TAPI – Desk Study

The Nigerian Healthcare System – Financing 2014-2019

Author: Dr. Jeremy Gaines, with assistance from Fatima Malumfashi, Dr. Samuel Omenka, Ngozi Oti, Abuja/Frankfurt
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"The health sector has suffered from chronic underfunding for many years now. We are even behind South Sudan, Angola, and Ethiopia."

Prof. Isaac Adewole (April,2016), at the time Minister of Health, Federal Republic of Nigeria

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Executive Summary

Can Nigeria realistically come good on its commitment to achieve the Sustainable Development Goal 3 to "Ensure healthy lives and promote wellbeing for all at all ages" in less than a decade's time? This study sets out to explore whether the Nigerian healthcare system receives financing such as could lay the basis for the country to meet that target. By way of introduction it outlines the components of SDG 3 and presents the main diseases affecting the Nigerian populace today.

In light of this, in Chapter 1 a discussion follows of the various international benchmarks for public, i.e. government, healthcare financing with regard to getting primary healthcare to the people. This elaboration starts specifically from the **famous Abuja Pledge in 2001 to spend 15% of each annual budget on healthcare** and contrasts this with other ratios such as expenditure to GDP or staffing ratios deemed crucial to being able to provide primary healthcare.

In a next step, in Chapter 2 these benchmarks are used to evaluate public healthcare expenditure in Nigeria since the years 2000 and in particular in the period 2015-2019. **The key findings are that public budgets have been far too small, indeed government healthcare expenditure has actually dropped in the 2015-2019 period. Moreover, healthcare in Nigeria today is mainly something accessible only to those who can privately afford it as an out-of-pocket expense**. For a large section of the population it is catastrophic health spending, meaning it constitutes more than 10% of their possible spending and that they therefore have to choose between healthcare or other necessities in life.

Chapter 3 outlines how heavily dependent the Nigerian healthcare system is on donors. It likewise pinpoints the **key inefficiencies** in the system that contribute to government health expenditure, meagre as it is, being misspent. Conversely, if spending was controlled properly, the scant resources would not be wasted.

Chapter 4 compares Nigeria with four peers: Ethiopia, Indonesia, Kenya and South Africa in terms of the international benchmarks Despite **Nigeria** being ahead of Ethiopia and Indonesia in terms of percentage of GDP committed to total health expenditure, it **is found to be far worse off as regards infant, under-5 and maternal mortality. The same applies to its death rates for malaria and tuberculosis.** The implication is that this bears out the inefficiencies identified in the prior chapter.

Chapter 5 concludes **that government expenditure on healthcare must be massively increased if it is to live up to its wish to provide primary healthcare to all the country's citizens as per SDG 3**.

Capital and operating expenditures need to be radically increased (infrastructure, drugs and medicines, human resources). Indeed, the original commitment to 15% of budget as stated

in the Abuja Pledge would be a minimum starting point in light of the number of years of 'negative' investment in healthcare when compared to population growth.

A general lack of political will to achieve SDG 3 is assumed to be the reason for this identified. The conclusion can only be that without clear political prioritization of healthcare, the status quo ante cannot be changed. To say that there is already a state of emergency in the Nigerian healthcare sector as regards financing is to understate the magnitude of the problem.

Chapter 6 cursorily outlines possible policy recommendations. Precisely because primary healthcare delivery is something that has to be incrementally implemented and financed until a certain standard is achieved (e.g., to cover minimum staffing requirements and minimum medicine provision for specified illnesses/diseases) **prioritization should be attached to achieving such targets as fast as possible rather than stoically upholding formula**. At the same time **policymakers much also ensure that there is a consistent focus on allocative efficiencies and avoid any misalignment of state and federal healthcare policies. In this regard, given the structure of healthcare financing (and the argument could be extended to the education sector, too) and its fundamental necessity for any prosperity in society, legislation and/or an audit agency is required to adjudicate such issues of alignment and expenditure shortfalls in order to monitor and sanction under-performance in the sector.**

Introduction

The Federal Republic of Nigeria is committed to trying to achieve the Sustainable Development Goals, having signed up to them in 2015 along with all other UN member states. The SDG trajectory is to attain the goals by the year 2030, meaning in less than a decade's time, or, in terms of legislative periods, by the end of two further terms of office.

SDG 3 is the commitment to "Ensure healthy lives and promote wellbeing for all at all ages."

Under this heading, SDG 3 sets specific health targets. They are as follows

3.1 By 2030, reduce the global maternal mortality ratio to less than 70 per 100 000 live births.

3.2 By 2030, end preventable deaths of newborns and children under 5 years of age, with all countries aiming to reduce neonatal mortality to at least as low as 12 per 1000 live births and under-5 mortality to at least as low as 25 per 1000 live births.

3.3 By 2030, end the epidemics of AIDS, tuberculosis, malaria and neglected tropical diseases and combat hepatitis, water-borne diseases and other communicable diseases.

3.4 By 2030, reduce by one third premature mortality from non-communicable diseases through prevention and treatment and promote mental health and well-being.

3.5 Strengthen the prevention and treatment of substance abuse, including narcotic drug abuse and harmful use of alcohol.

3.6 By 2020, halve the number of global deaths and injuries from road traffic accidents.

3.7 By 2030, ensure universal access to sexual and reproductive health-care services, including for family planning, information and education, and the integration of reproductive health into national strategies and programmes.

3.8 Achieve universal health coverage, including financial risk protection, access to quality essential health-care services and access to safe, effective, quality and affordable essential medicines and vaccines for all.

3.9 By 2030, substantially reduce the number of deaths and illnesses from hazardous chemicals and air, water and soil pollution and contamination.

3.a Strengthen the implementation of the WHO Framework Convention on Tobacco Control in all countries, as appropriate.

3.b Support the research and development of vaccines and medicines for the communicable and non-communicable diseases that primarily affect developing countries, provide access to affordable essential medicines and vaccines, in accordance with the Doha Declaration on the TRIPS Agreement and Public Health, which affirms the right of developing countries to use to the full the provisions in the Agreement on Trade-Related Aspects of Intellectual Property Rights regarding flexibilities to protect public health, and, in particular, provide access to medicines for all.

3.c Substantially increase health financing and the recruitment, development, training and retention of the health workforce in developing countries, especially in least developed countries and small island developing States.

3.d Strengthen the capacity of all countries, in particular developing countries, for early warning, risk reduction and management of national and global health risks."

This desk study will focus on government expenditure levels, budgets, and budget releases in relation to achieving targets 3.1-3.4 and 3.7-3.8. The question it will explore is what level "as is" expenditure has reached and how that stands in relation to international benchmarks and recommendations for achieving said SDG 3 targets. As-is expenditure will also be compared to what donors provide and the out-of-pocket contributions to health to offer a better understanding of the ratios. The budgetary figures will then be compared to a selected peer group of three African and one Asian country. A brief discussion will follow on systemic inefficiencies and accountability within the health system, as such leakages impact on the actual 'value for money' the government gets for the budgetary outlays, particularly in light of Nigeria's complex federal system, whereby the federal government, the state governments, the LGAs and the wards are all involved in various ways in rolling out healthcare.

Key diseases causing fatalities:

Before outlining government expenditures, it bears remembering what the main causes of death owing to disease are in Nigeria as this also helps in evaluating what challenges the primary healthcare system faces every day.

*Noncommunicable Diseases (NCDs)*WHO estimates that 29% of fatalities in Nigeria owing to disease can be attributed to NCDs. It puts the number of deaths for 2016 at 617,300.[1] The baseline for the population was assumed to be 186 million, so the number of deaths was 0.3% of the population.

Malaria

"According to the latest WHO data published in 2017 Malaria Deaths in Nigeria reached 112,371 or 5.53% of total deaths. The age adjusted Death Rate is 35.87 per 100,000 of population ranks Nigeria #25 in the world."[1] Firstly, what the figure does not, of course reveal, is the number of working hours lost to people suffering from malaria. Secondly, as is evidenced by the World Malaria Report 2018, the following table serves to illustrate pertinently the discrepancy between hard data gathered and the possible reality (indicated here are 'estimated cases':

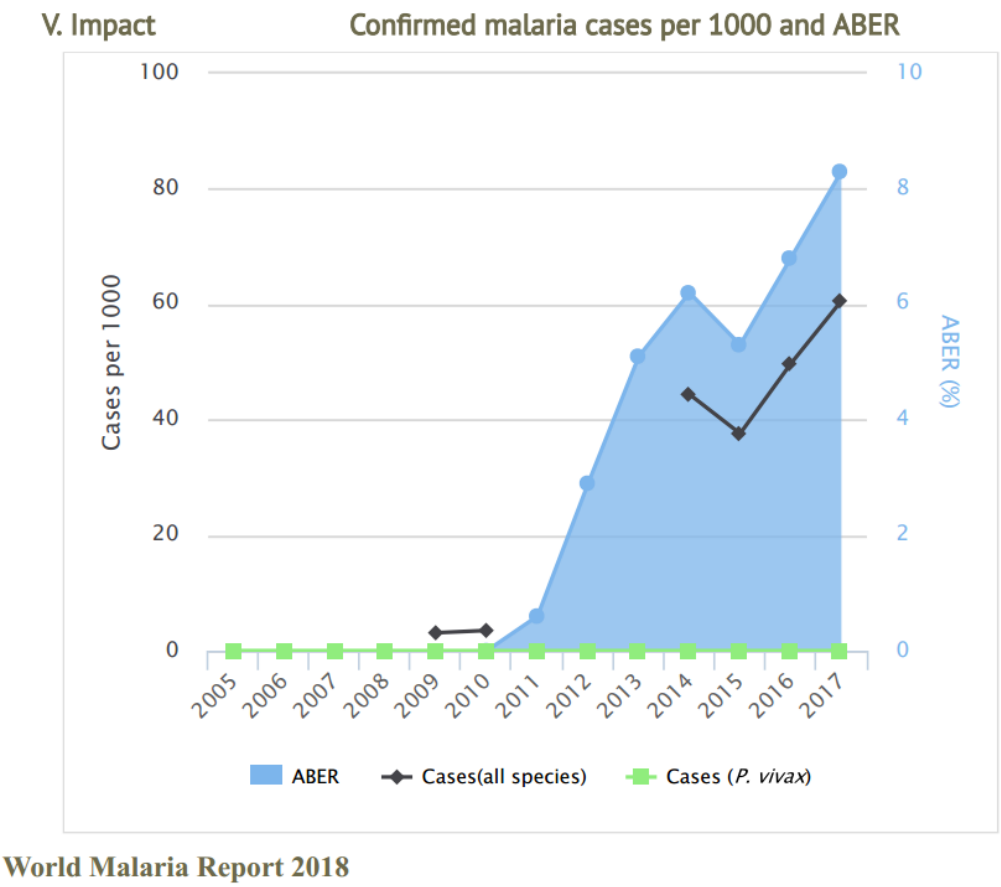
Fig. 1: Malaria - epidemiological profile

Reported confirmed cases (health facility)	11,571,958	Estimated cases	53.7m (36.3m, 75.9m)
Confirmed cases at community level	67,755		
Confirmed cases from private sector	1,448,165		
Reported deaths		Estimated deaths	79.8k (62.5k, 97k)

[1] World Health Organization: Noncommunicable Diseases (NCD) Country Profiles, (2018).

