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## Health Care Systems in Africa: Achievements, Challenges and Policy Implications for Achieving Sustainable Development Goal 3

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### **Abstract:**

*The overall objective of the study is analysis of the health outcomes and the challenges of the health care systems in Africa under the dominant neoliberal regimes. Despite the limitations of neoliberal policies, the health care outcomes in Africa have been encouraging: infant, under five, and maternal mortality rates have declined significantly, while access to maternal and child health care services, family planning and to skilled birth attendants has improved. However, African countries still have faced several challenges (i) rising non-communicable disease burden, (ii) inadequate governments' budgetary expenditures, (iii) high out-of-pocket payments, (iv) shortage of health professionals, (v) low quality health care services (vi) low client satisfaction with the services provided.*

*In commercial-oriented health care systems of Africa, there is inverse health care in which the poor with the highest health care needs receive the lowest while the rich with the lowest health care needs but with the highest means receive the highest. In order reverse the situation and to achieve the health-related SDG 3 by 2030, the following interventions are suggested (i) A shift from neoliberal policy stance to developmental state approach and ensure ownership and management of health programs that will enhance effectiveness of the health care systems and achievement of SDG3 by 2030. (ii) Enhancement of inclusive economic growth through increased investments so that African countries' governments will be able to allocate at least 5% GDP to the health care services which are accessible by all. (iii) Publically financed health care is the only means to achieve universal health coverage. To this end, expansion of fiscal space and increased budgetary expenditure on health care through mobilization of adequate domestic resources will eventually ensure achievement of SDG3. (iv) Introduction of mandatory health insurance to protect individuals from catastrophic expenditures while paving the way towards universal health coverage (v) Strengthening primary health care and ensure cost-effective and high impact interventions (vi) Increase public investment in health-related education to create awareness and as part of preventive measures for desired behavioral change among the public. (vii) External debt cancelation and rechanneling the proceeds to health care.*

**Keywords:** *Health care system, neoliberal policies, developmental state, mortality rate, sustainable development goals, catastrophic health expenditure, health insurance*

### **1. Introduction**

Following their independence, huge public investments were made by many African countries in their infrastructures such as roads, ports, telecommunications, power generation, health, education, agriculture and manufacturing industries and as a result encouraging economic progress was documented (Heidhues and Obare, 2011:56). Many African countries also showed significant progress in their health sector in terms of expansion of health services and greater access to the services (CODESRIA, 2015:6). However, in the 1980s, many African countries faced macroeconomic crises and the governments turned to the World Bank (WB) and the International Monetary Fund (IMF) and they were advised to implement structural adjustment programs (SAPs) which include a package of neoliberal policies to address their macroeconomic crisis (Heidhues and Obare, 2011:55; Kumssa and Jones 2015:14). Virtually every African country implemented SAPs, although there is substantial cross-national variation in the timing, speed, extent, and other characteristics of the programs implemented (Kumssa and Jones 2015:4). African countries which comply with IMF/WB Policies were given the opportunity to reschedule their external debts and obtain more loans in order to fill their resource gaps (Kumssa and Jones, 2015:12).

Health care reforms were implemented within a neoliberal framework in order to make health care service provision commercially-oriented and self-financing (Armada, Muntaner and Navarro 2001:729). With the commercialization of health care services and reduction of health care budgetary expenditure, large health costs have been covered from out-of-pocket payments resulting into catastrophic health expenditures, while many people continue

to forego necessary treatment because of their inability to pay (RIIA, 2015, p.23). Inadequate public expenditures on health care have kept health care systems in Africa underfunded, over-stretched, and understaffed, making more challenging in addressing their double disease burdens, communicable and non-communicable (AfDB, 2013 p.1). As a result, Africa has remained a region that has the highest disease burden and mortality rates in the world (AISA, 2010:8; Kumssa and Jones, 2015:1; CODESRIA, 2015:3).

## 2. Problem Statement

The colonization of African countries saw the introduction of "Western" medicine, with services being financed and organized by the colonial powers, largely to meet the needs of colonial officials, military personnel, and settlers rather than the health needs of the colonized people (Chimezie, 2015:209). Upon achieving their independence, many African governments invested in their health services both preventive and curative and funded these services from their tax revenues (Kaseje, 2006:8). Investments were particularly made in child and maternal health. As a result, improvements in health status of their populations were observed (Kaseje, 2006:8). However, in the 1980s, many African countries faced severe macroeconomic crises and they were advised by the international financial institutions (WB and IMF) to implement SAPs in order to reduce or remove distortions generated by government interventions and to eventually stabilize their macroeconomics by controlling inflation, reducing fiscal deficits and the size of the public sector while improving the business environment for the development of private sector and market institutions (Labonté and Stuckler, 2016:2; Colclough, 1995:1).

With respect to health care, public health reforms were made with the objectives to reduce public expenditure on health care and to bring in other forms of private financing such as cost-recovery scheme, and ultimately to make health care service provision efficient and self-financing (wfp, 1996:2; Bond and Dor, 2003:1; Labonté and Stuckler, 2016:2; CODESRIA, 2015:6; Kentikelenis, 2017:4; EQUINET, 2005:17). Thus, SAPs in Africa has resulted into marginalization of social policy and it reflects an ideological attack on the developmental states in the developing countries, while limiting real participation of the poor population in decision-making on all development matters, including health sector development. Under neo-liberalism, health care services have continued to weaken as reflected in the Millennium Development Report of 2015 that many African countries remained off-health related targets with respect to Goal 4: reduce child mortality, Goal 5: Improve maternal Health and, Goal 6: Combat HIV/AIDS, malaria and other diseases (UN, 2015). The health care systems which underpin health care for fee, as organized today in line with the neoliberal policy stance have been unable to effectively address the communicable and non-communicable disease burdens in Africa (Atim, et al., 2008:11).

