AJPMHS GLOBAL RESEARCH NETWORK

AMERICAN Journal of Pediatric Medicine and Health Sciences
Volume 3, Issue 5, 2025 ISSN (E): 2993-2149

Financing Primary Health Care in Nigeria: A Case for Regional Reform, Targeted Subsidies, and Accountability

Babatunde Owolabi
Morrison Child & Family Services, Portland, Oregon

Femi Toki
Heriot Watt University, School of Built Environment

Princess Obembe
Department of International Studies, Imo State University, Nigeria

Ibukunoluwa Okunade
Department of Microbiology, University College Hospital, Ibadan

Adebusola Adu
Trine University, Angola Indiana, USA

Background

Nigeria's healthcare system is a reflection of its economic situation. Health and wealth are intertwined. Good health improves productivity, strengthens household income, and contributes to national development and economic growth.[1] However, in Nigeria, a country grappling with health issues such as malaria, tuberculosis, HIV/AIDS, and high maternal and child mortality, health remains more of a personal burden than a public right.[2] These persistent health issues hamper health outcomes and economic development.

Despite several policies, including the National Health Insurance Scheme (NHIS) and the Basic Health Care Provision Fund (BHCPF), Nigeria is still far from achieving Universal Health Coverage (UHC). The Institute for Health Metrics and Evaluation ranked Nigeria 193rd out of 204 countries in UHC effective coverage.[3] The primary source of healthcare funding continues to be out-of-pocket (OOP) spending, which accounts for approximately 70% of all health payments.[4] For a population in which 63% are multidimensionally poor and 87% work informally,[5] [6] these expenses are not just unaffordable.

It is one thing to develop policies on paper, and another to ensure that they reach and serve the people. Why do well-designed policies and funding schemes fall flat in Nigeria? What structural, social, and economic bottlenecks prevent financing models from achieving their goals? These are questions for achieving UHC and economic development.

Our observations and studies have shown that the current financing system is not sustainable, subsidies favor the urban over rural areas, and governance issues lead to mismanaged health funds.[7] [8] Importantly, we advocate for a more regionally nuanced and economically realistic approach to funding primary healthcare. The aim is to highlight critical policy gaps and propose feasible, region-sensitive strategies that reflect Nigeria's current fiscal and socioeconomic realities.

This paper is not a research study with new primary data. It is a critical and informed appraisal of Nigeria's primary healthcare financing landscape, grounded in existing literature and informed by experience. It highlights how financing structures, originally designed to enhance equity, have often deepened it instead.

Overview of Existing Financing Schemes

In Nigeria, healthcare financing is derived from combinations of public, private, and donor sources. The system refers to how funds and resources are raised, allocated, and used for health-related purposes.[9] Below is the outline of each major scheme. Each of these schemes differs in terms of structure, impact, and coverage, but they are all aimed at improving access and promoting equity.

Tax-Based Public Financing

This government-led approach mobilizes funds from federal, state, and local taxes. These include revenue from oil and gas, corporate income taxes, customs and excise duties, VAT, and other levies.[10] This financing generates large sums of funds and risks shared across the population. In practice, health sits low on Nigeria's budget hierarchy, and boom-and-bust oil cycles make allocations unpredictable. As a result, Ministries of Health scramble each quarter to fund basic healthcare, essential drugs, and so on.[11]

National Health Insurance Authority (NHIA) Act (2022)

National Health Insurance Scheme (NHIS): Originally proposed in 1962 and later re-drafted in the late 1980s, Nigeria's NHIS was intended to provide formal sector workers with access to affordable health care.[12] Regrettably, coverage has remained low, with only a small percentage of Nigerians' formal sector workers covered. The poor uptake has been attributed to structural inefficiencies, low public awareness, and limited benefit packages.

Basic Health Care Provision Fund (BHCPF)

The Basic Healthcare Provision Fund (BHCPF) was established under the 2014 National Health Act, allocating new revenues as follows: 50% goes to the National Health Insurance Authority (NHIA), 45% to the National Primary Health Care Development Agency (NPHCDA), and 5% for emergency purposes.[13] [14] This policy was good on paper, but bureaucratic bottlenecks and corruption have hindered its effectiveness.

Out-of-Pocket (OOP) Payments

Even with policy advances, this is still Nigeria's most common form of health financing. Most Nigerians still pay for health costs at the point of care. Households directly finance health services at the point of delivery, drugs, consults, tests, etc. This model overloads households and tends to lead to catastrophic health expenditure, especially among poor households.[15] The Bamako Initiative of 1995 introduced user fees in the hopes that it would raise efficiency and resource levels,[16] yet it has worsened inequality and kept individuals from accessing care in a timely fashion.