As can be seen from the figure below, the more tests are done, the higher the number of cases reported:

Fig. 2: Malaria incidence and annual blood examination rates



Tuberculosis

"According to the latest WHO data published in 2017 Tuberculosis Deaths in Nigeria reached 175,124 or 8.62% of total deaths. The age adjusted Death Rate is 190.61 per 100,000 of population ranks Nigeria #1 in the world."[2] This compares with a situation seven years earlier, when Nigeria ranked 10th amongst the 22 high-burden countries. The WHO estimate for 2010 was a total of 210,000 new cases of all types of tuberculosis, which translates into 133 cases per 100,000 members of the population. The WHO statistics also state that in 2010 there were "an estimated 320,000 prevalent cases of TB in 2010, equivalent to 199/100,000 cases."[3]

Pneumonia / Paediatric Pneumonia

UNICEF reports that as regards mortality rates for pneumonia "Nigerian children made up the highest number of those who died, with an estimated 162,000 deaths in 2018 – 443 deaths per day, or 18 every hour. In Nigeria, 19% of child deaths were due to pneumonia in 2018, and it was the biggest killer of children under-five in 2017… The biggest risk factors for child pneumonia deaths in Nigeria are malnutrition, indoor air pollution from use of solid fuels, and outdoor air pollution."[4] The 2017 statistics reveal that in Nigeria over 300,000 or 15% of persons died of influenza and pneumonia, the second highest level in the world.[5]

HIV/AIDS

The WHO data for 2017 report "HIV/AIDS Deaths in Nigeria reached 168,900 or 8.31% of total deaths. The age adjusted death rate is 120.00 per 100,000 of population ranks Nigeria #18 in the world."[6]

Meningitis

While meningitis tends to be confined to specific areas of the country, its impact on overall health is not insignificant. According to the same WHO database, meningitis deaths in Nigeria for 2017 ran at 58,231 thus accounting for 2.87% of total deaths. The age adjusted death rate is 29.56 per 100,000 of population, which means that Nigeria actually placed 6th in the world rankings for such deaths.[7]

Diarrhoeal diseases

While typically the international focus is on outbreaks of cholera[8] and typhoid, in fact the prevalence of fatalities attributable to diarrhoeal diseases as a whole is often overlooked. In this regard, the 2017 figure for Nigeria was no less than 186,218 or 9.16% of total deaths. Given an age-adjusted death rate of 127.79 per 100,000, Nigeria places fourth in the world severity tables.[9]

With the exception of NCDs, the above figures can be roughly divided into two types: firstly, diseases where preventative measures and early warning systems are required (malaria, HIV/AIDS); secondly, diseases where swift diagnosis and medication are critical (diarrhoeal diseases, meningitis, paediatric pneumonia, tuberculosis). In other words, any healthcare system wishing to square up to the two challenges needs to be close /easily accessible to potential patients and have the requisite laboratory resources equally at hand.

1International Benchmarks – the Abuja Pledge and thereafter – How to judge whether we are spending enough…

The Abuja Pledge

"The NSHDP II builds upon the successes and challenges of NSHDP I which was implemented over the past six years. Some of the challenges identified in the NSHDP I end term evaluation and which have been considered in NSHDP II include: gaps in political will 1and poor programme ownership at lower levels especially state and LGA levels; weak donor coordination and harmonisation of development and technical assistance; low level of government financing of healthcare at the three levels of government; weak M&E systems to

monitor implementation of the state Strategic Health Development Plans and weak Primary Health Care structures."[10]

The detailed cost analysis in NSHDP II puts, for its moderate scenario, the cost per capita for delivery of the respective system at US$ 34 (baseline: US$ 24, aggressive, US$ 41), whereby the exchange rate assumed was US$1 = N 305.

These figures need to be put in the context of what the Federal government had pledged to do. In the declaration issued by the Heads of State and Government of the Organisation of African Unity (OAU) at the end of the AFRICAN SUMMIT ON HIV/AIDS, TUBERCULOSIS AND OTHER RELATED INFECTIOUS DISEASES in Abuja on 26-27 APRIL 2001, the governments pledged in section 26. "WE PLEDGE to set a target of allocating at least 15% of our annual budget to the improvement of the health sector. WE ALSO PLEDGE to make available the necessary resources for the improvement of the comprehensive multi-sectoral response, and that an appropriate and adequate portion of this amount is put at the disposal of the National Commissions/Councils for the fight against HIV/AIDS, Tuberculosis and Other Related Infectious Diseases."[11]

The pledge of 15% of the budget has not been kept. The current revised 2020 budget is for ₦10.5 trillion, on which terms the health-sector budget would need to be ₦1.575 trillion or ₦7,875 per capita (assuming a baseline population of 200 million), or US$ 21.57 (US$ 1 = ₦365). In other words, achieving the baseline scenario in the National Strategic Health Development Plan would already require a budget allocation and disbursement of over 15% of the total budget.

It bears stating in this context that the above figures ignore the contribution the 36 states and the FCT must themselves make from their own budgetary allocations. Since the states consistently eschew releasing breakdowns of their budgetary spending it is unclear what if anything they commit to healthcare. While they release a chunk of almost one half of the revenue from oil, just how that then translates into recurrent expenditure on healthcare let alone capital expenditure can simply not be said.

Other benchmarks

Another way of putting spending into perspective is to look at critical yardsticks other than allocations as a percentage of budget in order to evaluate healthcare system adequacy, performance, and sustainability. One such parameter is staffing levels per head of population, another is healthcare spending as a percentage of GDP. [12]

Before going into both we need to distinguish here between what the healthcare system is intended to do: Is it intended to provide universal health coverage for the populace or is it expected to deliver primary healthcare. The distinction is crucial as the related inputs and infrastructure are different.

Universal health coverage is a broad term that encompasses any action that a government takes to provide health care to as many people as possible. Some governments do this by setting minimum standards and regulations and some by implementing programs that cover the entire population. The ultimate goal in all cases is health coverage for all citizens.[13] Universal health coverage (UHC) means that all people and communities can use the promotive, preventive, curative, rehabilitative

and palliative health services they need, of sufficient quality to be effective, while also ensuring that the use of these services does not expose the user to financial hardship.

This definition of UHC embodies three related objectives:

1. Equity in access to health services - everyone who needs services should get them, not only those who can pay for them;

2. The quality of health services should be good enough to improve the health of those receiving services; and

3. People should be protected against financial-risk, ensuring that the cost of using services does not put people at risk of financial harm.

UHC is firmly based on the WHO constitution of 1948 declaring health a fundamental human right and on the Health for All agenda set by the Alma Ata declaration in 1978. UHC cuts across all of the health-related Sustainable Development Goals (SDGs) and brings hope of better health and protection for the world's poorest.[14]

By contrast, primary healthcare (PHC) is a whole-of-society approach to health and well-being centred on the needs and preferences of individuals, families and communities. It addresses the broader determinants of health and focuses on the comprehensive and interrelated aspects of physical, mental and social health and wellbeing. It provides whole-person care for health needs throughout the lifespan, not just for a set of specific diseases. Primary healthcare ensures people receive comprehensive care - ranging from promotion and prevention to treatment, rehabilitation and palliative care - as close as feasible to people's everyday environment.

Primary health-care is rooted in a commitment to social justice and equity and in the recognition of the fundamental right to the highest attainable standard of health, as echoed in Article 25 of the Universal Declaration on Human Rights: "Everyone has the right to a standard of living adequate for the health and wellbeing of himself and of his family, including food, clothing, housing and medical care and necessary social services […]".

WHO has developed a cohesive definition based on three components:

- meeting people's health needs through **comprehensive promotive, protective, preventive, curative, rehabilitative, and palliative care throughout the life course**, **strategically prioritizing key health care services aimed at individuals and families through primary care and the population through public health functions as the central elements of integrated health services**;

- systematically addressing the broader determinants of health (including social, economic, environmental, as well as people's characteristics and behaviours) through evidence-informed public policies and actions across all sectors; and

- empowering individuals, families, and communities to optimize their health, as advocates for policies that promote and protect health and well-being, as co-developers of health and social services, and as self-carers and care-givers to others.[15]

We shall below focus specifically on the highlighted section of the first part of the definition. The figures below thus relate to payroll etc. related to the provision of PHC thus understood.

The question to be asked is: Is the country spending enough on primary healthcare? There are four possible ways of measuring this:

- The peer pressure approach asks "how much should we spend *if we want to be more like our peers*?".
- The political economy approach asks "how much *would we be spending on health if the budget process were not unduly influenced by particular social actors*?"
- The production function approach asks "how much should we *spend in order to attain a specified change in health outcomes*?".
- The budgeting approach asks "how much should we spend *once we've identified what we need to buy*?".[16]

Below we will combine the first and the last approaches. The last will be defined in terms of WHO recommendations for basic PHC infrastructure. We shall therefore exclude the issue of the effectiveness with which public expenditure is used, i.e., how efficiently the resources lead to improved health outcomes. However, let us first look at what we should hope to have for our money.

What payroll is needed in order to provide primary healthcare?

WHO has set clear guidelines as regard staffing numbers for primary healthcare: It expects a total of 44.5 health staff per 10,000 capita.

At present, statistics suggest there is one doctor per every 5,000 persons as opposed to the 1 per 500 WHO recommends. Statistics on the number or registered doctors in Nigeria (approx. 73,000) are misleading, as purportedly as many as half of them practice outside the country.[17] WHO statistics for 2018 suggest there are 3.8 doctors per 10,000 members of the population and 11.7 nurses and midwifes. In terms of actual numbers, the WHO statistics show despite marginal improvement between 2013 and 2016, the growth between 2003 and 2018 for nurses and midwives has not been positive, but negative. While the number of doctors has doubled over that period, assuming that half of them work abroad, the figure has in fact stagnated.

Fig. 3 Numbers of doctors in Nigeria

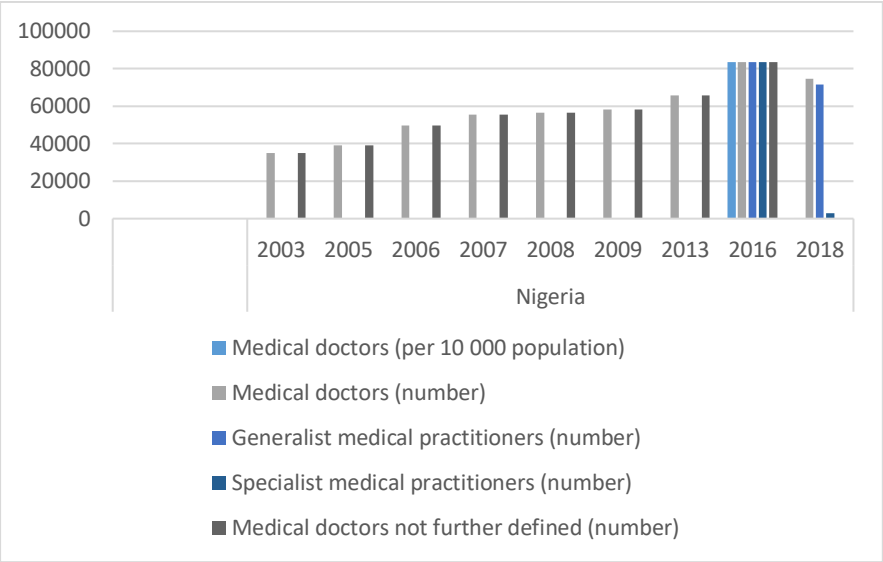
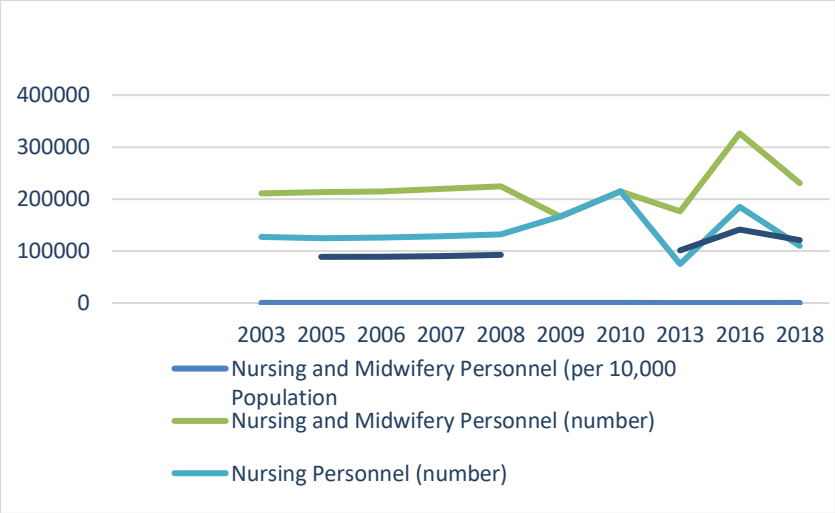


Fig. 4 Numbers of nurses and midwives in Nigeria



To summarize, WHO's studies reveal that in Nigeria the growth rate in staff has flatlined since 2004. This is consistent with the findings by Pozo et al, which put the average exponential growth rate for SHP (skilled health professionals) at between -1% and +1%.

