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Priorities and Health Packages in Reforming the Nigerian Health System: Experience from the Lancet Nigeria Commission

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ABSTRACT

Nigeria is projected to become the third most populous nation globally by 2100, which will place increasing pressure on the nation's health systems and necessitate widespread reform to ensure Nigerians have widespread access to affordable, quality health care. The Lancet Nigeria Commission built a case for targeted and high-value investment to support that goal and achieve substantial health gains through several highly cost-effective priority areas for health investment based on analyses of the local burden of disease, prevailing measures of cost-effectiveness, and a prioritization process involving key health system stakeholders. Specifically, the Commission undertook an analysis of existing literature, policies, programs, and governance frameworks, and used the OneHealth Tool[1] and the Lives Saved Tool[2] to project health and cost effects. It identified high–net gain areas including maternal and child health. The Commission's recommendations on health reform have had significant influence on national legislation to mandate health insurance and to create a Vulnerable Group Fund. Building on those early achievements will require health care system reform that leverages the strengths of the system and works within the realities of the complex, federalized system but still meaningfully and sustainably overcomes the limitations previously restricting population health outcomes and access to care. Significant scope remains for further development through carefully directed investment, particularly in primary care, health promotion, and interventions to improve the social determinants of health.

INTRODUCTION

The United Nations projects that Nigeria, with Africa's largest economy and population, will become the third most populous nation in the world by 2100 (UN DESA 2019). Although a nation of great promise, Nigeria must urgently address a series of challenges to reach its true potential. Nigeria experiences the worst outcomes in the world across several health and social outcomes such as malaria (WHO 2018), under-five mortality,[3] and the number of children out of school (World Bank 2022). Health expenditure remains low by global standards, and the health system is beset by a myriad of challenges. Recent analysis comparing Nigeria to other West African countries with similar or lower gross domestic product per capita and investment in health suggests that the country has room to increase both the efficiency of current levels of health spending and the overall envelope of investments (Angell et al. 2022). An increase in domestic funding is also essential to allow a gradual weaning from donor support.

The Lancet Nigeria Commission (LNC) drew together a multidisciplinary group of leading experts to develop evidence-based recommendations to strengthen Nigeria's health system and achieve universal health coverage (UHC) in the country (Abubakar et al. 2022). The LNC calls for "a new social contract centred on health to address Nigeria's need to define the relationship between the citizen and the state" (Abubakar et al. 2022, 1156). For Nigeria to achieve that goal, the LNC recommends a prevention agenda at the heart of health policy using a whole-of-government approach and community engagement. The large inequality between urban and rural areas, and between different regions of the country, requires equitable delivery of health, social welfare, education, and employment. The COVID-19 pandemic also exposed vulnerabilities in health security, which will require a whole system assessment of the investment needs, including for manufacturing capacity of essential health products, medicines, and vaccines.

This chapter draws on the expertise and expands the analysis of the LNC to build the case for targeted and high-value investment to achieve substantial gains in population health and health care for Nigerians. It focuses on the policy implications of the LNC's work, highlighting the links between the findings of the analyses, existing policy initiatives in Nigeria, and the reforms the LNC argues are necessary to propel Nigeria to UHC. There is a scarcity of robust local data to inform policy and investment decision-making in Nigeria (Abubakar et al. 2022). The LNC report and this chapter seek to begin filling that gap, presenting the case and priorities for targeted investment to progress the country toward reaching its potential. The chapter outlines the process through which priorities were set, the sources of data and tools used, and examples of care packages that will support UHC. Properly implementing those packages will require widespread health system and financing reform, and the chapter presents several recommendations to sustainably achieve that reform.

Overview of the Nigerian Health System

The inherently complex Nigerian health system involves three different levels of government, each responsible for the provision of different levels of care. Public funding is split between the federal government (53 percent), state governments (27 percent), and local governments (20 percent); as stated earlier, however, the overall level of funding devoted to health remains low by global standards. Wide inequities exist across the nation along with an imbalance between revenue-raising potential (dominated by the federal government) and the responsibilities of service provision for the other levels of government. On top of public funding, a substantial private sector also provides care to Nigerians, characterized by high out-of-pocket costs.

Recent reforms, notably the passing of the National Health Insurance Authority (NHIA) Act 2022, build on reforms from recent decades that have aimed at improving health care coverage and population health across Nigeria. Those earlier reforms include the establishment and implementation of the National Health Insurance Scheme (NHIS) in the late 1990s and early 2000s; the National Strategic Health Development Plan (NSHDP I), introduced in 2010 and prioritizing eight key areas for further health system reforms (later adopted in NSHDP II); the National Health Act of 2014, which introduced the Basic Health Care Provision Fund (BHCPF), a mechanism for the national government to finance health care provision at the state level; and, more recently, the introduction of the Essential Health Care Package designed to outline key services the population should be able to access. Despite gains through those programs, UHC remains elusive. Several shortcomings have hindered the impact of the reforms; the chapter outlines those shortcomings and develops recommendations to feasibly move the country toward UHC.

