Chapter

3

Health financing

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from

Nigeria: Country Health Systems & Services Profile, 2025

ISBN: 9789290314332

Suggested citation: Ezenduka, C. and Onwujekwe, O. (2025). Chapter 3: Health financing. In: Onwujekwe, O., Etiaba, E., Ezenduka, C,. Uguru, N., Okeke C., Okechukwu, E., Uzochukwu, B., Mbachu, C., Batialack, S. and Kreling, B. *Nigeria: Country Health Systems & Services Profile*. World Health Organization, Brazzaville, Congo (pp. 47–86).

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Abbreviations

BHCPF..... Basic Health Care Provision Fund
BMPHS..... basic minimum package of health services
CBHI ..... community-based health insurance
CBHIS..... community-based health insurance scheme
CHBP ..... comprehensive health benefits package
CHE..... current health expenditure
EHBP ..... essential health benefits package
FCT..... Federal Capital Territory
FFS ..... fee for service
FMoBEP ..... Federal Ministry of Budget and Economic Planning
FMoF ..... Federal Ministry of Finance
FMOH..... Federal Ministry of Health
FSSHIP ..... Formal Sector Social Health Insurance Programme
GDP ..... gross domestic product
GGE ..... general government expenditure
GGHE-D ..... government domestic general health expenditure
HBP..... health benefits package
HMB ..... health management board
HMO..... health maintenance organization
HSS ..... health systems strengthening
LGA..... local government area
LGHA..... local government health authority
MCH ..... maternal and child health
MSP ..... minimum service package
NAFDAC..... National Agency for Food and Drug Administration and Control
NBS..... National Bureau of Statistics
NCDC..... Nigeria Centre for Disease Control and Prevention
NGO ..... nongovernmental organization
NHA ..... National Health Act
NHFPS..... National Health Financing Policy and Strategy
NHIA..... National Health Insurance Authority
NHIS ..... National Health Insurance Scheme

NHP ..... National Health Policy
NPHCDA ..... National Primary Health Care Development Agency
NSHDP II ..... National Strategic Health Development Plan II (2018–2022)
NSHIP..... Nigeria State Health Investment Project
OOP..... out-of-pocket
PHC..... primary health care
PHI..... private health insurance
SDG ..... Sustainable Development Goal
SHI ..... social health insurance
SHIS..... social health insurance scheme
SMoH ..... state ministry of health
SOML ..... Saving One Million Lives
SSHIA ..... state-level social health insurance agency
SSHIS..... state-level social health insurance scheme
TB..... tuberculosis
UHC ..... universal health coverage
UN..... United Nations
VAT..... value-added tax
VHI..... voluntary health insurance
WHO..... World Health Organization

Chapter 3 key messages

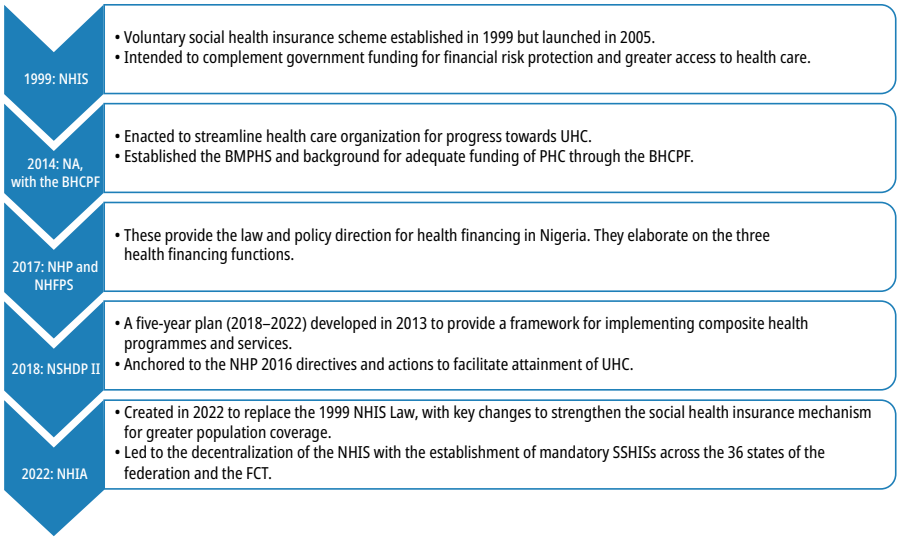
- The Nigerian health system is primarily funded by government tax revenue, health insurance, donor/external funding and private spending.
- Nigeria spends less on health as a share of gross domestic product (GDP) than nearly every other country in the world. The national health budget remains below 5% of the total government budget and below the Abuja Declaration target of 15%. Current health expenditure across both the public and private sectors was just 4% of GDP in 2021, which is below the global benchmark of 5%.
- Out-of-pocket (OOP) spending accounts for more than 75% of total health expenditure, one of the highest levels of OOP expenditure globally. This exposes the low-income population to catastrophic health spending and impoverishment.
- Only 5% of Nigerians are covered by any health insurance, prepayment or risk-pooling mechanisms. Coverage is limited by weak technical capacity to implement health insurance schemes nationwide, labour unions' refusal to accept worker contributions to the Formal Sector Social Health Insurance Programme (FSSHIP) and poor public understanding of health insurance. Existing enrolment is primarily through the FSSHIP of the National Health Insurance Authority (NHIA) and state-level health insurance programmes.
- The NHIA Act 2022, the Basic Health Care Provision Fund 2014 and the recently established subnational individual health insurance schemes across the 36 states and the Federal Capital Territory offer potential to improve coverage, with financial risk protection mechanisms and greater equity.

3.1 Health financing policies

Key policies

Five key policies commit explicitly to specific levels of health care financing in Nigeria. These are the previous National Health Insurance Scheme (NHIS) law (1999), now replaced with the National Health Insurance Authority (NHIA) Act 2022; the National Health Act (NHA) 2014, which encompasses the Basic Health Care Provision Fund (BHCPF); the National Health Policy (NHP) (FMOH, 2016c); the National Health Financing Policy and Strategy (NHFPS) (2016); and the National Strategic Health Development Plan II (NSHDP II) (2018–2022) (FMOH, 2018b) (Fig. 3.1.a).

Figure 3.1.a Timeline of recent health financing policies and frameworks



Notes: BMPHS = basic minimum package of health services; FCT = Federal Capital Territory; PHC = primary health care; SSHIS = state-level social health insurance scheme; UHC = universal health coverage.

Nigerian National Health Insurance Scheme Act, 1999 (now the National Health Insurance Authority Act, 2021)

The first NHIS Act was established in 1999 as a social health insurance (SHI) mechanism to complement government funding for health and provide financial risk protection and greater access to good-quality health care services. This

was replaced by the NHIS Act of 2004. This launched its flagship programme, the Formal Sector Social Health Insurance Programme (FSSHIP), in 2005, which focused on formal sector workers in the country (Onwujekwe et al., 2019b), in addition to three other programmes for specific population groups. However, in 2022 the NHIS Act 2004 was replaced with the NHIA Act 2022 (FGN, 2022c) (see Chapter 2, Section 2.5).

National Health Act, 2014

Nigeria's commitment to universal health coverage (UHC) is enshrined in the NHA 2014, which provides the legal framework for the operation of the health system in Nigeria (See Chapter 2, Section 2.2). The act streamlines the organization of health services, clarifying citizens' right to health through the basic minimum package of health services (BMPHS). It provided the foundation for adequate health funding by establishing the BHCPF as a financing vehicle for the BMPHS, to ensure that the most vulnerable populations have access to basic health care.

Basic Health Care Provision Fund, 2014

The BHCPF is an integral part of the NHA 2014, established to support primary health care (PHC) services and financial risk protection, and enhance access to affordable and quality health services targeting, mostly, Nigeria's poor and vulnerable population (see Chapter 2, Section 2.5). The fund specifies the development of a BMPHS that should be provided by and accessible through primary, secondary and tertiary health facilities (FGN, 2014). The sources of funding and spending priorities for the BHCPF are summarized in Table 3.1.a.

Initially, up to 50% of the fund was to be disbursed through the NHIS for the provision of BMPHS, 45% disbursed through the National Primary Health Care Development Agency (NPHCDA) for primary health facility upgrades, maintenance and essential medicines supply, among others, and 5% to be disbursed through the Federal Ministry of Health (FMOH) for national health emergency responses, such as emergency medical treatment. However, in 2022, the NHIA (formerly the NHIS) gateway was reduced to 48.5%, and 1.5% of the fund was allocated to the Nigeria Centre for Disease Control and Prevention (NCDC) as the fourth gateway. According to the NHA, access to the fund by states is contingent on meeting 25% counterpart funding from the states and local governments (FGN, 2014).

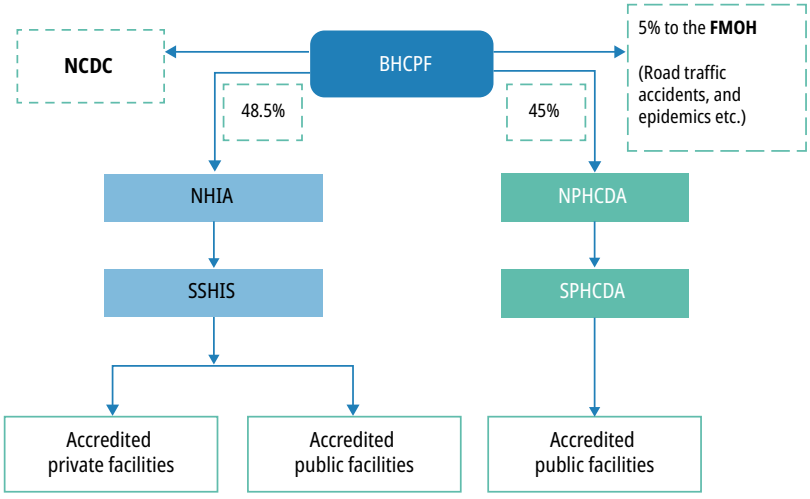
Table 3.1.a BHCPF funding sources and spending priorities/pathways

BHCPF funding source	BHCPF spending priority
Annual federal government grant of at least 1% of the Consolidated Revenue Fund	Paying for the provision of the BMPHS through the NHIS gateway
International partners/donor funds	Funding the PHC centres across Nigeria through the National Primary Health Care Development Agency gateway
Funds from other sources, such as states and local governments	Funding the provision of basic emergency medical services through the emergency medical treatment gateway
–	Paying for disease control through the Nigeria Centre for Disease Control and Prevention

Sources: FMOH, 2016b

The BHCPF is designed to leverage and galvanize additional domestic and external investments to increase fiscal space for health (FMOH, 2017c). Fig. 3.1.b illustrates key features of the fund.

