The Political Economy of Social Policy in Africa:

The Case of Universal Health Coverage in Nigeria

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Abstract

This PhD study seeks to generate novel insights into how social policy, here in the context of health, has taken form in Nigeria. At the global level, healthcare has been an area of social policy which has received much attention, with African Governments and national and international organisations promoting Universal Health Coverage (UHC) as an important social policy goal. Nigeria offers an interesting case study as it is in the midst of translating its 2014 National Health Act into practice. The Act provides the legal basis for efforts aimed at enabling all Nigerians to access healthcare without financial hardship. Part and parcel of the new law was the establishment of a novel health financing mechanism, the Basic Health Care Provision Fund, put into place to provide sustainable, predominantly public resources for the fast-tracking of UHC. Adopting Fine's "Systems of Provision" (SoP) approach with its emphasis on assessing country- and system-specific structures, I highlight the complexity of health policymaking and implementation in the Nigerian context. I illustrate how a broad range of various agents – which include Federal, State and Local Governments, health professionals, communities, the civil society, the private sector and international organisations – have impacted the final text of the NHAct (to different degrees) and influence the on-going operationalisation of the BHCPF. My research underscores how the combination of Nigeria's federal structure, the dominance of the private sector, the widespread disenchantment with the Government in Nigeria as well as competing views and priorities of international organisations continue to influence Nigeria's perspective in terms of attaining UHC. It also demonstrates how the trajectory of neoliberalism shapes the notion of what universal and integrated social policy is and should entail. In order to generate such insights, material gathered during fieldwork has been triangulated with information gained from various types of documents, including the academic literature as well as strategic, legal and policy documents, action plans, advocacy material of civil society organisations and budget and household survey data.

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List of acronyms

ABU	Ahmadu Bello University
ACE	Anti-Corruption Evidence
ASHIA	Anambra State Health Insurance Agency
BCG	Bacillus Calmette-Guérin
BHCPF	Basic Health Care Provision Fund
BMGF	Bill and Melinda Gates Foundation
BMPHS	Basic Minimum Package of Health Services
BWI	Bretton Woods Institutions
CAP	Change Agents Programme
CBN	Central Bank of Nigeria
CBO	Community based organization
CCT	Conditional cash transfer
CHAI	Clinton Health Initiative
CHE	Current health expenditure
CIPE	Critical International Political Economy
CMC	Christian Medical Commission
COVAX	COVID-19 Vaccine Global Access Facility Alliance
CRC	Convention on the Rights of the Child
CREHS	Consortium for Research on Equitable Health Systems
CRF	Consolidated Revenue Fund
CSDH	Commission on the Social Determinants of Health
CSO	Civil society organisation
DALY	Disability-adjusted life year
DFF	Decentralized Facility Financing
DfID	Department for International Development
DHS	Demographic and Health survey
DPA	Distributable Pool Account
DRG	Diagnosis related groupings
ECOWAS	Economic Community of West African States
EFCC	Economic and Financial Crimes Commission
FCT	Federal Capital Territory
FFS	Fee-for-service
FGD	Focus Group Discussion

FGON	Federal Government of Nigeria
FMCHP	Free Maternal and Child Health program
FMOH	Federal Ministry of Health
FRIS	Federal Inland Revenue Service
FSSHIP	Formal Sector Health Insurance Programme
GAIN	Global Alliance for Improved Nutrition
GAVI	Global Alliance for Vaccines and Immunisation
GBD	Global Burden of Disease
GDP	Gross Domestic Product
GOBI-FFF	Growth; Oral rehydration therapy; Breast feeding; Immunisation; Family spacing; Food supplements; Female education
HERFON	Health Reform Foundation of Nigeria
HFR	Health Facility Registry
HIUOR	Health Insurance Under One Roof
HMO	Health Maintenance Organisation
HPRG	Health Policy Research Group
HPSR	Health policy and systems research
HR	Human Resources
HSRP	Health Sector Reform Programme
ICF	International Finance Cooperation
IEO	Independent Evaluation Office
IFC	International Finance Cooperation
IFI	International Financial Institutions
IHC	International Health Commission
IHME	Institute for Health Metrics and Evaluation
ILO	International Labour Organisation
IMF	International Monetary Fund
LGA	Local Government Area
LGHA	Local Government Health Authority
LMIC	Lower middle-income country
LNHO	League of Nations Health Organisation
LSMS	Living Standard Measurement Survey
MASSOB	Movement for the Actualization of the Sovereign State of Biafra
MCH	Maternal and child healthcare
MDAs	Ministries, Departments and Agencies
MICS	Multiple Indicator Cluster Surveys

MOC	Ministerial Oversight Committee
MSS	Midwives Service Scheme
NAFDAC	National Agency for Food and Drugs Administration and Control
NASS	National Assembly
NBS	National Bureau of Statistics
NCDC	Nigeria Centre of Disease Control
NCH	National Council on Health
NCNC	National Council of Nigeria and the Cameroons
NEEDS	National Economic Empowerment and Development Strategy
NEMSAS	National Emergency Medical Services and Ambulance System
NEMTC	National Emergency Medical Treatment Committee
NEPU	Northern Elements Progressive Union
NGN	Nigerian Naira
NGO	Non-governmental organisation
NHA	National Health Accounts
NHAct	2014 National Health Act
NHIA	National Health insurance Authority
NHIS	National Health Insurance Scheme
NHREC	National Health Research Ethics Committee
NHS	National Health Service
NIEO	Declaration on the Establishment of a New International Economic Order
NIMC	National Identity Management Commission
NIMR	Nigerian Institute of Medical Research
NIN	National Identification Number
NLSS	Nigerian Living Standard Survey
NMA	Nigeria Medical Association
NPC	National Population Commission
NPC	Northern Peoples' Congress
NPHCDA	National Primary Health Care Development Agency
NPHDF	National Primary Healthcare Development Fund
NSC	National Steering Committee
NSHDP II	2018-2022 National Strategic Health and Development Plan
NSHIP	Nigerian State Health Investment Project
NSR	National Social Register
NSSNP	National Social Safety Net Project

