THE PRACTICAL POLITICS OF

Health financing in Nigeria

Health debates in Nigeria focus on the volume of funds entering the system, new infrastructure and disease-specific vertical funds. Far less attention is paid to health's background 'plumbing' – the complex system turning money into better health outcomes – and overall performance suffers as a result. One consequence is that households cover more than 70% of the country's current health expenditure 'out-of-pocket', paid to both private and public health providers. Shifting focus to plumbing, the out-of-pocket spending crisis and making markets work better could raise health's political salience and deliver outcomes in line with Nigeria's economic might.

Prince Agwu and Peter J Evans

Product 2 • July 2026

Practical insights

- Nigeria's health outcomes are improving, but remain disappointing for an economy of its size.
- Health's political and electoral salience lies more in the creation of visible infrastructure and avoiding catastrophe than in improving everyday outcomes. Donors also have incentives to invest in high-profile projects, such as vertical programmes focused on particular diseases.
- This comes at the expense of health system 'plumbing' – the less exciting infrastructure and mechanisms required to move funds to the frontline, feed data upwards and deliver a broad range of cost-effective services. Health plumbing remains underfinanced and undervalued.
- Weak public financial management continues to drive system-wide problems. Unpredictable budget releases turn planning into guesswork and drive discretionary workarounds to keep services running. Manual data entry creates lags, errors and low confidence in data used.
- Most Nigerians remain uninsured, leaving households vulnerable to shock. Tax-funded, non-contributory insurance and basic health packages are good in theory but limited in practice.
- International funders contribute to system dysfunction. They get disproportionate attention and parallel accountability, yet only cover around 7% of total funds.
- Astonishingly, citizens' out-of-pocket spending accounts for more than 70% of all health expenditure. With low confidence in public facilities, much of this is spent on private formal and informal providers, as well as formal and informal payments in public facilities. The private market is large, chaotic and works badly. Out-of-pocket spending is regressive and inefficient.

Practical propositions

There are politically feasible ways to shift the status quo. We recommend:

1. Get health politics on the policy table – and keep it there.
2. Make 'good health' politically salient, with a credible political case for health sector reform.
3. Funders should recognise themselves as players in, not observers of, health politics.
4. Focus on the 'out-of-pocket' crisis and making the private market work better.
5. Create and use one set of basic, trusted data – by all, for all.
6. Introduce both carrots and sticks to encourage more investment in system plumbing.

I. WHAT IS THE PROBLEM?

An enduring burden of ill health

Nigeria's health outcomes are slowly improving but remain below regional neighbours. Average life expectancy is 54 years compared to 64 in the WHO African Region; under-5 mortality is 105 per 1,000 compared to 68 for sub-Saharan Africa; and the maternal mortality ratio is around 950 deaths per 100,000 live births, but 531 regionally.[1] Despite the government explicitly prioritising maternal health, Nigeria remains on par with some of the poorest countries, such as South Sudan and Chad.[2]

There are also sub-national variations in outcomes, service quality and service utilisation. Northern parts lag behind the south, and rural areas lag behind urban centres – although urban slums are also hubs of poor health.[3]

Health finance: a gap filled from citizens' pockets

It is often argued that Nigeria has a health financing gap.[4] But poor outcomes also reflect ineffective use of existing funds.

Nigeria is Africa's most populous country – it has around 230m people and a sizeable economy supported by substantial oil reserves.[5] Government funding at all levels of government accounts for around 15% of total health expenditure, which is lower than estimates for countries such as South Africa (62%) and Ghana (55%) – though precise calculation and comparison are complicated.[6]

In Nigeria, external aid for health has been large in absolute terms – $6.4bn between 2002 to 2018 – yet accounts for just 7% of total health expenditure.[7] If all funds flowing into health are considered, Nigeria's biggest funders are private citizens. Out-of-pocket (OoP) spending accounts for at least 70%.[8] Much of this is spent outside the formal government system in private health markets.[9]

Both public and private health systems are part of Nigeria's wider health ecosystem. The government system and *formal* health markets intersect via insurance markets, pooled funds and procurement. *Informal* providers (including street drug vendors and traditional healers) exist outside these structures and may not be fully reflected in national health accounts. But they are major providers of health services, so OoP expenditure may actually exceed 70%.[10]

Nigeria's Country Health Systems and Services Profile states that 80% of the nation's public health infrastructure is dysfunctional. As a result, it is estimated that the private sector delivers at least 70% of services across all levels – primary, secondary and tertiary.[11]

Nigeria's informal health market has deep cultural roots. Its size reflects availability, affordability and perceived quality, as well as the absence and low quality of government services. Many Nigerians trust informal providers and may prefer them to formal services.[12] Gender effects are also strong. Women are the major users of maternal, reproductive and child health services, and traditional birth attendants are significant providers of maternal care. Nationally, skilled birth attendance remains below 50%, especially in underserved communities, with many deliveries occurring outside formal health facilities.[13] Health insurance coverage among women of reproductive age is also low. These factors intersect with cultural and religious considerations to create a situation where, if given a choice, few women would willingly deliver a baby in a government facility.[14]

In summary, the state underinvests in health, and the investments it makes are poorly managed. Government services often fail to meet citizens' expectations as a result, leading many to seek health services from private formal and informal providers. The private market can be costly and often of questionable quality. Informal health providers significantly contribute to poor health outcomes and impose high financial costs on service users.[15] Health is caught in a low performing status quo.

The political economy of this ecosystem – including political and business elites and their interests and incentives – strongly affects its functioning and outcomes. We refer to this as the 'small-p politics'

of the health system. Poor health has limited salience in Nigeria's 'Big-P politics' of electoral competition. But citizens, if they can afford to, 'vote with their feet' by seeking private alternatives to government care. They have yet to use the ballot box to demand better healthcare.

Finance dominates debate while system plumbing is neglected

Nigeria's formal health sector has seen decades of technical reform and financial intervention. Health sector politics, in contrast, have received little attention. Dominant national and international voices focus on the total volume of funds entering at the top (national budgets, aid flows, global finance), and on the spending mechanisms that direct this flow toward vertical interventions and disease-specific programming.[16] For reasons of small-p politics, they largely neglect the essential but complex system 'plumbing' and horizontal interventions that could lower costs, increase benefits to citizens and unlock greater effectiveness for funds from any source.[17] Instead they tend to focus narrowly so that they, and their partners, can demonstrate 'wins'.

OoP payments are inefficient and regressive.[18] They push families into poverty and undermine trust in health systems. The Nigerian government has pledged to cut OoP spending to approximately 30% of total funds, and initiated measures such as the National Health Insurance Authority (NHIA) law that mandates health insurance for all citizens. But citizens still bear the bulk of health costs.[19] We see this as the real crisis in Nigerian health finance.

Plumbing is an apt metaphor because health systems function like heating networks. Financial inflows cascade downwards through an architecture of sub-systems, valves and switches to reach final points of care. Data (funding flows and health statistics) is returned to monitor performance and adjust how resources move. Problems in any part of this plumbing reduce overall efficiency. They can even cause system failure.

While the total volume of pooled health funds is important, the plumbing that determines how resources are used needs even more attention.[20] This requires engaging with the politics of the health sector, which may be uncomfortable for many involved. But it is essential to overcoming the low performing status quo.

The health system and its basic plumbing – six key problems

We note six plumbing problems that stop the translation of financial inflows into better outcomes. These have been the focus of technical intervention and capacity building, yet little has changed. Political economy analysis helps explain why they endure.

I. Centralised federalism

Responsibility for healthcare delivery in Nigeria is constitutionally distributed across federal, state and local governments. The federal government is supposed to primarily provide stewardship and tertiary services. State governments oversee secondary healthcare. Local government authorities (LGAs) are formally responsible for primary healthcare delivery.

