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## **Failure of Primary Healthcare Delivery in Africa**

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### **Abstract**

An effective health system guarantees access to health as fundamental to improved health, and decreased morbidity and mortality. Health care deliveries in many African countries have been poor due to the failure of governments and their agencies to address the underlying challenges with strategic plans. . While many countries such as China, Cuba, Chile, and Costa Rica, the US, Canada, and Great Britain just few to mention have improved their health care services to fit the populations needs, access to primary health care in many African countries continues to be highly limited thereby leading to increased death and diseases from preventable causes. Majority of the health systems in Africa are characterized by bad leadership and management, poor funding, shortage of drugs, inadequate labor capacity, and absence of health promoting amenities in the rural areas among many other problems. Therefore, African countries need to adopt a well-established health delivery framework that is responsive to local and emerging health needs. This study was done by using critical research method of analyzing available secondary information. It reviewed literature on health care delivery in Africa and other developing countries, including World Health Organization reports.

**Keywords:** word; Healthcare access, primary healthcare, African health, health failures in Africa.

### **Introduction**

African countries have continued to occupy the lowest rung of the ladder in the area of primary health care delivery. In spite of the various global efforts, including funds and technical support, healthcare in most African counties has remained deplorable, unattractive, and irresponsive to peoples' needs. Deaths from preventable causes have become a norm for the poor and underprivileged while politicians in leadership and those with government affiliations seek health care abroad—at the expense of the poor. The reasons for this failure are inherent in the system and from method of health care delivery.

A review of literature show some of the responsible reasons for the failure of primary health care in Africa as: Irresponsive colonial model of healthcare, shortage of health workforce, inadequate funding, urban-rural divide, poor leadership and organizational issues, emergence of new and infectious diseases, mismanagement, unhealthy environment, lack of social amenities, and increase in out-of-pocket expenses.

#### **1. Colonial model of healthcare**

Most health-care systems in Africa are not designed from the ground up to respond to local health needs, but were either copied or adopted from colonialist governments (Kaseje, 2006; Ityavyar, 1987). Such health systems are inherently irresponsive to changing health needs of the adopting countries. For instance, the foundations of modern health systems in Nigeria (Ityavyar, 1987; Adeyemo, 2005), Tanzania (Kopoka, 2000), and Ghana (Baidoo, 2009) were the legacies of colonization and Christian missions. Health care in the colonial eras was discriminatory, as they catered to the health needs

of civil servants who worked for the colonial governments. Other needs served were those of the elite groups, military men, and domestic servants of some top government officials who were not white. Regrettably, its discriminatory approach to health care became the operating principle of health care in Africa. This ultimately resulted in the denial of health-care access to the less privileged and those living in rural and remote areas.

The colonial healthcare model was not intended to develop a system from the grounds up. The intent was to introduce European model of care that will replace whatever health system was available in Africa. Again, it was introduced to create job opportunities for European trained health providers and market for western designed drugs. The system discriminated against the use and practice of traditional medicine. It did not recognize or improve traditional medical practice which was present before Western medicine. The colonial and missionary health systems fought against traditional healing practices and medicine by referring to it as fetish, cultish, devilish, and idolatrous (Ityavyar, 1987). Despite the antagonism, traditional medical practice has persisted among Africans and waits for recognition and integration into the modern primary health-care system (Chimezie, 2013). Another issue with the colonial or inherited health system was that it did not emphasize disease prevention and health promotion components. As a result, disease prevention, health education and promotion have not taken prominence in many health systems in Africa. For instance, in Nigeria, preventable deaths from childbirth and malaria are still killers. Also, in Tanzania, "there is an apparent lack of proper balance among promotive, preventive, curative, rehabilitative, and socio-medical care" (Kopoka, 2000, p.4). The colonial health system which eventually characterized many health systems in Africa equally centered on the convenience of the elite rather than the needs of the vulnerable population. The copied colonial health system was not designed to meet the growing health needs of our contemporary time and thus needs to be changed.

## **2. Inadequate health labor force**

Shortage of health labor force has plagued African health systems for several decades. A health workforce is comprised of people whose primary intent is to promote health and well-being of the population. There is a dire shortage of direct health service providers such as doctors, nurses, dentists, midwives, pharmacists, laboratory scientists, epidemiologists and health educators in the entire health system. According to the World Health Organization (2006), there is a shortage of 4.3 million doctors, nurses, midwives, and support staff worldwide, and that 36 of the 57 countries with severe shortages are in Africa. Also, Rawat (2012) identified shortage of health labor force as a major obstacle to prevention and treatment for the 5.7 million people currently living with HIV/AIDS in South Africa. Many African countries lack updated data on their health labor force capacity. Nigeria, the giant of Africa even has not dedicated system of collecting such data.