PRIORITY-SETTING PROCESS

The priority-setting recommendations emerged from an evidence-based, multistage process led by the LNC. The Commissioners had expertise and experience in the diverse disciplines required to shape national health policy, including public health and epidemiology, political science, history, health economics, health policy and systems research, public policy, sociology, demography, law, anthropology, and health systems.

Ownership and Governance

The LNC ensured representation with respect to gender and local origin, included a range of political and health policy views among experts based within and outside Nigeria, and consulted with a diverse group of policy stakeholders to provide insight into the challenges of delivering health and health care in Nigeria. It set a 10-year time frame for all analyses, looking beyond the life span of the current Nigerian government, to ensure relevance to current and future administrations in Nigeria.

Although some Commissioners had roles within government and public agencies, the process took place outside government, and the LNC does not hold formal power to implement the recommendations. Nevertheless, the government has already adopted some of the LNC's recommendations.

Scope and Content

The LNC sought to generate and synthesize evidence to inform policy and program implementation and with a view to building a strengthened health system that meets the needs of all Nigerians. The process occurred over the following four stages used to generate final recommendations:

1. The LNC reviewed Nigerian history with a focus on the health system to understand current structures and systems by rooting them in precolonial, colonial, and modern-day trends and events.
2. It conducted a comprehensive analysis of the country's disease burden to identify the major causes of morbidity and mortality using the best available data.
3. It analyzed policy documents (health-specific and broader intersectoral policies that influence health beyond health care) and health system factors to identify key challenges and suggest systems-level leverage points for potential intervention.
4. It combined health and economic analyses to generate evidence on the most cost-effective combination of interventions to achieve health goals given Nigeria's disease burden and summarized approaches to improve health financing.

Criteria Used

The LNC's work was underpinned by the core values of fairness, equity, pragmatism, and evidence-driven approaches. Given the youth of the Nigerian population, the LNC's stated priorities include prevention and keeping young Nigerians healthy. The LNC conducted extensive analyses of Nigeria's disease burden and compared population health outcomes to those in neighboring nations to determine areas where the Nigerian system was underperforming and to identify cost-effective, sustainable reform options. An e-Delphi process was conducted in late 2020 with 23 Commissioners and Nigerian health policy makers to identify the key conditions and risk factors most important to address to improve population health in Nigeria (described in detail in the supplementary appendix in Abubakar et al. 2022). That group prioritized key conditions and risk factors using four criteria:

1. The *magnitude of need*, to assess how important an issue the condition or risk factor was to the Nigerian population and health system
2. *Available knowledge*, to assess the importance of further knowledge of the burden of the condition for the Nigerian population and health system
3. *Leverage*, to assess the potential for the LNC's work in this area to contribute to strengthening Nigeria's health system
4. *Equity*, to assess whether work to address the specific condition or risk factor would likely also act to reduce disparities across the population.

The group then presented respondents with a prioritized list of all conditions and risk factors, and asked them to either agree with the ranking or alter it to match their own priorities. The process resulted in the prioritization of 11 conditions and five risk factors considered particularly important to the Nigerian health system (table 9.1).

Table 9.1 Final List of Prioritized Conditions and Risk Factors, Nigeria

Condition group	Rank from prioritization process	DALY-based ranking
Maternal and neonatal conditions	1	1
Cardiovascular diseases	2	6
Diabetes and chronic kidney diseases	3	14
Neglected tropical diseases and malaria	4	4
Respiratory infections and tuberculosis	5	3
Neoplasms	6	11
Mental disorders	7	10
Enteric infections	8	2
Transportation injuries	9	16
Nutritional deficiencies	10	12
HIV/AIDS and sexually transmitted infections	11	5
Risk factors		
Child and maternal malnutrition	1	1
Unsafe water, sanitation, and handwashing	2	2
High systolic blood pressure	3	4
Air pollution	4	3
High fasting plasma glucose	5	6

Sources: Prioritization rankings come from Abubakar et al. 2022; DALY-based rankings use data from Institute for Health Metrics and Evaluation, Global Burden of Disease Study 2019, https://ghdx.healthdata.org/gbd-2019.

Note: DALY = disability-adjusted life year.

Accountability and Transparency Measures

Given that the LNC's work lay outside government and that the LNC had no authority over the implementation of recommendations, its work did not incorporate specific accountability mechanisms. Nevertheless, the LNC's review of current Nigerian policy settings identified several existing measures:

- *Federal and state budgets.* The development of annual health budgets by the Federal Ministry of Health (FMoH) and some state ministries of health was preceded by the development of Medium Term Sector Strategies, which attracted broad-based participation, including by civil society organizations (CSOs), in order to help ensure that annual budgets are used to buy essentials covered by the basic Health Benefits Package (HBP) Nigerians should receive (refer to the

third bullet item in this list). Unfortunately, the Medium Term Sector Strategy process is not very active or well established. Nevertheless, the published annual budgets give CSOs and other stakeholders the framework to monitor the contents of the budget and the implementation, and Nigeria's Open Treasury portal (https://opentreasury.gov.ng) enables them to monitor the HBP within FMoH's annual budget.