In practice, however, the federal government is the main player in health delivery. State-run secondary healthcare systems overwhelmingly underperform, and federal involvement in primary care has increased through nationally coordinated initiatives such as the Basic Health Care Provision Fund (BHCPF).[21] Today, much delivery happens at the federally coordinated tertiary level and through federally sponsored primary healthcare. Decisions are significantly shaped by the centre.[22]

Although states and LGAs vary widely in management strength, revenue autonomy, leadership and interest in the health of citizens, recent assessments generally characterise Nigeria's subnational health systems as uneven and weakly coordinated.[23]

2. Weak public financial management (PFM) drives system-wide problems

Budget appropriations may be approved on time, but fund releases are often late, partial or entirely missing. Unreliable and unpredictable flows turn lower-tier planning into guesswork and reduce allocative efficiency.[24] Furthermore, the connections between budget allocations and community health needs, facility responsibilities and operational plans are often opaque.[25] Even when budgets are allocated, actual spending often remains low – sometimes below 50%.[26]

Uncertainty compels health providers to find workarounds to keep basic services running. These put routine functions in perpetual crisis management mode and undermine compliance and accountability. They also create opportunities for corruption, erode trust and perpetuate risk-aversion by external actors.[27] To over-focus on corruption, however, misses the point: inefficiency and indiscipline prevent the system from delivering money to where it is needed or translating funds into outcomes. Corruption is one ensuing problem. But it is neither the biggest constraint nor the main driving logic of systemic dysfunction.

On paper, external funders try to avoid compounding problems by complementing, not duplicating, government funding. But delayed central releases create funding gaps that reportedly can incentivise donors to break rank and provide bridge funding for already budgeted expenditure.[28] Though well-intended, this increases overall costs and conceals underlying financial indiscipline. When central budgets are eventually released, often below approved levels, the resulting double payment can enable fraud.

3. Shiny infrastructure is a vote winner. Boring plumbing is not

Nigerian leaders have strong political incentives to deliver high-profile infrastructure, such as new buildings, and other relatively quick and visible wins that are tangible to voters. Donors also prefer visible over boring. Vertical programmes targeting specific diseases like malaria and polio, while understandable, also better lend themselves to building profile than investing in underlying systems.

Citizens are also attracted to prestige projects.[29] Surveys show that highly visible infrastructure shapes voting choices more than quality or health outcomes.[30] This may be because the salience of health is stronger with emergency care and avoiding catastrophe than routine services that generally improve outcomes (and particularly require better plumbing). Voter expectation is limited. Politicians offer little in return. There is little consequence for a politician or political party that does not prioritise citizens' health.

As a result, the primary care infrastructure and background systems required to deliver a broad range of cost-effective services remain serially underfinanced and undervalued, despite being essential for service delivery and financial accountability.[31] This includes nationwide systems that govern cascading finance and the upward flow of information needed for accountability, planning and targeting. It also includes background physical and IT infrastructure like data hubs, service delivery logistics, people management, e-claims and stewardship.

‘Shiny beats boring’ is not a new insight for political analysts. Yet it has proven extremely hard to overcome in Nigeria, where clientelism (votes in exchange for material benefit) is a prevailing political culture. Nigeria’s four-year electoral cycle creates incentives for politicians and political parties to prioritise short-term, visible interventions capable of generating electoral support within a single political term. But building resilient and effective health systems requires sustained investment, institutional continuity and policy commitment across electoral cycles.

Political accountability for background plumbing and service performance would require citizens to have a clearer idea of what quality looks like. Institutionalising and socialising standards for health planning, financing and service delivery would enable citizens to evaluate governments based on health outcomes and system performance, rather than infrastructure.

4. Data systems still creak

Nigeria's health system still relies on paper-based reporting from facilities, with manual digitisation upstream. The absence of sustained and strategic investments in data infrastructure and digital integration constrains performance, interoperability, continuity of care and real-time decision-making.[32] It also causes lags, errors and low confidence in the data used to set priorities, target specific geographies, track funds and verify results. This is a vicious cycle: evidence-based planning is questioned, central authority and vertical programmes appear safer bets, and backbone data infrastructure remains under-prioritised.

5. Continued fragmentation in funding and purchasing

Health funding pools are technically a good idea, but it is easy to do them badly. Nigeria has multiple health funding pools and purchasers: federal and state governments, the NHIA, '36 plus 1' state social health insurance schemes (SSHIS), the BHCPF, donor-funded vertical programmes and beyond them, the OoP market. Fragmentation increases administrative costs and limits cross-subsidisation, purchasing power and economies of scale. It also fosters claims backlogs, variable provider payment rules and uneven accreditation/verification. All tend to erode trust and undermine the delivery of optimal health benefit packages.[33]

6. Most Nigerians remain uninsured

Health insurance is also technically a good idea but easy to do badly. About 90% of Nigerians do not have health insurance. This undermines service continuity and strategic purchasing while leaving most households vulnerable to shock.[34] Nigeria's health benefit package is also chaotic. Price inflation of goods and services is often in the double digits, and the insured often pay for services that are theoretically covered. This is partly due to the low level of buy-in at sub-national level. States created their insurance schemes primarily to facilitate access to federal funds (the BHCPF), not because they saw insurance as a development priority.[35]

Insurance is just one of the routes to health service delivery, and also depends on system plumbing. That is why policy recommendations have consistently emphasised the need for tax-funded non-contributory health financing mechanisms operating at scale and offering broad benefit packages for the general population.[36] In Nigeria, the BHCPF, particularly through its health insurance gateway, and the Comprehensive Emergency Obstetric and Newborn Care (CEmONC) initiative are important examples of publicly financed non-contributory approaches to financial protection and service expansion. But these programmes target specific groups and focus on primary and preventive maternal and child health services rather than comprehensive, population-wide coverage.[37]

Health finance: a coordination problem or something else?

Nigeria's health equilibrium of poor outcomes and poor system plumbing is well-known. Recent reform efforts have focused on formal coordination, with the 'sector-wide approach' (SWAp) established in 2023 around 'one plan, one budget, one report, one conversation'.[38] It has made progress in coordinating donors and aligning planning templates. But SWAp is constrained by the broader system that it seeks to change. Slow fund releases, unclear decision rights and capacity gaps all undermine SWAp's impact. It has little traction within the wider health ecosystem, where most expenditure happens in the private market.

Funds are the major instrument of authority and control, therefore the politics of health and the politics of health finance are intertwined. The 'elite bargain' in Nigerian health – the unspoken deal determining the allocation of power and resources – persists at the expense of Nigerian citizens who struggle with poor health outcomes and high OoP costs.[39] Some dominant groups are well-served by the status quo, and OoP expenditure and donor behaviour arguably reduce pressure for change.

II. WHO ARE THE PLAYERS?

The health system is shaped by a variety of domestic and global players. These include:

Federal executive and central finance authorities

This central group includes the Presidency, the Ministry of Health and Social Welfare, the Ministry of Finance, Budget and Economic Planning, the Office of the Accountant-General and the Debt Management Office. Their priorities include macro-fiscal and policy control, delivering visible achievements in health, ensuring positive donor relations and fiduciary risk management. Their incentives include preserving central discretion over fund releases and prioritising initiatives aligned with political strategies, including appealing to voters within the narrow window of an election cycle.

Federal health agencies

This group includes NHIA for insurance/purchasing, the National Primary Health Care Development Agency (NPHCDA), disease control, regulatory bodies and presidential initiatives. Their interests include expanding service coverage and demonstrating results, partly to protect their own mandates and budget lines. Their incentives include ensuring that funds pass through spending gateways that they control, collecting data that supports their preferred delivery models, sustaining political narratives that build legitimacy and electoral success, and distancing themselves from visible failure.

Sector-wide approach platform (SWAp)

SWAp is embedded within the federal health leadership. Its priorities include successful coordination, donor alignment and the execution of Nigeria's unified plan. SWAp's convening power depends on ministerial support. But it risks becoming another 'meeting machine' if it does not simplify partner demands, rationalise working groups and coordination mechanisms, or drive shared verifiable standards across national and subnational health stakeholders.

State and local governments

At state level, there are 36 governors, ministries of health, state primary health care development agencies (SPHCDAs), and state health insurance agencies (SHIAs). There are also numerous central drug stores, local health authorities and facility committees. Their interests include access to resources, highly visible projects that address local priorities and political needs, financial flexibility and timely release of allocations from the centre. Their incentives are shaped by federal and donor programmes when resources flow. But they prefer discretion over rigid rules in order to focus on activities salient to local needs and interest groups.