Fig. 5 Average exponential growth rate (AEGR) in numbers of physicians, nurses and midwives per 10,000 population[18]

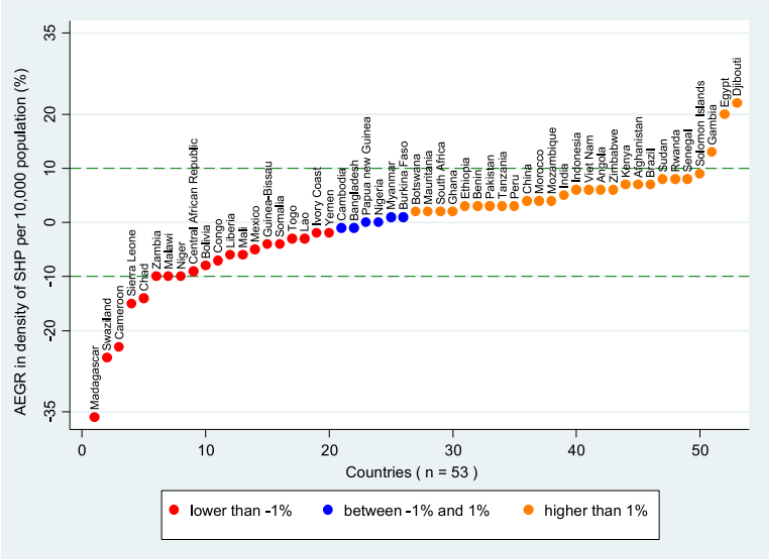


Fig. 7 Average exponential growth rate (AEGR) in number of physicians, nurses and midwives per 10 000 population for 53 Countdown countries with more than one data point between 2004 and the latest available year

The same study puts the annual growth rate currently required by Nigeria to meet the WHO target 2030 at 7.5%.

In other words, in absolute terms there are nowhere near enough doctors, midwifes or nurses in Nigeria to provide PHC at the level WHO recommends. If we assume approx. 14 healthcare staff per 10,000 people, then the figure is only a third of what the guideline says it should be.

How much should countries spend on primary healthcare?

Jowett et al in their WHO health financing working paper suggest that the best yardstick to take when determining how much a country should spend on healthcare is that of healthcare as a percentage not of the budget, but of GDP. Indeed, this is apposite for our case because, as we have seen above, we simply do not know how much the federal states spend on healthcare,

Jowett et al state:

> "This indicator captures both the priority given to health in budget allocations, as well as the fiscal context i.e. how large government is relative to the economy, measured in terms of "total public spending as % of GDP. The World Health Report 2010 noted that "...it is 'difficult to get close to universal health coverage at less than 4–5% of GDP."[19]

Jowett et al continue:

> "Evidence shows that for countries to make progress towards UHC their health system needs to rely predominantly on public revenue sources. By public, we mean those revenue sources which are prepaid, mandatory and pooled; this includes for example both government budgetary allocations as well as

mandatory contributions to health insurance schemes, typically in the form of payroll taxes."[20]

Let us take a step back in time to the mid-2000s, to be precise to 2006-9 period, as health expenditure statistics are available for this period: During that time Total Health expenditure (THE) rose from ₦ 1,163,009 million in 2006, to ₦ 1,679,439 million or by 44.4%. For the four years, as a % of GDP, THE came to 6.16%, 6.29%, 6.27%, and 6.76% respectively, all good figures and above the 4-5 percent bracket WHO recommends. However, these figures come with a caveat, as the financing was by no means "predominantly" from "public revenue sources" as called for above. Firstly, as proportion of the government expenditure, outlays for public health actually fell over the period from 6.28% to 5.18% - while per capita spending on health rose from ₦ 8,113.7 (US$64), to ₦ 8,814.9 (US$71.1/2007), and then ₦ 10,128.3 (US$86.6/2008) before dipping to ₦ 10,871 (US$74) in 2009 respectively.[21] In other words, the performance was driven not by government spending, but by private spending, exactly the opposite of what WHO calls for. We shall return to this below.

2 Current Indicators & Budgets

In light of the above benchmarks for metrics, the first set of statistics to consult to assess Nigerian government healthcare expenditure is the absolute figures for Federal budget allocations and then to distinguish between payroll costs and capital costs.

Fig 6 Healthcare budgets – the last five years[22]

Year	MoH		
	Recurrent	**Capital**	**Total**
2014	214.943.830.225	49.517.380.725	**264.461.210.950**
2015	237.075.742.847	22.676.000.000	**259.751.742.847**
2016	221.412.548.087	28.650.342.987	**250.062.891.074**
2017	252.854.396.662	55.609.880.120	**308.464.276.782**
2018	269.965.117.887	86.485.848.198	**356.450.966.085**
2019	315.617.344.056	57.085.655.234	**372.702.999.290**

However, these overall figures do not tell the entire story, as the actual budget releases for capital expenditure that were cash-backed were nowhere near as high. For simplicity's sake, we have excluded allocations to NPHCDA and NHIS because they together formed a negligible ratio of the whole of less than ten percent.

Fig 7 Breakdown of budget releases for capital expenditure [23]

Year	Recurrent	Capital		Capital Variance	
	Budget	Budget	Releases		
	(a)	(b)	(c)	(c) - (d)	%
2014	214,943,830,225	49,517,380,725	20,472,722,764	(29,044,657,961)	-58.7%
2015	237,075,742,847	22,676,000,000	16,445,053,729	(6,230,946,271)	-27.5%
2016	221,412,548,087	28,650,342,987	28,592,592,446	(57,750,541)	-0.2%
2017	252,854,396,662	55,609,880,120	46,827,448,599	(8,782,431,521)	-15.8%
2018	269,965,117,887	86,485,848,198	55,227,915,501	(31,257,932,697)	-36.1%
2019	315,617,344,056	57,085,655,234	24,086,508,094	(32,999,147,140)	-57.8%

If we assume a 100% performance for recurrent expenditures as actual recurrent releases always trail the budget, and focus on the 2014-2019 time series, we see that only in 2016 was the budget released anything near the figure actually budgeted. ₦ 191.65 billion released for capital expenditure over the six year period, or on average ₦ 31.94 billion and an average population of some 175 million (starting at 161.5 million in 2014 and rising to 190 million in 2019), then capital expenditure per capita per annum for the period was a mere ₦ 182.49.

Moreover, we need also to factor in population growth and inflation in order to get a comparable picture of what the *real* budget figure was. The National Bureau of Statistics (NBS) database gives average year-on-year inflation rates as follows: 2014: 8.0%; 2015: 9.0%; 2016: 15.62%; 2017: 16.55%; 2018: 12.15% and 2019:11.39. The difference between the MoH budgets for 2014 and 2019 is 40.9% in nominal terms. Discounting for the average inflation figure of 11.39% for 2019 implies that actual government expenditure for health dropped by 0.4% in real terms. For the purposes of argument, if we assume population growth of 3% p.a., population growth over the 2014-2019 period was 15.9% then health expenditure per capita in real terms amounted to N1,407 down from N1,638 in 2014. In other words, in real terms government health expenditure per capital fell per capita by 14.1% in 2019 when compared to 2014.

Fig 8: FGN Health expenditure in relation to GDP and FGN Revenue 2014-19 (in ₦ b)[24]

	FGN Revenue	GDP	Health / FGN Rev	Health / GDP
2014	3,731.00	48,066.29	7.6%	0.6%
2015	3,452.35	95,843.16	7.9%	0.3%
2016	3,855.74	102,921.72	7.0%	0.3%
2017	5,084.40	107,958.33	6.6%	0.3%
2018	7,165.87	113,088.88	6.2%	0.4%
2019	6,967.00	139,811.509	6.7%	0.3%

The figures fall far short of the benchmarks discussed above of 15% budget allocations (Abuja Declaration) and 4-5% of GDP (the WHO recommendation to achieve universal health coverage). Indeed, just how skewed the Federal budget now is revealed by a recent discussion of debt servicing

in the publication Quartz Africa, which pointed out that It perhaps bears stating here that Nigeria is at present spending three times its healthcare expenditure on debt servicing.[25]

The 2018 World Bank assessment of Federal government health financing is even more drastic in the picture it paints.

> **"Low government health spending over the last two decades has limited the expansion of highly cost-effective interventions, stunting health outcomes and exposing large shares of the population to catastrophic health expenditures.** Nigeria spends less on health than nearly every country in the world. … Funding for primary health care is especially affected as the bulk of spending occurs at the central level and is focused on tertiary and secondary hospitals. Coverage of promotive, preventive, and primary health care interventions is low with the universal health service coverage index – defined as the average coverage of tracer interventions for essential universal health coverage – at just 39 percent."

