

# NIGERIA HEALTH FINANCING SYSTEM ASSESSMENT

DISCUSSION PAPER

APRIL 2018

*Reem Hafez*



**WORLD BANK GROUP**  
Health, Nutrition & Population



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**April 2018**

## Health, Nutrition and Population (HNP) Discussion Paper

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# Health, Nutrition and Population (HNP) Discussion Paper

## Nigeria Health Financing System Assessment

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**Abstract:** Nigeria's commitment to universal health coverage was enshrined by the passage of the National Health Act of 2014 in response to the continued underinvestment and poor performance of its health care system. Lack of data on available resources for health, the cost and use of health services, and the performance of front line providers has made it hard for the health sector to efficiently plan and advocate for additional investments in health. However, in the last 18 months, two important sources of information were made available – the national health accounts (2010-2016) to look at resource allocation and spending decisions at the national level, and, a national health facility survey (2016) to assess the performance of service delivery at primary health care facilities. As such, while based on comprehensive analytics, this health financing system assessment was envisioned as a just-in-time policy brief on the health *financing* system that would provide actionable policy recommendations to the Ministries of Health, Budget and Planning, and the Vice President's office.

**Keywords:** Health financing, universal health care, Nigeria

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## ACRONYMS

ANC	Antenatal Care
BHCPF	Basic Health Care Provision Fund
BMPHS	Basic Minimum Package of Health Services
CHEW	Community Health Extension Workers
CIT	Company or Corporate Income Tax
CRF	Consolidated Revenue Fund
DAH	Development Assistance for Health
DFAAR	Decentralized Financing for Accountability and Results
DFF	Decentralized Facility Financing
DHPRS	Department of Health Planning, Research and Statistics
DTP	Diphtheria, Tetanus, and Pertussis
FAAC	Federation Account
FCT	Federal Capital Territory
FMOH	Federal Ministry of Health
Gavi	Global Vaccine Alliance
GDP	Gross Domestic Product
GON	Government of Nigeria
GPEI	Global Polio Eradication Initiative
HFSA	Health Financing System Assessment
HMIS	Health Management and Information System
HMO	Health Management Organization
IDA	International Development Agency
IGR	Internally-Generated Revenue
IMF	International Monetary Fund
IMG	International Monetary Fund
IMR	Infant Mortality
LGA	Local Government Agency
MDAs	Ministries, Departments, and Agencies
MMR	Maternal Mortality Rate
MTEF	Medium-Term Expenditure Framework
MTSS	Medium-Term Sector Strategy
NACA	National Agency for the Control of AIDS
NAFDAC	National Agency for Food Drug Administration
NHA	National Health Accounts
NHFS	National Health Facility Survey
NHIS	National Health Insurance Scheme
NIMR	Nigerian Institute of Medical Research
NIPRD	National Institute for Pharmaceutical Research and Development
NPHCDA	National Primary Health Care Development Agency
NSHIP	Nigeria State Health Investment Project
OOP	Out-of-Pocket
PAYE	Pay-As-You-Earn
PHC	Primary Health Centers
PHI	Private Health Insurance
PNC	Postnatal Care

RMNCH	Reproductive Maternal, Neonatal, and Child Health
SHI	Social Health Insurance
SHIS	State Health Insurance Scheme
SLGs	State and Local Governments
SMOH	State Ministry of Health
SPHCDA	State Primary Health Care Development Agency
THE	Total Health Expenditure
U5M	Under-five Mortality
UHC	Universal Health Coverage
USAID	United States Development Agency
VAIDS	Voluntary Asset and Income Declaration Scheme
VAT	Value-Added Tax
WDC	Ward Development Committees
WHO	World Health Organization



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## EXECUTIVE SUMMARY

**Nigeria's future success depends on the government's ability to transform its non-renewable (and often volatile) natural capital into productive wealth by investing more in the health of its people.** Blessed with large reserves of natural and human resources, Nigeria has already claimed the status of the largest economy in Sub-Saharan Africa. However, despite steady growth averaging 6.8 percent between 2005-2015 the government of Nigeria (GON) has struggled to translate growth into higher public revenues. In 2016 revenue as a share of GDP was 4.8 percent – the weakest revenue mobilization effort in the world – with severe implications for investments in human capital. Slow progress on poverty reduction, health outcomes, literacy, and governance threaten development as the risks associated with a large youthful unemployed population trapped in poverty can quickly turn opportunity to disaster.

**Low government health spending over the last two decades has limited the expansion of highly cost-effective interventions, stunting health outcomes and exposing large shares of the population to catastrophic health expenditures.** Nigeria spends less on health than nearly every country in the world. In 2016, government health spending was 0.6 percent as a share of GDP or just \$US11 per capita. Funding for primary health care is especially affected as the bulk of spending occurs at the central level and is focused on tertiary and secondary hospitals. Coverage of promotive, preventive, and primary health care interventions is low with the universal health service coverage index – defined as the average coverage of tracer interventions for essential universal health coverage – at just 39 percent. As a result, Nigeria significantly underperforms on key health outcomes. Maternal mortality at 576 deaths per 100,000 live births is one of the highest in the world (2.6 times the global average); one in eight children die before reaching their fifth birthday; and 25 percent of households spend more than 10 percent of their household consumption on health.

**Raising additional resources for health will be challenging, especially within the context of the health financing transition.** Revenue projections from the International Monetary Fund (IMF) are expected to remain muted slowly climbing to 7 percent as a share of GDP by 2022. And the federal government's interest payments as a share of revenue are expected to rise to 78.3 percent by 2022 – crowding out much needed government spending not only in health but other sectors as well. At the same time, many donor institutions currently providing support for the health sector have eligibility criteria that are tied to income and Nigeria's future access to preferential terms for grants, concessional loans and debt relief will be limited.

**Given this challenging macro-fiscal environment, it is imperative to target limited resources to the health services and populations that would benefit most.** Investing in primary health care and expanding coverage of reproductive maternal and child health and malaria interventions would have a significant economic impact on poor Nigerians driven by a healthier, more educated, and more productive young workforce. Seventy-two percent of the burden of disease remains from communicable, maternal, neonatal and nutritional diseases. Many of these conditions could be prevented and treated by highly cost-effective intervention packages. But wide variations exist in service delivery by place of residence, mother's education, and household wealth.

**The basic health care provision fund (BHCPF), mandated by the National Health Act of 2014, is meant to provide the needed financing so that all Nigerians may access a Basic Minimum Package of Health Services (BMPHS).** As a non-contributory, predominantly tax-financed scheme, the BHCPF will ensure the most vulnerable populations have access to basic care. On the one hand, it aims to provide primary health care facilities much needed operational budgets to improve their overall capacity to provide basic services as primary health centres have historically received little to no operating budget and frequently lack basic amenities, equipment, and drugs to be able to deliver quality services. On the other, the BHCPF will provide funding to the existing National Health Insurance Scheme (NHIS) to scale up access to a package of essential health services meant to cover 60 percent of the current burden of disease through accredited public and private providers – improving the coverage of low-cost high impact health interventions. While the resource envelope for the BHCPF would currently be inadequate to guarantee full coverage of the BMPHS to the entire population, the GON's proposed gradual expansion of the BHCPF is well within reach especially as the economy recovers and the size of the resource envelope increases.

**Social health insurance, often seen as a solution to raising a large and stable revenue for health, should complement the BHCPF but on its own is not a viable path towards achieving UHC. Currently, social health insurance does not have the capacity to enforce contributions or the ability to attract the informal sector.** In 1999, the government of Nigeria (GON) established the National Health Insurance Scheme (NHIS) as a public-private partnership to pool health risk and provide greater financial protection to households seeking healthcare. While there has been debate about making NHIS participation mandatory, to date it remains a voluntary contributory scheme. As of 2016, only 4.2 percent of the population was covered – predominantly federal government civil servants and their dependents. The informal sector, comprising most Nigerians – including the poorest and sickest individuals – are left to either forgo care when they fall ill or pay out-of-pocket for their health care expenditures. Globally, countries that have chosen a voluntary contributory path have needed to supplement insurance contributions with tax-based financing (like what would be provided by the BHCPF) that pay for poor and vulnerable groups and heavily subsidize premium contributions from the informal sector.

**Moving forward, it would be important to understand why NHIS coverage has failed to move beyond the formal sector.** The absence of data and information on the health seeking behavior and preferences of patients provides limited understanding on how to expand coverage. There are many factors influencing the demand for health insurance in developing countries – knowledge of the scheme, proximity to local health care facilities, perceived quality of local providers, and affordability of the premium. A review of NHIS contributions, utilization, and expenditures and health seeking behavior of households is needed to help inform the future of contributory insurance in Nigeria.

**Beyond low public financing, weak governance and public financial management directly impact the efficient financing and performance of the health sector.** First, inter-governmental fiscal transfers and the NHIS currently reinforce existing regional fiscal and health outcome imbalances, failing to provide adequate financial risk protection to the poorest and sickest households. Second, the absence of a formal mechanism to coordinate and consolidate information on health resources, the cost and

use of health services, and health outcomes across the tiers of government (federal, state, and local) and the various ministries, departments, and agencies (MDAs) responsible for the delivery of health services weaken the ability of the Federal Ministry of Health to effectively oversee the sector as a whole. Third, realistic revenue projections and perennial delays in the approval of the budget further undermine the efficient allocation and implementation of the health sector budget. Fourth, decentralization and the stated responsibilities of the three tiers (federal, state, and local) of government in service delivery largely determines where health spending occurs rather than any national strategic health priorities. As a result, spending is skewed towards curative care, especially in tertiary and secondary hospital settings, with little focus on low-cost high-impact areas of prevention, public health, and primary health care. Finally, current provider payment arrangements and infrequent supervision provide little incentive to increase the quantity and quality of care.

**The BHCPF – a federal program – overcomes some of the challenges of existing health financing arrangements. By committing to allocate funds to the BHCPF the GON will be providing *additional* resources directly to front line providers. However, it must simultaneously introduce strong accountability mechanisms to improve the quality and efficiency of spending.** By initially focusing on the rural population where most poor Nigerians live, and ensuring funds reach front line primary health care facilities, the scheme aims to provide greater financial protection to the poorest and sickest households. In addition, as a statutory transfer, the BHCPF ensures that funding for PHCs would be safeguarded guaranteeing that any unused funds that arise because of low demand, poor uptake, delays in the release of funds or in the receipt of claims from providers will be rolled-over to next year's fund. On the public accountability side, the disbursement of funds must be subject to receiving reports on the source and use of funds and incremental improvements in quality assurance. On the social accountability side, the scheme may consider using Ward Development Committees – an initiative made up of volunteer community members advocating for the health and social needs of their communities. Providers should also be required to display a large poster informing patients of the services they are entitled to receive for free and provide contact information for a complaints mechanism. And while discussions of payment systems is ongoing, their careful design could further help create incentives for improved efficiency in the use of health resources.

**The sector will also likely require targeted technical assistance to improve the governance and effectiveness of the health financing system in some areas.** Measures such as improving the quality and frequency of national/subnational health accounts, and establishing health management and information systems to produce timely and useful information for budget and planning, provider monitoring, and general oversight are needed to strengthen the relationship between public expenditure and health outcomes and to justify additional requests for increased sector funding. Support would also be needed to develop sector specific medium-term expenditure frameworks and sector strategies, improve accounting of donor resources, and provide capacity building and training to a central coordinating structure to better plan and budget across tiers of government and MDAs responsible for delivering health services.

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**KEY FEATURES OF BHCPF:**

- *A non-contributory scheme that will ensure the most vulnerable populations have access to a basic package of essential health services*
  - *Earmarked funding for primary health care that gives front line providers a much-needed operating budget for drugs, medical equipment, and supplies*
  - *Greater autonomy to primary health care facilities on use of funds that allows communities to tailor care to local needs*
  - *Financial incentives and accountability mechanisms that incentivize providers to increase quantity, improve quality, and use health resources more efficiently*
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# NIGERIA HEALTH FINANCING SYSTEM ASSESSMENT

## INTRODUCTION

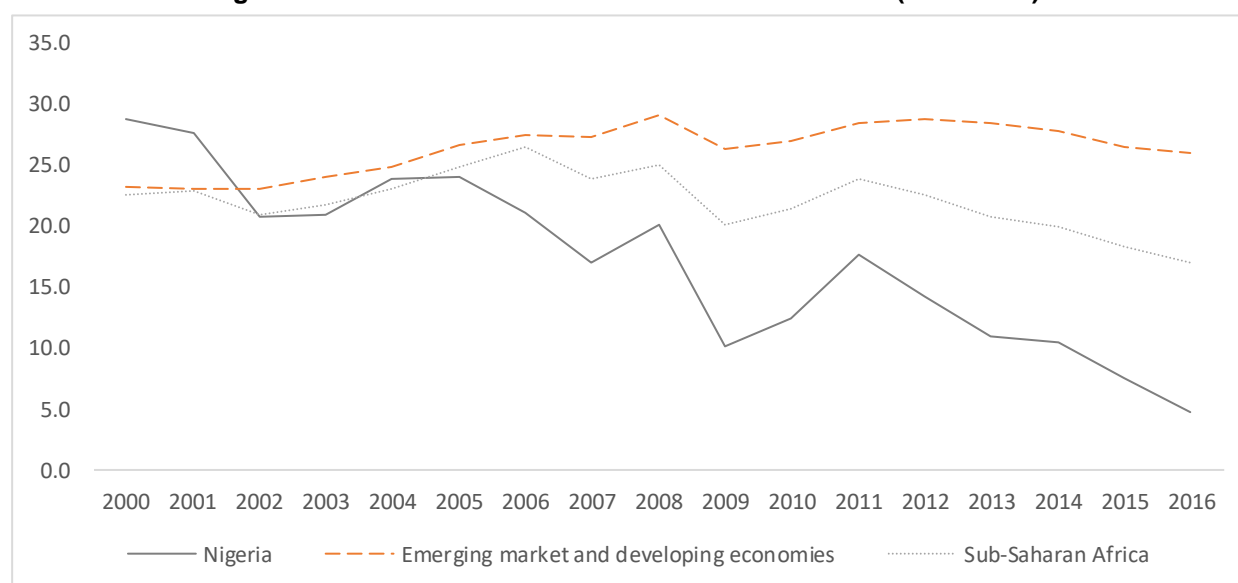
- 1. The Nigeria health financing system assessment (HFSA) highlights constraints and opportunities for building a sustainable health financing system that accelerates progress towards universal health coverage (UHC).** Nigeria's commitment to UHC was enshrined by the passage of the National Health Act of 2014 in response to the continued underinvestment and poor performance of its health care system. The Health Act mandated the establishment of a basic health care provision fund (BHCPF) to support the delivery of primary healthcare services, providing all Nigerians with a Basic Minimum Package of Health Services (BMPHS). However, to date, this mandate remains unfunded. Lack of data (and more importantly, use of data in decision making) on available resources for health, the cost and use of health services, and the performance of front line providers makes it hard for the health sector to efficiently plan and advocate for additional investments in health.
- 2. The HFSA makes use of existing literature and data sources to provide government officials and development partners just-in-time analysis of the health financing landscape and service delivery performance in Nigeria.** It benefits from the recent release of the national health accounts (2010-2016) to look at resource allocation and spending decisions at the national level, and, a national health facility survey (2016) to assess the performance of service delivery at primary health care facilities. It is also informed by a study costing the BMPHS as well as a capacity assessment of the Department of Health Planning, Research and Statistics housed within the Federal Ministry of Health providing a greater understanding of the financial and institutional investments required to implement the provisions of the Health Act. As such the audience for this work are the Ministries of Finance, Health, and Budget and Planning preparing the next medium-term health sector strategy and budget, federal and state level entities getting ready to implement the BHCPF, and development partners working in health.
- 3. The report aims to make the case for i) investing in human capital and, in particular, health; ii) increasing health spending to significantly ramp up service delivery and improve health outcomes, and iii) channeling additional federal funding through the BHCPF to complement and overcome some of the challenges of existing health financing arrangements.** It is organized as follows: section one provides country and sector background including the rationale for investing in human capital; section two describes levels and sources of health financing, including the health financing transition currently underway in Nigeria; section three looks at whether health resources are used in the most efficient way to maximize health outcomes; section four discusses options for additional fiscal space for health; and section five provides recommendations for addressing some of the sector's most pressing challenges in moving towards sustainable health financing for UHC.

#### COUNTRY AND SECTOR BACKGROUND

4. **Nigeria, an oil-rich federation<sup>1</sup> of approximately 182 million people, has the potential to become one of the top 20 global economies in the coming years – a vision it has articulated for itself in its 20:2020 National Plan and Economic Recovery and Growth Plan.** Blessed with large reserves of natural and human resources, it has already claimed the status of the largest economy in Sub-Saharan Africa as measured by GDP. Since the late 1960s, Nigeria's growth has been driven primarily by consumption and high oil prices. Oil receipts dominate fiscal revenue as it is the biggest oil exporter and holder of natural gas reserves in Africa (Ministry of Budget and National Planning, 2017) (National Planning Commission, 2009) (IMF, April 2017).

5. **However, the government of Nigeria (GON) has struggled to translate growth into higher public revenues.** Despite steady historical growth averaging 6.8 percent between 2005-2015, general government revenue has consistently trailed its emerging and developing market peers – with the gap widening to more than 20 percentage points. Failure to diversify sources of revenues and a protracted period of weak oil prices globally saw growth slow to -1.5 percent in 2016 and total revenue as a share of GDP dropped further to 4.8 percent – the weakest revenue mobilization effort in the world (Figure 1.1) (IMF, April 2017).

