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Factors Influencing Access to Healthcare Services

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Traditional Medicine and Healthcare Systems

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Abstract

Following several political upheavals, the country of Madagascar has become one of the poorest countries in the world. This level of poverty affects many aspects of life, especially access to healthcare services. The availability of both allopathic and traditional healthcare to the impoverished citizens of Madagascar was examined through discussions, interviews, and journal articles. It was found that although both the allopathic and traditional medicinal systems do not charge their patients for general consultations and care, there is a high cost for pharmaceutical medications in the allopathic system. These medications are sometimes too expensive for many Malagasy patients to afford. In traditional medicine, the remedies that are prescribed are free of charge, and most also have a scientific basis. In Madagascar and many other countries, this aspect of traditional medicine could fill in the gaps of the allopathic system. The most difficult part would be to erase the stigma attached to traditional medicine. With some effort in this matter, a complementary system between traditional and allopathic medicine could allow equal access to healthcare, no matter one's socioeconomic status.

Introduction

Many factors can influence the way individuals are treated and the type of healthcare they receive; poverty level is a large factor. The Gini Index is a tool that economists use to measure the financial inequality of a nation based on family's wealth, income, and consumption. The index runs from 0 to 1, with 0 indicating a perfectly equal society where everyone has the same amount of wealth and status, to 1 which indicates a completely unequal society, where only one person owns all of the wealth. As a developed economy and large divide between the rich and poor, the Gini coefficient for the United States was calculated to be .34 in the 2000s (Unbottled Gini, 2011). Comparably, the Gini index for Madagascar was .475 in 2007. Seventy-one percent of the population lives in poverty; while the poorest 10 percent of the population share 1.9 percent of the wealth, the richest 10 percent share 36.6 percent (Odedon, 2006). This division in wealth affects all aspects of everyday life, especially the access to and variety of healthcare available.

History of Healthcare in Madagascar

In Madagascar's past, the Malagasy health care system heavily relied on the use of medicinal plants and traditional healers. Traditional medicine had been deeply ingrained in the Malagasy lifestyle. It is believed that the body, soul, and spirit are separate entities, and traditional medicine has the ability to treat diseases in all three (Raharinjanahary, 2013). After colonization in 1896, Madagascar entered into a colonial pact with the French. In this agreement, the French provided technology, military and

financial support, and teachers, and in turn, Madagascar provided the country's natural resources. With the influx of the French culture came the introduction of hospitals and allopathic healthcare. With the appearance of hospitals and a governmental oppression of traditional medicine, Malagasy people began to turn away from traditional remedies and healers (Raharinjanahary, 2013).

With this new dependence on hospitals, the gap between the rich and poor became evident. The many successive political and economic crises that Madagascar has undergone has caused the country to become among the poorest in the world. Following the "coup d'état" of 2009, all foreign aid to Madagascar was suspended and the economy and health sectors were the most affected (Rasamindrakotroka, 2013). The level of poverty is higher in the rural areas than in urban cities, and therefore it is more difficult for people to be able to afford allopathic health care (Ramihantaniarivo, 2013). In urban areas, people are able to work and earn money, and therefore they are able to afford the costs of medical care in a hospital setting. But, in rural areas where there are very few educational and occupational opportunities, it is harder for the people there to afford modern medicines and healthcare services (Raharinjanahary, 2013).

Health Care Systems

The Malagasy health care system operates on the Fanome mechanism, in which general consultations and care are free-of-charge, but the patients have to pay for any drugs, consumables, lab tests, etc. The patients will know the cost of their service ahead of time, so they are able to make a decision. Mutual insurance and social insurance are

available to those with jobs that provide them or make them easier to afford, but only a small minority of the population can afford private health insurance. The Ministry of Health has tried to ensure that healthcare is accessible to the entire population, no matter their income level. An equity fund has been created to cover the costs of drugs and medical care for the poorest people. In this scheme, eligible people are identified by the head of the community as the poorest of their community (Ramihantaniarivo, 2013). This is to ensure that only those eligible for the program are able to receive its benefits.