Several states have their own initiatives for health insurance enrolment, personnel recruitment, procurement and service provision.[40] Multi-stakeholder initiatives, supported by development partners and private-sector actors, have used prizes, such as the Primary Health Care Leadership Challenge, to reward high-performing states and encourage inter-state competition.[41] Recent award cycles have been won by mostly southern states, underlining disparities in capacity and outcomes between southern and northern Nigeria.

Public and private providers, their unions and professional associations

This diverse group includes public facility managers, private hospitals and clinics, groups like the Nigerian Medical Association and the National Association of Nigerian Nurses and Midwives, pharmacists, laboratory scientists and health sector unions. Overall, their interests include predictable payments, fair tariffs, decent working conditions and protecting professional status and prestige. They are incentivised to resist sharp cuts or aggressive fraud controls, which limit positive 'good faith' discretion and workarounds, as well as limiting corruption. They also seek to reduce administrative burden and negotiate sufficient allowances and salaries from vertical programmes. Clearly, the interests of employers and employees converge in some areas and diverge in others.

The distinction between public and private providers can be unclear. Many private health providers also work in the public sector, where they enjoy greater job security and the ability to refer public sector patients to their private practices, promising better services while also making a profit. As a result, private sector actors may desire improvements in the public sector, particularly regarding employee benefits and working conditions, while simultaneously seeking to ensure that their own private practices continue to flourish.

International development partners

Many international health partners are active in Nigeria. These include the Global Fund, Gates Foundation, Gavi, Global Financing Facility, World Bank, WHO and other UN agencies, as well as bilateral aid agencies, other foundations and INGOs of various sizes. Though diverse in focus and scale, converging interests include measurable results, clearly safeguarding their own funds, credit for investments and successes, and strategic positioning for visibility, political access and influence.

International partners in Nigeria's health system often have incentives to support vertical or disease-specific programmes because they produce clearer, attributable and politically salient results for their funders, boards and domestic constituencies. At the same time, concerns about Nigeria's public financial management and fiduciary risk can spur donors to use parallel reporting systems, project-specific safeguards and bespoke implementation arrangements. These practices may improve accountability for individual projects, but can also contribute to fragmentation, duplication and reporting burdens within the Nigerian health system. Donors' public relations, visibility and security considerations may also shape the geographic location of projects.[42] Reform efforts such as the New Compact for Health Financing tend to focus on donor behaviour in relation to system inflows and pooling.[43] The compact explicitly puts government in control, but this does little to change incentives within the system or address the plumbing problems described above.

Private payers and suppliers

These include health management organisations (HMOs), health insurance managers, insurers, pharmaceutical and device suppliers, logistics and health tech firms. Their interests include increasing market share, ensuring timely payment and cashflow, and regulatory predictability. They are incentivised to target Nigeria's insured and urban markets, and to supply donor programmes and lobby for favourable procurement and pricing. The logic of any insurance provider is, understandably, to maximise collection of premiums whilst minimising payouts.

While data on the comparative performance of private and public providers is scarce, private providers appear to be the worse option. They are more strongly associated with catastrophic health expenditure, poorer patient satisfaction and the prescription of poor-quality medications than their public counterparts.[44]

High OoP spending and a failing government system create a significant market for private providers. Nigeria's health sector has echoes of its power sector, where stakeholders expected to guarantee a stable supply of power also have stakes in alternative sources, such as diesel fuel or generators.[45] Similarly, some private health service providers are involved with the government, influencing policies for both the private market and the public health system. Their incentives and ensuing conflicts of interest are seldom discussed.

Civil society organisations and media

This group's broad interests include affordable quality care and financial accountability. There are incentives in mobilising around scandals and tangible failures such as stock shortages and hikes in user fees. Elite-leaning, urban CSOs may prioritise access to government decision makers over grassroots mobilisation. Investigative media can help shift narratives around health and spur action. But to be effective, it needs access to facilities, administrative offices and data.

Religious, traditional and community leaders

Religious, traditional and community leaders have strong social and political influence. They are formally recognised in multiple Nigerian health policies and community health governance frameworks as important stakeholders in health promotion, mobilisation and decision-making.[46] However, concerns persist regarding the extent to which such leaders are empowered to demand accountability and enforce health rights. Their roles often focus more on mobilisation, gatekeeping and information dissemination than on sustained advocacy or action when health services fail to meet expectations.

At the same time, Nigeria's rapidly expanding digital community, including media influencers and online civic networks, is vocal on governance and social justice issues, including police brutality, elections and economic grievances.[47] Mobilisation around health-system accountability has been limited. Issues such as inadequate primary healthcare, medical negligence and health finance have yet to generate comparable levels of sustained digital advocacy or offline protest.[48]

Nigerian citizens

It is hard to do justice to Nigeria's near quarter of a billion citizens as a 'player' group. However, for this analysis we suggest three health-related categories.

The first group values an effective formal health system and relies mainly on domestic health services, including private formal providers. The second group primarily depends on informal providers such as drug vendors and traditional healers. Both would like improved health services, but lack the political power to catalyse change. The third group are elites who can afford to insulate themselves from Nigerian healthcare by seeking care abroad. They have political power, but little interest in improving general health services or outcomes. Cases where emergencies force these elites to come into contact with domestic realities can generate substantial media attention.[49]

Women are primary users of maternal and reproductive services, household caregivers and informal financial managers. Their low economic status and decision-making power often exclude them from care and insurance coverage, increasing their vulnerability. Recent reforms such as the NHIA Vulnerable Group Fund recognise women as priority beneficiaries. But Nigeria is still a long way from equitable or universal health coverage.

So what?

Nigeria's elites shape a system where security, economic growth and wealth are far more prominent than health. When politicians talk about the health sector, they typically focus on new infrastructure, procurement of drugs and equipment, and jobs. Citizens, meanwhile, do not assess politicians on the basis of promises or performance in health service quality or outcomes. A need for system strengthening is sometimes mentioned, but the low political or electoral salience of health system plumbing limits follow through.[50]

Instead, most dominant players have clear, rational incentives to pursue simple targets and visible wins. Politicians gravitate towards ribbon-cutting opportunities and favour the 'shiny' over mundane system improvements. Complex, long-term, often invisible plumbing improvements are neglected.

A desire for credit and an aversion to risk also push external funders toward discrete, vertical programmes. In a complex and chaotic system, agencies at all levels protect their own turf. States calibrate their effort to secure a share of top-down resources, not to their own assessment of citizens' needs. The result is that citizens and frontline providers carry much of the cost, while the backbone plumbing of the health system remains neglected.

III. WHAT ARE THE RULES OF THE GAME?

Formal rules define the health system's architecture. Informal rules determine how money and power are exercised, and whether outcomes are realised. It is naturally easier to discuss formal rules, which helps to explain some stubborn failures.

Formal rules

Legislation and regulation

Health policy is built on the National Health Act. It targets frontline service delivery (eg minimum standards, task shifting and sharing, the essential medicines list), the purchasing of health services (eg NHIA, SHIA and BHCPF), system organisation and coordination (eg Primary Health Care Under One Roof [PHCUOR], the Health Sector Strategic Blueprint, the National Strategic Health Development Plan, the National Human Resources for Health Policy and the National Drug Policy), and data management (eg information systems and data governance).

Financial disbursement

The annual budget process sets ceilings and appropriations. The norms of the Treasury Single Account govern cash. Procurement acts and financial regulations control spending. Audit and inspection mechanisms are clear.

Coordination

The SWAp's 'one plan, one budget, one report, one conversation' is an umbrella for national coordination. State annual operational plans (AOPs) increasingly list interventions and funding sources. They aim to adhere to the 'country-led' rule with government resources allocated first, after which external partners fill recognised gaps. Efforts are underway to automate AOPs templates.[51] SWAp is decentralising its operations by establishing a physical presence in each state and providing support to help them adopt SWAp's core principles.[52]

Informal rules

In practice the system is characterised by informality and discretion.