**Figure 1.1: General Government revenue as % of GDP (2000-2016)**

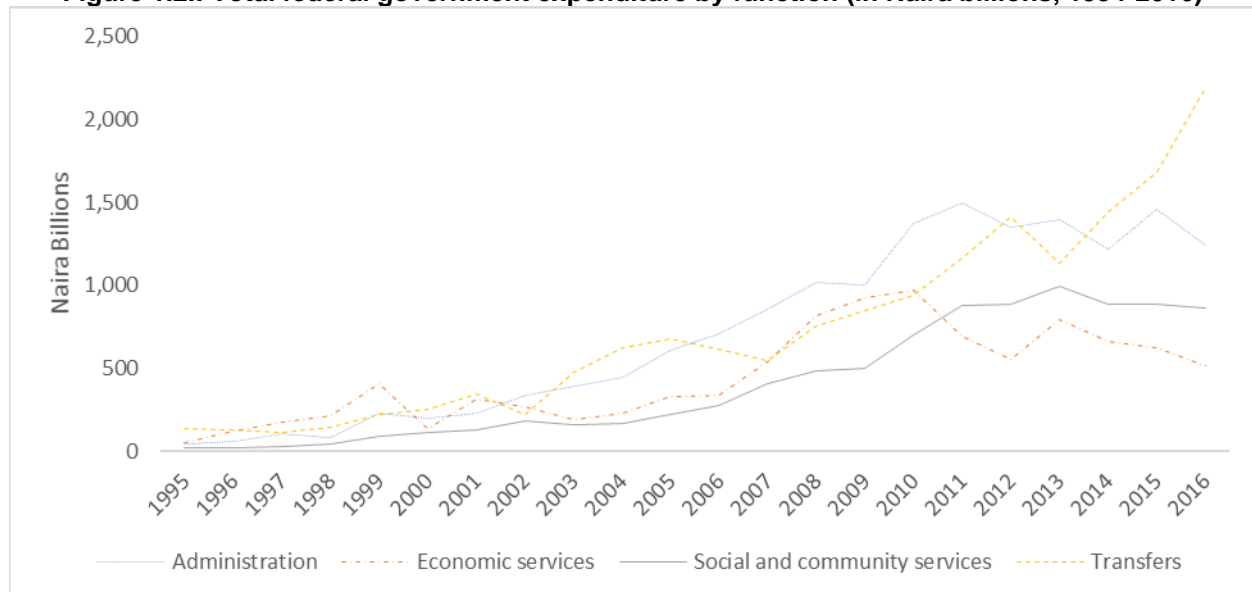


Source: International Monetary Fund (2017). World Economic Outlook Database

6. **The drop in revenue performance resulted in the doubling of Nigeria's debt service to revenue ratio from 33.2 percent in 2015 to 66.4 percent in 2016 with severe implications for investments in productive economic and social sectors** (IMF, April 2017). In 2015, agriculture, construction, transport and communication made up 11 percent of total federal government expenditure while health and education combined accounted for 18 percent. Instead, transfers, which include public debt servicing, overtook spending in all other categories from 2014 onwards (Figure 1.2).

<sup>1</sup> Nigeria is comprised of the Federal Government, 36 State Governments, and 774 Local Governments. Its 36 states are grouped into six geopolitical zones.

**Figure 1.2.: Total federal government expenditure by function (in Naira billions, 1994-2016)**



Source: Central Bank of Nigeria (2016). 2016 Statistical Bulletin. Notes: Includes recurrent and capital expenditures; 2016 figures are preliminary; administration includes general administration, defense, internal security, and national assembly; economic services include agriculture, construction, transport and communication; and transfers includes public debt servicing, pensions and gratuities, and contingencies/subventions.

7. **Nigeria’s future success depends on the government’s ability to transform its non-renewable (and often volatile) natural capital into productive wealth by investing more in human capital.** While GDP measures national income or economic output, it does not reflect changes in the underlying asset base – for example depreciation and depletion of natural resources – potentially sending misleading signals about the state of the economy. Instead, *wealth* measures the present and future value of a country’s assets including natural, produced, and human capital – allowing for a better assessment of sustainable growth. Increases in human capital<sup>2</sup> – which has been estimated to account for almost two-thirds of national wealth globally – are driven by population growth, educational attainment, and their resulting increases in labor productivity and earnings. In Nigeria, recent estimates show human capital accounting for 56 percent of its total national wealth (World Bank, 2018) (IMF, April 2017).

8. **As the most populous country in Africa that has yet to complete its demographic transition<sup>3</sup>, Nigeria’s human capital potential is substantial.** In “economic miracle” countries of East Asia during 1960-1990, the demographic dividend – the period of economic growth driven primarily by the increase in the share of working age population – contributed between a third to 44 percent of growth (Bloom & Williamson, 1998). In Nigeria, population projections are estimated to reach 294 million by 2035 – with more than 72 million new entrants into the work market (United Nations, 2017). Recent studies on the potential of the Nigerian demographic dividend estimated i) an increase in GDP by nearly 50 percent, ii) an additional 15-30 percent in per capita income by 2030, and iii) lifting an additional 32 million people out of poverty above

<sup>2</sup> Human capital is defined as the discounted value of future earnings for a country’s labor force. In Nigeria, total wealth per capita in US\$ 2014 was estimated to be US\$ 34,408 with produced capital, natural capital, and human capital accounting for US\$ 3,851, US\$ 12,963, and US\$ 20,934 respectively.

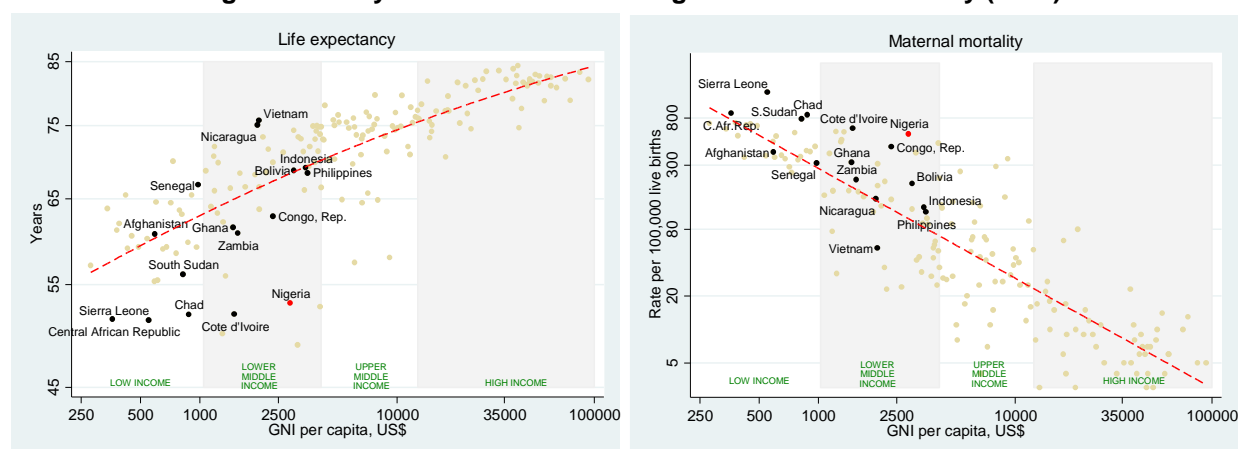
<sup>3</sup> In general terms, the demographic transition is a shift from high levels of mortality and fertility to low levels of mortality and fertility in a population.



and beyond the business-as-usual scenario (Bloom, et al., 2010) (Ashraf, et al., 2013). It has also been estimated that had Nigeria re-invested all the resource rents from oil and gas between 1980 and 2005 it would have accumulated more than three times as much produced capital per capita from US\$ 1,369 to US\$ 5,349 (in 2005 US\$) (World Bank, 2011). However, these benefits are not automatic. They are dependent upon substantial investments in human capital that are key to promoting inclusive and sustainable growth.

9. **But slow progress on poverty reduction, health outcomes, literacy, and governance challenges threaten further development.** Nigeria is home to the second largest number of people living in extreme poverty<sup>4</sup> after India – 86 million in 2013, a 69 percent increase from 1990 (World Bank, 2017). It significantly underperforms on key health outcomes such as life expectancy, maternal mortality, and child health compared to regional and lower middle-income averages (Figure 1.3). Youth and adult literacy was 73 percent and 60 percent respectively in 2015 compared with global averages of 91 percent and 85 percent. And it consistently ranks in the lowest 20<sup>th</sup> percentile on worldwide governance indicators that measure the capacity of the government to effectively formulate and implement sound policies<sup>5</sup> (World Bank, 2017).

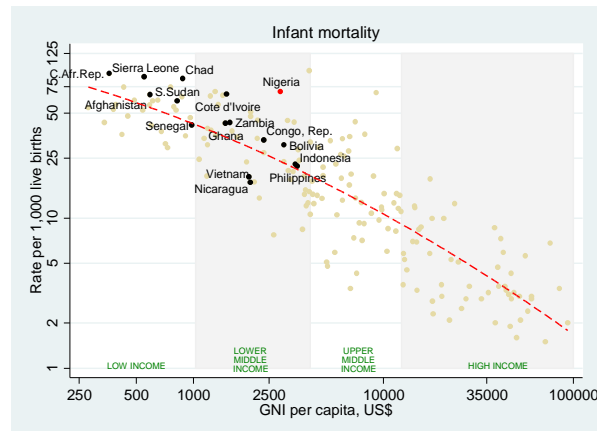
**Figure 1.3: Key health outcomes in Nigeria and internationally (2015)**



<sup>4</sup> Defined at the <\$1.90/day threshold.

<sup>5</sup> The Worldwide Governance Indicators project reports aggregate and individual governance indicators for over 200 countries and territories over the period 1996-2016, for six dimensions of governance: 1) voice and accountability; 2) political stability and absence of violence; 3) government effectiveness; 4) regulatory quality; 5) rule of law; and 6) control of corruption. WB (2017). Worldwide Governance Indicators.

<http://info.worldbank.org/governance/wgi/index.aspx#home>



Source: WB (2017). World Development Indicators. Nigeria maternal mortality from DHS.

10. **In health, low coverage of cost-effective interventions commonly used as tracer indicators for universal health coverage is a major reason why health outcomes are among the lowest in the world.** Seventy-two percent of the burden of disease remains from communicable, maternal, neonatal and nutritional diseases. Among children under five, more than half the disability-adjusted life years can be attributed to diarrhea, lower respiratory and infectious diseases, neglected tropical diseases and malaria. Malaria prevalence, the number one cause of premature death in the country, also accounts for nearly half of out-of-pocket health expenditures (Institute for Health Metrics, 2017) (Federal Republic of Nigeria, 2017). Many of these conditions could be prevented and treated by highly cost-effective intervention packages (Yamey, et al., 2016) (Table 1). But, service delivery of key maternal and child health interventions does not exceed 40 percent coverage among the eligible target population (Tables 1.2 and 1.3). Only 15 percent of married women use any method of family planning, the average total fertility rate remains high at 5.5 children per woman, and only 38 percent of deliveries are attended by a skilled provider. Nigeria also accounts for the highest number of children who are un- or under-vaccinated for diphtheria, tetanus, and pertussis (DTP) and the third largest population of chronically undernourished children in the world (National Population Commission, 2014) (WHO/UNICEF, 2017). As a result, maternal and child health outcomes have improved little over the last decade with one of the highest rates of maternal mortality in the world at 576 deaths per 100,000 live births – 2.6 times the global average – and one in eight children dying before their fifth birthday.

**Table 1.1: Benefit to cost ratio of best-buy interventions**

Health focus	Intervention packages	Benefit for every dollar spent
Nutrition	Stunting reduction interventions including: micronutrient supplementation; universal salt iodization; calcium supplementation; folate and iron fortification and supplementation; breastfeeding and complementary feeding education; zinc and vitamin A supplementation; community-based management of acute malnutrition	\$3-48
Immunization	Package of vaccines: DPT-Hep B-Hib or pentavalent vaccine; human papillomavirus; Japanese encephalitis; measles; mumps and	\$16-44

	rubella; rotavirus; pneumococcal conjugate vaccine; yellow fever	
Maternal and child health	Intervention packages for: maternal and newborn health; child health; immunization; family planning; HIV/AIDS; malaria	\$9-20
Non-communicable diseases	Aspirin therapy at onset of acute heart attack; management of chronic hypertension; 30 percent salt reduction in manufactured foods; 125 percent increase in tobacco price; secondary prevention of cardiovascular disease with polypill	\$9
Malaria	Malaria control is sub-Saharan Africa	\$5

Source: Yamey G, Beyeler N, Wadge H, Jamison D. Investing in Health: The Economic Case. Doha, Qatar: World Innovation Summit for Health, 2016.

**Table 1.2: UHC tracer indicators for prevention and treatment (2015)**

	Contraceptive prevalence rate		Any antenatal care	Skilled birth attendance	DPT3 coverage	Antiretroviral treatment for HIV	TB treatment
Bolivia	61		86	85	99	29	55
Congo, Rep.	45		90	93	80	28	48
Cameroon	34		85	65	84	27	40
Cote d'Ivoire	18		89	59	.	35	54
Ghana	27		96	74	88	34	29
Indonesia	63		96	83	81	9	28
Kenya	58		92	62	89	59	68
Myanmar	46		83	71	75	47	59
Nicaragua	80		95	88	98	34	70
<b>Nigeria</b>	<b>15</b>		<b>61</b>	<b>38</b>	<b>56</b>	<b>20</b>	<b>14</b>
Philippines	55		95	73	60	27	73
Sudan	12		74	23	93	8	41
Timor-Leste	22		84	30	76	.	56
Vietnam	76		96	94	97	42	68
Yemen, Rep.	34		60	45	69	15	76
Zambia	49		96	64	90	63	52
<b>LMIC average</b>	<b>50</b>			<b>77</b>	<b>86</b>	<b>34</b>	<b>57</b>

Source: WB (2017). World Development Indicators

**11. Targeted coverage expansion for reproductive maternal, neonatal, and child health (RMNCH) interventions to underserved populations would have an immediate impact on the health of women and children.** Wide variations exist in service delivery by place of residence, mother's education, and household wealth. Service delivery in the North regions is consistently worse than in the South. Coverage among urban women and children is 1.5-2 times more likely than among those living in rural areas. Mothers with more than a secondary education are 5 times more likely to deliver in a health facility and 6 times more likely to have their children fully vaccinated than mothers with no education. However, the most striking differentials occur between those in the highest wealth quintile compared to those in the lowest wealth quintile where some services are 7-10 times more likely in the former (for example, skilled birth attendance and fully vaccinated children) (National Population Commission, 2014) (Table 1.3).

**Table 1.3: Coverage of selected maternal and child health interventions, by region and socioeconomic status (2016/7)**

	% women aged 15-49				children		
	receiving ANC from skilled provider <sup>1</sup>	delivering in a health facility	delivered by skilled provider <sup>1</sup>	with PNC within 2 days after birth	% fully vaccinated <sup>2</sup>	IMR per 1,000 live births	U5M per 1,000 live births
<i>Residence</i>							
Urban	87.4	61	67.1	58.9	63.1	53	78
Rural	56.8	27.6	32.9	27.8	32.1	77	138
<i>Zone</i>							
North Central	62.5	44.4	50.3	46.6	26.2	72	103
North East	67	25.8	34	24.5	17.5	62	115
North West	53.6	17.8	23.6	19	7.9	87	162
South East	91.3	87.5	90.7	66.1	36.5	46	67
South	81	66.8	64	69.1	38.2	39	59
South West	89.5	76.6	82.7	76.1	47.9	52	67
<i>Mother's education</i>							
No education	48.2	17.1	22.4	17.6	8.6	82	145
Primary	73.6	39.1	44.1	39.3	22.6	67	110
Secondary	87.7	65.3	70.9	60	37.0	52	73
Above secondary	97.9	90.1	92.7	84.1	50.4	46	55
<i>Wealth quintile</i>							
Lowest	33.6	9.7	12.8	10.6	4.4	80	158
Highest	95	78.4	84.9	74.7	46.4	45	56
<i>Total</i>	<b>65.8</b>	<b>37.5</b>	<b>43</b>	<b>37.1</b>	<b>21.0</b>	<b>70</b>	<b>120</b>

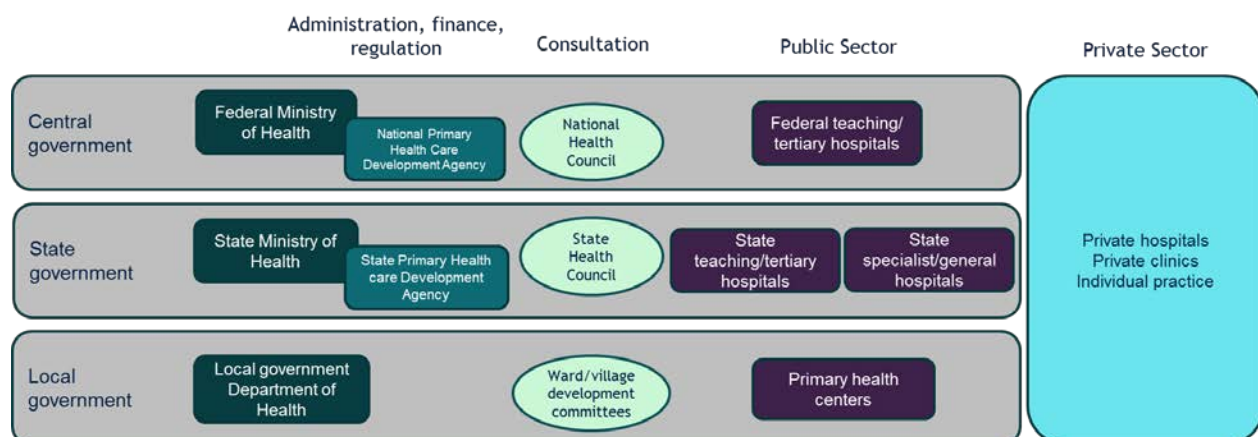
Source: MICS 2016/17; Notes: ANC=antenatal care; PNC=post-natal checkup; 1Skilled provider includes doctor, nurse, midwife, and auxiliary nurse/midwife; 2Includes: BCG, Polio3, PENTA3/DPT3, Measles and Yellow fever as per the vaccination schedule in Nigeria

**12. Provision of RMNCH and malaria interventions would also have a significant economic impact driven by a healthier, more educated, and more productive young workforce.** First, a significant factor to the East Asia dividend was the rapid decline in fertility over a period of 30 years. For comparison, the demographic transition is slower in sub-Saharan Africa projected to occur over a 90-year horizon (World Bank, 2015). To reap the benefits of the demographic dividend, a faster decline in fertility is needed – decreasing the long child dependency period and allowing greater opportunity to earn and save (National Population Commission, 2014). Second, exposure to malaria and the effects of chronic malnutrition in early life has profound impacts on brain development, affecting health, learning, and ultimately income<sup>6</sup>. Third, two-thirds of the burden of disease remains from illnesses affecting mothers and children hampering their potential participation in the workforce.