Figure 3.1.b Schematic illustrating key features of the BHCPF



Source: Adapted from Hafez, 2018

Notes: SPHCDA = state primary health care development agency; SSHIS = state-level social health insurance scheme.

National Health Policy, 2016

The NHP gives overarching policy direction to the health system (FMOH, 2016c) and sets operational standards (see Chapter 2, Section 2.2). It stipulated actions for efficient and equitable health financing to achieve UHC in line with the NHA 2014, including advocacy for increased budget allocation, facilitating budgetary provisions for the BHCPF, exploring additional sources for domestic resource mobilization, promoting revision of the 1999 NHIS Act to make insurance mandatory and the NHIS a regulator rather than an implementer, and promoting a strategic health purchasing mechanism, focused on high-impact cost-effective interventions (FMOH, 2016a). While the policy has helped establish key financing frameworks and infrastructure to improve health service delivery, it requires revisions to align with current health system trends.

National Health Financing Policy and Strategy, 2016

The NHFPS provides guidance to federal, state and local governments and other actors in the health system on how to maintain an equitable and efficient health financing system that can help the country to significantly strengthen health system financing to achieve UHC by 2030. It sets the goals, structure, governance and policy direction of health financing for UHC in Nigeria, including guiding revenue generation, revenue pooling and purchasing. It establishes the appropriate regulatory framework for health financing as part of the stewardship role of government. It details the roles and responsibilities at the federal, state and local government area (LGA) levels as well as for other stake stakeholders for achieving universal financial risk protection and UHC. The strategy also lays out policy directions for increasing efficiency and equity in the health system.

National Strategic Health Development Plan II, 2018–2022

NSHDP II provides the reference framework for implementing health programmes and services, anchored on the NHP 2016 (see Chapter 2, Section 2.2). From a health financing perspective it expands prepayment SHI schemes for UHC and aims to ensure that adequate and sustainable funds are available and allocated for accessible, affordable, efficient and equitable health care provision and consumption at the local, state and federal levels.

National Health Insurance Authority Act, 2022

The updated NHIA Act 2022 strengthened the country's health insurance mechanism (see Chapter 2, Section 2.5). The act has various programmes that cover different population groups. It makes the NHIA the regulator, aggregator (risk pooling) and standard-setter for some purchasing functions, including defining benefits packages and setting provider payment rates and mechanisms. The act provided for decentralization of the scheme and access to BHCPF support, catalysing the establishment of state-level social health insurance schemes (SSHISs) nationwide. As of 2023, all of the states of the federation have introduced mandatory SSHISs, backed by relevant laws, to further progress towards UHC. The decentralization of the mandatory insurance mechanism across states is expected to significantly increase population coverage in terms of financial risk protection. However, the insurance system is limited by challenges of weak technical capacity, administrative inefficiencies, poor public perception and financial sustainability (see section "Challenges of health insurance operations" in Section 3.1).

Sector-wide approach, 2023

As part of the Federal Government of Nigeria's strategic vision for the health sector (2023–2026), in 2023 the FMOH introduced a sector-wide approach to facilitate resource mobilization and allocation, and programme implementation, monitoring and reporting, as outlined in Section 2.5, Chapter 2. The approach is still being implemented, making it too soon to assess its effectiveness.

Key actors

Key health financing actors and their respective roles are set out in Table 3.1.b.

Table 3.1.b Key actors in health financing in Nigeria

Category	Key player	Role
Federal government and line ministries	Federal Executive Council	Approval of policies with macroeconomic and financial implications before operationalization.
	Ministry of Finance	Critical role in advising the Federal Executive Council to ensure that health financing reforms align with macroeconomic realities of the country.
	National Assembly	Responsible for budget allocations for the health sector and monitoring budget implementation through National Assembly standing committees on health.
FMOH and its agencies	FMOH	Statutorily responsible for developing health policies and designing programmes and interventions. The Health Financing Unit under the FMOH is responsible for promoting the use of evidence in the design and implementation of health reforms, coordinating the Technical Working Group on Health Financing Reforms and engaging with stakeholders. The ministry works with the NHIA and NPHCDA in developing guidelines for managing the BHCPF.
	NHIA	Runs and manages the FSSHIP while overseeing the HMOs' operations in the country. Through the zonal and state offices, the authority supports the SSHIS.
	NPHCDA	Focuses on improving quality and uptake of essential health services for vulnerable groups through interventions that incorporate both supply and demand-side financing, such as the Midwives Service Scheme, SURE-P and the NSHIP. The role of NPHCDA includes to ensure that services are provided at the primary health centre level.
Development partners and other donor agencies	Development partners and other agencies	Involved in the pooling and management of financial resources, technical expertise and support in health financing and public finance management. Technical support with strategic purchasing of services based on their experiences in using implementing partners to deliver critical health interventions to Nigerians.
Private sector	Upstream actors (e.g. the Private Sector Health Alliance)	The upstream actors are those involved in resource mobilization and domestic revenue mobilization, as well as investors. The upstream players also include foundations and corporate organizations that earmark resources for corporate social responsibility activities.
	Downstream	The downstream players are mainly the service providers; over 70% of health services are delivered by the private sector.

Table 3.1.b Continued

Category	Key player	Role
HMOs	HMOs	Interface between government and private providers of health care in the SHI schemes.
Academia	Academia	Expand the knowledge base and generate evidence to bridge the policy–research gap. Build capacity for health financing. Serve as a repository of knowledge.
Citizens and related groups	Civil society organizations	Ensure quality of care by guaranteeing accountability and value for money. Informing and mobilizing citizens.
	Media	Informing and mobilizing citizens.
States and local governments	SSHIAs	Important roles in initiating and sustaining health financing reforms. States are expected to own and domesticate all health policies that are approved and adopted by the National Council on Health, to ensure proper implementation. While the state government runs the SSHISs, community-based health insurance and mutual aid are often managed at the LGA level by the local government health authority.

Source: Onwujekwe et al., 2019b

Notes: HMO = health maintenance organization; NSHIP = Nigeria State Health Investment Project; SSHIA = state-level social health insurance agency; SURE-P = Subsidy Reinvestment and Empowerment Programme.

Key financing policies and strategies for universal health coverage

In addition to provisions in the country's financing policies, specific strategies have been put in place to provide a strong framework for achieving UHC and improving health outcomes more generally. Section "Key policies" in Section 3.1 describes the NSHDP II as a UHC policy framework and the BHCPF as a mechanism to generate additional funding for health care, alongside the NHIA and SSHISs. Other UHC relevant policies include the Presidential Summit Declaration on UHC in 2014, the national UHC policy framework and the country programme for achieving the United Nations (UN) SDGs. Most relevant is the Federal Government of Nigeria's 2016 NHFPS, which sets clear policy direction to guide governments at all levels to deliver an equitable, efficient and sustainable health financing system that will guarantee UHC by 2030 (Uzochukwu et al., 2015; FMOH, 2017c). However, minimal progress has been made in policy implementation due to inadequate funding and health system inefficiencies (Ams, 2020).

Health benefits package

Categories of health benefits packages

There are two broad categories of health benefits packages (HBPs) in Nigeria: the essential health benefits package (EHBP) and comprehensive health benefits package (CHBP) (Ogundeji et al., 2019). While the EHBP covers basic PHC services and occasionally a few related secondary health services (e.g. maternal and child health (MCH) care, minor surgery and services for minor illnesses), the CHBP covers a wide range of services across primary, secondary and emergency health care, as defined under the NHIA and many SSHISs. These services include management of chronic conditions, such as diabetes, and major surgery (Ogundeji et al., 2019). Most of the SSHISs' HBPs are comprehensive.

Essential health benefits packages: minimum service package

The NHA 2014 defines and designs the country's HBPs, as set out by the BMPHS, based on a minimum service package (MSP). This package includes priority services (promotive, preventive, curative and rehabilitative) (FGN, 2014). Services are provided across all three levels of government health care provision: local, state and federal (FMOH, 2016c). The package is to be applied across the states and adapted to the local disease burdens in line with NHP recommendations (Ezenduka et al., 2022). Following from this lead, fragmented HBPs now exist across the country, in the form of EHBPs and CHBPs that differ in disease focus and patient groups, depending on the government or programme.

Under the government budget system, the Department of Food and Drugs of the FMOH defines all EHBPs/MSPs to be provided in public health facilities, including the provision of medicines on the national Essential Medicines List. Service packages provided under the government system are supported in large part by donor-funded disease control priorities and funding streams (Ezenwaka et al., 2022). The MSPs adopted by the EHBPs do not specify any cost-sharing requirement/limit, allowing providers to charge users fees for services (FFSs) that are intended to be provided for free (FMOH, 2018b).

Comprehensive health benefits packages: Formal Sector Social Health Insurance Programme and state-level social health insurance schemes

The FSSHIP has an explicit benefits package that is more robust and comprehensive than the BMPHS (FGN, 2022c). The package comes with gatekeeping and a well-defined referral system, and with an existing mechanism for determining members' needs. Similarly, the SSHISs have benefits packages for their enrolees, adapting the BMPHS to suit the local prevailing disease burden and resource availability.

Health benefits packages funding

Under the NHIA Act 2022, nongovernmental organizations (NGOs) are included as members of the governing council, while development partners and NHIA support state-level social health insurance agencies (SSHIAs) in developing HBPs. The BMPHS is funded by the BHCPF, as established under the NHA. Therefore, the formulation of the BMPHS is informed by prioritization decisions, which are based on, for example, the availability of resources from the BHCPF. Consequently, budgets for the BMPHS reflect funding flows from the BHCPF, which also include contributions from donor/non-state actor funds. International/non-state actors therefore play important roles in supporting and influencing the HBP design, with financial contributions to the BHCPF.