In a multi-country, multidisciplinary cross-sectional study conducted by the WHO on health services delivery in Africa, respondents rated the health care services as poor. The main reasons for the poor health services were: unavailability of drugs and equipment, poor attitude of health providers, high cost of health care and delays in the provision of care and long waiting time (WHO, 2012:14). Women respondents in the focused group discussion organized by the WHO described the essence of health care organized around cost-sharing or in the form of service for fee as follows: "In all hospitals, even in clinics, there is no love. When you arrive at the hospital, they give you the patient form. He holds his pen. You tell him: Papa, write, my child is dying; he will answer, pay the money. He even crosses his legs; you are anxious, fidgeting and he will insist that you pay the money. Before the money arrives, the child dies. There is no love there. To use the hospital, it is money in full or you'll die if you do not have the money" (WHO, 2012:12).

Structural adjustment programs and neo-liberal policies on health care services in Africa thus have several negative impacts: (i) decrease in the volume and quality of health care services provided following the introduction of stabilization component, particularly austerity measure which reduced public health expenditures. (ii) Mass exodus of highly skilled health personnel leaving the health sector, especially in rural areas and public hospitals as a result of hiring freezes or wage cuts, which compromised provision of basic health care services on sustainable basis. (iii) Limited access of the poor to basic health care services because of shifting health care services provision from fully government funded to a partial or full cost recovery. (iv) Reduction of quality of health care services due to budgetary constraint. (v) Creaking disincentives to health-seeking behavior of people, which lead to lower utilization rates for health care and (vi) worsening of nutritional status of large segments of the populations with negative effects on their health (Bond and Dor, 2003:1; AID, 1995:7; Kentikelenis, 2017:4; CODESRIA, 2015:7).

Neoliberal policies have broader implications because they systematically undermine structural transformation as a social project that could be collectively embarked upon and managed predominantly by governments for a better quality of life of people. Despite the inappropriateness of neoliberal health policies to Africa situation, they have been dogmatically pursued for more than three decades and the health systems have been operating under severe resource constraints: inadequate funding, shortage of medical supplies and health professionals (WHO, 2012:16; PPHF, 1999:193). With only 2 percent of the global health workforce and only 1 percent of the world's health expenditures, health systems in African countries are ill-equipped to adequately address their health problems (WHO, 2013:4). As a result, Africa still bears the bulk of the global burden for maternal and infant mortality (WHO, 2013:4; Bonfrer, 2015:9). Thus, African governments have to rethink their health development strategies in order to make their public health care services efficient and equitable that would considerably improve the health status of their populations.

## 3. Objective of the Study

Health is crucial for sustainable human development, both as an inalienable human right and an essential contributor to the economic development of a country (SDSN, 2014:7). All people, regardless of their social status,

consistently rank good health as their top priority, and health care systems have central role in creating healthy populations (UNDP, 2010:34; AU, ECA; AfDB and UNDP, 2017:8). Health system has three main goals: (i) improve the health of the populations they serve; (ii) respond to the health care needs of populations; and (iii) collect funds from clients in a fair and equitable way (WHO 2000). In Africa, health care delivery systems like in other developing countries are expected to achieve multiple objectives: increase people's access to the health, reduce mortality rates, avoid catastrophic health expenditure, ensure client satisfaction and then achieve better health outcomes. In order to achieve these objectives, African governments also need to address other factors such as nutrition, education, gender equality, water and sanitation, and environmental protection because they also contribute to the achievement of better health outcomes (RIIA, 2015:12; AfDB, 2013:1; Rannan- Eliya, 2006:4).

However, in the era of neo-liberalism, ensuring equitable access to healthcare and achieving better health outcomes have remained among the major challenges of African policy makers. Notwithstanding with the dominance of neo-liberalism, an equitable distribution of health care, distributed according to people's needs instead of ability to pay has become an important goal featuring on many health policy agendas worldwide (UN, 2015:7; 2015 Bonfrer, 2015:49). In September 2015, the United Nations General Assembly adopted, the 2030 Agenda for Sustainable Development with 17 Sustainable Development Goals (SDGs) (UN, 2015:20). The Sustainable Development Goals are universal and all member States have the duty to try to achieve the 17 goals. Health is centrally positioned within the 2030 Agenda for Sustainable Development, with one comprehensive goal – SDG 3: ensure healthy lives and promote well-being for all at all ages, addresses all major health priorities, including reproductive, maternal and child health; communicable, non-communicable and environmental diseases; universal health coverage and access for all to safe, effective, quality and affordable medicines and vaccines (WHO, 2016:11).

The realization of sustainable development goal 3 (SDG 3) will require the development of a coherent, integrated health care system which involve many stakeholders in order to ensure that the health care services provided are equitable and cover all the populations, irrespective of their incomes and locations (WHO, 2018:37). A fundamental step a country can take to realize SDG3 and to promote health equity is to move towards universal health coverage by providing financial protection from rising costs of health services (WHO, 2010). Implementation of health policies for the achievement of universal health coverage need to fulfill four core requirements (i) adequate financing; (ii) availability of sufficient human resources, equipment, and infrastructure; (iii) strong synergies between sectors and involving several stakeholders; and (iv) good governance (SDSN, 2015:20). The efforts of African countries to achieve health-related MDGs and the efforts underway in post 2015 to achieve SDG3 are expected to improve health outcomes in African countries. The overall objective of the study is analysis of the health outcomes and the emerging health challenges of the health systems in Africa under the dominant neoliberal regimes. The specific objectives are:

- Analyze health outcomes in terms of life expectancy, maternal, infant, and under-five mortality rates and client/patient satisfaction;
- Analyze the accessibility of people to basic healthcare services such as reproductive health care and family planning and childhood immunization;
- Analyze the major health –related challenges African countries have faced; and
- Propose intervention measures that would strengthen African health care systems and ensure universal health coverage in line with SDG 3.

Taking into account the problem statement and objectives of the study, the central research questions are: (i). How effective have been health reforms in terms of accessibility and equity and quality? (ii). To what extent have the healthcare reforms meet expectations of the populations of Africa? (iii) What are the major challenges of health care systems in Africa? (iv) What opportunities do African countries have for achieving sustainable goals 3 which take into consideration historical lessons, and current opportunities and challenges facing Africans?

