

Virtual Mentor

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PERSONAL NARRATIVE

The Haves and Have-Nots

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To understand the health care system of a country, you must first understand its culture. This is so true in reflecting on the theme issue for this month's *Virtual Mentor*: disparities in health. It is far too simplistic to merely view the disparities as a problem in access to health care services. No, there is something more profound in the way that countries in East Africa approach basic human services. How these services are allocated is driven not only by how much money one has, but by tribal customs that span national boundaries in Africa and by the continent's history of colonialism. Though I do not claim to be a social scientist, I hope my observations can provide some insight into the complex factors that lead to disparities in health care in Eastern Africa.

First, we will start with the obvious. A walk through the campus of the new Aga Kahn Medical Centers in Nairobi and Dar es Salaam gives the impression of "state of the art" medical care. Most of the consultants have impressive post-graduate training, usually in Great Britain, and have the usual string of initials, confusing to Americans, after their names. The laboratory and radiology units with the latest scientific equipment reside in modern air-conditioned buildings. However, as you look around the campus, you see very few people with the typical dark skin of a native African. Most patients are either East Indian or of European ancestry. Almost all services are provided on a cash basis, paid for at the time of the service. Physicians are much more likely to diagnose by history and physical exam without the usual confirmatory lab or X-ray tests since even the "haves" must pay "out of pocket" for these tests and services.

Contrast this with Central Hospital, a government hospital in Lilongwe, Malawi. Here are the old stucco buildings with concrete floors and open windows without screens. The typical adult ward might house 8 patients with no visual barriers between stark cot-like beds. There is 1 toilet without a shower for each 3 or 4 wards. The nursing care is scant; most patients have 2 or more family members who stay with them and sleep on the floor. Family members prepare meals on small charcoal cookers in the room or hallway. There is an open drain down the middle of the hallway that carries a variety of wastes to the drain at the end of the hall. The odor and smoke combine to make the atmosphere as near to Dante's underworld as I care to see. Physicians routinely lament the lack of medications. Various aid groups supply medications in ample quantities, but most of these wind up on the black market and never reach the hospital and those who have little.

Beyond Health Care Services

It is easy to confirm that there is a wide disparity in health care services in Eastern Africa, but I don't believe health care differs in this respect from other aspects of life in this society that also have impact on people's health and quality of life. A fifteen-minute car ride takes one from the worst of the Nairobi slums to palatial mansions with green rolling lawns surrounded by electric security fences and 24-hour guards. The houses in the slums are little more than plywood or tin sheets held together by whatever is available. There are no toilet facilities, just the occasional water spigot with a line of children carrying "jerry cans" for water.

The public transport system is a combination of old school buses and the notorious Kenyan "matatu." The matatu needs a little explanation for the un-initiated. These are usually Nissan mini-buses decorated with wild colors and slogans. They are meant for 10 passengers. I counted 22 people exiting one at a nearby loading area. There is a driver and a "tout," a combination huckster, money collector, and pusher who crams in as many paying passengers as possible. The drivers are notoriously bad at the job, using horns in lieu of brakes that may or may not work. On the same road will be several Mercedes and other luxury autos with African drivers and Asian or European passengers.

Inequities reign in the utility sector also. When the electricity or telephone goes out in your house, you can expect the requisite 2-week wait for service, or you can ask the dispatcher for special service at an additional cost. Depending on the amount of the "special service" fee, you might get assistance within 15 minutes. Americans often become incensed with the concept of a bribe and rail openly against the system. Their outrage usually causes the waiting period to stretch to 3 weeks. If you have the resources, and are willing to spend them, you can live very well in Eastern Africa. When the drought in Kenya produced staggered electricity blackouts, the generator industry did a land office business. People with money were able to generate power on their own land, although at a major cost to the health of the environment.

The police are not immune to the temptation of providing "extra service" for a fee. I have witnessed a black Kenyan beaten with a police night stick following a minor auto accident while the other driver, a white man, was driven home in the police vehicle. I wonder how much that "special fee" was.

Not Merely a Matter of Money

Even given these glaring examples of the inequities between the haves and have-nots, it is nevertheless too simplistic to attribute all such disparity in service and in treatment to money and class. My "boss" is an African American woman born in South Africa. She is a PhD clinical psychologist whose style of dress puts my California casual to shame. Yet, when we travel together, she is routinely stopped and harassed by customs officials, visa clerks, and so on, while my Anglo face gets me waved through with little hassle. I have viewed more blatant racism at times in Africa than I saw, or, at least, remembered, in the US. The curious thing is that

much of the racism is by black Africans against other blacks; other factors in Africa's history and tribal culture contribute to this.

Many Africans continue to identify with their tribes rather than with their countries. The relatively new and somewhat artificial borders between countries seem strange even to a Western observer. Crossing border checkpoints is laborious, with rampant displays of bureaucratic hurdles to be cleared before one can transit to another country. (Yes, I am sure a special fee would help.) However, not 50 meters away from the checkpoint, is open land with no border fence or even marker. Tribal areas often transcend these country borders, and many view the border as either a colonial invention or a racket to extract visa fees from tourists. In the rural areas, the tribal customs seem to work, and the informal support system of the tribe meets many of the social needs of the group, but not the needs of other "blacks" who are outside the tribe. Perhaps not surprisingly, this tribal identity does not translate well to urban Nairobi, where individual interest, self-gain, and survival dominate the culture. Power and its ability to corrupt rule the political arena; leaders use brutal tactics of oppression to stay in power. The ethics of what people *ought* to do as an alternative to the ethics of "might makes right" is so foreign as to be almost non-existent.

My initial moral outrage at the disparity of health care services in Eastern Africa seems strangely to have lessened as I have begun to be acculturated to Africa. There will always be "haves" and have-nots." Ethics can help to set a floor or basic level of decency in how we interact with the "have-nots." In Eastern Africa, there is little interest or even recognition of what constitutes this floor. "Ethical" seems to be defined as what one can get away with. Perhaps it is not all that different in the US. With more resources, the "floor" and "ceiling" are less far apart in the US, so the disparity seems more tolerable.

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