The Global Initiative *for* Economic, Social and Cultural Rights

jei JUSTICE & EMPOWERMENT INITIATIVES - NIGERIA community legal support initiative

Policy Brief

The failure of commercialised healthcare in Nigeria during the COVID-19 pandemic

Discrimination and inequality in the enjoyment of the right to health

A report by the **Global Initiative for Economic, Social and Cultural Rights**, in partnership with the **Justice & Empowerment Initiatives** and with the support of **Corporate Accountability and Public Participation Africa**.

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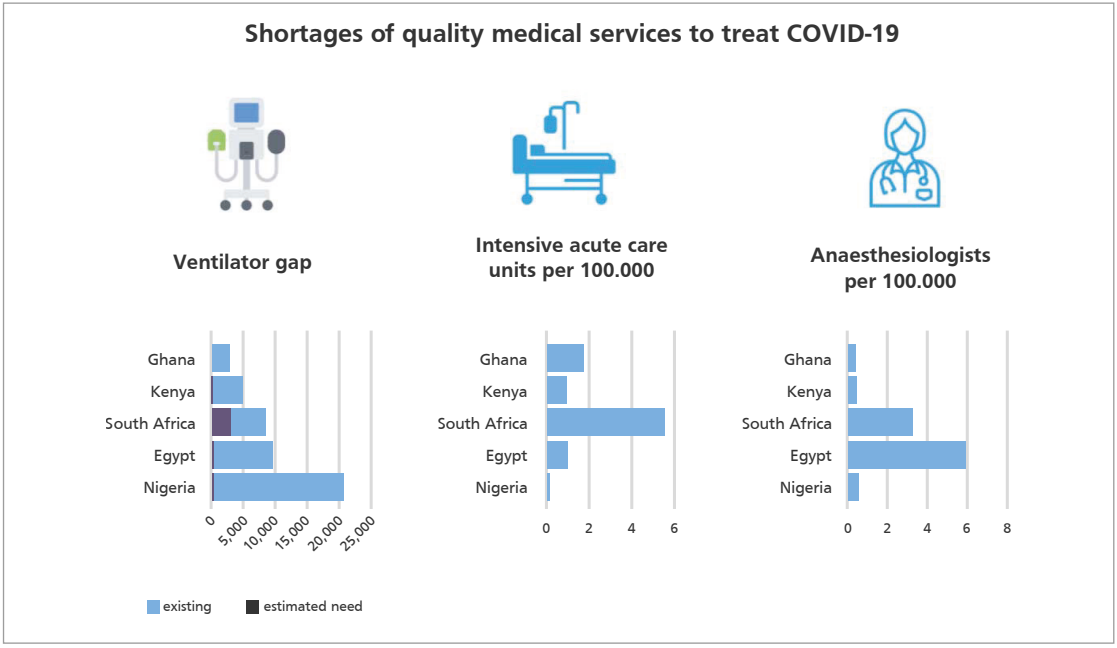
The Global Initiative for Economic, Social and Cultural Rights | jei Justice & Empowerment Initiatives - Nigeria | CAPPA Corporate Accountability & Public Participation Africa

Policy Brief

Nigeria has the obligation to respect, protect and fulfil the right to health, which is guaranteed under both its constitution and the international human rights treaties which it has signed and ratified. While the right to health does not require States to ensure that everyone is healthy, it demands that they establish the best possible health system, within their capacities, to reach the highest attainable standard of health – and of pandemic prevention and response.

However, since the first COVID-19 case was confirmed on 27 February 2020,[1] the West African country has been struggling to guarantee the right to health of all, amidst shortages of accessible health facilities, medical staff and drugs.[2] Unfortunately, this was to be expected, as the flaws of Nigeria's healthcare system predate the pandemic. Healthcare services are severely underfunded: health spending as a share of general government expenditure decreased from 7.3% in 2006 to as little as 4.4% in 2018.[3] Access to these limited resources is also extremely unequal, with the most marginalised facing multiple and interconnected socio-economic, geographical, information and technological barriers in accessing healthcare services, including during the pandemic.

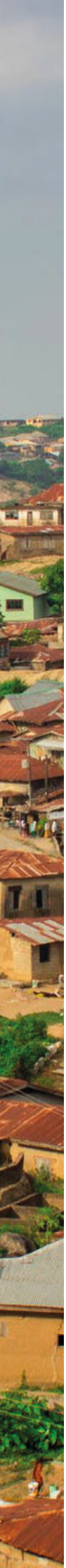


Source: Own elaboration of data from Reuters and World Federation of Societies of Anaesthesiologists (WFSA).

