Politics and Healthcare Finance in Nigeria

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ABSTRACT

Nigeria, as Africa's most populous nation, continues to experience a profound health financing crisis manifested by extremely high out-of-pocket expenditure (76–79% of total health expenditure; third highest in the world), chronic under-investment (4–5% of the national budget vs. The Abuja Declaration target of 15%), and severely fragmented risk pooling (covering <10% of the population). This study investigated the political economy of healthcare financing in Nigeria, focusing on how political institutions, stakeholders' vested interests, and governance structures shape Financing Outcomes and health inequalities. Using a sequential explanatory mixed methods approach, the study examined both quantitative health Financing and outcome indicators across Nigeria's 36 states and 774 Local Government Areas (2019–2024), traced the political process through which the National Health Insurance Act (NHIA) of 2022 was enacted, documented the unfolding of the 2025 National Health Financing Dialogue and conducted a systematic literature review. Results show that political executives wield considerable influence over Financing Decisions in Nigeria, (average scores: Executive 4.72 out of 5; citizen 1.86 out of 5; P <0.001) translating into regressive allocation favoring the wealthy populations (Concentration Index = 0.367; P <0.001). Gross geographic inequities persist, evidenced by up to 2.3-fold higher under-5 mortality rate in North-East states (148 per 1,000 live births) compared to South-West states (65 per 1,000). State budget transparency (= 0.238; P = 0.002), accountability quality (= 0.184; P = 0.024), health workforce density (= 0.412; P <0.001) and not debt service costs (= -0.142; P=0.021) significantly predicts state health expenditures. The impending 2025 Dialogue, may signify a potential rebalancing of the political forces and realignment as the initiative brings together several cross-sectoral stakeholders. The protracted crisis is fundamentally a political not technical one. Universal health coverage (UHC) requires complementary progress on enhancing domestic revenue mobilization, expanding risk pooling, improving allocative efficiency through, for instance, health technology assessment, building better accountability and citizen engagement. It will need a combined legislative- executive approach which should however, also include robust co-ordination between federal and states in Nigeria, and unwavering commitment from its political leaders.

Keywords: Political economy, health financing, universal health coverage, Nigeria, health inequities, out-of-pocket expenditure, health policy reform.

INTRODUCTION

Health care financing is among the most politically charged and structurally challenging policy domains in Nigeria. Although the country boasts Africa's largest economy and highest population, Nigeria lags miserably in global health outcomes, ranking 84th of 110 countries on health quality and 146th of 166 on the Sustainable Development Goals Index (World Health Organization, 2024). This disconnect between abundant resources and poor health outcomes is fundamentally a political problem rooted in how and by whom financing decisions are made and whose interests they serve. Nigeria's health financing structure is characterized by perpetually insufficient public investment, catastrophic out-of-pocket spending, and fragment risk-pooling mechanisms that most heavily penalize the poor and vulnerable.

With out-of-pocket spending accounting for about 76-79% of total health expenditure the third highest globally - it places millions of households at risk of poverty and financial ruin (Josiah et al., 2025). Public spending on health stands around 4-5% of the national budget, significantly lower than the 15% target set in the Abuja

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Declaration, and is a meager 0.37% of GDP (Federal Ministry of Health and Social Welfare, 2025). While the Basic Health Care Provision Fund (BHCPF), intended to increase coverage for the poor, is severely underfunded and underutilized, the National Health Insurance Authority (NHIA) covers under 10% of the population, largely formal sector employees (National Health Insurance Authority Act, 2022). These failures are not simple technical ones but deeply embedded political economy dynamics: conflicts in fiscal priorities (debt service, security, infrastructure), fragmentation between federal and state governments, rent-seeking behavior, limited accountability mechanisms, and insufficient citizen influence on budget allocation processes (Campos & Reich, 2019). The politics of Nigerian health financing thus centers on who's health matters, who pays the bills, and who controls the money.

Study Objectives

The core objective of this paper is to analyze the political economy of healthcare financing in Nigeria, examining the intersection of political institutions, the interests of key stakeholders, and governance arrangements in determining financing outcomes. Specifically, this paper aims to:

1. Describe the current financing landscape and identify its political determinants
2. Analyze the roles and influence of critical stakeholders including political executives, legislature, civil society, development partners, and private sector players
3. Examine current reform efforts, most notably the recent passage of the NHIA Act 2022 and the September 2025 National Health Financing Dialogue
4. Integrate human medical ecology and place-based epidemiology to capture contextual moderators linking political decisions to health inequities
5. Suggest politically viable, equity-focused options for sustainable financing reform

Justification

This study bridges two significant literature gaps. Firstly, while a wide array of studies has narrated Nigeria health's financing (health expenditure patterns, insurance coverage, fiscal space, etc.) technical challenges, there has been little focus on the political determinants of its poor outcomes (Onoka, 2025). Secondly, while there are recent developments, including the historic National Health Financing Dialogue of 2025, and presidential directives to make registration for national health insurance compulsory, scholarly focus has been limited to guide policy and program actions (Adirieje, 2025). This article, by drawing on political economy principles in conjunction with a human medical ecology framework, seeks to bridge technical diagnostics to a pragmatic agenda needed by policy makers, researchers, and practitioners.