<sup>6</sup> Globally, childhood stunting has been estimated to reduce at least 10 percent of potential lifetime earnings (World Bank, 2006). Other studies have shown that a 1 percent loss in adult height results in a 2–2.4 percent loss in productivity (Caulfield, et al., 2004) (Strauss & Thomas, 1998). Malaria also accounted for 32 percent in lost wages in Malawi and a loss in GDP ranging from 0.4 percent in Ghana to 9 percent in Chad (Yamey, et al., 2016). In

**13. According to the 1999 Constitution, the provision of health services is a shared responsibility between all three tiers of government.** The federal government, through the Federal Ministry of Health (FMOH) and its parastatal the National Primary Health Care Development Agency (NPHCDA), is responsible for overall policy-making, sector planning, coordination and regulation – particularly for public health functions. It also finances referral and specialized services through its federal teaching and tertiary hospitals. State governments, through State Ministries of Health (SMOH), are primarily responsible for curative care and basic medical specialties through its state-owned specialist and general hospitals<sup>7</sup>. They are also responsible for coordinating and overseeing the provision of primary health care services. Finally, local governments, through local departments of health, are responsible for the delivery of primary health care – including health prevention and promotion activities – through a network of primary health centers, community health posts, clinics and dispensaries. At the federal and state levels health councils act as consultative policy making bodies with regards to all health matters. At the local level Ward Development Committees – an initiative launched by the NPHCDA in 2000 as a framework to institutionalize community participation – are made up of volunteer community members that advocate for the health and social needs of their communities (Figure 1.4).

**Figure 1.4: Governance structure of health service delivery**



Note: There are also other government agencies that play a regulatory and surveillance role in specific aspects of the Nigerian health care systems such as the National Agency for the Control of AIDS (NACA), the National Agency for Food Drug Administration and Control (NAFDAC), the National Institute for Pharmaceutical Research and Development (NIPRD), the Nigerian Institute of Medical Research (NIMR), the Nigeria Centre for Disease Control (NCDC), and the National Health Insurance Scheme (NHIS).

**14. In recognition of the need to change its development strategy to achieve sustainable and inclusive growth that is reflective of its potential, the GON has reiterated its commitment to making progress toward UHC by focusing on primary health care and providing access to financial risk protection mechanisms.** In 1992, the National Primary Health Care Development Agency (NPHCDA) was established as a parastatal of the FMOH with the mandate to develop national primary health care policy which is implemented at the state level by State Primary Health Care Development Agencies (SPHCDA). In 1999, the National Health Insurance Scheme (NHIS) Decree No. 35 was signed into law and officially

Nigeria, rigorous studies showed that malaria testing and treatment increases worker earnings by approximately 10 percent (Dillon, et al., 2014).

<sup>7</sup> State governments sometimes also own and provide tertiary care through state teaching and tertiary facilities.

launched in 2005 as a public private partnership directed at providing accessible, affordable and qualitative healthcare for all Nigerians. Various programmes under the scheme are meant to cover different segments of the population (Table 4). And, in 2014, the GON passed the National Health Act entitling all Nigerians to a Basic Minimum Package of Health Services (BMPHS) and specifying the Basic Health Care Provision Fund (BHCPF) as the principal funding vehicle.

**Table 1.4: National Health Insurance Scheme Membership Eligibility and Contribution Rates**

Membership type	Contribution rates
Formal sector social health insurance programmes	<ul style="list-style-type: none"> <li>Federal public-sector employees: 5 percent of their salary (3.25 percent employer/1.75 percent employee) †</li> <li>Private sector and other tiers of government: 15 percent (10 percent employer/5 percent employee)</li> <li>Armed forces, police and other uniformed services: 5 percent of salary (fully by Federal government)</li> <li>Students of tertiary institutions: Minimum premium N1,600 per academic year</li> </ul>
Informal sector social health insurance programmes	<ul style="list-style-type: none"> <li>For voluntary contributors: N15,000 per person per year</li> <li>For community-based: Actuarially determined flat rate fee per household/individual</li> </ul>
Vulnerable group social health insurance programme‡	<ul style="list-style-type: none"> <li>For physically challenged persons; prison inmates; children under five; refugees, victims of human trafficking, internally displaced persons and immigrants; pregnant women: Federal, States, Local Governments, Development Partners and Civil Society Organizations pay contributions in advance to a Vulnerable Group Fund</li> </ul>

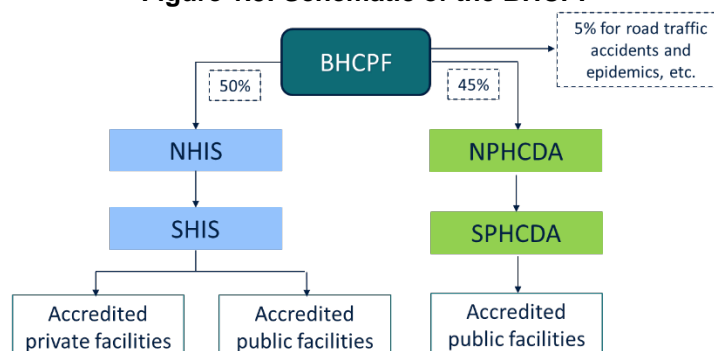
Notes: † Currently employer contribution is deducted directly from paycheck but employee contribution is not collected or enforced. ‡ Currently, this does not exist. Source: National Health Insurance Scheme (2012). Operational Guidelines.

**15. The BHCPF is a statutory federal program, meant to offer an *additional source of financing that is primarily dedicated to front line health care providers*.** Contributions to the BHCPF are mainly expected from i) an annual grant from the federal GON of no less than 1 percent of the Consolidated Revenue Fund (CRF), ii) grants from donors, and iii) funds from any other source including states and local governments<sup>8</sup>. The BHCPF provides mainly for two gateways ensuring demand and supply side financing are in sync to meet the expected increasing demand for BMPHS. The NHIS will manage 50 percent of the fund to scale up access to a minimum package of health services meant to cover 60 percent of the current burden of disease through accredited public and private providers (Annex 1) – the BMPHS. The NPHCDA will receive 45 percent of funds which will be transferred electronically to accounts of selected primary health care facilities to improve general supply side readiness (to maintain facilities, provide essential drugs, deploy human resources for community outreach and health promotion activities and provide training). The administrative expenses of both implementing agencies are capped ensuring funds reach front line health providers. The remaining 5 percent will be managed by the FMOH for national health emergencies including epidemics – referred to as the EMT gateway (not discussed further in this report) (Figure 5) (GON, 2016). Yet, to date, the GON has yet to allocate funds to the BHCPF. Table 5 summarizes the various features of the NHIS and the BHCPF (as envisioned).

<sup>8</sup> The National Health Act also makes access to funds contingent upon a 25 percent counterpart funding from SLGs. But, in the initial five years of the BHCPF, this requirement is being relaxed to having SLGs make annual budgetary provisions for operational expenses of primary health centres after which a fresh set of guidelines outlining the terms of provision of counterpart funding by SLGs may be revisited.



**Figure 1.5: Schematic of the BHCPF**



**Table 5: NHIS versus BHCPF**

	NHIS	BHCPF
<b>Legislation</b>	<ul style="list-style-type: none"> <li>National Health Insurance Scheme Decree No. 35 of 1999</li> </ul>	<ul style="list-style-type: none"> <li>National Health Act of 2014</li> </ul>
<b>Benefits</b>	<ul style="list-style-type: none"> <li>Comprehensive covering inpatient and outpatient services (including dental, provision of lenses, cancer treatment and renal dialysis) at primary, secondary and tertiary level facilities</li> </ul>	<ul style="list-style-type: none"> <li>Package of 56 essential interventions covering 60 percent of the disease burden: Antenatal care (16 interventions), delivery (6 interventions), postnatal care (9 interventions), child health (19 interventions), adult malaria (1 intervention), non-communicable diseases (1 intervention), and family planning (5 interventions)</li> </ul>
<b>Coverage</b>	<ul style="list-style-type: none"> <li>Intended to cover all Nigerians although because participation is voluntary only 4.2 percent of population currently covered, mostly civil servants</li> </ul>	<ul style="list-style-type: none"> <li>Intended to cover all Nigerians</li> <li>Will initially focus on rural population only (~60 percent of population)</li> </ul>
<b>Source of financing</b>	<ul style="list-style-type: none"> <li>Contributory scheme (premiums from employers, employees, and households) with Federal, State, and Local governments meant to set up a fund to pay premiums on behalf of vulnerable groups however this has not materialized as participation is not mandatory (see Table 4)</li> </ul>	<ul style="list-style-type: none"> <li>Non-contributory scheme</li> <li>Predominantly tax-based (i.e. no less than 1 percent of the consolidated revenue fund) plus contributions from States, and others (including donors, private philanthropists)</li> <li>To date, the BHCPF has not been funded</li> </ul>
<b>Financing channel</b>	<ul style="list-style-type: none"> <li>Demand-side financing only, reimburses providers for providing health care services</li> </ul>	<ul style="list-style-type: none"> <li>Demand-side financing (through the NHIS gateway, providers are reimbursed for providing health care services)</li> <li>Supply-side financing (through the NPHCDA gateway, facilities receive funding to fund operating costs)</li> </ul>
<b>Provider payment arrangement</b>	<ul style="list-style-type: none"> <li>NHIS pays capitation payments to primary health care and fee-for-service for secondary care</li> <li>NHIS payment is in addition to budget, in-kind support, and user fees that public facilities receive</li> </ul>	<ul style="list-style-type: none"> <li>Proposing to bundle payments and reimburse based on number of patients seen and quantity of services provided</li> </ul>

**16. One reason why the BHCPF remains unfunded has been the lack of detailed data on health spending and resource flows, including the cost and use of health services, making it difficult for the sector to efficiently plan and advocate for additional investments in health.** There has been little progress to institutionalize the National Health Accounts (NHA) – a tool for annually estimating and tracking health expenditures using a standardized classification system and methodology. The last one conducted in 2009 covered data from 2003-2005 and included only 17 states. However, more recently the government and development partners are heavily investing to fill these information gaps. A draft NHA report was produced in 2017 covering the 2010-2014 period and data for 2015-2016 has just been released. In addition, estimates of the economic and financial cost of the BMPHS have been produced in anticipation of three states (Niger, Abia, and Osun) piloting the implementation of the BHCPF. The following section brings together information from these sources providing a comprehensive look at the health financing landscape and a greater understanding of the investment required to guarantee access for all Nigerians to basic health care services.

#### THE HEALTH FINANCING LANDSCAPE

**17. The GON spends less on health than nearly every country in the world – a reflection of its under-prioritization of the sector.** In 2016, total government health expenditure was N588 billion (US\$ 2.2 billion) or 0.6 percent of GDP. As a share of total government expenditure, government health spending was also low at 6.1 percent amounting to just US\$ 11 per capita – well below regional and lower middle-income averages and the recommended US\$ 86 per capita low and middle income country benchmark needed to deliver a limited set of key health services (Table 1.6) (Federal Republic of Nigeria, 2017) (World Bank, 2017). While Nigeria's deteriorating macro-fiscal context partly accounts for low levels of spending, even in good economic times investments in health have been consistently lower over the last two decades compared to countries of similar economic status (World Bank, 2017) (Figure 1.6).

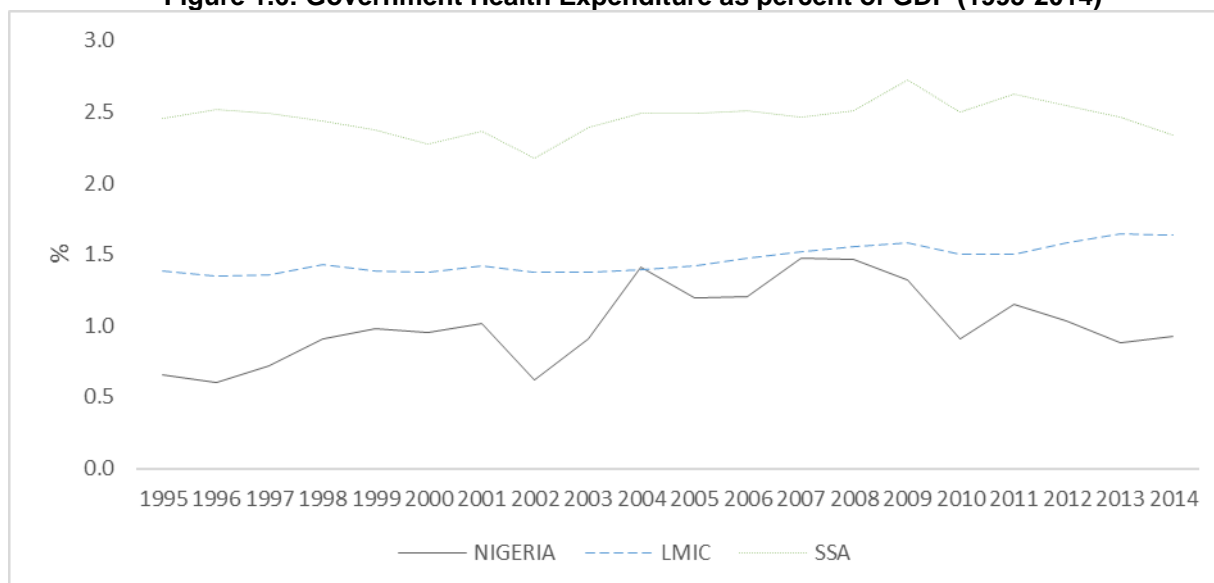


**Table 1.6: Health expenditure in Nigeria and selected low and lower middle-income countries (2014)**

	GDP pc, (constant 2010 US\$)	Govt. health expenditure as % govt. expenditure	Total health expenditure (THE) as % GDP	Govt. health expenditure as % GDP	Govt. health expenditure as % THE	Out-of- pocket expenditure as % THE	External health expenditure as% THE	THE pc, USD	Govt. health expenditure pc, USD	Catastrophic headcount at 10% threshold‡	Latest year available for catastrophic headcount
Timor-Leste	968	2.4	1.5	1.3	90.4	9.6	31.6	57	52	2.59	2001
Kenya	1076	12.8	5.7	3.5	61.3	26.1	27.6	78	48	5.89	2005
Yemen, Rep.	1101	3.9	5.6	1.3	22.6	76.4	6.4	80	18	17.06	2005
Myanmar	1266	3.6	2.3	1.0	45.9	50.7	21.8	20	9		
Cameroon	1294	4.3	4.1	0.9	22.9	66.3	11.1	59	13	10.78	2014
Cote d'Ivoire	1385	7.3	5.7	1.7	29.4	50.8	9.4	88	26	15.25	2008
Vietnam	1596	14.2	7.1	3.8	54.1	36.8	2.7	142	77	9.81	2014
Zambia	1621	11.3	5.0	2.8	55.4	30.0	38.4	86	48	0.29	2010
Ghana	1660	6.8	3.6	2.1	59.9	26.8	15.4	58	35	3.11	2005
Nicaragua	1813	24.0	9.0	5.1	56.4	37.5	5.5	178	100	29.39	2014
Sudan	1837	11.7	8.4	1.8	21.4	75.5	2.6	130	28	.	
Bolivia	2317	11.8	6.3	4.6	72.1	23.1	3.2	209	151	8.23	2002
Philippines	2506	10.0	4.7	1.6	34.3	53.7	1.4	135	46	6.31	2015
<b>Nigeria</b>	<b>2563</b>	<b>6.1†</b>	<b>3.7†</b>	<b>0.6†</b>	<b>15.7 †</b>	<b>75.2 †</b>	<b>7.6†</b>	<b>71 †</b>	<b>11 †</b>	<b>24.77</b>	<b>2009</b>
Congo, Rep.	2923	8.7	5.2	4.2	81.8	17.5	4.0	162	132	1.97	2011
Indonesia	3693	5.7	2.8	1.1	37.8	46.9	1.1	99	38	3.61	2015
<b>LMIC</b>	<b>2182</b>	<b>10.0</b>	<b>5.8</b>	<b>3.3</b>	<b>54.4</b>	<b>38.8</b>	<b>14.9</b>	<b>139</b>	<b>80</b>	-	-
<b>LIC</b>	<b>604</b>	<b>9.9</b>	<b>6.2</b>	<b>2.5</b>	<b>41.1</b>	<b>40.3</b>	<b>33.0</b>	<b>40</b>	<b>15</b>	-	-
<b>SSA</b>	<b>1949</b>	<b>9.9</b>	<b>5.9</b>	<b>2.8</b>	<b>49.6</b>	<b>35.9</b>	<b>26.5</b>	<b>104</b>	<b>57</b>	-	-

Sources: World Bank (2017). World Development Indicators; for † data is for 2016 and comes from Federal Republic of Nigeria (2017). National Health Accounts 2010-2016; for ‡ data comes from World Bank-World Health Organization (2017). Universal Health Coverage: Financial Protection in Health (Report on Trends in Catastrophic Health Spending Using 10 percent Threshold, By Country. Version: 4 May 2017). Note: Catastrophic headcount refers to the percent of households who spend more than 10 percent of their household income on health expenditures.

