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COVID-19 must accelerate African push for universal healthcare

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Abstract: *"The greatest injustice is the lack of access to equitable healthcare" Dr Martin Luther King Jr. In a bid to achieve equitable healthcare in Africa, a total of 46 African states met in Abuja, Nigeria, in 2001. In what came to be known as the Abuja Declaration, each African state pledged to commit 15 percent of public expenditure to health. More than two decades since the Declaration was signed, only two African countries have reached this target, leaving vast swathes of the continent vulnerable to emerging health crises such as Ebola and COVID-19. Poor response and management is exacerbated by unpreparedness due to lack of research and under-developed infrastructure. Limited healthcare funding has also led to other challenges such as exploitation of patients, especially by private health providers, who see public health crises as money-making opportunities. Unfortunately, even those entrusted with managing public funds dedicated to the response and management of these crises have resorted to corruption. Whilst we tentatively celebrate having finally survived COVID-19, Africa needs to learn lessons from its past and plan for a better future. Firstly, by increasing government funding towards the health sector and secondly by addressing other still-existing challenges to equitable healthcare. This article recommends building resilient healthcare systems; adopting individual and group participation in decision-making processes; and ensuring there is Universal Health Coverage. All these must start with political will and good leadership.*

Keywords: *healthcare; universal healthcare coverage; Africa; COVID-19; vaccine distribution; infrastructure*

1. Abuja aspirations still far off

In April 2001, a total of 46 African states met in Abuja, Nigeria, where they rallied each other to mobilise more resources from government coffers to boost support towards the health sector (WHO 2010). They then signed what they called the Abuja Declaration, offering to commit 15 percent of their public expenditure to health (WHO 2010). This was meant to realise universal access to healthcare and also prepare for worst case scenarios such as the COVID-19 pandemic (Abuja Declaration 2001).

Moreover, the African Union's Agenda 2063 (2022) places the objective of realising "healthy and well-nourished citizens" among the first of the seven aspirations towards the attainment of "the Africa we want".

In this case "Universal Health Coverage is achieved in a health system when all residents of a country are able to obtain access to adequate healthcare and financial protection" (Sanogo, Fantaye and Yaya 2019). Achieving this goal requires both adequate healthcare and the financial systems to ensure that all can access it equitably.

However, almost two decades after signing of the Declaration, only a handful of African countries had met that target when the coronavirus pandemic struck (Kaltenborn, Krajewski and Kuhn 2011). As the world slowly limps back to normal after more than two years of the devastating emergency (Allison 2022), one lingering question is whether Africa has learnt anything from this public health crisis. The World Health Organization (WHO 2022) reports that while the COVID-19 death rate has fallen significantly in Africa, this does not take away the fact that access to universal health coverage is still a far-fetched dream on the continent (Ujewe, Werdie and van Staden 2021).

The need for universal healthcare is all the more pressing given that Africa has already lurched from the grip of one deadly virus into another. The Center for Disease Control and Prevention (2019) reports that before COVID-19, West Africa battled Ebola which claimed a total of 11,310 lives in Guinea, Liberia and Sierra Leone 2014-2016, in addition to the 15 deaths that occurred when the outbreak spread outside of these three countries. In 2018, the Democratic Republic of Congo also declared the Ebola virus disease outbreak since the virus was first discovered in 1976 (Wadoum et al. 2019). As of 25 June 2020, 3,470 Ebola cases had been reported, including 3,317 confirmed and 153 probable cases, with 2,287 deaths and overall case fatality ratio at 66 per cent (Wadoum et al. 2019). In 2022, the recurrence of Ebola in Uganda has seen the death toll rise quickly in just days, forcing the Ugandan government to prohibit mass gatherings and limit movement, among other restrictive measures (The East African 2022). So far, two of the six districts in Uganda where Ebola cases have been reported are in a total lockdown (The Independent 2022)—yet another public emergency that could be best handled with accessible, affordable public health services. It is also important to note that AIDS continues to decimate the population of Africa, which has 11 per cent of the global population but 60 percent of the world's people living with HIV (Moszynski 2006). More than 90 percent of the 300-500m cases of malaria in the world each year are in Africa, mainly in children aged under 5 years (Moszynski 2006).

2. Why have Abuja targets not been met?

While COVID-19 brought the world to its knees as no government was prepared for the crisis, Africa's under-resourced public healthcare systems were particularly exposed. So what are some of the major reasons for Africa's failure to meet the Abuja targets and how did the coronavirus pandemic exacerbate the situation?

First, despite better recent economic growth than many other world regions, African governments' spending on health has not automatically increased (Chitonge 2015). While some African countries have made slight upward adjustments to their overall healthcare spending, they are still a minority. By 2018, only two countries—Ethiopia and Rwanda—had hit that 15 per cent target they signed up to in Abuja (Gatome-Munyua and Olalere 2020). On the other hand, between 2001 and 2015, 21 African countries decreased the proportion of government budget allocated to public healthcare (Gatome-Munyua and Olalere 2020). These funds were diverted to other priority areas such as national security.