Research Questions

This study addresses the following research questions:

1. What political economy factors drive health financing outcomes in Nigeria?
2. How do political decisions translate into place-based health inequities across Nigeria's states and local government areas?
3. What is the relative influence of different actors and institutions on health financing decisions, and how do their interests shape resource allocation?
4. What are the political feasibility and equity implications of current reform efforts (NHIA Act 2022, National Health Financing Dialogue 2025)?
5. What politically viable, equity-focused strategies can achieve sustainable health financing reform?

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Research Hypotheses

Based on the political economy literature and preliminary evidence, we test the following hypotheses:

1. Political executives (President, Governors, Finance Ministers) exert significantly greater influence on health financing outcomes than legislators, civil society, or citizens, reflected in budget allocation patterns.
2. Health financing decisions exhibit systematic regressive effects, with poorer states and northern regions receiving disproportionately lower per capita health spending relative to health needs.
3. Federal-state fragmentation produces a collective action problem, diffusing responsibility and impeding effective risk pooling across states.
4. The 2025 National Health Financing Dialogue represents a potential political realignment, with coalition-building across sectors increasing the probability of reform adoption.
5. Weak accountability mechanisms correlate with higher out-of-pocket expenditure and lower public health spending.

Definitions of Key Terms

Political Economy of Health Financing: The analysis of how power, institutions, and interests affect decisions about resource allocation within health systems (Campos & Reich, 2019).

Universal Health Coverage (UHC): Ensuring all people have access to needed health services of sufficient quality without experiencing financial hardship.

Out-of-Pocket Expenditure: Direct payments by households for health services at the point of service delivery, excluding insurance reimbursement.

Risk Pooling: The mechanism by which financial contributions from a population are collected and used to pay for health services for members, spreading financial risk across the pool.

Fiscal Space for Health: The budgetary room available in government to allocate resources to health without compromising fiscal sustainability.

Human Medical Ecology: The study of how environmental, social, and ecological factors interact with human health and healthcare systems.

Health Inequity: Systematic, avoidable, and unjust differences in health outcomes and access to healthcare across population groups.

Social Contract: The implicit agreement between citizens and state wherein government assumes responsibilities for public welfare in return for legitimacy and citizens' acceptance of its authority.

Health Technology Assessment (HTA): Systematic evaluation of the properties, effects, and impacts of health technologies, informing coverage and purchasing decisions.

Rent-Seeking: Behavior by individuals or groups to obtain economic gain through manipulation of the political process rather than through productive activity.

LITERATURE REVIEW

Theoretical Review: Political Economy of Health Financing

Political economy of health financing looks at how power, institutions and interests affect decisions about resource allocation within health systems. Three conceptual lenses are most helpful in thinking about this in

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the Nigerian context. First, Campos and Reich's (2019) framework for political economy analysis in health financing presents three main dimensions: stakeholders (the actors that influence financing decisions), institutions (the rules of decision-making) and politics (the processes by which stakeholders make decisions within these institutional constraints). The framework concludes that a successful health financing reform is more than technically correct; it is one that matches the incentives of relevant stakeholders, overcome institutional challenges and builds a political coalition that can neutralize resistance.

Second, the notion of the social contract underpins a normative understanding of citizen–state interaction around health financing. In democratic systems, government assumes responsibilities for public welfare in return for legitimacy and citizens' acceptance of its authority (Uzochukwu et al., 2025). The health financing crisis in Nigeria represents an unravelling of the social contract where citizens contribute tax money and private expenditure yet receive a poor health service package, while the state is insulated from electoral accountability from its citizens regarding health outcomes. Citizen involvement in the development and execution of health policies which is believed to enhance the appropriateness of policy and citizen buy-in is restricted (Uzochukwu et al., 2025).

Thirdly, fiscal sociology helps explain how public spending and taxation reflect and recreate relations of power in society. The over reliance on highly regressive out-of-pocket health payments, low tax to GDP ratios, and lack of progressive taxation in Nigeria can be seen as reflecting the limited fiscal capacity of the state and the strong political position of economic elites who often oppose redistributive policies (Federal Ministry of Health and Social Welfare, 2025). The unsuccessful introduction of earmarked sin taxes (e.g. On alcohol, tobacco, and sugar-sweetened beverages) despite evidence of their efficacy in mobilizing health financing revenues reflects the ability of economic actors to resist progressives reforms (Onoka, 2025).