[1] Reuters COVID-19 Tracker, 'Nigeria: The Latest Coronavirus Counts, Charts and Maps' *Reuters* (2021) <https://graphics.reuters.com/world-coronavirus-tracker-and-maps/countries-and-territories/nigeria/> accessed 26 October 2021.

[2] Siddharth Dixit, Kofoworola Ogundeji Yewande and Obinna Onwujekwe, 'How Well Has Nigeria Responded to COVID-19?' *Brookings* (2 July 2020) <https://www.brookings.edu/blog/future-development/2020/07/02/how-well-has-nigeria-responded-to-covid-19/> accessed 26 October 2021.

[3] WHO Global Health Expenditure Database, *Domestic general government health expenditure (% of general government expenditure)* (2022) <https://data.worldbank.org/indicator/SH.XPD.GHED.GE.ZS> accessed 29 January 2022; see also: BudgIT, 'Nigeria: Heath Budget Analysis' (2021) <https://yourbudgit.com/wp-content/uploads/2018/04/Nigeria-Health-Budget-Analysis.pdf> accessed 25 October 2021.



This report analyses the impacts of COVID-19 on the right to health in Nigeria, one of the largest economies in Africa,[4] in the context of the privatised healthcare system in the country, with a focus on people living in urban informal settlements in Lagos and Port Harcourt. Through a systematic review of academic literature and reliable news as well as interviews with individuals living in poverty, the report explains how Nigeria's healthcare system was largely unprepared to respond adequately to the current pandemic, with harmful impacts for several elements of the right to health. The report has four main findings:

1. Nigeria lacks universal, public healthcare services to respond to public health emergencies. The country is critically short of health facilities, staff and medical equipment necessary to deliver COVID-19 treatment, testing and vaccination to its population of more than 206 million in 2020.
2. Several barriers impede access to healthcare services amidst the pandemic, as such access is largely shaped by socioeconomic inequalities. The most marginalised groups not only face disproportionate hurdles in obtaining timely COVID-19 medical services but are also more exposed to the collateral damages of the pandemic on access to all medical services, as the healthcare system struggles to respond to the emergency.
3. Regulation and monitoring of private health providers by authorities are insufficient. There have been numerous cases of private clinics and hospitals not complying with scientifically appropriate medical standards and practices during the pandemic. The report documents how private facilities were initially not allowed to admit COVID-19 cases for treatment because authorities had concerns over their quality, and how this has translated into empty beds and untapped capacity when it was most needed. For example, based on a range of quantitative indicators, a study found that the private healthcare sector in Edo State was not adequately equipped to provide screening services for COVID-19.[5]
4. Several private health providers offer substandard healthcare services and fail to comply with appropriate medical protocols and standards, including by using expired drugs or employing unqualified staff, especially in urban informal settlements. Well before the pandemic, academic literature documented ineffective malaria therapies in the private health sector.[6] During COVID-19, there have been cases of private health facilities using expired reagents for COVID-19 testing.[7]

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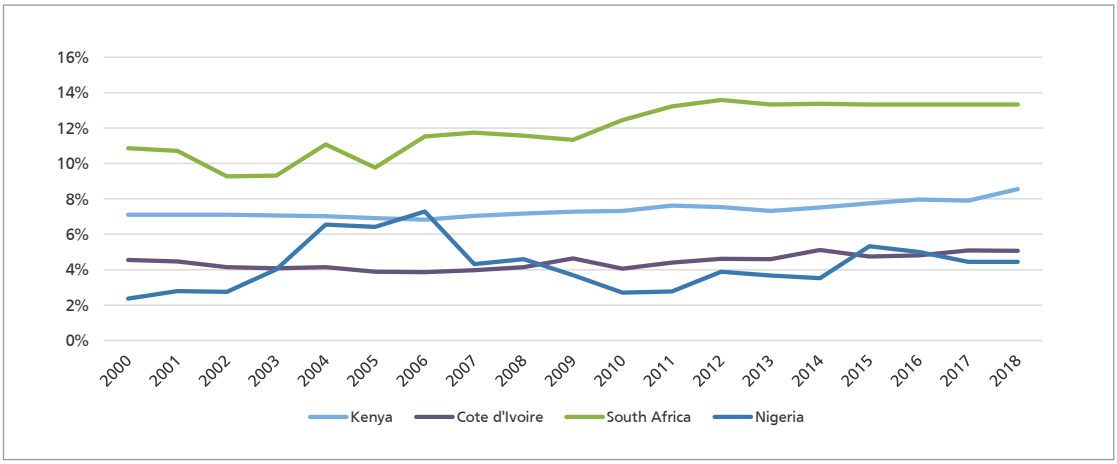
[4] World Bank national accounts data and OECD National Accounts data files, GDP (current USD) *Sub-Saharan Africa (2022)* <https://data.worldbank.org/indicator/NY.GDP.MKTP.CD?locations=ZG&most_recent_value_desc=true> accessed 19 January 2022.

