COVID-19 and the decline of the social state in Nigeria's federal democracy

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Abstract

The impact of the COVID-19 pandemic cuts across all spheres of human life, and it has exposed fundamental weaknesses in political values, governance systems, public health and social life in different parts of the world. In Africa, although with relatively less death rates than initially predicted, the pandemic has also exposed weaknesses in the continent's political and public health systems. This article analyses how Nigeria's public health sector has fared against the COVID-19 pandemic in the face of a declining social state and an ascending political state within a skewed federal democracy. This is useful for testing the relationship between effective public healthcare delivery and political systems in Africa.

Distinguishing between the social and political states, the article argues that the social state in Nigeria has declined further in the face of the COVID-19 pandemic. Dialectically, as the social state declines, the political state ascends, and this is reflected in the considerations that drive the strained intergovernmental relations which characterise the federal and state governments' responses to the coronavirus which keeps evolving. Therefore, like all countries of the world irrespective of ideological leaning and political system, Nigeria needs a strong state with a social component in the long term to combat COVID-19. In the short term, measures aimed at changing the behavior of Nigerians will help arrest the growing tide of infections and death rates.

Keywords: COVID-19, Nigeria, Political state, Public health, Social state

Introduction

Epidemics are not rare occurrences in Nigeria. In the last two decades, the country has at various times been confronted with several epidemics such as Lassa fever, acute hepatitis E, Cholera, meningococcal disease, polio, guinea worm, Ebola,[1] amidst a debilitating public health infrastructure. Ironically, despite the poor state of Nigeria's medical facilities, the country was able to achieve a globally admired feat by effectively managing and eradicating the deadly Ebola (as it did polio), a success credited to its existing polio surveillance infrastructure (Ebenso and Otu, 2020; Tomori, 2014). Given its notorious history of failed efforts in building and sustaining systems that are crucial to its survival and development, this was commendable. However, with the outbreak of the novel coronavirus (COVID-19), there were palpable and legitimate concerns about Nigeria's capacity to manage the pandemic considering how fast the virus was transmitted viz-a-viz the country's poor public healthcare facilities. As Ebenso and Otu (2020) noted, the concerns were primarily based on the fact that unlike polio and Ebola that already had vaccines, COVID-19 had no vaccine and also spreads very quickly. Worse still, modelling by Gilbert *et al*. (2020) classified Nigeria as a country that has moderate risk with respect to the importation of the virus, and a variable capacity to manage the pandemic with high vulnerability rate.

Based on the foregoing and bearing in mind Nigeria's huge population and high poverty levels, the projected infection and death rates in the event of COVID-19 spread, was better imagined than experienced. Although her infection (56, 256) and death (1,082) rates representing 272 infections and 5 deaths per 1 million as at 14 September 2020[2] have proven all projections including Gibert *et al*. (2020) wrong, Nigeria's public health system was stretched beyond capacity and exposed for its weaknesses.[3] Meanwhile, as reported cases rose in Africa through community transmission, experts' advice on how governments should respond revolved around three core pillars: detection, prevention, and control (Gilbert *et al*. 2020). Accordingly, and in line with the global approach of lockdown and curfews, national and sub-nation governments in the continent reeled out torrents of legislations and regulations designed to contain the spread and save lives and livelihoods.

In Nigeria's case, the pandemic further exposed the debility of political system described by Huntington (1968),[4] given its perennial failure to effectively deliver basic social services expected of a state. Also, given the increasing level of insecurity in the country wrought by Boko Haram and Fulani herders, it can be argued that as a state, Nigeria has failed in its primary responsibility of maintaining law and order, and protecting itself internally and externally. Concisely, in the face of the COVID-19 pandemic, Nigeria has witnessed a further decline of the "social" state that is efficient and effective in delivering social development – healthcare, education, and equal

[1] See https://www.who.int/csr/don/archive/country/nga/en/. Accessed 10/8/2020.

[2] The authors monitored Nigeria's daily infection and death rates daily on the Worldometer's COVID-19 Database (see https://www.worldometers.info/coronavirus/) between 08/09/2020 and 14/09/20 and Nigeria was one of the few countries that did not update its figures daily.

[3] Nigeria's Secretary to the Government of the Federation (SGF) acknowledged this; See https://www.vanguardngr.com/2020/04/i-never-knew-our-healthcare-infrastructure-was-in-such-bad-state-%E2%80%95-boss-mustapha/. Accessed 11/8/2020.

[4] Huntington posits that debile political systems suffer deficiencies in health, food, income, wealth, literacy, productivity, education, and productivity. Despite its wealth – billions of dollars from crude oil receipts, these have become the defining characteristics of Nigeria. Hence the collapse of its healthcare system and other critical infrastructure.

opportunities for all – with a corresponding ascendance of the political state that accords priority to regime security.[5] Indeed, Nigeria's political elites have prioritised the survival of the political system that keeps them secured in power at the expense of the citizens they govern. In this context, the enforcement of lockdowns and curfews by security agencies shrunk human rights in a manner reminiscent of a totalitarian state, as innocent Nigerians were gruesomely killed by security forces.

Another worrying aspect of Nigeria's response to COVID-19, which is a signifier of an ascending political state, is the lack of coordination and cooperation between the national and sub-national (state) governments that constitute the federation. Sharp disagreements between the federal and several states governments over spheres of influence reflected strained inter-governmental relations which impeded the implementation of harmonised policy responses to the pandemic.

Two key research questions emerge from the foregoing which this paper sought to answer: how has Nigeria's public health system fared against COVID-19 in the face of a declining social state, and second, how was Nigeria's governmental response managed within federal democracy? We contend that the social state in Nigeria has declined further in the face of the COVID-19 pandemic indicating a descent to a Hobbesian state. As the social state declines, the political state ascends, and this is reflected in the considerations that drive the inter-governmental relations tensions which mark the federal and state governments' response to pandemic in Nigeria.

