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**A prosperous future**

For many on the African continent, Covid-19 was not even the only public health emergency of the past year. In the Democratic Republic of the Congo, for example, people were also faced with the re-emergence of Ebola and a new measles outbreak. In Nigeria, a yellow fever outbreak detected in early November already claimed dozens of lives. In Cameroon, an outbreak of cholera in September killed at least 90 people. As our governments struggled to efficiently respond to multiple, interconnected public health crises, we became acutely aware of the shortcomings and failures of our health systems and social safety nets.

And perhaps for the first time in recent history, our political leaders also personally experienced the weaknesses of local health systems. With international travel coming to a halt, they found themselves unable to travel to Europe, Asia and the Gulf for treatment, and had to make do with the treatments and facilities available in their own countries. Burundian President Pierre Nkurunziza unexpectedly died in June, a week after travelling to Kenya for medical treatment, at the age of just 55.

So these last few days of 2020 should be an opportunity for every single one of us in Africa, but especially for our political leaders, to ask: Where did our health systems go so wrong, and what can we do to make sure we never again find ourselves in such a disastrous situation in the face of a global health emergency?

In 1952, when Kwame Nkrumah became Ghana’s prime minister, the country’s health system was crumbling. According to medical historian Stephen Addae, the health service consisting of a few mostly European doctors and a small cadre of auxiliary medical staff was only able to meet the needs of around 20 percent of the population and their efforts were mostly concentrated in the relatively prosperous southern regions of the country.

Yet, Nkrumah, who claimed the title of Ghana’s first post-colonial leader after the country’s declaration of independence from Britain in 1957, managed to turn the situation around in less than a decade. He built new health centres and medical field units across the country, adopted modern healthcare concepts, introduced holistic medical care to communities, invested in educating medical staff and created doctor-led health teams to oversee local medical operations. With no direct out-of-pocket payment at the point of service delivery, healthcare in the country was financed entirely through government tax revenue. As a result of his efforts, the infant mortality rate declined from a high of 350/1,000 in 1915 to 110/1,000 in 1960. The successful national health system Nkrumah managed to build in a matter of just a few years with limited resources is testament to what a government can achieve if it prioritises healthcare.

Tanzania also has a similar success story. In 1967, the government of independent Tanzania’s first president Julius Nyerere initiated major health sector reforms in line with the socialist principles outlined in the Arusha declaration, with the aim of providing high-quality public healthcare to the poor and marginalised citizens of Tanzania. By 1977, the government had banned private, for-profit healthcare in the country and was able to provide free health services to all Tanzanians.

These are only two examples of how in the early post-colonial era many young African states significantly improved their health indicators by making health a public investment priority. As renowned economist Thandika Mkandawire explains, during this period, most African states assumed a develop mentalist attitude and sought to improve the socio-economic conditions of their citizens, in addition to securing their newly earned political and civil rights.

But it all changed in the 1980s when the IMF and the World Bank introduced their so-called ‘Structural Adjustment Programmes’ to the continent. Following the advice they received from these institutions, African governments severely reduced their investments in social and public services, hoping that the private sector would fill the gap. As a result, healthcare institutions across the continent started charging patients, and unsurprisingly, health indicators plummeted. It was only in 2001 that the IMF and World Bank accepted that their policy experiments had been a failure in Africa.

After almost two decades of neoliberal ‘structural adjustments’ the situation on the continent was so dire that in 2001 African states gathered in Abuja and committed to spend at least 15 percent of their GDPs on healthcare.

This was an impressive and ambitious commitment. But today, almost two decades after that meeting, only a handful of countries have been able to meet, or even get close to that target. To the contrary, many African states are still reducing their health spending on a regular basis. In fact, instead of making the health of their citizens a state priority, many African governments in the past two decades left their national health services to the mercy of donor countries and international NGOs.

Today, the healthcare systems of many African countries are heavily subsidised by donor funding. We depend on the charity and whimsical decisions of donor countries to survive. The danger posed by this arrangement became ever more clear this year, as the economies of traditional donor states themselves have been shattered because of the pandemic, leaving them unable and unwilling to fund healthcare in Africa.

Excerpted: ‘After COVID, Africa needs to make healthcare a priority’

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