- *Social health insurance and other risk protection mechanisms.* The recent passage of the NHIA Act in 2022, based on the recommendation of the LNC (Adebowale-Tambe 2022), provides a further potential source of funds through the establishment of a Vulnerable Group Fund and mandatory health insurance for formally employed persons. A broad-based participatory mechanism will likely be used to develop a cost-effective HBP that assures value for money when deployed by the schemes. The existence of the law provides a governance framework, but ensuring transparent, efficient, and equitable use of the extra funds to cover the target population groups will require development of accountability mechanisms.
- *HBP under the BHCPF.* A broad-based technical working group—composed of government, CSOs, and development partners—led the development of the benefit package. The main implementing agencies at the federal level (the National Primary Healthcare Development Agency [NPHCDA], NHIS, and FMoH) are striving to create awareness about the HBP gateways among health care providers and consumers. The NHIA, through the NHIS gateway of the BHCPF and implemented by subnational (state) social health insurance schemes, purchases services from primary health care centers, a practice based on the agreed HBP of the BHCPF. The HBP was circulated for review, debated, and approved by the National Council on Health, which draws participation from all health sector leaders in Nigeria. It has an accountability framework, which involves both the public and private sectors in ensuring that the purchase of HBP follows the stipulated guidelines. The accountability framework is currently undergoing revision to address some practical issues with implementation of the BHCPF. It is also envisaged that the accountability framework will encompass the monitoring of health workers' presence and productivity, because absenteeism of frontline health workers can undermine the use of the fund. The FMoH has developed a capacity-building and awareness program on the BHCPF to further inform implementers, other decision-makers, and CSOs about the BHCPF's salient features, including the HBP. The current implementation of the BHCPF as a vertical program, however, does not align with the law that established it. That law envisioned integration of the BHCPF into the normal activities of the NHIS, NPHCDA, and their equivalents in states and local governments. Verticalization of the BHCPF has negative implications for efficiency and the amount of benefits the fund can buy.
- *NHIS Formal Sector Social Insurance Programme (FSSHIP).* Development of the initial HBP of the FSSHIP of the NHIS (now the NHIA) used a broad participatory method, involving academics, health insurance companies, NHIS staff, physician groups, and others. Although subsequent revisions of the HBP of

the FSSHIP have not followed such a broad-based approach, the NHIA regularly informs citizens and their accredited providers about the summary contents of the HBP, delineating the benefits to be provided or purchased at primary, secondary, and tertiary levels of care. With the passage of the NHIA Act 2022, that mechanism will need to be updated.

- *State Social Health Insurance Schemes.* The State Social Health Insurance Schemes, found at subnational levels, try to follow the steps taken by the NHIA in developing its HBP and creating accountability mechanisms for monitoring the provision and consumption of the HBP.
- *Other special financial risk protection interventions.* Examples include the Free Maternal and Child Health programs, especially the defunct National Health Insurance Scheme–Millennium Development Goals/Maternal and Child Health and Subsidy Reinvestment and Empowerment Programme/Maternal and Child Health Project programs that had HBPs developed using broad-based participatory co-creation methods involving both the public and private sectors. In some states and local councils, implementation of HBPs also involves community entities such as Ward Development Committees and Village Development Committees. Some also have adjunct accountability frameworks on paper.
- *NSHDP I and NSHDP II, State Strategic Health Development Plans I and II, and Federal Strategic Health Development Plans I and II*. The decision of which interventions/activities to include in NSHDP I, and especially in NSHDP II, followed a prioritization mechanism that ensured that the 10 Nigerian health system building blocks focused on key interventions to protect population health. In addition to priority-setting and consensus meetings with key stakeholders in the health sector to arrive at many priority interventions and activities, the process also used the OneHealth Tool to cost the interventions and activities, and model their potential benefits, to arrive at the final lists of benefits included in the plans. NSHDP II (2018–22) will soon undergo evaluation in preparation for the development of NSHDP III.
- *Non-Communicable Diseases and Injuries (NCDI) Poverty Commission priority setting.* In 2022, the NCDI Poverty Commission embarked on a detailed priority-setting process to arrive at an HBP on NCDI for the country. The HBP prioritization proceeded through ordered steps—following the NCDI poverty analytical framework that focuses on equity, cost-effectiveness, and value for money—to arrive at a draft HBP for NCDI.

ANALYSES AND TOOLS

A variety of analyses, undertaken using the best data available, informed the work of the LNC.

