



How Many Millionaires in Africa?

In recent years, numerous pharmaceutical companies installed their branch offices in Africa and are offering to sell medications at a price that is often not different from that in Europe or the United States of America. The people in Africa are poor and in many African countries the gross national product is expressed in hundreds, not in thousands of dollars. It seems paradoxical that, in developing countries, pharmaceutical companies are finding it possible to sell significant numbers of medicines, each of which costs more than the total governments' investment into the health of one of their citizen per year. The paradox is, of course, not limited to the pharmaceutical industry: other industrial sectors producing highly priced articles are also focusing their efforts on the Third World.

The paradox is only apparent. A recent newspaper article (1) drew attention to a report stating that, in Africa, there are more than 80 000 millionaires in \$US, half of them in South Africa and

the rest in other sub-Saharan African countries. Maybe the report was not quite correct in its estimation and it is possible that there are a few thousand more millionaires who have not declared themselves as such. Or, possibly, some have done so without really having all that money. The fact that there are many thousand millionaires in the poorest countries of the world is clearly a signal that we have to adjust our image of Africa and other developing countries and can no longer think of them as being ruled by a rich (and often corrupt) clique while the rest of the population is hopelessly poor. While many people in most countries in the Third World remain poor and starve, there is an increasing number of middle class and rich people who are well off and can afford to live a life similar to that of the middle class people in the developed world. There are, of course, countries that do not follow this rule – countries in which an overwhelming majority is poor and others in which an overwhelming major-

ity is rich: most of the countries of the Third World, however, do not follow either of these two extreme patterns.

Take India, for example. At present, India is the country with the largest middle class population in the world. It is true that 80% of the population is poor and that maybe half of them are never certain whether they will starve tomorrow or die from a disease because they will not have money to pay for a life saving treatment. Yet, in India, there are more than 200 million people who belong to the middle class, which imposes a new style of thinking about the organization of health care and about the Indian population as a target for marketing and sales. The situation is similar in many other countries and there is an urgent need to rethink our management strategies for the health system and for the provision of social services.

Another newspaper (2) recently reported that there are in all some 500 million people living in the countries with a *per capita* in-

come of more than US\$ 21 730, another 2 billion in the countries with a *per capita* income between US\$3260 and 21 730, and 4 billion are in the countries with a *per capita* income of less than US\$3260. If we take the figures for India with its 20% middle class population and apply that to countries with a similar *per capita* income we find another 400 million people in the middle class in those countries. Also, if we halve this proportion (ie, assuming that one person in ten in those countries is in the middle class range) and apply it to the poorest countries, there are another 400 million people that should be added to the total of the middle class population of the world.

These calculations are important from many points of view. Told differently, they mean that there are two times more middle class people in the Third World than in the industrialized countries. This group is unlikely to see the strategies of primary health care as being acceptable and just as unlikely to use any of it. They will seek and finance the development of elite medical care in their own country or indulge in extensive medical tourism, receiving the best of care abroad. They will use medications that are prescribed to them, regardless of the fact that they are considered expensive by a variety of criteria. They will visit specialists directly and pay them for their services without contacting the

general practitioner or a primary health care worker first. The development of “health care at two speeds” – one for the poorest and one for the middle and upper class – will also contribute to a further growth of the gap between the richer and the poorer in other fields – in sports, education, and many other pursuits. The globally-positioned industry will invest into the conquest of markets in the Third World and, being as effective as it is, further underline the difference between social classes. The middle class – being also influential and in positions of power – will also contribute to the image of primary health care as an enterprise suitable for the poor and therefore of a charitable nature – rather than accept it as an overall strategy for the country as a whole. Although often deprived of all health care, the poor will become more and more reluctant to accept primary health care and will continue to aspire to get health care similar to that of the rich. The quality of primary health care provided by the central authority contributes to the reluctance of all potential users to use it: services are often provided in dilapidated buildings, the waiting time is long, and the service is often provided without much smile by health care staff frequently on the verge of an emotional burn-out. Doctors, with rare exceptions, will also shun poorly-paid work far from the cities.

