarity (Globalfund, Gates Foundation, etc.) and pressures from civil society have made possible a number of successes against diseases such as onchocerciasis (river blindness), polio, human immunodeficiency virus, and tuberculosis. Here mention must be made of the 300 or so medical doctors trained at the School of Medicine in Dakar (Senegal) by French professionals between 1918 and 1950,[7] who made a major contribution to the almost complete eradication of the epidemic and endemic diseases that took a heavy toll on West African peoples, such as trypanosomiasis (sleeping sickness), plague, yellow fever, smallpox. Today, health care services have the opportunity of benefiting from technological (e-Health) and managerial innovations.[2,3,6]

Neurosurgeons and neurologists in sub-Saharan Africa

In our branch, whether neurosurgeons, neurologists, neuroradiologists, we find that in all of Sub-Saharan Africa, 650 million inhabitants, excluding the Republic of South Africa, there is not a single facility dedicated to diseases of the nervous system on the level of the criteria followed in the countries of the Northern hemisphere.

It is difficult to accept, from any conceptual, technical, ethical, or human viewpoint, that a total population equivalent to Europe's including Russia has no access to technical equipment, installations, and treatment resources similar to those offered in a medium-sized French, German, American region or city.

An abysmal lack of neurosurgeons and neurologists in sub-Saharan Africa:[8]

- Ratio neurosurgeon/capita: 1/3000,000 (Northern hemisphere 1:200,000)
- Ratio neurologist/capita: 1/3000,000 (Northern hemisphere 1:40000)

An enormous deficit in medical imaging:

- Northern hemisphere: 25 MRIs/one million inhabitants
- Sub-Saharan Africa: 1 MRI/25 million inhabitants.

There is a need to:

- Train a much greater number of neurosurgeons and neurologists if we are to meet Western standards;
- Establish and equip thousands of neurosurgical, neurological, and imaging services.

Treatment and courses in Africa dispensed by different organizations are no doubt useful, but they are short-term, one-shot missions. Continuing programs over longer periods need to be organized. Proposals and suggestions have been made on this point, with no significant result for the moment.[4,6] I take the occasion to repeat the call that this crucial question needs urgent attention.

Actions should concentrate preferably on training grants and equipment for personnel and services in neurosurgery, neurology, and neuroradiology. This requires funds and solidarity.[4,5,9]

James Ausman is right when he says that greed chokes off ethics. Must we then give up, and resign ourselves to things as they are? This would entirely contradict what makes us doctors and neurosurgeons in particular. Urgent action is required. As an African saying goes: We move forward by walking. All of us walking together would greatly help.

REFERENCES

1. Adeleye AO, Jite IE, Smith OA. A tale of two acute extradural hematomas. Surg Neurol Int 2016;7:54. Available from: http://surgicalneurologyint.com/surgicalint_articles/a-tale-of-two-acute-extradural-hematomas/ [Last accessed on 2016 Oct 26].
2. Brunet-Jailly Innovation in the health systems. Experiments of West Africa. (Innover dans les systèmes de santé. Expériences d'Afrique de l'Ouest) Karthala, Paris; 1997.
3. Dechambenoit G. Network of Healthcare in sub-Saharan Africa (Réseau de soins en Afrique subsaharienne). Thèse Economie de la santé CNAM, Paris; 2005.
4. Dechambenoit G. Action Africa! World Neurosurg 2010;73:251-3
5. Dechambenoit G. Who pays? Afr J Neurol Sci 2006;25:2.
6. Dechambenoit G. Financing health the twin needs of efficiency and solidarity. Afr J Neurol Sci 2004;2:4.
7. Houemavo A. African doctors in AOF: Socio-history study on the formation of a colonial elite. (Les médecins africains en AOF: étude socio-historique sur la formation d'une élite coloniale). Thèse de Maîtrise d'Histoire. Faculté des Lettres et Sciences Humaines, Dakar; 1979.
8. Pan African Association of Neurological Sciences (PAANS). Survey and data; 2011
9. Sachs J. Macroeconomics and Health -.World Health Organization, 2001 Available at: http://www.who.int/macrohealth/infocentre/advocacy/en/investinginhealth02052003.pdf. [Last accessed on 2016 Oct 26].
10. The GDP increased to about 18.04 trillion U.S. dollars in 2015 Available from: https://www.statista.com/statistics/188105/annual-gdp-of-the-united-states-since-1990/. [Last accessed on 2016 Oct 26].
11. Stiglitz J. Globalization and Its Discontents. Editor, Norton WW. 2002/La grande désillusion. Fayard: Paris; 2002.
12. World Bank. Available at: http://data.worldbank.org/indicator/SH.XPD.PCAP. [Last accessed on 2016 Oct 26].