Data Sources

The LNC relied heavily on the Global Burden of Diseases, Injuries and Risk Factors Study 2019,[4] which provides ongoing estimates of the mortality and morbidity

burden attributable to a wide array of conditions and exposure to risk factors in all countries (Murray et al. 2020; Vos et al. 2020). In addition to using those estimates, the LNC undertook bespoke data collection and assessed the quality of existing data to inform future disease burden estimates. It used population-level data (demographic surveillance sites and census information), national facility–based databases (DHIS2), surveys and surveillance databases (such as Surveillance Outbreak Response Management and Analysis System [SORMAS], the Nigeria HIV/AIDS Indicator and Impact Survey, and NPHCDA immunization coverage data), and morbidity and mortality records requested from hospitals across the country.[5]

The process of collating the data had its challenges, beginning with identifying where the data were situated and requesting permission to access the data, because of limited institutional memory and frequent leadership changes. Although some organizations were confused as to the rightful guardian of the data, others had several custodians with numerous channels to permission, each of whom had to consent to the release of data. Approval processes were therefore complex and slow. Even when data existed, as in many health facilities, the data were not captured using electronic medical record systems, leading to data that were often incomplete and marred with inaccuracies. Furthermore, despite having approval from the National Health Research Ethics Committee, the LNC had to follow different guidelines for different organizations before receiving data. Reluctance on the part of some institutions to share data arose because of concerns about opportunities to publish their own data, costs of extracting data, and apprehensions about privacy and data misuse.

Tools and Methods

The LNC undertook several reviews of the literature to summarize the best evidence available on Nigeria-relevant disease burden and priorities and health system reform to inform subsequent data analysis and modeling. It used the OneHealth Tool to project health system costs under different scenarios as specified under NSHDP II.

Because the e-Delphi process and the analysis of Nigerian health policy and burden of disease highlighted maternal and child health as a key priority, the LNC conducted specific analysis to assess the potential effect of investment targeting a package of cost-effective interventions to address that priority. The LNC used the Lives Saved Tool (LiST) to dynamically project the health and cost effects between 2021 and 2030 of three scenarios of policy intervention: (1) baseline (no improvements in intervention coverage), (2) moderate increased investment (defined as linear progress to 20 percent increased coverage of interventions relative to baseline), and (3) universal coverage (defined as linear progress to 90 percent coverage of interventions). The supplementary appendix to Abubakar et al. (2022) provides further details of the interventions included, LiST, and the projection methods.

SUMMARY OF ANALYSIS FINDINGS

The Basic Minimum Package of Health Services (BMPHS) aims to achieve fully functional primary health care facilities in Nigeria—with at least one in each political ward (with average population of about 23,000 per ward) by 2026, seven years after its launch via the Basic Health Care Provision Fund distributed by the federal government.[6] The package also aims for at least three fully equipped secondary facilities and a national ambulance service in each of Nigeria's 37 states by 2024. It includes a set of preventive, protective, promotive, curative, and rehabilitative services including basic emergency obstetric and newborn care. As of October 2021, 6,287 primary health care facilities, representing 68 percent of political wards, had been authorized to receive funds.[7] Box 9.1 outlines ongoing work on health benefits package design for primary health care in Nigeria.

Box 9.1

Health Benefits Package Design for Primary Health Care in Nigeria

Ongoing work by the National Primary Health Care Development Agency seeks to design a feasible benefits package for Nigeria's Ward Health Service (Oritseweyimi et al. 2023). The agency is using a framework for health benefits package design that considers the incremental cost-effectiveness ratio of the services currently provided by the Ward Health Service and the services that could be provided, and how those ratios relate to a cost-effectiveness threshold for current health spending in Nigeria of US$214 per disability-adjusted life year averted. The incremental cost-effectiveness ratios of interventions and services were obtained from the Tufts database;[a] when such data for interventions in Nigeria were not available, the analysis used data from countries deemed similar to Nigeria.