#### 4. Methodology

In methodological perspective, the research is document research. The sources of data are secondary and are collected by conducting extensive literature review from relevant journals, articles, books, relevant publications and reports of international organizations and relevant national policy documents related to healthcare.

##### 4.1. Sample

The study covers African countries in order to generate reliable findings regarding health outcomes under neoliberal era and emerging challenges of health care systems in Africa.

##### 4.2. Method of Data Analysis

The secondary data are processed using excel. The data gathered are contextualized and critically analyzed in line with the objectives and research questions of the study.

#### 5. Organization of the Paper

Following sections 1-4, section 5 deals with conceptual framework regarding health care delivery in the context of socio-economic conditions prevailing in Africa. Section 6 is the main part of the paper and focuses on health outcomes and the major challenges facing African health care systems in the era of neo-liberalism, while section 7 presents discussion, conclusion and intervention measures which are expected to improve health care outcomes in African countries.

### 5.1. Health Care Delivery: Conceptual Framework

Conceptually a health care system can be organized predominantly to meet the health needs of a society or in the form of commodity- service for fee. Economic theory underpins that in a perfectly competitive market, goods or services need to be produced guided by markets so that individual and social benefit will be maximized (Mannsfield, 1996:260). One pre-condition for a perfectly competitive market is that there should be free entry into the market. This means that if there is excess profit to be made; then new firms can start to produce and sell goods and services, bringing profit down to minimum level. Consumers are then paying no more than is absolutely necessary to cover the costs of production so that they have more resources available to satisfy their other needs (Mannsfield, 1996:260). However, the health care markets in African countries are characterized by pervasive market failures due to the existence of monopoly, positive externalities and asymmetry of information. The existence of positive externalities, for instance, justifies the intervention of a government in the health sector. Positive externalities associated with healthcare, water and sanitation exist and that public provision is a logical way to translate those externalities into real economic gains to the public (Çevik and Taşar, 2013:2).

Proponents of neo-liberalism, however, underpin that the state is inefficient in health service delivery and that market-oriented private provider is more efficient (Hahn, 2008:10). The policy implication is that public health care services need to be privatized or introduce user fees as a means of cost sharing while enhancing efficiency in the use of health care resources (Colclough, 1995:1; Chapman, 2014:124). Proponents of neo-liberalism underpin that without user fees, there will be excess consumption of health care services and that more resources will be diverted to the health care, compromising other sectors (Stewart, 1995:71). There are serious flaws in the argument. First, where social returns of investment exceed private returns as in the case of health and education, charging marginal cost will result to the use of services below what is socially optimal or desirable. Second, for both basic health care and education, universal use/access is socially desirable goal which all governments have to provide and that any measure which reduces use/access to basic health care services is socially undesirable (Stewart, 1995:72). Studies also indicate that introduction of user fees at health facilities caused a reduction in healthcare utilization of 5%–51% immediately after the introduction of the user fees (SDSN, 2015:4)

It is clear that left to their own devices, health systems do not gravitate naturally towards the goals of health for all through primary health care as articulated in the Declaration of Alma-Ata (WHO, 2008:15). To date, structural adjustment programs has deprived millions of people their access to basic social services such education and health care because they lack incomes (Global Health Watch 2006:2). From human rights approach there a "moral gap" in the international global health discourse which emphasis on efficiency and private provision in health care as promoted by neoliberal school (Ruger, 2013:3). Health systems where a hands-off or laissez-faire approach to governance has allowed unregulated commercialization of health to flourish, making it an inverse care, where people with the most means and whose health care needs are least often consuming most, whereas those with the least means and greatest health care needs consume the least (WHO, 2008:15). Experiences of other successful countries such as Cuba also suggest governments which develop effective health systems through sustained public investments for many decades have better health outcomes (Chaufan, 2014:92-93). In such countries more emphasis has been given for promotion of healthy communities through prevention, investment in health literacy and the promotion of healthy lifestyles to prevent diseases.

From basic needs approach, healthcare is considered as a basic necessity, not luxury commodity to be purchased in the market. In line with this, it is underpinned that development efforts in Africa have to be responsive to their respective national priorities, and all development programs, including health care programs are owned by their national leadership to meet the needs of their respective populations. Paradoxically, failed neoliberal policies are being replaced by other neoliberal policies defended in terms of 'logical' explanations and positive rhetoric such as 'voices of the poor', 'poverty' reduction strategies and 'participatory' development, with no guarantee to fair access to basic health care for all (Hahn, 2008:2). Thus, unlike neoliberal one-size-fits-all formula, each country in Africa has to lead its own health development, which reflects its specific needs, circumstances and challenges within a developmental state framework. Country ownership is critical because lack of country engagement in formulating health policy means that the policy is inherently inappropriate (UNDP, 2010:32). Thus a shift in paradigm from neo-liberalism to developmental state would be required so that African governments would have the opportunity to properly manage their economies in general and their health sectors in particular. Developmental state is that state, whose politics have concentrated sufficient power, autonomy, capacity and legitimacy at the center in order to shape, pursue and encourage the achievement of explicit developmental objectives (Leftwich, 2000:154). Developmental state has four characteristics. These are: (i). development-oriented political leadership; (ii). Autonomous and effective bureaucracy; (iii) Production-oriented private sector and (iv). Performance-oriented governance (Meyns and Musamba, 2010:21-25). With developmental state, public health care capable of providing services to all according to needs can be ensured. The underlying argument for the central role of the public health care is that people have a right to health care that is not dependent on their incomes. Health care systems in African countries can thus exist in different shapes and forms, but can achieve better outcomes when guided by the principle of social service universality. That is, availability of public services and their provision free-of-charge at the point of entry or at a subsidized level that sufficiently guarantees all people to have access to public health care based on their health care needs. To this ends, governments would be required to expand their fiscal space and commit to adequately finance their public health care systems which will be accessible by all and to achieve SDG3 by 2030 (RIIA, 2015:3).