NYSC	National Youth Service Corps
OECD	Organisation of Economic Co-operation and Development
OIC	Officer in Charge
OOP	Out-of-pocket (healthcare spending)
PBF	Performance-based financing
PHC	Primary Health Care
PHCUOR	Primary Health Care Under One Roof
PPM	Payment-provider mechanism
PPPs	Public-private partnerships
PSSoP	Public Sector System(s) of Provision
QALY	Quality-adjusted life year
RESYST	Responsive and Resilient Health Systems
SAP	Structural Adjustment Programme
SARS	Special Anti-Robbery Squad
SBIRs	State Boards of Internal Revenue
SDGs	Sustainable Development Goals
SEMTC	State Emergency Medical Treatment Committee
SHIA	State Health Insurance Agency
SHIS	State Health Insurance Scheme/State-supported health insurance scheme
SMOH	State Ministry of Health
SOC	State Oversight Committee
SOML	Saving One Million Lives
SoP	System(s) of Provision
SPHC	Selective Primary Health Care
SPHCDA/B	State Primary Health Care Development Agency/Board
SPIAC-B	Social Protection Interagency Cooperation Board
SSA	Sub-saharan Africa
SURE-P	Subsidy Re-investment and Empowerment Programme
TB	Tuberculosis
TBA	Traditional birth assistants
TMSoF	The Management Secretariat of the Fund
TSA	Treasury Single Account
U5MR	Under-5-mortality rate
UBEC	Universal Basic Education Commission
UHC	Universal Health Coverage

UN	United Nations
UNCTAD	UN Conference for Trade and Development
UNEC	Enugu Campus of the University of Nsukka, Nigeria
UNFPA	United Nations Population Fund
UNGA	United Nations General Assembly
UNICEF	United Nations Children's Fund
UNRISD	United Nations Research Institute for Social Development
WASH	Water, sanitation and hygiene
WDC	Ward Development Committees
WHO	World Health Organisation

INTRODUCTION

1. Introducing my research objective

At the time of writing, the world is more than a year into the COVID-19 pandemic. The long-standing debate of whether healthcare should be a public good or allow for private profit in a "bottom-of-the-pyramid" business model (Prahalad, 2009) has once more been reignited. After the arrival of COVID-19 on the African continent (with Nigeria being the first country to report a case in sub-Saharan Africa), discussions emerged on whether African countries' public healthcare system will have the capacity to absorb the potential number of COVID-19 patients alongside continuing their day-to-day operations.[1] Many African Governments can draw from their vast experiences of dealing with infectious diseases and it is unwise to jump to any conclusion about a general capacity and aptitude of "Africa" to contain the spread of COVID-19. Nonetheless, public healthcare systems across the world, including in Africa – and Nigeria – have been chronically underfunded for many years. In 2018, according to World Health Organisation (WHO) data, no African countries met the Abuja declaration target of allocating 15 percent of Governments' budgets to improving health.[2] In Nigeria, only 4.4 percent of total Government expenditure was spent on health in 2018, falling drastically short of the Abuja target and being amongst the lowest on the continent. Furthermore, in June 2020, despite such low levels of public health funding, the Nigerian Government announced cuts to the public health budget in response to a shortfall of revenue as a consequence of the effect of the pandemic on the economy.[3]

Prior to the on-set of the COVID-19 pandemic, discussions on how to strengthen and improve health systems and facilitate access to health for all were prominent. On a global stage, the WHO called for Universal Health Coverage (UHC) in its 2010 World Health Report "*Health systems financing: the path to universal coverage*" and, in 2012, the United Nations General Assembly (UNGA) adopted a resolution on UHC with the aim of guaranteeing "access without discrimination to nationally determined sets of the needed promotive, preventive, curative and rehabilitative basic health services and essential, safe, affordable, effective and quality medicines, while ensuring that the use of these services does not expose the users to financial hardship with a special emphasis on the poor, vulnerable and marginalized segments of the population" (UNGA 2012). More recently, and responding to the persisting criticism of an on-going fragmentation of national health systems as a

[1] See, for instance: https://www.ft.com/content/be024190-62b5-11ea-b3f3-fe4680ea68b5 (last accessed 14/05/2020).

[2] See: https://apps.who.int/gho/data/view.main.GHEDGGHEDGGESHA2011v (last accessed 04/10/2021).

[3] See: https://allafrica.com/view/group/main/main/id/00073460.html (last accessed 08/06/2020).

consequence of the promotion of vertical global health programs (Fox and Reich, 2015), the UNGA adopted another political declaration in October 2019 pledging the attainment of UHC by 2030.[4]

The Government of Nigeria – presiding over a country with one of the worst-performing healthcare systems in the world – has committed to strive towards achieving UHC. Notably, the publication of the WHO report on health systems in 2000, assessing the performance and ability of a country's health system to improve life expectancy, led to an intensification of civil society-driven advocacy efforts pushing for health sector reform.[5] This finally culminated in the adoption of the 2014 National Health Act (NHAct). Since the 2000 WHO report, similar exercises have been conducted, using different indicators and methodologies (Schütte et al., 2018).[6] For instance, *The Lancet* in 2018 concluded that Nigeria had enhanced its *Health Access and Quality Index* from a value of 27.5 in 1990 to 29.8 in 2000 to 41.9 in 2016, improving its ranking to 142nd out of 180 countries (Fullman et al., 2018).[7] This assessment concentrated on the Global Burden of Disease (GBD) and "death that should not occur in the presence of effective care", but did not include any measure of equity and/or financial risk protection (Fullman et al., 2018, p. 2238). The index, hence, did not take into account Nigeria's extraordinary levels of out-of-pocket (OOP) healthcare expenditures. These are the highest on the African continent (Mo Ibrahim Foundation, 2020, p. 14) and amounted to a staggering 76.6 percent of current health expenditure in 2017 (FMOH, 2019). Accordingly, in today's Nigeria, access to healthcare remains tied to a household's ability to pay and individuals bear the main responsibility to cater for their own health.