Conceptualising the social and political states in Nigeria

Pertinent to this paper is the concept of the state, which is the fulcrum of political activity. Basically, the state is seen as a hierarchical institution that concentrates power it uses to enforce order within its territory. In this paper, we adopt a binary approach in conceptualising the state namely, the social and the political state. By the social state we mean a state that is based on the ideals of social policy, one that addresses social justice, it is inclusive and effective in the distribution of public goods. In contradistinction to this is the political state. This is a state that has social policy vacuity, one that privileges the protection of elite interests and the pursuit of narrow ends over and above the common good. The political state is one that abdicates its responsibility in providing public goods while prioritisng regime security and survival of its abstract and territorial components, even when they have little or no social value for its citizens. The broad characteristic of the social state and its anti-thesis, the political state, are illustrated in Table 1 below:

Table 1 Characteristics of social and political states

The social state	**The political state**
Impersonal	Patrimonial
Inclusive	Elitist
Developmental in nature	Impedes development
Management of state resources for the common good	Private accumulation of state resources by the ruling elite for individual/group interests
Government dominance in the economy	Private sector dominance in the economy
Human security prioritised	State and regime security prioritised

Source: Compiled by authors

[5] The authors wish to appreciate Professor Kenneth Ombongi for sharing his thought on the social and the political states in an online conversation in April 2020.

It is important to note that the political state has its origins in the colonial state during Britain's foray – colonialism – into Nigeria, at the height of *laissez faire* capitalism, which focused more on the expropriation of resources of the colony and less on development (Falola, 1996). The wave of the Keynesian economic philosophy which advocated state intervention in the 1930s altered the *status quo* (*laissez faire* capitalism) by introducing the Colonial Development and Welfare Act in 1945.[6] As Falola (1996) noted, the addition of "welfare" meant paying attention to services that would improve the living standard of the subjects, which was implemented with the introduction of a detailed 10 Year Development Plan in 1946. The plan saw the expansion of healthcare services and welfare programmes in other sectors but also retained the goal of colonialism namely, expropriation of the colony's resources. However, it marked the birth/ascent of the social state in Nigeria (For details, See Falola, 1996:157-160).

This social character of the colonial state was retained at independence in 1960. Hence, Nigeria "accepted planning as a government function" (Falola, 1996:157). This is reflected in the subsequent Development Plans that were introduced, as Nigeria managed to sustain the fragile unity it inherited from the British under a federal democracy. As a latecomer in the industrialisation network, Nigeria grappled with how best it could drive development through industrialisation. Viewing its efforts in this regard through Khan's (1995) political settlement framework,[7] Nigeria witnessed the distribution of power by successive governments between the 1960s and 1970s. The first post-independence National Development Plan (NDP) which was modelled after the colonial one and aimed to modify the structure of the colonial economy covered the period 1962-1968. It introduced an import substitution strategy to promote industrialisation, at the core of which infant industries were protected (Iwuagwu, 2009).

The era of military rule in the 70s also saw more efforts by the state to consolidate the previous moves by promulgating the Nigerian Enterprises Promotion Decree in 1972 and 1977. This was the era of the second and third NDPs which covered the periods 1970-1974, and 1975-1980, respectively. Ojo (2012) posited that the development instruments outlined the goals, strategies, and techniques of the government in the form of public sector investment programmes and socio-economic policies in critical sectors that would expedite Nigeria's development process. Accordingly, the state invested heavily in the energy, agriculture, mining and quarrying, telecoms, and healthcare sectors. For instance, the distribution of expenditure in the first NDP showed that £14.6 million, £21.2 million, £30 million, £88 million, and £39.2 million were expended on transport, aviation, communications, Niger Dam, and health and education respectively (Dudley, 1982). The second and third NDPs were even more ambitious. According to Osaghae (1998:72), the total estimated expenditure for the whole country rose from N2 billion in the second NDP to N33 billion, and later revised to N43 billion in the third NDP. These ambitious NDPs were largely executed with crude oil proceeds (much of which was also mismanaged and embezzled), hence the label, "oil boom development planning". In the period between 1962 to late 1970s, Nigerians benefitted from the state's social policy in education and healthcare that were "free or heavily subsidised" (Asakitikpi, 2019; Osaghae, 1998; Babawale *et al*, 1996) as other essential services. It is important to note that as elaborate as the third NDP was, it had funding challenges due to the

[6] When the Act was first introduced in 1929, it was the Colonial Development Act. The inclusion of Welfare marked a crucial departure from the erstwhile colonial policy (Falola, 1996).

[7] Mustaq Khan conceived political settlement as the distribution of organisational power.

crash in oil prices in 1978, which led to the introduction of austerity measures and the gradual withdrawal of subsidy on public goods such as education. This started with the Olusegun Obasanjo led military government (1976-79), and later compounded by the blatant financial corruption of the Shehu Shagari civilian government (1979-1983) (Osaghae, 1998).

What finally stirred the hornet's nest was the advent of neoliberalism in the 1980s when Nigeria embraced the Structural Adjustment Programme (SAP) prescribed by the Bretton Woods institutions as an economic elixir to its balance of payment problems. This brought back *laissez faire* capitalism. Tied to the loans Nigeria needed to resolve its balance of payment problems was the condition that it must abandon state-led intervention approach to development and implement currency devaluation, privatisation and trade liberalisation, removal of subsidies, privatisation, etc.,[8] which it did. Impliedly, what the SAP meant was that Nigeria should stop planning, which was exactly what happened, and eroded the social character of the state. According to Mkandawire (2001:309) SAP "[delinked]…the state from its social roots while subjecting it to external 'agents of restraints' through a battery of conditionalities and technical assistance." This was the case in much of Africa where about 40 countries were said to have approached the IMF for balance of payment assistance (Loxley and Campbell, 1989)[9].

In Nigeria, the socio-economic impact of the SAP was devastating. In their study, Babawale *et al*. (1996:131) captured the impact as follows:

> sharp decline in the living standards of most Nigerians; deteriorating problems of urban housing and transportation; alarming rate of hunger and starvation; worsening public health service standards as most hospitals, including the specialist ones, run out of the most elementary drugs and equipment; deepening crisis in the education sector, falling standards, and extremely low morale among lecturers and students are some of the macro-social hallmarks of the adjustment programme. These problems have gone hand in hand with persisting and, in some instances, serious economic problems - problems of unemployment and inflation, payments and budgetary imbalances, exchange rate volatility as the value of Naira kept declining at the local foreign exchange auction, capital flight, and the failure of manufacturers to respond to the export incentives introduced by the government as part of the adjustment process.