Public policy towards mandatory and voluntary insurance schemes

The NHIA Act 2022 empowers the NHIA to regulate the operations of both voluntary and mandatory health insurance schemes, and to provide support to the various SSHIAs. Regulation, which is carried out in collaboration with stakeholders, is implemented through the development and enforcement of standards and operational guidelines; accreditation of facilities and providers; high-level advocacy for support and quality supervision; and monitoring and evaluation. Under the FSSHIP, the NHIA contracts with health maintenance organizations (HMOs) as third-party administrators to undertake purchasing functions. Regulation of providers and third-party payers is described below.

Challenges of health insurance operations

The major challenges facing health insurance systems include insufficient funding, ineffective management, and political and bureaucratic interference with scheme management by government, which contributes to unscrupulous practices and lack of managerial expertise. There are significant financial and operational sustainability challenges facing the schemes in terms of the availability of adequate and sustainable funding, a large informal sector that is not easily captured and enrolled, weak and inadequate infrastructure for health care delivery, and unfavourable public perceptions of the insurance mechanism (FMOH, 2012a). Other challenges include limited institutional and technical capacities to operate the schemes, limited enforcement of mandatory requirements and the existence of multiple pools (at both the national/NHIA and state/SHI levels) due to the federal system of operation (FMOH, 2012a). The NHIA operates over three pools – the FSSHIP, a community-based health insurance scheme (CBHIS) and a vulnerable group health insurance programme – in addition to the various SHI schemes/programmes across the states.

Resource allocation and expenditure processes

The federal government, through the Federal Ministry of Finance (FMoF) and Federal Ministry of Budget and Economic Planning (FMoBEP), allocates an annual budget envelope to the FMOH, which is then distributed to relevant departments, agencies and parastatals, such as the NPHCDA, the National Agency for Food and Drug Administration and Control (NAFDAC) and the NHIA (for BHCPF) (Akinyemi et al., 2021). The FMOH monitors all activities of the agencies involved in purchasing services to ensure adherence to established financial guidelines on the use of public funds. These processes are replicated at the state and LGA levels, where the state ministry of health (SMoH) and local government health authority (LGHA) play similar roles. For financial accountability, the NHIA Act mandates the NHIA to maintain an annual account of income and expenditure, which is to be audited by auditors appointed by the NHIA in accordance with the guidelines set by the Auditor General of the Federation (Etiaba et al., 2018). These reports/audited accounts are open for review by the legislature through the Public Account Committee and NGOs. However, public financial management is characterized by administrative

inefficiency, delays in budget approvals and releases, misappropriation, corrupt practices and embezzlement (FGN, 2022c).

Government regulation of third-party payers

The FMOH regulates third-party payers/insurance schemes through the NHIA, which has a mandate under the NHIA Act 2022 to monitor all health insurance operations (FMOH, 2017c). The NHIA governing council oversees NHIA management. The governing council reports to the government through the FMOH and has the autonomy to liaise with the FMoF and FMoBEP on budget matters and appropriation (FGN, 2022c). The NHIA contracts and regulates HMOs through guidelines and periodic reports. The HMOs contract with and regulate their providers through monitoring visits, to ensure that quality standards and guidelines are maintained. Similarly, for SSHISs, the SMoH and local government health authority, as the purchasing agencies, regulate and monitor providers (e.g. through periodic visits) (Akinyemi et al., 2021). Reduced premium rates are available via CBHISs targeting enrolment of low-income populations. At present, there are no provisions for tax incentives or subsidies. However, the health insurance agencies are currently engaging with tax authorities to stop tax being collected on capitation and to stop FFSs being paid to service providers.

3.2 Health expenditure

Health expenditure trends between 2011 and 2021 are shown in Table 3.2.1 and suggest notable underfunding of the health sector. Government domestic general health expenditure (GGHE-D) accounted for 13% of current health expenditure (CHE) in 2021, down from a peak of 16.4% in 2015. Within the same period, GGHE-D stagnated at 4% of general government expenditure (GGE), which is well below the 15% Abuja Declaration target (FGN, 2022c). Nigeria, alongside fellow African Union member states is a signatory to the 2001 Abuja Declaration, which commits signatories to allocating 15% of their annual government budgets to health (AU, 2001). Persistently low levels of government investment in health care over the years have undermined progress towards UHC, a critical indicator for achieving the SDG 3 health goal (WHO, 2011).

This is reflected in a lower-quality and inadequate health infrastructure and workforce (see Chapter 4).

Household out-of-pocket (OOP) expenditure – payments made by individuals or households at the point of accessing care – accounted for 76.2% of total health spending in 2021, having remained consistently high between 2011 and 2021 (Table 3.2.1) (Jowett et al., 2016). High OOP expenditure (resulting from low public health expenditure (DFID, 2018)) contributes to the inaccessibility of health services and to inequitable and inefficient health financing.

Voluntary health insurance (VHI) remained at just 1% of CHE between 2019 and 2021, down from a peak of 1.1% in 2010. Although this percentage had increased from 0.4% in 2018 to 1% by 2019, it remains very low, limiting the impact of VHI in complementing SHI in terms of population coverage and prepayment mechanisms.

External funding accounted for 7.9% of CHE in 2021, averaging 12.1% since 2010 and fluctuating from 8% in 2011 to a peak of 12.8% in 2013, before declining to 7% in 2018. This translates to an average of US$ 8.13 per capita over the period, and US$ 7 per capita in 2021. External funding remains influential in addressing specific disease conditions, such as HIV/AIDS, malaria, tuberculosis (TB) and COVID-19, as well as immunization services, which have benefited significantly from external funding support (Hafez, 2018) (see Section 3.7.1). The declining trend calls for increased domestic resource mobilization to sustain the gains of donor support, alongside improved coordination of external support to ensure alignment with national health priorities. Coordinating and tracking donor support over time remains a major challenge that may result in underestimates in reported data (DFID, 2018). The new NHA data should help address this shortcoming.

Table 3.2.1 shows that spending on PHC accounted for more than half (59%) of domestic government health spending in 2021. Government expenditure on/contribution to PHC represents just 10.4% of total PHC expenditure, when the contributions of other financing sources to PHC are taken into account. This indicator peaked at 73% in 2016 and significantly declined to 59% in 2021, indicating inconsistent and inadequate government prioritization of, and resource allocation to, PHC.

Table 3.2.1 Trends in heath expenditure in the country, 2010 to the latest available year (2021)

Indicator	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021
Domestic health expenditure as % of CHE	93.7	92.1	91.6	87.6	87.7	90.1	89.7	92.1	92.1	88	90	92.1
GGHE-D as % of CHE	13.6	14.4	16.2	14.3	13.3	16.4	13.0	14.2	14.9	16	15	13.3
PVT-D as % of CHE	80.1	77.7	75.4	73.3	74.4	73.6	76.7	77.9	77.3	73	75	78.9
VHI as % of CHE	1.1	1.0	0.8	0.7	0.7	0.6	0.6	0.4	0.4	1	1	1
OOP as % of CHE	76.9	74.7	72.8	70.9	71.9	71.9	75.2	77.2	76.6	71	75	76.2
GGHE-D as % GDP	0.4	0.5	0.5	0.5	0.4	0.6	0.5	0.5	0.6	0.48	1	0.5
GGHE-D per capita in US$	10.4	12.2	15.0	14.7	14.4	16.1	10.3	10.5	12.5	11	10	11
PVT-D per capita in US$	61.5	65.6	69.8	75.1	80.3	72.0	60.9	57.6	64.7	51	53	66
External health expenditure per capita in US$	4.8	6.6	7.8	12.8	13.3	9.7	8.2	5.8	6.6	8.0	7	7
OOP expenditure per capita in US$	59.0	63.1	67.5	72.7	77.5	70.3	59.7	57.1	64.2	50	52	64
PHC expenditure per capita in US$	NA	NA	NA	NA	NA	NA	NA	51.3	57.9	48	40	63
PHC expenditure as CHE	NA	NA	NA	NA	NA	NA	68	69	671	69	57	75.4
GGHE-D on PHC as % of GGHE-D	NA	NA	NA	NA	NA	NA	73	40	51	52	54	59.1
GGHE-D on PHC as % of PHC	NA	NA	NA	NA	NA	NA	14	8	12	12	14	10.4
GGHE-D as % of GGE	3	3	4	3	3	5	5	4	4	4	4	4.1
External health expenditure as % of CHE	6	8	8	12	12	10	10	8	7	12	10	7.9
CHE as % of GDP	3	3	3	3	3	4	4	4	3	3	3	4.1

Source: WHO, 2022a

Notes: GDP = gross domestic product; NA = data not available; PVT-D = domestic private health expenditure.

Current health expenditure as a share (percentage) of gross domestic product in the World Health Organization African Region

