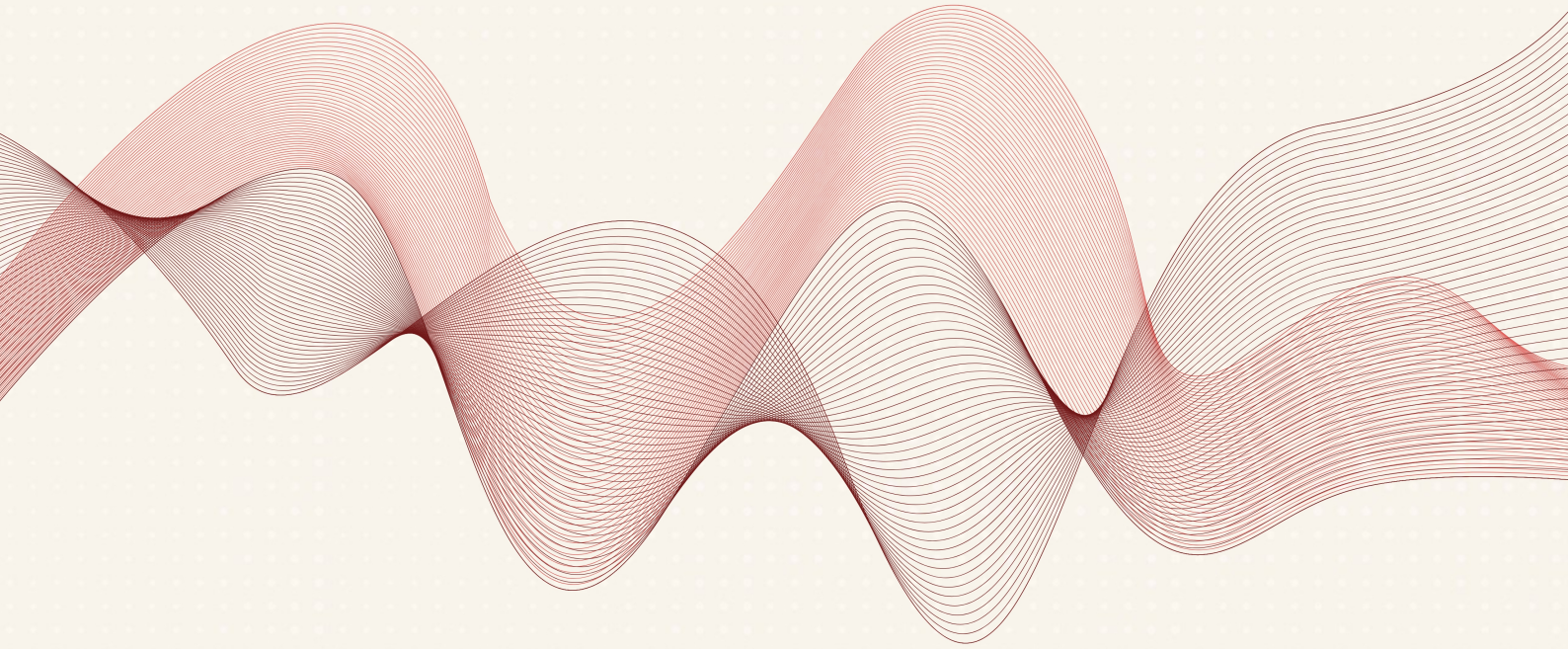

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Priorities and Health Packages in Reforming the Nigerian Health System: Experience from the Lancet Nigeria Commission

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

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Preface

Since the early 1990s, researchers involved in the Disease Control Priorities (DCP) effort have been evaluating options to decrease disease burden in low- and middle-income countries. This working paper was developed to support the Fourth Edition of this effort. It is posted to solicit comments and feedback, and ultimately will be revised and published as part of the DCP4 series.

DCP4 will be published by the World Bank. The overall DCP4 effort is being led by Series Lead Editor Ole F. Norheim, Director of the Bergen Centre for Ethics and Priority Setting in Health, University of Bergen. Core funding is provided by the Norwegian Agency for Development Cooperation and the Norwegian Research Council.

More information on the project is available at: https://www.uib.no/en/bceps/156731/fourth-edition-disease-control-priorities-dcp-4.

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

Abstract

Nigeria is projected to become the third most populous nation globally by 2100. The Lancet Nigeria Commission built a case for targeted and high-value investment to achieve substantial health gains. An analysis of existing literature, policies, programmes and governance frameworks was undertaken. We used the UN OneHealth tool and the UN inter-agency developed Lives Saved Tool (LiST) to project health and cost effects. We identified high net gain areas including on maternal and child health. Our recommendations of health reform have led to impact on national legislation to mandate health insurance and to create a vulnerable group fund.