Rule 1. Discretion over timing

Budgets are theoretical until political authorisation releases actual funds.[53] In Nigeria, even when budget appropriations should be automatic, fund releases are negotiated, discretionary and unpredictable. End-of-year rushes, virements and arrears are common. Delays cause short-term funding gaps and necessitate workarounds. They also precipitate 'bridge funding' from some donors. This may be well-intentioned, but bridge funding explicitly breaches 'country-led' commitments, funds items already covered by government budgets, displaces domestic effort and offers a rolling safety net that undermines pressure for fiscal discipline and better plumbing.

Rule 2. Political influence versus political corruption

It is rare for Nigerian politicians to be directly implicated in health corruption. High-profile cases typically implicate bureaucrats (health insurance executives, programme staff, HMOs and NGOs). However, indirect 'vapour trails' of political corruption are visible. NHIA/HMO scandals suggest patronage-based licensing and protection of non-performing HMOs. For example, a former NHIA director general reportedly received political protection despite adverse audit findings.[54] And COVID-19 fund probes suggest bad practice involving ministers and senior officials, but follow-up is incomplete.[55] Structural political corruption in the health sector may manifest less through overt embezzlement and more through the capture and control of financing pools by patronage and elite

networks. This differs from sectors such as electricity and energy where direct financial diversion has been more visible in investigations and in public debate.

Rule 3. Parallel accountability

External donors are wary of Nigeria's weak PFM and reputation for corruption, and so maintain parallel systems for procurement, reporting, and monitoring and evaluation. This raises transaction costs, fragments the focus of other players and draws attention away from system plumbing.[56] The negative effects of fragmentation on health systems are well-known, yet it persists. Short-term risk management continues to trump long-term system-wide transformation.

Rule 4. Old content, new packaging

New governments tend to release new 'flagship' health strategies. These overlap in substance with their predecessors (primary health care, reproductive health, financing reform etc), but rebranding disrupts continuity. Formal laws and governance reforms are more durable; they outlast administrations and shape subsequent plans. But they remain constrained by informal norms.

Rule 5. Top-down realities

Despite federalism, power generally flows top-down. The states and LGAs selected for new initiatives often appear to reflect profile, accessibility and key relationships more than objective need. Furthermore, slow and inaccurate paper-based data systems at facility level perpetuate distrust of the evidence used to assess need, set priorities and monitor performance. This sustains top-down power relations and discretion, as 'the centre knows best.'

Rule 6. Coordination: a technical approach to a political problem

SWAp is a rational technical effort, but it struggles in the political gap between rules and reality. This creates confusion over mandate and authority, with ambiguity over who arbitrates when different agencies propose overlapping financing routes, or when the Ministry of Finance's cash constraints undermine SWAp's commitments.[57] Some officials, including in the Ministry of Health, reportedly opposed the creation of SWAp. They questioned its long-term viability as a presidential initiative not backed by an act of parliament.[58]

'Platform sprawl' and duplication persist. Multiple working groups exist for some topics, as do duplicate requests for meetings, data and reports.[59] Implementation monitoring also remains a challenge. Rarely is there any functional, single, trusted regimen for tracking execution, delivery and donor disbursements at facility level (although expert information indicates that a PHC financial management system is in development).[60] Without common verification, policy discussion often reflects assertion, not evidence.

States vary significantly in the quality and discipline of their AOPs, SHISs and PFM. Only some states make their AOPs publicly available and engage in rigorous, evidence-based planning.[61] A few states allocate budgets for state health insurance initiatives, actively enrol citizens and generally prioritise health in their budget allocations.

However, these efforts are yet to yield significant results. Ideally SWAp would differentiate health support packages and steer donors toward places where needs are greatest. But SWAp meetings may descend into troubleshooting when federal releases are late, with external partners either delaying funds or offering bridge funding. Both weaken the SWAp compact's credibility and undermine budget discipline.[62] It remains to be seen whether SWAp can help shift attention away from prestige projects and toward investment in system plumbing and long-term reform.

IV. THE STATE OF PLAY

Nigeria's health system is stuck in a low-performing equilibrium. This is shaped by Nigeria's wider national elite bargain, with a subsidiary elite bargain in health which includes key donor partners. Health has had limited electoral salience (Big-P politics), and the small-p politics embedded within the health system sustain low performance, low expectation and avoidance for those that can afford it. Health sector realities become briefly visible when emergencies bring famous people into contact with the low-performing reality, and when scandals and inefficiencies catch media attention.

Discretion doom loop

Discretion is not always bad. It is essential for honest workarounds that keep services running, but it makes space for dishonesty and leakage. These in turn justify overbearing central control and parallel accountability systems, while also creating perverse incentives and perpetuating low performance. Even where laws mandate financial flows, execution depends on release decisions and compliance checks by the centre. Discretion is a bargaining chip, a buffer against risk and a wildcard creating unpredictability and undermining system reform. Discretion drives a self-perpetuating doom loop or vicious cycle which is hard to pull out of.

PFM fatigue, partner fragmentation and parallel systems multiply transaction costs for managers, who often spend more time on compliance than on system improvement.[63] Strategic purchasing, e-claims, fraud analytics, provider contracting and blended payments struggle to scale without predictable financing and trusted data.[64]

Human resource distrust and underemployment

Although Nigeria is often cited for a low number of health workers, it is also one of Africa's top producers of health personnel. Each year, around 20,000 health workers graduate in Nigeria, including about 15,000 nurses and 4,000 general medical practitioners.[65] Despite this, the health worker density remains very low: about 1.99 health workers per 1,000 people and 4.1 doctors per 10,000 – well below WHO's recommended levels of 4.45 health workers and 17 doctors respectively.[66]

Despite Nigeria's capacity to produce health workers, recruiting and retaining health personnel is not a political priority. Over 13,000 Nigerian-trained health workers emigrated to the UK between 2021 and 2022 alone.[67] It is still too early to say whether the 2023 National Policy on Health Workforce Migration can help address recruitment and retention. Narratives around 'brain drain' are simplistic and evidence suggests something more complex at play, including 'brain gain' whereby the potential to migrate helps to increase the number of skilled workers in the system.[68]

Little love for plumbing

Visible, vertical, near-term targets continue to trump long-term system improvements. This suits Nigerian elites *and* donors, as they meet electoral incentives (visibility), donor incentives (credit for visible results), and administrative incentives (control over gateways and procurement).[69]

In contrast, investments in plumbing offer little political return, and so are routinely delayed or underfunded.[70] Slow and uneven system reform is often framed as a problem of low capacity and funding gaps, rather than a consequence of underlying incentives. But system improvements rarely align with visibility, political strategy or electoral cycles. That comes with a cost: neglecting the plumbing reproduces the doom loop.

Donors in the doom loop

Faced with unpredictability and appeals for urgent help, some international partners reportedly offer fixes such as bridging funds. They may know that such stopgaps undermine the budget discipline required to sustainably transform Nigeria's health system. But, justified as exceptional emergencies, these also serve donors' home-country political motivations (to visibly be doing good) and reportedly buttress their visibility and political access in Nigeria. As elsewhere in global aid, perpetual urgency

reproduces dysfunction, which generates crises and requires more emergency measures. Emergency aid feeds the doom loop.

In this system, state governments adapt rather than transform. Faced with uncertain federal releases and donor discretion, most focus on securing projects and allowances rather than building disciplined purchasing and PFM. Nigeria's high-profile states still receive a substantial portion of development assistance for health, which may inadvertently contribute to inequity. For example, the State of Health of the Nation Report documents that Lagos, Nigeria's wealthiest state, has 42 donor and implementing partners – Taraba, one of the poorest, has nine.[71]

Donor and political interests converge on vertical programmes because attribution is more straightforward, procurement is bounded, results are more countable and justification to their own domestic audiences is more straightforward. System-wide reforms receive attention mainly when vertical outcomes are threatened.[72]

Donor funds are safeguarded from corruption by strong external audits and rapid recovery mechanisms. However, recurrent corruption cases indicate the limits of parallel oversight systems. Domestically managed pools, especially health insurance schemes, are consistently vulnerable to mismanagement of provider payments, procurement and allowances, with slow recovery and prosecution. Probes into COVID-19 losses found that emergency funds were particularly at risk. Accountability outcomes depend heavily on sustained legislative and prosecutorial follow-through. Durable change requires measurable improvements in PFM performance, transparent provider payment systems and stronger enforcement capacity – not just new schemes and donor safeguards.