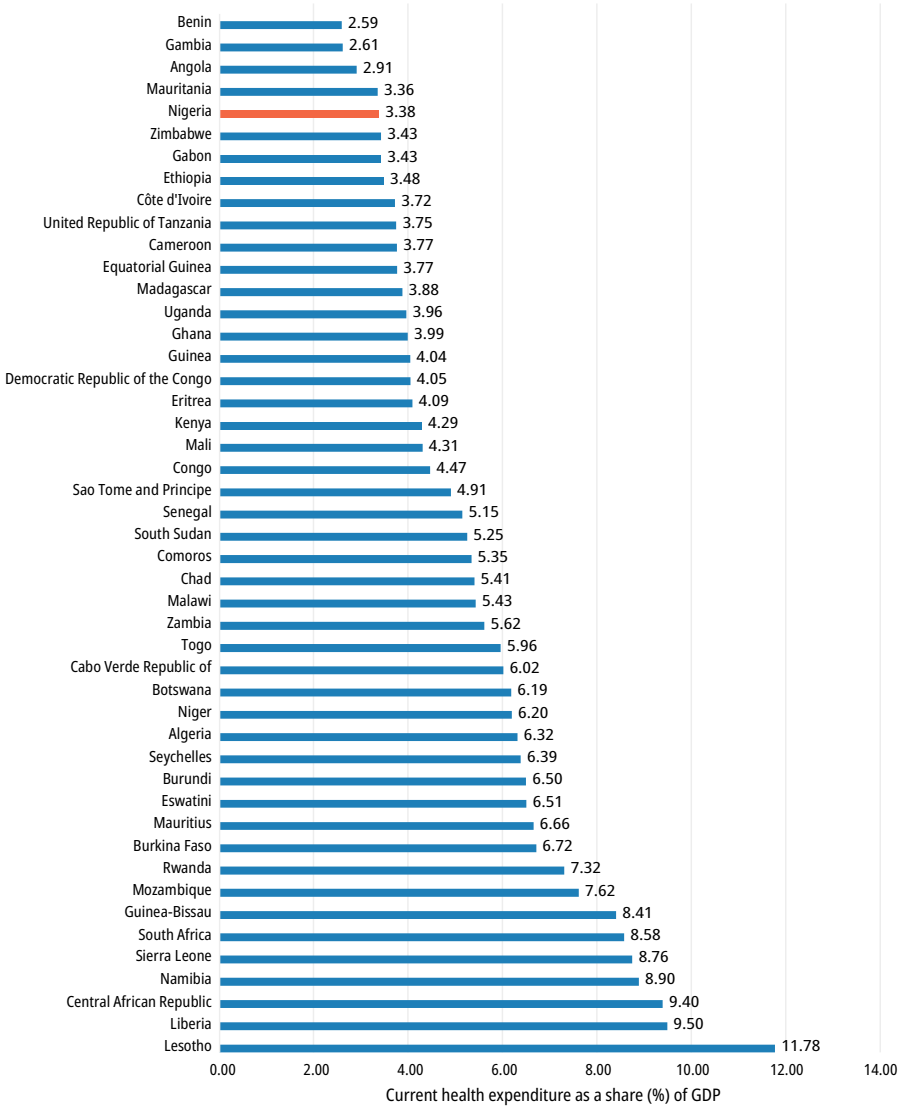
Nigeria's CHE as a share of gross domestic product (GDP) (3.38% in 2020) is well below the international benchmark of 5% and the World Health Organization (WHO) regional average of 5.6% (DFID, 2018). Comparator African countries with similar health system structures and health financing reforms, such as Ethiopia, Ghana, Kenya, Mali and South Africa, all have a higher CHE share of GDP – whether looking at a snapshot (Fig. 3.2.1) or at trends over time (Fig. 3.2.2). Of countries with similar democratic and health system governance structures, only India spends less than Nigeria, averaging 3.55% against Nigeria's 3.65%. South Africa sits significantly ahead of other direct comparator countries, averaging 7.58% for the period measured.

Trends in current health expenditure as a share (percentage) of gross domestic product in Nigeria

CHE as a share of GDP has been consistently low since 2000 (Fig. 3.2.2), declining from 5.1% in 2003 to 3.4% in 2020. The sharp decline from 3.9% in 2018 to 3.0% in 2019 is notable, indicating the lack of consistency in health care investment. The downwards trend overall suggests insufficient government efforts to increase investment in health care, even during a period of economic growth, although the likely impact of the deteriorating macroeconomic context in 2020/21 due to the COVID-19 pandemic is acknowledged (WHO, 2022a). Underinvestment has continued despite the increased focus on health resulting from the COVID-19 pandemic.

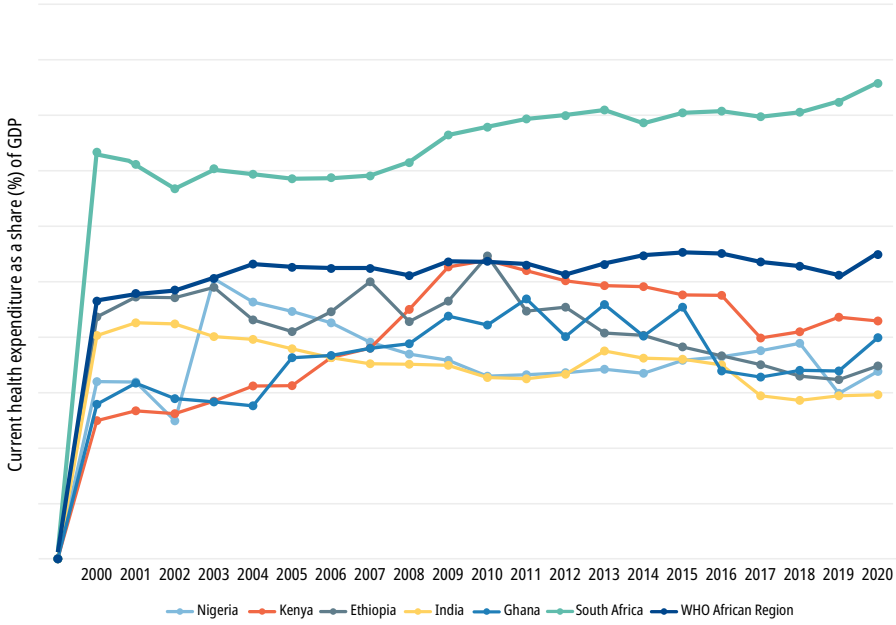
Fig. 3.2.3 compares the CHE trend within the same period across Nigeria's West and East African neighbours, including South Africa and India, which share similar democratic governance and health financing structures. It shows that Nigeria's performance falls below the rest of the countries, except for India and Ethiopia, which both averaged 3.55% against Nigeria's 3.65%. South Africa towers above the rest, at US$ 490 per capita within the period.

Figure 3.2.1 CHE as a share (%) of GDP in the WHO African Region, latest available year (2020)



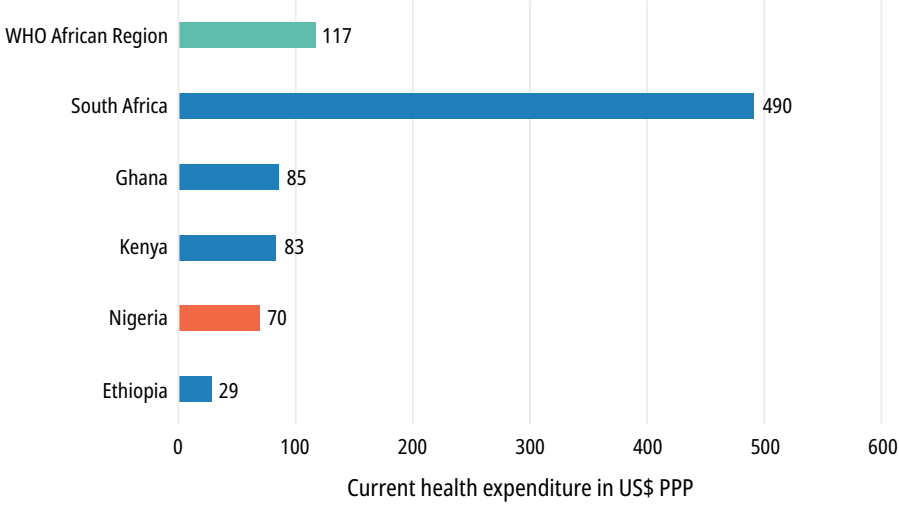
Source: WHO, 2022a

Figure 3.2.2 Trends in CHE as a share (%) of GDP in selected countries and WHO African Region, 2000 to latest available year (2020)



Source: WHO, 2022a

Figure 3.2.3 CHE in US$ purchasing power parity per capita in selected countries and the WHO African Region, 2000 to latest available year (2020)



Source: WHO, 2022a

Health expenditure in purchasing power parity per capita

When measured per capita in US dollars based on purchasing power parity, CHE amounted to US$ 70 per capita in 2020 (Fig, 3.2.3), which is lower than the regional average of US$ 116.9 and well below the WHO's recommended threshold of spending a minimum of US$249 per capita (WHO, 2024b). Data for high-performing South Africa, at US$ 490 per capita, and most other comparator countries reveal these comparator countries show a greater government commitment to health funding than Nigeria. Even low-performing countries such as Kenya, at US$ 83 per capita, and Ghana, at US$ 85 per capita, perform better than Nigeria. According to 2022 World Bank data, Nigeria's health expenditure per capita is less than nearly every country in the world. This is reflected in Nigeria's poor health indicators, as it accounts for a higher health burden for most diseases (FMOH, 2017c).

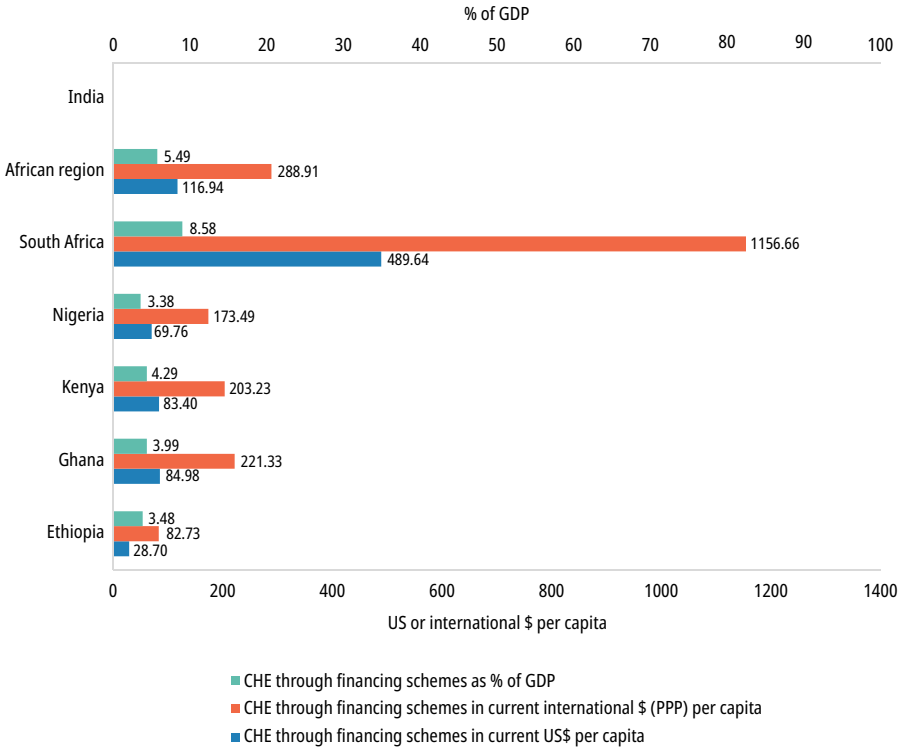
Fig. 3.2.4 compares Nigeria's CHE through financing schemes across selected countries and the WHO African Region in 2020, and, again, confirms Nigeria's regional underperformance in terms of health care financing:

- As a percentage of GDP, Nigeria's CHE stands at just 3.4%, below the WHO African Region's average of 5.49%.
- Measured in terms of US dollars per capita and current purchasing power parity, Nigeria's CHE amounted to US$ 70 and US$ 173 per capita, respectively, which are below the regional averages of US$ 117 and US$ 289, respectively. These performances are worse than those based on previous data (2018) for all described indicators, representing significant declines, consistent with Nigeria's sustained poor investment in health care.