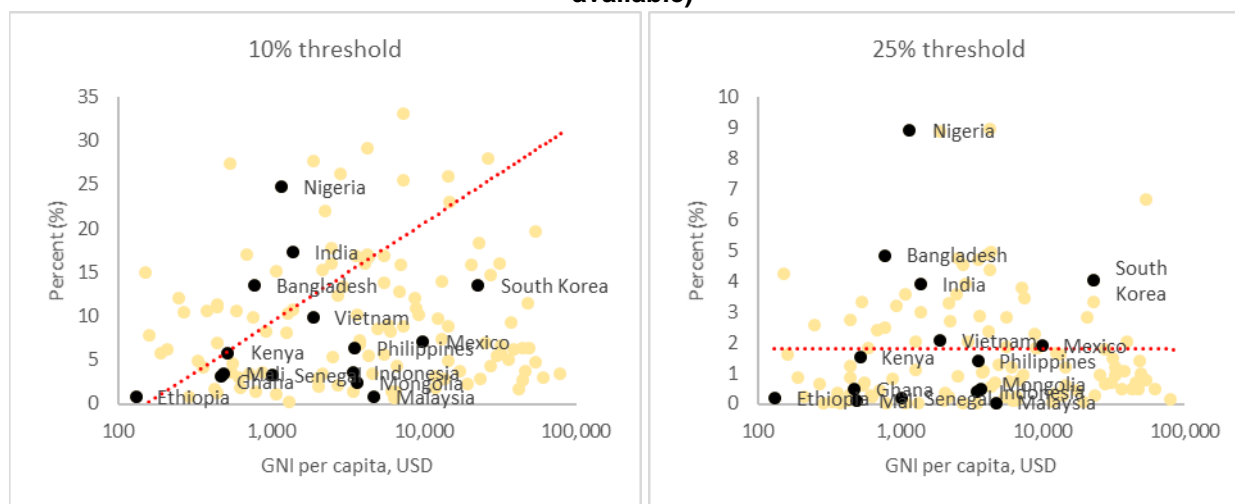
**Figure 1.6: Government Health Expenditure as percent of GDP (1995-2014)**



Source: World Bank (2017). World Development Indicators

18. **Because of limited government and pooled health financing, health spending is dominated by out-of-pocket (OOP) expenditures.** In 1999, the GON established the National Health Insurance Scheme (NHIS) as a public private partnership meant to complement government health financing, pool health risk, and provide greater financial protection to households. However, as of 2016, only 7.9 million people (~4.2 percent of the population) were covered – predominantly federal government civil servants and their dependents (Health and Managed Care Association of Nigeria, 2017). But together, government and the NHIS make up only 17.2 percent of total health financing. As a result, OOP spending accounts for 75.2 percent of total health expenditure – among the highest in the world – and 25 percent of households spend more than 10 percent of their household consumption on health (Figure 7).

**Figure 1.7: Catastrophic health expenditures at 10 percent and 25 percent thresholds (latest year available)**



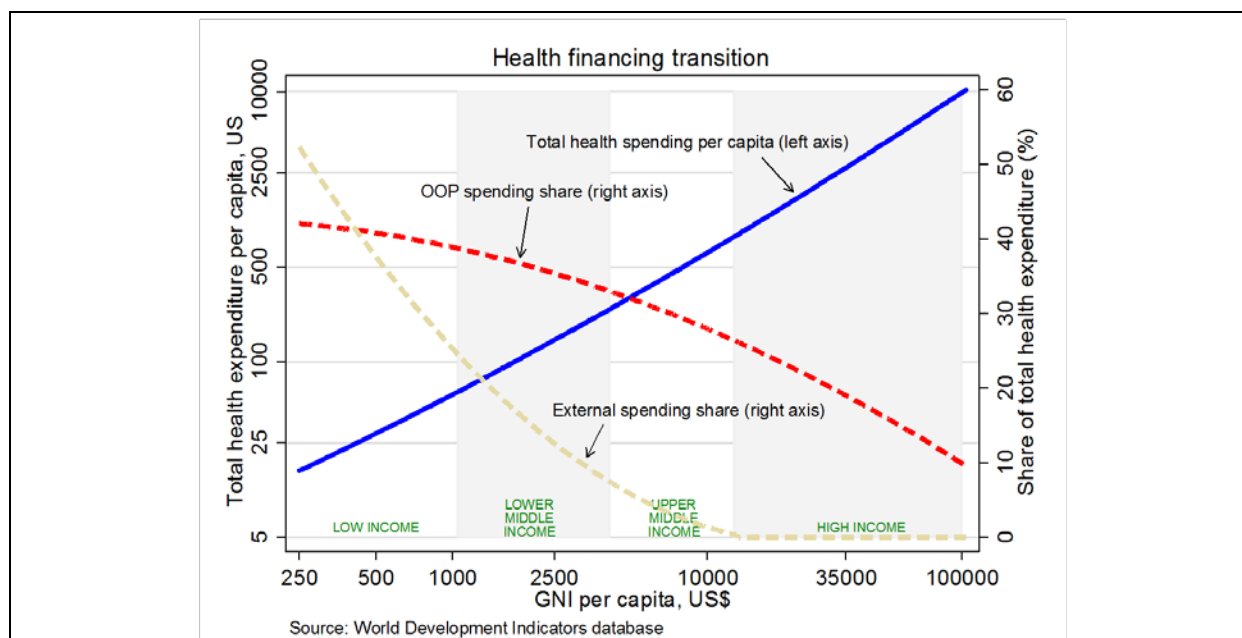
Source: World Bank-World Health Organization (2017). Universal Health Coverage: Financial Protection in Health (Report on Trends in Catastrophic Health Spending, By Country. Version: 4 May 2017). Note: Data for Nigeria is from 2009.

**19. Development assistance for health (DAH) rounds out the remaining sources of health financing and is expected to play an increasingly smaller role in coming years.** In 2016, external resources amounted to N285 billion (US\$1 billion) – almost half as much as the GON spends on health – or 7.6 percent of total health expenditure (Federal Republic of Nigeria, 2017). Funds are predominantly from a few institutions – the International Development Association (IDA), the Global Fund to fight AIDS, tuberculosis, and malaria (GF), the United States Agency for International Development (USAID), and the Global Vaccine Alliance (Gavi). As many of these institutions have policies on transition or “graduation”, Nigeria’s health financing transition will have a significant impact on its ability to access donor aid in the future (Box 1).

#### **Box 1 – The health financing transition**

Thirty-four countries transitioned from low to middle income status between 1995 and 2015 based on a GNI per capita income threshold of \$1,026 in 2015. By 2020, a half a dozen more are expected to join. This has a few implications to health sectors and their financing. In nearly all countries growth in income is accompanied by a growth in total health expenditure – particularly through pre-paid or pooled mechanisms – and a decrease in OOP spending as a share of total health expenditure. At the same time, access to development assistance falls as eligibility criteria is frequently tied to income thresholds (although disease burden, poor credit ratings and fragile and conflict status may also apply). These two trends are sometimes referred to as “the health financing transition”. However, countries often struggle to smoothly manage this transition and build sustainable health care financing systems that provide universal health coverage.

Within this context, Nigeria faces significant challenges in ensuring the sustainability of its health care system as it moves towards UHC. It transitioned from low to lower middle-income status in 2008 and is currently classified as an IDA-IBRD blend country limiting its future access to preferential terms for grants, concessional loans and debt relief. In addition, Nigeria entered Gavi’s accelerated transition phase in 2017 and will have five years before it fully transitions away from support. During this time, the government will be required to increase its co-financing levels for vaccines gradually over time, until it fully finances the program in 2022. The Global Polio Eradication Initiative (GPEI) is also transitioning and support has already started to decline, with an estimated end date of 2019. However, after two decades of support and close to one billion dollars of investment from Gavi, Nigeria’s immunization coverage remains one of the lowest in the world leading the GON to declare immunization a national emergency in July 2017.



20. **Health financing for UHC is often assessed by whether countries spend enough on health; and raising sufficient revenue for health is the first fundamental factor determining a country's ability to deliver basic health services. However, a second question asks whether countries use their limited resources in the most efficient way to deliver health outcomes and maximize value for money.** The following section looks at how efficient the government is at raising revenue, and specifically raising revenue for the health sector. It also looks at how revenues are organized to redistribute risk from unexpected health expenditures from regions who need it more to regions who need it less, from rich to poor, and from healthy to sick. Finally, it looks at how efficiently resources are allocated and used to deliver health services.

### EFFICIENCY IN HEALTH FINANCING

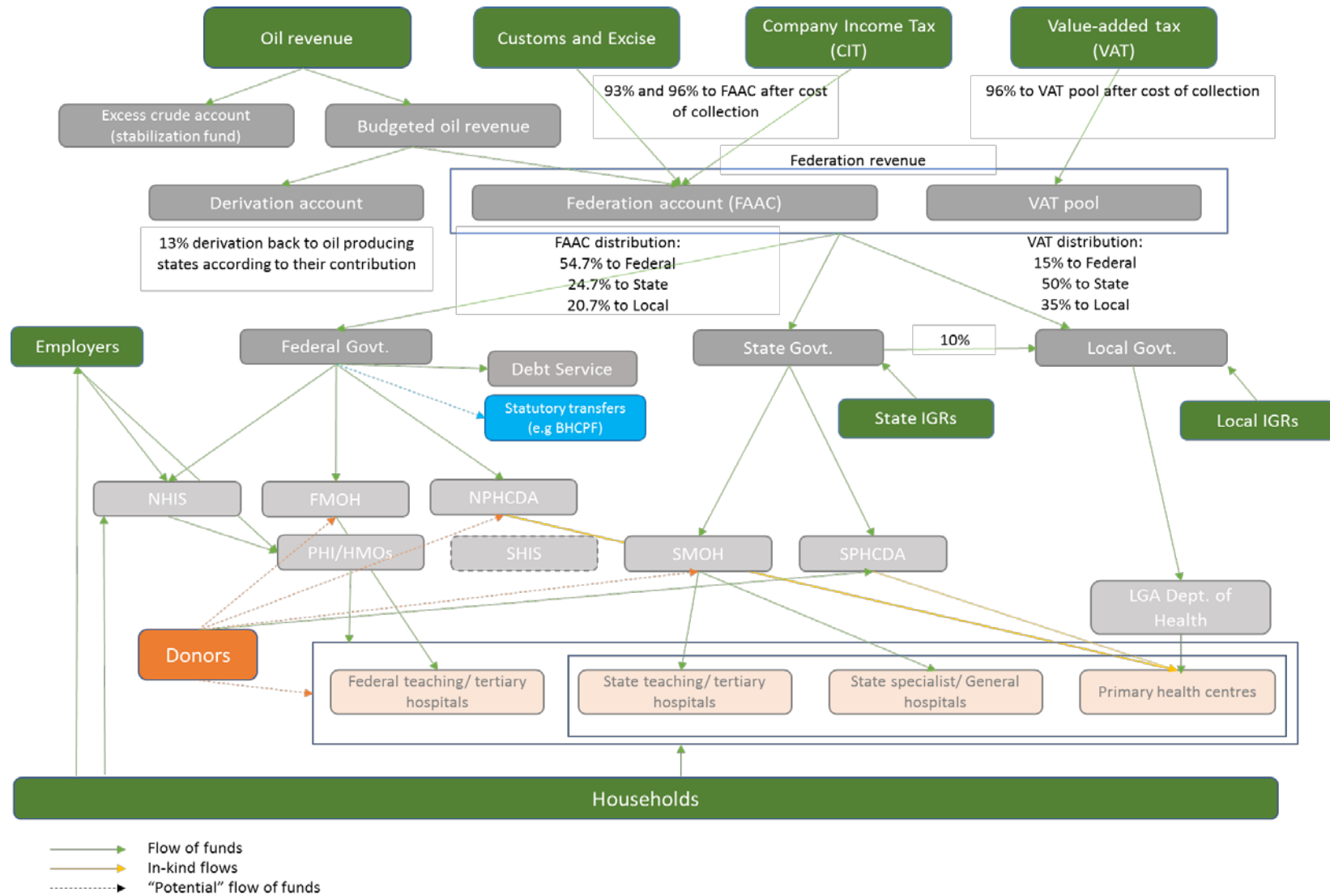
#### Efficiency in raising revenue

21. **According to Nigeria's Approved List for Collection (Act Amendment) Order, 2015, each level of government is assigned specific revenue collection responsibilities.** The federal government is responsible for the collection of nine taxes accounting for the most important sources of revenue mainly from crude oil sales, petroleum profit taxes, royalties and other oil charges, company income taxes, customs and excise duties, and value-added tax (VAT). States are responsible for collecting 25 taxes and levies primarily from personal income tax (pay-as-you-earn or PAYE for formal sector; direct assessment for self-employed) and ministries, departments, and agencies (MDAs) over the course of providing services to residents of the state (for example, user fees). And local governments are responsible for collecting an additional 21 taxes and levies mainly for license fees, market dues and other gazetted levies<sup>9</sup>.

<sup>9</sup> State and local taxes and levies are referred to as internally generated revenue (IGR).

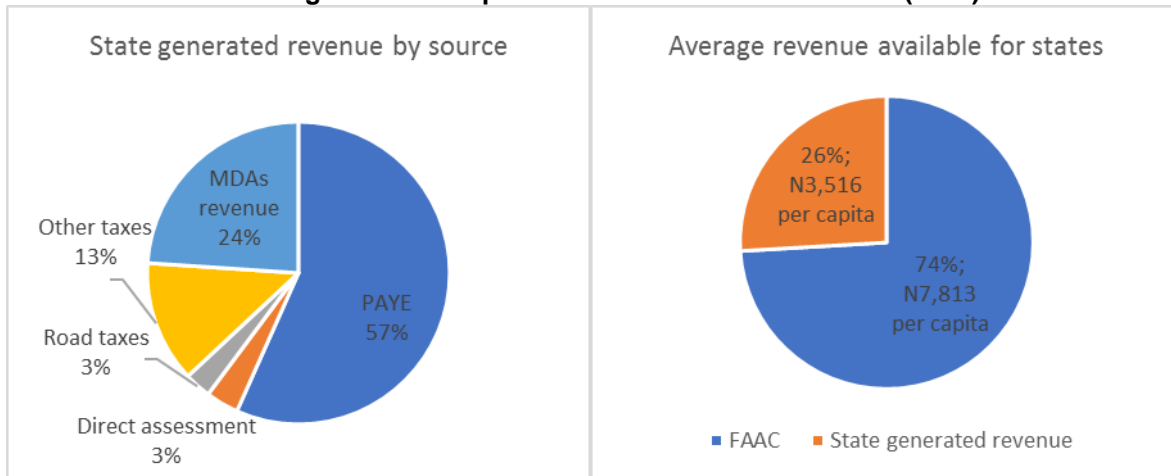
22. **While states and local governments (SLGs) are responsible for the bulk of health service delivery, they are heavily dependent on block grants from the central government for their resources.** Federation revenues accrue to two main accounts: the value-added tax (VAT) pool account and the Federation Account (FAAC) for oil and other non-oil revenue. Revenue from both accounts are then distributed across the three levels of government based on vertical revenue-sharing allocation formulas (Figure 1.8). On average, internally generated revenues accounted for just 26 percent of total state revenue in 2016 with wide variations across states (National Bureau of Statistics, 2017) (Figures 1.9 and 2.0). Weak tax administration, the wide prevalence of informal employment, and reliance on guaranteed central transfers explain the poor performance of state generated revenues. In addition, the multiplicity of state and local taxes and levies make it difficult for local governments to collect and enforce compliance and harder for individual members to distinguish official from fake taxes (Box 2). Weak revenue mobilization effort means a smaller pool of resources to distribute to all sectors, including health.