The author of the assessment goes on to conclude that:

> "As a result, Nigeria significantly underperforms on key health outcomes. Maternal mortality at 576 deaths per 100,000 live births is one of the highest in the world (2.6 times the global average); one in eight children die before reaching their fifth birthday; and 25 percent of households spend more than 10 percent of their household consumption on health. **Raising additional resources for health will be challenging…"[26]**

As alluded to above, on an international comparison, the figures for Federal government health spending are very poor, falling well short of regional and lower middle-income averages, and coming nowhere near the recommended US$ 86 per capita mark suggested for low and middle-income countries if they are to be able to provide a basic set of health services.[27] Moreover, WHO finds that "low and lower middle income countries that fund primary health care through government revenues tend to have better service coverage."[28]

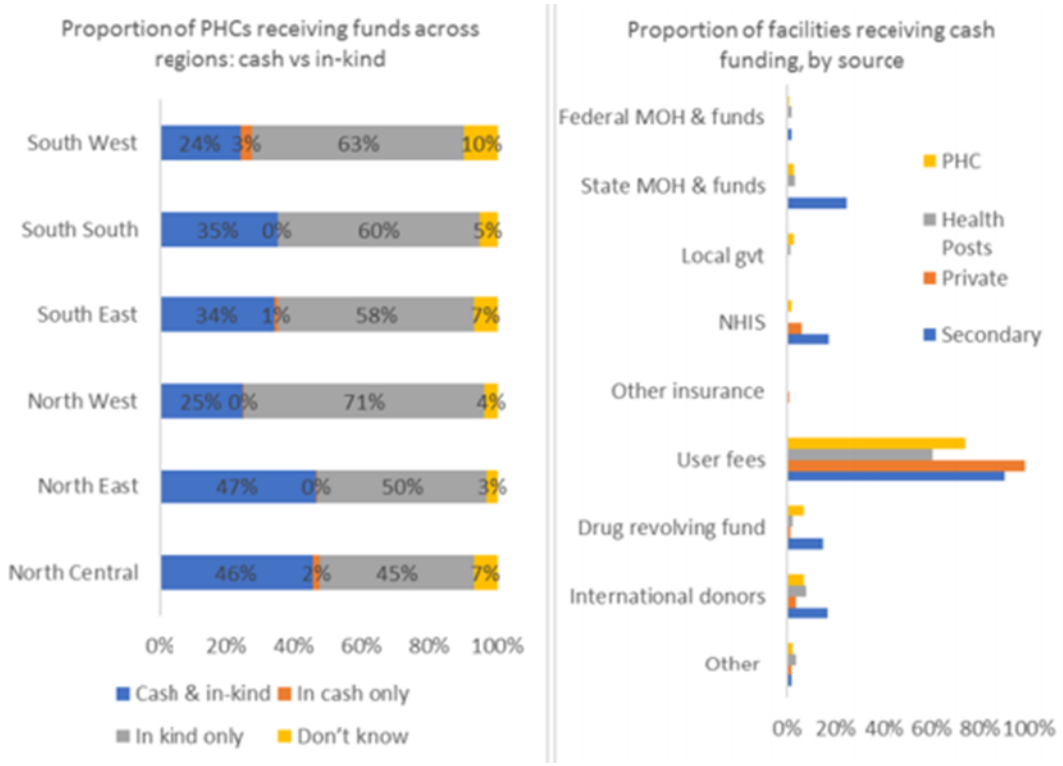
It bears noting two things in passing here. Firstly, as we shall see in the next chapter, a substantial portion of the primary healthcare services rely on donor funding to even exist. Secondly, as GDP increased as of the 2014 recession, government health spending did not. Moreover, scholars state that there is no necessary correlation that higher per capita incomes spell improved health outcomes (as income gaps often become more pronounced at the same time). In other words, even if GDP grew we cannot assume this spelled people having more disposable income to pay for healthcare services themselves. Indeed, other factors then come into play, such as the rural/urban divide. While the rural population remains largely unaffected by the establishment of primary healthcare centres, the urban population tends to benefit. Given a rural/urban split in Nigeria of approx. 50:50, health outcomes for around half the population would not be improved by greater government spending on primary health care in the current system.[29]

As can be seen from the above Fig. 6, rarely is more than a sixth of the budgetary allocation to the Federal Ministry of Health assigned for capital expenditure and only once in the six-year period discussed here was the actual budgetary allocation actually a cash-backed release. The vast majority

of the allocation is for recurrent payments, in other words for payroll and running costs for buildings. It therefore comes as no surprise that the World Bank states:

> **Primary health centres receive little to no operating budget.** Primary health centres are meant to receive cash and in-kind support through the various fund flow arrangements ... However, the 2016 National Health Facility Survey (NHFS) confirmed that on average providers received salaries with a two-to-three-month delay and only a third of facilities received any form of cash grants to meet their operational costs. If PHCs did receive cash support, the predominant sources were user fees (even for services that the National Health Act say should be free – that is, the BMPHS), drug revolving funds, and donors. Overall, 74 percent of PHCs reported charging user fees predominantly for drugs, delivery services, and antenatal care. In-kind support was provided predominantly by local government and international donors and consisted mostly of drugs (that is, vaccines) and medical records/forms.[30]

Fig 9 Healthcare financing at the frontline point of use[31]



The World Bank findings are consistent with an evaluation of total healthcare expenditure compared to government expenditure. While we have outlined Federal government budgetary allocations, we have not yet factored in the amount contributed by state governments. The chart on the above right indicates that state and local government cash allocations to primary healthcare centres is in fact far

lower than that to secondary healthcare facilities (e.g. hospitals). The paucity of state and LGA allocations overall is highlighted in a BudgIT policy brief on the healthcare sector, which states:

> "In 2018, the 36 state governments plan to spend N9.15tn, up from 2017 figures of N6.75tn. Two years prior, total health-related budgetary allocations by approximately 22 states was N343.28bn (in 2016). In 2017, the health budget of the 36 states was a little above N332.1bn, which was about 4.9% of total budget size, notably short of the "Abuja conference" target, where African Union countries pledged to set a target of allocating at least 15% of their annual budget to improve the health sector - and requested support from donors."[32]

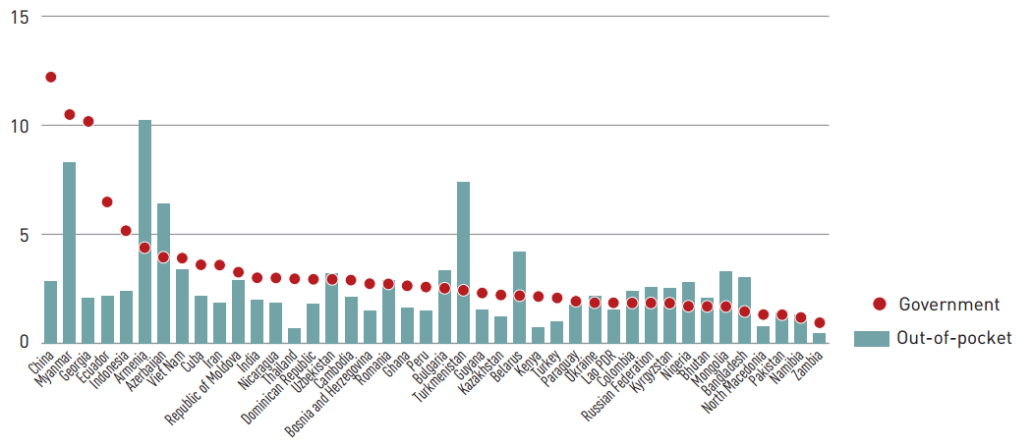
Put differently, and in line with the above-mentioned 'user fees', we can safely assume that the bulk of money spent on primary, secondary and private healthcare is – private, i.e., is an out-of-pocket (OOP) item. If we go back in time to figures released by the FGN itself and available for the 2006-2009 period, we find clear evidence of this trend back then.

Fig. 10 Healthcare spending as a % of GDP and of the Budget, 2006-9[33]

Indicator	2006	2007	2008	2009
GDP at Current Prices (NGN Millions)	18,868,694.17	20,605,601.31	24,333,760.78	24,859,731.35
Total Government Expenditures (NGN Millions)	3,530,302	4,464,670	6,186,062	6,057,772
Total Health Expenditure (THE) (NGN Millions)	1,163,009	1,295,361	1,525,982	1,679,439
PUBLIC (NGN Millions)	221,837	254,127	334,392	313,748
DONORS (NGN Millions)	40,484	52,628	73,424	120,655
PRIVATE SOURCES (NGN Millions)	900,688	988,606	1,118,167	1,245,037
HOUSEHOLD (NGN Millions)	858,863	915,173	1,052,941	1,180,808
PRIVATE (NGN Millions)	41,826	73,433	65,226	64,229
Population	143,338,939	146,951,477	150,665,730	154,488,072
Per Capita Spending on Health (NGN)	8,113.70	8,814.90	10,128.30	10,871.00
Per Capita Spending on Health (US$)	64	71	87	74
Health Expenditure, Public (% of government expenditure)	6.28%	5.69%	5.41%	5.18%
Health Expenditure, Public (% of total health expenditure)	19.07%	19.62%	21.91%	18.68%
Health Expenditure, Private (% of total health expenditure)	77.44%	76.32%	73.28%	74.13%
Out-of-Pocket Health Expenditure (% private expenditure on health)	95.36%	92.57%	94.17%	94.84%
Out-of-Pocket Health Expenditure (% total expenditure on health)	73.85%	70.65%	69.00%	70.31%
External Resources for Health (% of total expenditure on health)	3.50%	4.10%	4.80%	7.20%
External Resources for Health (% of GDP)	0.21%	0.26%	0.30%	0.49%
THE as a % of GDP	6.16%	6.29%	6.27%	6.76%
Health Expenditure, Private including HH (% of GDP)	4.77%	4.80%	4.60%	5.01%
Health Expenditure, Household (% of GDP)	4.55%	4.44%	4.33%	4.75%
Health Expenditure Public (% of GDP)	1.18%	1.23%	1.37%	1.26%

According to the World Development Indicators (WDI, 2020), out-of-pocket expenditure as a percentage of health expenditure was 77% in 2010. It declined to 71% in 2013 before rising to again to 77% in 2017. This observation is not a new phenomenon as data from Nigeria's National Health Accounts (Table 10) shows that out-of-pocket payments for health averaged 70% of health expenditure between 2006 and 2009. This suggests that little or no progress have been made in the 2006-2009 period toward providing universal health coverage. These facts are worrisome especially when one considers the position of health expenditure in the overall household expenditure. Recent estimates show that after food, which takes up to 57% of households consumption budget, transport, health and education (three essential public goods) top household spending. Thus, Unfortunately, the statistics above do not give the figure for out-of-pocket expenditure as a percentage of total private household spending.[34] This is unfortunate, as the metric this would provide would indicate whether private households in Nigeria are forced on average to choose between spending on health and spending on other necessities. [35]

Fig. 11 Cumulative per capita growth in government and out-of-pocket spending from 2000 to 2017 in %[36]



As the chart indicates, growth in per capita out-of-pocket expenditure has outpaced growth in government expenditure in the 200-2017 period. In other words, the proportion of THE accounted for by OOP per member of the population has risen consistently over time, with all the social consequences this has. It comes as no surprise that BudgIT concludes:

> "Out-of-pocket payments dominate in Nigeria, accounting for almost 71.7% of total health spending in 2014. Given that out-of-pocket health expenditure is the biggest proportion of private health-related spending, the working poor and the have-nots suffer more." [37]

Own calculations show that the trend thus mooted by BudgIT has not only not changed, in fact the opposite is the case: it has gained momentum. A glance at the figures for the period covered in this study from 2014-2019 reveals the following:

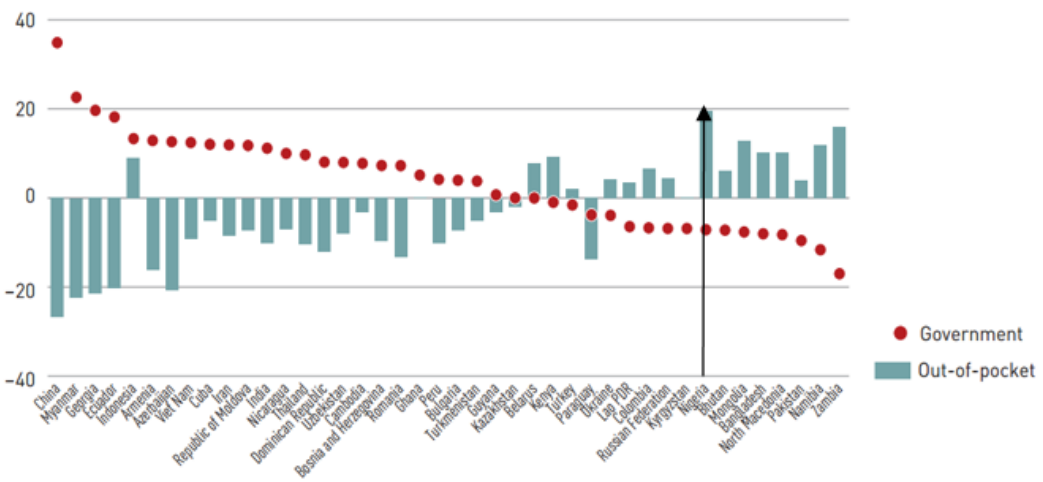
Fig. 12 Comparison of total expenditure on health by donors, states, LGAs, with OOP expenses[38]

Year	Donor	Out-of-Pocket	States	Local Government
Figs in ₦b				
2014	410.4	2,168.7	163.8	42.8
2015	338.1	2,451.1	214.4	41.3
2016	385.4	2,813.4	143.4	39.9

While OOP expenditure compared to combined spending by the states and LGAs (S&LGAs) for 2015 was ₦ 2,451.1 billion to ₦ 255.7 billion; in other words, total S&LGA expenditure came to a mere 10.43% of OOP. In 2016, the comparable figures were ₦ 2,813.4 and ₦ 183.3 billion respectively, meaning that S&LGAs expenditure now amounted to only 6.51%, and the relationship was clearly skewed even further toward OOP healthcare spending. If we include the MoH budget alongside the S&LGA outlays, then total public-sector expenditure for 2015 would be ₦ 515.45bn and for 2016 ₦ 433.36 billion respectively; the two figures amount to 21.03% and 15.4% of the respective OOP expenses. The ratios are therefore nevertheless still out of balance, especially as the figures do not factor in donor spending, which as we shall see in the next chapter is heavily weighted toward primary healthcare provision. The only conclusion is that out of pocket expenses shore up healthcare, not government spending.