Community-Based Health Financing (CBHF)

Community-Based Health Financing (CBHF): CBHF is a grassroots-driven scheme. It is founded on voluntary membership, community participation, prepayment, and community members usually have a stake in the management of the scheme.[17] [18] Membership contributions are pooled to offer basic health services and reduce out-of-pocket payments. A notable example is the Hygeia Community Health Plan in Kwara and Lagos States.[19] The program enables communities to take charge of their health financing, though its reach and sustainability are always at risk with the absence of technical assistance or government subsidy.[10]

Donor and Public-Private Partnership (PPP) Contributions

Donor Financing and Public-Private Partnerships (PPP): Donor financing continues to overwhelm Nigeria's health system, most especially for vertical programs such as HIV, malaria, and immunization. International partners like the WHO, World Bank, UNICEF, and UNDP provide grants, technical support, and equipment. While such assistance has filled critical funding voids, it is short-term. PPPs, if well-designed, will be in a position to complement public investment (NHIS, tax-based funding) by bringing innovation and efficiency from the private sector.[20]

Urban–Rural Disparities and Equity in Healthcare Facilities

In Nigeria, health financing schemes often widen rather than close inequities. Below are two key dimensions of this divide.

Facility distribution

The structure of Nigeria's healthcare system inadvertently favors urban populations, leading to an uneven distribution of health resources and subsidies. Secondary health facilities, complete with laboratories, surgical theatres, and trained specialists, cluster in the urban areas. According to the 2023 National Health Facility Survey, 68% of these urban health facilities boast at least basic equipment (weighing scale, BP cuff, stethoscope, thermometer, exam light), compared with just 29.9% of rural health facilities.[21] Essential drugs availability follows the same pattern; availability in half (50.6%) of all secondary facilities (urban areas) and barely one-third (34.3%) in primary ones (mostly in rural areas).[21]

Impacts on the poor

The allocation of most health resources to urban areas makes healthcare even harder for people in rural areas. With 70% of Nigeria's population living in rural areas, and 80% of the country's poor among them,[22] accessing well-equipped facilities often means high travel costs and out-of-pocket payments that can overwhelm a household's budget. Families choosing care in overcrowded urban clinics face user fees and informal charges that push many into debt or force them to skip treatment altogether.

Governance, Accountability, and Corruption

In the healthcare system, weak oversight and a lack of transparency create opportunities for corruption, which can sabotage even the best-funded programs.[23]

Inadequate financial record-keeping

Addressing the disparities in healthcare accessibility and strengthening financial management are important steps toward achieving equitable healthcare in Nigeria. The financial management practices within Nigeria's health system present significant challenges, particularly concerning transparency and accountability.[24] According to the 2023 National Health Facility Survey, only 19.8% of all facilities keep detailed records of user-fee collections (date, service, amount), and primary centers are even worse at 18.8%.[21] Additionally, about 48% of all surveyed facilities kept user fees in a safe location on-site until disbursed, a practice more common in secondary health facilities (64.2%) than in primary ones (47.5%).[21] These practices create opportunities for mismanagement of funds. The lack of standardized financial protocols and oversight allows for discretionary handling of funds, increasing the risk of corruption. These informal practices not only divert resources away from essential services but also erode public trust in the healthcare system

Weak Regulatory Oversight

Weak regulatory oversight and poor supervision undermine the impact of a good policy. Regulatory bodies lack the manpower and budget to inspect remote clinics regularly, and audits

often stop at urban referral hospitals. As a result, well-funded schemes or policies stall before reaching the frontlines. Bridging these gaps demands enforceable steps:

a. Digital cash-tracking: Roll out mobile-money or tablet-based fee logs that sync with state or local dashboards in real time.

b. Monitoring and evaluation: Empower local health committees and train them on how to utilize the Logistics Management Information System to review monthly financial reports, drugs, equipment, stationery, and flag discrepancies using the system for real-time documentation. The use of simple digital dashboards for real-time tracking of fund flows and service outputs.

c. Training: Provide adequate training for health workers on documentation, basic accounting, reconciliation, and the use of tools like Microsoft Excel, Microsoft Power BI, etc.

Advocacy

Nigeria's healthcare financing must move from one-size-fits-all to practical and targeted approaches. Below are three pragmatic advocacy points.

Targeted Subsidies for the Rural Poor

One of the major issues in the country's health system is that the blanket healthcare subsidy by the government mostly benefits urban residents due to the concentration of healthcare facilities. Consequently, rural areas, which are home to 70% of Nigerians and 80% of the country's poor,[22] benefit minimally from these subsidies. Also, based on the 2023 WHO data, Nigeria's doctor-to-patient ratio is 3.8 per 10,000 people, which is lower than the WHO recommendations.[25] Most of these doctors and health workers are based in urban areas, so rural areas often don't have enough staff to provide care or basic primary healthcare.