African countries are not producing enough health professionals and many of the few they produce migrate to overseas countries where better prospects and conditions of service. Absence of social amenities cause doctors and highly educated health professionals to prefer urban practice to rural environment. This situation greatly deepens the rural-urban divide in access to health care. Also, Africa's poor economic situation and unstable political climate have made the health systems fragile and deplorable.

When a country has a fragile health system, the loss of its health force can bring the whole system to collapse, with the consequences measured in lives lost (WHO, 2010). The remedies to the shortage of health professionals can be addressed through many angles including funding for physician training, and developing the skills of nurses, midwives, and community health workers to take higher responsibilities in primary health care. Advancing the knowledge base and skill sets of nurses and allied professionals will enable them perform preliminary assessments, diagnosis, and treatment on

patients and increase access to health care. African countries need to take a hard look at health labor manpower development by revising the process and requirements for medical education. Perhaps, it is time to open medical admissions to other graduates with undergraduate degrees in biological sciences who want to change career to medicine. African medical schools should understudy the American system as it will help increase enrollment in medical schools.

### **3. The emergence of new and infectious diseases**

Gaps in health outcomes continue to widen as gains of the previous efforts in PHC are wiped out by the emergence of new chronic and infectious diseases. Deaths from chronic health are on the rise due to limited access to primary health care. Interventions through health promotion and education have made no significant impacts with people believing that some diseases are caused by spiritual, or voodoo poisoning. Ignorance about disease causes and cures results in non-acceptance of modern remedies, hampers health care delivery, and complicates health conditions. Situation like these widens the gap of health inequality. A health inequity still abounds and is common throughout African.

The outbreak of HIV/AIDS epidemic brought many fatalities to Africa and thus wiped out the progress made through improved immunization and the reduction in global infant death in the Sub-Saharan African continent (Wibulpolprasert, Tangcharoensathien, & Kanchanachitra 2008). These epidemic and chronic health conditions weakened the efforts of the World Health Organization and the Alma-Ata Declaration to achieve the goal of health for all by the year 2000. The high mortality in Sub-Saharan Africa has been exacerbated by the prevalence of HIV/AIDS caused by widening inequality in income distribution (De Maeseneer 2009). The magnitude of deaths and diseases from preventable causes have wrecked the social, economic, cultural, and religious life of the people, which, in turn, affect their overall health and wellness (Obrist et al., 2007). Tuberculosis and leprosy are still public health issues in Nigeria with 460,000 and 5,000 cases, respectively, reported yearly (Federal Ministry of Health, 2010). This further raises the question of what the current systems of healthcare do to address new issues that defy old current approaches.

### **4. Poor leadership and organization factors**

According to the World Health Organization (2000) report, poor organizational structure, bad leadership, insufficient funding, and corruption are among the problems that affect the delivery of health care. The effects of poor leadership and inefficient health management greatly affect the manner in which rural residents have access to the health care they need. This problem is more peculiar in developing African countries. Healthcare leadership means the ability of the managers of the health-care system to look ahead, identify problems, propose solutions, and plan strategies to overcome them. Developing a health-care system is a high-level responsibility that requires effective leadership. Emphasizing the importance of a more reliable and responsible leadership in health care, the World Health Organization (2008) report stated as follow:

Health authorities can do a much-better job of formulating and implementing PHC reforms adapted to specific national contexts and constraints if the mobilization around PHC is informed by the lessons of past successes and failures. . . . They can no longer be content with mere administration of the system: they have to become learning organizations (p.20). Becoming a learning organization requires a concerted effort to review and evaluate all programs in the health system through provider-patient-community interactions. One evidence-based method of that will prevent repeating the mistakes of the past is community-based research.

Community-based research is a learning process, and provides an opportunity to explore consumer experiences in healthcare

delivery in order to make an appropriate health-delivery decision. Leaderships that think in this direction will ultimately make informed policy and financial decisions in the management of its resources. Such practice will improve health care access and improve the quality of service delivery.