If we take a longer view than that possible on the basis of our own statistical series, the picture is no better. The WHO report on health in transition calculates the time series from 2000 to 2017, and shows a gap ever widening, because while government expenditure has fallen, OOP spending has increased.

Fig. 13 Changes in government and out-of-pocket spending 2000 – 2017 in %[39]



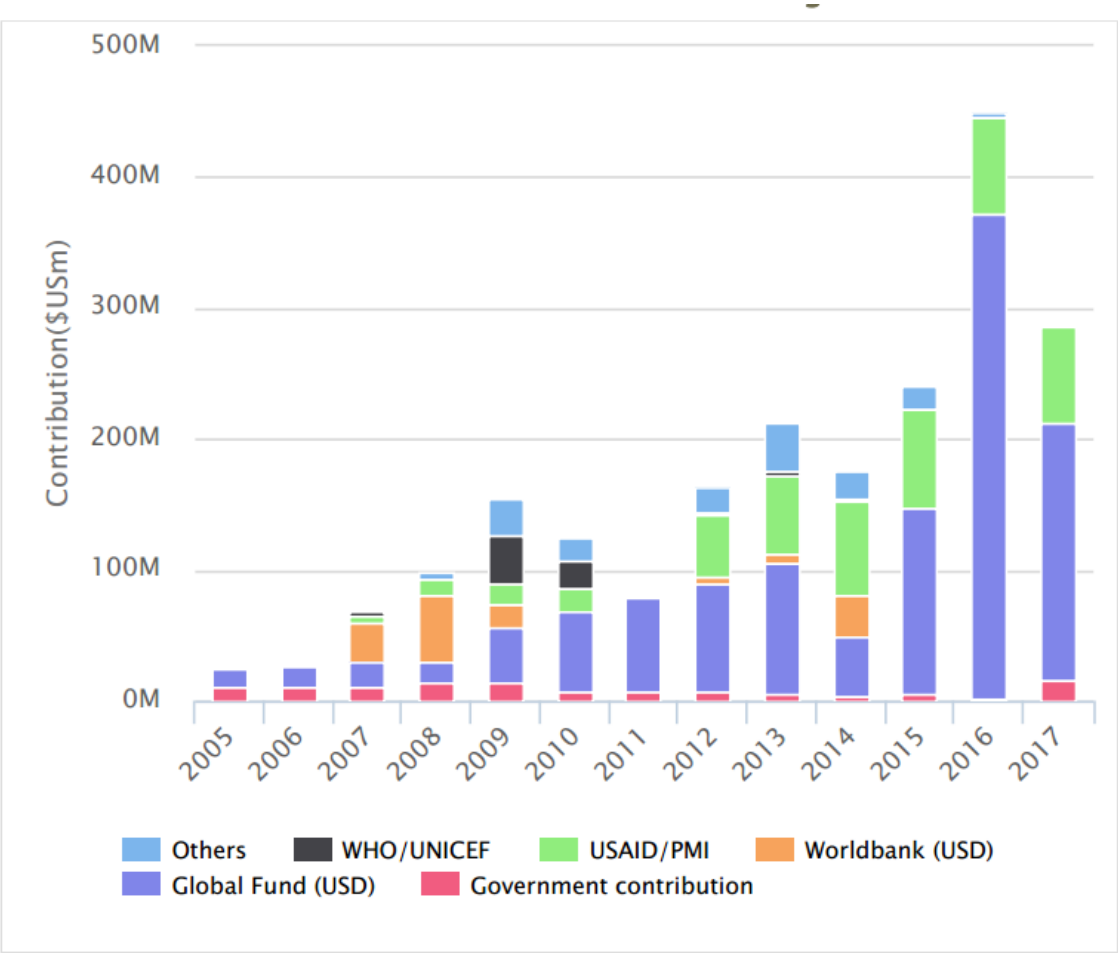
As the chart shows quite clearly, while out-of-pocket spending has increased by almost 20% over the period reviewed, government spending fell by closer to 7.5%. This is doubly disturbing as the 2000-2017 period saw government revenues surge in 2009 and 2011 without this leading to any rise in healthcare expenditure. In other words, the low ratio can only be the result of a conscious policy choice.

3 Donors and System Inefficiencies

Donors

In 2017, a full fifth of all donor funding for healthcare went to four countries alone, namely India, Kenya, Nigeria and Uganda. In the three immediate preceding years, the picture for Nigeria was as follows: Federal budget allocations for 2014-6 were ₦ 264, ₦ 259 and ₦ 250 billion respectively (again excluding NPHCDA and NHIS allocations). The donor funding provided was ₦ 410.4, ₦ 338.1 and ₦ 385.4 billion respectively. Put differently, the Federal Republic of Nigeria relied more on donors than on itself when it came to providing healthcare for the populace, with all the attendant impacts on lost labour time, greater poverty, etc.

Fig 14 Sources of financing for combatting malaria in Nigeria in 2017[40]



As we saw above, Nigeria officially records some 13 million cases of malaria a year, while the estimated total number of cases was 53.7 million. If we ignore for the moment the number of fatalities and focus only on lost work days, assuming three lost work days for 75% of the cases (to exclude the children), the socio-economic impact is immense – 120.8 million lost working days. That is without factoring in additional lost earnings due to an inability to harvest, etc. Yet, the Nigerian government contribution as shown above is negligible. Were the Global Fund or US AID, for whatever reason, to decide to lower their support as donors the effects could be expected to be catastrophic for the Nigerian economy.

A look at the overall spread of donor funding in the Nigerian healthcare sector reveals that by far the largest amount, namely 95.7% (2011 figures) was assigned to primary healthcare, with 9% of the total being for the provision of basic healthcare and infrastructure excluding human resource

development and health education programmes. A further 19% targeted reproductive health and family planning, i.e. midwives, primary healthcare nursing for infants, etc. Moreover, these ratios have increased significantly since the year 2000, which would suggest there has been a need, or, to put it differently, a major gap left by a shortfall in Federal, state and LGA expenditure on the same. One could infer from this, given that donor contributions are greater than government expenditure, that the primary healthcare sector is dependent on such outside contributions if it is not to collapse. Given the consistent government focus on covering recurrent expenses one could assume that the donor financing is critical to ensuring there is an intact primary healthcare infrastructure. However, this is partially contradicted by the fact that donor funding rarely goes to the LGA as the executing agent. Nevertheless, for those LGAs who do receive little or no financing from a state budget at all, the role of donor funding will be crucial to their ability to provide primary healthcare.

Fig. 15 Donor Commitments to Primary Healthcare in 2000 and 2001[41]

Functional Codes Used to Classify Commitments		% Share of Total Donor Commitments for Health	
		2000	2011
Total Donor Commitments		100.0	100.0
• Donor Commitments for PHC Service Delivery		82.8	95.7
• Donor Commitments for Health System Strengthening		17.2	4.3
Breakdown of Donor Commitments for PHC Service Delivery			
PHC Definition #1	*Basic health care & infrastructure (excl. PHC related health ed. & personnel development)*	2.5	9.0
PHC Definition #2	*Definition #1 + reproductive health care & family planning*	12.6	19.0
PHC Definition #3	*Definition #1 + #2 + control of infectious diseases, malaria & TB*	15.1	39.0
PHC Definition # 4	*Definition # 1 +#2 + #3 + STI Control & HIV/AIDS*	82.8	95.7

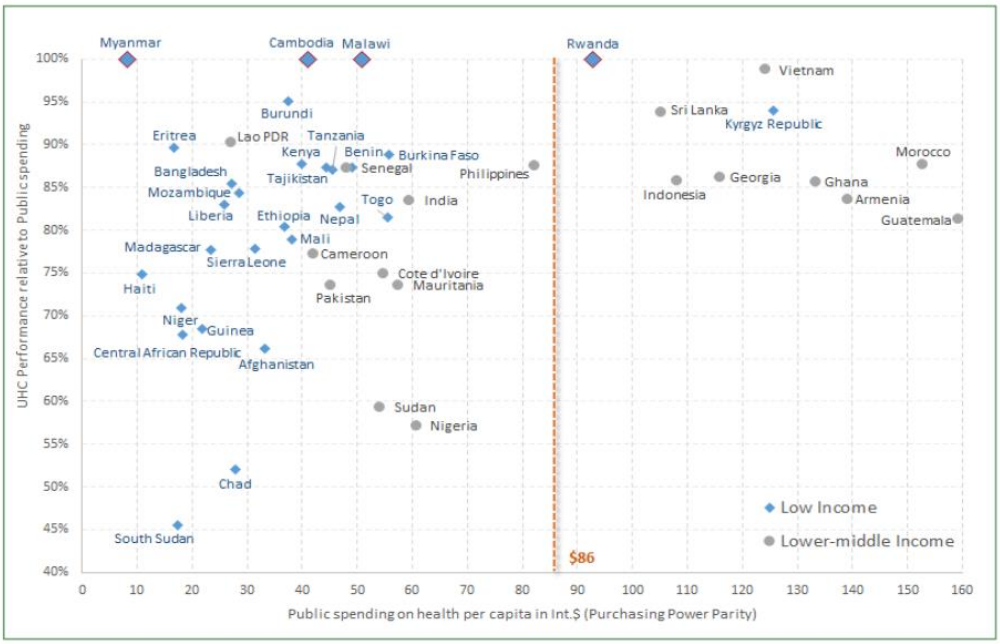
System Efficiencies

Another factor to consider as regards overall government expenditure on healthcare is the relative efficiency of what is disbursed, in particular if the majority is for recurrent expenses, i.e., human resources and operational expenses such as generator sets or water pumps. In their Health Financing Working Paper Spending targets for health: no magic number, Jowett et all argue that even without achieving the 5%-of-GDP mark countries can significantly reduce the proportion of OOP necessary, however that mark is required in order to create the UHC system in the first place. At the same time,

they discern strong differences in UHC delivery among countries spending less than $160 per capita, of which Nigeria is one. The conclude from this that:

> "This analysis clearly demonstrates that absolute levels of public spending on health are critical for progress on UHC, but that at any given level of spending, but particularly at low levels, there is significant scope for UHC progress through greater efficiency in how money is spent."[42]

Fig. 16 Comparison of UHC performance [43]



The chart clearly shows that Nigeria is significantly underperforming peers such as Ethiopia or Kenya and all the other West African countries monitored in terms of what the system provides per dollar spent by government, despite outranking most of them in terms of per capita expenditure in purchasing parity terms. This is consistent with two key findings by Shaw et al. Firstly, they write in the Nigerian context that "Once funds are dispersed, the federal government does not have a constitutional mandate to compel other tiers of government to spend in accordance with its priorities. Responsibility for PHC lies largely with Departments of Health in the LGs, and while State Governments contribute to LG resources, the release of funds held by states is often low or inconsistent."[44] This would suggest that a key inefficiency within Nigerian primary healthcare is an intrinsic and erroneous systemic structure. We shall return to this below in Chapter 6 with reference to the Federal Capital Territory.