**Figure 1.8: Funds flow diagram**



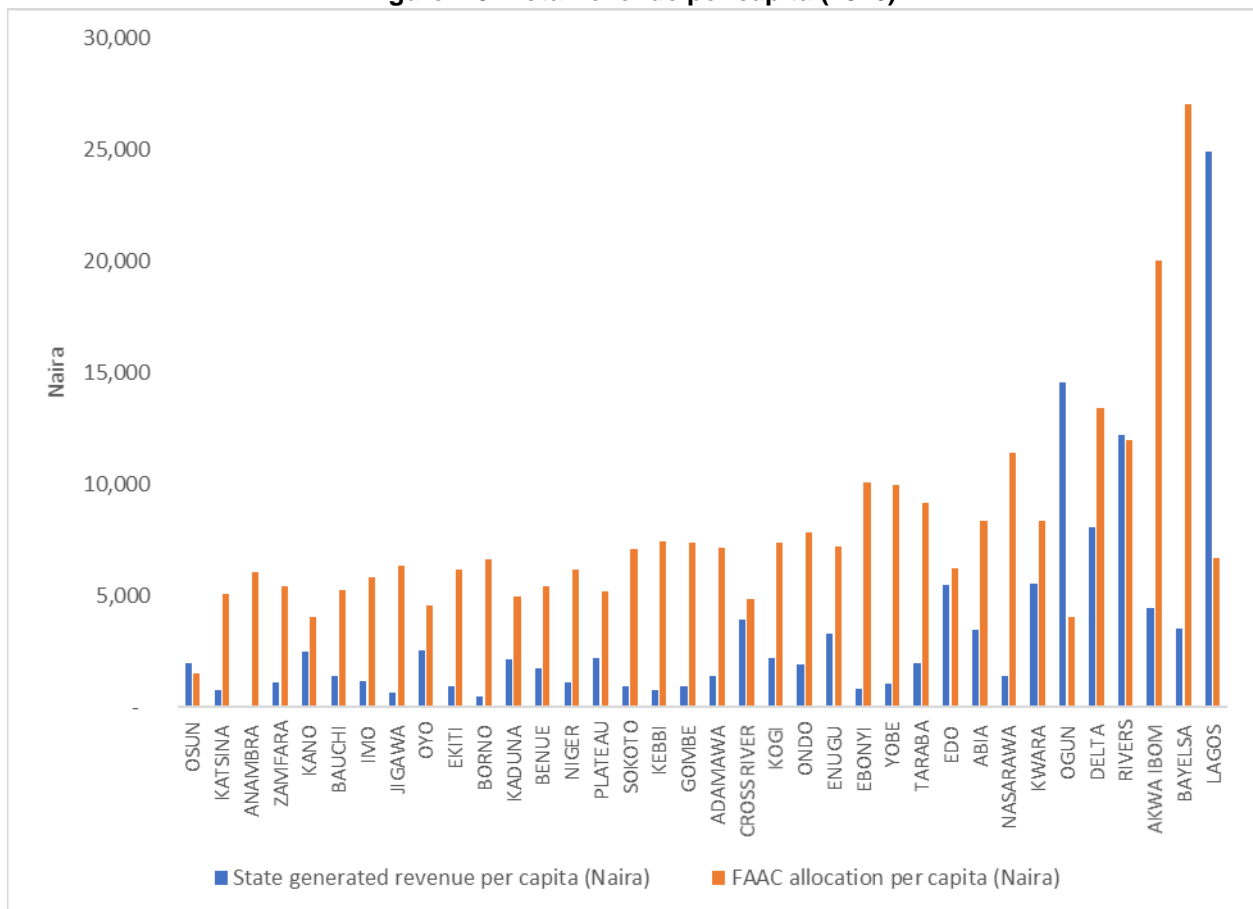
Notes: IGR=Internally generated revenue; N/SHIS=National/State Health Insurance Scheme; F/SMOH=Federal/State Ministry of Health; N/SPHCDA=National/State Primary Health Care Development Agency; LGA=Local government agency

**Figure 1.9: Composition of Subnational Revenue (2016)**



Source: National Bureau of Statistics (2017). Internally Generated Revenue at State Level. Accessed <http://nigerianstat.gov.ng/report/551> on 05/24/17. Notes: MDA=ministries, departments, and agencies; PAYE=pay as you earn, a form of personal income tax that is automatically deducted from the wages and salaries of employees operating in the formal sector; FAAC= federation revenue.

**Figure 2.0: Total revenue per capita (2016)**



## **Box 2 – Tax revenue performance in Nigeria**

At 4.8 percent as a share of GDP, Nigeria has one of the weakest revenue mobilization efforts in the world. Tax revenue depends on four factors: i) the tax base, ii) the tax rate, iii) administrative efficiency, and iv) compliance.

### *Tax base*

As of December 2016, the Joint Tax Board listed the number of individual payers on the tax roll in Nigeria at approximately 14 million people. Compared with a potential labor workforce of 103 million according to the National Bureau of Statistics, the number of people in the tax net is only 14 percent – the majority of which are in the formal sector. Therefore, bringing the informal economy into the tax net is often advocated as a means to increasing tax revenue in Nigeria. While there is no standard definition of informality, it is often defined by a combination of firm size, location of operation (for example, in the open market) and business registration far more than by whether businesses do or do not pay tax. In fact, informal actors in Nigeria end up paying a range of formal and non-formal (or illicit) payments which add to their tax burden. As such, it is not so much whether the informal sector pays taxes, but to whom and under what conditions.

### *Tax rate*

At 5 percent, Nigeria has one of the lowest value-added tax rates in the world. Health taxes that decrease the consumption of harmful products such as alcohol and tobacco have also been seen as a potential source of revenue in countries with low rates. In particular, Nigeria's tobacco excise rates at 20 percent are well below the 75 percent World Health Organization benchmark. In contrast, while Nigeria's corporate income tax (CIT) rate of 30 percent is slightly above global comparators, its revenue is much lower suggesting low tax efficiency.

### *Administrative efficiency*

Tax effort, defined as the ratio between a country's maximum tax capacity – estimated based on a set of variables such as GDP per capita, population growth, trade openness, share of agriculture, corruption, etc. that take into account a country's specific macroeconomic and institutional features – and the amount actually raised is low in Nigeria (24 percentage points beneath the lower income average of 65 percent), hinting at significant inefficiencies in revenue mobilization (Fenochietto & Pessino, 2013). The World Bank's annual Doing Business flagship report ranked Nigeria 171 out of 190 benchmarked economies on the paying taxes sub-index. The index records the number of taxes and mandatory contributions that a medium-sized company must pay or withhold in a given year, as well as the administrative burden in paying taxes and contributions. Exemptions, provided liberally in Nigeria, further accounts for the low tax efficiency of corporate income taxes.

### *Compliance*

While the non- or limited availability of tax statistics make the quantification of tax evasion and non-compliance difficult in Nigeria, it has been estimated that 75 percent of registered companies were not in the tax net. Of those in the tax net, 65 percent did not file returns or pay taxes. This translates to less than 9 percent of all companies operating in Nigeria paying taxes. Even the government – the largest employer – is not fully compliant in deducting and remitting taxes on salaries of their workers. And, the ratio of Value Added tax (VAT) registered entities that are filing returns and remitting VAT is only about 12 percent – although when compared to all taxable entities compliance will be even lower.



Sources: (Yelwa & Adam, 2017); (Nwaoba, 2017); (Meagher, 2016) (World Bank, 2018) (Ministry of Budget and National Planning, 2017) (Oyedele, 2016) (National Bureau of Statistics, 2017).

### Efficiency in pooling resources

23. **Intergovernmental fiscal transfers are a common feature used in most fiscally decentralized countries to redistribute income based on need. However, in Nigeria, horizontal revenue sharing formulas limit their ability to address regional fiscal and equity concerns.** Oil revenue is shared in part on a derivation basis (that is, 13 percent of oil revenue is taken off the top and goes back to oil producing states), with the remaining share distributed via the vertical formula shown in Figure 1.8<sup>10</sup>. The horizontal formula applied to states for the distribution of Federation Revenue predominantly follows a principle of equality – that is all states receive an equal share – with population, size, level of social development, and fiscal capacity playing a more minor role (Table 1.7). Thus, federal allocations are not only non-equalizing but they favor the wealthier oil producing states. Additionally, the measure used to determine health need is based on inputs – number of hospital beds and health personnel. This is a poor measure of health need for two reasons. First, wealthier states are more likely to have more hospital beds and health care workers. Second, it incentivizes states to push for more facilities rather than focusing on health outputs (for example, number of fully immunized children) or outcomes (for example, child mortality) which, as highlighted earlier, differ widely across regions.

**Table 1.7: Horizontal revenue sharing formulas applied to States**

Principle	Federation Account Revenues (percent)	VAT Revenue (percent)
Equality	45.23	40.00
Population	25.60	10.00
Population density	1.45	
Internal revenue effort	8.31	
Landmass	5.35	
Terrain	5.35	
Rural roads/inland waterways	1.21	
Potable water	1.50	
Education	3.00	
Health	3.00	
Derivation	0.00	50.00

Source: World Bank (2013). Public Expenditure and Financial Accountability (PEFA) Assessment.

24. **Health insurance is another common mechanism used to redistribute income by pooling risk for unexpected health expenditures across populations. However, given that NHIS coverage is predominantly limited to members of the formal sector, it too fails to provide adequate financial risk protection to the poorest and sickest households.** Participation in the NHIS is voluntary, and currently the predominant source of funding for the NHIS are premium contributions paid by the GON on behalf of federal civil servants. While contributions are meant to be split by the employer and employee (3.25 percent/1.75 percent),

<sup>10</sup> 80 percent of crude oil production is concentrated in Akwa Ibom, Bayelsa, Delta, and Rivers State. The remaining 20 percent comes from Cross Rivers, Imo, Abia, Anambra, and Ondo. Lagos has also recently joined the list of crude oil producing states.

only the employer contribution is made by the GON and the NHIS has been unable to collect payments from employees. This is akin to the GON subsidizing payment of an already better off population. Enrollment has also been slow with coverage limited to civil servants and private sector employees. The informal sector, comprising most Nigerians – including the poorest and sickest individuals – are left to either forgo care when they fall ill or pay out-of-pocket for their health care expenditures.

### **Efficiency in allocating and using resources**

**25. The planning and budgeting functions for the sector are weak.** A capacity assessment of the Department of Health Planning, Research and Statistics (DPHRS) housed within the FMOH – the department meant to provide leadership in defining and implementing the sector's priorities – found the department ill equipped to carry out its functions<sup>11</sup>. The department has not received any funding from the FMOH in the last three years and staff do not have the right tools, systems, or resources to do their work effectively and efficiently<sup>12</sup>. The overall medium-term expenditure framework (MTEF) is not sector or MDA specific and medium-term sector strategy (MTSS) ceilings relate mainly to capital budgets. MTSSs are also incomplete as they do not cover all sources of government expenditures (for example, off-budget donor expenditures); they are fragmented as there is no formal attempt to consolidate expenditures across tiers of government and MDAs (for example, FMOH, SMOH, NPHCDA, SPHCDA), and not costed as information on the cost and utilization of health services is not routinely available (Ministry of Budget and National Planning, 2017) (World Bank, 2013). Of particular note, the monitoring and evaluation division has not produced an annual health report since 2008; key performance indicators are not routinely set to track the implementation of annual activities; and the annual overall budget implementation report is limited to the federal budget and, in health, covers only capital expenditures (which represented only 11 percent of the 2016 health budget)<sup>13</sup>.

**26. Realistic revenue projections and perennial delays in the approval of the budget further undermine the efficient allocation and implementation of the health sector budget.** While the gap between projected and actual revenue decreased in 2017, significant shortfalls impact the amount released to sectors (Table 8). As MDAs are essentially guaranteed recurrent funding (personnel and overheads), it is capital budgets that are mostly affected. Additionally, late passage of the budget (May in 2016, June in 2017) and a lack of advance information on cash availability for capital expenditures<sup>14</sup> undercuts budget execution. At the federal level, health is one of the sectors that is most likely to see its capital budget scaled back compared with its annual appropriation, giving precedence to recurrent spending over development expenditure. In the 2016 budget, a total of N28.65 billion was allocated to the

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<sup>11</sup> DPHRS functions which consist of i) policy and planning for the sector, ii) monitoring and evaluating health system performance, iii) coordinating resource mobilization and healthcare financing including development partner funds, iv) planning for health human resource development, and v) sharing knowledge and research to promote health system strengthening activities. The budgeting process is technically not even a function of the DPHRS but of the Finance and Accounts Department which sees it purely as an accounting exercise using the government integrated financial management information system (GIFMIS). It does not link up with other units and strategic planning activities are not conducted regularly.

<sup>12</sup> Most staff use their personal laptops and internet connectivity and official emails are not provided.

<sup>13</sup> There is no separate formal annual performance review for the health sector.

<sup>14</sup> Current cash management uses cash rationing, rather than forward cash forecasting that would allow cash planning and budgeting.

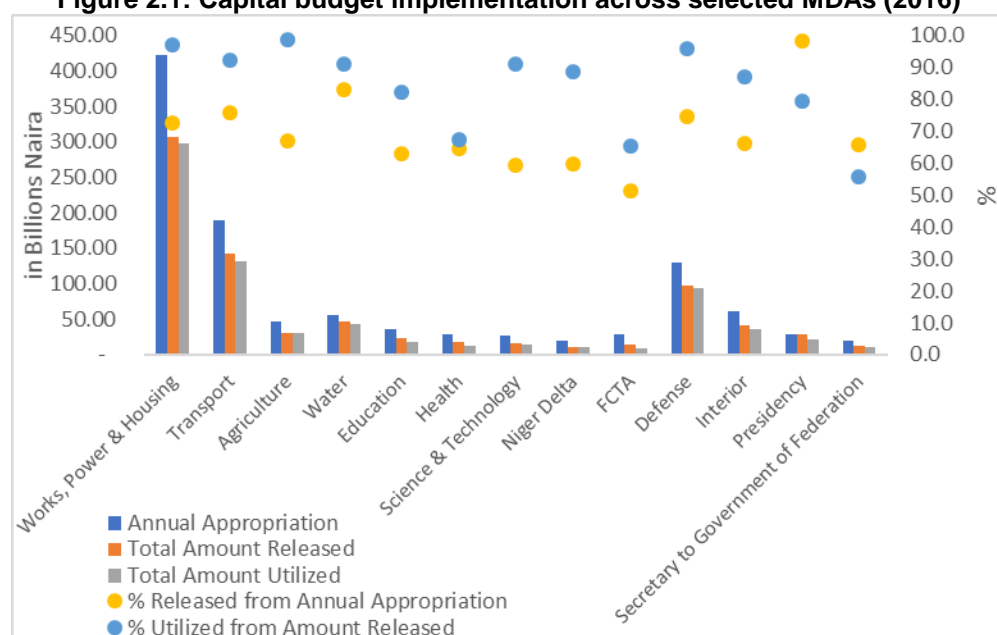
health sector to execute its capital projects and programmes. Out of this amount, N18.47 billion was released and N15.57 billion utilized by the end of the fiscal year. The sector also has one of the lowest capital budget execution rates at the federal level, utilizing 67.3 percent of funds released in 2016 (Figure 2.1) (Ministry of Budget and National Planning, 2016) (World Bank, 2013).

**Table 1.8: Revenue shortfalls, Naira billions (2015-2017)**

2015			2016			2017		
Projected	Actual	percent change	Projected	Actual	percent change	Projected	Actual	percent change
3.5	2.3	-34.6	3.9	2.9	-24.9	5.1	4.4	-14.0

Source: Budget Office of the Federation. Budget Speech (Years 2016-2018) and The 2018-2020 Medium Term Expenditure Framework and Fiscal Strategy Paper.

**Figure 2.1: Capital budget implementation across selected MDAs (2016)**



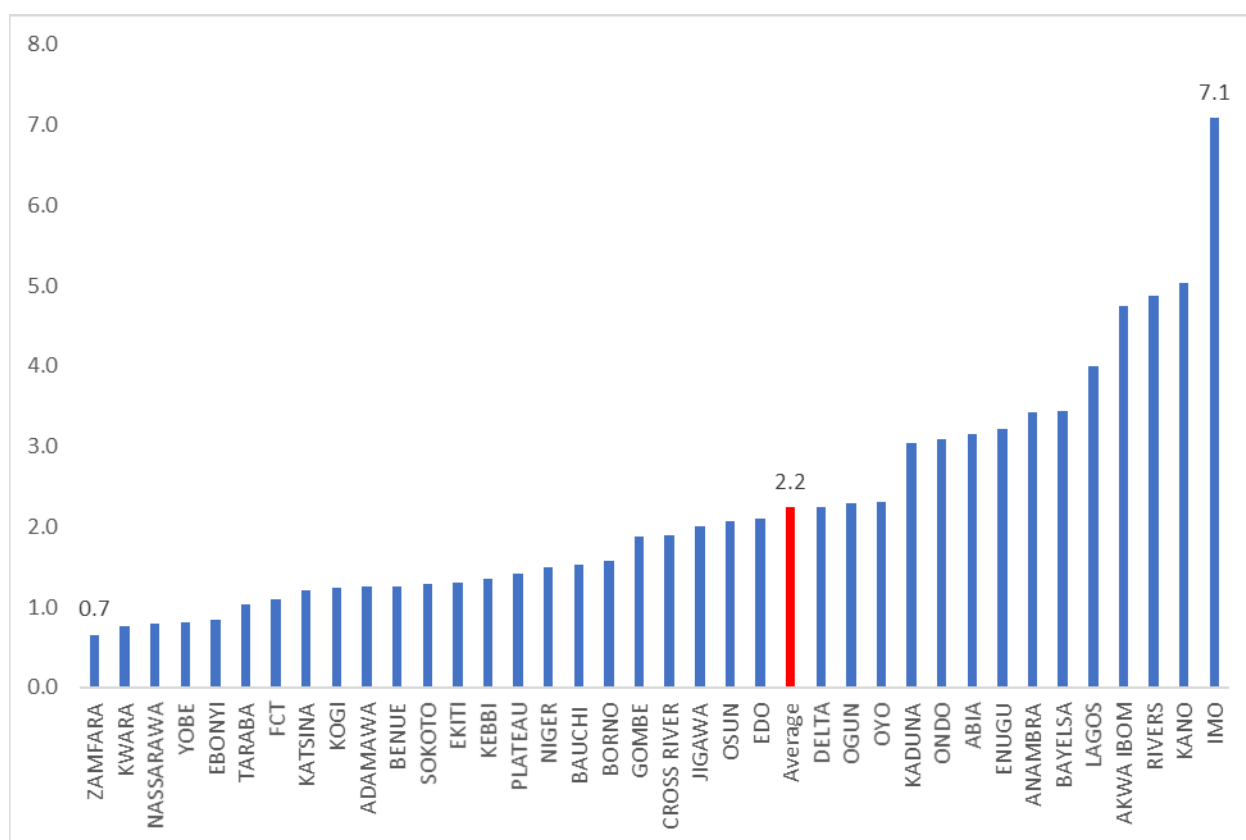
Source: Ministry of Budget and National Planning, 2016. 2016 Fourth Quarter and Consolidated Budget Implementation Report, Abuja.