[5] Darlington Ewaen Obaseki and others, 'Mainstreaming the Private Health Sector in the Response to COVID-19: Facility Readiness assessment for Screening Services in Edo State, Nigeria' (2020) 35 The Pan African Medical Journal 93.

[6] Roger Bate and others, 'Antimalarial Drug Quality in the Most Severely Malarious Parts of Africa – A Six Country Study' (2008) 3 PLoS ONE e2132; Benjamin SC Uzochukwu and others, 'Examining Appropriate Diagnosis and Treatment of Malaria: Availability and Use of Rapid Diagnostic Tests and Artemisinin-Based Combination Therapy in Public and Private Health Facilities in Southeast Nigeria' (2010) 10 BMC Public Health 486; Grace O Gbotosho and others, 'Potential Contribution of Prescription Practices to the Emergence and Spread of Chloroquine Resistance in South-West Nigeria: Caution in the Use of Artemisinin Combination Therapy' (2009) 8 Malaria Journal 313.

[7] National, 'COVID-19: Enungu lab shut for sharp practices' *The Sun* (29 October 2021) <https://www.sunnewsonline.com/covid-19-enugu-

Healthcare spending as a share of total government spending (%), 2000-2018, in selected comparable African countries



Source: WHO Global Health Expenditure Database, https://www.who.int/data/gho.

While multiple factors contribute to this difficult situation, the report argues that the commercialisation of Nigeria's healthcare system is amongst the main drivers of the right to health challenges described above. In Nigeria, the commercialisation of the healthcare system, marked by the growth of market mechanisms and private actors in health, began in the 1980s, partly as a result of structural adjustment programmes backed by international financial institutions,[8] and has continued until today. This is visible, for instance, through the rapidly expanding share of private spending for healthcare, which increased from 64.7% in 2000 to 77.27% in 2018. Policy decisions have propelled this trend. For example, the 2004 Revised National Health Policy dedicates an entire chapter to supporting the increase of partnerships with the private sector for health development,[9] and, in 2005, the Federal Ministry of Health developed the National Policy on public-private partnerships, which aims at strengthening and expanding public-private partnerships in health.[10]

After decades of privatisation in healthcare, a fragmented and varied private sector, made up of commercial actors as well as faith-based and civil society providers, covers an estimated 60% of health services.[11] In this system, the upper-income groups can obtain medical care of relatively higher perceived standards in expensive-looking facilities across major cities, such as Lagos. By contrast, those living in poverty in areas where public medical care might be absent or too far away, and with expensive private services beyond reach, are often forced to seek assistance at low-fee commercial healthcare facilities providing

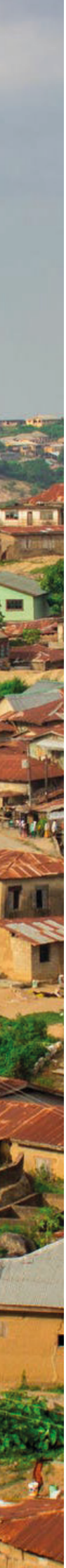
lab-shut-for-sharp-practices/> accessed 31 October 2021.

[8] U Onwudiegwu, 'The Effect of a Depressed Economy on the Utilisation of Maternal Health Services: The Nigerian Experience' (2009) Journal of Obstetrics and Gynaecology <https://www.tandfonline.com/doi/abs/10.3109/01443619309151701> accessed 3 December 2021.

[9] Federal Republic of Nigeria, *Revised National Health Policy (2004)* <https://cheld.org/wp-content/uploads/2012/04/Nigeria-Revised-National-Health-Policy-2004.pdf> accessed 3 November 2021, 50.