Moreover, a look at the most common health indicators demonstrates that the state of health in Nigeria has failed to improve substantially over the past two decades. Today, maternal and child mortality rates remain high and surpass national and international benchmarks. According to the 2018 Demographic and Health (DHS) survey, every tenth child in Nigeria dies before its fifth birthday (132

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[4] This followed a high-level meeting, which had taken place the preceding month. The outcome of the high-level meeting was the adoption of a political declaration on UHC; online available: https://undocs.org/en/A/RES/74/2 (last accessed 29/01/2020).

[5] The 2000 WHO report had ranked Nigeria 187th out of 191 WHO member states. Hence, Africa's "giant", with a population of more than 200 million people, only surpassed the (post-) conflict countries Sierra Leone, Myanmar, the Central African Republic and the Democratic Republic of the Congo (Tandon et al., 2000; WHO, 2000). The report ranked countries based on an overall measure of health system attainment, which is a composite indicator consisting of the five components level of health, health inequality, responsiveness, responsiveness inequity and fairness of financial contribution. For more information, see e.g. Tandon et al. (2000).

[6] Notably, Schütte et al. (2018) have recently reviewed the existing health system performance rankings and indicate the high quality of the 2000 WHO report in comparison with other (less broad) assessments.

[7] Measured on a scale from 0 to 100, 100 being the best value.

children under the age of five per 1,000 live births), with higher under-5-mortality rates (U5MR) in some of the Northern states of the country (National Population Commission Nigeria and ICF, 2019, pp. 164–165). This compares to 47.9 children under the age of five out of 1,000 dying in Ghana.[8] In 2018, only one Nigerian child out of three received all recommended vaccinations and two out of five deliveries did not take place in a health facility, potentially explaining why 31.3 percent of female deaths are maternal (National Population Commission Nigeria and ICF, 2019, pp. 223, 377).

Against the backdrop of this dire state of health in Nigeria, my motivation for this research is to understand the diversity of factors and interests that contribute to creating a social policy environment, which allows for such poor health outcomes and significant health inequities to materialise. I do not seek to investigate the effectiveness and/or challenges of the Nigerian healthcare system as such (i.e., the lack of qualified health personnel or fragile drug supply chains). Instead, my research interest lies in understanding how health policies, which influence the eco-system within which the Nigerian healthcare system takes shapes, are being developed and implemented. More specifically, I am interested in understanding how different agents, context-specific structures, and global processes and narratives affect the design and implementation of the country's newest health legislation, the National Health Act. This, in turn, affects the form UHC is taking in the country.

In this light, I seek to analyse more specifically:

- the extent to which the trajectory of neo-liberalism shapes and changes the conceptualisation of social policy, including views and ideas on how best to design and implement UHC policies in Nigeria, with special attention to the development of the 2014 National Health Act and the implementation of the Basic Health Care Provision Fund (BHCPF), a new Government funding mechanism and one of the Act's main contributions;
- the extent to which context- and system-specific factors, such as Nigeria's history and colonial legacy, its federal governance structure and the organisation of its public sector as well as the lobbying power of different agents and their relationship with each other shape health policy design and implementation across the country;
- the interplay between norms and patterns of healthcare consumption in Nigeria (what do people do?) and views and reflections on these norms and the wider social context that determines healthcare seeking behaviour (what do people believe?), and its impact on UHC policy and implementation.

[8] Data online available at: https://data.unicef.org/country/gha/ (last accessed 13/05/2020).

The objectives of the thesis are then three-fold. First, I seek to understand the context- and system specific factors and processes that have led to the enactment of the NHAct ("policy design"). Second, I aim to gather insights into the dynamics that influence the implementation of the National Health Act, and notably the operationalisation of the BHCPF ("policy implementation"). Third, I wish to discern prevalent patterns and norms of healthcare consumption and to understand the underlying material culture that informs healthcare seeking behaviour ("access/use"). This gives rise to the operational research questions summarised in Table 1.

Table 1: Operational research questions

Main operational research question	
How are universal health coverage policies designed and implemented in Nigeria?	
Subsidiary operational research questions	
Policy design	Q1.) Which factors, processes and agents drove the development and enactment of the 2014 National Health Act as well as the creation of the BHCPF?
Policy implementation	Q2.) Which factors, processes and agents influence the form UHC takes in Nigeria and notably, the operationalisation of the BHCPF?
Access/use	Q3.) What are the different views and beliefs of communities as well as agents involved in the Nigerian healthcare system on accessing healthcare?

These country-specific questions sit within a broader investigation regarding the extent to which changing conceptualisations of social policy (notably, as part of neo-liberal trajectories) shape views and ideas on how best to implement UHC in Nigeria. Health, as an area of social policy, has been exemplary of tensions between the rhetoric of universalism and practices of selectivity. Social policy development across countries heavily depends on politics and the balance of power between supporters of private service delivery and supporters of solidarity-based universalism (Yi et al., 2017). National debates on health system reforms aimed at paving the way to UHC have proven to be "intrinsically political" (Greer and Méndez, 2015, p. 637) and "highly politicised" (Koon and Mayhew, 2013, p. 1). While in the 1970s, a fairer distribution of power and resources across the globe was seen as an integral part of efforts targeted at improving people's health status, as stipulated in the 1978 Alma-Ata declaration on comprehensive primary health care (PHC), more recent calls for UHC "are silent on social determinants of health and community participation" (Sanders et al., 2019) and decision-makers tend to favour a more selective, basic minimum package of health services, reserved for the few (Cueto, 2004).

