

PERSPECTIVE ARTICLE

Beyond insurance numbers: Why Nigeria's health financing model continues to fail financial protection

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Abstract

Financial protection is a core pillar of universal health coverage and is explicitly captured under Sustainable Development Goal (SDG) 3.8.2. Yet Nigeria remains one of the poorest-performing countries globally on this indicator, despite over two decades of health financing reforms. Less than 5% of the population is covered by any form of health insurance, while out-of-pocket payments account for more than two-thirds of total health expenditure. Consequently, between one-quarter and one-third of Nigerian households experience catastrophic health expenditure annually, with the burden disproportionately borne by the poorest quintiles. This perspective aims to critically examine the structural determinants of Nigeria's financial protection crisis, spanning revenue generation, risk pooling, benefit design, and governance, and to propose evidence-based reform pathways grounded in secondary literature and regional policy lessons. Drawing on national data, global benchmarks, and comparative experiences from peer African countries, including Rwanda, Ghana, Ethiopia, and Kenya, it argues that fragmented, voluntary, and underfunded insurance schemes cannot deliver financial protection in a predominantly informal economy. A shift toward tax-funded, unified pooling with explicit protection for primary care, chronic diseases, and catastrophic illness is presented as the most viable pathway to achieving SDG 3.8.2 and restoring public trust in Nigeria's health system.

Keywords: Financial protection; Catastrophic health expenditure; Universal health coverage; Health financing; Nigeria; SDG 3.8.2; Out-of-pocket payments; Health insurance

1. Introduction

Universal Health Coverage (UHC) is globally recognized as a fundamental goal for health systems, based on the principle that everyone should have access to essential

health services of sufficient quality without facing financial hardship (WHO, 2010; WHO, 2022). Financial protection is not just a side issue of UHC but its core, both ethically and economically, protecting households from impoverishment, distress financing, and long-term welfare losses linked to illness. This principle is clearly outlined in Sustainable Development Goal (SDG) 3.8.2, which measures the share of the population experiencing catastrophic health expenditure (CHE) as a key indicator of progress toward UHC (UN, 2023; WHO, 2022). Despite sustained global momentum toward UHC, financial protection remains elusive in many low- and middle-income countries, where out-of-pocket (OOP) payments continue to dominate health financing (Saksena *et al.*, 2014; WHO, 2010). Evidence from the World Health Organization (WHO) and the World Bank demonstrates that high OOP reliance is strongly associated with increased poverty, delayed care-seeking, and avoidable mortality, particularly among vulnerable populations (Wagstaff *et al.*, 2018; WHO, 2022). Countries that have achieved meaningful reductions in CHE have done so primarily through increased public financing, compulsory prepayment mechanisms, and large, unified risk pools that enable redistribution across income and risk groups (Dieleman *et al.*, 2018; Saksena *et al.*, 2014). Nigeria's experience sharply illustrates the consequences of failing to operationalize these principles. Although the country has formally embraced UHC through multiple policy instruments, including the National Health Insurance Authority (NHIA), State Social Health Insurance Schemes (SSHIS), and the Basic Health Care Provision Fund (BHC PF), financial protection outcomes remain among the weakest globally (Chukwuma, 2023). Less than 5% of Nigerians are covered by any form of health insurance, while OOP payments account for more than two-thirds of total health expenditure, far exceeding the WHO-recommended threshold of 30% (WHO, 2010). As a result, between one-quarter and one-third of Nigerian households incur catastrophic health expenditure annually, with rates exceeding 40% among the poorest quintile (Eze *et al.*, 2022; NPC, 2019). This persistent exposure to health-related financial hardship reflects not only underinvestment in health but also deep structural flaws in Nigeria's health financing architecture. Over the past two decades, reforms have disproportionately emphasized insurance enrollment and institutional proliferation rather than effective risk pooling, equity, and protection against high-cost illness. The resulting system is characterized by fragmented pools, voluntary participation, shallow benefit packages, and weak governance, features that are widely recognized as incompatible with financial protection in predominantly informal economies (Abihiro & De Allegri, 2015; Saksena