Health care systems in other countries are weighted against the poor. Case studies from Nigeria and the United States show that poverty level and inequality are major factors that determine how inaccessible healthcare services are. In Nigeria, 77 percent of healthcare financing is through out-of-pocket payments. This shows that a very high percentage of families have to bear the entire burden of the illness, and in turn, they must make healthcare decisions based on their ability to pay. In a case study detailing catastrophic healthcare financing in Nigeria, it was found that healthcare payments increased poverty from 69 percent to 72 percent. This data suggests that healthcare payments increases poverty by about 3 percent (Ichoku & Fonta, 2009). In response, people near or under the poverty line use healthcare services less than needed in order to avoid falling deeper into poverty.

In the United States, a far greater percentage of African Americans and Hispanics are considered to be living in poverty than whites: 24.9 percent for African Americans, 21.8 percent for Hispanics, and 8.3 percent for whites (DeNavas-Walt, Proctor, & Lee,

2006). In minorities, specifically African Americans, the rates of infant and child mortality are higher and life expectancy is lower than in Caucasians. Also, cardiovascular disease, stroke, diabetes, and some cancers affect the African American community much more than white Americans. Along with poorer educational and employment opportunities, these disparities in health may be apparent because of the deficiency of all forms of health care in areas that serve the African American community (Beaglehole, 2003). In contrast, the accessibility to healthcare in Madagascar is affected more by financial constraints, than physical barriers.

Methodology

Through lectures and discussions by University of Antananarivo faculty and local health care workers, the health care practices and policies of Madagascar were explored. Interviews and discussions conducted during excursions to both traditional healers and modern laboratories served as primary sources. Most discussions occurred in a large group setting, but three (Madame Bozy, Dr. Rakotondrasana, and Madame Rasafindranto) were conducted in smaller groups or during a one-on-one interview.

Notes were taken by hand, but there may be human error due to language barriers. Some of the interviewees could speak English, while others spoke French or Malagasy. The responses of those who did not speak English were translated by the academic director, Nat Quansah. The intended meanings and statements may have been

lost in translation. Independent research was conducted with both online and print articles found by using the University of Pittsburgh's online database.

Results

In Madagascar, general health services provided by both allopathic professionals and traditional healers are free of cost to the public. But, the allopathic system charges for medications (Table 1).

Table 1: Responses of Medical Professionals

	Charge for Service?	**Charge for medication/ remedies?**	**Do you think cost is a factor for pt's?**
Urban Allopathic: Dr. Ramihantaniarivo	No – covered by gov't	Yes	Yes!
Rural Allopathic: Dr. Rakotonrasana	No – covered by gov't	Yes	Yes
Allopathic Midwife: Mme Rasafindranto	No – covered by gov't	Yes	Not much
Traditional Birth Attendant: Telovavy	No – no charge at all *Optional gift	No, but pt must come to her for medication	No

Pediatric Traditional Healer: Mme Bozy	No – no charge at all *Optional gift	No, and will inform pt how to get their own medication	No
Traditional Healers at Kingory	No – no charge at all *Optional gift	No	No

The rural allopathic doctor, Dr. Rakotonrasana states that this is one of the biggest problems in the allopathic system. Pharmaceutical drugs are very expensive, and without government subsidies, they are unaffordable to many people. This inability to pay leads to patients choosing to self- medicate with either dangerous, black market drugs or unregulated traditional remedies (Rakotondrasana, 2013).

Although neither Telovavy nor Madame Bozy charge for their services, Telovavy does not tell her patients how to harvest the needed materials for their treatments, but Madame Bozy does. This way, Telovavy's patients are required to come to her to receive their medication, but Madame Bozy's are not. Madame Bozy also stated that her number of patients has gone up in recent years. She believes this is due to the fact that the appreciation of her services has been spread through word of mouth, and also due to the fact that her patients trust her (Bozy, 2013). Dr. Rakotondrasana corroborates Madame Bozy's statements. He has noticed that his number of patients is also increasing, but it is because traditional practitioners are now encouraging people to go to the hospitals for allopathic care. He believes that this change has occurred due to the

fact that traditional medicine has now been legalized, so traditional healers and their patients can now practice freely rather than being concealed (Rakotondrasana, 2013).