Key messages

- Nigeria is home to a young, rapidly growing and dynamic population. Investments into the health and other social systems will determine the prosperity of the nation for decades to come.
- We identify a number of highly cost-effective priority areas for health investment based on analyses of the local burden of disease, prevailing measures of cost-effectiveness and a prioritisation process with key health system stakeholders.
- To ensure these can be effectively implemented requires reform to the healthcare system that leverages the strengths of the current health system and works within the realities of the complex, federalised system but meaningfully and sustainably overcomes the limitations that have restricted population health outcomes and access to care previously.
- Recent reforms have progressed the country towards these goals but there remains significant scope for further development through carefully directed investment, particularly in primary care, health promotion and interventions to improve the social determinants of health.

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1.0 Introduction

Nigeria has Africa's largest economy and population, projected by the United Nations to become the third most populous nation in the world by 2100 [1]. While a nation of great promise, Nigeria needs to urgently address a series of challenges to reach its true potential. Nigeria experiences the worst outcomes in the world across a number of health and social outcomes such as Malaria [2], under 5 mortality [3] or the number of children out of school [4]. remains low by global standards and the health system is beset by a myriad of challenges. Recent analysis comparing Nigeria to other West African states with similar or lower GDP per capita and investment in health suggests that there is room to increase both the efficiency of current levels of health spending and the overall envelope of investments [5]. An increase in domestic funding is also essential to allow a gradual weaning off from donor support.

The Lancet Nigeria Commission (LNC) [6], drew together a multidisciplinary group of leading experts to develop evidence-based recommendations to strengthen the Nigerian health system and achieve universal health coverage in the country. The Commission called for "a new social contract centred on health to address Nigeria's need to define the relationship between the citizen and the state". To achieve this, the Commission recommended a prevention agenda at the heart of health policy using a whole-of-government approach and community engagement. The large inequality between urban and rural areas, and different regions of the country also requires equitable delivery of health, social welfare, education and employment. The COVID-19 pandemic also exposed vulnerabilities in health security which will require a whole system assessment of the investment needs including for manufacturing capacity of essential health products, medicines and vaccines.

In this chapter, we draw on the expertise and expand the analysis of the Commission to build the case for targeted and high-value investment to achieve substantial gains in population health and healthcare for Nigerians. We focus on the policy implications of the work of LNC, highlighting the links between the findings of the analyses, existing policy initiatives in Nigeria and the reforms we argue are necessary to propel Nigeria to universal health coverage. There is a scarcity of robust local data to inform policy and investment decision-making in Nigeria [6], The Lancet Nigeria Commission report and this chapter seeks to begin to fill this gap, presenting the case and priorities for targeted investment to progress the country towards reaching its potential. Here, we outline the process through which priorities were set, the sources of data and tools used, and examples of care packages that will support universal health coverage. Properly implementing these will require widespread health system and financing reform and we present a number of recommendations to sustainably achieve this.

Overview of the Nigerian Health System

The Nigerian health system is inherently complex, involving three different levels of Government, each responsible for the provision of different levels of care. Public funding is split between the federal government (53%), state governments (27%) and local governments (20%) but, as stated above, the overall level of funding devoted to health remains low by global standards. There are wide inequities across the nation and ultimately an inbalance between the revenue raising potential (dominated by the Federal government) and the responsibilities of service provision for the other levels of government. On top of public

funding, there is a substantial private sector providing care to Nigerians, characterised by high levels of out of pocket costs. Recent reforms described in more detail below, notably the passing of the NHIA act 2022, build on a number of reforms over recent decades that have aimed at improving health care coverage and population health across Nigeria. Notably, the establishment and implementation of the National Health Insurance Scheme in the late 1990s and early 2000s, the National Strategic Health Development Plan (NSHDP) introduced in 2010 prioritising eight key areas for further health system reforms (later adopted in the NSHDPII), the National Health Act of 2014 introduced the Basic Health Care Provision Fund (BHCPF) – a mechanism for the national government to finance healthcare provision at the State level, and more recently the introduction of the Essential Health Care Package which was designed to outline key services for the population should be able to access. While there have been gains through these programs, universal health coverage remains elusive. A number of shortcomings have hindered the impact of these reforms, here we outline these and develop recommendations to feasibly move the country towards universal health coverage.

2.0 Priority Setting Process

Ownership and Governance

The priority setting recommendations emerged from an evidence-based, multi-stage process led by the Lancet Nigeria Commission. The Commissioners had expertise and experience in the diverse disciplines required to shape national health policy, including public health and epidemiology, political science, history, health economics, health policy and systems research, public policy, sociology, demography, law, anthropology and health systems. We ensured representation with respect to gender and local origin, included a range of political and health policy views among experts based within and outside Nigeria, and consulted with a diverse group of policy stakeholders to provide insight into the challenges of delivering health and health care in Nigeria. A 10-year time frame was set for all analyses, looking beyond the lifespan of the current Nigerian government, to ensure relevance to current and future administrations in Nigeria. While some Commissioners had roles within Government and public agencies, the process was conducted outside government, and the Commission does not hold formal powers to implement the recommendations. Nevertheless, some recommendations have already been adopted by the government.

Scope and Content

The Commission sought to generate and synthesise evidence to inform policy and programme implementation and with a view to building a strengthened health system that meets the needs of all Nigerians. This occurred over four stages, which were used to generate final recommendations:

1. We reviewed Nigerian history with a focus on the health system to understand current structures and systems by rooting them in pre-colonial, colonial, and modern-day trends and events.
2. A comprehensive analysis of the country's disease burden was conducted to identify the major causes of morbidity and mortality based on the best available data.