Empirical Review: Patterns and Determinants of Health Financing in Nigeria

Nigeria's health financing problems are serious, and supported by empirical literature. Using a mixed methods approach, Josiah et al (2025) analyzed Nigeria's health budgets and administered a survey to 2,212 people across nine states and determined that the average health spending per person was only $7.12, relative to an estimated per capita spend of $82.75. Though 87.36% of those surveyed utilize government facilities, 85% of them pay out of pocket, and 72.6% were not satisfied with the value of services. The survey cited that poor funding (85.65%), insufficient staff (90.73%), and absence of medicine (88.47%) were the primary barriers. Out-of-pocket expenses pose particularly catastrophic consequences to specialized care. Okeke et al (2025) conducted a scoping review of the financing of cancer care services in Nigeria, concluding that the continuum of care was mostly reliant on out-of-pocket expenditures, frequently surpassing a nation's GDP per capita, leading to nonadherence to treatment, delays, and poverty. The review found very few financing mechanisms for cancer care beyond out-of-pocket payments, personal loans, loans from family members and sporadic, limited, insurance coverage with unanimous agreement to scale up universal health insurance and pooling. The involvement of the general populace in the financing governance aspects of the health sector has not reached optimal levels. Uzochukwu et al (2025) administered a cross-sectional survey to 400 individuals, including CSOs and citizens across Nigeria and found limited engagement and knowledge of health policy by a significant segment of the population including the youth. Health was a central concern in the evaluation of political figures; however, not every individual prioritized the state's role as provider. Age had correlations with citizen engagement, though CSOs and individuals' low level of coordination among them meant there was limited collective power to demand better funding of health.

Policy and Institutional Framework

The structure of health financing in Nigeria involves many financing instruments and organizations. A BHCPF under the National Health Act 2014 stipulated allocation of minimum 1 percent to the primary health care from the Consolidated Revenue Fund (National Health Act, 2014). The delivery of BHCPF to the primary health care providers faced many challenges of bottlenecks, capacity deficiencies at the state level and lack of oversight even when the Ward Health Committees were mandated to be co-signatories on health facility accounts (Uzochukwu et al., 2025). The National Health Insurance Authority Act 2022 replaces the voluntary fragmented and fragmented National Health Insurance Scheme with an Act that mandates insurance

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enrollment, and pools risk in an integrated risk pool (National Health Insurance Authority Act, 2022). It provided the NHIA with the powers to act as insurer/purchaser, developed a package of services and laid the path for enrolment of people in the informal sector. Operationalization of the law is, however still under implementation because of the under-developed enrollment processes, unclear package and poor enforcement (World Health Organization, 2025). Among the recent initiatives includes the Presidential Initiative to Unlock the Value Chain (PVAC) in the health sector and a National Health Financing Dialogue that brought together the ministries of Health and Finance, Legislators, development partners and the private sector in September 2025 (Federal Ministry of Health and Social Welfare, 2025). At the Dialogue, commitments to, including the allocation by NHIA of $300,000 for research on health Financing policy, Presidential directive mandating federal public employees to insure and also directing insurance for applicants seeking to purchase federal assets, and strengthening of federal state financing interface was made (Adirieje, 2025).

METHODOLOGY

Study Design

This study employs a sequential explanatory mixed-methods design, integrating:

Quantitative political economy analysis of health financing and outcome data at national, state, and LGA levels

Qualitative policy process tracing of the NHIA Act 2022 passage and 2025 National Health Financing Dialogue

Systematic review of peer-reviewed and grey literature to contextualize findings

The quantitative phase (analysis of budget data, equity metrics, and health outcomes) establishes patterns and associations. The qualitative phase (process tracing) explains causal mechanisms, reconstructs policy events, and identifies how political actors and institutions shape financing outcomes.

Study Area

The study covers all 36 states and the Federal Capital Territory, with in-depth policy process tracing focused on federal-level policy events (NHIA Act 2022 passage and 2025 National Health Financing Dialogue). Quantitative analysis includes state and LGA-level data to capture subnational variation.

Method of Data Collection

A systematic literature search was conducted in PubMed, Scopus and African Journals Online databases of peer-reviewed empirical studies published in 2020–2025. A combination of search terms was developed relating to health financing, Nigeria and political economy. Grey literature was collected from WHO, AU, FMoH, NHIA, civil society organizations; and reported based on PRISMA checklist. The quantitative data were collected using a module that focused on health budget allocation, release and expenditure over 36 states for 2019-2024. Data were drawn from the FMoH and State Ministries of Health budget documents, NHIA financial reports, BHCPF disbursement records, National Bureau of Statistics (NBS) health expenditure data and LGA-level health outcome and service readiness data. These include: Total health budget (Federal and States); health expenditure per capita; budget execution rate (releases/budget allocation); BHCPF expenditure as a proportion of BHCPF fund; Health insurance enrollment rate (Bismarck Model); estimated private out of pocket expenditure; health workforce density; service readiness score; and health outcomes (under-5 mortality, maternal mortality and immunization coverage). For the qualitative part of the study, policy process tracing was employed and it was directed towards the analysis of two major policy events: passage of the National Health Insurance Authority (NHIA) Act 2022 (2019-2022), a transformative legislative action to replace fragmented schemes with mandated health insurance coverage and the National Health Financing Dialogue 2025, a current policy window showing shifts in coalitions and realignments. Data were obtained from policy documents: (NHIA Act 2022, National Health Act 2014, BHCPF Guidelines, FMoH reports, and documents

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from National Health Financing Dialogue 2025). Grey literature was sourced from civil society organization and development partners' reports and media reports (news articles, opinion pieces, press statements). The documents were analyzed using a structured coding framework consisting of actors involved, institutional rules and constraints, political strategies used by key actors, significant decision points, turning points in the policy process, factors enabling or blocking reform, and issues of equity.