Public health expenditure as a percentage of general government expenditure

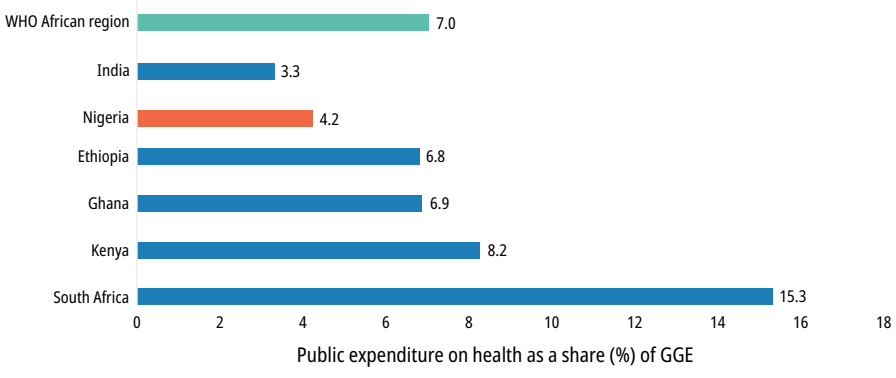
Data for public health expenditure as a percentage of GGE indicate a significant difference between Nigeria and the WHO African Region's better-performing countries. Fig. 3.2.5 compares public health expenditure as a share of GGE across selected countries. Nigeria performed better than India (3.3%), but ranks lowest among the remaining countries. South Africa and neighbouring Ghana invest more in health care than Nigeria, at 15.3% and 6.9% of GGE, respectively.

Figure 3.2.4 CHE through financing schemes across selected countries and the WHO African Region, latest available year (2020)



Source: WHO, 2022

Figure 3.2.5 Public expenditure on health as a share (%) of GGE across selected countries and the WHO African Region, 2021



Source: WHO, 2022

3.3 Sources of health financing and financial flows

As described in Section 3.2, health care is financed through government general tax revenue, health insurance schemes, private OOP expenditure and external/donor funds. OOP spending dominates as the leading source of health financing. However, data accuracy may be affected by the methodological challenges of estimating, tracking and linking health expenditure across states (FMOH, 2017c). The current institutionalization of the National Health Accounts (Odeyemi and Nixon, 2013) offers a standardized approach to estimating and tracking health expenditure data and linking them across states based on standardized classifications and methodology, supported by the WHO and the World Bank (FMOH, 2019a). This approach should make these data more reliable.

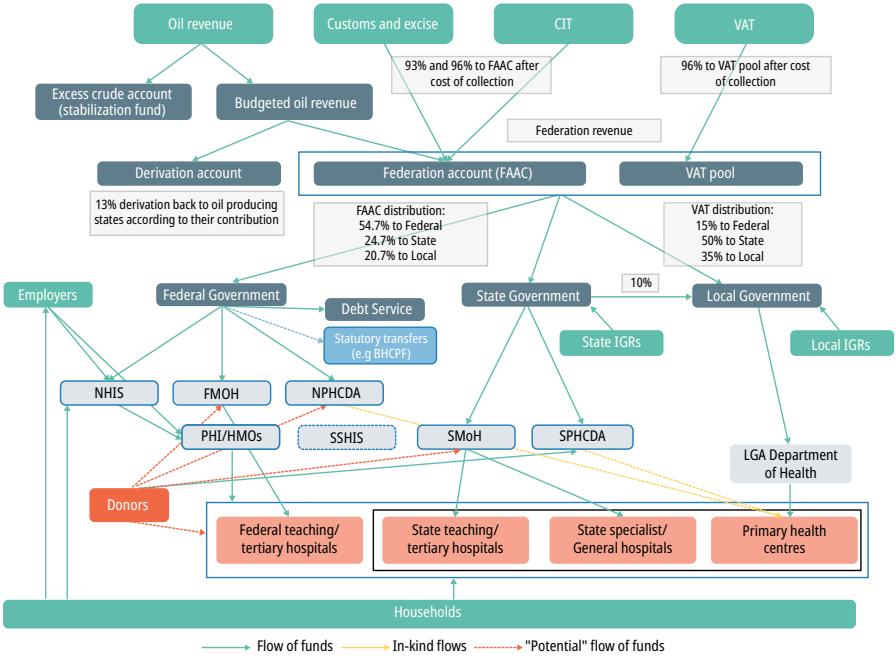
As at 2021, health insurance/prepayment mechanisms for financial risk protection made an average contribution of 1% to CHE. Population coverage has been sitting at 5% of the population over the last 10 years, with cover mostly coming from the NHIS. While the poor performance of health insurance systems has been attributed to low income, administrative inefficiency, poor public perception, lack of technical capacity, a large informal sector, etc. (Onoka et al., 2016), the lack of up-to-date data on health insurance coverage, especially for private or community-led VHI systems (private health insurance (PHI), CBHISs) (FMOH, 2019a), may also explain the failure of the NHIS to go beyond 4% coverage outside the formal sector (Onoka et al., 2016; Hafez, 2018). However, current efforts suggest that significantly higher coverage, beyond 5%, may be achieved, especially with the introduction of the SSHISs across the 36 states and the Federal Capital Territory (FCT).

The contribution of low GGHE-D as a share of GGE, high household OOP expenditure, at 75% of CHE, and critical external funding support are outlined in Section 3.2. However, the challenges of estimating and tracking these health expenditure indicators over time affect the reliability of the data available.

Financial flows

Fig. 3.3.1 illustrates the key financial flows for health care across the different segments of the health financing system. Funding for health care is generated through general tax revenues specifically assigned according to the level of government. The federal government collects revenue from nine sources,

Figure 3.3.1 Financial flows in Nigeria



Source: Uzochukwu et al., 2015

Notes: CIT = company income tax; IGR = internally generated revenue; SPHCDA = state primary health care development agency.

including crude oil sales, petroleum profit taxes, royalties and other oil charges, company income taxes, customs and excise duties, and value-added tax (VAT). State governments collect 25 taxes and levies primarily from personal income tax (pay-as-you-earn and direct assessment for the self-employed) and ministries, departments and agencies for services to residents (e.g. user fees). The LGAs collect 21 taxes and levies, mainly for licence fees, market dues and other levies (Onwujekwe et al., 2019b). Tax revenue efficiency depends on factors such as the tax revenue base, tax rates, administrative efficiency and financing compliance (NBS, 2017). Poor revenue generation from taxes, despite Nigeria's large revenue base, contributes to the low budget allocation for the health sector. Revenue generation is characterized by administrative inefficiency and high levels of corruption (FMOH, 2017c). In 2020, Nigeria's tax revenue decreased to 5.5% of GDP, from 6% in 2019, making it the lowest in the world, and significantly lower than the regional average of 16% (based on data from 31 African countries) (Hafez, 2018). Recent data from the National Bureau of Statistics (NBS) indicate that tax revenues have

since nearly doubled year-on-year to 10.9% of GDP in 2021, but this trend is mainly due to revised calculations.

Health insurance revenue sources, which operate single pools covering about 5% of the population (covered mostly by the NHIS), are based on payroll-tax contributions, equity funds, grants and other sources. The various SSHISs also operate single pools of revenue, including tax premiums from the formal sector, states' equity funds, enrolled citizens, grants and the BHCPF stream from federal allocation, in line with the NHA (Hafez, 2018). The percentage of the population covered by these state-level schemes is presumed to be growing, but data are not yet available to confirm this. Private health insurers also operate in Nigeria, relying solely on contributors' premiums (FGN, 2014), but their coverage is very limited.

3.4 Overview of the main public financing system

As a public system, revenue for health care derives from the government budget with inflows from taxes and other government revenue sources. The government budget funds federal, state and local governments. Other revenue sources include contributions from health insurance systems (e.g. community-based health insurance (CBHI) and private insurance) pooled by individual/statutory insurance schemes across the country. Various government agencies and insurance systems pool external sources' contributions depending on the funding target. While these sources contribute to the general revenue for health care, OOP spending accounts for the commanding share of CHE. Significant inefficiencies in resource generation from government sources have persisted, and data suggest that most states spend less than 5% of their total budgets on health (Hafez, 2018; FMOH, 2019a). Altogether, expenditure from all tiers of government represents less than 25% (including external funding) of total health expenditure in the country. Private sector expenditure accounts for the remaining 75%, over 95% of which is household OOP expenditure (FMOH, 2019a). The inefficiency of the government revenue system informed the establishment of national and state insurance mechanisms to complement government funding and provide financial risk protection to enhance access to high-quality services, although the success of these insurance mechanisms remains limited (see Section 3.3) (FMOH, 2017c).

There is wide variation in the level of financial mobilization for health care by the public sector across states, depending on their roles in health

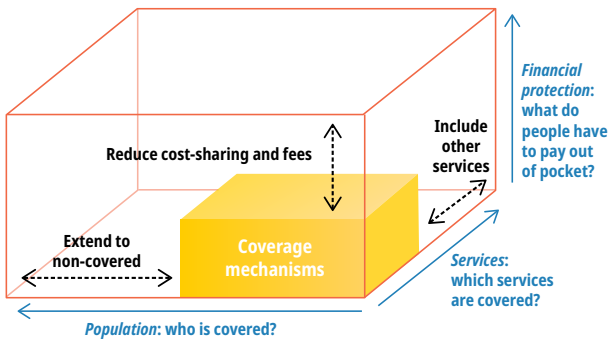
care provision. For instance, while the public sector provides about 30% of health care services in the southern part of the country, leaving over 70% to the private sector, the public sector in the north is responsible for over 90% of all health services (FMOH, 2019a). The extensive private sector health care provision, mostly based on an FFS model, explains the high OOP spending, reported to be over 92%, in the south-east (FMOH, 2019a). The lack of adequate and effective risk protection mechanisms make care costs prohibitive to many low-income populations. Financial inflows could be improved by increasing the fiscal space for health through domestic resource mobilization, enhancing development assistance targeted at social protection schemes/health insurance and improving financial management of public expenditure (USAID, 2014; Ezenduka et al., 2022).