27. **Within the sector, even though Nigeria delegates the delivery of health services to SLGs, most health spending is at the central level.** According to the latest National Health Accounts, 67 percent, 26 percent, and 7 percent of government health spending took place at the federal, state, and local levels respectively in 2016. Health expenditures at the state and local government level also make up only 1.5 percent and 0.4 percent of total government expenditure or 4.2 percent and 3.8 percent of state and local budgets respectively. Instead, health spending at the central level was 4.19 percent as a share of total government spending or 7.11 percent as share of the federal budget (Federal Republic of Nigeria, 2017).

28. **Given the budget autonomy of SLGs, subnational health spending as a share of total health expenditure also varies widely across states** (Figure 2.2). SLGs are not accountable to the federal government for the use of funds as all transfers are unconditional, with no legal mandate requiring a minimum spend on health. This, along with states' varying fiscal capacity and health need likely account for these variations. Disaggregated subnational

health expenditure data by source of financing (government, NHIS, out-of-pocket, and external) is not currently available. Additionally, the absence of systematic reporting that links health expenditure with health system performance across states and levels of government undermines the sector's ability to target limited government resources to the populations that would benefit most.

**Figure 2.2: Subnational health expenditure (from all sources) as percent of total health expenditure (2016)**



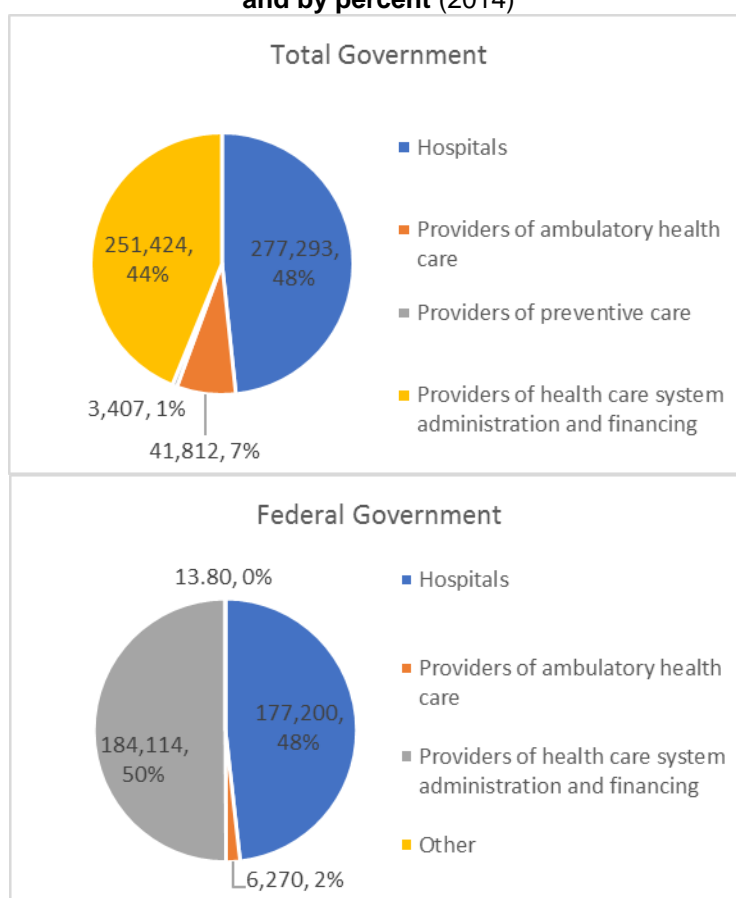
Source: Federal Republic of Nigeria (2017). National Health Accounts 2010-2016. Note: Disaggregated subnational health expenditure data by source of financing is not currently available. As a result, the above figure represents health spending from all sources (government, NHIS, out-of-pocket, and external).

29. **From a functional perspective, the stated responsibilities of the three tiers of government in service delivery largely determines where health spending occurs – predominantly towards curative care, especially in tertiary and secondary hospital settings, with little focus on low-cost high-impact areas of prevention, public health, and primary health care.** Federal and state health budgets primarily fund personnel and capital costs of their respective MDAs (for example, FMOH, SMOH, NPHCDA, SPHCDA) and teaching, tertiary, and secondary hospitals<sup>15</sup>. Local government budgets are meant to finance primary health centers (PHC) – the entry point to the health care system (Figure 8). Looking at government health spending by health care provider shows that federal and state governments spent 48 percent and 61 percent of their budgets on hospitals respectively. The large share

<sup>15</sup> The federal government also provides in-kind support to primary health centres for centrally procured drugs (including vaccines) primarily through the NPHCDA budget.

spent on providers of health care system administration and financing also suggests the prioritization of administration over service delivery (Figure 2.3). Combined, government health schemes only spent N41,606 million and N3,407 million on ambulatory health centres and prevention respectively in 2014 (predominantly by local governments) – this amounts to approximately 8 percent of government health expenditure or N248 per person (less than US \$2) (Federal Republic of Nigeria, 2017)<sup>16</sup>. To put this into perspective, the full cost of delivering the BMPHS<sup>17</sup> – interventions that would be carried out at ambulatory health centres and providers of preventive care – among the population in need would be N3,374 (or US\$11.04) per person. The fiscal impact of providing the BMPHS to the entire target population would be N662 billion (or US\$2.2 billion) or 0.54 percent of GDP, 6.40 percent of total government expenditure, and 58.6 percent of government health expenditure (World Bank, 2017)<sup>18</sup>.

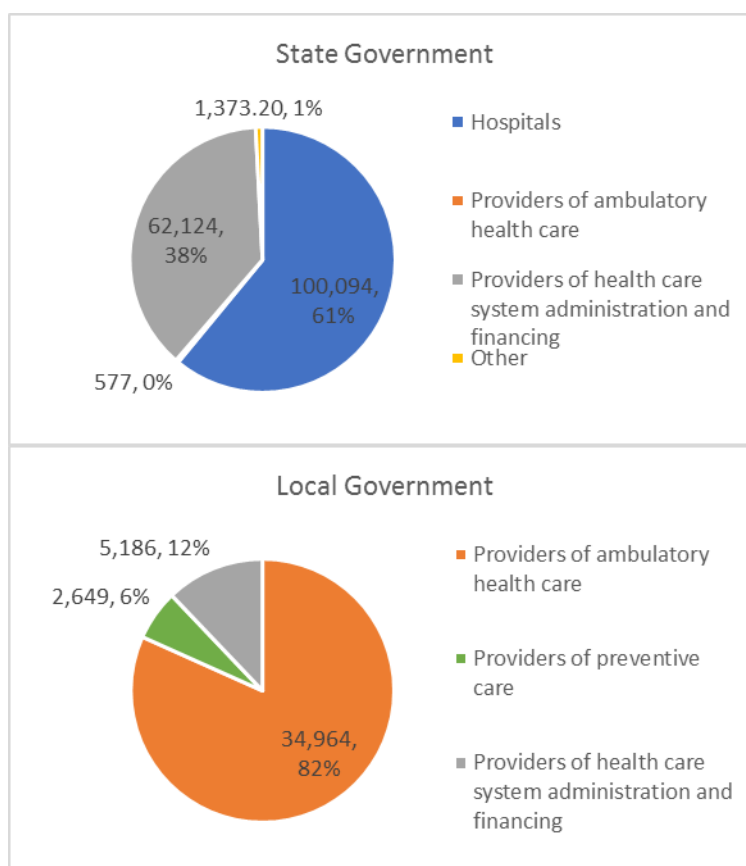
**Figure 2.3: Government Health Spending by Level and Health Care Provider, in millions of Naira and by percent (2014)**



<sup>16</sup> Government health spending data by health care provider and function is not currently available for 2016.

<sup>17</sup> The BMPHS includes intervention packages for antenatal care (16 interventions), delivery (6 interventions), postnatal care (9 interventions), child health (19 interventions), adult malaria (1 intervention), non-communicable diseases (1 intervention), and family planning (5 interventions). Population in need is defined as the population eligible to receive the intervention package based on population demographics, epidemiology, and service delivery method (e.g. community, outreach, clinic, hospital). Cost includes cost of personnel, drugs, and overhead.

<sup>18</sup> GDP based on IMF projections (USD 400.6 billion), total government expenditure based on World Bank MFM projections (USD 33.83 billion), government health expenditure assumes that public health spending as a share of government expenditure remains unchanged from 2014 NHA (0.92 percent of GDP).

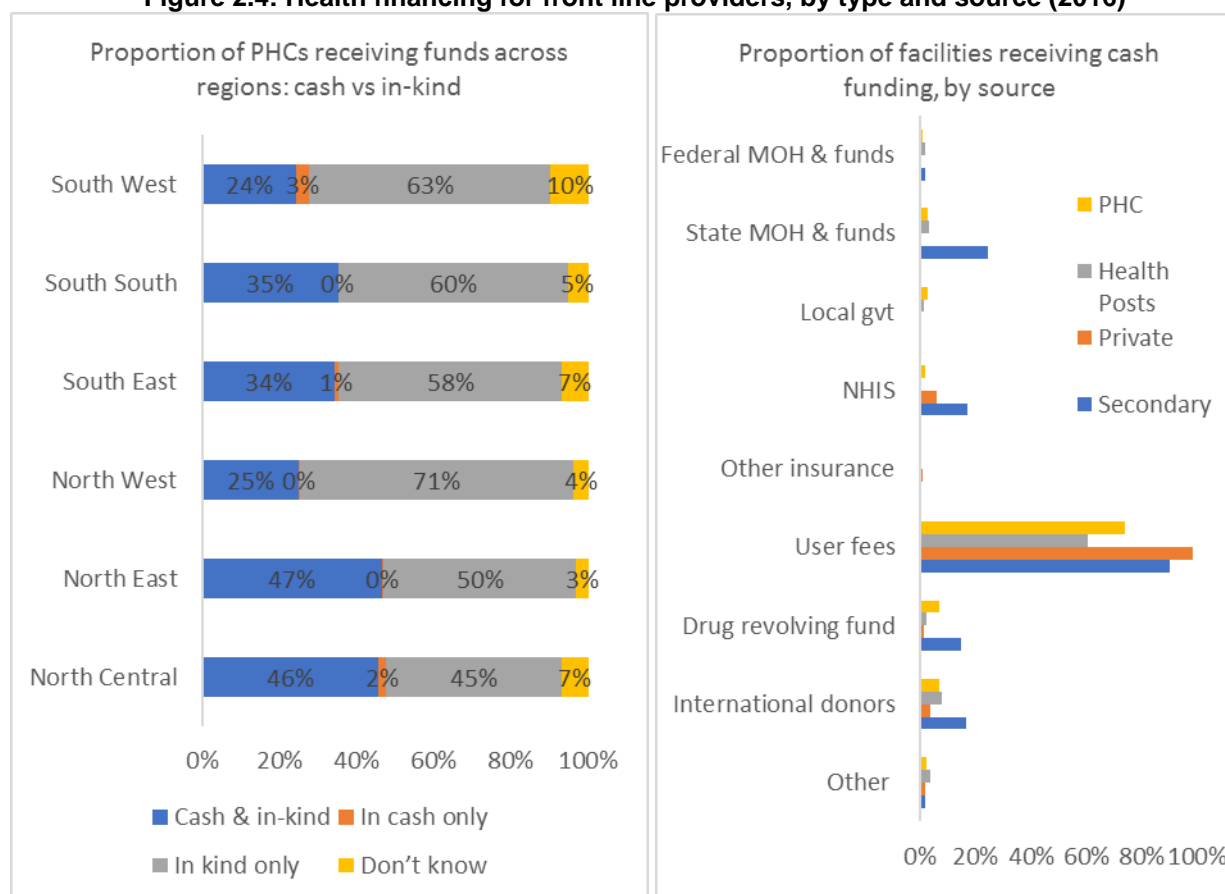


Source: Federal Republic of Nigeria, 2017. National Health Accounts 2010-2014.

30. **Primary health centres receive little to no operating budget.** Primary health centres are meant to receive cash and in-kind support through the various fund flow arrangements described in Figure 1.8. However, the 2016 National Health Facility Survey (NHFS)<sup>19</sup> confirmed that on average providers received salaries with a two-to-three-month delay and only a third of facilities received any form of cash grants to meet their operational costs. If PHCs did receive cash support, the predominant sources were user fees (even for services that the National Health Act say should be free – that is, the BMPHS), drug revolving funds, and donors (Figure 2.4). Overall, 74 percent of PHCs reported charging user fees predominantly for drugs, delivery services, and antenatal care. In-kind support was provided predominantly by local government and international donors and consisted mostly of drugs (that is, vaccines) and medical records/forms.

<sup>19</sup> The 2016 NHFS was designed to measure different dimensions of service delivery performance at health facilities in all 36 states plus the Federal Capital Territory (FCT) in Abuja. The questionnaire collected information mainly from primary care health facilities – the main unit of analysis. In each state, a total of ~90 health facilities (3,325 facilities nationwide) were surveyed including: 2,537 public primary health facilities, 351 private primary health facilities, 214 health posts, and 223 secondary hospitals. Data was collected in September-December 2016.

**Figure 2.4: Health financing for front line providers, by type and source (2016)**

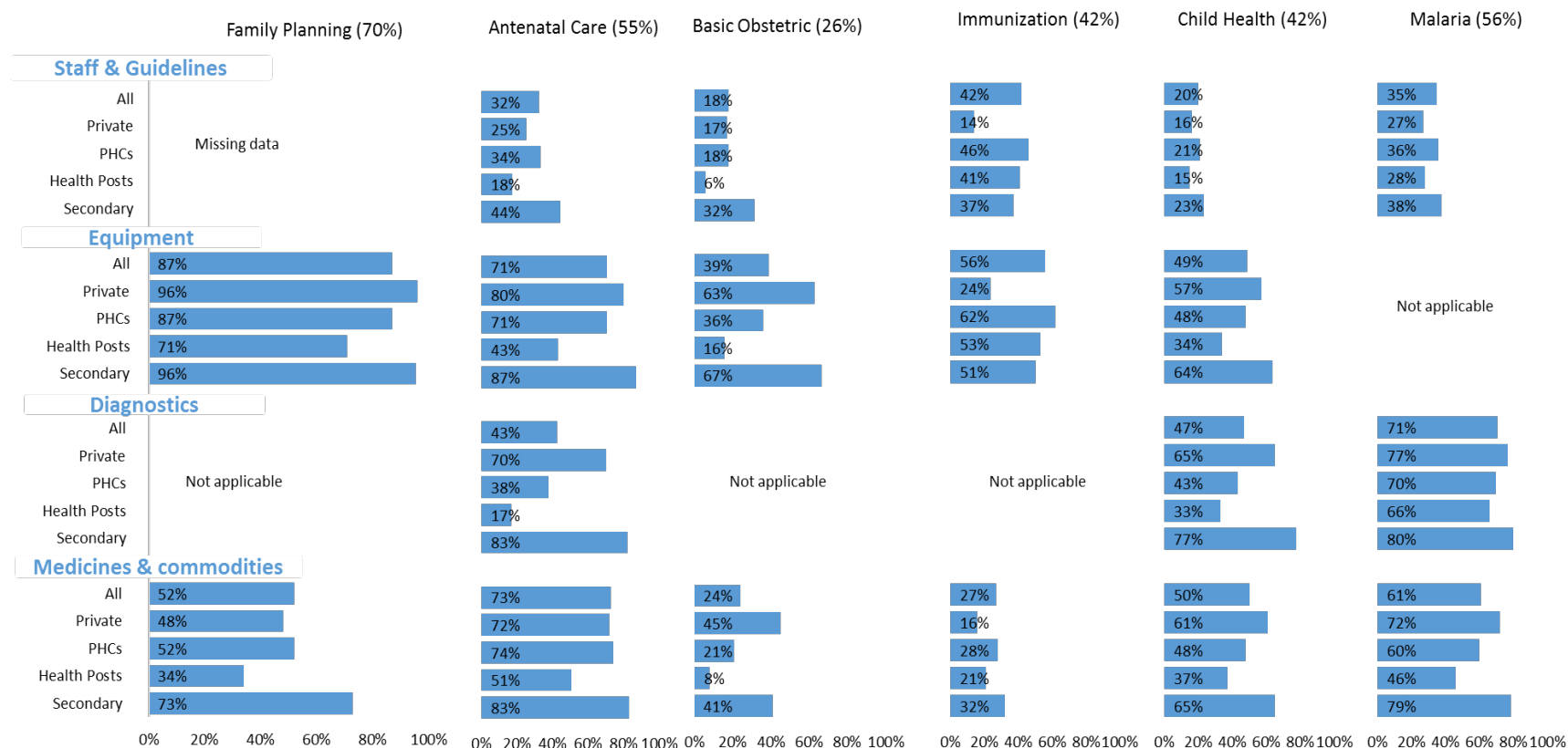


Source: Author's analysis of the 2016 National Health Facility Survey.

