COVID-19 and progress towards achieving universal health coverage in Africa: A case of Nigeria

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Abstract

Universal Health Coverage (UHC) 2030 is a global health target, and countries are making efforts to convert plans into tangible results. Nigeria, the most populated country in Africa, has made commitments towards UHC2030 target but is underperforming across many building blocks of health and progress has been slow. The arrival of COVID-19 poses additional pressure on the already feeble health system causing the government to direct focus towards containing the pandemic. However, existing gaps in health workforce density, weak primary health care infrastructure and inadequate budgetary allocation have resulted in inequitable access to basic healthcare services. This situation weighs most heavily on the poor who are mostly part of the informal economy thereby pushing people further into poverty. On the other hand, COVID-19 has provided valuable insights into Nigeria's current health system status which hopefully can be helpful in strengthening efforts towards building resilient health system and preparing the country towards future pandemic. The pandemic has highlighted the importance of essential health services and the need to strengthen primary healthcare system. It is, therefore, important that stakeholders in Nigeria and other African countries carry out situation analysis of the current health systems towards achieving UHC2030.

Keywords: Africa, COVID-19, health system strengthening, Nigeria, Universal Health Coverage

COMMENTARY

Coronavirus disease 2019 (COVID-19) is defined as an illness caused by a novel coronavirus called severe acute respiratory syndrome coronavirus 2 (SARS-COV-2).[1] It was first reported to the World Health Organization (WHO) on 31 December 2019.[2] The outbreak was declared a global health emergency by the WHO on 30 January 2020.[2] On 11 March 2020, the WHO declared COVID-19 a global pandemic at a press conference held in Geneva following 3-fold increase in the number of countries with confirmed cases within 14 days period.[3] With the rapid spread of COVID-19 and numerical increase in case counts worldwide, there are concerns among stakeholders on the potential impact of the pandemic towards achieving Universal Health Coverage (UHC) target by 2030. Nigeria alongside other African countries in the continent have moved from pandemic readiness to pandemic response and is directing all its resources towards containing the pandemic.[2] As of 10 January 2021, there are 97,478 cases and 1342 deaths across 36 states in Nigeria including the Federal Capital Territory.[4] The increasing case counts made the government to implement several public health and social measures such as local movement restrictions which have important implications on economy and health services including access to medicines. These have potential impact on the existing feeble health system and efforts towards achieving UHC target. This begs for the questions; (a). What are the impacts of COVID-19 on the current health system status? (b). Will Nigeria health system benefit from the pandemic towards achieving UHC by 2030?

Nigeria, the most populated country in Africa, is a federation of 36 states and a federal capital territory, and there are 774 local government areas across the country. According to the World Bank Group in 2015, Nigeria has a population of 200 million people and a gross domestic product of $397 Billion.[5] Nigeria healthcare system is predominantly run by the public sector with fewer private sector involvement. There is a total of 40,475 hospitals and clinics, 74.8% of which is own and run by three tiers of government (federal, state and local government) and 25% own by the private sector.[6] All tertiary health facilities and some public secondary health facilities are owned by the federal government. The state government owns most public secondary health facilities and host at least one federal tertiary-owned health facility. The local government runs the primary healthcare facilities. The public tertiary and secondary healthcare facilities are vastly located in urban areas and cities while primary health centres are mostly found in rural areas. Preventive healthcare services are substantially run by government agencies including non-governmental organizations. However, COVID-19 has brought to the fore several deficiencies in Nigeria's healthcare capacity. Some states in the country have reported shortage of bed space for COVID-19 patients. This calls for the need to strengthen the public health capacity as we continue to gear towards achieving UHC.

