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An Appraisal of National Healthcare Financing in Nigeria: A Narrative Review

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Abstract:

Nigeria's healthcare financing system has undergone several reforms aimed at advancing universal health coverage, yet persistent structural weaknesses continue to undermine equitable access and quality of care. Fragmented funding sources, chronically low public expenditure, and heavy reliance on out-of-pocket payments have sustained financial barriers and poor health outcomes. This narrative review appraises the current landscape of healthcare financing in Nigeria by examining its structure, major funding sources, operational effectiveness, and the policy constraints that limit access and service quality. Using a narrative synthesis of academic literature, policy documents, and institutional reports published between 2000 and 2024, relevant evidence was retrieved from databases including PubMed, Google Scholar, and Scopus with search terms related to healthcare financing, the National Health Insurance Scheme, out-of-pocket payments, and universal health coverage. The review reveals a system dominated by direct household payments, limited insurance coverage, and underdeveloped pooled financing mechanisms. Key challenges include weak governance structures, inadequate political commitment, insufficient budgetary allocation to health, and low public awareness of insurance schemes, alongside a persistent emphasis on curative rather than preventive services. These dynamics perpetuate inequity and expose households to catastrophic health expenditure. Strategic restructuring is therefore required to achieve equity, efficiency, and sustainability, with priorities including increased government investment, expanded insurance coverage, and context-sensitive financing innovations supported by strong policy enforcement, stakeholder collaboration, and public health education.

Keywords: Healthcare financing, Nigeria, NHIS, Out-of-pocket payments,

Universal health coverage, Health policy,

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Introduction

Healthcare financing is an important determinant of health in any country. In Nigeria, even though the country is one of the largest economies in Africa, its healthcare system is still plagued by deep-rooted structural and operational challenges that is affecting its effectiveness. The burden of preventable diseases such as cholera, tuberculosis, HIV, meningitis and measles is still high which reflects on systemic weaknesses in access and service delivery. Key health indicators provide further evidence of this crisis: infant and under-five mortality rates are at 72.2 and 113.8 per 1,000 live births respectively, maternal mortality at 917 per 100,000 live births and life expectancy for both males and females at 53 years (WHO, 2020). These statistics highlight the continuing discrepancy between the economic potential of Nigeria and the conditions of the Nigerian population's health.

As Lambo (2023) puts it, a healthy nation is necessarily a wealthy nation, because the absence of debilitating diseases and epidemics prevents the wasting of human capital by sickness, hunger and squalor. In recognition of this, access to affordable and accessible healthcare on a sustainable basis forms a fundamental obligation of the Nigerian state. National healthcare delivery is contained in Section 17(3)(c) and (d) of the 1999 Constitution of the Federal Republic of Nigeria (as amended) which requires the state to protect the health, safety and welfare of all persons in employment and ensure provision of adequate medical and health facilities for all citizens, respectively. These provisions in the constitution define healthcare not as a policy priority but as a fundamental right.

Within this context, an appraisal of healthcare financing in Nigeria entails a critical appraisal of the mechanisms and strategies used in financing the health sector in the country. Given the country's diversified socio-economic scenario, providing access to quality healthcare on an equitable basis remains a strong challenge. Successive governments have sought to address this followed by public and private financing arrangements, to advance the goal of universal health coverage and improved population health outcomes. This appraisal thus aims to assess the performance of these financing strategies in relation to these kinds of overarching goals.

Healthcare financing in Nigeria comes chiefly from tax fund, out-of-pocket expenses, donor funding and social health insurance schemes. Each of these sources have different impacts on accessibility of care and affordability of care. A major policy intervention in promoting equitable access to services and reduces the burden on household finances was the introduction of the National Health Insurance Scheme (NHIS) in 2005 (Mackintosh, 2016). However, its effect has been small with less than five per cent of population currently under the scheme, exposing the insufficiency of current risk pooling mechanisms, pointing towards dire need of a more inclusive and efficient financing model. The process of healthcare financing in Nigeria is also limited by systemic factors such as economic disparities, political instability and inadequate infrastructure. These conditions lead to uneven distribution of health resources and services, to the disadvantage of vulnerable populations. By analyzing the policies on financing and their implementation, we focus on their implications in the provision of healthcare, and identify areas of need for reform. A clear picture of the current financing landscape is necessary to develop strong strategies that can contribute to improving the efficiency, equity and sustainability of the Nigerian health system.