3.4.1 Coverage

As shown in Fig. 3.4.1, the achievement of UHC (as defined by the WHO) is assessed along three dimensions: the population covered by pooled funds, the services covered by pooled funds and the cost–benefit of services covered through pooled funds (Hagen-Zanker and Tavakoli, 2012). Current data indicate low coverage across these dimensions in Nigeria (see Chapter 10).

While the government's tax-revenue system targets every citizen, health care indicators reveal that low-income populations are disproportionately burdened by high OOP spending due to the paucity of financial risk protection mechanisms in place.

Figure 3.4.1 The three dimensions of UHC



Source: Mathur et al., 2015

Service coverage

As set out in Section 3.1, there are two categories of public HBP: the EHBP, defined by the FMOH, covers essential services provided at government health facilities, while CHBPs, for example the FSSHIP or SSHIS, contain more benefits, covering primary, secondary and tertiary services. Additional disease-specific services are often included in donor-funded or supported EHBP programmes, based on disease focus or patient groups (as described in Section 3.1). The BMPHS includes a more comprehensive package of services than just essential health services and is largely provided at PHC facilities. The BMPHS includes preventive, curative and rehabilitative health care services, such as MCH services, inclusive of immunization services, and is financed through the BHCPF. This forms the basis of the EHBP. However, the EHBP needs improvement, given that other sources are expected to contribute to the cost of the BHCPF (WHO, 2010c). Service delivery of key MCH interventions achieves at most 40% coverage of eligible target populations (USAID, 2014) (see Section 10.2 in Chapter 10). There is no cost-sharing policy and so providers charge user fees for the services delivered. For private and CBHI systems, there are no standard HBPs, but packages are designed according to the ability of the target population to pay for them. For CBHISs, which are mostly not-for-profit, targeting low-income populations, the benefit packages are based on the EHBP but are made more comprehensive when supported by the government, while the PHI packages are based on the CHBP.

Population coverage

FSSHIP remains the primary health insurance mechanism (WHO, 2010c) housed under the NHIA (formerly NHIS), and is the main strategic instrument for achieving UHC. However, since its inception in 2005, FSSHIP coverage has been limited to formal sector public servants and the organized private sector, who pay the earning-based premium to access services. The scheme is estimated to cover only 4% of the population (FGN, 2022c). For the mandatory SSHISs, enrolment is open to citizens in formal and informal sectors who pay annual premiums, as well as to poor and vulnerable population groups who are exempt from premium payments (Enabulele, 2020; Ezenduka et al., 2022). Other insurance schemes, such as PHI and CBHISs, complement the NHIS for enhanced coverage, and cover a further 1% of the population (Ezenduka

et al., 2022). As at 2020, available data suggest that less than 5% of Nigerians are covered by any prepayment mechanism, including the VHI (Uzochukwu et al., 2015), which is well short of the WHO recommended target of 90% (FMOH, 2017c). The NHIS's lack of legal frameworks for mandatory health insurance, weak technical capacity to implement health insurance schemes nationwide, and poor understanding and perceptions of health insurance among the population have been identified as the major constraints to achieving coverage objectives (WHO, 2010c; FMOH, 2017c). The establishment of the various SSHISs is expected to boost population coverage beyond 5%.

Financial protection

The SSHISs run an explicit benefits package of health services based on the BMPHS, adapted to suit the individual state's disease burden and resource capacity (FMOH, 2017c). While the FSSHIP adopted the BMPHS policy across health facilities, their FSSHIP package appears more robust than other schemes (FGN, 2022c), with cost-effectiveness information as a criterion for inclusion of interventions in the package. There are mechanisms for determining the health needs of enrollees, in addition to measures for awareness creation, benefit entitlement and choice of provider. The SSHISs have a well-defined cost-sharing policy for medications and some diagnostic tests (FMOH, 2012a). They operate a similar cost-sharing policy with the NHIA, which is 10% user charges on medications and selected laboratory services.

3.4.2 Collection

General government budget

Government tax revenues (see Section and 3.3 and Fig. 3.3.1) are pooled at the federal level (through the ministries, departments and agencies) and are shared between the three tiers of government. The states also generate taxes through internally generated revenue and allocations to the SMoH for health care purchasing (FGN, 2022c). Contributions from the national pool are then combined with state pools to finance services. Taxes include direct and indirect tax collected by state and federal governments. Consumption taxes are collected at the federal level as VAT – currently 7.5% on designated goods and services since 2020 (FGN, 2022c). Revenues are pooled into VAT

and Federal Allocation Accounts and then distributed across the three levels of government. The remainder is allocated horizontally across the states and local governments. However, according to the NBS, the states' total revenue in 2016 comprised 26% of internally generated revenue, and, hence, they relied more on federal allocation. The states' poor revenue performance has been attributed to weak tax administration, a large, inaccessible informal sector, huge reliance on federal allocations, the multiplicity of taxes, poor capacity to pay and the lack of compliance by individuals (Hafez, 2018; NBS, 2022b).

Low government revenue, more broadly, has been attributed to the following:

- A low tax base: only about 14% of eligible Nigerians pay tax.
- A low tax rate: Nigeria had the lowest VAT rate in Africa in 2016, at 5%. It rose to 7.5% in 2020.
- Inefficiency in tax administration and poor compliance by registered companies (NBS, 2022b). Even the federal government is not fully compliant, especially regarding deductions and remittances on workers' salaries (Hafez, 2018).

As a non-contributory and mostly tax-financed scheme, the BHCPF represents earmarked funding for health care intended to boost access to quality health care for vulnerable populations in Nigeria (Hafez, 2018), but the fund remains constrained by low tax revenues.

Taxes, contributions or premiums pooled by a separate agency

Revenue under the SHI system is generated through a single pool comprising premiums/contributions from enrollees and government equity funds for poorer and more vulnerable population groups, among other sources (see Section 3.4). Under the NHIA, the FSSHIP operates a single pool of premiums based on payroll-tax contributions of federal civil servants and the organized private sector (10% employers and 5% employees' basic salary, deducted from source), and the BHCPF stream from the federal government (45%) (DFID, 2018). Similarly, the SSHISs operate single pools of revenue comprising tax premiums from enrollee premium contributions, states' equity funds for poor and vulnerable groups, grants and the BHCPF streams. A few private health insurers also operate, depending exclusively on contributors' premiums (FMOH, 2018b). The NHIA and the various SSHIAs are responsible for setting premium/

contribution rates and payment methods after actuarial studies on benefits packages, in collaboration with other stakeholders (government, employees, employers, HMOs and health care providers) (FMOH, 2016a). The equity funds are used to pay for identified and registered poor and disadvantaged citizens within the population who are exempted from premium payments.

Progressivity and equity of financing

Progressivity and equity are constrained by limited risk protection and high OOP expenditure (Eboh et al., 2016). Low-income populations face significant barriers to accessing essential health services, with the burden of health financing disproportionately borne by individuals and households who are exposed to catastrophic health expenditure (FMOH, 2016a; World Bank, 2017). It is calculated that 14.8% of households in the south-west and south-east regions spend more than 10% of their annual income on health care (Hafez, 2018).

3.4.3 Revenue pooling

Under the government budget system, revenue is collected and pooled at the federal level by the FMoF. The FMoBEP allocates the budget envelopes to the FMOH (Fig. 3.3.1) and the FMOH distributes them to its relevant agencies and departments to pay their respective providers/health facilities for service delivery (see Section 3.3). As a pooling mechanism, budget estimates are often based on resource/funding needs. However, the envelope system, which is historically prorated based on funding availability, does not always realistically capture current needs.

Resource pooling under the insurance system is managed by the NHIA through the FSSHIP as a single risk pool, along with two other programmes for the informal sector (described in section "Challenges of health insurance operations" in Section 3.1) (Onoka et al., 2011). The operation of these three pools leads to fragmentation. The FSSHIP is implemented through a managed care model funded by contributions from employers and employees. Collected funds are pooled at the federal level and allocated to HMOs that then pay providers for service delivery. The pooling process is replicated by the SSHISs, where the insurance agencies act as both purchasers and pooling agents, receiving an allocation from enrollee premiums and other contributions and then allocating the funds to providers for service delivery. Various CBHISs and

PHI schemes across the country contribute little to coverage due to various challenges (Odeyemi, 2014; FGN, 2022c). Once fully implemented, the SSHISs should have sufficient citizen enrolment to reach an adequate size and spread the risk across the population.

3.4.4 Allocating resources to purchasers

The FMOH allocates approved health care budgets/pooled resources to its relevant agencies and departments (e.g. the NPHCDA, Health Management Board (HMB)and the NAFDAC for medicines and health commodities) for provider payments for service delivery at different levels of health care. Criteria for allocation across these purchasing agencies are based on the budget envelope system and Medium-Term Expenditure Framework, both of which are input based, comprising salaries, overhead, consumables and medical supplies (Eboh et al., 2016). The process is similar across state governments through each SMoH. The budgeting/financing processes in Nigeria have been characterized by poor governance and delays in approval and releases, leading to misappropriations, corrupt practices and embezzlement (FMOH, 2017c).

Under the FSSHIP, premiums/contributions from enrollees are transferred from the NHIA (under the NHIF) to the HMOs for payment to the providers (public and private) through monthly capitation to primary providers, based on a predetermined package of services and FFS payment to secondary and tertiary health care providers, based on volume of services after delivery. The prepaid monthly capitation is made 14 days before the due date (Ezenwaka et al., 2022). Other payment methods include monthly staff salaries or per diem payments to secondary and tertiary providers for bed space. In the social health insurance schemes (SHISs), the NHIA and the various SSHISs are the designated purchasing and pooling agencies.

3.4.5 Purchasing of services

Payment systems

Health care purchasing is based on contract arrangements between purchasers and providers. The government's tax-funded system operates the public health integrated payment system, and providers are directly employed by

the ministries of health and paid through salaries and line-item budgets for service delivery. The SHIS models employ a contract system where providers are paid through a mixed system of capitation for PHC and an FFS model (Ezenwaka et al., 2022). Other payment models include a block grant used to pay facility providers for the block purchase of services and per diem payments for inpatient bed space. Drug purchasing and health commodity supply are based on the approved list included in the operational guidelines and on NAFDAC approval for quality.