With respect to the health sector, after withdrawing subsidies the government introduced a healthcare system modelled after America with user fees (Nnoli, 2011; Osaghae, 1998). This resulted in the neglect of the health sector and other social services. The government's resolute position on SAP was met with civil disturbance from organised labour and it responded with repression. This effectively saw the capitulation of the social state.

[8] In President Obasanjo's second coming in 1999 as civilian president, he completed the SAP recommendation which Ibrahim Babangida started in the 1980s to latter (See Nnoli, 2011:252-262).

[9] It details the SAP's impact on Africa

A situation analysis of Nigeria's public health system

Healthcare systems vary across different countries globally. As Reid's (2009) showed, countries use different healthcare models ranging from the Bismark, Beveridge, National Health Insurance, and Out-of-Pocket model.[10] Given the importance of good health to human existence, which COVID-19 has underscored, the right model that would meet the healthcare needs of all citizens has been the subject of intense debate among scholars and policy-makers (Roberts *et al*., 1996). Since neoliberalism became the dominant ideology, it has created opportunities by promoting a free-market economy that is conducive for economic growth with positive spin-offs for jobs on the one hand. However, it has also created problems by privatising and commodifying public goods such as healthcare in some countries in ways that priced it out of the reach of the poor majority. This gave the impetus for healthcare reform calls to make it a right, and not a privilege as is the case in the United States[11]. Implicit in this reform idea is the attempt to emplace an egalitarian ethic of healthcare system, or what is sometimes referred to as universal healthcare (See, Roberts *et al*. 1996).

Nigeria, a federal democracy modelled after the American presidential system of government, is one of such countries where healthcare is commodified and priced out of affordability for the poor masses. In line with its federal system, the management of healthcare in Nigeria is shared and descentralised from the federal (national) to state (sub-national) and local government. Specific responsibilities are assigned to each level of government: federal government, 36 state governments and 774 local governments. For instance, the federal government, through the Federal Ministry of Health (FMOH) is responsible for tertiary healthcare and other responsibilities concerning national policies on healthcare, technical assistance to the entire health system in the country, management of health information, among others. Secondary healthcare service superintendence and technical assistance for primary healthcare services is the responsibility of the State, through the State Ministry of Health (SMOH) replicated in the 36 States of the federation. Lastly, the Local Governments are in charge of primary healthcare organised through the various Council Wards in the 774 Local Government Areas. For this reason, Nigeria is said to have a three-tier healthcare system (Adebisi, *et al*. 2020). As good as the decentralised arrangement is on paper, the health system does not operate as seamless and effectively as intended.

While there are many reasons for this, including the neoliberal approach to public health, successive years of chronic underfunding, pervasive corruption, mismanagement, manpower shortages to growing population, and general infrastructural decay in the country (Onwujekwe *et al*., 2020; Asakitikpi, 2019), there is only one outcome; the decay of the health sector in Nigeria. To understand the state of Nigeria's public health system, this section shall focus on how the neoliberal approach to public health impacts on healthcare funding which has progressively declined since 2014. The resultant decay is also discussed as a signpost of the ascending political state at the expense of a declining social state.

[10] The Out-of-Pocket model is a healthcare system that the poor who cannot afford any payment plan are left with. The rule here is: "the rich get healthcare, the poor stay sick and die" (Reid, 2009:18). This model is found in the developing world (For elaboration on how the Bismarck, Beveridge, and National Health Insurance works in countries that have adopted them, See Reid, 2009:17-19).

[11] In comparison with its counterpart in the industrial world, egalitarian liberals consider the United States healthcare system an unfair one, not based on equity (Roberts et al. 2004).

Impact of the neoliberal public health funding approach

The health sector generally across Nigeria is in a state of decay. As mentioned earlier, this started with the introduction of neoliberal orthodoxy in the 1980s. By 2002, a report by the African Development Bank described Nigeria's decayed public health sector as follows:

> one that is essentially noted for poor and inefficient provision of public healthcare services which results in abysmal outcomes; not effective at reaching those on the margins; huge disparities between the privileged class and the poor health status wise; insufficient standard government health service arising from the absence of drugs, poor public financing of the health sector; and short supply of human resources and lack of proficiency in managerial abilities (African Development Fund, 2002:2).

It is essentially an out-of-pocket model which has snuffed life out of countless poor Nigerians who cannot afford basic healthcare services. For instance, a prominent Emir (now deposed) in North-West Nigeria narrated a sad incident where a mother who came to his palace for financial support to enable her get medication for her sick daughter ended up losing the baby while waiting to be attended to. While lamenting in tears, the Emir asked rhetorically: "And how much was this? It was less than $5. This is what happens every day in this country".[12] Asakitikpi (2019) underscore how the neoliberal healthcare reforms implemented by the government tried to revamp the sector but only succeeded in coming up with a model that serves the interest of the upper and middle classes. Also, the National Health Insurance Scheme (NHIS) Act that was enacted in 2005 caters mainly for those in the public and private sectors thus excluding Nigerians at the margins. Impliedly, a vast majority of Nigerians who work in the informal sector are not insured in a society where healthcare is publicly underfunded.

Studies have shown that there is a correlation between budgetary allocation to the health sector and health outcomes (Rezapour, et al. (2019). Others go further show that it has a positive and substantial effect on economic growth (Piabuo and Tieguhong, 2017). A recurring conclusion of these studies which is also reflected in global development approaches such as the Millennium Development Goals (MDGs)/Sustainable Development Goals (SDGs) is that government should provide sufficient resources to improve the health well-being of their citizens. This was one of the considerations for the Abuja Declaration in 2001where African Union leaders resolved to allocate 15% of their national budgets to health[13] in line with the Millennium Development Goal (MDGs). For example, the few countries in Africa that spend more than 15% of their national budget for the health sector have better health performance than others in the continent who spend below that. As shown in Table 2 below, there were only 2 of such countries in 2001, 8 in 2005, and the number reduced to 5 in 2010[14] (WHO Report, 2013).