3. Policy documents (health-specific and broader inter-sectoral policies that influence health beyond healthcare) and health-system factors were analysed to identify key challenges and suggested systems-level leverage points for potential intervention.
4. Fourth, we combined health-economic analyses to generate evidence on the most cost-effective combination of interventions to achieve health goals given the disease burden of Nigeria and summarise approaches to improve health financing.

Criteria Used

The work of the Commission was underpinned by the core values of fairness, equity, pragmatism, and evidence-driven approaches. Given the young structure of the Nigerian population, prevention and keeping young Nigerians healthy were stated priorities of the Commission. We conducted extensive analyses of the disease burden of Nigeria and compared population health outcomes to those in neighbouring nations to determine areas where the Nigerian system was underperforming and identify cost-effective, sustainable reform options. An e-Delphi process was conducted in late 2020 with twenty-three Commissioners and other Nigerian health policymakers to identify the key conditions and risk factors most important to address to improve population health in Nigeria (described in detail in the LNC Appendix [6]). These were prioritised on four criteria:

1. The Magnitude of Need – to assess how important an issue the condition or risk factor was to the Nigerian population and health system.
2. Available Knowledge – to assess the importance of further knowledge of the burden of the condition for the Nigerian population and health system.
3. Leverage – to assess the potential for our work in this area to contribute to strengthening the Nigerian health system.
4. Equity – to assess whether work to address the specific condition or risk-factor would likely also act to reduce disparities across the population.

Respondents were then presented with a prioritised list of all conditions and risk factors and asked to either agree with the ranking or alter it to match their own priorities. Through this process eleven conditions and five risk factors were prioritised as particularly important to the Nigerian health system.

Table 1 – Final list of prioritised conditions and risk factors

Condition group	Rank from prioritisation process	DALY based ranking*
Maternal and Neonatal Conditions	1	1
Cardiovascular diseases	2	6

Diabetes and Chronic Kidney Diseases	3	14
Neglected Tropical Diseases and Malaria	4	4
Respiratory Infections and TB	5	3
Neoplasms	6	11
Mental Disorders	7	10
Enteric infections	8	2
Transport Injuries	9	16
Nutritional deficiencies	10	12
HIV/AIDS and Sexually Transmitted Infections	11	5
Risk Factors		
Child and maternal malnutrition	1	1
Unsafe water, sanitation and handwashing	2	2
High-systolic blood pressure	3	4
Air Pollution	4	3
High fasting plasma glucose	5	6

* *Global Burden of Diseases, Injuries and Risk Factors Study (GBD) 2019*

Accountability and Transparency Measures

Given the work of the Commission lay outside government and we had no authority over the implementation of recommendations no specific accountability mechanisms were incorporated through our work, however, our review of current Nigerian policy settings identified a number of existing measures that we pull together briefly here:

- *Federal and state Budgets:* The development of annual health budgets by the Federal Ministry of Health (FMOH) and some state Ministries of Health was hitherto preceded by the development of Medium Term Sector Strategies (MTSS), which attracted broad-based participation, including participation by Civil Society Organisations (CSOs) in order to help ensure that the annual budgets are used to buy essentials covered by the basic Health Benefits Package (HBP) Nigerians should receive (see below). Unfortunately, the MTSS process is not very active or well established. However, the published annual budgets give the CSOs and other stakeholders the framework to monitor the contents of the budget and the implementation. Nigeria has an Open Treasury portal (opentreasury.gov.ng) that enables CSOs and other stakeholders to monitor the HBP within the annual budget of the FMOH.

- *Social health insurance and other risk protection mechanisms:* The recent passage of the National Health Insurance Authority Act (2022), based on the recommendation of the Lancet Nigeria Commission [7], provides a further potential source of funds through the establishment of a Vulnerable Fund and mandatory health insurance for formally employed persons. It is expected that a broad-based participatory mechanism will be used to develop the HBP that are cost-effective and assure value for money for deployment by the schemes. The existence of the law provides a governance framework. However, accountability mechanisms will have to be developed to ensure that the extra funds are transparently, efficiently and equitably used to cover the target population groups.

- *HBP under the Basic Healthcare Provision Fund (BHCPF):* The development of the benefit package was led by a broad-based technical working group (TWG) that comprised government, CSOs and development partners. The main implementing agencies at the Federal level (the National Primary Healthcare Development Agency, NPHCDA; National Health Insurance Scheme, NHIS; and FMOH) are striving to create awareness about the HBP gateways among healthcare providers and consumers. The HBP was circulated for review, debated and approved by the National Council on Health, which draws participation from all the leaders of the health sector in Nigeria. There is an accountability framework, which involves both the public and private sectors in ensuring that the purchase of HBP is according to the stipulated guidelines. The accountability framework is currently undergoing revision to address some practical issues with implementation of the BHCPF. It is also envisaged that the accountability framework will encompass the monitoring of presence and productivity of health workers, since absenteeism of frontline health workers can undermine the use of the fund. The FMOH has developed a capacity building and awareness programme on the BHCPF, to further inform the implementers, other decision makers and CSOs about the salient features of the BHCPF, including the HBP. However, the

BHCPF is currently being implemented as a vertical programme, which is not in line with the law that established it. The law envisioned that the BHCPF will be integrated into the normal activities of the NHIS, NPHCDA and their equivalents in the states and local governments. Verticalisation of the BHCPF has negative implications for efficiency and how much HBP can be bought with the fund.