31. **As a result, PHCs frequently lack basic amenities, equipment, and drugs severely undermining service delivery and efforts to improve health outcomes.** General supply side readiness – often used as a proxy for quality – measures the capacity of health facilities to provide basic services based on the availability of selected tracer items for basic amenities, equipment, essential medicines, diagnostic capacity, and standard precautions for infection prevention. Primary health centres scored poorly across all categories (for example, facilities had on average only 36 percent of all tracer items) but performed particularly worse on the availability of essential medicines, basic amenities such as power, water, and sanitation, and diagnostic capacity for pregnancies, malaria, HIV, diabetes, and hypertension (results not shown). Similarly, service-specific readiness, based on the availability of selected tracer items for specific RMNCH services, was weak for all intervention packages that would be included in the BMPHS and across both public and private primary health care facilities (Figure 2.5).

32. **Provider training and knowledge of front line providers was especially poor.** The availability of trained staff and guidelines for the diagnosis and treatment of conditions performed worse than other sub-indices for all intervention packages except immunization. Even more worrying, was providers' (in)ability to diagnose patients for common conditions such as malaria and diarrhea and manage life threatening complications related to childbirth (Tables 1.9 and 2.0).

**Figure 2.5: Service specific readiness (2016)**



Notes: Overall service specific supply side readiness index is a composite of sub-indices in staff and guidelines, equipment availability, diagnostic availability, and medicines and commodities availability. They are to be interpreted as “facilities have on average X percent of all service specific readiness tracer items”. This analysis uses the World Health Organization’s Service Availability and Readiness Framework applied to the NHFS. Source: Author’s analysis of 2016 National Health Facility Survey.



Table 1.9: Provider knowledge at primary health centres (2016)

	Adherence to clinical guidelines (percent)		Diagnostic Accuracy (percent)	
	Public	Private	Public	Private
Diarrhea	31	43	26	43
Pneumonia	27	40	42	64
Diabetes	23	41	36	71
Tuberculosis	30	44	60	77
Malaria	39	50	11	26
Post-partum hemorrhage	17	32	59	79
Birth Asphyxia	9	17	37	62

Note: Adherence to clinical guidelines is comprised of three sub-categories – adherence to history questions, adherence to physical exam, and adherence to laboratory tests. The adherence to clinical guidelines indices are interpreted as “on average, providers ask/adhere to X percent of questions/exams they should be asking/doing when checking a patient for a particular condition”. For diagnostic accuracy, the interpretation is “on average, providers correctly diagnose condition X, X percent of the time. This analysis uses the World Bank’s Service Delivery Indicators Framework applied to the provider vignette survey data from the NHFS. Vignette data is based 5,193 people over 3,118 facilities. Source: Author’s analysis of NHFS.

Table 2.0: Ability to manage life threatening complications (2016)

	Treatment accuracy ( percent)		Ability to manage ( percent)	
	PHCs	Private	PHCs	Private
Post-partum hemorrhage	9	12	14	25
Birth Asphyxia	18	30	13	24

Note: Treatment accuracy for post-partum hemorrhage is interpreted as percent of providers who proposed all three treatments for postpartum. Treatment accuracy for birth asphyxia is interpreted as percent of appropriate treatments proposed from a list of 9 actions. Ability to manage is an aggregate score which not only considers treatment accuracy, but also adherence to physical exams and history questions relating to post-partum hemorrhage and birth asphyxia. This analysis uses the World Bank’s Service Delivery Indicators Framework applied to the provider vignette survey data from the NHFS. Vignette data is based 5,193 people over 3,118 facilities. Source: Author’s analysis of NHFS.

33. **Finally, low provider effort, as measured by absenteeism and caseload, is likely a reflection of current payment arrangements and suboptimal accountability and oversight.** Currently, primary care providers are paid by salary. In salary based payment schemes, the unit of payment is time regardless of the number of patients seen, quantity of clinical activities provided, or cost of services. There is little incentive to increase quantity, improve quality, or contain costs unless their salaries are made contingent on agreed-upon performance targets (for example, financial incentives) or strong oversight and management such as provider feedback and opportunities for continuing education and provider training (for example, non-financial incentives). Absenteeism, defined as the number of health professionals that are not off-duty who are absent during an unannounced visit, reflects a waste of resources. Absenteeism in Nigeria was 27 percent across PHCs. Another measure of provider effort is caseload, defined as the number of outpatient visits divided by the number of consulting health workers. Nigeria’s caseload of 5.3 is particularly low compared to other Sub-Saharan Africa countries. However, in Nigeria, outpatient visits at PHCs are predominantly seen by community health extension workers (CHEWs) – a group of health professionals that

are generally excluded when constructing caseload measures. When CHEWs are included, the average caseload decreases even further to 2.6 in PHCs (Table 11)<sup>20</sup>.

**Table 2.1: Absenteeism and caseload, all facility types, (latest year available, percent)**

	Kenya	Madagascar	Niger	Tanzania	Senegal	Mozambique	Togo	Uganda	Nigeria
<b>Absenteeism</b>	29.2	26.4	33.2	13.9	20.0	24.0	38.0	47.0	27
<b>Caseload</b>	15.2	4.0	7.3	7.1	-	17.4	5.2	6.0	5.5 2.6†

Note: † Caseload is generally constructed excluding cadre-types such as public health nurses and out-reach workers but as outpatients are predominantly seen by community health extension workers (CHEWs) in Nigeria, we provide a second measure of caseload that includes CHEWs that may better reflect provider effort at PHCs. Sources: World Bank. Service Delivery Indicators and Primary Health Care Performance Initiative; for Nigeria author's analysis of 2016 National Health Facility Survey.

Given the lack of resources, provider knowledge, and provider effort it is not surprising that health outcomes are underperforming. Looking forward, the GON needs to: i) invest more money in health; and ii) improve the quality of health expenditures especially by targeting limited resources towards high impact primary health care and public health interventions and amongst populations that would benefit most – the poor and vulnerable. The following section discusses options for where additional money for health might come from.

#### OPTIONS FOR ADDITIONAL FISCAL SPACE FOR HEALTH

**34. The biggest challenge for Nigeria's health sector is low government spending.** As highlighted in the previous sections, Nigeria spends less on health than nearly every country in the world – N248 (or less than US \$2) per capita on primary health care and prevention activities compared to the N3,374 (or US\$ 11.04) per capita it would need to drastically ramp up service delivery of key health interventions considered essential for attaining universal health coverage and included in the BMPHS (World Bank, 2017)<sup>21</sup>.

**35. In addition, many of the reforms needed to drastically increase revenue which would allow greater investment in health fall outside the reach of the health sector.** Nigeria's macrofiscal outlook remains challenging in the short to medium term. Revenue projections from the International Monetary Fund (IMF) are expected to remain muted slowly climbing to 7.0 percent as a share of GDP by 2022. And the federal government's interest payments as a share of revenue are expected to rise further to 78.3 percent by 2022 – crowding out much needed government spending (IMF, April 2017). Reforms to increase non-oil revenue, prioritize capital and development spending, and implement structural reforms that strengthen governance and promote financial and social inclusion are urgently needed for increased domestic resource mobilization. But reforms may not be immediately feasible given political economy realities. Nigeria is scheduled to hold the next presidential and parliamentary election in

<sup>20</sup> Low caseload could either be a supply side issue reflecting the poor management and allocation of resources (oversupply) or a demand side issue reflecting disease prevalence, financial or other access barriers, or patient preference (low demand). But data limitations do not currently allow us to explore this further.

<sup>21</sup> GDP based on IMF projections (USD 400.6 billion), total government expenditure based on World Bank MFM projections (USD 33.83 billion), government health expenditure assumes that public health spending as a share of government expenditure remains unchanged from 2014 NHA (0.92 percent of GDP).

February 2019 and there may be limited appetite to carry out any big change before then. While the Economic Recovery and Growth Plan lists an ambitious set of reforms for accelerating non-oil revenue, there is limited information on how they will be implemented. The main reforms discussed so far include increasing the VAT rate for luxury items from 5 percent to 15 percent from 2018 and the Voluntary Asset and Income Declaration Scheme (VAIDS) – a new tax reform program of the federal government aimed at addressing tax evasion and improving compliance<sup>22</sup>.

**36. Even though opportunities exist to further increase and diversify tax revenue, there is no guarantee that they will be invested in the health sector.** Increasing taxes on tobacco is often suggested as a way to raise additional resources for health while discouraging tobacco consumption, improving population health, and averting health expenditures from tobacco-related illnesses<sup>23</sup> (World Bank, 2017). In Nigeria, tobacco products, especially cigarettes, remain affordable to most users. By the end of 2016, the average retail price of a pack of 20 cigarettes was N190 (or US\$ 0.97) – low compared to the sub-Saharan Africa regional average of US\$ 1.24 and the global average price of US\$ 2.15. Scenarios that raise the ad valorem excise tax rate or change the cigarette tax structure estimate additional revenues ranging from N22.1 billion to N95 billion<sup>24,25</sup> (Marquez & Gonima, 2016). The IMF also suggests progressively increasing the VAT from 5 to 15 percent by 2020<sup>26</sup>. In 2016, revenue from VAT totaled N811 billion (Ministry of Budget and National Planning, 2016); instead higher rates of 7.5 percent or 15 percent would have contributed an additional N406 billion (US\$ 1.5 billion) or N1,622 billion (US\$ 6.0 billion) respectively assuming all other conditions remained the same. These amounts may even be higher with improvements to tax administration. But current revenue sharing formulas (Figure 1.8) means that more than half of tobacco tax revenue would go to the federal government which fails to reach primary health centres (unless through in-kind contributions via the NPHCDA). While a larger share of VAT revenue would be channeled to SLGs (85 percent), here too there is no guarantee they will be used for health.

**37. One of the only sources of funding that is earmarked for health is the NHIS; and it is often argued that social health insurance is the way forward to provide a large and stable revenue base for the sector.** Many low and middle-income countries associate social health insurance (SHI) with a means to generate more

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<sup>22</sup> VAIDS gives tax evading wealthy Nigerians and corporate bodies a 90-day ultimatum to declare taxable income and pay appropriate taxes or face severe punishment – up to 5 years in jail, penalties of up to 100 percent of outstanding tax due, compound interest at 21 percent per annum and the forfeiture of assets.

<sup>23</sup> Raising cigarette excise by US\$ 0.25 per pack in all developing countries, would generate an extra US\$ 41 billion in excise revenue from cigarettes in LMICs with total tax revenues expanding by 38 percent. The global literature also suggests a 10 percent increase in cigarette prices leads to a 6 to 8 percent decline in consumption in low and middle-income countries.

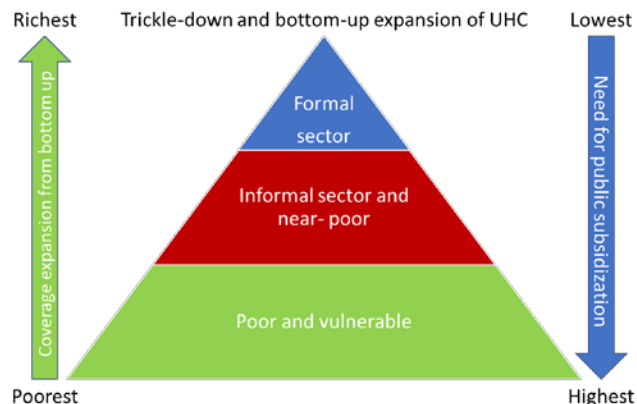
<sup>24</sup> Increasing the ad valorem excise tax rate from 20 to 60 percent would generate an additional N22.1 billion in tobacco excise tax revenue – assuming no change to the current ad valorem excise tax structure. Under a second scenario, assuming a change in the cigarette tax structure to a specific tax of N114 per pack (equivalent to 60 percent of the average retail price per pack of 20 cigarettes) an additional N69.5 billion in excise tax revenue could be raised. A third scenario, combining the proposed changes in the previous two scenarios, could add an additional N95 billion to the tobacco excise tax revenue.

<sup>25</sup> Estimates use the 2015 smoking prevalence in Nigeria of 19.2 percent among male youth population and 11.1 percent among female youth.

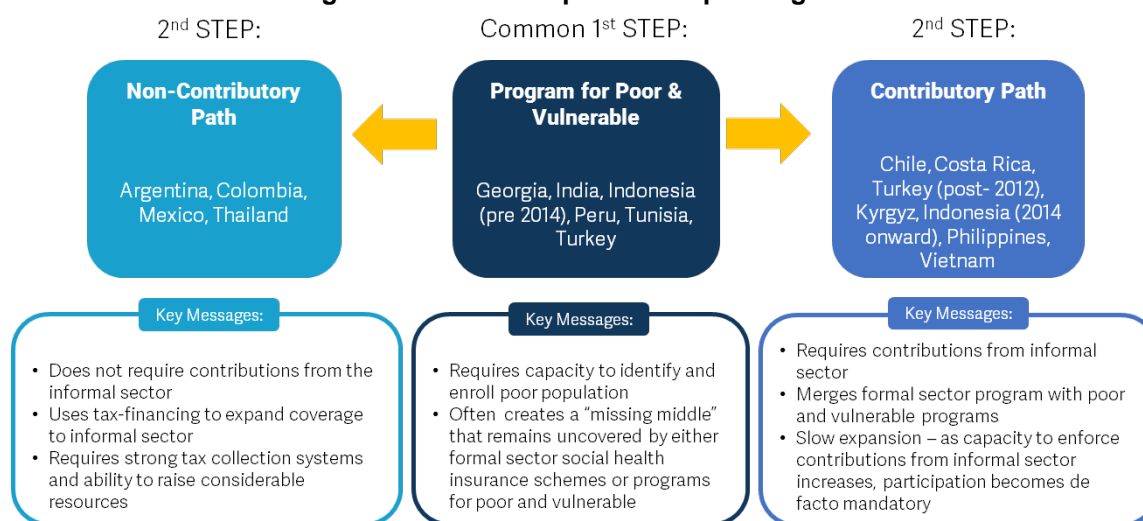
<sup>26</sup> A VAT of 15 percent would be more in line with the ECOWAS regional average

revenue – and Nigeria is no different. First, given its weak tax collection capacity, earnings-based insurance contributions from formal sector workers are generally more feasible to collect. Second, tax revenues may fluctuate with the economic cycle and impact allocations to the health sector budget. Instead, social health insurance contributions are more predictable because they are earmarked for health. Third, because contributions are directly linked to entitlements, the population might be more willing to pay compared with other taxes (Evans, et al., 2016).

**38. However, insurance without the capacity to enforce contributions or ability to attract the informal sector is not a viable path towards UHC. Instead, a mixed approach that combines social health insurance with significant government subsidies for the informal sector is increasingly emerging.** As described in Box 2, the informal sector in Nigeria is large, making it difficult to collect SHI premiums for all but a small base. And even among formal sector workers, the NHIS has failed to collect the employee share of premium contributions. When revenues are lower than expected because of contribution evasion the financial sustainability of the scheme could be threatened as demand for services increases. Globally, there is general agreement that poor and vulnerable populations should be targeted first when expanding coverage for UHC. However, where there is more policy divergence is whether the government should pay for the informal sector or whether the informal sector should pay contributions into social health insurance schemes like the NHIS. Typically, countries that have chosen a voluntary contributory path like Nigeria (as opposed to non-contributory tax-financed systems) have needed to supplement insurance contributions with tax-based financing that pay for poor and vulnerable groups and heavily subsidize contributions from the informal sector (Figure 2.5). The expansion path is slow and only as capacity to enforce contributions from the informal sector increases does participation become de-facto mandatory and universal (Cotlear, et al., 2015).



**Figure 2.5: Common paths to expanding UHC**



**'The Third Path':** financing the health care system through a **mix** of contributions and tax-based subsidies; for example both China (rural scheme) and Vietnam heavily subsidize contributions for the near poor

Source: Adapted from Cotlear, D. et al., 2015. *Going Universal: How 24 Countries Are Implementing Universal Health Coverage Reforms from the Bottom Up*. Washington, DC: The World Bank.

**39. For this reason, the BHCPF is crucial to Nigeria's UHC agenda. As a non-contributory, predominantly tax-financed scheme, the BHCPF complements the NHIS by ensuring the most vulnerable populations have access to basic care.** It offers an *additional* source of financing that is primarily dedicated to front line health care providers targeting investments for the services and populations that would benefit most. If implemented as envisioned, it has the potential to raise an additional US\$ 150 million per year based on revenue for 2017 without counting contributions from SLGs and other sources<sup>27</sup> (GON, 2016).

**40. While the resource envelope for the BHCPF would currently be inadequate to guarantee full coverage of the BMPHS to the entire population, the sustainability and affordability of the BHCPF is within reach especially given the GON's proposed gradual expansion.** The fiscal impact of providing the BMPHS to the entire eligible population was estimated to be US\$ 2.2 billion or 0.54 percent of GDP<sup>28</sup>. In practice, however, the BHCPF is designed to complement existing funding from SLGs. For example, SLGs already pay for personnel costs which account for 34 percent of the cost of the BMPHS and a share of drug costs may also be covered either centrally (e.g. vaccines) by the NPHCDA or by SLGs<sup>29</sup>. Full population coverage is also not expected to occur overnight. The marginal cost (that is, the cost above and beyond

<sup>27</sup> One percent (the minimum amount) of the current CRF translates to US\$150 million overall using World Bank total revenue figures of N4,577 billion or US\$15 billion for 2017.

<sup>28</sup> GDP based on IMF projections (US\$ 400.6 billion), total government expenditure based on World Bank MFM projections (US\$ 33.83 billion), government health expenditure assumes that public health spending as a share of government expenditure remains unchanged from 2014 NHA (0.92 percent of GDP).

