Towards universal health coverage: lessons learnt from the COVID-19 pandemic in Africa

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Abstract

Access to quality and affordable health services is a significant element of social protection, specifically, through Universal Health Coverage (UHC). This current pandemic has shown that health systems and economies in several countries are not strong enough to tackle a massive health crisis. It has revealed limited and underfunded health services, inadequate and ineffective equipment, few and often unprotected health workers and a generally fragile healthcare system.

Perspective

Access to quality and affordable health services is a significant element of social protection, specifically, through Universal Health Coverage (UHC) [1]. The World Health Organization defined Universal Health Coverage as ensuring that all people have access to needed health services (including prevention, promoting treatment, rehabilitation and palliation) of sufficient quality to be effective, while also ensuring that the use of these services does not expose the user to financial hardship [2]. As part of the 2030 Agenda for Sustainable Development, all countries have committed to achieve Universal Health Coverage by 2030 [3]. UHC aims at achieving three main objectives: equity in access to health care, quality health delivery and affordable health care services [1]. In December 2019, the city of Wuhan, China experienced an outbreak of pneumonia with unfamiliar etiology [4,5]. The initial outbreak of the disease was linked to a large seafood and live animal market in Wuhan. Further details were released by the National Health Commission of China suggesting viral pneumonia-the virus was identified as a novel coronavirus [4]. It was believed that the patients infected with the virus induced pneumonia had visited the Wuhan market or used infected animals as source of food but an increasing number of patients in the following weeks had no reported exposure to animal markets, which indicated an ongoing, sustained person to person transmission within China, and subsequently proliferated outside the country [4,5].

As the number of confirmed cases and deaths increased, the WHO convened and designated the novel coronavirus as a Public Health Emergency of International Concern (PHEIC) on January 30. After about 6weeks of designation as a PHEIC, more cases were reported from outside China than from within and the disease had already spread to every continent except Antarctica, which made the WHO raise the COVID-19 threat to the highest level, and officially declared it a pandemic on 11 March, 2020, citing nations were not acting as fast and aggressively as needed to contain the disease [4]. As of May 21, 2020, more than 180 countries have reported confirmed cases of COVID-19 with over 5 million infected individuals and more than 331,000 deaths worldwide and 107,747 infected individuals and 3,257 deaths in Africa as of May 24, 2020 [5].

Lessons: health emergencies such as COVID-19 pose a global risk and have shown the critical need for preparedness. Preparation is key, and...
it should be a major lesson to be learned from COVID-19. While many countries struggle to provide UHC, extended health emergencies such as the outbreak of COVID-19 puts enormous pressure on the supply side as health systems come under severe stress. In the process, social protection and access to essential health services of vulnerable populations, quality of healthcare and the health system (in terms of insufficient number of health workers, inadequacy of drugs and equipments) are issues of concern that have been revealed by the pandemic [6]. In the midst of the current crisis, shortage of health workers, personal protective equipments and availability of adequate infrastructures have been a dilemma. It has revealed limited and underfunded health systems inadequate and ineffective equipments, few and often unprotected health workers and a generally fragile healthcare system [7].

The most critical input in the delivery of health services are health workers [2]. Shortages and maldistribution, which have been a consistent impediment to achieving UHC in Africa, particularly severe in Sub-Saharan Africa, has led to shifting medical staff to COVID-19 care exacerbating shortages in delivery of other essential health services including non-communicable diseases, maternal and child health, HIV, tuberculosis, mental health and malaria [1,2]. On average, the World Health Organisation (WHO) calculates that the Africa has 1.4 health workers per 1000 people and needs 63% more health workers to meet the staffing requirements of universal coverage. There is no short cut to addressing this situation: more health workers need to be trained and recruited [7]. These set of people, that is, the health workers are always at the risk of super-spreading, a concept worsened by working in poor environmental conditions and scarcity of personal protective equipment (PPE) [8]. Furthermore, the capacity of African countries to address healthcare challenges remain hindered by a lack of data coverage, stemming from weak statistical capacity. Quality statistics are essential for all stages of evidence-based decision-making and policy formulation in healthcare. However, the lack of funding and autonomy for National Statistics Offices (NSOs) means that they still have inadequate access to and use of data, are unable to use the latest statistical methodologies, and have statistical knowledge gaps in metadata flow and data updating. This represents a significant challenge for the timely production of quality data, crucial in times of epidemic emergency [3]. The lack of statistical capacity thus represents a major obstacle to obtaining quality health data in Africa, consequently making the production of evidence-based policy and responses to health challenges more difficult [3].

UHC has been integrated as a goal in the national health strategies of most African countries but progress in translating these commitments into expanded domestic resources for health, effective development been slow [2]. The pandemic highlights the fact that many African countries still lack the technical expertise and capacity, in governance, in health economics, in health systems, in information systems, as well as in community participation in health [9]. A good health information system is particularly key for health campaigns, as although most of urban Africa is connected, 66% of Africans are still offline [3]. Moreso, in support of healthcare systems during the covid-19 pandemic and after, engagement of private sectors and international collaboration have proved to be very crucial. African governments must urgently increase their investments in scientific research, undertaking comprehensive and coordinated health system strengthening through improvement of infrastructure and equipment, upgrading of human resources, and procurement and supply of medicines and health technologies, and proactively seek partnerships at the continental and global levels to expand access to key services and interventions [10].

Conclusion

COVID-19 has brought into focus the need for health care reforms that promote access to affordable care. Now more than ever, the bold commitments towards UHC made by governments must be upheld. Implementing rapid UHC reforms where they are needed the most will create pathways for actions that will not only help to address health inequities made worse by the pandemic, but also support the development of stronger and more resilient health systems able to provide timely responses to emergencies, also provides the best protection against any future outbreaks becoming epidemics and achieve progress towards Universal Health Coverage.

Competing interests

The authors declare no competing interests

Authors’ contributions

All the authors have read and agreed to the final manuscript.

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