Data Collection Procedure

A structured document analysis protocol addressed 5 domains: actor analysis (involved actors, their interests, resources and strategies), institutional analysis (formal and informal rules, federal state relationship and accountability mechanisms), process analysis (chronology of events, crucial decision points and turnarounds), outcomes (policy content, implementation state, barriers and enablers) and equity (distributional implications, affected groups). A structured quantitative data extraction tool was developed and applied to identify variables related to budget with precise definitions and reliable data sources to ensure a high degree of comparison between states and years. A spatial data extraction protocol ensured proper calculation of measures of equity, such as concentration index, Theil index, or coverage gap ratio.

Sampling Technique

Eligibility Criteria for The Systematic Literature Review For the SR, we included peer-reviewed empirical literature from 2020–2025 about health financing in Nigeria, written in English, and excluding opinion papers, articles not primarily about Nigeria, and literature published before 2020 (with the exception of foundational articles). Initial searches of the databases produced 412 records, of which we removed 87 duplicates, screened 325 and assessed 78 in full-text to find 42 relevant studies. Case selection was based on most different case selection for policy cases to ensure variation: The National Health Insurance Act 2022 (bottom-up advocacy led legislative reform), The National Health Financing Dialogue 2025 (top-down coalition building in the executive-driven arena). We used these two cases to ensure a variety of reform pathways are analyzed. All 774 LGAs were considered for data extraction if data was available and missing data was dealt with using multiple imputation via chained equations with 20 imputed datasets, amounting to 13.2 percent of observations being missing.

Data Analysis

In qualitative analysis, we applied a policy process tracing technique (Beach & Pedersen, 2019) according to the 5 step model; "theorizing a causal mechanism (stakeholder interests > political strategies > institutional processes > policy outputs > implementation outcomes), developing evidence-based operationalization of the causal mechanism, collecting data to find evidence for operationalization using triangulation methods, exploring alternative explanations (e.g. Technical constraints, limited resources and capacity shortages, donor influences) and tracking a process over time through chronological reconstruction and finding of "critical junctures". A systematic coding frame identified actors, their interests, relevant institutions, political strategies, potential barrier and enablers and elements related to equity. The methods for validity involved triangulations, negative case analysis, peer debriefings and audit trails. The quantitative analyses performed in Stata 17 included descriptive, bivariate analyses, calculation of equity indicators and descriptive Epidemiology for small-areas. The mixed methods integration was realized using joint display tables, weave methods, a narrative synthesis and causal path mapping.

Methodological Limitations and Bias Mitigation

Multiple limitations were faced. Document limitations prevented some internal negotiation and close door documents from being public, this was dealt with by using media articles, grey literature, and triangulation. Politically, participants are likely to have tried to present public documents to paint a good image; to address this, we checked documents against one another and scrutinized deviations from a norm. Demonstrating causality demanded strong evidence, so we used strong process tracing with tests for sufficiency and alternative explanations. We cannot say that the results of our research are applicable beyond the two case countries; we chose the most different cases approach and a method for theoretical generalization in line with

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existing concepts. Quantitative data missing (13.2% of LGA observations) was handled through multiple imputation and sensitivity testing. Measures used to prevent bias included clear selection criteria, standardized extraction, investigation of negative cases, peer debriefing, and re-creating history using as many sources as possible for verification.

Ethical Considerations

All data sources are publicly available documents; no primary human subjects data collection was conducted. Documents were analyzed in compliance with copyright and fair use provisions.

RESULTS

Descriptive Results: Health Financing Landscape

Table 1: Health Financing Indicators by Geopolitical Zone (2023-2024)

Indicator	NW	NE	NC	SW	SE	SS	National
Per capita health spending (USD)	3.82	4.15	5.21	12.45	8.73	14.28	7.12
Budget execution rate (%)	61.3	58.7	67.2	78.4	72.1	75.6	68.9
Out-of-pocket (% of THE)	82.4	80.3	77.1	71.8	74.2	73.5	76.5
Insurance coverage (%)	4.2	3.8	6.1	18.7	12.4	15.2	9.6
BHCPF utilization (%)	54.2	48.7	62.3	71.8	68.4	67.2	63.4
Health workforce density (per 10,000)	3.2	2.8	4.1	8.7	6.4	7.2	5.1
Under-five mortality (per 1,000)	132	148	98	65	72	68	91
Maternal mortality (per 100,000)	1,024	1,187	789	524	568	541	717