- NHIS FSSHIP: The initial HBP of the Formal Sector Social Insurance Programme (FSSHIP) of the National Health Insurance Scheme (NHIS), now the National Health Insurance Authority (NHIA), was developed through a broad participatory method, with involvement of academics, health insurance companies, NHIS staff, physician groups, etc in its development. However, subsequent revisions of the HBP of the FSSHIP have not followed such a broad-based approach. Nonetheless, the NHIS regularly informs the citizens and their accredited providers on the summary contents of HBP, delineating the benefits that are to be provided/purchased at primary, secondary and tertiary levels of care. This mechanism will need to be updated in view of the NHIA Act 2022.

- SSHIS: The State Social Health Insurance Schemes, which are found at sub-national levels, try to follow the steps that were taken by the NHIA in developing its HBP and creating accountability mechanisms for monitoring the provision and consumption of the HBP.

- Other special financial risk protection interventions such as Free Maternal and Child Health (MCH) programmes, especially the defunct NHIS-MDG programme and SURE-P/MCH had HBP that were developed using broad based participatory co-creation methods that involved both the public and private sectors. In some states and local councils, their implementation also involved community entities such as Ward Development Committees and Village Development Committees. There are also adjunct accountability frameworks on paper.

- National Strategic Health Development Plans 1 and 2 (NHSDP 1 and 2), State Strategic Health Development Plans 1 and 2, Federal Strategic Health Development Plans 1 and 2: The decision of the interventions/activities that were included in the NHSDP 1, especially in NHSDP 2 followed a prioritisation mechanism that ensured that the 10 Nigerian health systems building blocks focused on key interventions that will protect population health. In addition to priority setting and consensus meetings with key stakeholders in the health sector to arrive at many priority interventions and activities, The One Health Tool (OHT) was ultimately used to cost the interventions and activities and model their potential benefits, in order to arrive at the final lists of HBP that were included in the plans. The NHSDP 2 (2018 to 2022) will soon undergo evaluation in preparation for the development of NHSDP 3.

- Non-communicable diseases and injuries (NCDI) poverty commission priority setting: The NCDI poverty commission in 2022, embarked on a detailed priority setting process to arrive at a HBP on NCDI for the country. The HBP prioritization followed ordered steps, which followed the NCDI poverty analytic framework, which focused on equity, cost-effectiveness and value for money to arrive at a draft HBP for NCDI.

3.0 Analyses and Tools

Data Sources

We relied heavily on the Global Burden of Diseases, Injuries and Risk Factors Study (GBD) 2019, which provides ongoing estimates of the mortality and morbidity burden attributable to a wide array of conditions and exposures to risk-factors in all countries [8,9]. In addition to the use of GBD results, the Commission undertook bespoke data collection and assessed the quality of existing data to inform future disease burden estimates. Population level data (demographic surveillance sites and census information), national facility-based databases (DHIS2), surveys and surveillance databases (such as SORMAS, NAISS, NPHCDA immunisation coverage data) and morbidity and mortality records from hospitals across the country were requested.

The process of collating the data was not without challenges, beginning with identifying where the data was situated and requesting permission to access it, due to limited institutional memory and frequent leadership changes. While some organisations were confused as to who the rightful guardian to the data was, others had several custodians with numerous channels to permission, each of whom had to consent for data to be released. Approval processes were therefore complex and slow. Where data existed, as in many health facilities, it was not captured using electronic medical record systems, and was therefore often incomplete and marred with inaccuracies. Furthermore, despite approval from the National Health Research Ethics Committee, each organisation had its own guidelines which were expected to be fulfilled before data issuance. Reluctance to share data in some institutions was based on concerns about opportunities to publish their own data, cost of extracting data and apprehensions about privacy and data misuse.

Tools and Methods

Several reviews of the literature were undertaken to summarise the best evidence available on Nigeria relevant disease burden and priorities and health system reform to inform subsequent data analysis and modelling. The UN OneHealth tool was used to project health system costs under different scenarios as specified under the National Strategic Health Development Plan II.

As maternal and child health was highlighted as a key priority through the e-Delphi process, Nigerian health policy and the comprehensive burden of disease analysis, specific analysis was conducted to assess the potential effect of health system investment targeting a package of cost-effective interventions to address child and maternal mortality. We used the UN inter-agency developed Lives Saved Tool (LiST) to dynamically project the health and cost effects between 2021 and 2030 of three scenarios of policy intervention: (1) baseline (no improvements in intervention coverage); (2) moderate increased investment (defined as linear progress to 20% increased coverage of interventions relative to baseline); and, (3) universal coverage (defined as linear progress to 90% coverage of interventions). Further details of the interventions included, the LiST tool, and projection methods are detailed in the LNC appendix [6].