## 6. Empirical Findings

### 6.1. Health Outcomes

#### 6.1.1. Human Development Index (HDI)

The United Nations Development Program (UNDP) has started published a human development index (HDI since 1990 (UNDP, 2018:1). The HDI is calculated using three dimensions of human development: (i) the ability to lead a long and healthy life, measured by life expectancy at birth; (ii) the ability to acquire knowledge, measured by mean years of schooling and expected years of schooling and (iii) the ability to achieve a decent standard of living, measured by gross national income per capita (UNDP, 2018:1). The HDI of countries ranges between 0-1, and it is a useful comparing inter-country and inter-temporal of living standards of people as it reflects differences in investments in different countries on their social and economic sectors. As shown in Table 1, the HDI of sub-Saharan Africa (SSA) which was 0.398 in 1990 increased to 0.537 in 2017, but still remained lower than the global HDI (0.728), Latin America and the Caribbean (0.758) and East Asia and the Pacific (0.733).

Regions	1990	2000	2010	2017
Sub-Sahara Africa	0.398	0.421	0.498	0.537
Latin America & the Caribbean	0.626	0.686	0.731	0.758
East Asia & the Pacific	0.517	0.597	0.692	0.733
World	0.598	0.642	0.709	0.728

*Table 1: Human Development Index in SSA and Other Regions, Selected Years (1990–2017)  
UNDP, 2018:29*

UNDP defines a value of HDI of 0.504 as low human development and that SSA countries are ranked in the low human development category. The low human development in SSA was because of inadequate investments in their social sectors and that SSA governments still have to exert more efforts in order to build their human resources through increased investments, particularly in health care, education, clean water supply, sanitation and in poverty reduction.

#### 6.1.2. Life Expectancy

A longer life expectancy indicates general improvements in the economic and health of a population. Table 2 shows that life expectancy in the African Region increased by 11 years; from 50 in 1990 to 61 in 2016. But life expectancy in Africa in 2016 was still lower than the Region of the Americas (77 years), South-east Asian region (70 years) and the global average life expectancy (72 years). Life expectancy in African region remained behind other regions because of low per capita income and inadequate investment in health care and other social services such as safe drinking water and sanitation. As a result, there have been persistently large burdens of communicable diseases such as HIV malaria and TB while the non-communicable disease burden continued to deepen (WHO, 2018).

Regions	1990	2013	2016
African Region	50	58	61
Region of the Americas	71	77	77
South-East Asia Region	59	68	70
European Region	72	76	78
Global	64	71	72

*Table 2: Life Expectancy in WHO African and Other Regions, Selected Years (1990-2016)  
Source: WHO, 2015:52; WHO, 2018:66*

Increasing life expectancy in African countries would require increased investment in many sectors, particularly agriculture, health care, education, clean water supply, sanitation. To this and governments must mobilize adequate domestic resources and ensure effective utilization of public resources.

#### 6.1.3. Maternal Mortality Ratio (MMR)

Maternal deaths tend to decline if women have improved access to skilled birth attendants and increased access to family planning (UN, 2009: 30; AU, ECA; AfDB and UNDP, 2017:9). As shown in Table 3, MMR in the WHO African Region decreased from 960 deaths in 1990 to 542 deaths in 2016 per 100,000 live births. Although WHO African Region showed substantial decrease in maternal mortality, still the region bore the highest burden with more than double of global maternal deaths occurring in 2016. Maternal deaths per 100,000 live births, is categorized as very high if it is 300 or higher and as extremely very high if it is 1000 or higher (AU, ECA; AfDB and UNDP, 2017:48). A significant number of African countries still have a very high maternal mortality ratio. Twenty African countries reported a maternal mortality ratio of more than 500 deaths per 100,000 live births in 2015. Sierra Leone had the highest maternal mortality, at 1,360 deaths per 100,000 live births (AU, ECA; AfDB and UNDP, 2017:48). Factors influencing the slow progress on MMR in

African countries include low skilled attendance at delivery, a low prevalence and uptake of modern contraceptives and high unmet needs for family planning, a low met need for emergency obstetric and neonatal care (AU, ECA; Af DB and UNDP, 2017:50).

Region	1990	2000	2013	2015
African Region	960	820	500	542
Region of the Americas	110	81	68	52
South-East Asian region	520	340	190	164
European Region	42	29	17	16
Global	380	330	210	216

Table 3: Maternal Mortality Ratios in WHO African and Other Regions, Selected Years (1990-2015)

Source: WHO, 2015:74; WHO, 2018: 66

In sub-Saharan Africa, only half of live births benefitted from skilled care during delivery in 2016 (UN, 2017:21). The maternal deaths can be addressed at relatively low cost by establishing clinics in rural areas and by training midwives and ensure women have access to good quality antenatal, childbirth and postpartum care (WHO, 2016:54). In the 2030 Agenda for Sustainable Development, the SDG MMR target is to reduce the global maternal mortality ratio to less than 70 per 100 000 live births by 2030 (WHO, 2016:54). To this end, African governments need to increase public investments and scale up essential interventions that are critical for the improvement of maternal, reproductive health and family planning.

#### 6.1.4. Under-Five Mortality Ratio (U5MR)

The under-five mortality rate is a general indicator of child health, of the socioeconomic, environmental and nutritional status of children, not just access to medical care (AU, ECA; AfD Band UNDP, 2017:54). Table 4 shows under-five mortality decreased from 175.6 deaths in 1990 to 80.3 deaths in 2015 per 1000 live births in the WHO African region mainly due to increase in immunization coverage for children (AU, ECA; AfDB and UNDP, 2017:48). However, the under-five mortality rate in the African region was still higher than Region of the Americas (14.7), South-East Asian region (42.5) and the Global (42.5). In the Africa region, a large number of deaths in children fewer than 5 years of age resulted from a small number of common causes, such as diarrhea, malaria, and poor prenatal care (Wesolowski et al., 2015:223). These deaths are largely preventable through health services that are often available at local health facilities, including childhood immunizations and antenatal care for pregnant women. Under-five mortality has also been declining faster among the poorest households in countries such as Eritrea, Ethiopia, Liberia, Madagascar, Malawi, Mozambique, Niger, Rwanda, Uganda and United Republic of Tanzania because of improved equity and effective interventions (UN, 2015:35). Thus, even in resource-limited contexts, governments have the ability to make the political commitments necessary to create sustainable, high-performing healthcare systems.