There is a general trust deficit. Donors hesitate to fund horizontal system improvements. States doubt that new federal plans will be financed. Facilities doubt that claims will be paid on time. And citizens doubt that reforms will lower their healthcare costs. All hedge their bets with the private market or use it because it is the only available option.[73]

Finally, accountability to citizens is rare. Civil society engagement is often mediated by urban elites. Routine publication of comprehensive health accounts and budget performance is rare, and verification systems remain fragmented.[74] Citizens vote with their feet (or wallets), buying health services they value despite their generally poor quality. Health has critical salience in real life, but extremely low salience in political life.

Consequences

The problems described in Section I are the direct consequence of this state of play. Without reliable system plumbing, households pay at point of service – whether by going private or paying for government services that are in theory free. This drives catastrophic expenditure and delayed care.[75] OoP spending may also act as a pressure valve, reducing the imperative for the state and donors to pull the health system out of its doom loop. Problems are more pronounced in poorer and conflict-affected areas, yet donors tend to cluster in more capable and geographically accessible states.[76] This may be understandable, but it is not justifiable and needs to be called out.

Shifting Nigeria's elite bargain in health will be impossible without openly discussing politics, informal realities and incentives. The professional and personal interests of politicians, national finance and health officials, their state and local counterparts, and international donors need to be shifted so that these actors have compelling reasons to invest in system plumbing alongside infrastructure and vertical programmes. This is not to upend their interests or dominance. Rather, Nigeria needs to construct an elite bargain in health that brings win-wins for citizens and elites alike.

V. OUR PROPOSITIONS

Nigeria already has many capable individuals and organisations committed to tackling the practical problems set out in this note. But despite decades of effort, Nigeria stubbornly lags behind regional averages in health's most emblematic outcomes – maternal mortality, infant mortality and life

expectancy – as well as service coverage and quality metrics. Meanwhile, Nigerians pay through the nose to buy poor quality healthcare.

Nigeria is capable of positive change. It has shown this in other sectors already, such as banking, telecommunications and aviation. It has also shown the capacity to coordinate and deliver complex health-system reforms and primary healthcare interventions under the Partnership for Transforming Health Systems (PATHS) in the early millennial era.[77] We offer six propositions to help catalyse positive, sustainable and country-led change in health.

Proposition 1. Get health politics on the policy table – and keep it there

Nigeria's challenge is not deciding what to do, but persuading dominant players to want to do it. Something has been missing in the debate. We contend that this is a polite but frank discussion of political constraints, both in the Big-P politics of electoral competition and in the small-p politics of how power and interests shape health systems, investments and outcomes.

The politics of all actors, international and domestic, should be put on the table. They should also be open to public comment, so citizens may actively participate in shaping the healthcare they receive. Better services and outcomes are the key measures of success. Open PEA aims to put politics on the table, and we intend to update this product on a regular basis to reflect on progress and inform ongoing debate. We also plan to deliver products on other critical parts of Nigeria's health ecosystem, such as the politics of formal and informal health markets and pharmaceutical manufacturing.

Proposition 2. Make 'good health', rather than just avoiding catastrophe, politically salient and put forward a credible political case for reform

For system reform, health needs a viable political and electoral strategy that creates win-wins for both elites and citizens. Any such strategy needs to increase the political salience of health outcomes and improve health system plumbing, and distinguish these from ribbon-cutting and infrastructure. Rationalising and ensuring minimal standards in Nigeria's private health market could also be part of the longer-term political strategy. All of this rests on finding a feasible way to encourage Nigerians and politicians to vote for and support long-term health outcomes, rather than only focusing on the symbols of avoiding catastrophe – such as new hospitals.

Rebalancing health politics from visibility to plumbing quality needs thought and experimentation. At the national level, we suggest creating and testing flagship reform projects with clear milestones and public dashboards. At the state level, enterprising governors could pilot and champion whole-household coverage through SHIS (not just single-service subsidies) and showcase the results at the National Council on Health and public platforms. Throughout this, all levels of government should experiment with different ways of making health legible and salient to citizens – and external funders could partner in this.

Proposition 3. Funders should recognise themselves as players in, not observers of, health politics

We contend that external funders view themselves as well-intentioned observers of health politics in Nigeria, rather than political players in their own right. They fail (or refuse) to acknowledge their own power, interests and agency in Nigeria's elite bargain and dysfunction in health.

They 'talk the talk' in terms of backing country leadership and convergence, but their own political incentives often prevent them from consistently walking the walk. External funders reinforce political constraints and doom loops. Even the best-intentioned externally driven reform initiatives tend to focus on formal inflows at the top rather than system plumbing. This addresses one important area of inefficiency. But not the most binding system constraints.

It is time that donors' self-perceptions account for their own politics and interests. This requires a willingness to talk about them. Our understanding is that health politics is rarely a formal item on

donors' policy agenda – either in dialogue or documentation. We hope that this Open PEA product can help make this a more routine agenda item by providing a public starting point for discussion.

Proposition 4. Focus on the out-of-pocket spending crisis and making private markets work better

Households, not donors, bear the main costs of Nigeria's health finance gap and system failure. OoP spending pushes families into poverty and undermines trust in the system. We recommend that governments and international partners shift focus from aid crisis narratives to improving the chaotic private market in which most OoP funds are spent. We also recommend paying attention to quality, efficiency and affordability in government facilities, and actually realising the benefits of tax-funded non-contributory health insurance schemes that cover priority health needs.

International partners could help catalyse the shift by explicitly changing the type of the expertise that they deploy (such as more market expertise), their strategic priorities and their investments in health. We recommend committing at least 30% of time, effort and funding to addressing Nigeria's OoP crisis, and to improving quality and efficiency in the private market. This is not a dismissal of the public system, but an honest reminder that the government must lead on disciplined financing of the public health system, with donors filling only the gaps.

Making the reality of health finance more visible to the public is also important, and this could cover the entire health ecosystem (private and state together). This could mean redesigning the *State of the Health of the Nation Report* as a two-tier product: a technical annex for specialists, and community-level summaries that answer the questions people actually ask, like 'what changed?', 'where did the money go?' and 'what's next?' Answers could be actively disseminated via radio, SMS, social media and town-hall meetings. Protecting space for non-elite civil society organisations to track budget execution and purchasing, as well as galvanise social action, could also help, as could sponsoring watchdog and financial journalism.[78]

Proposition 5. Create and use one set of basic, trusted data. By all for all.

A compact that rewards predictable domestic effort and makes system plumbing visible could help realign system incentives. Nigeria's SWAp *could* deliver this – if it focuses on the basics and streamlines decision making, rationalises platforms and prioritises basic PFM performance and budget execution. International partners can help by tying their funds to the same basics, sharing credit for shared outcomes and going where the needs are greatest. This 'back to basics' approach can help shift health from OoP survivalism toward pooled protection and reliable care for households across the federation.[79]

Accountability requires credible data. Local facilities need basic digital tools, with data linked directly to the DHIS2 platform (including health insurance and BHCPF payment records). Quarterly micro-audits accessible to the public would help ensure accuracy, building the trust and transparency needed to reduce OoP burdens and reorient health financing around citizens' interests, not donors.

Proposition 6. Use carrots and sticks to encourage investment in plumbing

There are few incentives for external funders to invest in system plumbing. This may require new 'sticks' (pressure, threat of discipline) as well as 'carrots' (incentives related to shared success). Even if vertical funds continue, there may be an opportunity for a 'plumbing surcharge' on all external funds to help finance no-regrets plumbing that addresses system problems. This could include rolling out e-claims and electronic verification for NHIA/SHIS payments, starting with high-volume benefits; funding facility-level data capture (devices, power supply, connectivity, basic health records staff), so entries reflect real-time service and financing data; financing integrated digitalisation of the health sector; investing in facility-based customer care services as a means of emphasising patient-centred care; ensuring that priority health policies are widely known and implemented at the frontline; and advancing a National Provider Registry and a single master facility list across platforms.