4.0 Summary of Analysis Findings

The Basic Minimum Package of Health Services (BMPHS) aims to achieve fully functional primary health care (PHC) facilities in Nigeria - at least one in each political ward (average population ~23,000) by 2026, 7 years after the BMPHS was launched via the Basic Healthcare Provision Fund distributed by the Federal government [10]. The BMPHS also aims for at least 3 fully equipped secondary facilities and a national ambulance service in each of Nigeria's 37 states by 2024 [10] . The BMPHS includes a set of preventive, protective, promotive, curative and rehabilitative services including Basic Emergency Obstetric and Newborn Care. As of October 2021, 6287 PHC facilities, representing 68% of political wards had been authorised to receive funds [10]. Box 1 outlines on-going work on health benefits package design for primary health care in Nigeria.

Box 1: Health Benefits Package design for Primary Health Care in Nigeria

On-going work by the National Primary Health Care Development Agency (NPHCDA) seeks to design a *feasible benefits package* for Nigeria's Ward Health Service [11]. The NPHCDA are using a framework for Health Benefits Package (HBP) design that considers the incremental cost effectiveness ratio (ICER) of the services currently provided by the Ward Health Service, and those that could be, and how these relate to a cost-effectiveness threshold for current health spending in Nigeria of $214 per disability-adjusted life year (DALY) averted. ICERs of interventions and services were obtained from the Tufts database and where ICER data for interventions in Nigeria were not available data from countries deemed similar to Nigeria were used [12].

The emerging findings of this work are that overcoming supply and demand constraints to increase coverage of Ward Health Service interventions in PHC in Nigeria have large net health and monetary benefits, of the order of ~$1billion per 10% increase in PHC utilisation, up to ~$15bn at 100% utilisation, $9bn more than at the current 44% utilisation [11].

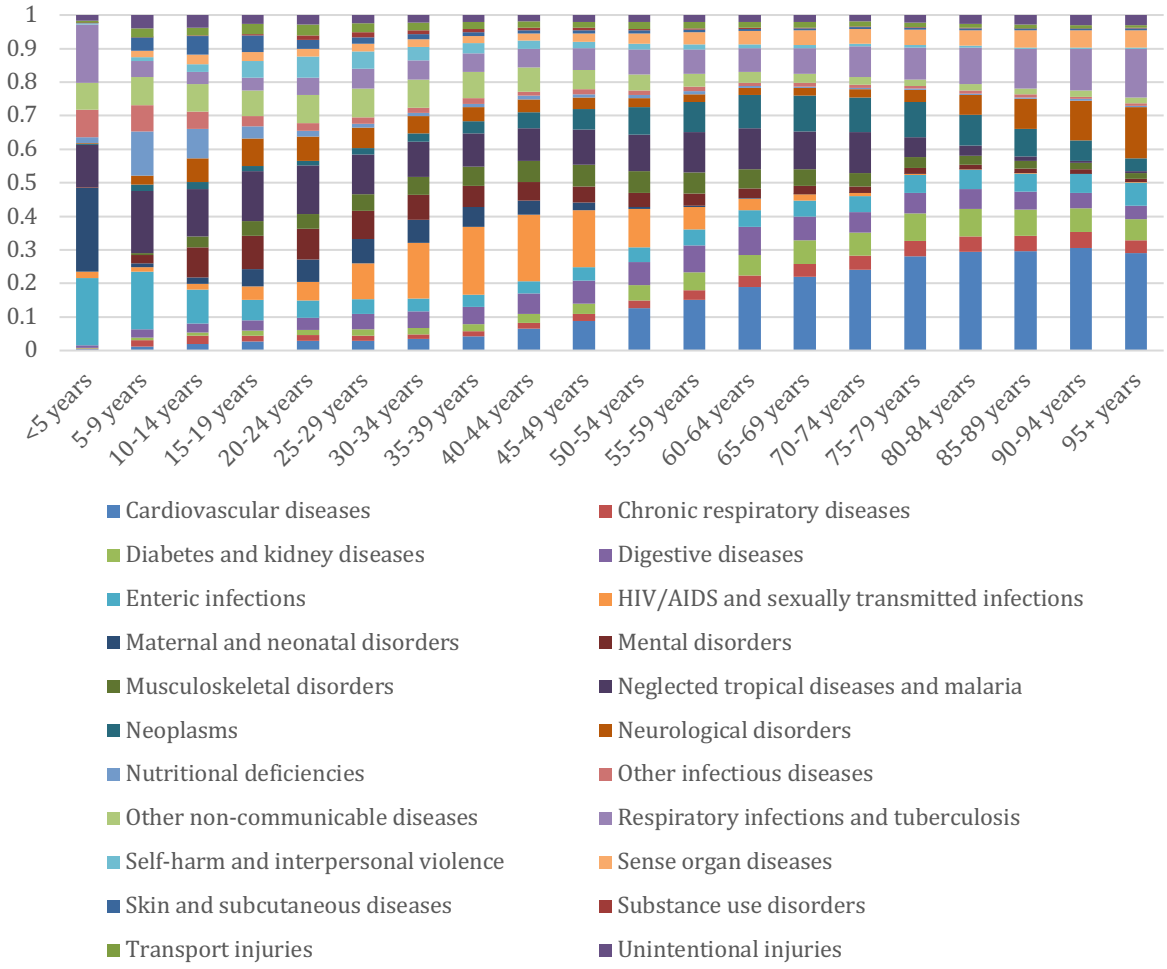
Further work is required to investigate the equity implications of increasing coverage, particularly with regard to scaling up interventions close to the cost-effective threshold, given interventions included in health benefits coverage should be available for all those expected to utilise services (up to 100% coverage). The costs and benefits of broader health