et al., 2014). This perspective argues that Nigeria's health financing crisis reflects not a failure of insurance expansion itself, but a failure to prioritize financial protection as the central objective of reform. By emphasizing coverage numbers over household economic outcomes, current policies risk entrenching a system in which illness continues to drive poverty despite nominal insurance gains. Drawing on global UHC evidence and regional policy lessons, the article calls for a conceptual and practical shift from fragmented, contribution-based schemes toward a unified, publicly financed model that prioritizes protection against catastrophic health expenditure. Reframing the national debate from "how many people are insured" to "how many households are protected" is essential for Nigeria to achieve SDG 3.8.2 and uphold the equity promise of universal health coverage.

2. Methodology

This perspective draws on a critical review and synthesis of peer-reviewed literature, national household surveys, and policy documents from the WHO, World Bank, United Nations, and the Nigerian government. Relevant articles were identified through searches of PubMed/MEDLINE, Scopus, Google Scholar, and AJOL, using terms including "catastrophic health expenditure Nigeria," "out-of-pocket payments Nigeria," "universal health coverage Africa," and "health financing reform LMICs," with priority given to systematic reviews, meta-analyses, and empirically grounded policy evaluations published between 2010 and 2025. Comparative evidence from Rwanda, Ghana, Ethiopia, and Kenya was drawn from published program evaluations and health system assessments. The analysis was structured around five dimensions of financial protection: revenue generation, risk pooling, benefit package depth, governance and accountability, and equity in financial burden distribution.

3. Structural financial protection crisis

Nigeria presents a striking paradox: despite being Africa's largest economy by gross domestic product, it invests inadequately in health while relying heavily on private household payments. Government health expenditure has persistently remained below 5% of total government spending, far short of the 15% target set by the Abuja Declaration and below levels associated with meaningful financial protection in comparable lower-middle-income countries (McIntyre *et al.*, 2017; WHO, 2022). In parallel, more than 95% of Nigerians lack effective financial risk protection and depend largely on direct OOP payments at the point of care (WHO, 2022). National household surveys and global estimates consistently indicate that approximately 25–30% of Nigerian households incur

CHE, commonly defined as health spending exceeding 10% of total household consumption (WHO, 2022). Among the poorest quintile, the incidence exceeds 40%, underscoring the regressive nature of Nigeria's health financing system (Eze *et al.*, 2022). Such expenditures frequently compel households to sell productive assets, reduce food consumption, withdraw children from school, or forgo care altogether. Financial hardship linked to illness is therefore not an occasional shock triggered by rare events, but a structural feature of daily life for millions of Nigerians, shaping decisions about when, where, and whether to seek care. These vulnerabilities are amplified by broader socioeconomic inequalities. Urban households with relatively stable incomes may partially cushion OOP payments through savings or social networks, while rural and peri-urban households with precarious livelihoods have little capacity to absorb even modest health costs (Eze *et al.*, 2022). In such contexts, small payments for consultations, diagnostics, or medicines can become catastrophic in practice, particularly when multiple illness episodes occur within the same household over a short period. The multi-dimensional nature of this crisis, spanning income groups, geographic zones, and disease categories, underscores that financial protection failures in Nigeria are systemic rather than episodic.

4. Why insurance expansion has failed

Health financing reforms in Nigeria have largely focused on expanding insurance schemes, yet these schemes remain narrow, fragmented, and exclusionary. The NHIA, multiple SSHIS, and the BHCPF were introduced with the stated objective of enhancing financial protection, but their design and implementation have constrained their impact (Chukwuma, 2023).

First, risk pooling is weak and fragmented. The NHIA program for formal-sector workers, state-level insurance schemes, and the BHCPF operate largely in parallel, with separate governance arrangements, benefit packages, and information systems. Limited coordination and the absence of systematic cross-subsidization prevent effective redistribution of resources across income and risk groups. Global evidence consistently shows that strong financial protection is associated with large, unified pools capable of redistributing from the healthy to the sick and from the wealthy to the poor; Nigeria's current architecture moves in the opposite direction (Saksena *et al.*, 2014).