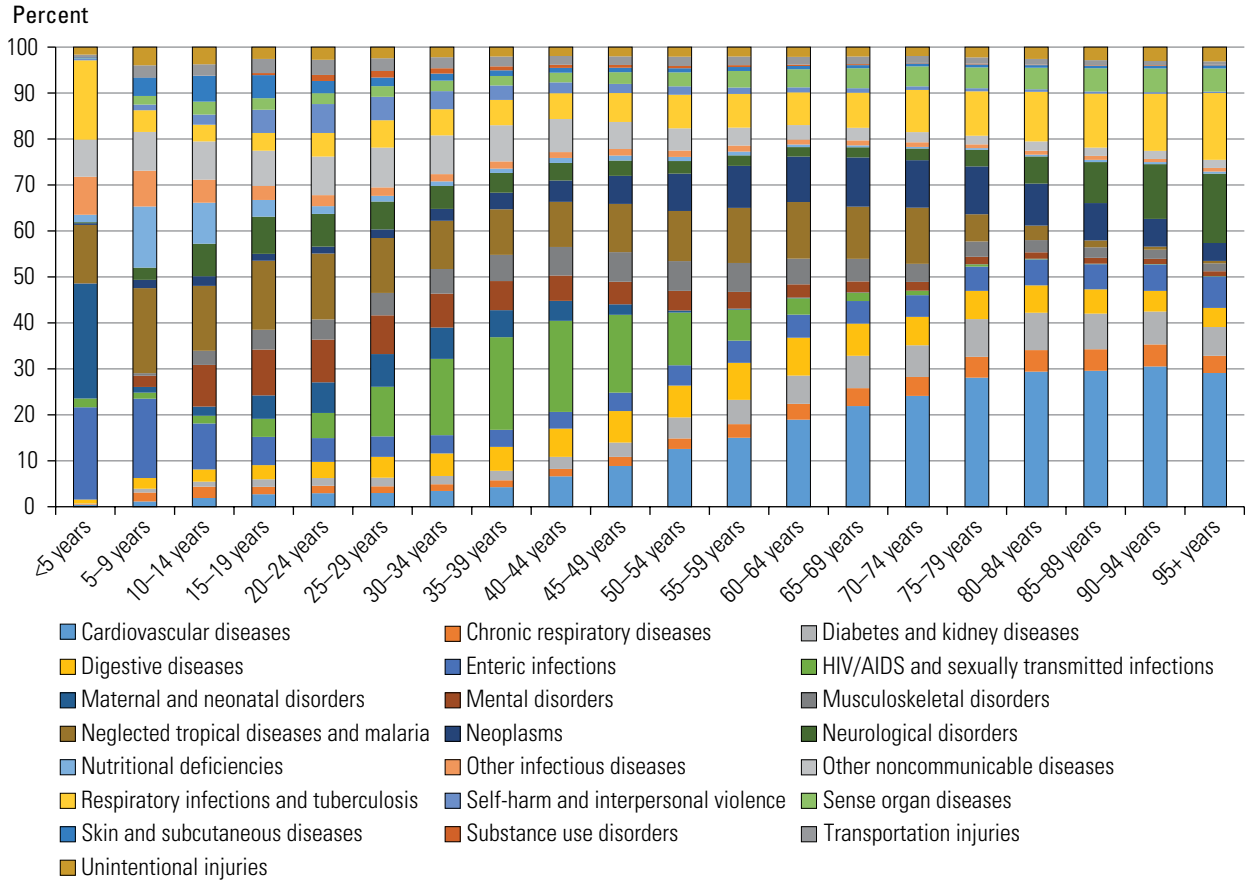
The emerging findings of this work indicate that overcoming supply and demand constraints to increase coverage of Ward Health Service interventions in primary health care in Nigeria have large net health and monetary benefits, on the order of approximately US$1 billion per 10 percent increase in primary health care use and up to about US$15 billion at 100 percent use—US$9 billion more than at the current 44 percent use (Oritseweyimi et al. 2023).

Further work is required to investigate the equity implications of increasing coverage, particularly with regard to scaling up interventions close to the cost-effective threshold, given that interventions included in health benefits coverage should be available for all those expected to use services (up to 100 percent coverage). Such work needs to consider the costs and benefits of broader health system strengthening efforts including recruiting, training, paying, and retaining health workers, and building and maintaining new health facilities. Overall, the work should guide investment decisions as health budgets increase to meet the large unaddressed primary health care needs of Nigeria's population.

a. Tufts Medical Center, Center for the Evaluation of Value and Risk in Health, "GH CEA Registry," https://cevr.tuftsmedicalcenter.org/databases/gh-cea-registry.

The comprehensive burden of disease analysis highlighted several key priorities for the Nigerian system (Angell et al. 2022). Outcomes for children under 5 years and maternal mortality remain poor in Nigeria, with children under 5 years bearing most of the nation's mortality burden. In contrast, outcomes for adults over 50 years, particularly men over 50 years, are among the best in West Africa. Those relatively good outcomes, however, are threatened by a growing burden of noncommunicable diseases that account for an increasing proportion of the total disease burden for older population groups (figure 9.1). Preventing such diseases early will be essential to ensure that scarce health care resources are not unduly diverted away from overcoming the burden of maternal and child mortality and that the already stretched health care system can meet the needs of the population.

Figure 9.1 Proportion of DALYs Attributable to Diseases, by Age Group, Nigeria, 2019



Source: Institute for Health Metrics and Evaluation, Global Burden of Disease Study 2019, https://ghdx.healthdata.org/gbd-2019.

Note: DALYs = disability-adjusted life years.

