The Inverse Care Law: Inequity in Health Status and Access to Health Care in Africa

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Africa is not a healthy continent. On all indicators of health, Africa lags behind the rest of the world. Africa’s population is generally poor, and it is subject to diseases that have been eradicated or brought under control on most other continents. It is also neglected by private healthcare providers and underserved by governments, relying instead on irregular help from abroad. Dr. Marie-Paule Kieny of the World Health Organization has noted the paradox of healthcare in Africa: “The world’s most disadvantaged people are missing out on even the most basic services.” In short, those most in need are receiving the least.

How can policymakers address inequities in the global distribution of healthcare? The first step is to acknowledge their existence. Generally speaking, the inadequacy of global healthcare is the subject of a steady rumble of discontent, but from time to time there is a spike in awareness and creative attempts to address longstanding problems. Global response to the 2014 Ebola outbreak in West Africa is a recent example. The Millennium Development Goals and

1 The views expressed in this article are personal and do not reflect the official policy or position of the United States Military Academy, Department of the Army, Department of Defense, or the United States government.
4 The recent Ebola outbreak in West Africa is a case in point. The severity of the outbreak was due, in large part, to weak health systems, including a lack of capacity in surveillance and response. Because of Ebola, basic services,
the Post-2015 Sustainability Goals have also increased attention on issues of equity in health and healthcare with the renewed commitment of governments and international organizations to improve the health status of the poor and marginalized.5

The aim of this paper is to frame questions facing U.S. policymakers as they relate to health systems in the African region.6 The paper will examine the current state of health systems in Africa. It looks at both current challenges and promising reforms. Finally, the paper will explore some trends which should be kept in mind when thinking about the future of healthcare in Africa.

Current State of Health Systems in Africa

In many African countries, health systems have been weakened by war, economic crises and debt, among other things, that have led to drastic loss of medical staff and failure to maintain buildings, technology, and supplies. A weak national health system can be viewed as an important contributor to poverty and inequality in the African region. Persons who are in poor health less frequently move up and more frequently move down the social ladder than healthy persons. The role of the health system becomes particularly relevant through the issue of access to preventive and curative health services. The health system can directly address inequities by improving equitable access to care. The health system is also capable of ensuring that health treatment for common conditions, vaccinations and maternal health are all at serious risk. World Bank and World Health Organization, “Tracking Universal Health Coverage, First Global Monitoring Report,” Geneva 2015, 6.

5 World Health Organization, “Health and the Millennium Development Goals,” Geneva 2005. In September 2000, 189 heads of state adopted the UN Millennium Declaration and endorsed a framework for development. The plan was for countries and development partners to work together to reduce poverty and hunger, and tackle ill health, lack of education, gender inequality, lack of access to clean water, and environmental degradation. Eight Millennium Development Goals (MDGs) were established. Three MDGs relate directly to health; to reduce child mortality by two thirds (MDG 4), to reduce maternal deaths by three quarters and achieve universal access to reproductive health (MDG 5), and to halt and reverse the spread of HIV/AIDS, achieve universal access to treatment for HIV/AIDS by 2010, and halt and reverse the incidence of malaria and other major diseases (MDG 6). The remaining MDGs have a direct impact on health.

6 This paper will focus on sub-Saharan African countries.
problems do not lead to a further deterioration of people’s social status and of facilitating sick people’s social reintegration.

Equitable and sustainable access to properly functioning health systems, however, has not been attained across the African region. Although some countries have effectively reduced child and maternal deaths by improving access to skilled care and prevention services, there are still gaps in the region, including the gap between the level of services enjoyed by the wealthiest and the lack of access for the poorest. There have always been geographic disparities. Many people, particularly those in rural areas, often have to travel long distances to receive basic health care. Once they reach a hospital or clinic, they may only receive care if they can pay for it. Inevitably, many people forego treatment because they cannot afford it, while those who pay may find the cost ruinous and the quality of services limited. Rapid turnover of people in key positions, lack of continuity in policy, lack of resources, poor management of available resources and poor implementation are seen in many countries as major constraints on improving health systems. Dr. Margaret Chan, Director General of The World Health Organization, has said, “Social deprivation is not a matter of fate. It is a marker of policy failure.” Making healthcare more equitable means understanding and improving not only the way society allocates health resources, but the power relations involved. A functioning health system needs many things.

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7 A health system consists of all organizations, institutions, resources, and people whose primary purpose is to improve health. The six building blocks of a health system are health services and infrastructure, the health workforce, a health information system, medical products, vaccines and technologies, health financing, and leadership and governance. WHO, “Accelerating progress towards the health-related Millennium Development Goals,” 2010, accessed September 24, 2015, http://www.who.int/topics/millenium_development_goals/who_dgo_2010_2/en/.