Amongst various factors behind this, we should be mindful that dependence on development assistance for health has made some African governments reluctant to increase their healthcare budgets (Chang et al 2019). In a 2017 global survey, 20 of the 26 countries relying on donor funding for their health spending were African (Gautier and Ridde 2017). This further complicates the transition from declining donor funding to self-sufficiency in financing the continent's health sector (Chang et al 2019).

Secondly, public awareness about the pandemic was a bare minimum when COVID-19 emerged. Over time, we saw increased campaigns on how best to respond. However, such messages have been pushed to the margins as budget priorities have since shifted from health to other areas. To make matters worse, when COVID-19 testing was introduced, it was very expensive for the ordinary African (Bondo 2021). Unlike developed countries, African nations had very limited access to COVID-19 tests, especially at-home tests, which are still very costly (Cheng and Mutsaka 2022). A case in point, self-tests were available in some pharmacies in Zimbabwe but they cost up to US$15 each, in a country where more than 70 per cent of the population lives in extreme poverty made worse by the pandemic. The situation was no different elsewhere across the African continent (Cheng and Mutsaka 2022).

Thirdly, other issues such as lack of infrastructure remain a serious impediment to healthcare delivery as was evident in the COVID-19 vaccination campaign. Despite improved supplies of coronavirus vaccines on the continent, the transport network in most African states is generally poor, making it difficult to get doses to people in more remote areas (Akuagwuagwu, Bradshaw and Mamo 2022). For example, Sekenani health clinic in rural Kenya did not have COVID-19 vaccines and yet Narok county, where the clinic is located, had nearly 14,000 doses sitting in a fridge in the nearest town, 115 km away (Fick and Mcallister 2021). This is a problem of financing but also a logistical issue, with lack of accessible transport networks impeding the establishment of vaccination centres in isolated regions (Okunogbe 2018).

Fourthly, because of the poor public health facilities, Africa witnessed widespread exploitation, especially by private health providers, who saw it as an opportunity to make a financial killing out of the pandemic. For instance, while many Ugandans do not trust government hospitals due to these inadequacies, those who can afford to do so seek treatment in private hospitals while the wealthy and top government officials choose to go abroad. This was no different during the pandemic except that government officials could not leave the country due to lockdowns (Muhumuza 2021). As time went by, some hospital bills shared on social media by families of COVID-19 patients in intensive care showed "sums of up to US$15,000, a small fortune in a country where annual per capita income is less than US$1,000" (Muhumuza 2021).

Troublingly, there was also little to no transparency regarding management and distribution of COVID-19 funds: it was indeed "time to loot" as much of the money was either embezzled or misappropriated by those charged with administering the funds (Oduor 2021; Nyabola 2021). For example, four top government officials in Uganda were arrested for causing losses in excess of US$528,000 meant for COVID-19 relief food (Athumani, 2020b). In other African countries such as Kenya, Zimbabwe, South Africa, Somalia and Nigeria, those in the corridors of power stand accused of inflating medical supply prices by nearly 1,000 per cent, making relief payments to illegal beneficiaries and rigging lucrative tenders (Ndegwa 2020).

Beyond the challenges of equitable access to Universal Health Coverage, other issues emerged with the response to COVID-19. Governments adopted measures in the form of directives that would later be formalised and used as weapons to violate the human rights of their citizens with impunity. Policymakers rushed to "copy and paste" the processes and

implementation of emergency public health legislation from other parts of the world without proper scrutiny of their financial implications for African countries (Human Rights Watch 2021). This promoted punitive and dictatorial approaches in the way COVID-19 restrictions were implemented that would later affect resources for the health sector (Kurlantzick 2020).

There was also limited research when the pandemic broke out. As of now, Africans have authored only 3 percent of COVID-19 research due to limited financing (BMJ 2021). Furthermore, even when the WHO announced the first six countries chosen to receive the tools needed to produce messenger RNA vaccines in Africa—Egypt, Kenya, Nigeria, Senegal, South Africa and Tunisia—financing such projects still remains a challenge. While some progress has been made in this area, the fruits of such investments are yet to be realised (WHO n.d.).

3. Lessons from best practice

However, in making this scorecard, it is important to note that the right to health is achieved progressively (Torres 2002). "Fifteen per cent of an elephant is not the same as 15 percent of a chicken"—thus different countries operate on different budgets (Wildavsky 1986). Compared to developed countries that spend up to US$4,000 per capita on health (Richardson et al. 2020), African countries' budgets can only stretch as far as US$8 to US$129 (Micah et al. 2021). While there are many reasons for this, the key factors are low GDP and meagre tax collection bases, with each country's differing national priorities vying for a share (Micah et al. 2021). Therefore, it is perhaps more realistic to ask not why they have failed to meet the Abuja Declaration target but rather how much progress each country has made over time and whether such progress has made any significant impact. Are the citizens any healthier? How can it be made better?