VI. Key readings

For those wanting to read more we suggest the following texts:

1. Abubakar, I. et al (2022) 'The Lancet Nigeria Commission: investing in health and the future of the nation', *The Lancet*, 399(10330), 1155-1200.
2. Onwujekwe, O. et al (2025) 'Country health systems and services profiles: Nigeria', African Health Observatory, World Health Organisation.
3. Drake, T. et al (2025) 'A new compact for health financing: donor priority setting', CGD Note, Center for Global Development.
4. Onwujekwe, O. et al (2024) 'Assessing root causes and solutions to address cross-programmatic inefficiencies in a subnational health system: a case study of Anambra State, Nigeria', *Health Systems & Reform*, 10(3), 2441533.
5. Croke, K. and Ogbuoji, O. (2024) 'Health reform in Nigeria: the politics of primary health care and universal health coverage', *Health Policy and Planning,* 39(1), 22-31.
6. Oladimeji, S. et al (2026) 'Nigeria health intelligence report – accelerating change: insights into Nigeria's health sector transformation, 1st edition, November 2024', *Gates Open Res*, 10(19).
7. Barasa, E. et al (2025) 'Avoidable pitfalls on the path to health financing self-reliance in low-income and middle-income countries', *BMJ Global Health*, 10(11).
8. British High Commission Nigeria (2025) 'Twenty years of UK health system strengthening programming in Nigeria - thematic evaluation', Cadmus.

VII. References

1 Onwujekwe, O. et al (2025) 'Country health systems and services profiles: Nigeria', African Health Observatory, World Health Organisation; World Bank (2026) 'Maternal mortality ratio (modelled estimate, per 100,000 live births – Nigeria'; Abubakar, I. et al (2022) 'The Lancet Nigeria Commission: investing in health and the future of the nation', *The Lancet,* 399(10330), 1155-1200.

2 World Health Organisation AFRO (2023) 'Maternal mortality: the urgency of a systemic and multisectoral approach in mitigating maternal deaths in Africa'.

3 Agwu, P. et al (2024) 'Ungoverned spaces among informal health providers in Nigeria and health security implications', *Journal of Social Service Research*, 51(3), 788-800. Multidimensional poverty indicators (MPIs) highlight these disparities, showing higher incidence and intensity in northern Nigeria. MPIs assess more than just income, including access to health, education, decent living conditions and employment. The north has an average combined MPI incidence and intensity score of 57.45%, while the south's score is 44.4%. Rural areas in Nigeria face greater poverty, and urban slums are increasingly populated with individuals experiencing severe multidimensional poverty.

4 Abubakar, I. et al (2022) 'The Lancet Nigeria Commission: investing in health and the future of the nation'.

5 World Bank (2026) 'Nigeria'.

6 WHO (2025) 'Global health expenditure database'.

7 Demeshko, A. et al (2025) 'A new era for global health: can African countries agree a new compact with external donors?', CGD Brief, Center for Global Development.

8 Demeshko, A. et al (2025) 'A new era for global health: can African countries agree a new compact with external donors?'.

9 Onwujekwe, O. et al (2025) 'Country health systems and services profiles: Nigeria'.

10 Ozor, O. et al (2025) 'Inequities in household out-of-pocket spending among urban slum dwellers in southeast Nigeria', *International Journal of Public Health*, 70, 1607969.

11 Onwujekwe, O. et al (2025) 'Country health systems and services profiles: Nigeria'.

12 Onwujekwe, O. et al (2025) 'Institutionalizing linkages between informal healthcare providers and the formal health system in Nigeria: what are the facilitating and constraining contextual influences?', *Health Policy and Planning,* 40(4), 471-482.

[13] Federal Republic of Nigeria (2024) 'Nigeria demographic and health survey 2023–24'.

[14] Agwu, P. et al (2025) 'Solving delayed referrals of childbirth cases from unskilled to skilled birth attendants in Nigerian urban communities: a case study exploration of new frontiers', *Midwifery,* 146, 104397; Ntoimo, L.F.C. et al (2022) 'Why women utilize traditional rather than skilled birth attendants for maternity care in rural Nigeria: implications for policies and programs', *Midwifery*, 104, 103158.

[15] Ozor, O. et al (2025) 'Inequities in household out-of-pocket spending among urban slum dwellers in southeast Nigeria'.

[16] Cairncross, S. et al (1997) 'Vertical health programmes', *The Lancet*, 349(S20-S21). 'Indeed, some observers find the situation so bleak, especially in Africa, that vertical programmes are hailed as the only way to produce success stories and so maintain the enthusiasm of donors and governments for investment in public health.'

[17] Madu, A.C. and K. Osborne (2023) 'Healthcare financing in Nigeria: a policy review', *International Journal of Social Determinants of Health and Health Services*, 53(4), 434-443.

[18] Ataguba, J.E. et al (2024) 'Financial protection in health revisited: is catastrophic health spending underestimated for service- or disease-specific analysis?', *Health Economics*, 33(6), 1229-1240.

[19] Federal Ministry of Health and Social Welfare (2024) 'State of health of the nation report'.

[20] Mahmood, A. (2025) 'Where the money fades: a new way to diagnose budget failures in health systems', *Fiscal Health Insights Substack*.

[21] Uzochukwu, B. et al (2018) 'Accountability mechanisms for implementing a health financing option: the case of the basic health care provision fund (BHCPF) in Nigeria', *International Journal for Equity in Health*, 17(1), 100; Balogun, J.A. and P.C. Aka (2022) 'Strategic reforms to resuscitate the Nigerian healthcare system' in Udogu, I. (ed) *Nigeria in the fourth republic: confronting the contemporary political, economic and social dilemmas*, London: Bloomsbury, 81-105; Obi, C. et al (2025) 'Referral experiences of healthcare consumers: results from a cross-sectional study in urban slums in southeast Nigeria', *Frontiers in Public Health*, 13, 1561158.

[22] Ogundeji, Y.K. et al (2023) 'Is Nigeria on course to achieve universal health coverage in the context of its epidemiological and financing transition? A knowledge, capacity and policy gap analysis (a qualitative study)', *BMJ Open*, 13(3), e064710.

[23] Agwu, P. et al (2026) 'Poor accountability and corruption in primary healthcare in Nigeria: subnational governance deficiencies matter', *Health Systems & Reform*, 12(1), 2630426; British High Commission Nigeria (2025) 'Twenty years of UK health system strengthening programming in Nigeria - thematic evaluation'; Alawode, G.B. et al (2026) 'An enabler or a barrier: implications of local government autonomy for effective primary health care (PHC) reforms in Nigeria', *The Pan African Medical Journal*, 53, 30.

[24] Onwujekwe, O. et al (2024) 'Assessing root causes and solutions to address cross-programmatic inefficiencies in a subnational health system: a case study of Anambra State, Nigeria', *Health Systems & Reform*, 10(3), 2441533.

[25] Adebisi, Y.A. et al (2020) 'Assessment of health budgetary allocation and expenditure toward achieving universal health coverage in Nigeria', *Journal of Health Reports and Technology*, 6(2).

[26] For example, only ₦36m (~$26,000) of the ₦218bn ($160m) capital allocation for health had been released from the 2025 budget by February 2026. See: Olaniyi, O. (2023) 'Examining budget credibility in Nigeria's health sector', International Budget Partnership.

[27] Onwujekwe, O. et al (2024) 'Assessing root causes and solutions to address cross-programmatic inefficiencies in a subnational health system: a case study of Anambra State, Nigeria'.

