Executive summary

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Abbreviations

BHCPF..... Basic Health Care Provision Fund
FMOH..... Federal Ministry of Health
GDP ..... gross domestic product
HIS ..... health information system
LGA..... local government area
NHA ..... National Health Act
NHMIS ..... National Health Management Information System
NHP ..... National Health Policy
OOP..... out-of-pocket
PHC..... primary health care
PPP ..... public–private partnership
SDG ..... Sustainable Development Goal
SWAp..... sector-wide approach
THE ..... total health expenditure
UHC ..... universal health coverage

Description of the health system

- **A rapidly expanding population, slow economic growth, weak governance and a high disease burden constrain health care provision and outcomes.**

Nigeria has the largest population in Africa, estimated at over 200 million, and, with a median age of 18, substantial population expansion is forecast. This large population, combined with a high fertility rate, high disease burden and lower-than-average adult literacy rate, has a significant impact on the health sector. Despite being the largest economy in Africa, with a gross domestic product (GDP) exceeding US$ 430 billion, Nigeria grapples with low growth and high inflation. These economic hurdles have far-reaching implications for the country's health care, and nearly 63% of the population live in multidimensional poverty and lack access to basic necessities such as clean cooking fuel, adequate sanitation and health care.

Nigeria's health system lacks resilience and is not currently on track to achieve the health-related Sustainable Development Goal (SDG) targets, especially universal health coverage (UHC). Performance against core governance indicators, including control of corruption, freedom of expression, accountability, the rule of law, climate change vulnerability and security, is weak compared with regional averages and remains a cause for concern, with knock-on effects on health system governance. Confidence in the health system is undermined by weak enforcement of laws and regulations, further exacerbated by the complexity of the health sector and the still evolving devolved federal system. However, recent health sector reforms initiated by the Federal Ministry of Health (FMOH) are expected to significantly strengthen health service provision.

- **Nigeria's three-tiered, regionally devolved health system is well organized in theory, but, in practice, better implementation of recent reforms is needed to address significant governance and delivery challenges.**

Health governance is devolved in line with the existing federal governance structure into three tiers: federal, state and local government. Governed by the National Health Act (NHA) 2014 and National Health Policy (NHP) 2016, teach of the three tiers has substantial autonomy in principle, although less

in practice, over the allocation and utilization of resources. Party political affiliations influence relationships between tiers, weakening coordination in the system.

The federal level is primarily responsible for tertiary health services through a network of teaching and specialist hospitals, although several states also own tertiary hospitals. The FMOH, through its departments, agencies and parastatals, supervises national programmes and provides technical support to states. State governments control secondary health care facilities through state ministries of health and health management boards. The state primary health care development agencies and local government health authorities supervise primary health care (PHC) facilities, guided by the Primary Health Care Under One Roof (2013) policy. Overlaps between tiers and actors, alongside party political influences at all levels, weaken coordination in the system.

Private health providers currently deliver 70% of all health services despite accounting for only 35% of health facilities. Partnerships for health are recognized as a building block of the health system, and strengthening public–private partnerships (PPPs) is seen as key to enhancing health system performance. However, mechanisms for regulation and accountability in the private sector remain weak.

Policies, National Strategic Health Development Plans, monitoring and evaluation frameworks, implementation plans and programme-specific guidelines guide health system governance and organization, albeit with some implementation challenges. State and non-state actors develop and implement these guidelines with aligned interests and defined coordination platforms and mechanisms. However, many of the policies and strategic plans currently in place, including the flagship NHP, need to be revised and updated to align with current trends in the health sector.

Since independence, Nigeria has undergone several core governance reforms, most recently focused on addressing the governance and funding of PHC through a sector-wide approach (SWAp). The current Nigeria Health Sector Renewal Investment programme is expected to help strengthen the health system and improve performance. However, implementation challenges persist, exacerbated by the complexity of the devolved health system and weak accountability and law enforcement at all levels.

- **Low government health spending, high out-of-pocket (OOP) expenditure and limited health insurance coverage characterize health financing.**

Health and health care are primarily funded by government tax revenue from all tiers, health insurance, donor/external funding and private spending, notably OOP payments. Total health expenditure (THE) at the national level is among the lowest globally at just 5% of total government expenditure, well below the Abuja Declaration target of 15%. The overall current health expenditure across the government and private sectors was just US$ 13.56 billion in 2020, or 3% of GDP, substantially below the global benchmark of 5%. However, there is also scope for increasing spending efficiency and achieving better health outcomes with the available funds.

By contrast, OOP expenditure is among the highest globally, accounting for 75% of THE and giving rise to concerns as to how public expenditure is channelled across the three tiers of government. This leaves the burden of health care costs to individuals/households, exposing Nigeria's predominantly low-income/vulnerable population to catastrophic health expenditure. This undermines progress towards achieving UHC and the SDGs for a largely healthy and wealthy nation.