The Nigerian government has examined several health developments plans and structural adjustment programs in an effort to strengthen the health system and to attain sustainable strategies towards achieving UHC. However, this examination must be followed with action. An important milestone in the history of world health is the declaration of Alma-Ata in 1978 which put health equity on international policy concern and prescription of primary healthcare as a core concept of WHO's goal of health for all. This declaration led to the establishment of Basic Health Service Scheme with the setting

up of primary healthcare as an integral part of health development in Nigeria. The objectives of the scheme were to increase the proportion of population who have access to health service from 25% to 60%, promote even distribution of health facilities and provide infrastructural base for preventive health services.[7] This lofty goal has not been achieved in past 2 decades as development trends in Nigeria's health system have not been marked by any spectacular change. The health system capacity developed from previous strategies have been overstretched and infrastructural health system broken beyond repair. A recent analysis revealed that for Nigeria to achieve UHC, it has to increase its budgetary allocation and ensure prudent spending of the health allocations.[1] The distribution of resources across the three tiers of healthcare in Nigeria is inequitably executed with bulk of the expenditure favouring secondary and tertiary health facilities. This is complicated by loss of highly skilled manpower due to brain drain and inadequate budgetary allocation of at least 15% as recommended by the Abuja 2001 declaration.[1] This situation doubly compounded by COVID-19 has significant impact on the 51.4% of Nigeria's population living in rural areas resulting in lack of access to quality healthcare.[8]

The emergence of COVID-19 pandemic appears to pose pressure on an existing fragile health system in Nigeria revealing shortcomings in several health components.[9] Government has remained undeterred in the face of the pandemic, putting in place various steps to limit and contain the spread of the virus; the national emergency operation from the Federal Ministry of Health through the Rapid Response Teams from Nigeria Centre for Disease Control; measures were also put in place by the Presidential Task Force on COVID-19 to curtail the spread of the disease and protect the lives of the citizens. While Nigeria continue to struggle and show commitment towards achieving UHC target through its national agenda, advancement have been slow due to underperformance in health service delivery, health workforce, health information system, health financing, governance and access to essential medicines.[9] Unprecedented health emergency such as COVID-19 has undermined progress towards achieving UHC in Nigeria. Although there have been relative successes in identifying and tracking suspected cases due to increase in numbers of laboratories across the country, the pandemic presents extra stress on the supply aspect of the health system. As a result, there is further disruption in access to essential health services and social security.

The pandemic has caused deterioration in quality of health service delivery (in relation to inadequate workforce capacity, insufficient equipment and medicine supply). Nigeria has the highest stock of health workforce in Africa but is not sufficient to effectively meet the essential healthcare needs of its citizens. Health workforce density is 1.9 per 1000 population which is below the WHO recommended standard of 2.3 per 1000.[10] COVID-19 has reorganized health workforce in Nigeria as resources are being channelled to prevent spread of the virus. The shortage of health workers has led to posting of medical staff to COVID-19 isolation facilities which further deteriorates delivery of essential medical services including non-communicable diseases, HIV, tuberculosis and maternal and child health. A direct implication of this situation is on the poor whom otherwise have to seek for essential medical services in private hospitals in the cities resulting in high out-of-pocket (OOP) spending which may further push people into poverty and potentially leading to increase in health insecurities amongst the population. The shortage of health workforce coupled with insufficient personal protective equipment

have made hospitals across the country to consider the option of postponing patients' appointment and discharging patients in order to avoid overcrowding. This will potentially have a huge impact on acute and chronic disease progression. COVID-19 pandemic has brought to the fore the limited health workforce in the country. It is important that the country and other African countries start to invest in increasing human resources for health as we geared towards ensuring good health and well-being for all.

Health financing is one of the critical input in health service provision and helps determine a country's ability to achieve UHC and socioeconomic development.[11] An ideal healthcare financing strategy ensures adequate access to primary healthcare which increases capacity to respond to health emergencies such as COVID-19. The major sources of financing for health sector in Nigeria are government budget using tax revenue, direct OOP payments, social insurance scheme and donor funding. Over the years, Nigeria's health system has been rated poorly in terms of health care financing. Inadequate institutional capacity, corruption, unstable economic and political context, public distrust, poor stakeholders' involvement, gaps in areas of stewardship and vertical donor funding have been identified as factors that undermine effective functioning of the different health financing strategies.[12] The introduction of COVID-19 in Nigeria has put pressure on the limited financial resources which further incapacitate the system's ability to effectively respond to other essential health services. It is important that Nigeria and other African countries begin to address the challenges of health financing. This will positively transform health indices and initiate a new era of increased productivity in health care.