<sup>29</sup> Personnel, drugs, and overhead account for 34 percent, 57 percent, and 9 percent respectively of the total cost of the BMPHS.

current levels of spending) of expanding BMPHS service coverage from 30 to 50 percent by 2022 is estimated to cost US\$ 37.8 million in year 1, US\$ 161.5 million in year 3, and US\$ 357.5 million in year 5 <sup>30</sup> (World Bank, 2017). To ensure the sustainable expansion of the BHCPF, the GON has also decided to initially limit coverage to the rural population only (~60 percent of the population) – focusing on areas where most poor and vulnerable households live. This would knock down the cost to US\$ 22.7 million in year 1, US\$ 97.0 million in year 3, and US\$ 214.5 in year 5. In addition, unlike federal or state health budgets, any annual surpluses that arise from the BHCPF because of underutilization, poor uptake, delays in the release of funds or in the receipt of claims from providers will be rolled-over to next year's fund. Given this, the presented estimates suggest that a gradual expansion of the BHCPF is well within reach especially as the economy recovers and the size of the resource envelope increases beyond the current US\$ 150 million per year estimate.

The following section provides recommendations for addressing some of the health sector's most pressing challenges in moving towards sustainable health financing for UHC. Recommendations are organized around three buckets for: i) funding and implementing the provisions of the National Health Act; ii) measuring and communicating results on the performance of the health sector; and iii) addressing remaining challenges and knowledge gaps.

## RECOMMENDATIONS

### Implementing the provisions of the National Health Act

41. **Nigeria's future success depends on the government's commitment to fund and implement the provisions of the National Health Act – beginning with an allocation in next year's budget to the BHCPF.** The National Health Act mandated the establishment of the BHCPF to support the delivery of primary healthcare services, providing Nigerians with access to affordable, quality health care services. Seventy-two percent of the burden of disease remains from communicable, maternal, neonatal and nutritional diseases. Many of these conditions could be prevented and treated by highly cost-effective intervention packages at the primary health care and community level. But current fund flow arrangements and the stated responsibilities of the tiers of government in service delivery mean that the bulk of health expenditures occurs at secondary and tertiary care facilities. However, the BHCPF, targets its spending on the interventions and populations that would benefit most. If the GON is serious about investing in the country's most valuable resource – its people – it must first invest in reproductive maternal and child health and malaria interventions. This is an essential prerequisite for a healthier, more educated, and more productive young workforce. But, increasing the amount of resources alone, without improving the quality of health expenditures is unlikely to improve health outcomes. Low levels of provider knowledge and high absenteeism of health care providers further suggest that a focus on training, management, incentives, and accountability is important to improve service delivery.

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<sup>30</sup> Estimates for more ambitious scenarios are presented in Annex 2.

42. **For the BHCPF to succeed it must establish public and social accountability mechanisms that help improve service delivery.** On the public accountability side, the disbursement of funds must be subject to receiving financial reports showing the source and use of funds as well as improvements in monitoring and quality assurance criteria (Annex 2). On the social accountability side, renewing the social contract between government and the people it is meant to serve will be imperative. One proposal includes reviving the Ward Development Committees (WDCs) – an initiative made up of volunteer community members advocating for the health and social needs of their communities – and giving them autonomy over the utilization of funds for PHC improvements and outreach activities. Providers should also be required to display a large poster informing patients of the services they are entitled to receive for free under the BHCPF. A functioning and responsive complaints mechanism should also be established. Five percent of the BHCPF has been set aside specifically for fund administration including setting up some of these accountability mechanisms.

43. **The careful design of payment systems under the BHCPF must also create or reinforce incentives for improving service delivery.** While discussions on payment systems are still ongoing, payment to providers under the NHIS gateway is intended to be based on the number of patients seen and services rendered incentivizing providers, at least in the first instance, to focus on increasing the quantity of services delivered. Payment to facilities under the NPHCDA gateway is intended to follow a decentralized financing for accountability and results (DFAAR) mechanism based on meeting monitoring and evaluation criteria. Both payment mechanisms would be results-based, in line with international best practice, either rewarding or penalizing health care providers for meeting or failing to meet agreed-upon performance targets<sup>31</sup>. Under each gateway, providers would enter a contractual relationship with the Health Commissioner representing the state or the NHIS (the purchasers) specifying the price, quantity, and quality to be delivered within a given time-period. These arrangements help strengthen the relationship between public expenditure and health outcomes and build on Nigeria's experience in performance-based financing (PBF) and decentralized facility financing (DFF) (see Box 3).

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<sup>31</sup> The most commonly chosen performance targets are output or process indicators that are easily measurable and where there is well-established evidence linking them to good outcomes.

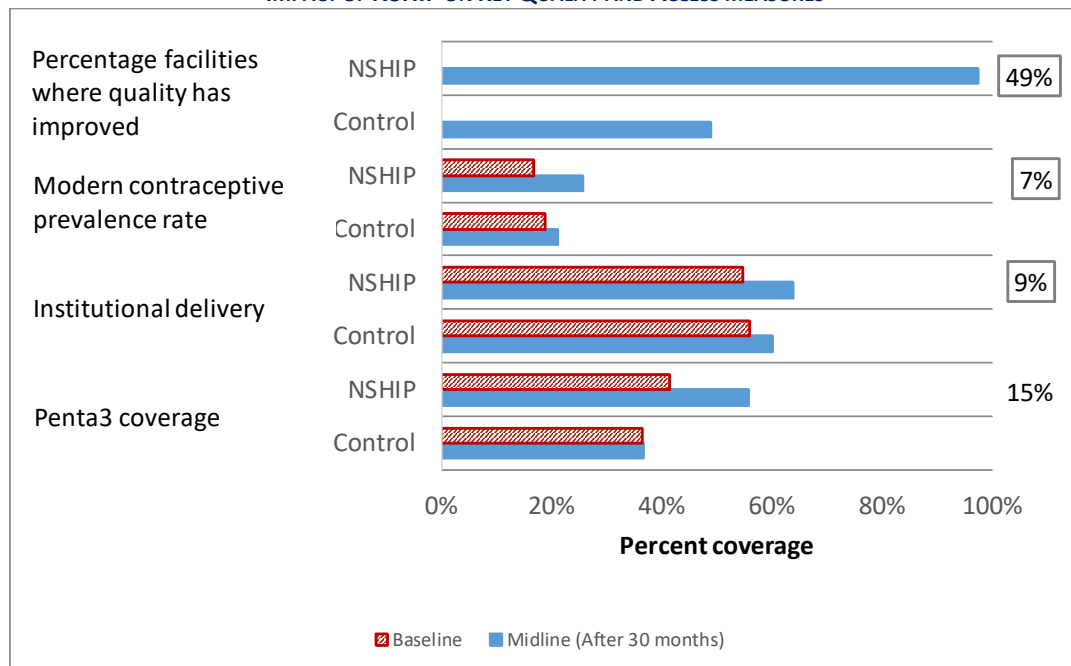


### Box 3: Performance-based financing in Nigeria

**The Pilot:** The Nigeria State Health Investment Project (NSHIP) was the country's first results-based financing pilot (operating in three states – Adamawa, Nasarawa, and Ondo) aiming to increase coverage of high impact health interventions. Individual health facilities were directly given additional financing. In half, cash payments were conditional on the quantity and quality of key maternal and child health services – the PBF facilities. In the other half, financing was given as a lump sum. In both, facilities were given considerable autonomy on the use of those resources, including for facility upgrading, drug purchases, or financial rewards to staff.

**Impact:** The NSHIP facilities significantly improved key aspects of PHC performance. A randomized impact evaluation found that after more than 30 months of implementation, participating NSHIP facilities increased coverage of pentavalent vaccine by 15 percentage points, facility births by 9 percentage points and modern contraceptive prevalence rate by 7 percentage points compared with the status quo – all at the relatively modest cost of US\$ 1.20 per capita per year. Furthermore, NSHIP improved quality of care in 49 percent more of facilities.

IMPACT OF NSHIP ON KEY QUALITY AND ACCESS MEASURES



Source: Baseline and Midline surveys, NSHIP 2014-2016

**Key factors for success included:** i) the provision of legitimate operating funds at the health facility level; (ii) a clear signal to health providers of priority services; (iii) the substantial autonomy of front-line health workers on the use of funds; and (iv) strengthened supervision.



### **Measuring and communicating results on the performance of the health sector**

**Fundamental to increasing accountability and improving the quality of health expenditures will be establishing national/subnational health accounts and health management and information systems (HMIS) that can produce timely and useful information for budget and planning, provider performance monitoring, and general oversight.** The absence of systematic reporting that links health expenditure with health system performance across states and levels of government undermines the sector's ability to target limited government resources to the populations that would benefit most. On the expenditure side, there are issues regarding the timeliness and quality of national health accounts data that need to be addressed. Subnational health accounts disaggregating spending by source of expenditure (for example, government, NHIS, out-of-pocket, and external) are also still not available. On the health system performance side, the national HMIS is meant to keep track of the utilization of health services, drug needs, disease patterns, and coverage rates at the health facility level. Fifteen different patient registers are meant to be consolidated into monthly and quarterly forms and forwarded on to local government authorities for use in planning activities and patient follow-up. This places a significant burden on front line providers resulting in low reporting compliance rates and limited useful information for oversight and planning purposes (Federal Ministry of Health, 2015). But the BHCPF presents an opportunity to standardize HMIS efforts, streamline the various patient registers, and increase reporting compliance. To ensure data quality it will be important to introduce coding standards, protocols, and training for providers to follow.

**44. The GON must also institutionalize processes for regularly communicating results on the performance of the health sector and in particular the BHCPF. This will be important for securing additional resources from subnational governments, donors, and private citizens.** The lack of reporting requirements or formal mechanisms to consolidate information on health budget and expenditure at all tiers of government (federal, state, and local) and across agencies (for example, FMOH, NPHCDA, NHIS), including the lack of transparency and accountability in the government system overall have greatly limited the governance and effectiveness of the health system. Regular and timely information on the cost, utilization, and impact of front line services will be critical for the health sector to efficiently plan and advocate for additional investments in health. The FMOH should conduct a yearly review of the sector's budget implementation performance – on both capital and recurrent expenditures. It will likely need targeted public financial management support to carry this out. However, the FMOH has already earmarked some of its own resources in next year's budget to i) support the design and rollout of a linked sector MTEF and MTSS, ii) make greater efforts to capture off-budget financing from donors, and iii) strengthen capacity to implement a zero-based budgeting approach to better make the case for investing in health. Development partners are also expanding their support to strengthen planning, budgeting and related functions at the federal and state level.

### **Addressing remaining challenges and knowledge gaps**

**45. State capacity to implement the BHCPF is at different stages across the country. Therefore, the FMOH must develop manuals/plans for improving national**

**and state-level processes under the NHIS and NPHCDA gateways, assess state-level readiness, and support states in introducing the BHCPF.** While open to all states and the Federal Capital Territory (FCT) of the Federation, fund access is contingent upon setting up functioning SPHCDA and SHIS agencies or their equivalent<sup>32</sup>. But without strong central oversight there is a risk of states setting up their own schemes which would be difficult to absorb into the BHCPF later on. Similarly, provider access to the fund is open to both public and private providers subject to accreditation<sup>33</sup> and other contracting requirements which may limit eligibility of weaker facilities to benefit. Accreditation criteria must be kept simple to start to avoid reinforcing existing inequities. As the BHCPF will initially be piloted in Abia, Niger, and Osun states in 2018, the phased approach should present an opportunity to learn and improve implementation arrangements as the BHCPF gets rolled out to the rest of the country.

46. **Finally, the absence of data and information on the NHIS and the health seeking behavior and preferences of patients provides limited understanding for why the NHIS coverage has failed to move beyond the formal sector. Moving forward, it would be important to fill in these gaps to better inform the future of contributory insurance in Nigeria.** There are many factors influencing the demand for health insurance in developing countries – the most common being knowledge of the scheme, proximity to local health care facilities, perceived quality of local providers, and affordability of the premium. However, in Nigeria, unstable leadership and accusations of financial malfeasance have plagued the NHIS likely undermining confidence in the institution. Since commencement of operations 12 years ago, the NHIS has had seven Chief Executive Officers – the last four each spending less than 18 months in office. Participation in the NHIS also remains voluntary. While Nigeria is close to reforming the NHIS to make the contributions from the formal sector mandatory it will also need to improve compliance and trust in the institution. The availability of additional financing through BHCPF may also incentivize states to establish schemes and enroll beneficiaries – especially if state governors see positive results coming out from the front-runner pilot states of the BHCPF.

#### CONCLUSION

47. Nigeria's future success depends on the government's ability to transform its non-renewable (and often volatile) natural capital into productive wealth by investing more in the health of its people. However, low government health spending over the last two decades has limited the expansion of highly cost-effectiveness interventions, stunting health outcomes and exposing large shares of the population to catastrophic health expenditures. In 2014, the GON passed the National Health Act establishing the BHCPF as an earmarked fund to guarantee the delivery of an essential package of health services (the BMPHS) to all Nigerians. Funding will be targeted to community and primary health care services that reach those with the greatest health care needs – rural, poor households. New financing rules and mechanisms will give local providers greater control over the use of operating funds while creating strong incentives to improve the reach, quality, and efficiency of services. In 2018, the BHCPF will be piloted

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<sup>32</sup> Most states have established SPHCDA's, albeit of varying capacity but only Lagos, Delta, Kwara, Kano, and Ekiti states have passed SHIS laws – although a few have draft laws.

in three states as a proof of concept, reaching 8 million Nigerians. In conjunction with this milestone, the health sector will need to continue strengthening core health financing functions including overall planning and budgeting, and, system performance monitoring and evaluation.

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<sup>33</sup> Conditions for participation under the NHIS and NPHCDA gateways are listed in Annex 2.

### Annex 1: Marginal cost of BHCPF expansion (US\$, millions, 2017)

	2018	2019	2020	2021	2022
<b>50 percent (by 2022)</b>	37.8 (35.0-40.5)	91.2 (84.5-97.9)	161.5 (149.7-173.3)	249.8 (231.6-268.1)	357.5 (331.4-383.7)
<b>60 percent (by 2022)</b>	51.0 (47.2-54.7)	125.1 (115.9-134.2)	224.1 (207.7-240.5)	349.7 (324.1-375.3)	503.9 (467.1-540.8)
<b>70 percent (by 2022)</b>	64.2 (59.5-68.9)	159.1 (147.4-170.7)	286.8 (265.9-307.8)	449.9 (417.0-482.8)	650.8 (603.2-698.4)

Source: World Bank (2017). Costing of the Basic Minimum Package of Health Services (BMPHS) in Nigeria. Notes: Presented ranges reflect different assumptions about possible efficiency gains under BHCPF arrangements. Estimates reflect projected population growth as well as expected efficiency gains under the financing arrangements of the BHCPF. Investment is backloaded (assuming that the current macro-fiscal situation improves over the next five years).

### Annex 2: Conditions for provider participation under the NHIS and NPHCDA gateways

<input type="checkbox"/> NPHCDA conditions	<input type="checkbox"/> NHIS conditions	<input type="checkbox"/> Monitoring and evaluation indicators
<ul style="list-style-type: none"> <li>- Annual facility licensure by MOH or other prescribed state entity</li> <li>- Compliance with conditions for initial accreditation or as updated by NHIS or SHIS</li> <li>- Submission of all returns to LG HMIS and SPHCDA</li> <li>- Possession of valid current licenses of personnel and registration with regulatory bodies</li> <li>- Evidence of internal quality management system and demonstrable incremental quality improvement</li> <li>- Compliance with the BHCPF manual</li> <li>- Other criteria as announced by NSC/NPHCDA/NHIS</li> </ul>	<ul style="list-style-type: none"> <li>- Basic accreditation criteria:               <ol style="list-style-type: none"> <li>1. Skilled health worker (doctor, nurse, midwife, or CHEW)</li> <li>2. Sphygmomanometer</li> <li>3. Foetoscope</li> <li>4. Stethoscope</li> <li>5. Delivery bed</li> <li>6. Battery-powered torch or other light source</li> <li>7. Partogram</li> <li>8. Patient records</li> <li>9. Mobile phone</li> <li>10. Essential drugs (Magnesium sulphate and Oxytocin or Ergometrin or Misoprostol)</li> <li>11. Disposable or reusable gloves</li> <li>12. Sterilisable scissors</li> <li>13. Sterilisable cord ties</li> <li>14. Functioning bank account</li> <li>15. Running water and soap or hand sanitiser</li> </ol> </li> </ul>	<ul style="list-style-type: none"> <li>- Process measures               <ol style="list-style-type: none"> <li>1. Verification that services paid for under NHIS actually provided</li> <li>2. Funds transferred in timely manner to participating providers</li> <li>3. Funds received by providers used appropriately</li> <li>4. Actual cost of services to patients</li> <li>5. Patient satisfaction</li> </ol> </li> </ul>

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Nigeria's commitment to universal health coverage was enshrined by the passage of the National Health Act of 2014 in response to the continued underinvestment and poor performance of its health care system. Lack of data on available resources for health, the cost and use of health services, and the performance of front line providers has made it hard for the health sector to efficiently plan and advocate for additional investments in health. However, in the last 18 months, two important sources of information were made available – the national health accounts (2010-2016) to look at resource allocation and spending decisions at the national level, and, a national health facility survey (2016) to assess the performance of service delivery at primary health care facilities. As such, while based on comprehensive analytics, this health financing system assessment was envisioned as a just-in-time policy brief on the health *financing* system that would provide actionable policy recommendations to the Ministries of Health, Budget and Planning, and the Vice President's office.

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