Region	1990	2000	2013	2015
African Region	175.6	154.9	90.1	81.3
Region of the Americas	42.4	26.1	14.7	14.7
South-East Asian region	118.3	83.4	46.9	42.5
European region	31.9	22.7	12.2	11.3
Global	90.2	75.8	45.6	42.5

Table 4: Under -Five Mortality Rates in WHO African and Other Regions, Selected Years (1990-2015)

Source: WHO, 2015:53; WHO, 2017:92

The SDG target for under-five mortality is to achieve at least as low as 25 per 1,000 live births by 2030 (WHO, 2016:58). To this end, substantial public investments have to be mobilized by governments of African countries in order to scale-up the required interventions directed to child health care services, particularly in rural areas.

#### 6.1.5. Delivery at Health Facility by Trained Personnel

A key strategy for reducing maternal morbidity and mortality is ensuring that every birth occurs with the assistance of skilled health personnel, meaning a medical doctor, nurse or midwife (UN, 2015:39). As shown in Table 5 births attended by skilled health personnel in WHO African region was on the average 53% during the period 2005-2016, much lower than Region of the Americas (96%), South-East Asian region (78%) and global average (78%). Over 18 million African women still do not give birth in health facilities (AfDB, 2013:8). Various factors prevent pregnant women from seeking care during childbirth: limited availability of health services, a lack of information on available services, certain cultural beliefs and attitudes which discourage delivery at health facilities and poverty (AU, ECA; AfDB and UNDP, 2017:50). Such barriers must be addressed at all levels of the health care systems. From the supply-side, training of health professionals will increase the maternal health care services while removal of user fees will increase the demand for delivery at health facilities' assisted by skilled health personnel. For instance, removal of fees in rural Zambia in 2006 and 2007 resulted in a 55% increase in the use of government health facilities. Attendance rates at health centers in Uganda

jumped to 84% when fees were scrapped in 2001. Similarly, when Ghana introduced policy of exemption for women who deliver at health facilities, maternal mortality rate decreased from 500 per 100,000 live births in 2000 to 350 in 2008 (KPMG Africa, 2012:9)

With respect to delivery at health facilities attended by skilled health personnel, the global SDG target is to attain 90 per cent by 2030 (AU, ECA; AfDB and UNDP, 2017:50). To this end, African governments must invest in cost-effective interventions, such as the deployment of health extension workers and community health workers to address the immediate and urgent health needs of women, particularly in rural areas as well as creation of awareness to promote women's desire to deliver at health facilities assisted by health professionals.

Region	Year (2005-2016)
African region	53
Region of the Americas	96
South-East Asian region	78
European region	99
Global	78

Table 5: Births Attended by Skilled Health Personnel in who African and Other Regions (Percent), Selected Year, 2005-2016

Source: WHO, 2017:92

#### 6.1.6. Access to Modern Family Planning

Family planning includes reproductive health information and provision of contraceptives of various types, often highly subsidized or delivered at no cost to the user with the objective to help families reach their desired fertility levels while reducing undesired pregnancy (Perkins, et al, 2013:246). Preventing unintended pregnancy through universal access to family planning is critical to further improvements in the health and wellbeing of women and children (UN, 2017:21). In the African Region, where women are at greater risk of dying in pregnancy or childbirth than anywhere else in the world, family planning becomes essential for the prevention of unintended pregnancy and further reduction of maternal deaths (WHO, 2006:26). Table 6, shows that 52% of women of reproductive age had access to modern family planning methods in African region during the period 2007-2016, lower than Region of the Americas (83%), South-East Asia Region (75%) and the Global average (77%).

When women have greater access to family planning, this ensures better health outcomes for both mother and child. In line with this, the SDG target is to ensure universal access to the services and integrate reproductive health into countries' national strategies and programs by 2030, (AU, ECA; AfDB and UNDP, 2017:47). With the strengthening of integrated reproductive health and family planning, there are gains such as improvements in women's educational attainment, increase in women labor force participation, increase women labor productivity and income earnings and higher households' savings (AU, ECA; AfDB and UNDP, 2017:61). African governments must thus exert more efforts and increase investment in reproductive health services and family planning, creating awareness on the importance of family planning and ensure universal access to the services

Table 6: Women of reproductive age who have their family planning need satisfied in WHO African and other regions (percent), selected years, 2007-2017

WHO	2007-2017
African Region	52.20%
Region of the Americas	83%
South-East Asia Region	75.10%
European Region	75. Region 10%
Global	77.40%

Table 6: Births Attended by Skilled Health Personnel in who African and Other Regions (Percent), Selected Year, 2005-2016

Source: WHO, 2018, P.74

#### 6.1.7. Childhood Immunization Coverage

Childhood immunization coverage measured by coverage of DPT3 (diphtheria toxoid, tetanus toxoid and pertussis vaccine) helps to improve child, newborn and maternal health (WHO, 2018:5). As shown in Table 7, immunization coverage in African region reached 74% in 2016, which is lower than region of the Americas (91%), South-East Asia region (98%) and the global average (86%). Based on Table 7, more than a quarter of children are still unvaccinated against vaccine-preventable diseases in Africa. Thus more investment and scaling up of the vaccination coverage will be required to reach universal coverage and to substantially reduce child mortality rates in African countries.