Leadership and governance, human resources, health financing, and service delivery are just a few.

**Leadership and Governance**

The government plays an important role in supporting provision of healthcare. Ideally, governments would direct resources in a transparent, accountable, and equitable manner, responsive to population needs. But this is not always the case. Run-down, poorly staffed and equipped health facilities allowed Ebola to explode last year. Liberia’s minister of health, Bernice Dahn acknowledged that Liberia’s “health infrastructure was not designed to cope with the kind of outbreak we had.”

The healthcare systems in Liberia, Sierra Leone, and Guinea were so overwhelmed with Ebola victims that many other patients could not receive care for common diseases like malaria, heart disease or pregnancy complications.

Improving the health of people is complex and requires much more than just one or two interventions. It is dependent on good partnerships between communities, providers, organizations carrying out interventions, governments, and international partners. Given the substantial proportion of external resources on health as a percentage of total health expenditures, coordination and harmonization of effort is essential to avoid waste and target real needs. There are concerns that the increasing number of initiatives aggregate around issues, themes or diseases rather than on more comprehensive approaches to health, such as health systems development. Beyond the international partners’ priorities, some of the most

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11 Betsy McKay.
12 “The African Regional Health Report 2014,” Fig. 2.1., 20.
significant challenges facing the region include legislative frameworks, policies, and sustainability.

Partnerships have been strengthened in several ways: public-private partnerships are in place in 82% of sub-Saharan African countries while 56% have signed compacts.\textsuperscript{14} Public-private partnerships spell out areas of collaboration and the roles and responsibilities for each partner. Compacts, defined as “a negotiated and signed time-bound agreement in which partners commit to implement and uphold the defined priorities outlined in the country health strategy,”\textsuperscript{15} encompass more partners, including international partners, civil society, and governments. An example of such strengthened alignment is the Millennium Development Fund established in Ethiopia in 2007, which has been joined by 14 international partners who channel their support through a common funding mechanism.\textsuperscript{16}

\textit{Human resources}

Health systems in sub-Saharan Africa serve 10% of the world’s population and carry 25% of the global burden of disease. Yet, they only have 1% of the global number of health professionals.\textsuperscript{17} In 2006 the World Health Organization estimated that Africa needed an additional 1.5 million health workers.\textsuperscript{18} Nearly a decade later progress is slow and facing setbacks.\textsuperscript{19} Liberia, for example, has just one medical school and 117 doctors in its public healthcare system. At the height of the Ebola outbreak, one of the largest facilities in Monrovia

\begin{itemize}
  \item \textsuperscript{14}“The African Regional Health Report 2014,” 114.
  \item \textsuperscript{15}Ibid.
  \item \textsuperscript{16}Ibid.
  \item \textsuperscript{19}WHO. A universal truth: no health without a workforce. 2014
\end{itemize}
lost its head surgeon, as well as 11 other doctors and nurses to the virus.\textsuperscript{20} For many low and middle-income countries to attain specific Millennium Development Goals pertaining to health, they need to reduce the shortages of a trained, motivated, and supported health workforce, as health personnel have a direct role in strengthening societal health that is strongly linked with sustainability of human and economic development.

Another complicating factor is the migration of healthcare workers. Public health facilities, in particular in rural areas where the majority of low-income populations live, are typically characterized by poor living and working conditions, large work burdens, low and irregular salary, inadequate or non-existing staff accommodation, and few educational or occupational possibilities for the rest of the family.\textsuperscript{21} Urban facilities, in contrast, tend to attract healthcare workers. Thus, a large part of the migration of healthcare workers is from underserved, rural communities where the needs for health care are highest. International migration, both in and out of the region, to more stable countries with better economic conditions, results in an inequitable geographical distribution of skilled health workers at the global level. According to OECD more than 50\% of the best educated health professionals in some low-income countries choose to migrate. For instance, 60\% of Ghanaian doctors who graduated in the 1980s had emigrated by 1999, and by the year 2000, Zambia’s public health system employed 50 of the 600 doctors educated in the country.\textsuperscript{22} One study suggests that 23,000 healthcare professionals emigrate annually from Africa.\textsuperscript{23} Interestingly, high-income countries are also experiencing a real shortage of medical staff relative to the standards of care offered and demanded. This

\begin{itemize}
\item \textsuperscript{20} Betsy McKay.
\item \textsuperscript{21} “The Health Worker Crisis,” 3.
\item \textsuperscript{22} Ibid., 4.
\end{itemize}
creates an impetus to recruit healthcare workers from abroad. For example, in 2002, 23% of all physicians in the U.S. had graduated abroad, and 64% of them were from sub-Saharan Africa.24

Who Pays for Healthcare?