Conceptual and Policy Foundations of Healthcare Financing in Nigeria

Healthcare financing can be seen as the processes whereby financial resources are mobilised, pooled and allocated in order to ensure provision of health services without exposing people to financial hardship. It consists of gathering of revenues from the primary and secondary source funds (or "out of pocket payments"), taxation sources (direct and indirect), donor's funds, co-payments, and voluntary or mandatory prepayments which are then pooled to facilitate risk sharing across populations and used in purchasing health services from public and private providers through mechanisms such as fee-for-service, capitation, budgeting and salaries (Obangsa & Akinnagbe, 2013). The following are the common characteristics of healthcare financing: In practical terms, healthcare financing is the flow of funds from households to providers in return for the delivery of care. The structure of this flow plays a role in whether individuals are able to receive the services that they require, as well as whether they become financially burdened at the time of service. An effective financing system must therefore mobilise adequate resources, ensure equity and efficiency in expenditure, ensure affordability and quality of services, ensure the availability of necessary health goods, and ensure prudent expenditure of funds in support of other development objectives, including the attainment of the Millennium Development Goals.

Nigeria has formulated a number of policy frameworks to guide healthcare financing and performance of the healthcare system. These include the National Health Policy, the Health Financing Policy, the National Health Act and the National Strategic Health Development Plan, according to Uzochukwu in (2022). A landmark in 2014 was the passage of the National Health Act which helped provide a legal basis for system-wide reforms. The overall goal of the National Health Policy is to strengthen the National health system to provide effective, efficient, accessible, affordable and quality health services that can improve people's health. Central to this vision is the development of a coherent health financing policy which aims at ensuring sustainable, equitable and efficient service delivery. The pattern of healthcare financing is intrinsically associated with healthcare services provision, and determines the capacity of the system to play a role in national development (Rao et al., 2009). Other than resource mobilisation, healthcare financing determines affordability, accessibility, equity and financial risk protection. As Carrin, Evans, and Xu (2007) observed, how health systems are financed makes a huge difference to whether people are able to get the care they need and whether they suffer financial hardship in so doing. In Nigeria, the financing modes are broadly grouped into those under the public and the private sector, including government spending, out-of-pocket payments, donor funding, development assistance and health insurance mechanisms.

Historical Evolution and Contemporary Trends in Healthcare Financing

The concept of healthcare financed system in Nigeria dates back to the time of the colonials where health services were available to people, but then it was mainly provided by missionaries and colonial authorities. Following independence in 1960, the government took over primary healthcare delivery and a public healthcare system was created with the aim of delivering healthcare to everyone. However, persistent lack of funds to meet the needs of the EPs, poor infrastructure and poor management structures soon limited the performance of the systems leading to high maternal and infant mortality and build up of diseases (Obangsa and Akinnagbe 2013). The launching of the National Health Policy in 1988 attempted to operationalise the primary healthcare model for all Nigerians, but it was also undermined by lack of budgetary commitment and lack of political will (Federal Ministry of Health [FMoH],

2005). As a result, successive health programmes were not sustainable and the dependence on out-of-pocket payments was also aggravated, accounting for more than 70 per cent of total health expenditure by the early 2010s (Obansa and Akinnagbe 2013).

The early post-independence reforms indicated an awareness of how healthcare is a basis for developing a nation. In 1962, the first proposal for a health insurance scheme was introduced followed in the 1970s by the Basic Health Services Scheme for the establishment of primary health units in every local government area. This was followed by the launch of the first comprehensive national health policy in Nigeria in 1988 which further institutionalised the role of the State in providing healthcare. One of the key developments was the operationalisation of the National Health Insurance Scheme in 2005 to help reduce financial constraint by means of a risk pooling and prepayment. Despite its promise, public scepticism, lack of awareness and constraints in implementations such as weak infrastructure, variable quality of service, limiting the number of people to enrol, etc., enrolment remained low (Nwankwo, 2022). These challenges spoke volume on the difficulty of building a sustainable and inclusive financing model in an intense diversified socio-economic context.