### **5. Widespread corruption in medical practice and health delivery**

Poor leadership and inefficient organizational are responsible for ineffective oversight and preponderance of corrupt practices in healthcare delivery. Corruption in health care systems is global and invades both developed and underdeveloped countries, resulting in the channeling of billions of dollars into private pockets (Bulletin of WHO, 2006). Corrupt practices in the government and among health professionals corrode health-care success in Africa. According to World Health Report, corruption; . . . deters poor people from using services they need, making health financing even more unfair, and it distorts overall health priorities (World Health Report, 2000, p. 14). In some health systems, doctors demand bribes from patients before they could be seen, use government facilities to provide private services at the expense of the public, report very late to work, and leave early. Some doctors perform treatments beyond their licenses and expertise at the expense of the patients. These situations are commonplace in the Nigerian health system, and are not difficult to encounter when seeking health care.

Widespread corruption also has enabled counterfeit and expired drugs to enter the health-care system and is sold freely in the open markets. Agencies charged with this function look the other way while drug importers bring fake and expired drugs in the health system. The people who commonly buy and consume these fake drugs are the locals who may be unaware of the serious health risks they present, including disease complications and even death. To change these situations, governments, agencies, medical organizations, and healthcare leaderships in Africa need to step up efforts to improve oversight and ensure that quality of healthcare provided to the communities is of the best quality possible. Also, providing drugs and health supplies in stock at health facilities will be a way toward mitigating this problem. This will reduce the frequency of buying from the open market.

### **6. Mismanagement**

Poor management is another factor responsible for failing health systems in Africa. The problem of poor management comes in many dimensions. It comes from poor policy formulation and analysis, weak implementation of programs, and lack of effective human resource planning. Good management involves a thorough understanding of health problems, health resources, and proper allocation of funds, effective quality control, and formulation of good health-care policies. A good policy produces better health outcomes than higher spending on health care (World Health Report, 2010). Without the ability to match resources to programs, health systems are bound to experience poor performances or failures. Accordingly, health systems should be well funded and provided with an adequate workforce and oversight in order to provide a quality service to the people (WHO, 2007).

The World Health Report (2000), advised that it is essential that financial resources are properly balanced between equipment and facilities and workforce development and training. Facilities and equipment cannot deliver healthcare alone if there are no well-trained and rewarded workforces. The director-general of the WHO, Dr. Margaret Chan, in her 2010 address to the WHO, charged health leaders to experiment with different health schemes as well as seek proper guidance on the best way to spend their funds for the best health benefit of their people. Health systems that operate in a firefighting manner are unable to act proactively and are bound to have poor health outcomes from preventable diseases (World Bank,

2005). Health systems can only be effective if they adopt strategic and proactive approaches to respond to the health needs of the population it cares for. Health systems should be a work-in-progress. Most health systems in Africa lack strategic plans to reach out to the rural population, but do so only in response to global health issues where programs and finances are sponsored by the World Health Organization or similar nongovernmental agencies.

### **7. Urban-Rural divide**

Inequality in health outcomes also result from the fact that a greater majority of the African population still live in rural areas and lack basic amenities that promote healthful living (Mervin, Snyder, & Katz, 2006; Healthy People 2010, 2007; De Maeseneer, 2009). The UN World Urbanization Project 2007 Report for 2010 indicated that of the 49.4 percent of the world population who live in rural or remote areas, Sub-Saharan Africa has the highest proportion of its population that live in rural areas. Of this percent, Sub-Saharan Africa has 62.7 percent; Asia, 57.5 percent; United Kingdom, 9.9 percent; and Western Europe, 23 percent. However, not all rural or remote communities experience the same health outcomes or have lower life expectancy. Effective rural health policies and plans can compensate for the cost of remoteness or poverty, as is the case in the Cuban health system (WHO Report, 2008a).

Extending PHC to the remote or rural people is the essential yardstick of an efficient health-care system irrespective of how much is spent on health care. Some countries with a large rural population and lower income and expenditure in health care have been ranked highly in health performance by the WHO. For example, Cuba, with 24.3 percent rural population, was ranked 39; Bangladesh, 71.9 percent rural population, 88; India, 69.9 percent was 112; while Nigeria, with 50.2 percent, was at rock bottom with 187. The difference in health-care performance or efficiency between Nigeria and countries like Bangladesh and India lies in the effort to extend health care to the rural and poor population, and not only total health expenditures alone. While higher spending may be related to better health outcomes, differences among countries, however, lie in the overall public policy and effort of the government to reduce inequality in the distribution of social amenities that promote healthful living and improved access to preventive health care (World Health Organization, 2008b).