In too many countries in Africa it is the poorest people who are paying proportionally most for healthcare. Countries with a low level of public investment in health tend to have high levels of out-of-pocket payments, which are a major hindrance to accessing health care. Across much of the continent, out-of-pocket healthcare expenditures comprise more than 85% of households’ spending on health.25 Most of this goes into primary healthcare. When families arrive at health centers with a dying child or a woman struggling to give birth, the fees demanded before care is given may consume all their ready funds, forcing them to borrow and pushing them into deeper poverty. Further care might be sought from more trusted and less costly sources such as traditional healers or village “wise women.”26

The Abuja Declaration of 200127 proposed that 15% of public expenditure be allocated to the health sector. However, progress towards this target has been slow and health spending continues to be seen as “consumption” rather than “investment.” Only five countries, Botswana, Madagascar, Rwanda, Togo, and Zambia have been able to achieve the target set in the Abuja Declaration.28 Government expenditures on health in the World Health Organization’s Africa Region averaged 9.7% of their total budgets in 2011, the last year for which figures are available.

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27 The 2001 Abuja Declaration was a historic milestone for Africa. For the first time, the nations of Africa declared that the AIDS epidemic was a full-fledged emergency on the continent. In response, AU Member States offered unprecedented commitments to strengthen their responses not just to AIDS, but also to Tuberculosis and Malaria. As they left the summit, heads of state of African Union countries pledged to set a target of allocating at least 15% of their annual budget to improve the health sector by 2015. They also pledged to support vaccine development, to make medical commodities and technologies more available, and to intensify their efforts to mobilize AIDS-fighting resources. WHO. “Abuja +12: Shaping the future of health in Africa,” 2013.
28 Ibid.
compared with the global average of 15.2%. Total expenditure on health was on average 6.2% of GDP in Africa, against a global aggregate of 9.1%.²⁹

Many countries are making progress to remove financial barriers to healthcare. Burkina Faso, for example, removed user fees for healthcare, doubling attendance.³⁰ Botswana is one of a few countries in the region to make a significant government investment in health. Its government expenditure on health, at US$384 per capita is considerably higher than the average (US$147 per capita) for other countries in the region.³¹ Many countries, such as Comoros, Cote d’Ivoire, Gambia, Sierra Leone, and Swaziland for example, are now raising money for health services through taxes on products known to damage health, such as tobacco and alcohol, and for health-damaging activities such as environmental pollution and drunk driving. By using this money to finance healthcare, countries are achieving a double gain: better health finances and lower rates of non-communicable diseases.³²

Service delivery

Reaching all the people who need healthcare, when they need it, and where they need it, is particularly difficult in Africa, where geography, poverty and limited human resources conspire against service delivery. Some countries are applying innovative approaches to bring scarce expertise to remote communities, such as the Phelophepa train in South Africa.³³ Other countries, such as Ethiopia, Ghana, and the United Republic of Tanzania are strengthening their reach into communities by strengthening the numbers, capacity, and financial support from community health workers, known as health extension workers. In Ethiopia, for example,

²⁹ Peter Guest, “The Cure.”
³¹ Ibid.
³² Ibid.
³³ “American Friends Phelophepa Train of Hope,” http://trainofhope.org. Two unique trains that operate as mobile healthcare hospitals, bringing much needed medical and educational services to impoverished rural areas of South Africa. It has been operating since 1994 and has thus far reached 23.5 million people.
workers deployed in remote communities delivered two and a half times more treatments for childhood diarrhea, malaria, and pneumonia, than all the facility-based providers in the same district.\textsuperscript{34}

Undoubtedly, proximity is an essential aspect of any geographic understanding of access to healthcare, but we must note that distance is not merely physical but sociocultural. Gender inequities are multidimensional and affect women’s access to health care in multiple ways. Women generally have higher life expectancies than men, due to biological and behavioral factors. Yet this advantage is overridden in many contexts, and female life expectancy at birth is sometimes lower than or equal to that of males. Additionally, women’s greater longevity often does not translate into healthier lives, and in many low- and middle-income countries, women undergoing pregnancy and childbirth are often unable to access maternal health care due to systematic discriminations or inequities rooted in gender norms within the society they live in. Lack of autonomy, male dominance in relationships, and gender-based violence are other examples of gender inequities that affect access to health care.\textsuperscript{35}

