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India looks to improve African health

Dec 1, 2015 | Nilanjan Banik and Philip Stevens

India can be proud of its role in driving down the cost of HIV treatment in Africa, write Nilanjan Banik and Philip Stevens

AT THE recent India-Africa summit in Delhi, Prime Minister Narendra Modi met 54 African heads of state to discuss ways of deepening relationships, including working together to improve public health.

For India, the main goal is to increase its lucrative pharmaceutical exports to Africa, which make up about 16% of total exported items including 85% of all antiretroviral drugs used to treat HIV. African ministers, meanwhile, are keen to copy India's success in developing its drug manufacturing industry, both to secure their own medicine supplies and to give their economies a fillip.

India can be proud of its role in driving down the cost of HIV treatment in Africa and elsewhere through its supply of cheap drugs. It would be unwise, however, to assume that what has worked for HIV will work for all the other health problems faced by Africans and Indians.

HIV has been singled out for attention by western governments, which have poured billions of dollars into health infrastructure in addition to paying for the majority of the (largely Indian-made) antiretroviral drugs that are currently relied on by African patients.

Yet outside a handful of sub-Saharan African countries such as SA, HIV/AIDS constitutes only 3.1% of all deaths (0.77% in India). Far more people die from heart disease, strokes and lung disease, and easily treatable diseases such as diarrhoea remain a leading cause of death.

India manufactures vast quantities of cheap off-patent medicines that could slash death rates for these diseases in Africa and India, but they are not getting to those who need them, either at home or abroad.

India is home to 3,000 pharmaceutical companies and 10,500 drugs factories, yet its citizens struggle to access the most basic medicines.

In New Delhi, essential medicines are frequently only available in a quarter of state government facilities, the primary source of free medicines for the majority of India's low-income population.

Across sub-Saharan Africa, clinics and pharmacies frequently fail to stock basics such as antibiotics.

Even the cheapest, off-patent medicines are unaffordable to the majority on both continents. A single asthma inhaler can cost 50 days' wages in Mozambique, while in India it can cost 2.3 days wages for the lowest-paid government worker.

These generally unaffordable prices are compounded by long-term failures by African and Indian states to create workable health insurance models. These failures impoverish 63-million Indians a year as a result of healthcare costs, which rarely happens in developed countries.

Even if medicines are provided for free, it means little if the health infrastructure is not there to deliver them. There are only 0.7 doctors per 1,000 of the population in

India, well below the three to four seen in most high-income countries.

Relatively wealthy SA has only 0.8 doctors per 1,000 people. These are terrible statistics that are unlikely to improve while governments spend so little on health.

In 2001 there were 189 African governments committed to spending 15% of total government expenditure on health, the minimum amount recommended by the World Health Organisation.

Only Rwanda, Botswana, Zambia and Togo have met this commitment, whereas 19 African countries actually now spend less (SA spends 14%). India only commits 4.3% of government expenditure to health — nowhere near enough.

To improve healthcare in India and Africa, there needs to be more focus on the basics — recruiting staff, building infrastructure, working on pharmaceutical supply chains, committing funds and ensuring people have insurance. India has the resources to make this happen for its people, and it can help Africa develop its own health infrastructure through skills in areas such as telemedicine.

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