Second, voluntary and contributory designs structurally exclude the informal sector, which accounts for approximately 80% of Nigeria's workforce (World Bank, 2023). Premium-based enrollment assumes stable incomes, reliable records, and enforceable contribution

mechanisms, conditions largely absent in informal labor markets. As a result, insurance schemes disproportionately benefit salaried workers and public employees, while market traders, casual laborers, and smallholder farmers remain uninsured. Those most vulnerable to CHE are therefore least likely to benefit from existing insurance arrangements (Abihiro & De Allegri, 2015; Eze *et al.*, 2022).

Third, benefit packages are shallow, and cost-sharing remains high. Even insured individuals frequently face copayments, exclusions of essential services, medicine stock-outs, and informal fees charged by providers. Coverage for chronic conditions such as hypertension and diabetes is limited, while high-cost care for cancer or renal failure is rarely comprehensive (Chukwuma, 2023). Under these conditions, insurance status does not reliably translate into financial protection, and households may still incur substantial OOP payments during serious illness.

Finally, fragmented purchasing undermines price and quality regulation. Multiple small purchasers negotiating independently with providers and suppliers have limited leverage to secure fair prices or enforce quality standards. This weakens the protective effect of prepayment mechanisms, as potential efficiency gains are not passed on to households. Collectively, these structural failures mean that Nigeria's existing insurance architecture is not merely incomplete but is architecturally incapable of delivering universal financial protection without fundamental redesign.

5. Out-of-pocket payments as a symptom of system failure

Persistently high OOP spending in Nigeria is less a deliberate policy choice than a marker of systemic failure. It reflects inadequate public investment in health, weak regulation of prices and purchasing, and the absence of effective protection mechanisms for most of the population (McIntyre *et al.*, 2017; Saksena *et al.*, 2014; WHO, 2021). The dominance of OOP payments creates a regressive financing system in which poorer households contribute a larger share of their income to health than wealthier households, directly contradicting the equity principle underpinning UHC (Eze *et al.*, 2022). Evidence from low- and middle-income countries shows that user fees rarely improve efficiency or resource allocation; instead, they deter care-seeking, delay treatment, and worsen health outcomes (Lagomarsino *et al.*, 2012; Saksena *et al.*, 2014). In Nigeria, formal user fees at public facilities coexist with informal charges, particularly where health workers rely on fees to compensate for irregular salaries or inadequate facility funding. For uninsured patients, who constitute the vast majority, private providers often set prices with minimal

oversight, and pharmaceutical mark-ups can be substantial (World Bank, 2023). This creates an environment of cost uncertainty in which fear of unaffordable bills becomes a barrier to early care, reinforcing a vicious cycle of delayed treatment, more severe illness, and higher costs. Nigeria's epidemiological transition further magnifies this problem. The rising burden of non-communicable diseases (NCDs), including hypertension, diabetes, cancer, and chronic kidney disease, imposes sustained, multi-episode costs on households that are entirely incompatible with OOP-dominated financing systems (Jia *et al.*, 2025; Odunyemi *et al.*, 2023). Unlike acute illnesses that generate single, discrete expenditure events, NCDs require ongoing medication, monitoring, and specialist care over years or decades. In the absence of prepayment mechanisms, the financial burden of NCDs is borne entirely by households, frequently resulting in treatment abandonment, avoidable complications, and premature mortality among those who cannot afford sustained care.