Secondly, and equally importantly, Shaw et al. conclude:

> "…the allocative efficiency of donor spending on PHC…is likely to be highly conditional on how it is managed and implemented by executing agents responsible for improving PHC outcomes. Raising more donor and domestic resources for PHC is certainly important, but what happens when the funding enters into the domestic system is

> hugely important as well. … we suggest that allocative efficiency of public spending on PHC benefits can be differentiated among recipient countries, depending on (i) political will to improve both financing and delivery of PHC services in the recipient country, (ii) harmonization or at least strong synergies of external and domestic spending on PHC, and (iii) allocation of spending to PHC services most relevant to reducing country's burden of disease.[45]

We have seen that consistent with (iii) above, donor spending in Nigeria does indeed concentrate on reducing the country's burden of disease (significantly on HIV/AIDS and then on preventing infectious diseases such as TB and malaria. By contrast the discussion in chapters 2 and 3 would indicate that there has been neither (i) the political will to improve financing and delivery of PHC services in Nigeria over the period studied, nor has an effort been enacted to ensure harmonization of approaches (ii), despite the clear wish to do so as epitomized by the Second National Strategic Health Development Plan 2018 – 2022.

The only conclusion can be: The Federal Government of Nigeria is not only spending not nearly enough on primary health care and on universal health coverage, but what it spends is not used efficiently either.

4 Peer-Group Comparisons

For our peer group comparison on government expenditure on healthcare, we have chosen four countries, namely Ethiopia, Indonesia, Kenya, South Africa. The rationale behind the selection is as follows: After Nigeria, Ethiopia is the African country with the second largest population. Like Nigeria, it receives a massive inflow of donor finance, and like Nigeria government has prioritized PHC as the silver bullet to achieving SDG 3. Like Nigeria Kenya is, like Nigeria, a regional titan, being the country with the largest GDP in East Africa, while South Africa boasts the continent's largest GDP. For our non-African comparable we have chosen Indonesia. It is the best 'emerging' comparable in Asia, with a population somewhat larger than Nigeria's and GDP larger by a factor of close to 3. While Pakistan is closer to Nigeria in both regards it cannot, like Indonesia, look back on two decades of exporting hydrocarbons. Moreover, Indonesia is a presidential and a federal system, both of which do not apply to Pakistan. A different continental choice would have been Brazil, but the discrepancy in terms of GDP is simply too great (factor of 6).

In order to place the comparison on a solid footing, the data used needs to be drawn from the same source. To this end we have opted to rely on the like-for-like data assembled by the Alliance for Health Policy and Systems Research and published as case studies on all four countries and on Nigeria by WHO in 2017.[46] The data polled is for the 2015-2016 period and is always compiled from official sources.

We have combined the data provided for certain indicators in the table below for the purposes of simplicity as this way they give the reader on overview of the comparable figures for key aspects of the respective country's healthcare system.

Fig. 17 Peer group comparison of healthcare expenditures

Country	THE as a % of GDP	Public expenditure on health as a % of THE	OOP expenses as a % of THE	% of households experiencing catastrophic health expenditure
Nigeria	3.70%	23.90%	69.35%	14.80%
Ethiopia	2.66%	14.69%	36.00%	***
Indonesia	3.10%	16.90%	47.00%	1.26%
Kenya	5.70%	61.30%	26.10%	12.70%
South Africa	8.60%	48.50%	6.40%	0.42%

***: Figures not available; sources vary greatly. Hailemichael et al. [47]put the figure at 12.1%

What immediately catches the eye is that in Nigeria the OOPs play a dominant role, and the percentage of households experiencing catastrophic health expenditure (defined as where more than 10% of household consumption has to be paid for healthcare) is likewise very high. While total heath expenditure in Nigeria as a percentage of GDP is higher than in Indonesia, the number of households exposed to catastrophic health expenditure is worse by over a factor of 10.

Bilateral comparison: Ethiopia v. Nigeria

As regards Ethiopia, a detailed comparison is available in Shaw et al. In their case study of donor funding, the authors compare Ethiopia and Nigeria and reach the following conclusion:

> "Ethiopia out-performs Nigeria on several PHC-related indicators, even though its capita income and per capita spending on health was only one-quarter that of Nigeria's, on average, between 2000–11. Data not reported here further show that for all PHC-related outputs listed in Table 3, the rate of improvement was far greater in Ethiopia than Nigeria from 2000 to 2012."

It bears noting that in absolute terms of GDP to population the two countries the situation is exactly the reverse, as Nigeria far outperforms Ethiopia. Per capita GDP for Nigeria in 2019 is $ 2,222 or $ 6,055 in PPP terms, while the figures for Ethiopia are $ 953 and $ 2,511 respectively. Indeed, in Ethiopia, a primary healthcare centre serves anywhere between 15,000 and 25,000 people. Moreover, per capita expenditure on health in US dollars is likewise far higher in Nigeria than in Ethiopia. Nevertheless, as regards most indicators, Nigeria falls short. The afore-mentioned Table 3 shows the following:

Fig. 18 Comparison of Healthcare Performance Ethiopia/Nigeria[48]

Indicator	Ethiopia	Nigeria
Population (millions)	94	173
Average per capita income, 2000–11 ($US)**	233**	971**
Per capita expenditure on health ($US)	18	94
Health Outcomes		
Infant Mortality Rate	44	74
Under 5 Mortality Rate	64	117
Maternal Mortality Ratio	460	585
PHC-Related Health Outputs		
Immunization, DPT (children 12-23 months)	61	41
Immunization, Measles (children 12-23 months)	61	42
Contraceptive prevalence rate	29	18
Pregnant women receiving prenatal care	43	66
Adolescent fertility rate (15–19 yrs. of age)	78	120
Prevalence of HIV/AIDS (15–49 years of age)	1.3	3.1

Five-Country Comparison

Let us turn to a five-way comparison. In this context, it bears stating the per capita GDP and per capita GDP in purchasing parity terms for the remaining three countries to get an idea of what financial baseline is involved. Indonesia reports for 2019 (est.) $4,164 (nominal, 2019 est.) $13,998. The data for Kenya are $ 2,010 and $ 3868 respectively, while for South Africa the numbers are $ 6,100 and $ 13,754. While in terms of per capita income in PPP terms, Nigeria only achieves half that of Indonesia or South Africa, the figure is three times that in Ethiopia and twice that in Kenya. A comparison of key indicators shows that Nigeria's public health outcomes are by no means on a level with peers.

Fig 19 Peer group comparison: Key health and healthcare indicators[49]

Country	Infant mortality rate, per 1,000	Doctors per 1,000	Nurses per 1,000	under-5 mortality	Maternal mortality per 100,000
Nigeria	**75,40**	0.38	0.60	**119.9**	**800**
Ethiopia	59	0,1	0,84	55.2	353
Indonesia	22,23	0,378	2,06	26,29	305
Kenya	27,00	0,20	1,54	52	362
South Africa	34,40	0.93	6,10	33,8	132,5

The above pattern is also to be discerned if we look instead at deaths from tuberculosis in 2018:

Fig. 20 Deaths from tuberculosis amongst HIV negative persons[50]

	HIV neg deaths	Population (millions)	Deaths per million
Ethiopia	24,000	109	220.18
Indonesia	93,000	268	347.01
Kenya	19,000	51	372.54
Nigeria	**125,000**	**196**	**637.75**
South Africa	21,000	58	362.06

A similar picture emerges for deaths from malaria.

Fig. 21 Deaths from malaria[51]

	Death rate per 100,000
Nigeria	**35.87**
Kenya	27.79
Ethiopia	5.43
Indonesia	0.78
South Africa	0.33

To summarize, despite Nigeria placing ahead of Ethiopia and Indonesia in terms of percentage of GDP committed to total health expenditure, and despite having the second-best statistics on numbers of doctors per 1,000 inhabitants, Nigeria is far worse off as regard infant, under-5 and maternal mortality. The same applies to its death rates for the two diseases selected as examples from the list mentioned at the outset of this study are likewise far higher.

Nigeria places worst in terms of the number of nurses/midwives per 1,000 inhabitants, which may offer one reason. Another reason may be that the number of doctors given is that for the number registered, of which half are said to reside outside the country, therefore distorting the statistics.

Be that as it may, not only do Nigerians have to pay by far the highest percentage of healthcare costs out of their own pocket, the outcomes of what the system offers is worse than in other countries. Perhaps this is a reflection of the systematic long-term shortfall in THE as a % of GDP that we have seen has plagued the sector in Nigeria since 2000.

5 Conclusions & Proposals for Financing

1 Massive increase in expenditure

What is abundantly clear from the above is that government expenditure on healthcare must be massively increased if it is to live up to its wish to provide primary healthcare to all the country's citizens. Capital and operating expenditures need to be radically increased (infrastructure, drugs and medicines, human resources). Indeed, the original commitment to 15% of budget as stated in

the Abuja Pledge would be a minimum starting point in light of the number of years of 'negative' investment in healthcare when compared to population growth. In their conclusive study of the fiscal space available for health expenditures within the FCT, which is the second placed state in Nigeria in terms of IGR, Carlson et al speak in unusually bald terms for a piece of research commissioned by an international donor agency (USAID). They write

> "Overall, one can conclude from these three findings that *resource mobilization efforts will need to dramatically escalate* over the next few years to close the annual gap between the SHDPII cost requirement and fiscal space available for health under current baseline conditions."[52]

This is consistent with our findings on the shortfalls in expenditure and the recommendations given by Richardson Edeme in his analysis of the relation between public health expenditures and health outcomes in Nigeria. He writes:

> "If healthcare expenditure is to boost and promote better health status, there is need to pay attention on massive and efficient expenditures in the health sector. This might require the mobilization of massive resources and a combination of enhanced and improved domestic resource mobilization and increased foreign aids and grants."[53]

Given the strictures on government financing imposed by the collapse in the price of oil in the wake of the COVID-19 pandemic in spring 2020, it hardly seems feasible that the Federal government is likely to increase its allocations to healthcare at a time when it has slashed its budget.[54] Indeed, the opposite is the case as at the time this paper was written: The Federal government took the quite unprecedented step internationally of cutting capital expenditure for healthcare while the country was still in the grips of the Coronavirus pandemic. This would attest to a lack of political to change healthcare funding. Is there then fiscal space to be identified that could source the requisite financing?

2 Operationalizing the BHCPF – a silver bullet?

One mechanism often mentioned in the past as being available to provide the 'massive expenditure' required is the Basic Healthcare Provision Fund (BHCPF). This financing tool was of course set up by the National Health Act, section 11, of 2014. The law envisages that 1% of the Federal consolidated revenues be released to the BHCPF for disbursement through three gateways, namely the National Health Insurance Scheme (NHIS), which is to receive 50 per cent of the fund, the National Primary Health Care Development Agency (NPHCDA) 45 per cent, and finally the Ministry of Health itself, will gets the remaining five per cent to cover outbreaks of diseases and emergency responses. States have to pay ₦ 100 million as a kind of matching fund in order to be eligible for disbursements through the first two gateways.