In this context, this dissertation studies the political economy of social policy in Nigeria by focusing on the development and on-going implementation of the country's 2014 NHAct. The Act provides the legal basis for endeavours aimed at enabling all Nigerians access to equitable and quality healthcare without financial hardship. Paragraph 11 of the 2014 NHAct received wide-spread attention. It mandates the establishment of a novel health financing mechanism – the BHCPF. The Fund was put into place to provide sustainable public resources for the fast-tracking of UHC and has a three-fold purpose. First, the BHCPF funding is expected to be used to provide a defined Basic Minimum Package of Health Services (BMPHS) to the most vulnerable groups of the Nigerian population free at the point of service. It aims to expand access to social health insurance in order to reduce the high levels of out-of-pocket healthcare expenditure in Nigeria. Second, it is expected to strengthen the public primary healthcare delivery system. And, third, it provides public resources to expand emergency medical treatment services. While I do not try to evaluate the impact of BHCPF on health outcomes, I seek to understand and unpack the contestations that characterised the process of developing the NHAct as well as the on-going process of operationalising the BHCPF. Concretely, I aim to discuss how Nigeria's federal structure, the country's socio-economic context as well as the ascendancy of neo-liberalism paired with an attachment to the privatisation of healthcare service delivery influence policymaking and implementation in Nigeria. Moreover, I seek to assess the impact that the shift in global discourse – from genuine universalism to the delivery of selective services for the few – has on Nigeria. Thus, while the adoption of the target of UHC in Nigeria is emblematic of the determination of many governments around the globe to ameliorate healthcare systems and ease households' financial burden in accessing healthcare, Nigeria's pathway towards implementing UHC allows me to examine whether, and if so how, neo-liberal ideology shapes notions of universal and integrated social policy in a specific sector and country-specific setting. The literature to-date has not yet seen an in-depth analysis of efforts targeted at the implementation of the NHAct and/or the BHCPF in the context of a broader study of how social policy, or, more narrowly, UHC in Nigeria is conceptualised, by whom, why and to what effect.

In view of the overarching objective of this dissertation to identify, unpack and understand the key dynamics and aspects that affect health policy design and implementation in Nigeria and that continue to shape the performance of the nation's healthcare system with regard to UHC, Ben Fine's "Systems of Provision" (SoP) approach is adopted. The SoP approach allows to assess how interactions between diverse agents, structures and beliefs on who should be able to access what type of health service (and why) underpin the contemporary Nigerian healthcare system. It also permits to dissect the extent to which its trajectory reflects broader neo-liberal trends of commodification and privatisation of social services (Fine and Leopold, 1993; Fine, 2002a; Bayliss et al., 2016a). Understanding the specific

structures, driving forces and dynamics that can explain why and how health polices in Nigeria are being designed and put into practice is essential to articulate recommendations, aimed at improving the state of health of the Nigerian people. In order to generate such insights, material gathered from four months of fieldwork in Nigeria (January to April 2019) has been triangulated with information gained from various types of documents, including the academic literature as well as strategic, legal and policy documents, action plans, advocacy material of civil society organisations and budget and household survey data. The following section 2 highlights the relevance and timeliness of my research. Section 3 presents the structure of the PhD thesis.

2. Relevance of research and critical reflections on global public health research

With the COVID-19 crisis, the importance of engaging in health policy and systems research (HPSR) with the purpose of identifying and addressing existing public health challenges has been re-emphasised. Yet, the significance of HSPR was acknowledged prior to the pandemic. For instance, the outcome document of a health summit (organised by and for the world's Ministers of Health held in Mexico in 2004) highlighted the importance of "doing research" with the aim of strengthening health systems across the globe and making them more equitable (Remme et al., 2010).[9] In the African context, the "Algiers Declaration on research for health in the African region" and a corresponding implementation framework were adopted in 2008 (Kebede et al., 2014).[10] On the global stage, the WHO continues to promote research for health.[11] Notably the WHO-led Alliance for Health Policy and Systems Research emphasises the importance of investing in knowledge generation on health *policy* and *systems*. Its ambition is to understand how policy guides action aimed at bolstering health systems, while, data on health systems (including on processes, participants, etc.) informs policy:[12]

> HPSR is an emerging field that seeks to understand and improve how societies organize themselves in achieving collective health goals, and how different actors interact in the policy and implementation processes to contribute to policy outcomes. By nature, it is inter-

[9] The outcome document of the summit is available online: https://apps.who.int/iris/bitstream/handle/10665/20384/WHA58_34-en.pdf?sequence=1&isAllowed=y (last accessed 20/09/2020).

[10] The framework for the implementation of the Algiers Declaration is available online: https://apps.who.int/iris/bitstream/handle/10665/92233/AFR-RC59-5%20Framework%20for%20the%20implementation%20of%20the%20Algiers%20Declaration%20on%20Research%20for%20Health%20in%20the%20African%20Region.pdf?sequence=1&isAllowed=y (last accessed 22/09/2020).

[11] See their missions statement on the website here https://www.who.int/health-topics/research#tab=tab_1 and their official strategy here: https://www.who.int/phi/WHO_Strategy_on_research_for_health.pdf (last accessed 22/09/2020).

[12] See: https://www.who.int/alliance-hpsr/about/hpsr/en/ (last accessed 22/09/2020).

> disciplinary, a blend of economics, sociology, anthropology, political science, public health and epidemiology that together draw a comprehensive picture of how health systems respond and adapt to health policies, and how health policies can shape − and be shaped by − health systems and the broader determinants of health.

As illustrated in Figure 1, health systems – as the "institutional basis and expression of health policies" (Mackintosh and Koivusalo, 2005, p. 5) – have commonly been broken down into six interconnected "building blocks". These include (i) service delivery; (ii) health workforce; (iii) information; (iv) medical products, vaccines and technology; (v) financing; and (vi) leadership/governance (De Savigny and Adam, 2009). HPSR is therefore considerably broader than research assessing the functionality of a healthcare service delivery system. It is targeted at offering insights that have "fairly clear **policy relevance**" (Gilson, 2012, p. 32-34; emphasis added). Yet, for Gilson (2012), HPSR does not aim to address questions relating to scientific research on technological or pharmaceutical products, clinical effectiveness or measurement of population health patterns.