(Note 27 continued) Major corruption cases in Nigeria health sector

Case and Period	What Happened	Finances at Risk / Lost	Source	Actions Taken	Refs
Global Fund grants (2010–2016)	OIG audits/investigations revealed systemic control failures, fraud and collusion in HIV/TB/malaria grants	$19.8m ineligible /unsupported; $3.8m confirmed fraud	Global Fund grants	Disbursements suspended; 'additional safeguards' applied; recoveries/sanctions pursued	[1], [2]
Gavi immunisation audit (2011–2013, reported 2015)	Gavi CPA uncovered misuse of immunisation cash support	$2.2m misused	Gavi support funds	Gavi demanded reimbursement; Nigerian agencies petitioned for investigation	[3], [4]
NHIS/HMO mismanagement (2005–2016; probes peak 2017)	35 HMOs accused of diverting NHIS capitation payments, starving providers of funds	₦351bn [$1.15bn]	NHIS insurance pool	House probes; ICPC recovery drive; ~92% of funds reportedly recovered	[5]–[7]

NHIS Exec. Sec. Usman Yusuf (2017–2025)	Panels & Auditor-General flagged procurement breaches and illegal allowances; later criminal charges	₦919m [$2.6m] (2017); ₦6.8bn [$18.9m] (2017); ₦90.4m [$70k] (2025)	NHIS funds	Suspension (2017), dismissal (2019), EFCC arraignment (2025, case ongoing)	[8]–[12]
COVID-19 intervention funds (2020–2024)	Parliament alleged mismanagement of pandemic allocations across MDAs (incl. health)	₦100bn [$260m]	Federal budget & donor relief	House hearings (2023–24); probes ongoing	[13], [14]
PSI – Global Fund malaria grant (2015–2018)	OIG found fraudulent & non-compliant expenses by the implementer Population Services International	$551,608 fraudulent + $175,818 non-compliant ($727,426 total)	Global Fund grant	PSI refunded full amount; case closed	[15]
NHIS illegal allowances (2017 audit, published 2020)	OAuGF exposed systemic unapproved allowances paid by NHIS	₦6.8bn [$18.9m]	NHIS funds	Findings published; basis for ongoing NHIS oversight/prosecutions	[10]
BHCPF corruption and accountability issues (2018 – 2022)	Evidence of returned unspent World Bank funds not traced. Unauthorised investment of BHCPF in fixed deposit in a commercial bank by a state	₦2bn ₦499m	BHCPF	Findings published via an internal audit report (not available online) Minister wrote a 'red letter' flagging corruption in BHCPF and calling for vigilance	[16]

References in this table

1. Global Fund OIG Audit Report: *Grants to Nigeria* (2016).
2. Global Fund OIG Investigation Report: *Nigeria – DPRS fraud* (2016).
3. Gavi: Reimbursement of misused amounts – Nigeria (2015).
4. Premium Times: Petition over US$2.2m Gavi refund (2015).
5. Guardian: Reps may indict 35 HMOs over ₦351bn NHIS fund (2017).
6. ICPC: 92% of looted NHIS funds recovered (2017).
7. ThisDay: HMOs return NHIS funds (2017).
8. SIGNAL NG: NHIS boss sent on compulsory leave (2018).
9. Punch: After indictment, FG pays suspended NHIS boss (2019).
10. Premium Times: NHIS squandered ₦6.8bn on illegal allowances (2020).
11. Premium Times: Usman Yusuf dismissed as NHIS boss (2019).
12. EFCC: Arraigns ex-NHIS boss Usman Yusuf for ₦90m fraud (2025).
13. Channels TV: Reps query ₦100bn COVID-19 funds (2023).
14. Punch Healthwise: Reps probe COVID-19 funds mismanagement (2024).
15. Aidspan: PSI refunds US$727k on malaria grant (2018).
16. Health Anticorruption Project Advisory Committee: Solutions to corruption in the Basic Health Care Provision Fund (BHCPF) for primary healthcare facilities in Nigeria (2025).

[28] Onwujekwe, O. et al (2024) 'Assessing root causes and solutions to address cross-programmatic inefficiencies in a subnational health system: a case study of Anambra State, Nigeria'; Croke, K. and Ogbuoji, O. (2024) 'Health reform in Nigeria: the politics of primary health care and universal health coverage'.

[29] Zovighian, D. (2026) 'Clientelist politics in Nigeria: core voters, control and compliance', *World Development*, 200, 107281; Chukwuma, A. et al (2019) 'Health service delivery and political trust in Nigeria', *SSM-population health*, 7, 100382.

[30] Gatefield (2023) 'Insecurity is the main concern for Nigerian voters in the 2023 elections'; Croke, K. and Ogbuoji, O. (2024) 'Health reform in Nigeria: the politics of primary health care and universal health coverage', *Health Policy and Planning*, 39(1), 22-31.

[31] Croke, K. and O. Ogbuoji (2024) 'Health reform in Nigeria: the politics of primary health care and universal health coverage'.

[32] Egwudo, A.E. et al (2025) 'Integrating digital health technologies into the healthcare system: challenges and opportunities in Nigeria', *PLOS Digital Health*, 4(7), e0000928.

[33] Onwujekwe, O. et al (2024) 'Assessing root causes and solutions to address cross-programmatic inefficiencies in a subnational health system: a case study of Anambra State, Nigeria'.

[34] NOI Polls (2024) 'Only 19 in 100 Nigerians have health insurance, new poll reveals'.

[35] Effiong, F.B. et al (2025) 'Coverage and predictors of enrollment in the state-supported health insurance schemes in Nigeria: a quantitative multi-site study', *BMC Public Health*, 25(1), 2125.

[36] Barasa, E. et al (2025) 'Avoidable pitfalls on the path to health financing self-reliance in low-income and middle-income countries', *BMJ Global Health*, 10, e021270; Aregbeshola, B.S. (2018) 'A tax-based, noncontributory, health-financing system can accelerate progress toward universal health coverage in Nigeria', *MEDICC review*, 20, 40-45.

[37] National Health Insurance Authority (2026) 'From policy to progress: financing access to CEmONC intervention reaches over 32,000 mothers'.

[38] Nigeria Health Watch (2024) 'What does Nigeria's sector-wide approach mean for the health sector?'.

[39] On elites and the elite bargain: 'Those with power' are the economic and political elite—the business leaders, the political establishment, military commanders, and often public intellectuals and journalists, union leaders and prominent academics—that is, those who in the end have the power and influence to drive decision-making about the economy and society. … Their power stems from a deal, called the elite bargain, that determines the allocation of power and resources. This bargain or agreement is typically informal and implicit: a shared commitment and not some kind of legally binding arrangement.' From: Dercon, S. (2022) *Gambling on Development: why some countries win and others lose*, London: Hurst and Company, 4.

[40] Effiong, F.B. et al (2025) 'Coverage and predictors of enrollment in the state-supported health insurance schemes in Nigeria: a quantitative multi-site study'; Moses, T. (2026) '11 million enrolled as state health agencies map out UHC plan', *Leadership*; Nweze, C. (2026) 'Rivers health agency plans enrollment of children in public schools', *The Trumpet*.

[41] Ihekweazu, V. (2024) 'The primary health care leadership challenge—where winning should save lives', *Nigeria Health Watch*; Amaan, M. (2025) 'PHC leadership challenge: NGF to award $6.1m to top states', *Health Reporters*.

[42] Federal Ministry of Health and Social Welfare (2024) 'State of health of the nation report'; Okeke, C. et al (2023) 'Analysing the progress in service delivery towards achieving universal health coverage in Nigeria: a scoping review', *BMC Health Services Research*, 23(1), 1094.

[43] Drake, T. et al (2025) 'A new compact for health financing: donor priority setting', CGD Note, Center for Global Development.

[44] Onwujekwe, O. et al (2012) 'Examining inequities in incidence of catastrophic health expenditures on different healthcare services and health facilities in Nigeria', *PLoS One,* 7; Onwujekwe, O. et al (2009) 'Quality of anti-malarial drugs provided by public and private healthcare providers in south-east Nigeria', *Malar J.*, 8(22).

[45] Roy, P. et al (2023) 'Breaking the cycle of corruption in Nigeria's electricity sector: off-grid solutions for local enterprises', *Energy Research & Social Science*, 101, 103130.

[46] Federal Republic of Nigeria (2014). 'National Health Act',; Agwu, P. et al (2023) 'Targeting systems not individuals: institutional and structural drivers of absenteeism among primary healthcare workers in Nigeria', *The International Journal of Health Planning and Management*, 39(2), 417-431.

[47] Uwalaka, T. (2024) 'Social media as solidarity vehicle during the 2020 #EndSARS Protests in Nigeria', *Journal of Asian and African Studies*, 59(2), 338-353.

