Health care in Africa: What next?

By Robert Guest and Slavea Chakova

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NAIROBI, Kenya - In the war between humanity and disease, perhaps the greatest victory of recent years took place in Africa. At the turn of the millennium, serious analysts expected HIV/AIDS to kill up to half the people in some southern African countries. But then the price of anti-retroviral drugs fell from $10,000 a year to as little as $100, thanks to a loud campaign for access to treatment, some technical advances and a dollop of aid.

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Suddenly, millions of HIV-positive Africans started taking pills that kept them alive. Also, by reducing the viral load in their bloodstream, the drugs made them less likely to infect other people, and thereby slowed the spread of the epidemic. AIDS is still deadly, but it is being brought under control. That's something to celebrate.

Africa still has greater health problems than any other continent, but progress is visible on several fronts. Malaria is being beaten back. The World Health Organisation estimates that the deaths of nearly 4 million African children were prevented between 2000 and 2013 thanks to the use of insecticide and bednets. Several African countries, such as Swaziland, have plausible plans to eliminate the disease altogether. A vaccine already exists, though it is only partially effective. With luck, future vaccines will work better.

Progress

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In several countries, recent years have seen the rise of low-cost private clinics, which provide essential services at a reasonable price. The spread of information technology has transformed health care. For example, at clinics in Kenya run by Access Afya, an NGO, staff upload patient data into an iPad app so it can be analysed centrally. Nurses also text patients to make sure they are taking their drugs.

Rwanda has shown that it is possible to provide national health insurance on a limited budget. Some 91% of Rwandans now have insurance—a higher proportion than in the United States. This is one reason why maternal mortality has fallen by three-quarters in Rwanda since 2000. Costs are kept down by using an army of community health workers to offer the first check-up before referring those who need more treatment to a doctor. If Rwanda can do it, so can others.

Huge problems remain. Fake drugs, for example, are far too common in Africa. In Nigeria, a study by the World Health Organisation in 2011 found that 64% of antimalarial drugs were fake. Such drugs are incredibly dangerous. Some are actually poisonous; the rest are harmless in themselves but make people think they are being properly treated when they are not. Governments and drug firms need to work harder to fight the fakes. Scanning systems that verify the origins of every box of pills are available and not too expensive.

Another challenge is the chronic shortage of trained health workers, especially in rural areas. Sub-Saharan Africa has a quarter of the world's disease burden but only 3% of its medical workers. One problem is that many doctors and nurses emigrate to rich countries, but a bigger one is that not enough are trained in the first place. A partial solution is to train rural people as community health workers, the way Rwanda has. Another would be for rich countries to subsidise medical education in Africa.

Big challenges create big opportunities for smart investors. The demand for inexpensive health insurance in Africa is vast and barely tapped. As the mobile telephone revolution has shown, Africans will pay in advance for a service that works. Who will be the M-PESA of African health care?

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