My research goal is to understand the interplay between material systems of healthcare provision in Nigeria and the material cultures attached to the "consumption" of healthcare, which are both impacted by broader narratives and global dynamics. Thus, my research endeavour does not include finding technical solutions to clinical problems, but it seeks to anchor an analysis focused on policy in its underpinning factors, structures and norms. I aim to understand the processes and factors that have led to the adoption of the 2014 NHAct (and policies and legislation prior to that) and am interested in understanding the interplay and reciprocal effect of health policy and the emerging **practices** within a health system.

Figure 1: The dynamic architecture and interconnectedness of the health system building blocks

Source: De Savigny and Adam, 2009

My dissertation responds to the prompt of the Nigerian Federal Ministry of Health (FMOH) to intensify context-specific research for health in order "to utilise research to inform policy and programming for improved performance of the health sector and better health outcomes; and to contribute to global health knowledge production".[13] Moreover, part IV of the 2014 NHAct on national health research and information system, mandates the establishment of a National Health Research Committee with the directive of promoting health research on priority issues (as outlined in a national strategy for health research). Following the enactment of the NHAct, a document entitled "National Health Research Policy and Priorities 2014" was made publicly available.[14] The importance of conducting research on the Nigerian health system, e.g. related to "impediments or solutions for scaling-up critical interventions for achieving UHC", as well as research relating to "financial equity in accessing and using services" are key priorities within the strategy (FMOH, 2014, p. 20). Due to my deployment of

[13] See the Ministry's 2018-2022 National Strategic Health Development Plan (FMOH, 2018, p. 94)

[14] The policy is available online: https://drive.google.com/file/d/0B1DAmtM1BcbMZzV4ZGg1dG9QbkJLZ2ZhRmc1QzFINE52NDZn/view (last accessed 22/09/2020).

the SoP approach, which emphasises the importance to link production/provision with consumption, my research fits into several "areas of concern" (see Box 1).[15] Moreover, the National Health Research Ethics Committee (NHREC), also put into place on basis of the NHAct, approved my research project, assuring that it is beneficial to Nigeria and in accordance with certain norms and standards.[16]

Box 1: Research areas of concern

My research contributes to the following areas of concern of the 2014 National Health Research Policy:

- Area (i) on health systems (including issues on PHC, healthcare financing, HR [Human Resources], interventions aimed at achieving UHC, equity, PPPs [Public-private partnerships], accountability, community-based health care)
- Area (viii) on socio-cultural factors in health (including issues such as health beliefs and health care-seeking behaviours)
- Area (ix) on economics and socio-anthropology of health and healthcare (including public finance management and the link between macro-economics and health)
- Area (x) on the social determinants of health
- Area (xiii) on political-economy and institutional assessments in health systems (including questions related to understanding constraints and enabling factors to explain the deployment and use of different health programmes and interventions)
- Area (xiv) on health policies and systems research and analysis (including issues such as system governance, human resources for health, availability of critical supplies and drugs, PPPs, community participation, health financing, service delivery, including factors affecting access and utilization of health services)
- Area (xv) on healthcare financing (including issues on financial risk protection, UHC, national and sub-national health accounts, estimates of health expenditure, health sector reform)

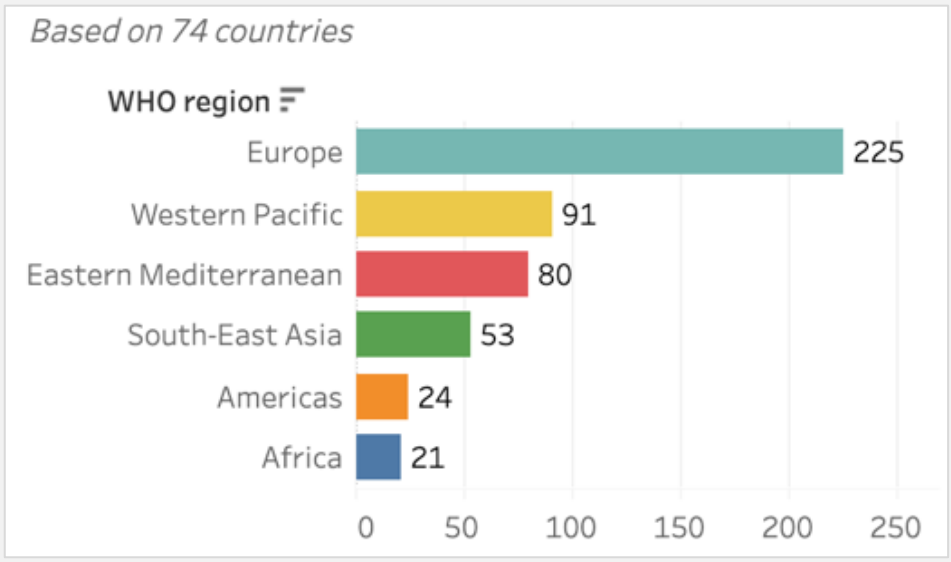
Before I proceed, it is important to reflect on the history of the discipline of global public health and its precursors (colonial medicine, tropical medicine and international health) as well as knowledge production more broadly. According to WHO data, there are ten times more researchers engaging in HPSR (as a share of population) in Europe compared to Africa (see Figure 2). This inevitably leads to bias. According to the latest GBD report, the top five diseases contributing the most to the GBD in

[15] The 2014 National Health Research Policy also makes reference to the contributions of the Nigerian Institute of Medical Research (which is in existence since the 1970s) as well as the important work that many of Nigeria's universities and research institutes are already rendering (FMOH, 2014).

[16] Both committees report to the Department of Health Planning, Research and Statistics within the FMOH.