system strengthening efforts including recruiting, training, paying and retaining health workers, and building and maintaining new health facilities also need to be considered. Overall, this work should guide investment decisions as health budgets are increased to meet the large unaddressed primary health care needs of the population of Nigeria.

The National Health Insurance Authority, through the NHIS gateway of the BHCPF and implemented by sub-national (states) social health insurance schemes, is purchasing services from primary healthcare centres, which is based on the agreed BHP of the BHCPF.

The comprehensive burden of disease analysis highlighted a number of key priorities for the Nigerian system [5]. Outcomes for children under five and maternal mortality remain poor in Nigeria and children under 5 bear most of the burden of mortality in the nation. In contrast, outcomes for adults over 50, in particular men over 50, were amongst the best in West Africa. These relatively good outcomes, however, are threatened by a growing burden of non-communicable diseases which account for an increasing proportion of the total disease burden for older population groups (Figure 1). Preventing these diseases early will be essential to ensure that scarce healthcare resources are not unduly diverted away from overcoming the burden of maternal and child mortality that needs to be the priority for the system and to ensure the already stretched healthcare system is able to meet the needs of the population.

Figure 1 - Proportion of DALYs attributable to diseases by age, Nigeria 2019



Source: *Global Burden of Diseases, Injuries and Risk Factors Study (GBD) 2019*

Following the National Strategic Health Development Plan II (2018-2022) [13] the Lancet Nigeria Commission [6] costed provision of all health programme areas[1] at $2-3 USD and all health system strengthening[2] at $17-27 per capita per year during 2021-2030 for a moderate scale up scenario of coverage increase of 17.5% during 2018-2022 extrapolated to 2030. An aggressive scale-up scenario - extrapolation of a 30% increase during 2018-2022 to 2030, would cost $19-29 per capita per year for all programme areas, and $19-30 for health system strengthening. This would entail the Nigerian government massively increasing health

[1] Maternal and reproductive health, child health, immunisation, adolescent health, malaria, tuberculosis, HIV/AIDS, nutrition, water, sanitation and hygiene, non-communicable diseases, mental health, neglected tropical diseases, health promotion and social determinants of health, emergency hospital services, public health emergencies and preparedness and response.

[2] Programme activity costs, human resources, infrastructure, logistics, medicines, commodities and supplies, health financing, health information systems, governance.

expenditure, especially government health expenditure (only $11.85 per capita in 2019) given three-quarters of health expenditure is out-of-pocket in Nigeria [6].

Our analysis of scaling up maternal, newborn and child health services found that an additional $64 per capita in total during 2021-2030, or $10.5 per capita in 2030 at 90% coverage of services, could avert a total of 309,000 maternal deaths, 967,000 neonatal deaths, and 2.61 million child deaths [6]. This represents highly cost-effective spending as, given a total population ranging from 206 million in 2021 to 263 million in 2030, the ~4 million lives saved over the decade are saved at a cost of ~$600 each. Given most lives saved are newborn babies or children with their whole lives ahead of them this is <$15 per DALY averted. Such increased health spending should be affordable despite requiring an almost doubling of current government health expenditure just for maternal and newborn health, when considering it only represents around 0.5% of Nigeria's GDP per capita of $2097 in 2020.

Linkage to Service Delivery Reforms

A Healthcare Reform Committee (HRC), chaired by the Vice President, has been inaugurated with a remit to lead the development of a people-centric healthcare system which is fundamental to the socio-economic development of Nigeria. The committee with a 6-month timescale to deliver its outputs has been delayed due to political and other considerations. At the time of writing, the secretariat of the HRC has completed consultation with stakeholders and worked closely with state governments and the Federal Capital Territory to outline actions needed at all locals of government and in communities to improve health. The Lancet Nigeria Commission report provided data and information to inform the recommendations of the HRC. While system reforms are an ongoing process in the country, and the Lancet Nigeria Commission had no power over implementation, a number of recommendations have already been adopted including the inclusion in the NHIA Act 2022 of the requirement to mandate basic health insurance, to pool risks, to create a vulnerable group fund that will be part funded by BHCPF. Further, initiatives have been incorporated by the ongoing work of Commissioners with a number of sub-committees of the HRC, and the group continues to engage with the new government to pursue further implementation.