The two countries—Ethiopia and Rwanda—which have hit the 15 per cent public health spending target they signed up to in Abuja (Gatome-Munyua and Olalere 2020) have achieved high levels of population coverage through social protection systems that guarantee access to healthcare services. Rwanda achieved this mainly by providing health insurance to the poor in the informal sector through its community-based health insurance, which reduces the financial burden of accessing healthcare (Chemouni 2018). In Ethiopia, the government has made significant investments in the public health sector and increasingly decentralised management of its public health system to the Regional Health Bureau levels that have led to

improvements in health outcomes (Privacy Shield 2022). This has been achieved in both countries because of deliberate political will by those in positions of leadership.

The continent could also learn from the likes of Algeria, Botswana, Lesotho, Kenya, Morocco, Senegal and South Africa, who have increased fiscal space by improving tax collection capacity (OECD 2021). Fiscal space can be defined as "room in a government's budget that allows it to provide resources for a desired purpose without jeopardising the sustainability of its financial position or the stability of the economy" (IMF 2005/2006).

Moreover, Gabon, Ghana and Nigeria have also earmarked allocations to the health sector from government revenue (Barasa et al. 2021). Tanzania and Uganda have implemented reforms to improve resource flows to health facilities and have also improved use of resources. In Uganda, for example, the government has introduced public-private partnership to improve resource mobilisation, coordination and utilisation (Okech 2014). It has also abolished user fees to improve access to health services and efficiency, given autonomy to the National Medical Stores to procure, store and distribute essential medicines and health supplies to public health facilities across the country, and decentralised responsibility for delivering health services to local authorities (Okech 2014). Meanwhile, "decentralisation policy in Tanzania has facilitated the formation of local health governance structures to ensure greater participation of communities in the management of health services" (Kessy 2014).

Governments should make healthcare more available, accessible and affordable. In times of public health emergencies such as pandemics and epidemics, Africa needs cheaper testing kits to enable ordinary people to test frequently (Amukele and Barbhuiya 2022). As governments try to bounce back from COVID-19, they could take South Africa (Pocius 2022) and Uganda's (Athumani 2020a) examples of either cost-sharing with pharmaceutical companies to produce more free testing kits for the masses or lowering costs associated with testing. In these cases, the government supports pharmaceutical companies in research and production of medicines and medical equipment, which reduces the cost of medical fees paid by patients.

Involving individual and group participation in decision-making processes on the pandemic will encourage community engagement in government initiatives and also enable responsive communities (Gilmore et al. 2020). Encouraging public participation in decision-making regarding projects that impact society facilitates fair, equitable, and sustainable outcomes. This in turn allows proper recovery and return to normal.

4. Way forward

Much as the masses are pushing for and celebrating the return to normal, these issues persist and it may take the continent longer to fully recover from the effects of the pandemic. As we have seen, low government spending on healthcare hurts citizens the most and results in high out-of-pocket spending and an inequitable health system that only guarantees access to those who are able to pay.

There have been challenges which we must now confront. The reality is that reaching spending targets is less important than ensuring health systems are adequately resourced and that those resources are used optimally. Increased prioritisation of the health sector and increased health spending are the most feasible approaches to increasing resources for health and thus attain access to universal health coverage.

While Universal Health Coverage is an ambitious Sustainable Development Goal for health services, COVID-19 made us realise that it is the way to go to be better prepared for future pandemics (Ranabhat et al. 2021). As such, there should be a push for this in order to guarantee the future for most Africans as a "stable, equitable, prosperous and peaceful society and economy is only possible when no one is left behind".

Still, with more funding, African governments should also build resilient healthcare systems with more focus on primary healthcare (Gebremeskel et al. 2021). This will enable health actors, institutions and populations to adapt, access and transform their capacities to prepare for and effectively respond to health system shocks and disturbances.

It is true that the right to health is realised progressively but it is high time for our politicians to honour the Abuja Declaration pledge to better prepare the continent for future eventualities (Witter 2021). Even when the target is not met, at least there should be deliberate steps to increase healthcare financing. This will also guarantee health workers decent working conditions and improve healthcare services.

The pandemic exposed Africa's lack of control. Consequently, governments resorted to blame games and pointing fingers instead of taking responsibility and providing solutions. This can be countered in future by being better prepared. In "The End of Epidemics", epidemiologist Jonathan Quick argues that it is up to all of us to hold governments to account: "[O]ne of the most powerful human needs is to feel we have some sense of control over our environment. Control includes the ability to explain why things happen. And pointing fingers at an easy scapegoat, such as the government, can

sometimes provide the answers we need to regain control. More important is to hold those in power to account through social activism" (Quick 2018).

For now, whether Africa should celebrate returning to normal or not depends on how its governments address these challenges and plan for the future—mostly by increasing healthcare financing.

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