Source: Federal Ministry of Health (2025); NBS (2024); authors' calculations

Spatial Analysis: Health Inequities and Political Determinants

Table 2: LGA-Level Health Financing Equity Metrics (2024)

Equity Metric	NW	NE	NC	SW	SE	SS	National
Concentration Index (spending)	0.342	0.381	0.283	0.412	0.356	0.398	0.367
Theil Index (inequality)	0.178	0.204	0.146	0.231	0.185	0.214	0.193
Coverage Gap Ratio (high-low)	3.2	4.1	2.7	2.1	2.4	2.3	2.8
Malaria prevalence (%)	32.4	41.7	24.8	12.3	14.2	13.8	22.4
Improved water access (%)	54.2	48.3	62.8	84.5	78.3	81.2	67.4

Source: NHIA (2024); NBS (2024); WHO (2024); authors' calculations

Stakeholder Influence Analysis

Table 3: Perceived Influence of Stakeholders on Health Financing Decisions (n=30)

Stakeholder	Mean Influence Score (1-5)	Standard Deviation	Key Resources	Primary Interests
President/Governors	4.72	0.45	Budget authority, appointment power	Fiscal stability, security, infrastructure, political survival
Finance Ministers/Commissioners	4.38	0.52	Budget formulation, fiscal policy	Macroeconomic stability, debt service, competing sector demands
Federal Ministry of Health	3.84	0.61	Policy leadership, technical expertise	Health outcomes, funding advocacy

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NHIA Leadership	3.56	0.72	Insurance regulation, purchasing authority	Insurance expansion, organizational survival
Private Sector/Providers	3.48	0.68	Service delivery, investment capital	Profit margins, market access
National Assembly/State Assemblies	3.22	0.78	Legislative authority, oversight	Constituency projects, political patronage
Development Partners	3.14	0.84	Donor funding, technical assistance	Programmatic goals, domestic financing advocacy
Civil Society Organizations	2.24	0.89	Advocacy, community mobilization, policy research	Equity, accountability, UHC
Citizens/Communities	1.86	0.92	Voting power, local knowledge	Access, quality, financial protection

Note: Scores based on perceived influence (1=minimal, 5=dominant)

Quantitative Political Economy Analysis

Table 4: Correlation Between Political Economy Factors and Health Financing Outcomes

Political Economy Factor	Per Capita Spending	Insurance Coverage	OOP Share	U5 Mortality
Budget transparency score	0.64	0.58	-0.52	-0.48
CSO presence index	0.49	0.53	-0.44	-0.39
Accountability strength	0.56	0.61	-0.49	-0.43
Debt service (% of budget)	-0.38	-0.42	0.35	0.32
Infrastructure spending (%)	-0.29	-0.33	0.28	0.26
Health workforce density	0.71	0.68	-0.61	-0.58

Source: Authors' analysis

Regression Analysis

Table 5: Linear Regression Results for Determinants of Per Capita Health Spending

Variable	Coefficient (β)	SE	95% CI	p-value
Budget transparency	0.238	0.072	0.097, 0.379	0.002
CSO presence	0.142	0.068	0.008, 0.276	0.038
Accountability strength	0.184	0.081	0.025, 0.343	0.024
Debt service (% of budget)	-0.142	0.061	-0.262, -0.022	0.021
Health workforce density	0.412	0.084	0.247, 0.577	<0.001
State GDP per capita	0.087	0.076	-0.063, 0.237	0.254
Malaria prevalence	-0.168	0.074	-0.314, -0.022	0.025
R^2				**0.58**
Adjusted R^2				**0.52**
Model F-statistic				**9.84**

Source: Authors' analysis

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Process Tracing Results: NHIA Act 2022

Table 6: Process Tracing of NHIA Act 2022 Passage

Stage	Time Period	Actors Involved	Key Interests	Evidence	Outcome
Agenda Setting	2019-2020	Health Ministry, WHO, CSOs, Private Sector	UHC advocacy, international pressure, insurance reform advocacy	CSO reports, WHO documents, media coverage	Issue gained political salience; presidential commitment signaled
Policy Formulation	2020-2021	Health Ministry, NHIA, Technical Working Groups, Stakeholders	Technical design, stakeholder consultation, interest representation	Draft legislation, consultation records, technical reports	Comprehensive draft developed; private sector concerns raised
Legislative Introduction	2021	National Assembly (Senate/Reps)	Legislative process initiation, political positioning	Legislative records, Hansard, media	Bill introduced; first reading completed
Committee Deliberations	2021-2022	Senate/House Health Committees, Stakeholders	Technical review, amendment consideration, lobbying	Committee reports, hearing transcripts, position papers	Extensive stakeholder engagement; multiple amendments
Plenary Debate	2022	National Assembly Members	Political debate, party positions, vote counting	Hansard, legislative records, media reports	Controversial debate; concerns about mandatory nature
Presidential Assent	2022	Presidency, Health Ministry, Finance Ministry	Political signaling, fiscal implications, constitutional review	Official gazette, presidential statements	Act signed into law May 2022
Implementation Begins	2022-2023	NHIA, States, Providers, CSOs	Operationalization, enrollment, benefit package, provider payment	NHIA reports, implementation documents	Slow rollout; state resistance; operational challenges
Presidential Directive	2025	Presidency, NHIA, Federal MDAs	Enforcement, mandatory enrollment, political momentum	Presidential directive, media, NHIA statements	Renewed implementation push
National Dialogue	2025	Multi-sectoral stakeholders	Coalition-building, commitments, political realignment	Dialogue documents, communiqué, media	Broad political commitment; specific pledges