2019 were neonatal disorders, ischaemic heart disease, strokes, lower respiratory infections and diarrhoeal diseases (Vos et al., 2020, p. 1210). Overall, developing countries, and notably African countries, are answerable for the lion share of the GBD (see Figure 3). Holst (2020) attributes this to the "double burden of disease" that many developing countries are faced with. Sub-Saharan Africa and South Asia regions have to combat both persisting non-communicable diseases persist as well as communicable/infectious, maternal, neonatal and nutritional diseases occur (see Figure 4). Yet, as Figure 5 demonstrates, most of global health research focuses on "high-burden" diseases in high-income countries (Yegros-Yegros et al., 2020). This shortcoming is exacerbated by the fact that, in general, there is disproportionate attention for biomedicine at the expense of research on the economic, political and social conditions, which determine people's health status (Holst, 2020, p. 6).

Figure 2: Number of full-time equivalent health researchers per million inhabitants



Source: WHO, January 2020[17]

[17] Online available: https://www.who.int/research-observatory/benchmarking/researchers_whoreg/en/ (last accessed on 24 November 2020).

Figure 3: Burden of disease, by country, 2017

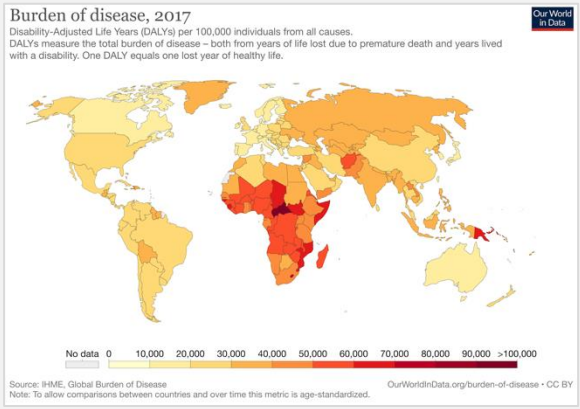
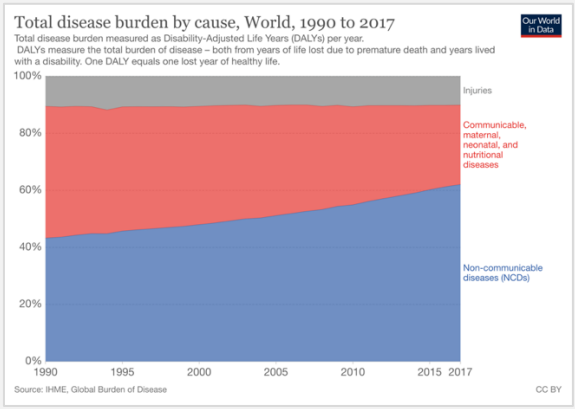
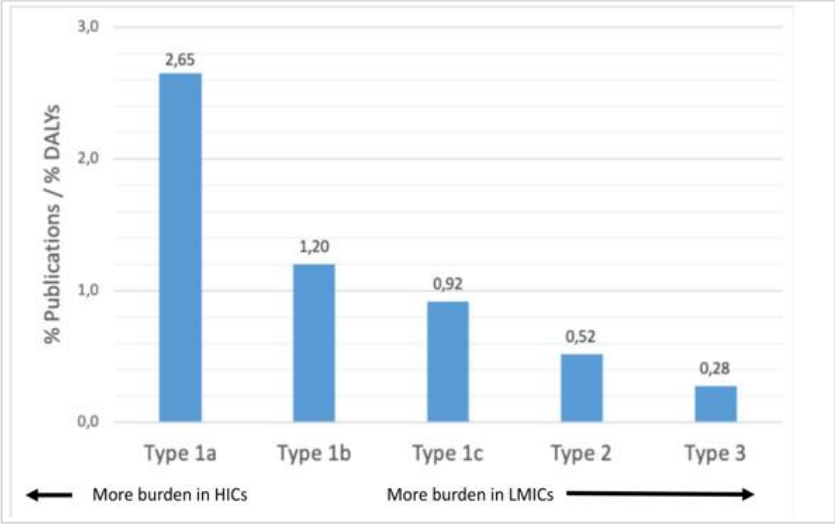


Figure 4: Burden of disease, by cause, 2017



Source: Our World in Data (based on Institute for Health Metrics and Evaluation, Global Burden of Disease)[18]

Figure 5: Relative research effort in relation to disease burden by disease types (see below classification)



Type	Relative disease burden per capita[a]	Description	# Diseases	Exemplary cases
1a	< 0.75	More burden in HICs	34	Colon cancer, breast cancer, Alzheimer's disease
1b	0.75 ≤ x < 1.25	Equal burden	28	Depression, schizophrenia, ischemic heart disease
1c	1.25 ≤ x < 3.00	A bit more burden in LMICs	26	Cirrhosis, stroke
2	3.00 ≤ x < 35.0	More burden in LMICs	22	Maternal conditions, HIV
3	≥ 35.0	Quasi exclusive of LMICs	24	Malaria, diarrhoeal diseases

[a]Relative disease burden per capita is calculated as the ratio of disease burden per capita in LMICs over disease burden per capita in HICs [10]

Source: Yegros-Yegros et al. (2020)
Note: low- and middle income countries (LMICs); high-income countries (HICs)

[18] Online available: https://ourworldindata.org/burden-of-disease#:~:text=At%20a%20global%20level%2C%20in,over%2010%20percent%20from%20injuries (last accessed on 24 November 2020).

The under-representation of research on, and relevant for Africa, more broadly, has also been demonstrated in a recent analysis of peer-reviewed economic journal articles by Porteous (2020). He shows, firstly, that in spite of a drastic increase over the past two decades, the share of articles about Africa in peer-reviewed economics journals (which includes global development journals, with *World Development* leading the list) is still only 4 percent. Secondly, he highlights the uneven distribution of research across countries on the African continent. Porteous' analysis shows that 65 percent of articles, published in the top five journals, concentrate on five Eastern and Southern African countries, all English-speaking (in addition to African languages), namely Kenya, South Africa, Ghana, Uganda and Malawi. Yet, these countries account for only 16 percent of Africa's total population (Porteous, 2020, pp. 2; 8). Across these five countries, "health" is the second most frequent key word (after "policy"). Journal articles on Nigeria are manifold but seem to be less frequently published in top journals (Porteous, 2020).