Regions	2013	2015	2016
African region	75	76	74
Region of the Americas	90	91	91
South-East Asia region	77	87	98
European region	96	93	92
Global	84	86	86

*Table 7: Immunization Coverage of DPT3 among 1-Year-Olds in WHO African and Other Regions (%), Selected Years, 2013-2016  
WHO, 2015:98; WHO, 2017:100; WHO, 2018:5*

## 6.2. Challenges Confronting Health Care Systems in Africa

### 6.2.1. Rising Non-Communicable Disease Burden

While Africa has still faced overwhelming burden of communicable diseases (CD) non-communicable diseases (NCD) such as diabetes and hypertension are becoming another major disease burden. The incidence of non-communicable disease accounts for 21% of Africa's overall disease burden and the NCD is predicted to overtake the burden of CD by the year 2030 (AfDB, 2013:17; WHO, 2016:1). The main drivers of NCD are rapid urbanization and changes in lifestyles associated with economic development, increase in risk behaviors of people including smoking and drinking alcohol, changes in diets and inadequate physical activities (Dalal, et al. 2011:2). Non-communicable diseases cause billions of dollars in losses of national income, while pushing millions of people below the poverty line (WHO, 2011). The epidemiologic transition to NCD is thus competing for more resources with CD, because patients with NCD make significant demands on health care resources. Thus governments would be required to mobilize more resources for cost effective prevention and treatment of the NCD. A "no-priority" position in relation to non-communicable disease will hinder achieving SDG target of reducing premature mortality from NCD by one third by 2030 (AU, ECA; AfDB and UNDP, 2017:47).

### 6.2.2. Inadequate Budgetary Expenditures on Health Care Services

In Africa, the main sources of financing health care services are from governments' budgets. However, the governments' expenditures on health sector have historically remained low because of their limited fiscal space and their low public revenues, a reflection of the low economic development of their respective countries. As shown in Table 8, during the period 2001-2014, general governments' expenditure on health as a share of total general government expenditure in the ten African countries had big variations and with fluctuating trends. In 2014, general governments' expenditure on health as a share of total general government expenditure was between 3.6% (Eritrea), lowest in the group to 11.3% (Zambia), highest in the group. However, the expenditures of the countries were far below the Abuja Declaration target of allocating at least 15% of national budget to health (WHO, 2013:3). Recently, there has been a shift from the Abuja target to a target of allocating at least of 5% of GDP to the health care and move towards universal health coverage expected to be achieved by 2030 (McIntyre and Røttingen, 2017). To date, inadequate budgetary expenditures in many African countries still remain a persistent challenge to address their double disease burdens.

Addressing the issue of sustainable health care financing is a public health matter of utmost importance. Thus, governments need to enhance their economic growth so that they will be able to mobilize adequate revenues that will adequately finance their health care systems on sustainable basis, and subsequently reach the target of universal health coverage by 2030. To this end, fiscal spaces of African governments need to be expanded so that they will be able to manage their economic development in general and health care systems in particular.

Countries	2001	2005	2010	2014
Algeria	10	8	9	9.9
Benin	12	11	10	9.6
Botswana	10	17	17	8.8
Cameroon	7	8	9	4.3
Chad	14	13	3	9
DRC	3	7	9	11.1
Eritrea	5	2	4	3.6
Rwanda	10	16	20	9.9
Uganda	10	11	12	11
Zambia	11	15	16	11.3

*Table 8: General Government Expenditure on Health as a Share of Total General Government Expenditure (Percent), Selected African Countries, 2001-2010  
Source: WHO, 2013:23; WHO, 2017:94-100*

### 6.2.3. Impoverishing Health Care Services due to Catastrophic Out-of-Pocket Payments

With the commercialization of health care services following the adoption of neoliberal policies, people have no option but to cover their healthcare services from out-of-pocket payments (OOP). out-of-pocket payments weighs heavily on household's budgets and forces many into a poverty trap due to unpredictable catastrophic health expenditure (KPMG

Africa, 2012:9). OOP for health care in African countries which is less than 20% of the total health expenditures is considered as non-catastrophic and not impoverishing (WHO, 2010:97-99; WHO, 2012 :11). Studies also indicate that, on the average, 45 percent of total health expenditures in African countries come directly from households as out-of-pocket payment (Atim, et al 2008:21). Out-of-pocket expenses on health care services are the most expensive, least efficient and least inclusive financing method (RESYST, 2013:6).

Table 9 shows that the OOP as percentage of current health expenditure in African region ranged between 41% - 35% during the period 2006-2015. This means more than one-third of the current of health care expenditures is covered from OOP, much higher than 20% total health expenditure. Around 11 million Africans fall into poverty every year as a result of high OOP for health care services (The Economist Intelligence Unit, 2017:.8). Despite rising costs of public health care services and a considerable increase in OOP, most African population are still not covered by health insurance, making more people vulnerable to catastrophic expenditures. Catastrophic out-of-pocket payments to health care can be avoided by introducing mandatory health insurance as a means of protection against impoverishing effect of health payments. Also efforts by public authorities to determine health care fees and set care standards among private providers which have remained weak need to be strengthened.

	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015
Africa Region	41	41	40	40	39	38	38	37	36	35
South East Asian Region	46	46	45	44	45	44	43	41	42	42
Region of the Americas	37	37	36	35	35	34	34	34	33	33
World	36	36	35	34	35	34	34	34	33	33

*Table 9: Out-of-Pocket Payments as Percentage of Current Health Expenditure in WHO African and Other Regions, Selected Years, 2006-2015*  
Source: WHO Global Health Expenditure Database

#### 6.2.4. Shortage of Health Professionals

African countries traditionally had fewer healthcare workers per head than anywhere else in the world (AfDB, 2013:9). The shortage of health professionals has also been aggravated by the outmigration of the health professionals such as nurses and doctors from Africa (Naicker, Saraladevi et al 2009:2). According to WHO the shortfall of health workers in Africa exceeded 1.5 million people (United Nations 2009:172). African countries affected by health workforce shortage are facing challenges in their efforts to provide basic health care services that meet the health needs of their populations (AfDB, 2013:9).