Limited access to healthcare for rural communities is greatly contributes to increased infant mortality and under-5 mortality rates in most countries. In Ethiopia, 85 percent of the population live in rural areas without accessible road and modern infrastructure and is ranked 7 out of 22 in the world with increased under-5 infant mortality (WHO, 2009). Thus, Ethiopia is burdened with increased communicable diseases caused by its poor and weak health-delivery system and limited access to health services. Studies abound to support the fact that rural dwellers are impacted by their lower socio-economic status, and consequently, poor health. While a health system cannot be held accountable for equity in income status or education, it is grossly and solely responsible for “avoidable deaths and illness from childbirth, measles, and malaria or tobacco consumption can properly be laid at their door” (WHO, 2000, p. 23). Such has been the driving force toward efforts to provide people-centered health care to mitigate this gap and save the lives of millions of men, women and children.

### **8. Environmental issues and lack of social amenities**

Environment is a big determining factor of health outcomes. The environment in which people find themselves daily has a great influence on how well—or bad—they live in addition to their level of education, type of housing, food, and job status (WHO, 2010). Studies show that where people live has a great impact on their lifespan and that those who live in the poorest neighborhoods will die 7 years earlier than in the wealthiest. People in poor and rural communities suffer from “Deprivation amplification” (Kawakami, Winkleby, Skog, and Szulkin et al.; 2011). Deprivation amplification is a pattern

by which people living in deprived neighborhoods have lower accessibility to health-promoting goods, services, and resources such as health-care centers and physical activity facilities, than people living in affluent neighborhoods (Kawakami et al., p. 6.). As a result, people who are deprived of services that promote healthful living become easily exposed to sufferings, diseases, and deaths from preventable sources.

How can PHC be effective when the majority of communities in Africa lack essential living amenities such as safe drinking water, sewage, or disposal system, good housing, an adequate power supply, and good roads? Without directing efforts to improve these, attainment of good health will be unrealizable (Abiodun & Kolade, 2005). Kaseje (2006) noted that 50 percent of the African population lack access to modern health facilities, and consequently, have high levels of maternal, infant, and child mortality, and as well as low rates of immunization. A major step to improving health outcomes begins with improving the living conditions of the people through the provision of the basic necessities of life.

### **9. Poor funding and increase in out-of-pocket expenditures**

PHC is poorly funded because most governments do not see health expenditures as a worthy investment in economic development. An investment in health and health-support infrastructures will improve health and support a productive society. Perhaps the lack of this understanding explains why PHC in Nigeria is under the control of the local government: a sector of the government with poor and weak administrative structure, insufficient funding capacity, and human resource capabilities (Adeyemo, 2005; Kopoka, 2000; World Bank Report, 2004). Government funding of healthcare has been low: 18.69 percent in 2003, 26.40 percent in 2004, and 26.02 percent in 2005 (Soyibo, Olaniyan, and Lawanson, 2009), and consequently, placed more burden on the households to pay for health costs (Lawanson, 2014). The average total household health expenditures in Nigeria continues to rise from 64.25 to 68.45 percent from 1998–2002, and up to 86 percent in the northern states of Nigeria (Soyibo et al.). Gambian government expenditures on health care was below the Abuja Declaration that required Economic Community of West African States (ECOWAS) to spend at least 15 percent of total government expenditures on health care (WHO, 2007). WHO reported that between 2002, 2003, and 2004, Gambia spent 11.7 percent, 13.03 percent, and 10.86 percent, respectively, of its total government annual budget on health sector improvement. Only Burkina Faso and Liberia met the Abuja target by 2004 among all ECOWAS countries.

As individual expenditures dwindle due to increasing poverty and less government expenditure on healthcare, demand for healthcare drops due to the increase in individual out-of-pocket expenditures. The consequence is increased disease and death. In view of the implications of big out-of-pocket expenses on health outcomes, the director-general of the WHO, Dr. Margaret Chan, warned member countries that “No one in need of health care should have to risk financial ruin as a result” WHO (2010; 2013). She emphasized again that universal health coverage means that everyone has access to quality health services that they need without risking financial hardship from paying for them. Dependence on out-of-pocket expenditures for medical expenses makes it difficult to achieve universal health coverage for all. Out-of-pocket expenditures for health care is a major threat to health access for the rural African population (Labiran, Mafe, Onajole, and Lambo, 2008), whose major income comes from subsistence farming. Poor funding of healthcare only compels the poor to pay more, and thus, excludes those whose health needs are usually greatest (World Health Organization, 2010). As long of out-of-pocket expense continues to be the main source of healthcare financing mortality and morbidity will continue to rise due to limited access to essential and required health services.

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