The disparate attention to diseases that impact African countries proportionately more, has once more become obvious with the spread of the COVID-19 virus on the European continent. Infectious diseases that predominantly affect lower-income regions (i.e., malaria, HIV/Aids, Ebola, etc.) have not received the same interest, as we see Governments in the Global North reacting to the on-going COVID-19 crisis. The pandemic also highlights that the field of global health itself is not a "unified field" (Lakoff 2010, p. 59). Lakoff distinguishes between two different regimes within global public health: global health security concerned with cross-border threats to health (mainly concerned with keeping wealthy countries safe from infectious disease emanating from the Global South) and humanitarian biomedicine, which focuses on "alleviating the suffering of individuals, regardless of national boundaries or social groupings" with a particular focus on developing countries (Lakoff, 2010, p. 60). While industrialised countries are believed to have passed through an epidemiological transition, where ill-health is more likely to occur as a result of old-age and lifestyle than because of exposure to an infectious pathogen (O'Laughlin, 2016, p. 659), COVID-19 has highlighted how, in a globalised world, global health inequalities are dangerous for everyone. In a similar vein, Holst (2020, p. 2) emphasises that "acute epidemic outbreaks are often seen to be a symptom of globalisation, while Global Health tends to ignore and conceal long-term diseases like tuberculosis and the structural causes of bad health and health inequalities".

Holst furthermore makes the link to the origins of "global health", tracing it back to colonial medicine in the 19th and early 20th centuries and later tropical medicine, concerned with "preserving the health of the European colonial rulers and protecting them from the health hazards of tropical diseases". Similarly, Manton (2011) has highlighted that tropical medicine emerged at the end of the 19th century as a platform to discuss and conduct research relating to clinical and sanitation issues pertinent for

Europeans living in African and Asian colonies. At the beginning of the 20th century, colonial and tropical medicine metamorphosed into international health, notably with the establishment of the International Health Commission (IHC) by the Rockefeller Foundation in 1913, which concentrated on (mostly self-interested) disease control interventions, such as the hookworm or yellow fever campaigns (Packard, 2016). Holst (2020, p. 3) also accentuates that there was a push by high-income countries to put in place a worldwide system of infectious disease control, "mostly driven by their own security interests". Since then, international health, which, throughout the 2000s, was replaced by global (public) health (and even more recently, planetary health), maintains its commitment to global health security, often to the detriment of its mandate of humanitarian biomedicine and the wider need to address global structural inequalities determining health inequities (Holst, 2020; Lakoff, 2010; O'Laughlin, 2016).

For Affun-Adegbulu and Adegbulu (2020), the legacy of colonialism, which was accompanied by "processes of dehumanisation and othering", remains palpable in global public health today. During the period of colonial domination, European colonial powers, rooted in racist beliefs, made use of Africa and Africans for their medical experimentation (aside from causing ill-health amongst African due to colonial exploitation, including, for instance, through forced work in mines) (Tilley, 2016). Recent remarks by French medical researchers – suggesting to test to what extent the Bacillus Calmette-Guérin (BCG)/tuberculosis vaccine could protect people from COVID-19 in Africa "where there are no masks, no treatment, no intensive care"[19] – reminded many of a such an attitude (Affun-Adegbulu and Adegbulu, 2020, p. 2). Moreover, the rather widespread astonishment about lower rates of COVID-19-related casualties on the African continent and the disbelief that this, to some extent, may have been the result of appropriate and timely policy response by (some) African governments furthermore demonstrates the persistence of attitudes of Western superiority.

Finally, the COVID-19 pandemic is demonstrating the consequence of the world's interconnectedness and the form globalisation has taken over past decades, highlighting and exacerbating existing inequalities that result and are reproduced under the current capitalist international economic world order.[20] While African countries may not have had similar headcounts of people dying from COVID-19, *per se*, the economic impact of the crisis is hitting lower-income countries hardest, and within

[19] Verbatim, Dr Jean-Paul Mira, exchanging with Professor Camille Locht, was reported to have said: "If I can be provocative, shouldn't this study be done in Africa, where there are no masks, no treatment, no intensive care, a bit like it is done in some studies on AIDS or among prostitutes. We try things because we know they [sex workers] are highly exposed and they don't protect themselves. What do you think about that?" (See, for instance https://hbr.org/2020/09/white-coats-black-scientists [last accessed 25/11/2020]).

[20] Also see Stevano et al. (2021) for a discussion on how COVID-19 has exposed the systemic shortcomings of capitalism.

these countries, the most disadvantaged people. Capital outflow, production and supply chain disruptions, mounting debt and imposed austerity measures are likely to have a detrimental impact on people's health status, their livelihood and well-being. Moreover, the reality that, as an example, the pharmaceutical company *Pfizer* sold 80 percent of its vaccine doses, which it is able to produce until the end of 2021, to mainly rich governments within days of announcing the existence of an effective vaccine – in spite of clear instigation by civil societies across the globe to ensure a fair and just distribution of a potential COVID-19 vaccine (which culminated in the establishment of the COVID-19 Vaccine Global Access Facility Alliance [COVAX]) – is a blatant demonstration of the unwillingness of rich nations to make public health truly "global".[21] While rich nations in the West continue to stockpile vaccines and expand their vaccination plans to younger and younger segments of the population, most of the most vulnerable people in the Global South remain without access to the life-saving vaccine.[22] Health policy and systems research needs to account for the reality that national healthcare systems are embedded within a capitalist world economy with its attendant global power structures. Concentrating my analysis on the Nigerian health system alone, without acknowledging the pressures from the "outside" world on the form and shape the system takes would be incomplete – a consideration embedded within the SoP approach.

3. Structure of dissertation

This PhD proceeds as follows.