6. Governance, trust, and the credibility gap

Weak governance and accountability further undermine financial protection. Delays in fund disbursement from federal to state and facility levels, opaque claims management processes, and inconsistent benefit delivery erode confidence among both providers and beneficiaries (Chukwuma, 2023). The BHCPE, intended to guarantee free or highly subsidized primary healthcare, has been constrained in several states by delayed releases, incomplete transfers, and variable facility readiness, creating a persistent gap between policy intent and lived experience (Chukwuma, 2023). Trust is central to any prepayment and pooling system. Households are more willing to contribute when they believe funds will be managed transparently and translated into accessible, quality care. Nigeria's experience demonstrates how governance failures can neutralize even well-designed financing instruments. When people doubt that contributions will yield reliable services, they rationally opt out, preferring to "pay when sick" despite the heightened risk of catastrophic expenditure (Saksena *et al.*, 2014). This behavioral response to governance failure creates a self-reinforcing cycle: low enrollment reduces premium revenue, which weakens benefit delivery, which further depresses enrollment and public confidence. Moreover, accountability deficits extend beyond financial management. The absence of robust provider payment reform, strong strategic purchasing, and functional grievance mechanisms limits pooling institutions' ability to improve care quality and act as credible stewards of public resources. Strengthening these governance dimensions is

therefore a precondition, rather than a complement, to expanding financial protection in Nigeria.

7. Lessons from African peer countries

Regional experience demonstrates that Nigeria's predicament is neither inevitable nor determined solely by income level. Several African countries facing comparable resource constraints have achieved meaningful gains in financial protection through deliberate policy choices centered on pooling, public subsidies, and strong governance. Their experiences offer directly applicable lessons for Nigeria's reform agenda.

7.1. Rwanda

Rwanda achieved high levels of UHC coverage and substantial reductions in catastrophic health expenditure by consolidating community-based insurance schemes (*mutuelles de santé*) into a unified national pool, heavily subsidized through public revenues and external support, and reinforced by strong accountability mechanisms (Nyandekwe *et al.*, 2020). Community health insurance coverage expanded from under 10% in 2004 to over 80% by 2010, with premium subsidies for the poorest quintiles financed through general taxation (Nyandekwe *et al.*, 2020). The Rwandan model is notable for integrating social solidarity with progressive financing, enabling cross-subsidization across income groups within a single, coherent institutional framework. Critically, Rwanda's success was underpinned by strong political leadership, regular outcome monitoring, and community accountability structures that built public trust in the pooling system.

7.2. Ghana

Ghana's National Health Insurance Scheme, established in 2003 and financed largely through earmarked taxation, specifically a 2.5% national health insurance levy on goods and services, has reduced OOP spending and expanded coverage for vulnerable groups such as pregnant women, children under five, and the elderly, despite persistent operational challenges (Alhassan *et al.*, 2016). Ghana's experience illustrates both the potential and the limitations of tax-financed pooling: while the levy provided a stable and growing revenue base, fiscal pressures, claims management inefficiencies, and provider payment delays have periodically undermined benefit delivery (Alhassan *et al.*, 2016). Nevertheless, the fundamental architecture of compulsory tax financing with explicit exemptions for vulnerable groups remains a stronger platform for financial protection than Nigeria's contribution-based voluntary schemes.

7.3. Ethiopia

Ethiopia has pursued a differentiated approach to expanding coverage, combining community-based health insurance for the rural informal sector with social health insurance for formal-sector workers, while maintaining a strong foundation of government-financed primary health care through the health extension program (Mebratie *et al.*, 2015). Community-based health insurance pilots, launched in 2011 and scaled nationally thereafter, achieved enrollment rates exceeding 50% in participating districts by 2018, with evidence of reduced OOP payments and improved care utilization among enrolled households (Mebratie *et al.*, 2015). Ethiopia's success in reaching informal rural populations, Nigeria's most intractable coverage gap, reflects the value of community-level enrollment systems, government subsidies for indigents, and integration with existing primary care infrastructure. The Ethiopian experience directly challenges the assumption that informal-sector populations cannot be effectively enrolled in prepayment schemes.

7.4. Kenya

Kenya's health financing trajectory offers both cautionary lessons and positive innovations. The National Hospital Insurance Fund (NHIF), Kenya's primary pooling institution, has struggled with fragmented benefit packages, low enrollment among informal workers, and sustainability challenges, parallels that resonate strongly with Nigeria's NHIA (Kazungu & Barasa, 2017). However, Kenya's Linda Mama program, which provides free maternity care financed through government subsidies to the NHIF, demonstrated that targeted cross-subsidization of vulnerable groups within an existing institutional framework can rapidly improve financial protection for high-priority populations (Kazungu & Barasa, 2017). Kenya is also advancing social health authority reforms under the Social Health Insurance Act 2023, which aims to integrate multiple schemes into a unified architecture with mandatory participation, a reform trajectory that Nigeria could adapt to its own institutional context.