Following the NSHDP II (FMoH 2018b), the LNC costed provision of all health program areas[8] at US$2–US$3 and all health system strengthening[9] at US$17–US$27 per capita per year during 2021–30 for a moderate scale-up scenario of coverage increase of 17.5 percent during 2018–22 extrapolated to 2030. An aggressive scale-up scenario extrapolation of a 30 percent increase during 2018–22 to 2030 would cost US$19–US$29 per capita per year for all program areas and US$19–US$30 for health system strengthening. Achieving those scenarios would entail massive increases in health expenditure, especially government health expenditure (only US$11.85 per capita in 2019), given that three-quarters of health spending in Nigeria is out of pocket (Abubakar et al. 2022).

The LNC's analysis of scaling up maternal, newborn, and child health services found that an additional US$64 per capita for the period 2021–30, or US$10.5 per capita in 2030 at 90 percent coverage of services, could avert a total of 309,000 maternal deaths, 967,000 newborn deaths, and 2.61 million child deaths (Abubakar et al. 2022). Those numbers represent highly cost-effective spending: given a total population ranging from 206 million in 2021 to 263 million in 2030, the approximately 4 million lives saved over the decade are saved at a cost of about US$600 each. Because most lives saved are newborn babies or children with their whole lives ahead of them, that cost translates to less than US$15 per disability-adjusted life year averted. Such increased health spending—despite requiring an almost doubling of current government health expenditure just for maternal and newborn health—should be affordable because it represents only about 0.5 percent of Nigeria's gross domestic product per capita of US$2,097 in 2020.

Linking to Service Delivery Reforms

A Healthcare Reform Committee (HRC), chaired by the Vice President, has been inaugurated with a remit to lead the development of a people-centric health care system—fundamental for Nigeria's socioeconomic development. The HRC had a six-month timeline to deliver its outputs but faced delays due to political and other considerations. At the time of writing, the HRC secretariat had completed consultation with stakeholders and worked closely with state governments and the Federal Capital Territory to outline actions needed at all levels of government and in communities to improve health. The LNC report provides data and information to inform the HRC's recommendations. Even with the ongoing nature of the system reforms process in the country, and the LNC's lack of power over implementation, the country has already adopted several LNC recommendations; for example, the NHIA Act 2022 includes requirements to mandate basic health insurance, to pool risks, and to create a vulnerable group fund to be financed partly by BHCPF. Further, initiatives have been incorporated by the ongoing work of Commissioners with several HRC subcommittees, and the LNC continues to engage with the new government to pursue further implementation.

To strengthen domains for action and policy in Nigeria's health system, the LNC proposes a reformed setup of centrally determined (albeit with active involvement

of a broad range of health system stakeholders) but locally delivered systems. The reform will require that Nigeria digitize its health system; thoughtfully centralize standards; pool and streamline resources; improve supply chains, local manufacturing, and data management while localizing production of basic products and allocation decisions; define basic health services packages to align with local risk factors; and implement modes of community service delivery sensitive to socio-cultural norms.

Centralization and Localization

In a large, diverse, and federally governed country like Nigeria, careful calibration of a centrally determined cost-effective HBP with flexibility in its local implementation is essential. For example, although a federal entity, NPHCDA, is designing the HBP for Nigeria's Ward Health Service, the state governments (through state primary health care boards/agencies) will implement the HBP in each state. The BHCPF itself is centrally legislated (by the federal parliament) and coordinated (by federal entities NHIA and NPHCDA), but is implemented by state governments (again, through their state primary health care boards/agencies). More broadly, certain health system functions must not only be centrally determined but also be centrally financed—especially those functions that benefit from national uniformity or economies of scale. For example, implementing a national initiative such as the BHCPF requires having nationally uniform information systems to inform its design and monitor its ongoing implementation. As such, the federal government must bear the costs of developing and providing central guidelines and forms (paper-based and electronic) with resources for adaptations to suit different subnational levels and local contexts; the costs of training and mentoring; and the costs of personnel to ensure data collection and quality assurance. Similarly, developing and providing national quality of care guidelines, improving the health commodities supply chain system, and strengthening logistics and quality assurance of border transactions on importation will require central efforts. These examples of functions that require centralization mean the federal government must take on costs and responsibilities.

Nevertheless, the central government can only do so much, especially given its distance from local needs and preferences in as large and diverse a country as Nigeria. Subnational governments must play a major role in the adaptation and implementation of national benefits packages, systems, guidelines, and standards. Although the federal government may provide support at early stages of implementation (because doing so is efficient and sets a good example), it may phase out and means-test such support over time, based on the level of available financial and technical resources in each state.

Linking to Financing Mechanisms

For Nigeria's health system to deliver UHC will require health financing reform. The recent passage of the NHIA Act 2022 presents an ambitious framework that if implemented will allow a substantial rise in the funds available to the Nigerian

health sector. Specific elements of the act include mandatory health insurance for all residents of Nigeria irrespective of employment status, additional powers for NHIA to regulate and integrate schemes, a specific mandate to promote UHC, expanded options for organizations to act as third-party administrators but with limited fund management function, and the establishment of a Vulnerable Group Fund. The act mentions numerous sources of potential funding for the Vulnerable Group Fund, including levies and new taxes. The recent amendment of the Finance Act to allow taxation of sugar-sweetened beverages should provide further revenue.