Only 5% of Nigerians are covered by any form of health insurance, prepayment or risk-pooling mechanism. Existing enrolment is primarily through the Formal Sector Health Insurance Programme of the National Health Insurance Authority. The new National Health Insurance Authority Act 2023 – which prescribes mandatory national health insurance – the 2014 Basic Health Care Provision Fund (BHCPF) and subnational individual health insurance schemes across the 36 states and the Federal Capital Territory offer the potential to improve coverage with financial risk protection mechanisms and equity in pursuit of achieving UHC. This potential has yet to translate into significant progress, with delays largely attributed to insufficient political will, weak governance and inefficiency of public financial management.

Improvements in health financing are dependent on improvements in the three health financing functions of resource mobilization, resource pooling, and management of funds, as well as a move from the passive to strategic purchasing of health services. The SWAp strategy is expected to lead to the enrolment of more Nigerians into prepayment schemes such as social health insurance schemes.

There is scope to increase the fiscal space for health through domestic resource mobilization, enhanced development assistance targeted at social protection/health insurance schemes and improvements in the financial management of public expenditure. However, all of these rely on enhanced political will to increase funding for health care and drive stronger governance, accountability and efficiency of public health funding.

- **Nigeria's large but insufficient health workforce lacks centralized oversight and monitoring, negatively affecting distribution and capacity, with knock-on effects on health outcomes.**

The health workforce in Nigeria is one of the largest in Africa but remains insufficient to meet population demand, falling below international thresholds for most professions and cadres. With 3.95 doctors for every 10 000 people, its provision is well above the regional average of 1.5, but still below the recommended regional threshold of 4.45 doctors per 10 000 people. The current health workforce crisis is attributed in part to the insufficient implementation of existing policies and strategies, notably strengthening coordination between the national and subnational levels.

Capacity and competency shortfalls, industrial unrest, unfavourable working conditions and poor remuneration, especially in the public health sector, have negatively affected clinical outcomes and eroded public confidence in the health workforce. Mass emigration of health care personnel ("brain drain"), especially after the COVID-19 pandemic, has significantly weakened the remaining workforce. Health workforce production, distribution, deployment and retention are constrained by common implementation challenges. The unreliability and incompleteness of health workforce data pose a significant challenge, with data on the distribution of the health workforce by cadre, gender and facility being mostly unavailable. A robust health workforce register to help identify gaps and plan and implement existing policies and strategies could help improve health worker distribution and progress towards achieving UHC. Government at all tiers fails to strategically coordinate and manage the health workforce, across both public and private sectors, resulting in persistent staff shortages; underemployment of trained health workers, particularly at the PHC level; the uneven geographical spread of skilled health workers; and disparities between urban and rural areas. Numerous, heterogeneous and fragmented

private health providers, especially informal traditional birth attendants and patent and proprietary medicine vendors, operate in ungoverned spaces to the detriment of their patients.

Health workforce challenges could be addressed by strengthening governance and management at and between the national and subnational levels; improving recruitment, training and retraining programmes (particularly targeting unemployed PHC health workers); and developing a workforce information management system that facilitates evidence-informed improvements to practices and staff retention.

- **Low production capacity and poor supply-side regulation result in stock shortages and over-reliance on foreign drug imports.**

National policies and guidelines on medical product regulation and distribution exist but are poorly implemented and audited. Nigeria's National Agency for Food and Drug Administration and Control plays a critical role in regulation, market authorization and supply. Annual procurement plans for medical products and health technologies in Nigeria are coordinated and prepared by the FMOH Department of Procurement for ministries, departments and agencies. Assessing the quantities of medical products that need to be produced and imported is based on past consumption patterns. More stringent policy implementation, tighter policy evaluation structures and the stipulation of sanctions are needed to support supply-side regulation.

Existing national production capacity meets just 30% of the country's needs, making Nigeria overly reliant on imported pharmaceuticals and medical supplies. Foreign direct investment in the pharmaceutical sector and tax incentives offered to local producers are needed to increase domestic production capacity.

The lack of a systematic, well-regulated drug distribution system results in drug deterioration during storage, stock shortages and the circulation of fake products. Prescribing branded medicine is still prevalent despite the specifications of the National Drug Policy to prescribe generic versions of drugs. Regular training in rational drug use for the health workforce could address this. Poor availability of medical technologies for diagnosis and limited capacity to maintain existing health technologies affect the quality of care, as does underinvestment in health technologies.

Most Nigerians in rural and semi-urban areas receive health care from traditional medical practitioners. Efforts to standardize and formally integrate traditional medicine into the health system are under way but this is incomplete.