[48] Aubyn, F.K. and O.B. Frimpong (2022) 'Digital activism, transnational support, and the EndSARS movement in Nigeria', in Bangura, I. (ed) *Youth-led social movements and peacebuilding in Africa,* London: Routledge, 69-85.

[49] In 2026, examples include the deaths of Latif Ayodele and Sina Ghami in a car crash; friends and team members of boxer Anthony Joshua; the death of author Chimamanda Ngozi Adichie's infant son; and the death of 'The Voice' singer Ifunanya Nwangene's following a snake bite in Abuja.

[50] Malaria Consortium (2021) 'Political economy analysis for malaria programming in Nigeria', SuNMap 2.

[51] Gulma, K.A. (2024) 'Charting the course: a policy perspective on the evolution of Kebbi State's health sector annual operational planning', *Science,* 12(4), 144-151.

[52] Lagos State (2025) 'Lagos flags off Nhsrii Leadership Workshop to deepen health sector reforms'.

[53] Mahmood, A. (2026) 'The missing link in fiscal space: how political authorisation turns affordability into spending', *Fiscal Health Insights Substack*.

[54] Onwujekwe, O. and P. Agwu (2022) 'Can strategic health purchasing reduce inefficiency and corruption in the health sector? The case of Nigeria', *Health Systems & Reform*, 8(2), e2057836.

[55] Erameh, N.I. and V. Ojakorotu (2021) 'The Nigerian state, corruption and the political economy of Covid-19 governance', *Gender and Behaviour*, 19(1), 17597-17608.

[56] Onwujekwe, O. et al (2024) 'Assessing root causes and solutions to address cross-programmatic inefficiencies in a subnational health system: a case study of Anambra State, Nigeria'; Kalu, K. (2022) 'Assessing the impacts of donor support on Nigeria's health system: the global fund in perspective', *International Social Science Journal*, 72(243), 243-253.

[57] Gideon, J. (2025) 'Sector-wide approach explained: Nigeria's blueprint for stronger health coordination', Equicare Strategies; Moghalu, C. (2024) 'Transforming Nigeria's health sector: the SWAp advantage', *Financial Nigeria*.

[58] Pitan, O. et al (2025) 'Spotlighting Nigeria's new health agenda: a case study on the alignment of global health initiatives with national health priorities through the SRMNCAEH+ N lens', *British Journal of Healthcare and Medical Research*, 12(1), 103-127; Agbaoye, K. (2024) 'What does Nigeria's sector-wide approach mean for the health sector?', Nigeria Health Watch.

[59] Onwujekwe, O. et al (2024) 'Assessing root causes and solutions to address cross-programmatic inefficiencies in a subnational health system: a case study of Anambra State, Nigeria'.

[60] Adeoye, M.I. et al (2024) 'Stakeholder perspectives on the governance and accountability of Nigeria's Basic Health Care Provision Fund', *Health Policy and Planning*, 39(10), 1032-1040.

[61] Igbokwe, U. et al (2024) 'Evaluating the implementation of the National Primary Health Care Development Agency (NPHCDA) gateway for the Basic Healthcare Provision Fund across six northern states in Nigeria', *BMC Health Services Research*, 24(1), 1404; Chaitkin, M. (2022) 'Intergovernmental rivalry and fragmentation: how federalism shapes public financial management and health financing in Nigeria', *Thinkwell*.

[62] Oladimeji, S. et al (2026) 'Nigeria health intelligence report – accelerating change: insights into Nigeria's health sector transformation, 1st edition, November 2024', *Gates Open Res*, 10(19), 19.

[63] Croke, K. and O. Ogbuoji (2024) 'Health reform in Nigeria: the politics of primary health care and universal health coverage'.

[64] Ezenduka, C. et al (2022) 'Examining healthcare purchasing arrangements for strategic purchasing in Nigeria: a case study of the Imo state healthcare system', *Health Research Policy and Systems,* 20(1), 41.

[65] Asamani, J.A. et al (2024) 'State of the health workforce in the WHO African region: decade review of progress and opportunities for policy reforms and investments', *BMJ Global Health*, 7(Suppl 1).

[66] WHO Regional Office for Africa (2026). *State of the health workforce in Africa 2026: plan, train and retain*; Oguntola, I. and A. Nwankwo (2025) 'Health workers' impossible workloads are deepening Nigeria's doctor-patient crisis', *Nigeria Health Watch*; Josiah, B.O. et al (2024) 'Perceptions of healthcare finance and system quality among Nigerian healthcare workers', *PLOS Global Public Health*, 4(11), e0003881.

[67] Lawal, L. et al (2022) 'The COVID-19 pandemic and health workforce brain drain in Nigeria', *International Journal for Equity in Health*, 21(1), 174.

[68] See, for example, Yang, D. (2026) 'Brain gain versus brain drain', *VoxDev*.

[69] Kalu, K. (2022) 'Assessing the impacts of donor support on Nigeria's health system: the global fund in perspective', *International Social Science Journal*, 72(243), 243-253.

[70] Agwu, P. et al (2026) 'Poor accountability and corruption in primary healthcare in Nigeria: subnational governance deficiencies matter'.

[71] Federal Ministry of Health and Social Welfare (2024) 'State of health of the nation report'.

[72] Ewe, O. (2025) 'MAMII: a promising initiative to crash maternal mortality in Nigeria', *Nigeria Health Watch*. Kalu, K. (2022) 'Assessing the impacts of donor support on Nigeria's health system: the global fund in perspective'.

[73] Aniebo, C.L. et al (2026) 'The burden and socioeconomic inequality in catastrophic out-of-pocket health expenditure in post-pandemic Nigeria', *Global Social Welfare,* 13, 205-218.

[74] WHO (2025) 'Health accounts'; Olaniyi, O. (2023) 'Examining budget credibility in Nigeria's health sector', International Budget Partnership.

[75] Ataguba, J.E. et al (2024) 'Financial protection in health revisited: is catastrophic health spending underestimated for service-or disease-specific analysis?', *Health Economics*, 33(6), 1229-1240.

[76] Federal Ministry of Health and Social Welfare (2024) 'State of health of the nation report'.

[77] British High Commission Nigeria (2025) 'Twenty years of UK health system strengthening programming in Nigeria - thematic evaluation'.

[78] Alhassan, E.O. and O.O. Ade-Banjo (2025) 'Citizen participation in the political economy of primary healthcare financing in Nigeria: a cross-sectional survey', *Discover Health Systems*, 4, 30.

[79] Drake, T. et al (2025) 'A new compact for health financing: donor priority setting', CGD Note, Center for Global Development; Amref Health Africa (2025) 'Beyond aid: Africa's moment to reclaim health sovereignty'.

Preferred citation: Agwu, Prince and Peter J Evans (2026) 'The practical politics of health financing in Nigeria', Oxford: Open Political Economy Analysis Programme.

About the authors

Prince Agwu is an academic affiliated with the University of Dundee in the UK and a Senior Research Fellow at the Health Policy Research Group, University of Nigeria. He earned a PhD in social policy funded by the Commonwealth Scholarship Commission. Agwu is an editor for Health Research, Policy & Systems (HRPS) and Health Economics, Policy & Law (HEPL) journals. His research areas are health systems and migration, particularly examining governance models and their impact on well-being outcomes.

Peter J Evans is the Programme Director of the Open PEA programme. His interest in the politics of health began with his PhD research on community-based malaria control in Tanzania.

About the Open Political Economy Analysis Programme

The Open Political Economy Analysis Programme (Open PEA) delivers nuanced political analysis on pressing issues in growth and development alongside actionable advice for increasing the effectiveness of policy and investment, regardless of source of funds. Its products are public goods: high quality, open access and written in plain English so all stakeholders may benefit.

Founded in 2025, Open PEA is initially focusing on health, education and energy issues as well as civil service and public procurement reform in Africa and South Asia. It emphasises elite bargains, development gambles and viable 'win-wins'. Open PEA is an initiative of the Centre for the Study of African Economies and the Blavatnik School of Government, University of Oxford. It receives financial support from Coefficient Giving and the John D. and Catherine T. MacArthur Foundation.

Email: open.pea@bsg.ox.ac.uk

Web: openpea.csae.ox.ac.uk

LinkedIn: linkedin.com/company/open-pea