Discussion and Analysis

In the past, traditional medicine had been used by the entire community. But now, it is mainly used by the poor and underprivileged who cannot afford allopathic treatment, or with the rich who are in search of healthy alternatives. (Randimbivololona, 2013). Traditional medicine has been diminished to a backup plan; only to be used when allopathic medicine fails. But in reality, traditional medicine may be a better, more cost efficient method. In contrast to the professionals of the allopathic system, traditional medicine practitioners do not normally charge for their services. Typically, patients come back with a gift, but that is not entirely necessary. So the financial burden for traditional medicine is much less than that of allopathic medicine.

Although allopathic medical care is free of cost, the price of many medications is very expensive – much more than many families can afford. This is where traditional medicine could work. Traditional medicine could fix this problem with the medical system by providing a more cost-efficient method of serving the community. And it has already been proven to work in the case of the Clinique de Manongarivo, which was in a rural village in northwestern Madagascar. Priority was given to traditional medicines, and pharmaceutical products where only prescribed if there was no local remedy available (Quansah, 2001). In this system, neither financial nor pharmaceutical resources

were wasted, and the community the clinic served learned how to use their environment in a sustainable manner.

From examining techniques used at the Centre Nationale de l'Application des Recherches Pharmaceutiques (CNARP) and SOTRAMEX, it was seen that both labs use plants that traditional healers have been using for centuries. So, this would show that allopathic medicine is based on a foundation of traditional medicine. But although traditional medicine may have a scientific basis, it would be hard to erase the stigma of these remedies. Traditional medical systems have often been deemed primitive and compared to witchcraft, especially in African nations (Quansah, 2001). For example, In Nigeria, the integration of traditional medicine into the allopathic system may be difficult, even though it would be very beneficial to a significant proportion of the population. In nations such as the United States, much effort would have to be devoted to proving that certain traditional remedies are just as effective as their allopathic counterparts. Instead of spending millions of dollars a year on pharmaceutical drugs, a fraction of that could be used towards the advancement of traditional medicine remedies; these alternatives would be much cheaper, but just as effective. But, in order for these changes to be effective, a change in attitude is first required.

Conclusion

By examining the availability of healthcare to the poor and/or underprivileged in the United States, Nigeria, and Madagascar, it is seen that a person's access to allopathic healthcare is dependent on their means. In Madagascar, allopathic medications are more expensive and difficult for the poor to afford. Traditional medicine and integrated

healthcare may be viable ways to alleviate these problems in the allopathic system. Allopathic healthcare systems are generally not beneficial to the poor, but traditional medicine would be available to all, with minimal relation to financial means. If the stigma of traditional medicine could be eradicated, healthcare could be available to all.

Suggestions for Further Research

With the recent legalization of traditional medicine, Madagascar has become the first African country to have traditional medicine ingrained in its health system (Randia, 2013). The evidence from the Clinique de Manongarivo in Ambodisakoana Village shows that allopathic doctors and traditional healers can work together successfully in an integrated health care system. This system should be brought to other nations that have serious problems in their healthcare systems. A test facility could first be implemented in inner city Baltimore, an area of the United States where there are higher rates of disease and death mainly due to the financial inaccessibility of allopathic healthcare. This facility should operate for at least a year and keep records on the socioeconomic statuses of the patients that come in, and also the reasoning behind their choice to come to this clinic. If the clinic is as successful as the previous one in the Ambodisakoana Village, this system should be implemented in other cities around the United States and other nations to help combat the inaccessibility of healthcare to the poor or disadvantaged.

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