To strengthen domains for action and policy in the health system in Nigeria, we propose a reformed set-up of centrally determined, with active involvement of a broad range of health system stakeholders, but locally delivered systems. The reform will entail Nigeria digitising its health system, thoughtfully centralising standards, resource pooling and streamlining, improving supply chains, local manufacturing and data management, as well as concurrently localising production of basic products, allocation decisions, defining basic health services packages to align with local risk factors, and modes of community service delivery sensitive to socio-cultural norms.

Centralisation and Localisation

In a large, diverse, and federally governed country like Nigeria, careful calibration of centrally determined cost-effective HBP with flexibility in its local implementation is essential. For example, although a federal entity - NPHCDA - is designing a health benefits package for Nigeria's Ward Health Service, it is up to state governments (through state primary health care boards/agencies) to implement the HBP in each state. The BHCPF itself is centrally legislated (by the federal parliament) and coordinated (by federal entities NHIS and NPHCDA) but implemented by state governments (again, through their state primary

health care boards/agencies). More broadly, it is not only essential that certain health system functions are centrally determined, but also that they are centrally financed - especially functions that benefit from national uniformity or economies of scale. For example, having nationally uniform information systems is essential for implementing a national initiative such as the BHCPF - to inform its design and monitor its ongoing implementation. As such, the federal government needs to bear the costs of developing and providing central guidelines and forms (paper-based and electronic) with resources for adaptations to suit different sub-national levels in different local contexts; the costs of training and mentoring; and the costs of personnel to ensure data collection and quality assurance. Similarly, central efforts are required to develop and provide national quality of care guidelines, the health commodities supply chain system, and to strengthen the logistics and quality assurance of border transactions on importation. These examples of functions that require centralisation means the federal government must take on costs and responsibilities.

However, it is important to recognise that there is only so much the central government can do, especially given their distance from local needs and preferences in as large and diverse a country as Nigeria. Sub-national governments must play a major role in the adaptation and implementation of national benefits packages, systems, guidelines and standards. While implementation support may be provided at early stages of implementation (as it is efficient and sets a good example), such support may be phased out over time and means-tested, based on the level of available financial and technical resources in each state.

Linkage to Financing Mechanisms

Health financing reform will be essential if Nigeria's health system is to deliver UHC to its population. The recent passage of the National Health Insurance Authority Act (2022) presents an ambitious framework that if implemented will allow a substantial rise in the funds available to the Nigerian health sector. Specific elements of the act include mandatory health insurance for all residents of Nigeria irrespective of employment status, additional powers for NHIA to regulate and integrate schemes, and a specific mandate to promote UHC, expanding options for organisations that can be third party administrators while limiting their fund management function and the establishment of a Vulnerable Group Fund. Numerous sources of potential funding are mentioned in the act for the Vulnerable Group Fund including levies and new taxes. The recent amendment of the Finance Act to allow taxation of Sugar Sweetened Beverages should provide further revenue. The implementation of the act should prioritise increasing government funding for health, improving resource management through strategic purchasing, and the creation of a more robust benefit package. The new legislation provides the statutory basis to establish strong systems for oversight and regulation of providers such as Health Maintenance Organisations (HMO). Ultimately, to improve financial risk protection and the effectiveness of health financing mechanisms such as social health insurance in Nigeria, implementation bottlenecks must be addressed within the three health financing functions: revenue mobilisation, pooling and purchasing. There should be evidence-based and systematic development of government annual health budgets so that the funds will collectively be used to achieve set goals and targets, e.g. achieving some of the health-related SDG targets.

Options for Revenue Mobilisation

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

Health spending would be improved by instituting a dedicated pre-determined budget at the federal and state levels, outside of the electoral cycle, and with mechanisms to ensure it is spent efficiently and equitably. The budget must be made public and subject to independent auditors to ensure equity in the distribution of resources and setting of health priorities. An increase in state internally generated revenue (IGR) would also lower state dependence on federal funding and could refocus priorities on internal needs in determining health spending if a good proportion of the increased resources are allocated to the health sector. A transparent, public process for assigning and using grants from international donor partners, subject to independent regular audits, is also needed. To address some of these issues, in 2014 Nigeria established the Basic Healthcare Provision Fund, financed by an annual federal government grant of not less than 1% of the Consolidated Revenue Fund, grants from external donors, and other sources. Fifty percent of the funds gathered are to be administered by the NHIA to provide basic health services to citizens and for subsidy payments to state insurance agencies to provide healthcare to the very poor who are unable to afford premium payments. The NHIA Act (2022) complements and potentially increases the revenue available and should be the basis of a far-reaching reform to reach Nigeria's goal of UHC.

Reducing the burden and financial risk from healthcare spending for individuals, families and communities will therefore require a dramatic provision of and access to pooled funding (insurance) or pre-paid government provision of healthcare. Pooling is the health financing function whereby collected health revenues are transferred to purchasing organisations, which manage revenues and distribute risks. Nigeria should strive to develop large pools, since having small, scattered, and uncoordinated pools will not lead to efficient and equitable financial risk protection. However, in the case of multiple pools such as the various State Social Health Insurance Schemes (SSHIS), the FSSHIP, free programmes funded by the budget, community-based health insurance schemes and private health insurance, risk equalisation can be achieved via mechanisms including a dedicated fund and health re-insurance, under the leadership of the Federal Ministry of Finance, FMOH, the National Council of Health and the Nigeria Governors Forum.