Implementation of the act should prioritize increasing government funding for health, improving resource management through strategic purchasing, and creating a more robust benefit package. The new legislation provides the statutory basis to establish strong systems for oversight and regulation of providers such as health maintenance organizations. Ultimately, improving financial risk protection and the effectiveness of health financing mechanisms, such as social health insurance, in Nigeria will require addressing implementation bottlenecks in the three health financing functions: revenue mobilization, pooling, and purchasing. An evidence-based and systematic process should guide the development of government annual health budgets to ensure collective use of funds to achieve set goals and targets—for example, achieving some of the health-related targets of the Sustainable Development Goals.

Options for Revenue Mobilization

Fiscal space for increased domestic funding of health services requires increases in overall government revenue and increasing the share of government resources devoted to the health sector. Nigeria's current overreliance on oil revenue for foreign exchange exposes the country to continuous financial shocks. Health system actors will have to negotiate for increased allocation to the health sector, even when the overall government revenue increases, because the Ministry of Finance may decide to allocate the increased resources to other sectors of the economy.

The country could improve health spending by instituting a dedicated predetermined budget at the federal and state levels, outside of the electoral cycle, and with mechanisms to ensure it is spent efficiently and equitably. Ensuring equity in the distribution of resources and setting of health priorities will require making the budget public and subject to independent auditors. Increasing states' internally generated revenue would also lower their dependence on federal funding and could refocus priorities on internal needs in determining health spending if states allocate a good proportion of the increased resources to the health sector. A transparent, public process for assigning and using grants from international donor partners, subject to independent regular audits, is also needed. Nigeria established the BHCPF in 2014 to address some of those issues, financing it through an annual federal government grant of not less than 1 percent of the Consolidated Revenue Fund, grants from external donors, and other sources. The NHIA will administer 50 percent of the funds to provide basic health services to citizens and for subsidy

payments to state insurance agencies to provide health care to people who cannot afford premium payments. The NHIA Act 2022 complements and potentially increases the revenue available and should provide the basis for far-reaching reform to reach Nigeria's goal of UHC.

Reducing the burden and financial risk of health care spending by individuals, families, and communities will therefore require dramatic provision of and access to pooled funding (insurance) or prepaid government provision of health care. Pooling is the health financing function whereby collected health revenues are transferred to purchasing organizations, which manage revenues and distribute risks. Nigeria should strive to develop large pools because having small, scattered, and uncoordinated pools will not lead to efficient and equitable financial risk protection. However, in the case of multiple pools—such as the various State Social Health Insurance Schemes, the FSSHIP, free programs funded by the budget, community-based health insurance schemes, and private health insurance—the country can achieve risk equalization via mechanisms such as a dedicated fund and health reinsurance, under the leadership of the FMoH, the National Council of Health, and the Nigeria Governors Forum.

Alternatively, mandatory social insurance for health could be levied, though it too would need to be done equitably to guard against increasing inequality and resulting health, social, and economic harms. Additionally, the country will need to find solutions for barriers to coverage of those working in the informal sector and the unemployed (Onwujekwe et al. 2019). Levying taxes and social insurance is also difficult because most work in Nigeria takes place in the informal sector. However, as in other countries like Ethiopia and India, should UHC become an election issue both nationally and at the state level, concerted advocacy and community engagement efforts from committed institutions and CSOs could provide creative approaches to facilitate UHC.

To further improve pooling and management of revenue, the federal, state, and local governments should ensure the development and institutionalization of efficient, equitable, and transparent fund management systems. Development partners should move from their current opaque systems to ensure the pooling of donor funds that will be transparently managed. The government, through the health and finance ministries, should ensure harmonization and alignment of donor funding to health with national policies, strategies, and priorities. Third-party funds pooling agents can be public, quasi-public, or private entities depending on the context and preferences of the different levels of government.

Furthermore, the federal government needs to revise the benefit package so that every citizen has social health insurance coverage, implemented with strict oversight and regulation of health maintenance organizations. It should also increase the awareness and benefits of social health insurance. At regular intervals, NHIA's implementation strategy should undergo review to fast-track and improve the level of coverage among informal and formal sector workers, with government covering

the poorest Nigerians, in order to provide universal financial risk protection and reduce both out-of-pocket spending and the proportion of expenditure it covers. Federal and state-specific strategies should address context-related challenges of individual states (such as the inability to reallocate funds into FSSHIP).