[12] See https://thecitizenng.com/sanusi-weeps-as-kano-mother-loses-sick-child-over-5-medical-bill/. Accessed 25/8/2020.

[13] See https://www.who.int/healthsystems/publications/abuja_report_aug_2011.pdf?ua=1. Accessed 2/9/2020.

[14] The 5 countries that met the 15% Abuja Declaration in 2001 are: Botswana, Rwanda, Togo, Madagascar, and Zambia (WHO, 2013).

Table 2 Percentage of African Countries National Budget allocation
To Health Sector in 2001, 2005, and 2010

Years	Less than 10%	10-15%	More than 15%
No. of countries in 2001	22	21	2
No of countries in 2005	20	17	8
No of countries in 2010	19	21	5

Source: World Health Organisation (2013)

According to the WHO report, inadequate funding of the health sector accounts for the lowest life expectancy at birth in Africa, and at age 60 in the world.[15] Further underscoring the relationship between funding and outcomes, the WHO Report notes that the progressive cuts explain why most African countries fall under the less than 10% and 10-15% brackets. It also noted the lack of political will by leaders, and where there is political will, a weak revenue base constitutes a constraint.[16] This seems to be the case with Nigeria, where despite enormous oil revenue, there has been a steady decline in government spending on health service delivery over the last decade (2010-2020).

Focusing on a seven-year period, Adebisi *et al*. (2020) show that the decline in budgetary allocation to the health sector in 2014 and 2017 accounted for the decrease in neonatal and infant mortality in Nigeria, and the steady decline, yearly, of life expectancy. This is illustrated in Table 3, which shows the national and health budgets in the seven years period.

Table 3 A Brief Summary of Nigeria's National Budget Between 2014-2021

Year	National Budget in Trillion	Health Budget in Billions	% of Health Budget	15% of Total Budget	Gap to Cover Abuja Declaration Requirement
2014	4695.19	339.38	7.23	704.28	364.90
2015	5067.70	347.26	6.85	760.19	412.90
2016	6060.48	353.54	5.83	909.07	555.53
2017	7441.18	380.16	5.11	1116.18	730.02
2018	9120.33	528.14	5.79	1368.05	839.91
2019	8830.00	372.70	4.22	1324.50	951.80
2020	10594.36	463.80	4.38	1589.15	1125.35
					N4.99 trillion

Source: Adebisi et al. (2020) with modifications

Clearly, as the table shows, Nigeria has never met the Abuja Declaration threshold as the highest was 7.23% in 2014. The gap to cover the Declaration in the years under review amounts to N4.99 trillion (approximately $13.1 billion). As indicated in the findings of studies on the relationship

[15] This is for 2019, updated 07/12/2020. Healthy life expectancy for both sexes at birth in 2019 was 56.0, 45.8 for male, and 57.1 for female, while Healthy life expectancy at age 60 for both sexes in the same year was 13.3, 12.6 for male, and 13.9 for female, respectively. See https://apps.who.int/gho/data/view.main-afro.HALEXREGv?lang=en. Accessed 30/04/2021.

[16] The percentage of African countries national budget allocation to the health sector during the SAP era is difficult to access. But as indicated in the volume edited by Loxley and Campbell (1989), situation was not different with Nigeria. Most African countries approached the Bretton Woods institution for balance of payment assistance.

between budgetary allocation and health outcomes, the assumption is, if the said amount ($13.1 billion) was allocated and not siphoned as is always the case in Nigeria, both health infrastructure and health outcomes would have improved significantly.[17]

Ironically, despite the COVID-19 pandemic, the health percentage in the 2021 budget saw a decrease. A total of N380.21 billion ($26.9 million) was allocated to the health sector, representing 4.4% of N13.58 trillion of the country's national budget. This is by far the lowest budgetary allocation to the health sector during the last 7 years period reviewed. Worst still is the statutory transfer[18] to basic healthcare prevention for the entire country in the 2021 budget, which is N35.0 billion ($85.6 million). In the same year, that of the National Assembly (NASS) which has a staff strength of approximately less than 2500 (109 Senators, 360 House of Representatives (HOR) members plus administrative staff) had a statutory transfer of N128 billion ($313.4 million). The difference is not only huge, but it also signposts the self-serving and predatory nature of the political elites on issues of social service delivery that benefit the citizens. This is reflective of the political state.

Elite medical tourism and lack of political will

A closely related factor that has also impacted negatively on Nigeria's public health system is medical tourism which is frequently undertaken by the country's elite. In many ways, this has also contributed to why the governing elites lack the will to invest in the public health sector despite Nigeria's huge resources. The plausible explanation is that, unlike those on the margins, the governing elites and their families have the medical tourism option which is financed by taxpayers' money. They routinely go for treatment and medical check-up for themselves and their family members making them oblivious of the poor state of health facilities in Nigeria until COVID-19 forced them to patronize it[19]. The Secretary to the Government of the Federation (SGF) who is the Chairman of the Presidential Task Force on COVID-19 affirmed this at a meeting with the leadership of the NASS when he stated that he never knew Nigeria's entire health infrastructure was in such bad state until he was appointed to do this job.[20] This is the nature of the entrenched political state that COVID-19 exposed.

While the foregoing appropriately captures the fate of the poor, the political elite who are responsible for the poor state of health infrastructure in the country and others in the upper-class operate by different rules in terms of assessing healthcare until global lockdowns limited their access to world-class healthcare abroad which they were not willing to provide at home. As indicated in the literature on medical tourism, about 18, 000 wealthy Nigerians spend as much as $20 billion yearly on medical care overseas (Connell, 2011). Those who constitute the "wealthy Nigerians" category are members of the ruling elite, former government functionaries, and their associates in the corporate world. This has kept the phenomenon of health tourism flourishing in

[17] For example, the slight from 5.11% in 2017 to 5.79% had a corresponding impact on improvement in the mortality rate Adebisi et al. (2020).
[18] Statutory transfers are budget allocations to specific institutions of government that are constitutional and cannot be altered by the executive.

[19] While the pandemic exposed the sorry state of Nigeria's health facilities, it also acted as a "leveler" for all, regardless of social status. The global lockdown which restricted international travel compelled the rich to seek medical care from the same collapsed health system they neglected for decades. Incidentally, from reported casualties, it appears the governing elites have been hard hit by COVID deaths.