Purchaser–provider operations

Under the government budget system, the FMOH is the purchasing agency and it delegates purchasing functions to its relevant agencies, such as the NPHCDA for PHC and the HMB for secondary and tertiary health care. The NAFDAC purchases medicines and health commodities (FGN, 2022c). Health care purchasing under this system is undertaken for the entire population. Fund transfers to health facilities are mostly made through in-kind commodities and global budgets (FMOH, 2012a). The purchasing agencies monitor/interact with providers through quarterly visits and reporting as part of the regulatory mechanisms to ensure adherence to quality standards and guidelines. However, this approach is rarely enforced due to challenges within the public integrated system where providers' employer ministries are not separate (FGN, 2022c). Providers are selected based on qualifications as registered health workers and not on contract arrangements. As a result, there is no purchaser–provider split, and therefore no incentive for provider accountability and performance improvement, falling short of strategic health care purchasing principles (FMOH, 2012a). Penalties/sanctions are in place for deviation from guidelines but are rarely enforced (Ezenduka et al., 2022). The FMOH, through the departments, agencies and parastatals, undertakes purchasing functions, including selecting and monitoring benefits package design. The decentralization of governance and complexity of the health system means multiple purchasers across the states (Ezenduka et al., 2022). Under the public health model, there are no cost-sharing policies, and so providers charge users FFSs.

Purchaser–provider regulation

Under the FSSHIP, the NHIA, as the main purchasing agency, contracts with the HMOs that purchase services, paying providers for service delivery through

capitation and FFS payments. The NHIA regulates and monitors the HMOs in accordance with guidelines, to ensure adherence to contract requirements and timely payment of providers. The HMOs submit annual audit reports through the NHIA to the governing council (Ezenwaka et al., 2022). Deviation or default from the agreement is subject to sanctions, as provided for under the law. Unfortunately, monitoring of HMOs is rarely enforced due to conflicts, political interference and corruption, as most HMOs are members of the NHIA Board (Ezenwaka et al., 2022; FGN, 2022c). On behalf of the NHIA, HMOs contract with providers (public and private) that meet the required standards. The contract process involves application, screening, accreditation and reaccreditation processes. The NHIA selects the providers based on their ability to provide relevant services, expecting them to satisfy a set of minimum requirements regarding facilities, personnel, equipment and registration with relevant professional bodies (Onwujekwe et al., 2019b). The providers are monitored for performance quality and standards through quarterly on-site inspections of facilities and reports sent to NHIA for analysis and decision-making. The HMOs also perform secondary performance assessments using qualitative and quantitative methods at the facility level. Cost-sharing requirements limit providers' use of service charges.

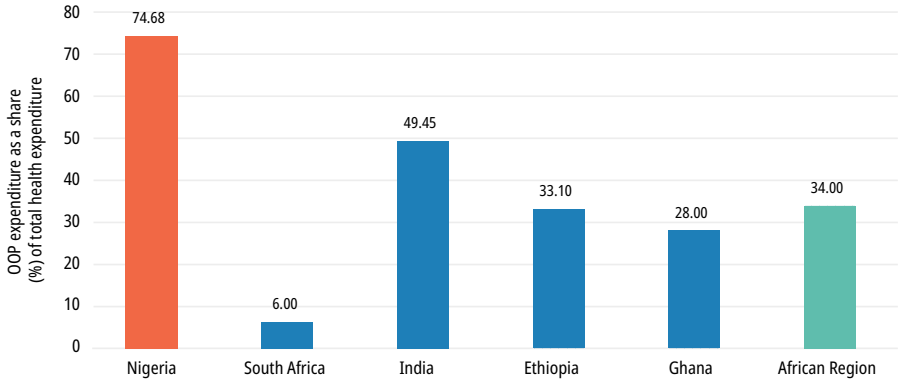
The dominance of the government tax-funded/public health system makes passive purchasing the predominant purchasing arrangement across states, contributing to inefficient resource allocation (FGN, 2022c). Given the inadequacy of the government's health funding and very limited financial risk protection, payments are made directly to providers at the point of care, contributing to high OOP spending.

3.5 Out-of-pocket payments

Nigeria's consistently high OOP spending (outlined in Section 3.2) is among the highest in the world (Ezenduka et al., 2022), considerably higher than the regional average of 34% in 2020, and substantially higher than the WHO target of 30–40% (Hafez, 2018) (Fig. 3.5.1). Individual states – for example Anambra and Imo states – report even higher OOP spending, at over 92% (WHO, 2010c).

Consistently high OOP spending has exposed most low-income populations to the risks of catastrophic health spending (WHO, 2010c) (see Section 3.4). The establishment of the NHIS in 1999 was intended to reduce OOP spending

Figure 3.5.1 OOP expenditure as a share (%) of total health expenditure across selected countries and the WHO African Region for the latest available year (2020)



Source: WHO, 2022a

through enabling risk pooling, offering greater financial risk protection and providing higher-quality services through public–private partnership. However, given that only 5% of the population has insurance coverage, this has yet to be achieved.

OOP expenditure mostly comprises direct payments for health goods and services to health care providers at the point of care, although more data are needed on the exact proportions. Health insurance users pay part of the cost of health care received via user charges. Table 3.5.1 shows user charges spread across different health services in Nigeria, indicating services that attract co-payment arrangements and their cost-sharing levels. Primary care services do not receive user charges, but outpatient prescription medicines attract up to a 10% co-payment and high-cost medicines attract up to a 50% co-payment. Some specialty services, such as high-cost investigations (e.g. computed tomography scan, magnetic resonance imaging and radiotherapy), attract a 50% co-payment, but these are reduced for children (DFID, 2018).

Table 3.5.1 User charges for health services

Health service	Type of user charge in place	Exemptions and/or reduced rates	Cap on OOP spending	Other protection mechanisms
Primary care	For some services, including MCH services in some places	Exist in some instances on a case-by-case basis	No	Yes; include free MCH services and BHCPF
Outpatient specialist visit	For some services, including MCH services in some places	Exist in some instances on a case-by-case basis	No	Yes; include free MCH services and BHCPF
Outpatient prescription drugs	10% co-payment, generally 50% on high-cost medicines for people covered by NHIA or SSHIA. Non-enrollees pay up to 100%	Exist in some instances on a case-by-case basis	No	Yes; include free MCH services and BHCPF
Inpatient stay	For some services, including MCH services in some places	Exist in some instances on a case-by-case basis	No	Yes; include free MCH services and BHCPF
Dental care	No	No	No	No
Medical devices	No	No	No	Limited
Other (please specify)	50% co-payment on high-cost investigations (e.g. CT scan, MRI, radiotherapy)	Reduced rates for children on high-cost investigations (e.g. CT scan, MRI)	No	NA

Source: Authors compilation from NHIA (2022) data (FGN, 2022c)
Notes: CT = computed tomography; MRI = magnetic resonance imaging; NA = data not available.

3.6 Voluntary health insurance

VHI is provided via CBHI and PHI schemes (FGN, 2022c).

Community-based health insurance schemes

A rural CBHIS was introduced by the NHIS in 2010 (FMOH, 2012a). It was intended to improve basic service coverage for poor and vulnerable rural populations working in the informal sector who lack access to adequate public, private or employer-sponsored insurance (FGN, 2022c). Implemented mostly as a public–private partnership model, CBHI was piloted on a small scale in Anambra, Lagos and Kwara states, but operations later expanded to many communities across the country (Adinma and Adinma, 2010). Poor enrolment rates have constrained implementation due to challenges including lack of trust in scheme management, poor benefits packages, the unaffordability of the premium and the quality of the health care provided (Adinma and Adinma, 2010). To enhance enrolment and coverage, CBHISs were packaged with incentives, including tax exemptions, a comprehensive benefits package (BMPHS) and minimal premiums. However, these incentives have yet to translate into increased enrolment due to poor targeting and failure to enforce exemption systems (Aregbeshola, 2018).

Private health insurance schemes

PHI schemes were introduced as a profit-based mechanism for individuals willing to pay a premium for additional health services. These PHI schemes were set up across a few federation states to contribute to expanding coverage and are estimated to cover about 1 million people, less than 1% of the population (Aregbeshola, 2018).

Evidence of the impact of both community and private voluntary schemes is mixed (Adinma and Adinma, 2010). Indications are that CBHISs failed to expand coverage to the poor and vulnerable populations (Bonfrer et al., 2018), while PHI schemes similarly showed poor capacity to extend coverage (Odeyemi, 2014). Voluntary membership, limited government support and poor management are cited as explanations for the poor performance of these schemes (Onoka et al., 2016). Data on the contribution of both schemes to total health expenditure

are unreliable, but Table 3.2.1 suggests that VHI contributions have remained at about 1% of CHE since 2011 (Obansa and Orimisan, 2013).

3.7 External sources and other systems of financing

3.7.1 External sources of funds

External funding support represents a key source of financing for Nigerian health care. It comes in different forms, including direct loans and grants, technical assistance and expertise, commodities (drugs and medical equipment), training and research funding (WHO, 2022a). Donor support has also been provided in the form of debt relief attached to the financing of programmes implemented to achieve the SDGs (e.g. distribution of free insecticide-treated bed nets and antimalarial medicines), making a positive contribution to the financing of PHC (Uzochukwu et al., 2015; Eboh et al., 2016).

As described in Section 3.2, external or donor-funded support for health care has declined over the period and currently contributes about 7.9% of CHE in 2021 (Oyibo and Ejughemre, 2015), which is relatively low compared with total funding requirements. Nevertheless, external contributions have significantly impacted the health system. The majority of resources are applied to health programmes used as vehicles for managing and addressing key diseases (Oyibo and Ejughemre, 2015), including HIV/AIDS, malaria, TB and COVID-19 (DFID, 2018). Table 3.7.a lists major donor agencies and institutions that contribute to external funding for health care. Data on the level of funding provided are not readily available.

Many donors, including global public–private partnerships, focus on specific health conditions or diseases: the Global Alliance for Vaccine Initiative, the Medicines for Malaria Venture and the Partnership for Maternal, Newborn and Child Health have all invested in Nigeria (Oyibo and Ejughemre, 2015), and the Global Fund allocated US$ 660.7 million to Nigeria for three diseases in their 2017–2019 funding cycle, one of the largest country donations made by the fund (Oyibo and Ejughemre, 2015).