In keeping with the recommendation to localize certain aspects of health services provision, it is important to allocate more funds at the state and local government levels for purchasing health services, with evidence-based, strategic, and appropriately tracked spending to ensure efficient use of resources and the removal of financial barriers to access by reducing out-of-pocket expenditure in both absolute and relative terms (Hirose et al. 2018). Innovative strategies are also needed to enable potential beneficiaries, especially in the informal sector, to better comprehend and accept the concept of prepayment methods for financing health care. Such strategies can also ensure that all formal sector employees have adequate information about the FSSHIP. State and local governments can establish a tax-based health-financing mechanism targeted at vulnerable groups, the poorest, and those working in the informal sector of the economy to accelerate progress toward UHC. Health insurance schemes in Ghana and in Anambra State offer lessons about potential strategies to expand health insurance coverage among informal sector workers (Abubakar et al. 2022).

Monitoring and Evaluation

NSHDP II was accompanied by a comprehensive monitoring and evaluation plan agreed by all stakeholders involved in developing NSHDP II (FMoH 2018a). The monitoring and evaluation plan set indicators and targets covering all the main areas of health and programming addressed in NSHPD II. The data collected on those indicators, and analysis assessing the progress of NSHDP II, including a long-awaited Joint Annual Review midterm review, have not yet been published. Embedding the use of monitoring and evaluation of the plan in the health policy system requires further attention.

LIMITATIONS AND FUTURE DIRECTIONS

Despite clear priorities for the health system, and the financing opportunities provided in the NHIA Act 2022, the Finance Act needs to be modified to generate some of the revenue to support the Vulnerable Group Fund. The NHIA Act, a federal law, should be domesticated in all states for national implementation. Otherwise, the whole burden of implementing the law, including providing health insurance for 83 million people, will fall entirely on the federal government.

New financing approaches must be undertaken with simultaneous reform of governance and increased probity in the use of revenue. Health is not immune to the widespread corruption that affects other sectors in Nigeria. Nigeria needs holistic and participatory accountability systems that track not only supplies and financial

management systems but also the human resources for health required to ensure efficient use of available funds, and that citizens receive the services they need when they need them.

A critical test of the reforms currently in their embryonic stage is whether the government newly elected in 2023 adopts and implements positive changes. Nigeria's last change of leadership allowed the partial implementation of the Health Act 2014 by the previous government. It is possible that future political cycles and the next government will continue to implement those reforms. Beyond specific health system changes, major population health can be achieved only with concrete and substantial action outside the health sector, which requires an all-of-government approach.

LESSONS LEARNED

The future of health in Nigeria will be determined by the ability of political leaders to learn from past failures and successes to identify and implement locally appropriate priorities to address the many health challenges facing the population. The priority setting for health in Nigeria makes clear the overly donor-dependent nature of the process for formulating national development plans such as NSHDP II. Without donor funding and coordination of the process, such plans may not happen—as suggested by lack of a published midterm review of NSHDP II or any movement on a new plan. Political leaders in Nigeria urgently need to chart a course for locally led and driven policy formulation and implementation, with donors playing a supportive role.

The LNC's experience shows the importance of involving the main actors in the health policy space in Nigeria so that their ownership of the work takes it forward. At the same time, ensuring that priority setting sufficiently covers everyone's health needs requires truly engaging the public through a bottom-up consultation process. Local and national ownership of the policy agenda, engagement with policy makers in formulating recommendations, and public engagement are essential to guarantee the success of health prioritization and the ultimate impact on population health.

NOTES

1. Avenir Health, "OneHealth Tool," https://www.avenirhealth.org/software-onehealth.
2. For more on the Lives Saved Tool, refer to its website https://www.livessavedtool.org.
3. World Health Organization, "Child Mortality (Under 5 Years)," https://www.who.int/news-room/fact-sheets/detail/levels-and-trends-in-child-under-5-mortality-in-2020 (accessed August 1, 2022).
4. Institute for Health Metrics and Evaluation, Global Burden of Disease Study 2019, https://ghdx.healthdata.org/gbd-2019.
5. For more information about DHIS2, refer to the University of Oslo's DHIS2 web page, https://dhis2.org; for more information about the Nigeria HIV/AIDS Indicator and Impact

Survey, refer to its website, https://naiis.ng; for more information about SORMAS, refer to the SORMAS Foundation website, https://sormas.org.

6. NPHCDA, "Basic Health Care Provision Fund (BHCPF)," https://nphcda.gov.ng/bhcpf/ (accessed January 13, 2023).
7. NPHCDA, "Basic Health Care Provision Fund (BHCPF)."
8. Maternal and reproductive health, child health, immunization, adolescent health, malaria, tuberculosis, HIV/AIDS, nutrition, water, sanitation and hygiene, noncommunicable diseases, mental health, neglected tropical diseases, health promotion and social determinants of health, emergency hospital services, public health emergencies, and preparedness and response.
9. Program activity costs, human resources, infrastructure, logistics, medicines, commodities and supplies, health financing, health information systems, and governance.

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