[20] See *Vanguard* https://www.vanguardngr.com/2020/04/i-never-knew-our-healthcare-infrastructure-was-in-such-bad-state-%E2%80%95-boss-mustapha/. Accessed 31/8/2020.

Nigeria with the country's presidents leading the pack. For instance, late President Umaru Yar'Adua received medical care in Germany and Saudi Arabia until he died in 2010 in a controversial circumstance that created a constitutional crisis. Since his presidency began in May 2015, President Muhammadu Buhari is said to have spent 170 days overseas for medical care, the latest of which happened when healthcare workers embarked on a national industrial action protesting poor working conditions and non-payment of salaries.[21] At the peak of the COVID-19 pandemic when lockdown regulations were enforced, the President's wife was flown to Dubai to receive medical attention.

Ironically, the medical needs of the President and other top government functionaries are well provided for in the budgetary allocation to the State House Clinic. And although this should obviate medical tourism by the presidential family and others in this category, that is not the case given an entrenched taste for medical care abroad. This has further encouraged the looting or misappropriation of allocations to the State House Clinic knowing the president and family will never use the clinic. As shown in Table 2, approximately N6.4 billion ($17.0 million) was allocated to the State House Clinic between 2016 and 2021.

Table 4 Aso Rock Clinic Budget Between 2016-2021

Year	State House Clinic Budget
2016	2, 825, 597, 363
2017	331, 730, 211
2018	1, 030, 458, 453
2019	799, 00, 000
2020	703, 440, 241
2021	687, 000, 000
Total	6, 377, 226, 268

Source: Dataphyte with modifications

Even with N331.7 million ($871.7 thousand) allocated to the Clinic in 2017, the First Lady revealed that the Clinic lacked basic equipment when she called to book an appointment for medical a check-up (Daka, 2017). Failure to check this sort of corruption in the presidency over the years (especially under the current administration which has anti-corruption as one of its cardinal objectives) and in the entire health sector explains why government officials and members of the upper class resort to medical tourism which is costing the country a lot in terms of capital flight. There is no incentive for the governing elite to fix the health system since they do not use it. This has made it easier to for them embezzle monies allocated for their healthcare in Nigeria and also double-dip the state by also using public funds for their medical treatment abroad. These are all signposts of the ascent of the political state. Unlike Nigeria, countries such as Indonesia, Oman, and Tunisia that lost substantial revenue to medical tourism changed tracks and redirected the monies expended on medical tourism to revamp their health facilities relatively good public health care systems to show for it (Connell, 2011).

[21] See the Africa Report https://www.theafricareport.com/76967/nigeria-buhari-heads-to-uk-for-medical-treatment-as-doctors-strike-erupts-at-home/. Accessed 03/05/2021.

State response to containing COVID-19 and strained intergovernmental relations

Federal Government Response

Given Nigeria's federal state structure, the response measures adopted in combating the pandemic were implemented at the national and sub-national levels of government. Since COVID-19 is a public health crisis with an international dimension, it fell under the jurisdiction of the federal government to initiate and implement the requisite action such as closing international borders and airspace. Overall, the federal government's response was slowly phased and in a lethargic manner. After the index case was reported on 27 February 2020, it only took its first response measure on 9 March by setting up the Presidential Task Force on COVID-19, led by the SGF, Boss Mustapha. Thereafter, the ban on international flights from countries with high infection rates of the COVID-19 came on 18 March, and 5 days later, the land borders and airspace were closed. This was followed by lockdown in Lagos and Ogun States, and the Federal Capital Territory (FCT) on 30 March.

At the economic level, the federal government took steps to cushion the impact of the pandemic by introducing a number of support measures. It injected N500 ($1.3 billion) fiscal stimulus targeted at upgrade the country's deplorable health infrastructure; it withdrew $150 million from the Nigerian Sovereign Investment Authority Stabilisation Fund and channelled to sub-national governments to sustain the provision of essential services; it established a N50 billion ($131 million) credit facility for SMEs; and it introduced a N100 billion ($26 million) intervention fund for local pharmaceutical companies and others in the healthcare value chain to enable them to expand in order to meet up with the rising demands for healthcare products (for details on the fiscal intervention from the government, see Ejiogu *et al.*, 2020). While this intervention was timely, there were stringent conditions attached to accessing these credit facilities. It is, however, worth noting that the government allowed a one-year moratorium on repayment, and also slashed the interest rate from 9% to 5%.

To support the federal government's effort in combating the pandemic, members of the HOR announced that they would be donating 100% of their salaries (for the months of March and April) to the national relief fund account which was set up for the fight against COVID-19 (Omilana, 2020). Similarly, members of the Senate also pledged to donate 50% of their salaries for the same course (Oroanusi, 2020). These gestures from an arm of the government that is the highest paid in Africa[22] without commensurate outcomes in terms of quality rulemaking and representation, clearly indicates that the political elite in Nigeria only respond to national problems that affect the masses when they are also affected. However, despite these federal government interventions, the manner it in which it implemented its policy measures to curtail the spread of the virus further exposed the absence of the social state and the prominence of the political state that protects the enclave of the political elite. For example, the implementation of national lockdowns by the federal government saw the political state in full swing. Instead of pushing out more personal protective equipment, medical supplies and personnel to save lives, the government elected to send more of

[22] This ranking is according to a report by a UK based Independent Parliamentary Standards Study. See https://www.businessdailyafrica.com/bd/economy/kenyan-legislators-emerge-second-in-global-pay-ranking-2037344. Accessed 05/05/2021. Also, according to Senator Shehu Sani in 2018, the salary of a Nigerian Senator is N13.5 million per month ($32.9 thousand) (See https://www.premiumtimesng.com/news/headlines/261085-confirmed-nigerian-senators-receive-n13-5-million-monthly-apart-from-salaries.html). Accessed 8/9/2020. This is in a country where the citizens live on less than $2 per day with a collapsed healthcare system and other infrastructural challenges.

security forces to the streets to enforce national lockdowns in a manner that suggests regime security instead of people security was at stake. As a result, people's rights were brazenly and brutally abused by security forces in the name of restricting movements. Considering that majority of Nigerians work in the informal sector of the economy and depended on daily wages for survival, livelihoods were gravely affected without social support interventions.