- **About 80% of Nigeria's health infrastructure is dysfunctional, impeding health care delivery and resulting in losses of US$1 billion annually to outbound health tourism.**

Insufficient funds for equipment maintenance, absence of planned maintenance programmes and inadequately trained personnel exacerbate the poor health infrastructure and equipment nationwide. This affects service delivery, particularly for conditions requiring specialized care, driving those who can afford it to seek health care outside Nigeria.

Policies and guidelines governing health care infrastructure and equipment exist but are dispersed across various health-related laws and guidance. The absence of an overarching national policy has contributed to poor distribution and allocation of health care facilities within states and across the country. While the BHCPF offers a predictable funding window for infrastructure and equipment, including emergency ambulance services, overall investment is too low to maintain functionality. Private health care providers deliver an estimated 60% of health care services in the country. However, regulation and monitoring of the sector by the government are weak, and the enforcement of standards and compliance is limited.

Existing government reforms to address health infrastructure gaps (e.g. the Central Bank of Nigeria's intervention fund, PPP models and concessionary arrangements) have produced mixed results. Further plans exist to establish a Nigerian health infrastructure development bank to facilitate the acquisition of health infrastructure and equipment.

- **Essential health service coverage is very limited and specialist services are insufficient and unevenly distributed, contributing to Nigeria's poor performance against health indicators. Service delivery reforms and community-level structures exist but need to be more effectively implemented to address limitations.**

The PHC level is the weakest level of health care delivery. However, facilities that can deliver essential health services are lacking at primary, secondary

and tertiary levels. Specialist and emergency services exist but are insufficient. Specialized services are confined primarily to urban areas and are often dictated by funding sources. Referral systems are suboptimal, and many patients bypass lower levels of care to access higher levels of care. Emergency medical care exists, but many communities lack ambulance services and prehospital care, and hospital units are ill-equipped to resuscitate critically ill patients. Palliative care is new in Nigeria, with poor access in rural areas and infrastructure challenges being indicative of the larger difficulties in ensuring fair and equal distribution of health care services. Despite the existence of quality assurance mechanisms, they are not effectively used.

Strong community-level structures exist to provide health care services to people who lack access, utilizing a mix of public and private sector providers. However, these structures have not yet translated into the scaled-up delivery of essential health services at the PHC level. This discrepancy constrains progress towards achieving UHC and the health-related SDGs, especially in relation to maternal and child health, and communicable and noncommunicable diseases.

Traditional medicine services are popular due to their perceived efficacy, availability and cultural compatibility. However, the coexistence of traditional and contemporary medicine poses possible risks, emphasizing the need to regulate and incorporate traditional medicine practices into the health system to guarantee patient safety and advocate for evidence-based health care practices.

Service delivery reforms will improve basic package provision and thus accelerate progress towards achieving UHC, but implementation challenges remain. Recent reforms to allocate at least 1% of the Consolidated Revenue Fund to the BHCPF will improve service delivery, providing one functional PHC centre per ward and one general hospital per local government area (LGA). In addition, it is hoped that recent FMOH policy reforms using the SWAp strategy and the gateways of the BHCPF, especially the National Primary Health Care Development Agency and emergency transport gateways, will revitalize service delivery and decrease health burdens. The financial autonomy that was recently granted to LGAs should also enable them to better support the PHC level for better service delivery.

- **Health information policies and systems exist but are not reflected in practice – normalizing routine data collection and use across the system could improve decision-making and service delivery.**

Nigeria has an established National Health Management Information Systems (NHMIS) policy, and most states have equivalent state-level policies. However, aspirational policy provisions are not reflected in practice, and there is no standardized mechanism for the real-time use of data from routine health management information systems for decision-making. The NHMIS deploys District Health Information System 2 (DHIS2) software to effectively capture routine health data. However, the level of adoption of DHIS2 remains low, and the achievement of NHMIS policy objectives is constrained by poor integration of data, incomplete data from public facilities and persistent underreporting from the private sector.

Routine health facility data are collected through the DHIS2 platform, which harvests data from 38 500 private and public primary and secondary facilities. While the average reporting rate through DHIS2 in 2023 was 92.3%, the on-time reporting rate was just 84.8%. Collecting complete data is also a huge challenge, with significantly fewer data being reported at the health facility level than are collected from national sources. Data use in decision-making could be improved by normalizing the production and dissemination of digital information products, including bulletins, statistical reports and compendia.

The implementation of national health information system (HIS) policies is constrained by chronic underfunding; inadequate basic information and communications technology infrastructure; a weak data use culture and insufficient capacity to collect and utilize health data; the lack of dedicated health records officers; and poor coordination and clarity on HIS roles and activities. HIS governance structures need strengthening to effectively monitor and enforce data reporting from all sectors, notably tertiary health facilities and the private sector. Ensuring that data-reporting requirements are met before renewing annual operating licences could support this strengthening. Scaling up the DHIS2 mobile phone client to all primary health centres and private hospitals could also help address data completeness and underreporting.