On paper, the system would help greatly. However, there were no provisions to the BHCPF until 2018. That year, ₦27.55 billion was released, whereby half the money was first assigned to states in September 2019However, there were no budget releases to the BHCPF until 2018. That year, ₦13.775billion was released, whereby half the money was first assigned to states in September 2019,[55] a sum that does not reflect one percent of the CRF that year. This happened **although** ₦ 55

billion and ₦ 51 billion were budgeted in 2018 and 2019 respectively. A second issue is that of the NHIS itself, as at present the number of participants signed up for the scheme is not only low but also drawn almost entirely from the public sector itself. **Put differently the NHIS functions at present as the government's health insurance scheme – for itself.** How quickly can the Federal government at long last operationalize the BHCPF in the current climate of budget cuts? This is critical if any progress is to be made rectifying the disastrous health outcomes as regards infant and maternal mortality, to mention but two areas requiring immediate amelioration.

In a policy brief prepared for USAID, the organization Health Policy Plus outlines what it considers are musts if the BHCPF is to be operationalized at the three levels of governments:

- Cement the BHCPF as a **statutory transfe**r, rather than a health capital expenditure;
- Increase the **share of Federal Consolidated Revenue allocated to the BHCPF to exceed the minimum one percent dictated by the National Health Act**
- **Release, on-time and in-full**, the BHCPF allocation;
- Bolster state readiness to implement the BHCPF, including through: Establishing, operationalizing, and strengthening key agencies (e.g., **state health insurance agencies and state primary healthcare development agencies**).[56]

This is consistent not only with our findings but also bears out our recommendation that the Federal government return to the 15% of budget target set in the Abuja Pledge. It is also in line with the results of the National Advocates for Health who found clear implementation, disbursement and auditing deficits in the BHCPF system when appraising it in early 2019.[57] Their score-card findings would again suggest an absence of political will to prioritize healthcare spending and push this through.[58]

3 Rely on insurance or special taxes?

One alternative tool some commentators have suggested be deployed to help mitigate the severe shortfall is healthcare financing is health insurance. However, this comes with a caveat. There are multiple reasons why health insurance cannot plug the current gap and should therefore be seen less as an ameliorative and more as a possible add-on. The National Health Insurance Scheme (NHIS) established as long ago as 1999 still remains a voluntary contribution scheme. Perhaps as a result, according to the World Bank, by 2016 only 4.2 percent of the population was covered by it, and those contributing were primarily federal government civil servants and their dependents. [59] In other words, to date the NHIS as good as completely excluded the entire informal sector, meaning the most vulnerable in society, yet as indicators show, precisely the proportion of the population in poverty and extreme poverty (who thus come into this group) is increasing. Put differently, the proportion of the population excluded from healthcare as they cannot pay for it is growing at the same rate. PriceWaterhouse Cooper provide further evidence of this when they write: "A survey by the Lagos Bureau of Statistics revealed that only 11% of household members in the state have their healthcare costs covered by any form of health insurance."[60] To quote the World Bank in summary:

> Social health insurance, often seen as a solution to raising a large and stable revenue for health, should complement the BHCPF but on its own is not a viable path towards achieving UHC. Currently, social health insurance does not have the capacity to enforce contributions or the ability to attract the informal sector. [61]

One method taken to improve the situation has been to set up state health insurance schemes. PriceWaterhouse Cooper report that at present some 19 states have started implementing such schemes. "These schemes typically involve the establishment of a governing agency to oversee the implementation and management of the scheme. They have also defined benefit packages to cater to the most common healthcare occurrences. Of significant note though: State Governments commit to dedicate a percentage of their consolidated revenue to the scheme to fund premiums for the poor and vulnerable in the state."[62] This does not per se avoid the problem of the exposure of states' consolidated revenues to oil-price volatility, for example. In the 2020 year, states' consolidated revenue has been as hard-hit as that of the Federal government, so that even committing 'x' percent of it to the scheme does not guarantee the scheme financial viability at all.

The World Bank states in the context of voluntary contributions as follows:

> Globally, countries… have needed to supplement insurance contributions with tax-based financing (like what would be provided by the BHCPF) that pay for poor and vulnerable groups and heavily subsidize premium contributions from the informal sector.[63]

While this may be the case globally, it certainly does not apply in Nigeria in its current structure. Indeed, the disadvantage to such a reliance on an additional, tax-based form of healthcare expenditure is, however, inadvertently highlighted in passing by Carlson et al in the afore-mentioned study of the fiscal space for health in the FCT, which as noted is the state that places second in the national internally generated revenue rankings and is therefore ideally positioned to deploy such a tax-based approach. They write that the "fiscal space for health in FCT is more responsive to fluctuations in internally generated revenue collections than fluctuations in CRF collections."[64]. If the authors are right, and this applies in the case of the FCT, then surely the fiscal space will be exposed to even greater volatility in states that can access less internally generated revenue?

Given that the two above 'standard' approaches do not seem feasible in the present context, what tools remain for policymakers to draw on to raise financing for healthcare expenditure? Uzochukwu et al in their call for tax-based funding try to identify alternative, innovative sources of healthcare financing:

> The excise, value added tax or "sin taxes" on products such as alcohol and tobacco (products that pose risks to health) can be extended to include unhealthy foods such as sweets, sugary drinks and foods high in salt and trans-fats. Other possibilities for innovative fund-raising include solidarity levies on mobile phone call tariffs (over 90 million Nigerians own and use mobile phones), raising diaspora bonds (from our large diaspora population), and taxing specific profitable sectors of the economy like banking, oil and gas.[65]

In their discussion of possible financing models particularly to protect the poor and vulnerable from OOP, Michael et al add a rider to this when they suggest that mixing social health insurance and a tax-based funding is not sufficient, as what is also required is "commitment by all stakeholders is

also required for the provision of efficient services, and efficient and equitable use of resources must also be insured."[66]

4 Vastly improve efficiencies

If financing for healthcare cannot be raised overnight, what can be raised is the efficient allocation of the existing resources. Numerous commentators, including the Ministry of Health itself in its Strategic Plan, point to leakages and wastage in the system. Items worthy of further discussion are to increase human resources, to ensure they are better trained and deployed where they are needed, and to improve procurement workflow.

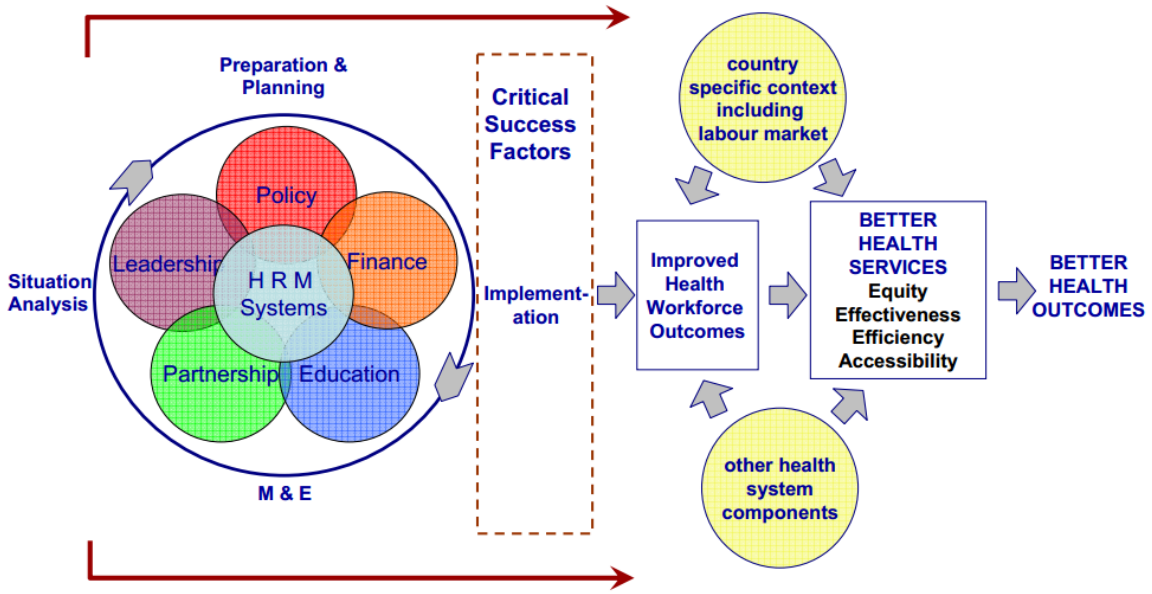
Carlson et al have gone into the question of efficiency in great depth as regards the FCT. To summarize their cogent findings[67]:

- Doctors/nurses/midwives tend to be posted to urban not rural areas. In the latter as a consequence, rural residents' healthcare demands cannot be met. Redistribution would slash HR costs.
- Bulk purchasing of health commodities would trigger substantial savings.

They suggest that if the scope for improvement in efficiency levels is exploited, the FCT would be able to reduce costs by nine percent overall - savings in human resource and procurement costs would make up 58 percent and 42 percent of total savings respectively.[68] Such a reduction in costs logically translates into greater financial resources being available. While the percentages may differ in other states given the local conditions specific to the FCT, the principle remains the same. Ensure staff is where it is needed (this is incumbent on the LGAs) and change procurement patterns.[69] Car

At the same time, as we have seen, the absolute number of healthcare staff needs to be increased considerably (to reach the WHO-recommended level of 23 per 10,000) if the primary healthcare system is to function in the first place. In addition to all attention to financing measures, policymakers need also to initiate a nation-wide audit of healthcare staff, including their qualifications and their location. Since the Federal health budget is largely dedicated to recurrent expenditure it is key that the government identify whether that expenditure is committed rationally, meaning to the right staff in the right places. The audit must, of course, take place at the state and LGA levels, but subject to Federal supervision. While healthcare delivery may be an LGA matter, and healthcare roll-out decided by the individual states, the audit must culminate in binding national guidelines for staffing levels in line with WHO standards. To this end the latter has created the Human Resources for Health Action Framework, as exemplified by the following chart:

Fig. 22 Human Resources for Health Action Framework[70]



Capacity development

6 Cross-Administration Continuity, Accountability Streams

As the history of the National Health Act and the BHCPF shows, cross-administration continuity is critical if healthcare financing is to be delivered as originally intended. The discussion of the BHCPF has also shown how by the time it was implemented the pro-rata basis on which it was calculated already no longer fit the intended purpose. However, rather than focusing on addressing the problem, the subsequent administration simply 'copied' it into reality. **Precisely because primary healthcare delivery is something that has to incrementally implemented and financed until a certain standard is achieved (e.g., to cover minimum staffing requirements and minimum medicine provision for specified illnesses/diseases) prioritization should be attached to achieving such targets as fast as possible rather than stoically upholding formula.**

At the same time policymakers much also ensure that there is a consistent focus on allocative efficiencies and avoid any misalignment of state and federal healthcare policies. In this regard, given the structure of healthcare financing (and the argument could be extended to the education sector, too) and its fundamental necessity for any prosperity in society, legislation and/or an audit agency is required to adjudicate such issues of alignment and expenditure shortfalls in order to monitor and sanction under-performance in the sector. Such an Ombudsman would function independent of any Administration and should ideally have the power to report violations in a manner that would require the Executive to impose fines according to a standard table. If

necessary, the Ombudsman would need to be instructed to publicly report all negative findings to a specified set of media outlets to ensure impartiality.