On day two of the lockdown, a young man was shot dead by an Army officer in Delta State (Onoyume, 2020). Since the government did not reprimand security personnel, they became emboldened and the number of deaths arising from lockdown enforcement continued to increase. According to renowned human rights lawyer, Mr Femi Falana (Senior Advocate of Nigeria), 21 persons were killed by security personnel (Chiedozie, 2020). In Osun State, South-West Nigeria, two Policemen were caught on camera assaulting a woman who came out to get medication and other essentials for her family (Kabir, 2020). The repugnant video which went viral on social media attracted the attention of the top hierarchy of the Police force. After investigating the incident and the officers involved were found guilty, they were summarily dismissed (Erezi, 2020). While this is commendable in a country where many of such acts go unpunished, justice would be seen to be done if other officers who brazenly killed Nigerians under the lockdown also face the full wrath of the law. Security forces' high-handedness was also extended to the media (Mwantok and Aikulola, 2020) whose effort in containing the spread of COVID-19 in terms of reportage was commendable. In addition to the use of violence on citizens, enforcement of inter-state lockdown by police officers created an extortionist economy as officers extorted money from taxi drivers and allowed them free entry and exit into the various states across the federation.[23] The repression from the state across all sectors of society was reminiscent of the Hobbesian state.

Apart from exposing the decayed social state in Nigeria, COVID-19 also exposed structural problems in Nigeria's healthcare law. It does appear Nigeria does not have an effective law to combat a pandemic. The federal government had to rely on an *antediluvian* legislation enacted by the colonial state in 1926 (the Quarantine Act) to declare lockdown in Lagos, Ogun, and the FCT. Even though there is the National Programme on Immunisation Act (2004), the Environmental Health Officers Act (2002), and most importantly, the National Health Act (2014) which makes provision for disease surveillance, the concern about the inadequacy of these legal instruments in combating a pandemic has been raised by experts. For instance, Makinde and Odimegwu (2018:5) observed that "the level of detail in the National Health Act for disease surveillance is considered inadequate by most respondents as it was not enacted for the purpose." While the President derived his power to declare lockdown from the Quarantine Act, prominent human rights activists in the country reacted in protest, questioning if the exercise of such power on state borders and limiting the constitutional rights of the Nigerian people to move freely was constitutional.[24] Even though the lockdown was eventually enforced, the tension that ensued exposed the weakness of the law in combating the pandemic in a federal democracy.

Also, the political state manifested in the way the government handled the welfare of frontline health workers. The poor state of the health sector in Nigeria also includes the poor welfare and condition of service for health workers. At a time when the government should proritise their

[23] *Punch*, 31/5/2020 https://punchng.com/covid-19-govs-fume-as-interstate-travel-ban-collapses/. Accessed 8/9/2020.
[24] *Punch* 31/3/2020 https://punchng.com/abuja-lagos-ogun-lockdown-soyinka-san-agf-fight-over-legality-of-buharis-directive/. Accessed 9/9/2020.

welfare for risking their lives to save others, it failed. Coupled with the accumulated grievance relating to poor health facilities, failure to review upward, health workers hazard allowance of N5000 ($13) and non-payment of outstanding COVID-19 allowances and salaries resulted in industrial action by the health workers across the country[25] in July 2020. A few months later in March 2021, President Buhari embarked on his routine medical check-up in the United Kingdom 2 days before health workers embarked on another industrial action (Osae-Brown, 2021; Okunola, 2021). It is worth noting that the Nigerian state deprioritise giving the health sector the attention it deserves by increasing its budgetary allocation to address problems of welfare of health workers and the poor state of facilities in the sector, yet it allocates billions of naira to service the luxury of elected and appointed officials whose contribution to the nation in terms of governance, development, and growth outputs is more self-serving than service to the people.

The political state is one that is essentially clientelist and thrives on corruption. Given Nigeria's dismal credential in this regard, the federal government's handling of the distribution of palliatives to the vulnerable population was also shrouded in secrecy and corruption[26] hence the bedlam that ensued across the country. At issue was the parameters used in drawing up the beneficiaries of the N20, 000 ($52) conditional cash transfer (CCT) (Njoku *et al*., 2020). While the government insisted it distributed palliatives to the poor, most Nigerians within that category said they did not receive palliative as announced. For instance, in Enugu State, South-East Nigeria, it was reported that the distribution was characterised by corruption and diversion as expected beneficiaries told reporters they only heard about palliatives on the radio.[27] The State government refuted this allegation, but the allegation was confirmed when Nigerians started looting state warehouses where COVID-19 palliatives meant for the vulnerable population were hoarded by State Governors across the federation[28]. In Lagos State, South-West Nigeria, COVID-19 palliatives were found in the homes of politicians[29] and the Oba's palace during the End Sars protest.[30] This is the context within which we argued that the pandemic saw the further erosion of the social state that prioritised the welfare of its citizens and the ascent of the political state that thrives on clientelism, primitive accumulation of wealth, regime security, and elite corruption.

Sub-national government response to COVID-19

Taking a cue from the federal government, state Governors equally swung into action to contain the spread of COVID-19 and strengthen hospital preparedness. With community transmission at its peak, the 36 Governors agreed to implement a 14-day inter-state lockdown in their various states and set up COVID-19 Committees at the regional levels which will be superintended by

[25] *Vanguard*, 7/9/2020 https://punchng.com/resident-doctors-begin-strike-today-woo-other-health-workers/. Accessed 11/9/2020.

[26] *The Guardian*, 8/8/2020 https://guardian.ng/saturday-magazine/fgs-covid-19-palliatives-why-nigerians-are-not-feeling-the-impact/. Accessed 8/9/2020.

[27] *AllAfrica*, 27/07/2020 https://allafrica.com/stories/202007270097.html. Accessed 07/05/2021.

[28] *Reuters*, 9/11/2020 https://www.reuters.com/article/uk-health-coronavirus-nigeria-food-idUKKBN27P0YZ. Accessed 07/05/2021.