8. Common themes and implications for Nigeria

The common thread across these countries' experiences is a strong political commitment to pooling, subsidies, and accountability, rather than reliance on fragmented, voluntary contributory schemes. In each case, meaningful gains in financial protection were associated with:

- Consolidation of risk pools rather than the proliferation of parallel schemes.
- Public financing of premiums or services for informal,

rural, and vulnerable populations.

- Compulsory or quasi-compulsory participation mechanisms.
- Transparent governance with functional accountability to both providers and beneficiaries.

These experiences collectively challenge the notion that Nigeria must wait for higher per capita income before improving financial protection, highlighting the decisive role of fiscal choices, institutional design, and political leadership.

9. From insurance expansion to financial protection guarantees

This perspective advocates for a conceptual and practical shift from "insurance expansion" to "financial protection guarantees." Public spending on health must increase through progressive taxation and health-dedicated levies. This approach treats health as an investment in human capital and social stability, rather than a discretionary expenditure. Incremental increases, explicitly earmarked to subsidize coverage for poor and informal workers, would signal genuine political commitment. Nigeria's persistent underperformance against the Abuja Declaration's 15% target reflects not merely a fiscal shortfall but a governance failure that demands sustained public accountability (McIntyre *et al.*, 2017). Fragmented pools should be progressively consolidated into a unified national financing platform. This platform should align NHIA, SSHIS, and BHCPSF resources under a common benefit package, shared information systems, and clear cross-subsidization rules. While a full legal merger may take time, functional integration through common enrollment systems and coordinated purchasing can begin earlier and yield meaningful gains, as demonstrated by Rwanda and Kenya. User fees for primary care, maternal and child health, and essential medicines for chronic diseases should be eliminated or substantially reduced, with compensating budgetary allocations to frontline facilities. Ghana's exemptions for pregnant women and children offer a directly adaptable model. Concurrently, explicit protection against catastrophic illness is needed to prevent diagnoses of cancer, stroke, or renal failure from resulting in lifelong poverty. National catastrophic coverage funds, reinsurance mechanisms, and dedicated budget lines for high-cost conditions, already operational in Thailand, India, and South Africa, offer concrete design lessons (Lagomarsino *et al.*, 2012). Finally, governance and accountability must be strengthened through real-time fund tracking, routine public reporting, and functional grievance mechanisms. Digital health infrastructure can underpin more transparent administration of pooled funds. Without visible improvements in resource

management, prepayment expansion will continue to face skepticism and low enrollment.

10. Conclusion

Nigeria's failure to achieve financial protection under SDG 3.8.2 is not due to a lack of policy but to policy misalignment. Fragmented insurance schemes, inadequate public financing, and weak governance have produced a system where illness routinely translates into economic catastrophe, particularly for the poorest households. Moving beyond simply increasing insurance numbers toward genuine financial protection will require political courage, fiscal commitment, and institutional reform that place equity and solidarity at the center of health financing. The evidence reviewed in this perspective points to a clear and actionable reform agenda: increase and earmark public health revenues, consolidate fragmented risk pools, eliminate user fees for essential services, establish explicit mechanisms for catastrophic coverage, and strengthen governance and accountability. Regional experiences from Rwanda, Ghana, Ethiopia, and Kenya demonstrate that these reforms are achievable at Nigeria's income level when backed by sustained political leadership and coherent institutional design. Without decisive action, Nigeria risks entrenching health-related poverty for another generation. With it, the country can transform its health system into a foundation for resilience, social justice, and sustainable development, and make measurable progress toward the equity promise that lies at the heart of universal health coverage.

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Conflict of interest

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