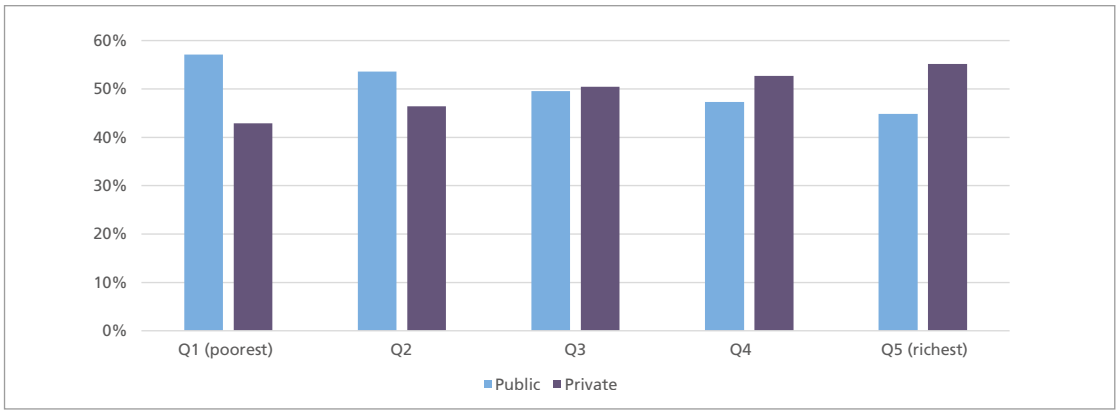
[10] Federal Ministry of Health, *National Policy on Public-Private Partnership for Health in Nigeria (2005)* <https://goolnk.com/WXzjbG> accessed 3 November 2021.

[11] Federal Government of Nigeria, *National Strategic Health Development Plan (2018 – 2022) (2018)* <https://www.health.gov.ng/doc/NSHDP II Final.pdf> accessed 26 October 2021, p. 6.



low-quality services.[12] In the worst cases, these services might be unlicensed, unsafe and unregulated, employing untrained and unqualified staff, selling expired drugs and operating without adhering to scientifically appropriate medical standards and ethics. Such low-quality commercial services can severely threaten the health and lives of those who use them, while also entailing severe epidemiological risks. For instance, a study shows that public health providers are significantly more likely to use rapid malaria diagnostics and the recommended combination of therapies than private providers in South-East Nigeria.[13] Poor adherence to guidelines in prescription practices in the private sector has also been associated with a rise in drug-resistant malaria in the country.[14] While genuine high-quality, non-commercial private actors, such as some of the faith-based or civil society providers, also exist and can play a positive role in enhancing access to medical care, they are the exception rather than the rule.

Where individuals look for medical care (%), by wealth quintile



Source: WHO Global Health Observatory data, https://www.who.int/data/gho. Data are available here.

Health inequalities and socioeconomic barriers in Nigeria are thus inherent to the overall marketised healthcare system, where access to medical care, and thereby survival and dignified life, is highly dependent on one's social and economic status.

It does not have to be this way. The answer is to build a strong, well-coordinated public healthcare system for all. Commercial healthcare will not fulfil the rights of everyone in Nigeria, let alone address public health priorities as well as present and future pandemics. Expanding the availability of public healthcare services for everyone is urgent, including inverting the current national and international development policies intended to encourage higher private sector engagement in healthcare. At the same time, Nigeria should ensure that all healthcare providers are strictly monitored and regulated at the federal, state and local levels.

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[12] Anna Marriott, 'Blind Optimism: Challenging the Myths about Private Health Care in Poor Countries' *Oxfam* (1 February 2009) <https://policy-practice.oxfam.org/resources/blind-optimism-challenging-the-myths-about-private-health-care-in-poor-countrie-114093/> accessed 28 October 2021.

[13] Benjamin SC Uzochukwu and others, 'Examining Appropriate Diagnosis and Treatment of Malaria: Availability and Use of Rapid Diagnostic Tests and Artemisinin-Based Combination Therapy in Public and Private Health Facilities in South-East Nigeria' (2010) 10 BMC Public Health 486.

[14] Grace O Gbotosho and others, 'Potential Contribution of Prescription Practices to the Emergence and Spread of Chloroquine Resistance in South-West Nigeria: Caution in the Use of Artemisinin Combination Therapy' (2009) 8 Malaria Journal 313.

'I am Mrs Victor. I live in Nanka community, Port Harcourt. During last year outbreak Covid-19, many people really fell sick. Their experience was too bad, and most people did not go to any health clinic because they were afraid of being quarantined. Also, there was not enough money to go to the hospital. Therefore, many people only went to the medicine shop to get some drugs.

My neighbour, Ms Ifeoma, wanted to go to a health centre, but due to restriction of movement, she could not. Even some pregnant women on my street found it difficult to go for their normal check-ups because of police harassment. My younger sister had a miscarriage, and it was very difficult rushing her to the health clinic due to roadblocks and police everywhere.'