[29] *BBC News*, 26/10/2020 https://www.bbc.com/news/world-africa-54695568. Accessed 07/05/2021/.

[30] *PremiumTimes*, 22/10/2020 https://www.premiumtimesng.com/regional/ssouth-west/422474-endsars-lagos-princes-princesses-react-to-attack-on-oba-of-lagos-palace.html. Accessed 07/05/2020.

State Commissioners of Health.[31] This coordination from the States was necessary because the federal government cannot legislate in their jurisdiction considering the federal nature of the country's democracy. The resolve by the Governors to enforce lockdowns in their various States is instructive. Given the protest by civil rights activists when the President announced lockdowns in two states (Lagos and Ogun) and the FCT, enforcing the same measures at the sub-national level shows presidential directive alone is not sufficient without the concurrence of the State Governors. For the first time in Nigeria, most Governors were seen deploying their executive power to a productive cause, instead of politics, as is always the case. Being the epicentre of the pandemic, Lagos State Government took the lead in combating the pandemic. The State Assembly passed the Infectious Disease Regulation,[32] pursuant to the Quarantine Act, which provided a legal instrument for the fight against COVID-19. Within a short period, the State was able to set up well-equipped isolation centres across its Local Governments Areas and converted its Cardiac Renal Hospital to a COVID-19 isolation centre. It also got support from the corporate world in this regard.[33] These steps were helpful in enhancing treatments and the recoveries the state recorded in large numbers, thereby, making it a reference point on best practice for dealing with the pandemic in Nigeria. Considering the deplorable state of healthcare facilities in virtually all the States in Nigeria, they were all compelled in the face of the ravaging pandemic to establish isolation centres and other preventive measures aside from the lockdown and the State Action Committees they set up. This should have been the first response instead of the use of security forces. In addition, the Coalition Against COVID-19 (relief fund), a private sector-led initiative Chaired by Aliko Dangote, Africa's richest man, supported the efforts of sub-national governments' in providing health facilities. However, the complicity of the state Governors in compounding the woes of the vulnerable population as pointed out above with many Nigerians losing their lives, reversed whatever good these intervention measures were designed to achieve.

Inter-governmental relations and tensions in the management of COVID-19

The federal system practiced in Nigeria has its origins in the Lyttleton Constitution of 1954. However, this was restructured during the 1979 Constitution making which introduced innovative designs aimed at addressing Nigeria's governance problems ahead of the Second Republic. Accordingly, the autochthonous political framework was credited for being "one of the most imaginative and carefully designed transitions ever staged by a withdrawing military government" (Diamond, 1988:2). According to a commentator, Nigeria's federalism "is one of the most ingenious federal systems in the world" because it "integrates micro identities into political identities large enough to constitute a state and fragment large ethnic identities in a way that disables their mobilisation as regional ethnic powers."[34] At the level of governance, the sub-national governments exercise wide legislative powers spelt out in the concurrent and residual lists that cannot be exercised by the federal government.

[31] *Vanguard*, 23/4/2020 https://www.vanguardngr.com/2020/04/covid-19-governors-opt-for-2-week-inter-state-lockdown/. Accessed 10/9/2020.

[32] See https://pwcnigeria.typepad.com/files/infectious-diseases-regulations-2020.pdf. Accessed 10/9/2020.

[33] See https://allafrica.com/stories/202004240059.html. Accessed 10/9/2020.

[34] Oluwatosin Orimolade shared this idea on Nigeria's federalism with one of the author's in an online conversation.

However, this is not to suggest that Nigeria's federal design is perfect. Since the inauguration of the Fourth Republic in 1999, vertical inter-government relations have been conflictual; mostly on fiscal matters. This is one of the most perennial problems that has defied previous attempts for a permanent solution to Nigeria's federalism (Ojo, 2010). While much of the tension has been about constitutional principles and the common good, they have also been about power flexing and regime security for the respective actors, and therefore, indicative of the political state. The outbreak of COVID-19 and the attendant response measures engendered this conflict between the federal and sub-national governments. We shall focus on two examples (Rivers and Kogi States) of these conflicts that were more about power flexing and regime security than about the rule of law in the public's best interests amidst a public health crisis.

In Rivers State, South-South Nigeria, Governor Nyesom Wike of the People's Democratic Party (PDP) which is the official opposition to the ruling APC, arrested two Caverton Helicopters Pilots said to be on a national assignment authorised by the federal government to airlift oil workers to an oil field in Rivers State. While the federal government considered this assignment "essential", the Governor thought otherwise, because it violated the lockdown imposed in Rivers State.[35] This generated a kind of constitutional crisis as the Federal Minister of Aviation, Hadi Sirika resorted to tough talk, noting that civil aviation is under the exclusive legislative list constitutionally reserved for the federal government to legislate, which in his opinion, the Governor undermined. As the impasse ensued, there were threats by the Air Traffic Union and others in the aviation sector of possible industrial action.[36] This also signposts the political state in operation instead of the social state. Since the primary function of the state in the liberal sense is to protect its citizens first, what was expected from governments at all levels in the face of a public health crisis was to synergistically cooperate and coordinate to save lives and livelihoods rather than get embroiled in claims over territorial authority. But to keen observers of recent politics between Rivers State and the federal government, the roots of the strain intergovernmental relations was not unconnected to the long-standing inter-party feud and power play between the PDP and APC in the state.[37]

In the case of Kogi State, North-Central Nigeria, Governor Yahaya Bello who is a member of the ruling APC denied the existence of COVID-19 in his state. In a Trump-like manner, he called it a hoax. According to him, COVID-19 is "out to shorten the lifespan of people. It is a disease propagated by force for Nigerians to accept it"[38]. The Governor also accused the Nigerian Centre for Disease Control (NCDC) of making up data for his state, when in fact COVID-19 deaths in the State confirmed the NCDC's claim. Ironically, he ordered the NCDC's visiting team to his State to go on 14-day isolation, even though he believed the virus was a hoax.[39] Despite the Governor's denial of its existence in Kogi State, some of the prominent casualties in the State include the Chief Judge of the State, President of the Customary Court of Appeal, and one of the Governor's aides. This denialist attitude from a State chief executive did not only reflect strained intergovernmental

[35] *Thisday*, 12/4/2020 https://www.thisdaylive.com/index.php/2020/04/12/we-arrested-pilots-passengers-for-refusing-covid-19-checks-says-rivers-government/. Accessed 12/9/2020.