Donor support has significantly strengthened Nigeria's health system, particularly PHC. Reduction in HIV/AIDS and TB prevalence, guinea worm eradication, as well as capacity development and health facility infrastructural upgrades, have all been attributed to donor support (DFID, 2018). However,

Table 3.7.a Major institutional donors for health care financing and areas of support in Nigeria

Main donor institution	Support area(s)
Bill and Melinda Gates Foundation	Health financing services across programmes and immunization, among others
Global Alliance for Vaccine Initiative	Immunization/vaccine provision
Global Fund to Fight AIDS, Tuberculosis, and Malaria	HIV/AIDS, TB and malaria
International Development Association	MCH, nutrition and SOML initiative
Swiss Agency for Development and Cooperation	COVID-19 palliative care
United Kingdom of Great Britain and Northern Ireland Foreign Commonwealth and Development Office (formerly Department for International Development)	PHC, HSS, MCH, malaria/support to national malaria project
United States Agency for International Development	HSS, PHC, health workforce, HIV/AIDS (PEPFAR)
World Bank	HSS, PHC and MCH (International Development Association, Global Fund)
WHO	HSS, health finance, PHC, MCH, nutrition and immunization
Other UN agencies (UNDP, UNICEF, UNFPA, UNAIDS, among others)	RH, MCH, adolescent health, immunization and HIV/AIDS, among others

Notes: HSS = health systems strengthening; PEPFAR = President's Emergency Plan for AIDS Relief; SOML = Saving One Million Lives; UNAIDS = Joint United Nations Programme on HIV/AIDS; UNDP = United Nations Development Programme; UNFPA = United Nations Population Fund; UNICEF = United Nations Children's Fund.

between 2010 and 2021, donor funding declined from US$ 13.2 per capita in 2014 to US$ 7.0 per capita in large part due to the recategorization of Nigeria as a middle-income country in 2008 (Oyibo and Ejughemre, 2015). The recategorization will limit the country's ability to access future preferential terms for grants, concessional loans and debt relief (Oyibo and Ejughemre, 2015). External funding also brings challenges, notably around sustainability but also in terms of the lack of coordination of vertical programmes, misdirection of donor funds from areas of greatest need, corruption in donor-supported programmes and over-reliance on donor funding, leading to the rolling back of government provision at all levels (Oyibo and Ejughemre, 2015).

3.7.2 Other systems of financing

Various levels of government have explored other financing initiatives to complement health financing, including conditional cash transfers, free MCH programmes, fee exemption schemes, the Saving One Million Lives (SOML) initiative, the Midwives Service Scheme and free malaria programmes (Oyibo and Ejughemre, 2015). Primary health centres are meant to receive cash and in-kind support through the fund flow arrangements described in Fig. 3.3.1 (Oyibo and Ejughemre, 2015). The SOML initiative, a federal government-led initiative funded by a World Bank facility, and the Nigeria State Health Investment Project (NSHIP) were established for improving PHC services (for MCH, HIV/AIDS, malaria and TB immunization coverage, and essential medicines and commodities). The initiatives contributed significantly to improving MCH outcomes (Oyibo and Ejughemre, 2015). Despite these systems, OOP remains the most common source of external health financing (Hafez, 2018).

3.8 Payment mechanisms

3.8.1 Paying for health services

Table 3.8.1 shows the mixed payment mechanisms used to pay providers for health services across different service levels in Nigeria. While capitation is paid to PHC providers, FFS models dominate at the secondary and tertiary health service levels. However, salary payments remain the major payment mechanism in areas of the health system yet to be included in SHI mechanisms. As an input-based system, this has been fraught with attendant poor performance and inefficiencies in service delivery (Hafez, 2018). Output-based payment systems, such as performance-based financing or payment for results, which tie payment for health services to performance, have been used by the SOML initiative and NSHIP, among other programmes, to enhance service quality through staff motivation and infrastructure strengthening in several states, with significant positive impacts on the health care delivery system. However, these positive impacts are undermined by the challenges of inadequate funding, poor infrastructure and limited workforce (WHO, 2022a).

Table 3.8.1 Provider payment mechanisms

Payer/provider	Ministry of Health	Other ministries	Regional ministry of health/health service	Local health authority	Central SHI institution	SHI funds	Other SHI systems	Private/ voluntary health insurers
Health centres	Salary	Salary	Salary	Salary	Capitation	Capitation	Capitation	Capitation
General practitioners	Salary	Salary	Salary	Salary	Capitation/ salary	Capitation/ salary	Capitation/ salary	Capitation/salary
Ambulatory specialists	Salary	Salary	Salary	Salary	Not covered	Not covered	FFS	FFS
Other ambulatory provision	Salary	Salary	Salary	Salary	Not covered	Not covered	FFS	FFS
Acute hospitals	Salary	Salary	Salary	Salary	FFS	FFS	FFS	FFS
Other hospitals	Salary	Salary	Salary	Salary	Capitation/FFS	Capitation/FFS	FFS	FFS
Hospital outpatient	Salary	Salary	Salary	Salary	Capitation/FFS	Capitation/FFS	FFS	Capitation/FFS
Dentists	Salary	Salary	FFS	FFS	FFS	FFS	FFS	FFS
Pharmacies	Salary	Salary	Salary	Salary	FFS	FFS	FFS	FFS
Public health services	Salary	Salary	Salary	Salary	Not covered	Not covered	NA	FFS
Social care					Not covered	Not covered		FFS

Source: Authors' compilation

Notes: NA = data not available.

Paying for health workers

Current health system operations are geared towards strategic health purchasing, and PHC providers are therefore paid monthly salaries. This input-based approach results in inefficiencies in service delivery due to a lack of incentives or motivation. By contrast, given the operation of the SHISs across the federation, at the secondary and tertiary levels, health care providers are paid via an FFS model. Other output-based payment mechanisms include the block grant and per diem payments to secondary and tertiary providers for bed space.

3.9 Recent reforms

The Nigerian health system has undergone various reforms to improve health care delivery and enhance population health objectives (see Chapter 2 for an overview of health system governance and reforms). Fig. 3.1.a shows the progression of health care financing reforms.

Pre-National Health Policy reforms

Health care financing reforms before the introduction of the NHP in 2016 focused on reallocating public expenditure in line with identified priorities, appropriate pricing policies, the NHIS and community financing (FMOH, 2018b). Spending reallocation prioritized shifting investment from curative services to preventive services, to address the high risk of morbidity from preventable infectious and avoidable diseases (FMOH, 2018b).

Health system strengthening reforms

Weak health systems cannot achieve UHC. Consequently, the Presidential Summit Declaration on UHC in 2014 led to the creation of a central coordinating unit for UHC within the health systems strengthening (HSS) division of the Department of Health Planning, Research, and Statistics, FMOH, in June 2015 (FMOH, 2017c). This unit was mandated to provide overall policy and strategic direction for achieving the presidential mandate on UHC. Its activities involved

galvanizing and technically coordinating relevant health care financing efforts by leveraging existing resources and building appropriate partnerships, which led to the development of the National Health Care Financing Roadmap, the establishment of the National Health Care Financing Equity and Investment Technical Working Group in 2015, and the development of the NHFPS in 2016. Subsequently, these efforts were replicated in all 36 states and the FCT. Health insurance and contributory scheme laws were also enacted in all states and the FCT (FMOH, 2017c).

Universal health coverage focused reforms

Subsequent reforms were geared towards achieving UHC, a key target of the UN's health-related SDGs (Target 3.8). They started with the enactment of key financing policies and strategies (NHA 2014, BHCPF 2014, NHP 2016 and NHIS (now NHIA)) (see Fig. 3.1.a), all of which were designed to achieve UHC (Obansa and Orimisan, 2013). Reforms centred around implementing a sustainable health financing system, to ensure that every citizen has equal access to good-quality, efficient and equitable health care, irrespective of socioeconomic status. This requires restructuring the health care financing strategies needed to achieve UHC, as described in Section 3.1. Measures were implemented to increase funding, improve efficiency, promote innovative health financing and ensure equity in providing and utilizing health services with assured financial risk protection, to achieve improved health indices and global health goals (Obansa and Orimisan, 2013).

Impact of reforms

Reforms to address the arrangement and management of health funding and financing were implemented to support UHC principles. These include the decentralization of the NHIS, for greater financial risk protection and improved access to good-quality health care (FGN, 2022c), and implementation of the BHCPF (FMOH, 2017c), for increased funding. Measuring the impact of these reforms is difficult: many health NGOs and development partners implement vertical programmes, resulting in poor coordination and measurement challenges (FGN, 2022c). When their effectiveness is measured by key performance indicators linked to UHC, data suggest that, to date, they are

not achieving their objectives: population coverage by the new insurance mechanism remains less than 5%, well below the 90% target; and OOP expenditure is above 75% of CHE, well above the 30–40% regional benchmark (WHO, 2022a). This poor performance can be attributed to the challenges of persistent government underinvestment in health care, limited capacity to implement health insurance programmes and administrative inefficiencies. SHISs are considered a critical step towards UHC and are expected to boost performance, but further data are needed before a more objective assessment and wider financing reforms can be undertaken (Onwujekwe et al., 2019b).

Chapter summary

Chapter 3 analyses the level of available resources and the financial flows in Nigeria's health system. Health care financing in Nigeria is characterized by insufficient investment in health, high OOP expenditure and limited financial risk protection mechanisms. Health expenditure as a percentage of GDP is among the lowest globally, while OOP expenditure is among the highest. Only 5% of the population has health insurance of any form. Budget allocation to health is hampered by Nigeria's minimal tax revenues, which are among the lowest regionally and globally. The burden of health care costs falls on individuals/households, exposing Nigeria's predominantly poor and vulnerable population to catastrophic health expenditure. This undermines progress towards achieving UHC and the SDGs for a healthy and wealthy nation. Reforms, including establishing a new health insurance mechanism and the earmarked BHCPF, have not made significant progress towards increasing equitable access to good-quality health care. Lack of progress has been attributed to insufficient political resolve, weak governance and the inefficiency of public financial management. Improvements in the three health financing functions of resource mobilization, pooling funds and managing funds are needed, along with a move from the passive to strategic purchasing of health services. There is scope to increase the fiscal space for health through improved 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 resolve to increase funding for health care and drive stronger governance and efficiency of public financial management.

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