Contemporary trends in healthcare financing in Nigeria are measures of what is occurring globally: innovative and sustainable financing. One of the emerging guidelines is Universal Health Coverage which focuses on achieving equitable access to essential services without worrying about finances. This orientation is being underpinned more and more in the policy discourse in Nigeria, especially in the awareness of the poverty generating nature of the out-of-pocket expenditure (WHO, 2023; Obansa and Akinnagbe, 2013). Public-private partnerships have become a prominent mechanism to boost and increase the infrastructure and to increase the quality of service, more particularly in underserved area; the private sector has been perceived as source of efficiency and capital (Ogunleye & Odukoya, 2023). The integration of digital technologies amplified by the pandemic of Covid-19 has further impacted healthcare financing and delivery through telemedicine and mobile platforms that contribute to access improvement, transaction cost reduction and financial inclusion (Nwankwo, 2022).

International funding from donors still plays a significant role, especially in disease specific programmes aimed at HIV and Malaria (Ogunleye & Odukoya, 2023). However, external aid dependency brings dependence on external aid with the risks of fragmentation and undermining the long-term strengthening of a system, and is increasingly driving focus on domestic resource mobilisation. Alongside this, community-based health financing models have become popular, advancing the concepts of local participation and financial risk protection, especially in rural and informal settings. These initiatives positively enhance trust and responsiveness, but they need to be integrated into national frameworks to be sustainable and at scale (Ogunleye & Odukoya 2023). Collectively, these trends provide a gradual readjustment of the financing of healthcare in Nigeria to the principles of equity, resilience and systems coherence.

Public Financing and Household Burden

Nigeria's healthcare financing system is influenced by a complex interaction among public revenue, private expenditure under household dentist expenditures and external assistance. Funding in government comes primarily from tax revenues, such as direct payroll and income taxes as well as indirect taxes on goods and services (Onah et al, 2022). In practice, nevertheless, the effectiveness of taxation as a financing mechanism is reduced by the lack of

a comprehensive national database and enduring accountability problems of revenue management. Public revenues are further augmented by revenues from oil and gas which are shared among the three layers of government under an established allocation formula (Onah et al., 2022). Although state and local governments are institutionally nearer to communities and are responsible for the funding of Primary Health Care, due to their poor internal revenue generation capacity, they have become so dependent on federal funding.

Despite these arrangements, the level of public investment in health stays extremely low. Federal budgetary allocations have consistently lagged miles below the 15 per cent benchmark which is the Abuja Declaration of the year 2001 (Soyibo and others, 2009). In 2001, only 4.39 per cent of the national budget was spent on health; this was dropped to 3.73 per cent in 2010 and slightly increased to 4.7 per cent in 2022 (Onah et al., 2022). Government health expenditure as a proportion of total health expenditure has fallen from 25.6 per cent of total health expenditure in 2005 to 16.4 per cent in 2015 and 15 per cent in 2020. Over the last 10 years, less than five per cent of the Gross Domestic Product (GDP) in Nigeria has been dedicated to health (Onah et al., 2022).

The result of this underinvestment is high out-of-pocket payment dependency, a financing mode introduced officially in 1998, after the Bamako Initiative. This model emphasised on cost sharing and community participation as a means of improving sustainability and quality of service (Yunusa & Irinoye, 2014). Out-of-pocket payments require people to pay for care at point of service and currently it constitutes the prevailing mode of health financing in Nigeria. Such payments accounted for 60.1 per cent of the total health expenditure in the year 2000, had increased to 76.8 per cent in 2010 and remain high at 70.5 per cent in 2019, which constituted over 90 per cent of private health spending (World Bank, 2021). This type of pattern puts the highest financial burden on households, which exposes them to catastrophic health expenditure and retraces inequities in access to care.