[36] *Thisday*, 15/4/2020 https://www.thisdaylive.com/index.php/2020/04/15/unnecessary-tug-of-war-in-rivers/. Accessed 12/9/2020.

[37] Rivers state is governed by the opposition PDP, while the APC governs at the centre. There have been unsuccessful attempts by the ruling APC at the center in two elections (2015 and 2019) to unseat the incumbent Governor without success.

[38] *The Nation*, 1/7/2020 https://thenationonlineng.net/covid-19-is-a-hoax-says-kogi-governor/. Accessed 12/9/2020.

[39] *BusinessDay*,8/7/2020 https://businessday.ng/coronavirus/article/gov-bello-places-visiting-ncdc-officials-on-14-day-isolation/. Accessed 12/92020.

relations between the State and a federal government agency but was also at odds with the containment measures of the federal government which had implications for coordination and implementation of government response. It is worth noting that such incoherent intergovernmental relations and the Governor's attitude also play into the attitude and behaviour of most Nigerians towards the pandemic which cannot be legislated.

For example, this has given rise to vaccine hesitancy. Again, the hesitancy was worsened by conspiracy theories propagated by some religious leaders who dismissed the vaccine as satanic[40] including the whole idea that COVID-19 is not real but a political move by politicians to loot state resources. It is not entirely wrong to say this thinking stems from the fact that the mortality rate in Nigeria is very low compared with Europe; hence the belief that the existence of the pandemic is untrue. While Nigeria has managed to deal with the Alpha Variant without any reported case of the Beta and Gamma Variants, vaccine hesitancy and denial of the virus's existence are very serious issues the government should put into consideration if it is to effectively combat the pandemic. This is especially with the advent of the third wave after the discovery of the Delta Variant in Nigeria on 8 July 2021, which has been reported in 124 countries (WHO, 2021). According to the WHO, it is the "most transmissible variant". This has been reflected in the surge in transmission two days after it was reported in Nigeria from 110 to 186.[41] Since then, the daily infection has gone up to 747 by 4 August 2021, the highest in the last six months.[42]

Conclusion

This article analysed how Nigeria's public health system fared against the COVID-19 pandemic in the face of a declining social state and an ascending political state which are both occurring in a skewed federal system. This analysis was useful to test the relationship between effective public healthcare delivery and political systems in Africa using the specific case of Nigeria. The findings show that public goods such as healthcare, and its effective delivery are compromised by a political system that does not value the social aspect of the state and the social responsibilities that go with it. In the case of Nigeria, the decline of the social state which started in the 1980s following the introduction of neoliberal orthodoxy, and continued through to its liberal current democratic era, has also come with a dialectically opposing ascendance of the political state. Indeed, the character of the political state which manifests in the looting of the public purse, prioritisation of state and regime security over human security, and the privatisation of public enterprises are antithetical to the social state. This is because it privileges the protection of elite interests and the pursuit of narrow ends over the common good.

However, this does not imply the social and political states are incompatible in a federal democracy such as Nigeria, which has a history of their compatibility in the early years of its political independence. For example, there are elements of the political state such as state security that can align with the human security element of the social state. Also, the social state needs the liberal (profit-driven) element of the political state to drive economic growth to help pay for social services and sustain the social state. In this regard, borrowing from Huntingtonian wisdom, the

[40] See *ICFIR* https://www.icirnigeria.org/nigerian-preachers-chris-okotie-david-oyedepo-wrong-on-negative-side-effects-of-covid-19-vaccine/. Accessed 03/09/2021.
[41] See *PremiumTimes* https://www.premiumtimesng.com/news/headlines/472744-covid-19-infections-rise-in-nigeria-after-delta-variant-emerges.html. Accessed 03/09/2021.
[42] See *Africa* http://www.xinhuanet.com/english/africa/2021-08/07/c_1310112686.htm. Accessed 03/09/2021.

distinction between the social and political states is not so much about their form or content, but the degree of their presence at any given time in the political existence and development of a state. What must remain constant however is the political elites' sense of *noblese oblige* which is required to always maintain a healthy balance of both the social and political states. This is what Nigeria's governing elites lack and its necessity has been further underscored by COVID-19.

Finally, with different variants of COVID-19 emerging almost quarterly, there is no say that the world will be getting over it any time soon. Like the Delta variant, it is only a matter of time before the latest variants (C.1.2. and Mu) in South Africa spread to Nigeria. The country therefore must be prepared with the requisite social and development infrastructures. This also applies to all countries of the world regardless of their ideological leaning as COVID-19 has humbled both the rich and poor. It has shown that a strong state with a social component is required to combat the virus because, at the end of the day, it is the state that will still be responsible for ensuring that vaccines are available, not the profit-seeking capitalist Health Management Organisations.

Therefore, a long-term policy suggestion for Nigerian governing elites is to act in their enlightened self-interest and consider a new social compact between state and citizens that will be focused on social service delivery and infrastructure development. Such a state must prioritise a universal public health system fully funded by the state for all citizens as COVID-19 has shown that a sound public health, not a sound economy is the basis of state survival and progress as economies stood still and declined globally because of a pandemic. In the short term, behavioral change is critical to combating COVID-19, and if Nigeria is to effectively arrest the pandemic, it must address vaccine hesitancy and public aversion to public health safety measures such as mask wearing, physical distancing, temperature check, and regular handwashing. Nigerians will need to be reoriented by government at all levels to embrace vaccination and public health safety measures through aggressive and consistent public communication in all languages. Also, research has shown that to address vaccine hesitancy in Nigeria, people are more likely to take the vaccine when it is recommended by their healthcare provider (Kayode, et al., 2021). Getting religious and traditional leaders on board its vaccination drive is also critical. The government will do well to explore these options as well to promote vaccine acceptance including jacking up its current efforts to institute vaccine mandates that make it compulsory for public servants to get vaccinated to access their places of work.

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