**Future Trends**

Improving the quality of African healthcare will mean more than simply increasing the number of providers. Disease eradication and treatment is likely to be a priority in remote and rural areas, but the continent is rapidly becoming an urban one. At current rates, by 2030 more than half of all Africans will live in cities, and their healthcare needs – and concerns – will

\textsuperscript{34}“The African Regional Health Report 2014,” 126.

change. With an urban lifestyle comes an urban diet, and the so-called “lifestyle diseases”, such as diabetes, cardiac and liver complaints, and cancer. The World Health Organization forecasts that by 2030, more people will die from such non-communicable diseases than from communicable ones. In some ways this is progress, demonstrating that the continent is, slowly, winning the fight against HIV, malaria, and other diseases. However, few major African cities have advanced oncology or cardiac facilities. The continent’s healthcare systems remain focused on acute, short-term treatment, and on fighting the traditional battles against infectious and tropical diseases. Healthcare systems in Africa are currently ill prepared to serve the needs of populations with high incidence of chronic diseases, which require complex, ongoing care and a greater emphasis on the patient’s own capacity to manage their health outcomes.

Reversing the focus from acute to preventive care, and from treating single ailments to tackling multiple conditions, will require a significant overhaul of Africa’s healthcare systems, in terms of mindset, structure, and human resources. “We need to better leverage health workers. We don’t necessarily need doctors and nurses to provide basic things like health education. We can use so many other types of people with very little training at little expense to build the model of individual, family and community ownership of health,” explains Dr. Darkoh of BroadReach Healthcare.

Improving the way that African healthcare systems work will also require governments to strengthen supply chains for pharmaceuticals and medical supplies, and it is likely to involve

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37 Ibid.
38 In 2013 an estimated 2.1 million people were newly infected with HIV; down from 3.4 million in 2001. By the end of 2013 about 12.9 million people were receiving antiretroviral therapy (ART) globally. Of these, 11.7 million lived in low and middle income countries, representing 36% of the estimated 32.6 million people living with HIV in these countries. During the period 2000-2013, malaria incidence and mortality rates of populations at risk have both fallen globally, 30% to 47% respectively. Globally, the MDG target of halting by 2015 and beginning to reverse the incidence of malaria has already been met. See WHO, “Millennium Development Goals Fact Sheet no 290, 2015, accessed on September 25, 2015, http://www.who.int/mediacentre/factsheets/fs290/en/.
more local production of medicine in Africa. Currently, many African countries experience regular shortages of medical products. As governments and multilateral health organizations work to improve adoption of antiretroviral drugs for HIV/AIDS or medicines for tuberculosis, a reliable supply network will be crucial to maintain regular treatment courses. With healthcare systems gearing up to address chronic conditions too, procurement issues will move to the forefront.

Technology could also be a huge enabler of cross-border cooperation, and it is likely to play an important role in the development of a multi-tiered health workforce. “A lot is happening in the IT realm to make medicine more efficient and reach a population that is underserved but all have cell phones,” says Heather Sherwin, an investment manager for the Netherlands-based Investment Fund for Health in Africa (IFHA). Indeed, many applications and services are already being developed in response to the remarkable penetration of mobile phones in Africa.

Forty-three percent of the world’s 400 million people without access to essential health services, and live in sub-Saharan Africa. Barriers to access take a variety of forms, the most obvious being the basic lack of quality health services, but there are obstacles such as the distance to the nearest health facility. The cost of the health services may also deter use, especially where direct, out-of-pocket payment is involved. Other significant barriers include sociocultural barriers such as constraints related to gender.

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41 Ibid., 21.  
42 One example is Project Masiluleke, in South Africa, a mobile health initiative that promotes HIV/AIDS awareness, education and treatment. It sends 1-2 million messages a day to South Africans, providing information or asking them to call into the national AIDS health line.  
International donors often focus on single diseases such as AIDS or Malaria. This has produced significant progress in combating these diseases but it has also led to discrepancies with government policy aims and often unintended substitution of national spending. With international donor flows under pressure, how is the U.S. changing the way it provides international aid? How can Africa’s healthcare systems accelerate programs in the fight against chronic disease? How can policymakers increase the number of healthcare workers in African countries? What areas of African health systems should the U.S. government focus on in order to mitigate the far-reaching social and economic effects of outbreaks like Ebola? As we come to the end of the Millennium Development Goals era, which was marked by significant advances on many fronts, the international community is faced with the challenge of establishing a new set of goals and, and measuring progress towards them.
Recommended Readings