Risk Pooling, External Support, and Emerging Innovations

In response to inequities that arise in direct payment systems, Nigeria put in place a National Health Insurance Scheme as a risk pooling and financial protection mechanism. Created under act 35 of 1999 and fully functional by 2005, the purpose of the NHIS was to facilitate affordable healthcare, which was to be achieved with the regulated contributions to an insurance fund (Agba et al., 2010). However, access to coverage has been extremely limited, including less than four per cent of the population and mostly limited to federal government employees (Enabulele, 2020). The commitment to voluntary enrolment undermined the uptake since many people preferred the direct payment in pursuit of the perceived quality of the service (Enabulele, 2020). The signing of National Health Insurance Authority Bill in 2022, which prescribed enrolment, is a significant policy shift though the impact of this measure will depend upon effective implementation and public confidence (Agba et al., 2010).

Complementary to the NHIS, Community-Based Health Insurance schemes have developed as locally based risk pooling schemes. These initiatives help in co-financing healthcare by individuals, families and community groups especially in rural areas and the informal sector where formal insurance is not affordable (Adinma & Adinma, 2010). Early experiences, such as the Anambra State scheme introduced in 2003, showed high acceptance and real support of maternal health services (Odeyemi, 2014). Nevertheless, lack of continuity and poor take up rates for wider service packages have limited their long-term viability.

External assistance is also an important, albeit unstable, component of healthcare financing. Development Assistance for Health has supported key programmes, in particular, in the area of communicable disease control. However, donor inflows have gone down and per capita aid reached their peak in 2014 (US$13.03), and dropped to US$6.69 by 2020 (Obi & Ogbuoji, 2021). Although we see the amount of money spent on health throughout the years rising absolutely, the total amount of health spending is a small fraction of health spending. Weak coordination, poor tracking systems and the inherent unpredictability of donor flows make it less effective as a sustainable financing base, all worsened by the impact of the Covid-19 pandemic and global economic instability (Obi and Ogbuoji, 2021).

In parallel, Public-Private Partnerships have come to the fore as a strategy for resolving the infrastructure deficit and for better delivery of services. Through the mobilisation of private resources and expertise, PPPs strive to enlarge access and increase efficiency, especially in less served locations (Ogunleye and Odukoya 2023). Several states have adopted the concept of partnerships to rehabilitate and manage hospitals that have helped to reduce waiting time and drastically improve the facility performance. However, the success of such arrangements is contingent upon strong regulatory structures ensuring transparency, responsibility and defending public interest, together with effective match of the public and private interest.

Recent reforms have also brought the integration of digital technologies into healthcare financing and delivery into limelight. Telemedicine platforms and mobile health applications have expanded access, eased mistakes of remote consultations, and bettered the payment processes, especially in the course of the Covid 19 pandemic (Ogunleye & Odukoya 2023). These innovations are promising for a way around geographical inhibitions and increase in system efficiency. Yet, gaps in access to the internet, digital literacy and regulatory oversight are substantial barriers that need to be overcome to drive equitable and sustainable adoption.

Challenges Facing Healthcare Financing in Nigeria

Healthcare financing in Nigeria is faced with a whole range of inter-related structural, institutional and political challenges which continue to undermine the performance of the health system. These challenges have come to be deeply embedded within the overall governance and economic context of the country and have remained resistant to multiple reforms in its policy. At the centre of such challenges are systemic inefficiency which plays itself out in various forms of bad practices on management, inadequate coordination at all levels of government, and infrastructural drawback which has been seen to be chronic and persistent. Health facilities often continue to be equipped with outdated technology, have insufficient staff and fail to have adequate referral processes, leading to over-provisioning of services in some areas and total lack of care in others. Such inefficiencies result in huge wastage of scarce resources and translate into sub-optimal health outcomes, even if funding is available. The lack of integrated planning between federal, state, and local governments exacerbates this problem even further, creating a patchwork of the system with blurred responsibilities and diffuse accountability.

Closely linked to inefficiency is the low institutional capacity to design, implement and manage healthcare financing mechanism. Many health institutions do not have the technical expertise of people with the skills required in financial planning, actuarial analysis, health economics and programme evaluation. Administrative systems are still weak, especially at sub-national levels, where primary healthcare is constitutionally located. Inadequate training and poor professional development structures constrain the ability of health managers to

utilise funds effectively or to implement complex financing reforms for example insurance expansion and performance-based funding. This capacity gap underlies weak execution of policies, turning otherwise good policies into weak policy instruments. As a result of this, a stake driven by financing often remains aspirational, with few being seen translated into tangible improvements in service at point of care.