Mrs Victor, Port Harcourt

(Credit: photo and interview by Ruth Samuel, narrative by GI-ESCR)

Read more: Corona Diaries of the Urban Poor, Justice & Empowerment Initiatives

From the analysis presented in this report, we make the following recommendations for the federal and state governments, within their respective areas of competencies:

- **Increase governmental funding to health to at least 15% of the budget to meet the Abuja commitment and expand the availability of quality, well-coordinated public healthcare services**

  Nigeria is among the African Union States that pledged to raise the proportion of government funding for health to at least 15% of the overall national budget in the 2001 Abuja Declaration.[15] However, Nigeria is still far behind on that target. Authorities should thus consider increasing general government expenditure on health from the current 4.4% share of general government expenditure (as of 2018)[16] to at least 15%, in line with the Abuja Declaration commitment. Committing more public finances in health would be in line with Nigeria's obligation to invest the maximum of its available resources to ensure that everyone has access to universal, public healthcare services, which is set out in the African Charter on Human and Peoples' Rights and the other international human rights treaties to which Nigeria is a party.

- **Reverse the current policies intended to encourage higher private sector engagement in healthcare**

  The 2016 National Health Policy and the National Health Development Plan (2018-2022) set out as a goal the promotion of public-private partnerships in healthcare.

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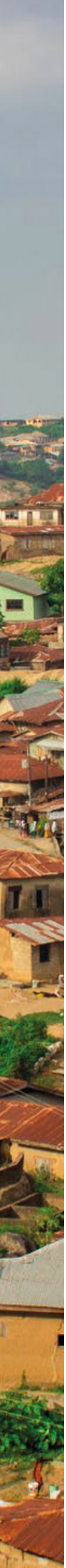
[15] WHO, *The Abuja Declaration: Ten Years On (2011)* <https://www.who.int/healthsystems/publications/abuja_report_aug_2011.pdf?ua=1> accessed 25 October 2021.

[16] WHO Global Health Expenditure Database, *Domestic general government health expenditure (% of general government expenditure)* <https://data.worldbank.org/indicator/SH.XPD.GHED.GE.ZS?locations=NG> accessed 17 January 2022; see also: BudgIT, 'Nigeria: Heath Budget Analysis' (2021) <https://yourbudgit.com/wp-content/uploads/2018/04/Nigeria-Health-Budget-Analysis.pdf> accessed 25 October 2021.



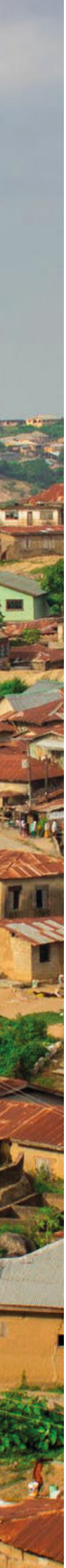
As shown in this report, market mechanisms involving competition, that are typically at play in public-private partnerships, fail to adequately fill the gaps left by a weak public sector. Rather than promoting market-based solutions in healthcare, which have dangerous impacts on the realisation of the right to health, Nigeria should invest in a strong public healthcare system, that is democratically managed, funded, and delivered by non-commercial actors, and reinforce the public healthcare sector's capacity.

- **Ensure that all healthcare providers are strictly monitored and regulated at the federal, state and local levels**

  This report has shown that in practice the quality of private healthcare provision is sometimes very low and not in line with medical standards. Stronger regulatory and monitoring efforts are needed. In particular, the federal, state and local governments should coordinate efforts to ensure that all providers in the country operate under a Certificate of Standards, as provided in the National Health Act (2014), with harmonised eligibility criteria and meaningful follow-up quality monitoring and enforcement.

- **Take concrete steps to ensure universal access to social health insurance or another pre-pooled financing scheme**

  This report has highlighted once again that participation in the National Health Insurance Scheme is extremely low, covering mostly some workers in the formal sector. While the existence of programmes targeting the informal sector, individuals living in poverty, and marginalised groups is a positive step, in practice these programmes are poorly implemented, as data on enrolment rates show.



Read the full report on the Global Initiative for Economic, Social and Cultural Rights website at the following link: https://www.gi-escr.org/publications/report-the-right-to-health-during-covid-19-in-nigeria-discrimination-and-inequality-in-a-commercialised-healthcare-system

The Global Initiative for Economic, Social and Cultural Rights

About GI-ESCR

The Global Initiative for Economic, Social and Cultural Rights (GI-ESCR) is an international non-governmental human rights advocacy organisation. Together with partners around the world, GI-ESCR works to achieve a world in which every person and community lives in dignity and in harmony with nature.