Recent reports also indicate a counter-current in the brain drain – while many highly qualified people from the Third World still migrate to industrialized countries there are also many highly trained managers and other specialists who migrate to the countries of the Third World. According to a recent study (3), the best pay (taking the buying power of the salary into account) for managers is in Turkey; India (where there are already some 25 000 expatriate managers) is on the second place and the earlier eldorados take lower places – USA is on the 13th place and Sweden on the 29th place of 29 countries ordered by the best salaries for managers. Another more important trend – almost completely in the blind spot of governments and intergovernmental organizations – is the growth in the numbers and proportions of doctors in the Third World engaged exclusively or partially in private practice. While abiding by general rules they are not governed by the ministry of health – which often speaks about the health care in their country without any mention of the private sector. Doctors in private practice are often the best in the country, many of them trained abroad for at least some part of their postgraduate education: those who emigrate are frequently those who do not seem to succeed all that well in private practice. Even those seem to be

more reluctant to emigrate now if one is to take as an indicator the relatively slow yield of the active recruitment campaigns for experienced doctors undertaken by the UK and other industrialized country governments.

All this makes the concept of primary health care as originally conceived outdated and insufficient as the chief strategy for the health of the world's citizens. It is probable that it would be wiser to veer toward a different organization of care and policy, using a pragmatic rather than an ideological approach. Medicine has provided three types of technology – primary technology that is of low cost and high effectiveness; secondary technology that is of higher or high cost but is also highly effective; and tertiary technology that is usually of high cost but of mediocre or medium effectiveness. Vaccination against yellow fever belongs to primary technology; appendectomy is an example of secondary technology; and heart transplantation could represent tertiary technology. There will be health care interventions that are on the limits between these three categories, but for a large majority of interventions, the classification should not be too difficult. The primary health care strategy as defined by the Alma Ata conference and subsequent meetings observed this difference to a certain degree, defining some primary technological tools as being its essential ele-

ments. It is however silent about the application of other types of technology and errs by including some examples of secondary and tertiary technology as its essential elements. In addition, and perhaps more importantly, primary health care is a policy directive, and not a guideline or procedure for the organization of health services and the provision of health care (4).

The full application of all three types of technology does cost a lot of money – probably more than even rich countries could provide without harming other vital interests of their society such as education and social welfare. Perhaps governments, in both rich and poor countries, could do more without spending more than they can tolerate if they 1) concentrated on making primary technology tools easily accessible to all citizens through appropriate instruction of all concerned – lay persons and medical staff – and by appropriate orientation of the national health industry toward the production of material related to primary technology; 2) making every effort possible to make secondary technology available to as many of its citizens as possible; and 3) informing the population about tertiary technology, its possibilities and limitations.

Such a reorientation is likely to be immensely difficult for a variety of reasons, including 1) the probable opposition of the medical profession, of the

general public, and of many of the governments' officials; 2) the need for additional investment into health care to ensure the wide application of secondary technology; and 3) the cost of making the population understand the rationale of the changes of health care strategy. The reorientation would also require changing the priorities for governments which currently seem to be moving in the opposite direction, reducing their investment into health care while proclaiming the virtues of private initiatives, of new forms of health insurance and of the decentralization of payment for services to the communal or individual level. Because of all the opposition the change is going to be slow and the acceptance of the need for it even slower: but the reform is inevitable and will have to be accepted by governments and populations alike if the benefits of all that we know about health care are to be preserved and enhanced.

References

- 1 In Africa there are 83 000 millionaires [in French]. 20 minutes. 2006 Aug 10; p. 12.
- 2 Wall B. Facing global challenges while turning a profit. International Herald Tribune, 2006 July 8-9; p. 15.
- 3 Ben Frost report. Available from: <http://www.baygroup.com/uk/media/headline.asp?PageID=2998>. Accessed: November 23, 2006.
- 4 Sartorius N. Psychiatry in the framework of primary health care: a threat or boost to psychiatry. Am J Psychiatry. 1997;154 6 Suppl:67-72. [Medline:9167547](https://pubmed.ncbi.nlm.nih.gov/9167547/)