Although the 2020 HIS policy and accompanying strategic plan ignited and set the pace for improving health information management in the country, the need for better coordination and data governance remains. The advent of disease-specific programmes with independent information systems has

severely weakened the overall HIS. Intersectoral collaboration and data fragmentation need to be addressed to ensure better health outcomes. Ongoing structural reforms could strengthen in-country capacity in HISs and improve the quality and usage of health data in decision-making.

Health system assessment

- **Nigeria's health system performance remains insufficient for attaining UHC, with performance in the areas of access to, quality of and demand for services being weak and uneven, and overall system resilience being in need of further strengthening.**

Nigeria's health system still faces challenges in delivering optimal outputs and attaining UHC. Performance in the dimensions of access, quality and demand for health services is still suboptimal, at 41%, 40% and 42%, respectively. Moreover, Nigeria's overall health system performance, at 45%, is below the World Health Organization African Region average of 56%. Performance in terms of sociocultural access has improved, with more women and girls in education and employment than before, which could in turn improve access to health services if financial risk protection and functional health facilities are implemented.

The quality of services remains suboptimal, resulting in low demand, especially in the public sector. Access to, the quality of and demand for health services vary significantly across regions, states, urban–rural areas and socioeconomic statuses, in both the public and private health sectors. Disaggregated data are needed to address these discrepancies and facilitate effective UHC planning. Effective implementation of the BHCPF and the National Health Insurance Authority Act is expected to help narrow the wide gaps in these performance dimensions.

Both allocative and technical efficiency are poor due to suboptimal budgetary allocations and use. Identified drivers of technical inefficiencies, such as weak governance and leadership, weak public finance management, corruption and poor accountability, need to be addressed.

Suboptimal health budgets and poor utilization of allocated funds diminish allocative efficiency, while corruption in the health sector plagues technical efficiency. Nigeria has improved its scores in relation to detecting external

shocks, especially communicable disease outbreaks. However, inherent health system resilience, including preparedness and response, remains poor and needs to be strengthened.

- **Core health system outcomes – coverage of health services, health security, patient satisfaction and financial risk protection – are all below regional averages, primarily due to sustained underinvestment, poor health infrastructure and inadequate human resources capacity.**

Despite progress for a subset of indicators, Nigeria's absolute coverage of essential services is relatively low at 1.7% below the African Regional average. Nigeria's UHC Service Coverage Index score is also low, at 38.4%, largely due to poor service capacity and access, notably weak health infrastructure and inadequate human resources capacity. This leads to gaps in the availability of essential health services – for example, only 51% of deliveries are supported by skilled birth attendants. The NHA sets out policies and plans to strengthen health service delivery and various essential services. However, regular subnational benchmarking and continuous monitoring are needed to track success and health system performance and promptly address challenges as they arise.

Mandatory health insurance is progressively being implemented, but not rapidly enough, and Nigeria is still far behind its regional and global peers in expanding health insurance coverage. OOP payments as a proportion of THE are extremely high, at 75%, exposing the predominantly poor population to catastrophic health expenditure: 5.8% of multigenerational households experience catastrophic health expenditure over the 10% threshold, almost twice the WHO African Region average of 9.4%.

No nationally representative data are available on user satisfaction with essential health services. Available data suggest variations in client satisfaction by type of health service and by region. Further data collection is needed to inform future service provision.

Preparedness for public health emergencies is poor, as indicated by the low Global Health Security Index score of 38.0 in 2021 and the downwards trend in the country's International Health Regulations core capacity score since 2022. Critical capacities to monitor and detect zoonotic diseases and dispense medical countermeasures for national use during public health emergencies need to be expanded and sustained. Greater focus on effective

government collaboration and commitment to reignite, expand and sustain the preparedness capacities developed during the COVID-19 pandemic could help address current performance issues.

Conclusions

- **Nigeria has made consistent efforts to reform its health system, but sustained investment and effective implementation of reforms are now essential to drive further progress towards UHC.**

Although Nigeria has undertaken numerous policy reforms to enhance its health system and progress towards UHC, significant functionality issues remain. The existence of crucial laws and reforms, such as the NHA, the National Health Insurance Authority Act and the Nigeria Health System Renewal Investment Initiative, demonstrates government dedication to reforming the health system. Nevertheless, converting these ideas into concrete improvements in service provision and health outcomes remains difficult. Implementing existing reforms is essential to achieving UHC and progressing towards achievement of the health-related SDGs. Implementation will facilitate efforts to increase investment in the health sector, bolster health care infrastructure, improve the quality of care, reinforce regulatory frameworks, and ensure fair and equal access to health care services throughout the country.