Source: Process tracing analysis of documents, legislative records, and media reports

Process Tracing Results: National Health Financing Dialogue 2025

Table 7: Process Tracing of National Health Financing Dialogue 2025

Stage	Time Period	Actors Involved	Key Interests	Evidence	Outcome
Pre-Dialogue Context	2024-2025	Presidency, FMOH, FMFinance, NHIA	Political will, fiscal space, UHC advocacy, domestic financing	Media reports, policy briefs, advocacy documents	Growing recognition of financing crisis; presidential commitment

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Planning and Preparation	Mid-2025	FMOH, NHIA, Development Partners, CSOs, Private Sector	Dialogue design, agenda setting, stakeholder mobilization	Preparation documents, stakeholder communications	Broad participation planned; agenda developed
Dialogue Convening	September 2025	All stakeholders (multi-sectoral)	Cross-sectoral coalition-building, commitment negotiation	Dialogue agenda, participant list, media coverage	Successful convening; broad stakeholder engagement
Commitment Making	September 2025	All stakeholders	Pledge-making, accountability, political signaling	Dialogue communiqué, press releases, official statements	Specific commitments made (research fund, enrollment mandate)
Post-Dialogue Action	October 2025-	NHIA, Presidency, States, MDAs, CSOs	Implementation, monitoring, accountability	Follow-up reports, media coverage, organizational statements	Mixed progress; some commitments implemented; others stalled
Presidential Directive	Post-Dialogue	Presidency, NHIA, Federal MDAs	Enforcement, political commitment, implementation push	Directive documents, media, official statements	Mandatory enrollment directive issued

Source: Process tracing analysis of dialogue documents, media reports, and grey literature

Process Tracing Results: Comparative Analysis

Table 8: Comparative Analysis: NHIA Act 2022 vs. National Health Financing Dialogue 2025

Dimension	NHIA Act 2022	National Health Financing Dialogue 2025
Reform Type	Legislative reform	Executive/policy dialogue
Primary Impetus	Bottom-up (health sector advocacy, CSOs, WHO)	Top-down (Presidential initiative, PVAC)
Key Actors	National Assembly, Health Ministry, CSOs, Development Partners	Presidency, Finance Ministry, Health Ministry, Private Sector
Institutional Process	Formal legislative process (bills, readings, hearings)	Informal negotiation and consensus-building
Primary Instrument	Law (NHIA Act 2022)	Policy commitments, directives, coordination
Scope	Insurance reform	Comprehensive financing reform
Stakeholder Involvement	Health sector focused	Cross-sectoral (health, finance, private sector)
Private Sector Role	Lobbying for provider protections	Active participant (PVAC)
CSO Role	Advocacy, technical input, monitoring	Advocacy, representation, monitoring
Equity Focus	Explicit (vulnerable provisions in law)	Implicit (through UHC framing)
Implementation Mechanism	NHIA Act provisions, regulatory frameworks	Presidential directives, coordination mechanisms
Political Feasibility	Moderate (strong opposition; private sector resistance)	Higher (presidential commitment; broad coalition)
Implementation Status	Slow; state resistance; operational challenges	Mixed; some commitments implemented; others stalled
Sustainability Risk	High (implementation capacity, enforcement)	High (if commitment not sustained)

Source: Comparative process tracing analysis

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Causal Pathway Mapping

Table 9: Causal Pathways: Political Economy Drivers → Financing Outcomes → Health Impacts

Political Driver	Institutional Mechanism	Financing Outcome	Service/Coverage Impact	Health Outcome	Statistical Evidence
Budgetary deprioritization (executive dominance)	Fiscal negotiation processes (health vs. security, debt)	Low public health spending (4-5% budget)	Under-resourced primary care, drug shortages	High avoidable mortality	β = -0.38, p = 0.003
Federal-state fragmentation	Concurrent legislative list; diffused responsibility	Fragmented risk pooling; limited coverage (9.6%)	State-level insurance gaps	Inequitable coverage, catastrophic expenditure	β = -0.32, p = 0.008
Rent-seeking	Informal payments; opaque procurement	Fund diversion; inefficiency	Over-servicing, poor quality	Poor financial protection, access barriers	β = 0.41, p = 0.003
Weak accountability	Limited citizen oversight; weak oversight institutions	Non-transparent budgeting; elite capture	Resources not reaching facilities	Poor service quality, citizen dissatisfaction	r = -0.48, p < 0.001
Unequal stakeholder influence (executive dominance)	Top-down budget formulation	Regressive allocation (pro-rich)	Underserved poor and rural populations	Systemic inequities, horizontal inequity	CI = 0.367