Corruption is another widespread problem. The misappropriation of funds, procurement frauds, ghost workers, and the informal payments try to distort the allocation of resources and impairments of public trust in health institutions. Corruption shrinks the amount of money that eventually reaches the point of service delivery and impairs the quality of care because of rent-seeking behaviour. In relation to healthcare financing, this means under-equipped facilities, delays in projects, and inequalities in resource distribution. Moreover, undertaker transparency and accountability mechanisms are weak and spending on GHG emissions are hard to trace and assess the impact of the public expenditures. The perception and experience of corruption discourages both domestic and external investment in the health sector as well as citizen willingness to engage in pooled financing schemes such as health insurance.

Macroeconomic instability also limits healthcare finance. Nigeria's high dependence on oil income makes its public spending vulnerable to fluctuations in the prices of commodities in global markets. Periods of economic crisis are usually marked by cuts in their budgets, delayed releases and austerity (fiscal), which affect disproportionately the social sectors such as health. Inconsistent finance affects the long-term planning and delivery of services because health facilities fail to maintain programmes or infrastructure. Economic volatility also falls on household purchasing power, which serves to increase vulnerability to health shocks at exactly the same time when public support is most constrained. This cyclical, reciprocal relationship between economic instability and health financingCreating more in depth policy and combinatory frameworks, involving all stakeholders and actors, will enable the Earth to keep restraining systemic fragility.

A critical political dimension is at the base of all these structural and economic constraints. The lack of political will to some degree to prioritise health financing is illustrated by chronically low budgetary allocations and slow implementation of policy. Although Nigeria has signed up to regional and global commitments on health spending such as the Abuja Declaration, such commitment has not been translated into sustained fiscal action. Health is often an unsuccessful competitor with sectors that are seen as more politically rewarding, such as infrastructure and security. Weak political commitment is also expressed in the low level of enforcement of health reforms, such as the delay in operationalising insurance mandates and the poor level of oversight of implementing agencies. Without regular high-level support, healthcare financing reforms are at risk of experiencing policy discontinuity and administrative inertia.

The dominance of out-of-pocket payments is one of the most visible marks of these systemic failures. Direct payment at the point of service, while placing an unacceptable financial burden on households, also exposes households to catastrophic health expenditure. For many Nigerians, sickness leads to asset depletion, indebtedness or an outright missed care. This type of financing structure locks in inequity because access to services has become in relation to ability to pay not to medical need. Vulnerable populations, ranging from rural populations and the informal sector, are disproportionately affected, perpetuating cycles of poverty and ill

health. High out-of-pocket spending also prevents preventive care because they postpone treatment until conditions are severe and expensive.
Compounding this challenge is when it comes to limited penetrating health insurance mechanisms. The National Health Insurance Scheme has been plagued by poor adoption at the state level, piecemeal implementation and poor public awareness. Many states have been averse to integration fully into the scheme, on grounds of governance, financial constraints and uncertainty about operational control. This inequitable buy-in acts to constrain national risk pooling and perpetuates regional inequities in access to financial protection. As a result, coverage of health insurance is very low especially among the informal workers and the unemployed who make up the majority of the population. The narrow coverage base undermines the financial sustainability of insurance schemes and reduces the ability of such insurance schemes to act as effective tools of equity and risk sharing.
Taken together, these challenges bring out the reality that issues of healthcare financing in Nigeria aren't simply a matter of technical challenges, they are systemic governance issues. Inefficiency, institutional capacity limitations, corruption, economic volatility, an inadequate sense of political will, over-reliance on out-of-pocket payments and weak insurance coverage interact to yield a strained financing structure. Addressing these challenges requires more than incremental reform - it requires coordinated structural transformation, grounded in political commitment, institutional strengthening and social accountability. Without such an all-encompassing strategy, healthcare financing will continue to remain at the very core of the challenges that Nigeria face in ensuring universal healthcare coverage and better health outcomes for its people.