Irrespective of the need for such an institution, a series of checks and balances are already required if only to ensure that the BHCPF itself is implemented efficiently and effectively. To this end, a transparent accountability system needs to be created for the BHCPF, specifically, as is pointed our in the HP+ Policy Brief, at "the facility and community levels" while likewise "controlling the quality of healthcare facilities". Otherwise, the status quo will simply continue, whereby each state reports that it has the requisite number of primary healthcare centres, for example, without the feedback loop noticing the fact that these are all in main LGA towns and therefore do not reach rural communities, a trend we have seen even exists within the FCT.[71]

The systemic weaknesses within government healthcare financing have been apparent for some time and numerous researchers have focused on how to address not to mention prevent them. One of the most cogent sets of recommendations is that developed by Uzochukwu et al and presented as Annex 1.[72] While putting its finger on the inevitable need for transparency in order to inhibit illicit cashflows or disbursements it makes two salient observations: Firstly, there is a general need for the States and LGAs to involve qualified financial managers in the healthcare system and by extension for the release of funding to be pegged to past performance, namely results of the last disbursement as certified by independent auditors. Secondly, at the same time LGAs and the health facilities themselves (in the person of the respective manager/physician) to table annual plans to show what the financial resources will be used for and thus enable performance measurement in the first place. Interestingly, the scorecard rating for implementation of the BHCPF identifies exactly those shortcomings that Annex 1 seeks to avoid happening.

Annex 1

1 Recommended mechanisms to strengthen accountability in implementing the BHCPF

State government:

State Ministry of Health, SPHCB, State Ministry of Finance, Ministry of Local Government

- Provide supportive supervision to LGHA such as mentoring or training on how to address specific challenges.
- Consider making dispersal of funds from SPHCB to LGHA conditional on the results of previous disbursements.
- Employ qualified finance managers to be responsible for disbursing funds.
- Demonstrate transparency by separating BHCPF account from the State health account, and by publishing financial reports on SPHCB websites in accordance with the Freedom of Information act and Fiscal Appropriation Act.

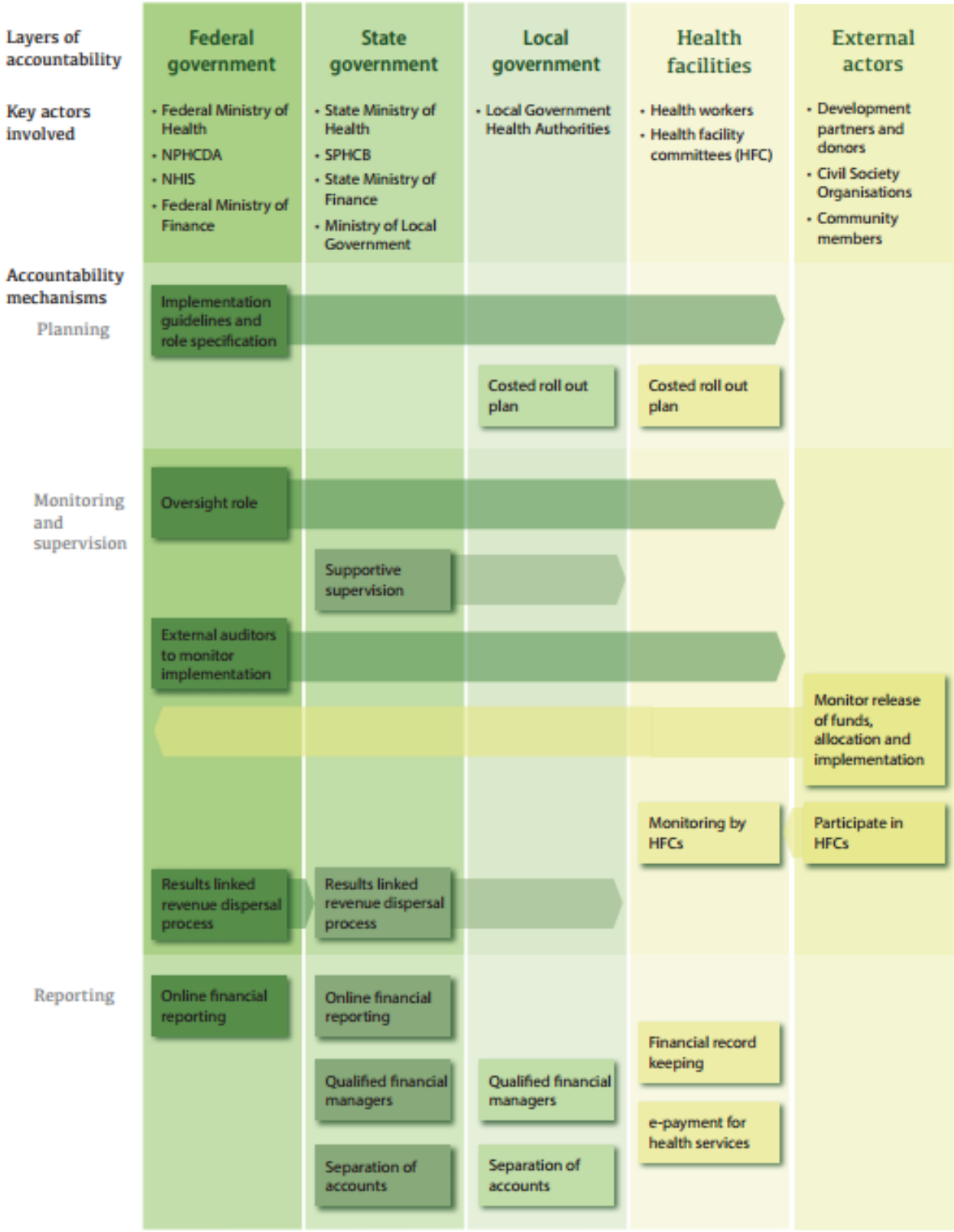
Local government

- Produce a plan for how the BHCPF will be disbursed to health facilities.
- Employ qualified finance managers to be responsible for disbursing funds.
- Demonstrate transparency by separating the BHCPF account from other sources of funding for PHC facilities.

Health facilities

- Produce a plan for how the BHCPF will be spent
- Health Facility Committees should monitor how revenue from the Fund is spent.
- Put in place systems for keeping records about how funds are managed.
- Use e-payment or banks for consumer payment of charges at health services, rather than cash payments to reduce potential for corruption.

2 Accountability Framework for Implementation of BHCPF



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[4] https://www.unicef.org/nigeria/press-releases/nigeria-contributes-highest-number-global-pneumonia-child-deaths, report of 12 Nov 2019, last retrieved 14 May 2020

[5] Loc. cit.

[6] Loc. cit.

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[11] OAU/SPS/ABUJA/3, p. 5; available from https://au.int/sites/default/files/pages/32894-file-2001-abuja-declaration.pdf

[12] It bears noting in this context that given Nigeria's population explosion some reports already assume a baseline population of 205 million.

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[20] Jowett M et al: op. cit., p. 7

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[22] Own calculations.

[23] Own calculations.

[24] Own calculations.

[25] See Quartz Africa: "African economies are spending up to five times their health budgets on debt repayments," (April 30, 2020)

[26] Reem Hafez: Nigeria Health Financing System Assessment being: "Health, Nutrition and Population (HNP) Discussion Paper," (The International Bank for Reconstruction and Development & The World Bank, Washington, 2018), p. viii; emphases in the original.

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[28] WHO, 2018, op. cit., p. 44

[29] Internal TAPI paper by Ms Fatima Malumfashi, March 2020. This is consistent with the remark by R. K. Edeme that "the negative relationship between urban population and infant mortality rate in Nigeria can be largely attributed to the fact that residents in the urban areas tend to adopt more health improvement techniques, largely due to their increased knowledge of the benefits of better health status, as compared to their counterparts in the rural areas and this accounts for the difference between concentration of healthcare services which are more in the urban areas than in the rural areas. This difference in healthcare concentration reveals the effect of urban population on a decreasing infant mortality rate in Nigeria." Ex: Richardson Kojo Edeme: "Public Health Expenditure and Health Outcomes in Nigeria," in: American Journal of Biomedical and Life Sciences 2017; 5(5), pp. 96-102, here p. 101.

[30] World Bank 2018, p. 36.

[31] World Bank 2018, p. 37

[32] BudgIT: Nigeria: Health Budget Analysis, being Policy Brief, 1st Quarter 2018, (Lagos, 2018)- p. 6

[33] National Health Accounts 2006-2009, op. cit., p. 8

[34] See Nigeria Living Standard Survey (NLSS) 2019-2020.

[35] Global spending on health: a world in transition, (Geneva: World Health Organization; 2019) offers the following useful definition: "OOPS as a share of total current health expenditure measures the size of OOPS in the total national current health spending. It shows how much the health system relies on households' out-of-pocket spending to finance it. Catastrophic health spending measures household financial hardship. It reflects a concern for households having to choose between spending on health for the services and products they need AND meeting other basic needs such as education, housing and food. In the SDG monitoring framework, it is defined as out-of-pocket payments as a share of total household consumption or income exceeding 10% or 25%." The WHO draws here on the definition given in the United Nations Statistics Division: "Indicator 3.8.2: Proportion of population with large household expenditure on health as a share of total household expenditure or income".

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[49] See footnote 46

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[51] All data from the world rankings given by https://www.worldlifeexpectancy.com/cause-of-death/malaria/by-country/. Last retrieved 1 June 2020

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[53] Richardson kojo Edeme: "Public Health Expenditure and Health Outcomes in Nigeria," in: American Journal of Biomedical and Life Sciences, 2017; 5(5): pp. 96-102, here p. 102

[54] The ICIR reported on 31 May 2020 that "according to the revised document seen by Dataphyte, the Federal Ministry of Health had a downward cut of ₦15.17 billion. Likewise, the Ministries of Education, Science and Technology, Water Resources, and the Federal Capital Territory are also among the worst hit by capital expenditure reductions." See: https://www.icirnigeria.org/fg-slashes-health-budget-leaves-legislatures-library-and-constituency-projects-intact/#.XtTMs-QS5FU.email. Last retrieved 2 June 2020.

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[58] Carlson et al note in this context as regards the FCT: "As much as NGN 26 billion in new fiscal space could be created through **improvements in health prioritization**, which is just above the NGN 23 billion that could be mobilized from health sector-specific resources. This finding suggests that similar gains in fiscal space can result from similar levels of resource mobilization effort targeting health prioritization and health sector-specific resources." In: op. cit., p. 23, my emphasis.

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[69] Carlson et al provide a list of measures they believe need to be taken immediately at state/LGA level to enable this to happen: "Set Up/Operationalize Ward Development Committees; Conduct Facility Assessments of Ward Primary Healthcare Facilities; Rotational Posting of Hospitals Management Board Healthcare Workers; Leverage National Youth Service Corp and N-Power Programs to Resource Rural Primary Healthcare Facilities; Implement National Council on Health Resolution on Rotational Posting of Resident Doctors to Rural Areas," op. cit., p. 25

[70] The chart is copyright WHO, Department of Human Resources for Health, Geneva, Switzerland 2008. For greater depth, see https://www.capacityproject.org/framework/about/. The HRH Action Framework website is an initiative of the Global Health Workforce Alliance (GHWA) and represents a collaborative effort between the U.S. Agency for International Development (USAID) and the World Health Organization (WHO).

[71] See HP+: Policy Brief November 2019, p. 2

[72] Uzochukwu B., Onwujekwe O., & Mbachu C.: "Implementing the Basic Health Care Provision Fund in Nigeria," being: Health Policy Research Group Policy Brief March 2015, published by Resyst Resilient and Responsive Health Systems Research Consortium.