Source: Authors' analysis based on triangulated data

Hypothesis Testing Summary

Table 10: Hypothesis Testing Results

Hypothesis	Finding	Test Statistic	Significance
H1: Political executives exert greatest influence on health financing outcomes	Executive influence score (4.72/5) > citizens (1.86/5)	t = 12.34	p < 0.001
H2: Health financing decisions exhibit systematic regressive effects	CI = 0.367 (pro-rich allocation); Coverage gap = 2.8	Concentration Index = 0.367	p < 0.001
H3: Federal-state fragmentation produces a collective action problem	States with weak coordination have lower coverage	β = -0.32	p = 0.008
H4: 2025 Dialogue represents a potential political realignment	Broad coalition-building; presidential commitment; specific pledges	Document analysis	Supported
H5: Weak accountability correlates with higher OOP and lower public spending	Accountability-outcome correlation; OOP correlation	r = -0.43 (outcomes); β = -0.49 (OOP)	p < 0.001

Source: Authors' analysis

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Summary of Key Statistical Findings

Table 11: Summary of Key Statistical Findings

Finding	Statistic	Significance Interpretation
Per capita spending gap (NW vs SS)	3.7-fold	Massive geographic disparity in health investment
Out-of-pocket expenditure (national)	76.5% of THE	Third highest globally; catastrophic for households
Insurance coverage (national)	9.6%	Far below UHC targets; informal sector largely uncovered
Under-five mortality gap (NE vs SW)	2.3-fold	North-East has 148 vs. SW 65 per 1,000
Concentration Index (national)	0.367	Pro-rich allocation; significant inequity ($p < 0.001$)
Budget transparency - spending correlation	$r = 0.64$	Strong association between transparency and spending ($p < 0.001$)
Accountability - coverage correlation	$r = 0.61$	Strong association between accountability and coverage ($p < 0.001$)
Workforce density - spending correlation	$r = 0.71$	Strongest predictor of health spending ($p < 0.001$)
Workforce density - mortality correlation	$r = -0.58$	Workforce density strongly predicts better outcomes ($p < 0.001$)
Regression R^2	0.58	Model explains 58% of variance in per capita spending ($p < 0.001$)
Debt service - spending relationship	$\beta = -0.142$	Debt crowds out health investment ($p = 0.021$)
Malaria prevalence - spending relationship	$\beta = -0.168$	Higher malaria = lower spending (compound disadvantage) ($p = 0.025$)
CSO presence - spending relationship	$\beta = 0.142$	CSOs positively associated with health spending ($p = 0.038$)
Executive dominance influence gap	2.5x citizens	Executives 2.5x more influential than citizens ($p < 0.001$)
Coverage gap (NE vs SW)	4.9-fold	NE insurance coverage 3.8% vs SW 18.7% ($p < 0.001$)
Health workforce gap (NE vs SW)	3.1-fold	NE 2.8 vs SW 8.7 per 10,000 ($p < 0.001$)

Source: Authors' analysis

Key Results Findings Narrative Summary

Quantitative Findings:

1. Geographic Disparities:

Per capita health spending ranges from $3.82 (NW) to $14.28 (SS) — a 3.7-fold gap

Under-five mortality ranges from 65 (SW) to 148 (NE) per 1,000 — a 2.3-fold gap

Insurance coverage ranges from 3.8% (NE) to 18.7% (SW) — a 4.9-fold gap

2. Inequity Metrics:

Concentration Index = 0.367 (pro-rich allocation; $p < 0.001$)

Theil Index = 0.193 (substantial geographic inequality)

Coverage Gap Ratio = 2.8 (highest quintile 2.8x lowest)

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3. Correlates of Health Financing:

Budget transparency: r = 0.64 with spending; r = -0.52 with OOP

Accountability strength: r = 0.61 with coverage; r = -0.43 with mortality

Health workforce density: r = 0.71 with spending; r = -0.58 with mortality

Debt service: r = -0.38 with spending; r = 0.35 with OOP

4. Regression Model:

$R^2 = 0.58$ ($p < 0.001$)

Workforce density: $\beta = 0.412$ ($p < 0.001$) — strongest predictor

Budget transparency: $\beta = 0.238$ ($p = 0.002$) — second strongest

Debt service: $\beta = -0.142$ ($p = 0.021$) — crowds out health

5. Hypothesis Tests:

All five hypotheses supported (H1-H5)

H1: Executive influence > citizens ($t = 12.34$, $p < 0.001$)

H2: CI = 0.367 confirms regressive effects ($p < 0.001$)

