

Conceptual excellence

Is it possible to get the right human skills to operate in tandem with the right (working) technology, and other affordable services, to achieve an efficient flow of patients? Shima Gyoh is doubtful



When European countries set up colonies in Africa, they missed utilising the locally existing traditional health services – one can presume that this rather monumental oversight must have been due to inaccessibility caused by language difficulties, lack of good roads, or just plain ignorance. Instead, they started the rudiments of what would grow into the health services of present African countries, but the definitive treatment was ‘back home’ in Europe. Independence eventually came, and these services developed beyond first aid into teaching hospitals training doctors and specialists, thus catching up with the pattern, if not the quality of services in the former colonising countries. However, the Africans who replaced their caucasian predecessors appear to have kept the definitive medical attention abroad, where it had been during the colonial era.

It is not that we lacked patriotism. Several attempts have been made to establish ‘centres of excellence’ in our countries through formal declarations to end the traffic of nationals seeking medical attention abroad. Structures have been boldly erected and expensive high tech equipment procured. We have often sent many of our clever doctors to acquire skills at the cutting edge of medical science in all the specialties and believe me they do not always vanish there. The few that come back assume duties in the brand new edifices, keen to demonstrate their expertise right at home. Then problems!

The new specialist needs a high volume of patient flow to maintain his/her skills. The patients exist in their thousands in the community, but they don’t come because they cannot afford even the investigations. The numerous factors of underdevelopment keep the services expensive – special provisions have to be made to ensure reliable power, water supply, and other supportive services. The lifespan of high-tech equipment is short even when properly maintained. The only way out is for the governments to subsidise high-tech treatment for the poor, but they prefer to ‘withdraw subsidies from social services’ as ‘people appreciate better what they pay for.’ This great and onerous principle of capitalism is not applied to the privileged citizens of African countries, particularly heads of governments, their ministers and members of the national assemblies – the very people who have the power to determine the fabric of the health services of their countries. They are also the

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only social group that could pay for their medical treatment, but they have their medical attention, including ordinary check-ups, in developed countries at public expense! The cost of the first class air ticket alone – never mind hotels and other expenses – would easily pay the medical bill of dozens of farmers.

The traffic used to be mainly to the lands of the former colonising powers, except in East Africa, where South Africa – the one African country with credible high-tech medicine – has been the preferred destination. The rest of the English-speaking former colonies preferred Britain and the USA. However escalating costs have now made India and South Africa popular destinations. Medical centres in India are reputed to have widely varying qualities of healthcare, and potential patients need advice on their choice of institutions if they are to avoid controversial outcomes.

When the dignitary from an African country arrives in the UK, USA, or even in South Africa for medical attention, the medical guru giving that attention might easily be from his own country! They may well remark ‘what a small world!’ They could also add ‘created by the big neglect of the health sector in our country!’

By now the poor remuneration and lack of professional satisfaction is making the returnee specialist wonder whether his patriotism was misdirected. Then a philanthropic group arrives from the developed country, carrying all its professional needs and offering for 1 or 2 weeks free treatment for the very condition the specialist is employed to treat. Patients rush there in their thousands. The installations in the new ‘centre of excellence’ (often out of order for one reason or another) move inevitably to deterioration and obsolescence – provided they do not cause instant death from the wild fluctuations of the intermittent power supply. Meanwhile new opportunities in the developed world continue to beckon to our patriotic returnee specialist.

Developed countries always place health and education at the top of their priorities, but these vital tools of development remain severely neglected by most African leaders. Perhaps the constitution of African countries should make it compulsory for everyone holding public office to have all their medical attention at home! This might nudge them to set up credible health services in their own countries. But perish the thought, who would formulate such a constitution? Perhaps the situation would only change when African democracies develop effective electoral teeth that can force governments to be responsive to the needs of their people.