Table 10 shows that skilled health professional density in African countries and taking Finland and Cuba as benchmarks. With respect to physician density, African countries had less than two physicians per 1000 population during the period 2007-2016, a very low density compared, to those of Finland (3.20) and Cuba (7.5). With respect to density of dentistry, most African countries had zero value except Algeria (0.3) and South Africa (0.2). Density in Africa was extremely far away from those of Finland (0.7) and Cuba (1.8) during the period 2007-2016. With regards to density of nursing and midwifery, South Africa had the highest density (5.2), but the density ratios of many African countries remained far lesser than those of Finland (15) and Cuba (8).

Country	Density of physicians per 1000 population	Density of Nursing and Midwifery personnel per 1000 population	Density of dentistry personnel per 1000 population	Density of pharmaceutical personnel per 1000 population
	2007-2016	2007-2016	2007-2016	2007-2016
Algeria	1.2	1.9	0.3	0.2
Gabon	0.4	2.9	0	0.1
Gambia	0.1	1.6	0	0.1
Ghana	0.1	0.9	0	0.1
Kenya	0.2	1.6	0	0.1
Madagascar	0.1	0.2	0	0
Mali	0.1	0.4	0	0
Senegal	0.1	0.3	0	0
South Africa	0.8	5.2	0.2	0.7
Uganda	0.1	0.6	0	0
Zimbabwe	0.1	1.2	0	0
Finland	3.2	15	0.7	1.1
Cuba	7.5	8	1.8	0.3

*Table 10: Density of Health Professional in Selected African Countries, 2007-2016*  
WHO, 2018: 69-75

Thus, African government need to increase investments for the development of healthcare workforce (doctors, nurses and other health professionals) while creating attractive working environment to reverse outmigration of their health professionals in order to achieve sustainable healthcare goal 3 by 2030.

#### 6.2.5. Low Quality Health Care Services Due to Shortage of Health Professionals and Other Resources

For the clients and communities served by health care facilities, quality care is that which meets their perceived health care needs, and is delivered courteously and on time. Inpatient bed density, physician density and lost life expectancy serve as a proxy for the overall quality of health service delivery (UNDP, 2018:83). Inpatient bed density is measured by hospital beds per 10,000 people. Lost health expectancy is the relative difference between life expectancy and healthy life expectancy expressed as a percentage of the life expectancy at birth. The higher the value, the higher will be the lost health expectancy because of disease and injury (UNDP, 2018:51). Physician density is measured by the number of physicians per 10,000 people.

Table 11 shows that lost health expectancy in SSA is 12 % of the life expectancy, same as global average and not far from other regions in 2016. However, physician per 10,000 populations was 1.9 for SSA much lower than Latin America and the Caribbean (20.4), South Asia (7.8) and the world average (18.3) during the period 2007-2017. SSA also had lower hospital bed per 10,000 populations (15) lower than Latin America and the Caribbean (20), European and central Asia (51) and world average (27) during the period 2007-2014.

Region	Lost Health Expectancy%	Physicians Per 10,000 People	Hospital Beds Per 10,000 People
	2016	2007-2017	2007-2014
Sub-Saharan Africa	12	1.9	15
South Asia	13.7	7.8	8
Latin America & the Caribbean	11.6	20.4	20
Europe & central Asia	12	24.7	51
World	12	18.3	27

*Table 11: Quality of Health Care in Sub-Sahara Africa and Other Regions, Selected Years, 2007-2017  
UNDP, 2018: 83*

In most Africa countries shortage of resources (health professionals and other resources) still remains a major constraint in providing high quality health care services to the public (WHO, 2018: 52). In line with this, WHO conducted a study on health care systems performances in the African Region using four attributes of health system performances: (i) Access to health and health related essential services (ii) quality of care during provision of essential health and health-related services; (iii) effective demand for health and health-related essential services and (iv) resilience in provision of essential health and health-related services (WHO, 2018:61). The aggregated health system performance score for the African Region was 49% in the scale of 0%-100%. This means that the health systems on the average were only functioning at 49% of their achievable levels of performances (WHO, 2018:6). The study also indicated wide variations in health system performances with the combined score ranging from 0.26 to 0.70. This shows that the best performing health system in the African Region was only performing at 70% of what was feasible. However, most of the African countries (41 Countries) the performances of their health systems ranged from 40%-60%, a rather narrow performances range (WHO, 2018:61). Thus, African governments would be required to increase investments in order to improve the performances and quality of their health care services to achieve health related SDGs by 2030.

#### 6.2.6. Low Client /Patient Satisfaction with Health Care Services

One way of measuring client/patient satisfaction is assessment of responsiveness of health care systems to the individual needs of patients and all inhabitants (WHO 2010:34). Responsiveness in health care systems is the extent to which (i) clients/patients are treated with dignity, autonomy and confidentiality; (ii) patients /clients receive prompt attention; (iii) patients receive the quality of basic amenities; (iv) patients have access to social support networks while receiving care and treatment; (v) communication between providers and clients is smooth; and (vi) patients /clients can make choose health-care providers (WHO 2010:34).

Table 12 shows that 47% of respondents from SSA expressed their satisfaction with the provision of health care services which is higher than Latin America & Caribbean (43%), but lower than South Asia (62%) and the world average (60%) during the period 2012-2017. The overall responsiveness varies across countries of the Region, from a high of 0.85 to a low of 0.14 in the scale of 1-0 (WHO, 2018:54). With regards to "prompt attention to clients or patients" only 12 % of the total respondents felt that clients can get to a facility offering services they need in less than 30 minutes, as compared with 68% who disagreed. Furthermore, only 7% of total respondents thought that clients usually spend under 30 minutes at a facility before they received services, in contrast with 81% who disagreed (WHO, 2018:52). Thirteen per cent of respondents agreed that clients usually receive all the services they need within 2 hours of arriving at a health facility as compared to 62% who disagreed; that clients will usually spend an unnecessarily long time waiting for elective procedures was agreed by 71% of respondents (WHO, 2018:52).