The main strategic mechanism in Nigeria towards achieving UHC is its National Health Insurance Scheme (NHIS), which is a contributory social health insurance scheme.[1] Prior COVID-19, many Nigerians do not benefit from this scheme. More than 14 years after the launch of NHIS on 6 June 2005, Nigeria still parades a poor level of health coverage for its populace with an increasing double burden of disease and poor health outcomes. Only 5% of Nigerians have health insurance and 70% still finance their healthcare through OOP spending.[13] This situation weigh most heavily on the poor (mostly part of the informal sector) living in rural communities who lack the capacity to enroll in the scheme. With the emergence of COVID-19 pandemic, the lack of health insurance coverage for COVID-19 patients may result in higher OOP expenditure. This situation can further push people into poverty especially COVID-19 patients with chronic medical conditions. In addition, it has been reported that medicine security, an integral component of UHC, is threatened by the pandemic due to international travel restriction and the heavy reliance of Nigeria on medicines importation.[9] This further reiterates the need to strengthen laboratory capacity and ensure access to lifesaving healthcare services and essential medicines in the country in order to achieve effective containment of the pandemic.

COVID-19 has provided valuable insight into the inefficient state of Nigeria health system and revealed the need for health system strengthening for UHC and health security.[1] The pandemic has brought to light the critical need for technical expertise in health economics, governance and community engagement in health. This revelations will hopefully enable policy makers to critically review programs, policies and infrastructures in order to come up with legislative framework that will reinforce focus on primary

healthcare as key foundation of health system strengthening and promote local manufacturing of medical and pharmaceutical products. In addition, it will prepare the country's health system towards future pandemic by reinvigorating the health sector in the best possible way without severely disrupting other forms of healthcare provisions.
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CONCLUSION

UHC2030 is a global movement for stronger health systems. Although Nigeria has shown efforts towards achieving this target, the arrival of COVID-19 has shown the need for preparedness and reform in healthcare that ensures access to affordable quality care. There is need for policy makers to critically review the current health systems status and strengthen commitment towards UHC. It is, therefore, important that governments and national authorities examine current health management and financial policies and develop sustainable plans that will revitalize the future of healthcare and achieve progress towards UHC in Nigeria.

CONFLICT OF INTEREST

The authors declared no competing interests.

ETHICS STATEMENT

Hereby, I Oladunni Abimbola Amos consciously assure that for the manuscript titled COVID-19 and Progress Towards Achieving Universal Health Coverage in Africa: A Case of Nigeria, the following is fulfilled: (1) this material is the authors' own original work, which has not been previously published elsewhere; (2) the paper is not currently being considered for publication elsewhere; (3) The paper reflects the authors' own research and analysis in a truthful and complete manner; (4) the paper properly credits the meaningful contributions of co-authors and co-researchers; (5) the results are appropriately placed in the context of prior and existing research; (6) all sources used are properly disclosed (correct citation). Literally copying of text must be indicated as such by using quotation marks and giving proper reference; (7) all authors have been personally and actively involved in substantial work leading to the paper, and will take public responsibility for its content.

AUTHOR CONTRIBUTIONS

The concept of this commentary was developed by Yusuff Adebayo Adebisi and Oladunni Abimbola Amos. The manuscript was drafted and prepared by Yusuff Adebayo Adebisi, Adeola Bamisaiye, Esther Bosede Ilesanmi, Alaka Hassan Olayemi and Oladunni Abimbola Amos. Don Eliseo Lucero-Prisno III, Aniekan Ekpenyong and Alumuku Iordepuun Micheal

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DATA AVAILABILITY STATEMENT

Data sharing not applicable to this article as no datasets were generated or analysed during the current study

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