In practice, the purpose of the blanket subsidies can be assumed to have been defeated since the major beneficiaries are urban dwellers, and secondary and tertiary health facilities users. A more practical approach, aligned with the current socioeconomic reality of Nigeria, is that the targeted subsidies should focus exclusively on vulnerable groups (income-based subsidies) and a compulsory health insurance or health taxes. The removal of blanket subsidies would put an end to cost control. This will allow insurers to manage risk effectively, attract private investment, and improve service quality. It will also drive most Nigerians to access healthcare using the insurance and reduce out-of-pocket expenses due to the cost of health services.

Advocacy for Universal Health Coverage (UHC) at the Regional Level

Rather than waiting for national consensus, geopolitical zones should experiment with various insurance models. The advocacy for a geopolitical zonal approach to Universal Health Coverage (UHC) in Nigeria is in line with the country's diverse socioeconomic situations. It will allow for customized solutions that address specific zones or regional needs. This decentralized strategy will improve efficiency and also promote community involvement, ensuring that health services are accessible, affordable, and equitable for all Nigerians.

a. North-east and North-west: Considering the high poverty rates (76.5% and 75.8%, respectively) and informal employment in these two regions,[22] the implementation of Community-Based Health Insurance (CBHI) schemes can pool community resources to provide basic health services.

b. North Central: Building on existing community structures, state governments can subsidize premiums to improve coverage through CBHI, state-supported. The involvement of private companies through the Public-Private Partnership (PPP) model can help improve health infrastructure and how services are delivered in this region

c. South-east and South-south: With relatively better economic indicators in these regions,[22] implementation of contributory schemes (social schemes) where employers, employees, and

the informal sector contribute will improve healthcare and service delivery in these regions. The removal of blanket subsidies must be encouraged to increase enrollment in all sectors and economic statuses. This will also encourage private health insurance participation.

d. South-west: Social health schemes through the state governments and the private insurance system are viable in this region. This region is economically stronger, and sustainability through shared contributions is feasible. A good example and model for other states is the Lagos State Ilera-Eko program.[26] Lagos State has a mechanism to track and ensure accountability for maternal and child health (Lagos State Accountability Mechanism for Maternal, Newborn, Child and Adolescent Health).[27] The Lagos State model can be replicated on a smaller scale in other states in this region.

Conclusion

It is no longer news that Nigeria's healthcare financing is in crisis, not for lack of ideas, but for lack of execution, equity, and accountability. For decades, we've relied on overlapping schemes, donor dependency, out-of-pocket payments, and subsidies, while the majority of Nigerians, who live in rural communities and work in the informal sector, remain underserved.

This paper has examined the reality of existing financing means, tax-based funding that's vulnerable to economic volatility, a national insurance scheme that is still struggling to cover 10% of Nigerians, unreliable donor funding, and high out-of-pocket payments among vulnerable families. We've also spotlighted urban–rural disparities, the bureaucracy strangling well-meaning funds like the BHCPF, and the governance weaknesses that allow leakages and corruption.

The road to Universal Health Coverage (UHC) in Nigeria will not be paved by donor grants or policy documents alone. It must be driven by coordinated state or regional action, community participation, political will, and smart financing strategies that prioritize the rural poor. Reforming PHC financing in Nigeria demands confronting the informal economy directly, prioritizing rural equity, and strong accountability. Only then will our advocacy for UHC translate into meaningful coverage for every Nigerian.

There is a practical path forward. We've outlined clear, region-specific reforms, starting with zoning insurance systems by geopolitical region, leveraging digital financial tools for accountability, and replacing blanket subsidies with income-based and place of residence safety nets. These steps are realistic, grounded in Nigeria's socioeconomic conditions, and capable of delivering measurable results.

Bibliography:

1. Muysken J. Health as a principal determinant of economic growth. Maastricht University, Maastricht Economic Research Institute on Innovation and Technology (MERIT); 2003.
2. Abubakar I, Dalglish SL, Angell B, Sanuade O, Abimbola S, Adamu AL, Adetifa IM, Colbourn T, Ogunlesi AO, Onwujekwe O, Owoaje ET. The Lancet Nigeria Commission: investing in health and the future of the nation. The Lancet. 2022 Mar 19;399(10330):1155-200.
3. Global Burden of Disease Collaborative Network. Global Burden of Disease Study 2019 (GBD 2019) UHC Effective Coverage Index. Seattle, WA: Institute for Health Metrics and Evaluation; 2020. http://ghdx.healthdata.org/record/ihme-data/gbd-2019-uhc-effective-coverage-index-1990-2019
4. Eze OI, Iseolorunkanmi A, Adeloye D. The National Health Insurance Scheme (NHIS) in Nigeria: current issues and implementation challenges. Journal of Global Health Economics and Policy. 2024 Jun 24;4:e2024002.