Region	%Age of Respondents Satisfied with the Health Care Services
	2012-2017
Sub-Sahara Africa	47
Latin America & Caribbean	43
South Asia	62
Europe and central Asia	55
World	60

Table 12: Client Satisfaction with Basic Health Care Services Provided in SSA and Other Regions (Percent), Selected Years (2012-2017)

Source: UNDP, 2018:75

Respondents indicated that inadequate health professionals, long queues due to overcrowding in public facilities, including secondary and tertiary facilities, lack of health facilities near households seeking health care, particularly in rural settings as the main reasons for delayed attention while seeking health care services (WHO, 2018:52). Thus, given that health care systems in Africa have been operating under serious resources constraints, it is plausible that health care services in most African countries to remain below the expectation of their clients. Thus, increase public investments will be required in order to make the health care systems more responsive to the clients' health needs and to achieve the health-related sustainable development goals by 2030.

## 7. Discussion, Conclusion and Suggested Interventions

This paper analyzed health care systems in Africa: achievements and challenges in view of the dominant neoliberal paradigm and the 2030 Agenda for health related sustainable development goal 3. While making appreciable social and economic progress in their early periods of their independence, in the 1980s, many African countries faced macroeconomic crises. The respective governments turned to the World Bank and International Monetary Fund and agreed to implement neoliberal policies that are externally driven by Western neoliberal ideology with low endogenous policy contents. Structural adjustment programs fostered by the WB and IMF have required African governments to cut their social spending while pushing governments for health care reforms within a neoliberal framework that strengthen the role of the market in the provision of health care services and eventually to make health care service provision self-financing and commercial oriented. African countries which comply with IMF/WB policies were given the opportunity to reschedule their external debts and obtain more loans while their fiscal spaces were kept limited.

Despite resource constraint, over the past three decades, health care systems in Africa have shown encouraging outcomes. There have been, on the average, significant declines in infant, under five, and maternal mortality rates. Also there have been expanded accesses to material and child health care services, family planning and to skilled birth attendants. Despite encouraging trends in the outcomes of the health care systems, most African countries still have faced several challenges: rising non-communicable disease burden, inadequate governments' budgetary expenditures, high out-of-pocket payments, shortage of health professionals, low quality health care services low client satisfaction with the services provided. With the rapidly increasing NCD such as diabetics and hypertension the demand for health resources is rapidly increasing and that there is real concern because resources are inadequate to deal with the double diseases. The challenge is mobilizing more resources to address the communicable and non-communicable disease burdens.

In commercially oriented health care system organizations, high dependence on out-of-pocket payments has also led to impoverishment of millions of people in Africa. Thus, neoliberal policies have become a form of structural barrier in accessing health care services, disproportionately for the poor because they have low paying capacity for their health care services. Given the absence of social health insurance in many African countries and commercial orientation of the health care systems, there is inverse health care. That is the poor with the highest health care needs will receive lowest, while the rich with the lowest health care needs will receive the highest because they have the means. As a result, ensuring equitable access to public health care has remained another challenge in Africa. Moreover, within the context of limited fiscal space, governments in African countries have faced even more challenge in their efforts to achieve the health-related SDG 3: Ensure healthy lives and promote well-being for all at all ages.

The externally designed neoliberal health policies do not reflect the socio-political realities of African countries and the expectations of populations with respect to health care have not been met. Thus, a paradigm shifts from neoliberal to developmental state approach to the African countries' development in general and their health sector in particular is needed so that governments fiscal space will be expanded and that the agenda for health sector development will be fully under the control and management of the respective governments in which their respective communities will also play central role. The developmental state approach to health sector development would not ignore the concerns about the rising cost of health care and the importance of achieving greater efficiency in their health care systems. Spending has to be reoriented from costly high- technology services for the few to primary health care approach that meet the needs of the majority of people, thus enhancing simultaneous efficiency and health care performances. The starting point for creating a sustainable healthcare system is to prioritize the needs of the population so that the limited resources are deployed in the most effective way.

The paper concludes that while encouraging trend has been observed in the health outcomes in Africa, most health systems are still fragile due to resource-limited settings and inappropriate neoliberal policies. As a result, most African countries are overwhelmed with the double burden of disease and that the health care systems still have faced challenges with regards to accessibility, equity, and quality of services. While implementing health-related SDG3 African

countries will even face more challenges due to resource constraints. African governments should thus take the responsibility at the highest levels in mobilizing resources for ensuring health for all and making health and human well-being central goals of all their development activities. Thus, unlike neoliberal all size-fit, each country in Africa has to lead its own health development, which reflects its specific needs, circumstances, and challenges within a developmental state framework. Country ownership in health sector development is critical because lack of ownership in formulating health policy means that the policy will be inherently inappropriate. In a developmental state approach health care systems African countries can thus exist in different shapes and forms, but can achieve better outcomes when guided by the principle of social service universality in which communities play their respective roles. To promote physical and mental health and well-being of their respective populations, African governments must push for universal health coverage and ensure access to quality health care services based health needs. To these ends the following interventions are suggested.

### 7. 1. Suggested Interventions

- A shift from neoliberal policy stance to developmental state approach and ensure ownership and management of health programs in order to enhance effectiveness of the health care systems and achievement of SDG3 by 2030.
- Enhancement of inclusive economic growth through increased investments so that governments will be able to allocate at least 5% GDP to the health care services which are accessible by all.
- Publically financed health care is the only means to achieve universal health coverage. To this end, expansion of fiscal space and increased budgetary expenditure on health care through mobilization of adequate domestic resources will eventually ensure achievement of SDG3.
- Introduction of mandatory health insurance to protect individuals from catastrophic expenditures while paving the way towards universal health coverage.
- Strengthening primary health care and ensure cost-effective and high impact interventions.
- Increase public investment in health-related education to create awareness and as part of preventive measures for desired behavioral change among the public.
- External debt cancelation and rechanneling the proceeds to health care and education.

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