Alternatively, mandatory social insurance for health could be levied, though both would need to be done equitably to guard against increasing inequality and resulting health, social and economic harms. Additionally, solutions for barriers to coverage of those working in the informal sector and those unemployed would need to be found [14]. Levying taxes and social insurance is also difficult whilst the majority of work is in the informal sector in Nigeria. However, as has been seen in other countries such as India and Ethiopia, should UHC become an election issue nationally and at state level, concerted advocacy and community engagement efforts from committed institutions and civil society organisations could provide creative approaches to facilitate UHC.

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

Furthermore, the Federal government needs to revise the benefit package so that every citizen is covered by social health insurance, implemented with strict oversight and regulation of HMOs. Awareness and benefits of social health insurance should be increased and should be mandatory for all. At regular intervals, the NHIS's implementation strategy should be reviewed to fast-track and improve the level of coverage among informal and formal sector workers, with the poorest Nigerians covered by government, with the objectives of providing universal financial risk protection and eliminating both the high level of OOP and the proportion of expenditure it covers. Federal and state-specific strategies should address context-related challenges of individual states (such as the inability to reallocate funds into FSSHIP).

In keeping with our recommendations of localising certain aspects of health services provision, it is important to allocate more funds at the state and local government levels for purchasing health services, with evidence-based, strategic, and appropriately-tracked spending to ensure that resources are used efficiently while removing financial barriers to access by reducing OOP expenditure in both absolute and relative terms [15]. Innovative strategies are also needed to enable potential beneficiaries, especially in the informal sector, to better comprehend and accept the concept of prepayment methods of financing health care and ensure all the formal sector employees are adequately informed about the FSSHIP of the NHIS. State and local governments can establish a tax-based health financing mechanism targeted at vulnerable groups, the poorest, and those working in the informal sector of the economy to accelerate progress towards universal health coverage (UHC). Lessons can be learned from health insurance schemes in Ghana and Anambra State about potential strategies to expand health insurance coverage among informal sector workers [6].

Monitoring and Evaluation

The NHSDPII was accompanied by a comprehensive monitoring and evaluation plan agreed by all stakeholders involved in the process of developing the plan [16]. Indicators and targets were set covering all of the main areas of health and programming addressed in the NHSPDII. To date the data collected on these indicators, and analysis assessing the progress of the NHSDPII, including a long-awaited Joint Annual Review 'mid-term' review, has not been published. Embedding the use of monitoring and evaluation of the plan in the health policy system requires further attention.

5.0 Limitations and Future Directions

While the priorities for the health system are clear, and the NHIA Act 2022 provides the opportunity to finance improvements, there is a need to modify the Finance Act to generate some of the revenue to support the Vulnerable Fund. The NHIA Act, which is a federal law, should be domesticated in all states for a national implementation of the law. Otherwise, the whole burden of implementing the law, including providing health insurance for 83 million people will be left entirely to the Federal government.

New financing approaches must be undertaken with simultaneous reform of governance and increased probity in the use of revenue. Health is not immune to widespread corruption which affects other sectors in Nigeria. Nigeria needs holistic and participatory accountability systems that not only track supplies and financial management systems, but also the human resources for health required to ensure that available funds are used efficiently, and citizens receive the services they need, when needed.

A critical test of the reforms that are currently in their embryonic stage is whether the newly elected government in 2023 adopts and implements positive changes. Nigeria's last change of leadership allowed the partial implementation of the Health Act 2014 by the previous government. It is possible that future political cycles and the next government will continue and implement these reforms.

Beyond specific health system changes, major population health is only possible with concrete and substantial action outside the health sector which requires an all of government approach.

6.0 Lessons Learnt

The future of health in Nigeria will be determined by the ability of the political leaders to learn from past failures and successes to identity and implement locally appropriate priorities to address the many health challenges faced by the population. Reflecting on the priority setting process for health in Nigeria it is apparent that the process of formulating national development plans such as the NHSDPII (2018-2022) is overly donor-dependent. Without donor funding and co-ordination of the process they may not happen as suggested by lack of a published mid-term review of the NHSDPII or any movement on a new plan that might follow on to start in 2023. Political leaders in Nigeria need to urgently chart a course for locally led and driven policy formulation and implementation with donors playing a supportive role.

Our own experience of the Lancet Nigeria Commission shows the importance of involving the main actors in the health policy space in Nigeria so that, through their ownership of the work, it is taken forward. At the same time, it is important to truly engage the public through a bottom-up consultation process to ensure priority setting is done in a way that sufficiently considers everyone's health needs. Local and national ownership of the policy agenda, engagement with policy makers in formulating recommendations and public engagement are essential to guarantee the success of health prioritisation and ultimate impact on population health.

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