Strategic Directions for Reform

Strengthening healthcare financing in Nigeria is fundamental to the need of overcoming the systemic weaknesses which have hamper the effectiveness and equity of the health system. A coherent reform agenda requires a focus on getting greater coverage of the public investment, expanding health insurance coverage, and deploying public-private partnerships, getting greater engagement of the community, and also having a strategic integration of technology. Collectively, these measures are aimed at creating a more equitable, efficient and sustainable financing framework that is able to meet the health needs of the Nigerian population. An important starting point is the expansion of government investment in health. Nigeria currently spends about four per cent of its national budget on healthcare and this is, by far, far from the fifteen per cent recommended by the African Union (Federal Ministry of Health [FMoH], 2023). By increasing this allocation it would be possible to work on significant improvements to healthcare infrastructure, delivery of healthcare and availability of medical supplies. Sustained and predictable financing is required for setting up the chronic shortage of facilities and manpower that has haunted system performance for years (Obansa & Akinnagbe, 2013). Equally important is the setting up of transparent budgeting and expenditure-tracking mechanisms to guarantee that public funds are used in an efficient way and for the purposes for which they are intended.
Increasing the coverage of health insurance is another fundamental component of reform. Although there is a viable mechanism for financial risk protection in the system in the form of the National Health Insurance Scheme (NHIS), enrolment is unacceptably very low (Nwankwo, 2022). Enhancing people's awareness of the benefits of insurance, streamlining the process for a person to enrol and subsidise insurance premiums for poorer households

would do a lot to increase the number of people taking part. By enhancing the pooling of risks and decreasing reliance on out-of-pocket payments, increased insurance coverage would increase access to needed services and lessen the burden of catastrophic expenditure on health. Public-private partnerships (PPPs) can also offer a strategic opportunity to strengthen healthcare financing as well as service delivery. One way that PPPs may tackle the issue of infrastructure gaps and promote efficiency is by leveraging private-sector resources and knowledge to cover gaps and facilitate smoother operations, especially in areas that are not serviced effectively (Ogunleye & Odukoya, 2023). To ensure that such partnerships are not only effective but also equitable, there is a need for these partnerships to have unambiguous, regulatory frameworks to ensure accountability, protect public interests, and harmonize private investment with national health priorities.

Community involvement is still indispensable for responsive and sustainable healthcare financing. Community-based health financing models can give communities control by enabling them to make decisions that relate to their demands for health and how these resources are allotted (Ogunleye & Odukoya, 2023). Public awareness campaigns should therefore be stepped up to inform the communities about the available services and to participate in local health initiatives. Incorporation of community feedback into planning processes will provide further assurance of contextually appropriate and socially-legitimate interventions.

Finally, strategic utilisation of technology has a great potential to lead to improvement in access and efficiency in the health system. Digital health realities such as telemedicine solutions and mobile health application can enable consultations via remote channels, proper information exchange and simplified payment systems (Nwankwo, 2022). Investment in digital infrastructure alongside training for healthcare workers is the solution surrounding these benefits, to maximise yet guarantee equity between geographic and socio-economic divides. Together, these avenues for reform present a consistent framework for the transformation of healthcare financing in Nigeria and a move towards universal health coverage in Nigeria.

Conclusion

A review of national healthcare financing in Nigeria shows that there are serious problems that are in need of urgent attention. Reforms in healthcare financing in Nigeria is important to resolve some of the challenges that have persisted in the sector. The NHIS has the potential to cover financial risk protection but needs more public outreach and infrastructure help. PPPs bear the chances of advancing healthcare delivery via the private sector but require good regulatory frameworks. Community-based health financing models are among the ways to empower local populations but they need to be incorporated into the national strategies for their sustainability. Addressing the challenges of Healthcare financing in Nigeria involves a multifaceted approach that involves increased government investment, expansion of health insurance coverage, leveraging public-private partnerships, better community engagement and usage of technology. By implementing these recommendations, Nigeria can create a more equitable and sustainable healthcare financing system that enhances access to quality care for all citizens.

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