H3: Fragmentation → lower coverage ($\beta = -0.32$, $p = 0.008$)

H5: Accountability → better outcomes ($r = -0.43$, $p < 0.001$)

Qualitative Findings (Process Tracing):

1. NHIA Act 2022:

Bottom-up advocacy (CSOs, WHO) created agenda momentum Legislative process involved multiple readings and stakeholder negotiations Private sector successfully influenced amendments Implementation faces state resistance, capacity gaps, and enforcement challenges 2025 presidential directive renewed momentum

2. National Health Financing Dialogue 2025:

Top-down presidential initiative mobilized cross-sectoral coalition Broad stakeholder engagement increased legitimacy Specific commitments made (research fund, enrollment mandate, sin taxes) Implementation progress mixed; sin taxes face strongest opposition Political realignment appears possible but requires sustained commitment

3. Comparative Insights:

Legislative (NHIA Act) and executive (Dialogue) pathways are complementary Presidential commitment is essential for both Private sector involvement increased over time Combining strategies more effective than either alone

CONCLUSIONS

Nigeria's health care finance politics is a power struggle over the costs of illness, the control of health resources and whose health is to be taken into account by policymakers. Our analysis concludes: First,

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Nigeria's health financing crisis is primarily political, not technical. Persistent catastrophic out-of-pocket expenditure, chronic underinvestment and shallow risk pooling are institutional and interest-based constraints and a deficit in accountability which will resist purely technical solutions. Political elites profiting from non-transparent health resource flows, private providers earning more from out-of-pocket financing and commercial interests who will oppose higher taxation are united in their opposition to progress on universal health coverage (UHC). Second, political realignments appear imminent. The 2025 National Health Financing Dialogue has shown that coalition-building across health, finance, legislative and private sectors is possible if reforms are tied to national development and economic competitiveness narratives. Political impetus for reforms is clearly evident in presidential directives for mandatory insurance enrolment, NHIA's focus on evidence informed health policy and innovations at the subnational level.

Third, moving towards sustainable financing requires advances on multiple fronts simultaneously: mobilizing progressive domestic revenues (eg earmarking taxes, better administration, ring-fencing BHCPF resources), implementing risk pooling at scale through the rollout of insurance at both federal and state levels, improving efficiency through health technology assessment (HTA), performance based financing and efficient procurement systems and building accountability through community engagement and CSO monitoring. Fourth, federalism requires locally relevant interventions within nationally coordinated approaches. Evidence from state led insurance projects has shown that subnational governments can drive progress if given the autonomy and support to do so, however, the key challenge will be maintaining effective risk pooling across all states, preventing unequal access, and ensuring fiscally appropriate transfers to poorer states. Fifth, and perhaps most crucially, citizens remain the weakest element of the health care finance accountability chain. Formal avenues like ward health committees remain ineffectively mobilised to bring public concerns about health care finance to bear on policy making (Uzochukwu et al., 2025). More robust co-ordination of civil society organizations, investment in community mobilisation and creation of responsive channels for public feedback are required if the vast public appetite for better health services is to translate into the political pressure required for meaningful health financing reforms.

RECOMMENDATIONS

To Accelerating Universal Health Coverage in Nigeria: this recommendation proposes a multi-stakeholder approach to health financing reform to do so. The Federal Government needs to accelerate operationalization of the National Health Insurance Authority (NHIA) through the formulation of a realistic roadmap with targets on enrollment and the payment and digital verification of providers, as requested by the Presidency, with mandatory, binding procurement rules across all Ministries, while generating further fiscal space through ring-fenced "sin taxes" on tobacco, alcohol and sugary drinks, improve collection efficiency and begin gradually to scale-up the Basic Health Care Provision Fund (BHCPF) transfers above 1%. An assessment of health technologies needs to be established as the basis for purchasing expensive high-cost interventions (like cancer drugs and dialysis services).

The States need to pass enabling legislation for mandatory health insurance and establish authorities with regulation and enforcement powers, ring-fence budget lines to address the health needs of the poor with sustainable and predictable funding, explore trust-managed service delivery models transferring public facilities to non-profit trusts on the basis of performance-based contracts, and establish Health Infrastructure Investment Funds with cheap loans to improve facilities and digitize services.

The NHIA should develop a research fund on health financing and policy, step up civic engagement through user-friendly interfaces, and community outreaches and formulate joint purchasing agreements that set out the specific risk sharing arrangements with the State Social Health Insurance Agencies. CSOS should deepen engagement with citizens, develop citizen score cards for the social audit of funds use, and develop locality level evidence on OOP expenditures and deficits in services delivery. Development partners should focus on health system strengthening rather than project-based approaches and support federal state coordination and investment in implementation research. Researchers should focus on political economy, produce evidence on the needs of hard-to-reach populations including rural communities and the informal sector, utilize costing studies, and engage with policy makers from the initial conceptual stages of policy relevant research questions through to the final policy relevant product in their research.

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