5. National Bureau of Statistics. Nigeria Multidimensional Poverty Index Survey 2021. Nigerianstat.gov.ng. 2021 https://microdata.nigerianstat.gov.ng/index.php/catalog/71/related-materials
6. National Bureau of Statistics. Nigeria Labor Force Survey Q3 2023. Nigerianstat.gov.ng. 2024. https://microdata.nigerianstat.gov.ng/index.php/catalog/76
7. Okpani AI, Abimbola S. Operationalizing universal health coverage in Nigeria through social health insurance. Nigerian Medical Journal. 2015 Sep 1;56(5):305-10.
8. CDD West Africa. Civil Society in the Fight for Universal Health Coverage in Nigeria. 2025. https://www.cddwestafrica.org/blog/civil-society-in-the-fight-for-universal-health-coverage-in-nigeria/
9. Olakunde BO. Public health care financing in Nigeria: Which way forward? Annals of Nigerian Medicine. 2012 Jan 1;6(1):4.
10. Oyefabi AO, Aliyu AA, Idris A. Sources of health care financing among patients at the Ahmadu Bello University Teaching Hospital, Zaria, Nigeria. Journal of Medicine in the Tropics. 2014 Jan 1;16(1):27-31.
11. Oleribe OO, Momoh J, Uzochukwu BS, Mbofana F, Adebiyi A, Barbera T, Williams R, Taylor-Robinson SD. Identifying key challenges facing healthcare systems in Africa and potential solutions. International journal of general medicine. 2019 Nov 6:395-403.
12. Adefolaju T. Repositioning health insurance in Nigeria: Prospects and challenges. International Journal of Health Sciences. 2014 Jun;2(2):151-62.
13. Eze OI, Iseolorunkanmi A, Adeloye D. The National Health Insurance Scheme (NHIS) in Nigeria: current issues and implementation challenges. Journal of Global Health Economics and Policy. 2024 Jun 24;4:e2024002.
14. Basic Health Care Provision Fund – National Health Insurance Authority. Nhia.gov.ng. 2022. https://www.nhia.gov.ng/basic-health-care-provision-fund/
15. World Health Organization. World Health Report (The): Health Systems Financing: the path to universal Coverage. World Health Organization; 2010.
16. McPake B. User charges for health services in developing countries: a review of the economic literature. Social science & medicine. 1993 Jun 1;36(11):1397-405.
17. Bukola UA. Preferred mode of payments for community-based health care financing scheme among households in Osun State, Southwestern Nigeria. J Nat Sci Res. 2013 Nov 27;3(1):93-101.
18. Rouyard T, Mano Y, Daff BM, Diouf S, Fall Dia K, Duval L, Thuilliez J, Nakamura R. Operational and structural factors influencing enrolment in community-based health insurance schemes: an observational study using 12 waves of nationwide panel data from Senegal. Health Policy and Planning. 2022 Aug 1;37(7):858-71.
19. Hendriks M, Brewster L, Wit F, Bolarinwa OA, Odusola AO, Redekop W, Bindraban N, Vollaard A, Alli S, Adenusi P, Agbede K. Cardiovascular disease prevention in rural Nigeria in the context of a community-based health insurance scheme: QUality Improvement Cardiovascular care Kwara-I (QUICK-I). BMC Public Health. 2011 Dec;11:1-9.
20. Jütting J. Public-private-partnership and social protection in developing countries: the case of the health sector. In ILO workshop on "The extension of social protection 1999 Dec (Vol. 13, pp. 14-12).
21. National Bureau of Statistics. National Health Facility Survey 2023. Nigerianstat.gov.ng. 2023. https://microdata.nigerianstat.gov.ng/index.php/catalog/149/related-materials

22. National Bureau of Statistics. Nigeria Labor Force Survey Q3 2023. Nigerianstat.gov.ng. 2024. https://microdata.nigerianstat.gov.ng/index.php/catalog/76
23. Crossing the Global Quality Chasm: Improving Health Care Worldwide at NAP.edu. nap.nationalacademies.org. https://nap.nationalacademies.org/read/25152/chapter/8
24. Uzochukwu B, Onwujekwe E, Mbachu C, Okeke C, Molyneux S, Gilson L. Accountability mechanisms for implementing a health financing option: the case of the basic health care provision fund (BHCPF) in Nigeria. International journal for equity in health. 2018 Dec;17:1-6.
25. World Health Organization. Global Health Workforce Network (GHWN). https://www.who.int/teams/health-workforce/network
26. Lagos State Health Management Agency. Ileraeko.com. 2025. https://ileraeko.com/
27. Nigeria. Exemplars in Global Health. https://www.exemplars.health/emerging-topics/epidemic-preparedness-and-response/essential-health-services/nigeria