Chapter 1 documents contemporary trends within social policymaking. I illustrate how the scope of social policy has narrowed over time, with social assistance programmes nowadays being favoured over more comprehensive forms of social policy. I argue that, overall, social service delivery has been subject to privatisation with the ascendency of neo-liberalism. I highlight the existing contestations relating to the understanding of what social policy is and point to two main "strands" within the debate: the so-called instrumentalists, who see social policy as a tool to reduce poverty and a means to promote economic growth, and the activists, who are proponents of a human rights-based approach to the different dimensions of well-being. Subsequently, the chapter moves on to provide an overview of the relevant literature discussing the evolution of welfare states (and their retrenchment). With an initial focus on the European context, I survey theories according to which

[21] See, for instance, Ghosh's analysis of a looming "vaccine apartheid": https://www.project-syndicate.org/commentary/pfizer-vaccine-doses-claimed-by-rich-countries-weakens-covax-by-jayati-ghosh-2020-11 (last accessed on 25/11/2020).

[22] See for instance here: https://apnews.com/article/coronavirus-vaccine-inequality-dac9c07b324e29d3597037b8dc1d908a (last accessed 25/07/2021).

welfare states emerged as a consequence of industrialism, were the outcome of class struggles or a result of historical institutionalism and/or power relations. I then explore contributions that make the link between the rise of neo-liberalism on the one hand, and the contraction of welfare states and expansive social policy on the other hand. I then move on to review concepts and theories that account for social policy trajectories in countries of the Global South, and Africa in particular. Many of Africa's post-colonial states sought to promote social policy as a way of facilitating social cohesion and nation-building and in order to create inclusive states. Still, the rise of neo-liberalism significantly shaped and influenced their particular practices. Finally, I introduce Ben Fine's SoP approach as the theoretical framework, which stands out amongst the various theories seeking to explain social policy trajectories as an apt guide for my analysis of the Nigerian healthcare system. A crucial benefit of the SoP approach is that it encourages and facilitates a context- and system-specific analysis, helping to understand how contextual factors and structures determine consumption outcomes in a specific setting. Moreover, it takes account of both social dynamics and constructs as well as global trends, such as globalisation and neo-liberalisation, which impact processes and narratives as well as the meaning that participants within a system of provision attach to the consumption of a specific good and/or service. Thus, in this last section of Chapter 1, I present the key tenets of the SoP approach, trace its origins and document its adaption to examine public provision and consumption.

Chapter 2 focuses on health policy, with healthcare as a fitting example of the broader trend of the narrowing scope of social policy and the associated marketisation and commodification of social services. Through a historical account, today's calls for UHC and practices of implementing a basic minimum package are contrasted with previous conceptions of health as a human right. I present some of the political and economic factors that may help explain the degree of universalism of different health systems as well as policy makers' willingness and ability to assure access to healthcare for all.

In **Chapter 3**, I argue for the applicability of the Systems of Provision approach to researching the Nigerian healthcare system of provision, with a particular focus on the policy-making sphere and in light of making a contribution to the social policy literature. In this chapter, I furthermore present my research methodology and I outline the research methods I have employed, notably providing information on my fieldwork research in Nigeria.

The following three chapters (4 to 6) present the findings of my primary research, discussing how health policies are designed and implemented in Nigeria in view of understanding who accesses healthcare in Nigeria, how and why. I investigate the factors, interests and processes that drove the enactment of the 2014 NHAct, including its paragraph on the establishment of the BHCPF, and have driven health policy development since the 1950s. At the same time, I inquire which structures and

elements impact policy implementation (with a focus on the factors affecting the operationalisation process of the BHCPF) and, hence, obstruct or further the attainment of (a form of) UHC. To present a coherent analytical picture, I report the findings from my empirical research as follows.

First, **Chapter 4** presents the state of health and healthcare in Nigeria in view of laying the groundwork for my research endeavour, which is to understand the country- and system-specific processes, structures and interests that underpin the way UHC policies are designed and implemented in Nigeria. It consists of three sections. First, I document who is accessing and consuming healthcare in Nigeria, where and with what effect. Specifically, I present health outcomes trends and highlight prevalent health inequities. Second, I outline how the Nigerian healthcare system of provision, underpinning these health outcomes and inequities, is organised and funded. Third, I present prevalent healthcare consumption norms and patterns, highlighting how they are the result of the interconnectedness of, on the one hand, the material structures that constitute the Nigerian healthcare system of provision with, on the other hand, the meaning Nigerians attach to healthcare consumption. This enables me to single out and present the agents of significance, who are majorly involved in the Nigerian healthcare system of provision and who affect health policy design and implementation in Nigeria. This, then, is the foundation on which Chapters 5 and 6 proceed in their investigation of the development of the NHAct and the implementation of the BHCPF as its important cornerstone.

In **Chapter 5**, I place the design and passing of the National Health Act and its mandate to create the BHCPF in the broader context of social policy development in Nigeria to better understand the scope to implement UHC today. I pay particular attention to how the country's socio-economic, political and historical context and a set of structures and processes impact how the agents of significance relate to each other and influence Nigeria's health policymaking trajectory. I highlight that the British colonial power accorded little priority to elevating the health status of Nigerians during its rule, but argue that, after its departure, newly elected political leaders emphasised the provision of adequate levels of healthcare in view of fostering social cohesion and investing in its citizens. I demonstrate that the ascendency of neo-liberal thinking in the West coincided with a sharp decline in oil revenues in Nigeria, contributing both to the adoption of more regressive social policies and a drop in funding for healthcare. I maintain that the power relations between different interest groups within the healthcare system, which manifested themselves throughout the second half of the 20th century, are crucial explanatory factors for why the adoption of the final text of the NHAct took more than a decade of work and leaves room for ambiguity as to how UHC will be attained.

In my last results chapter, **Chapter 6**, I concentrate on analysing the interplay between the various agent and how the identified set of structures and processes contributes to creating contestation with regard to how to best implement the NHAct. In the face of understanding the processes, structures,

agents and their relations influencing the form that UHC is taking in Nigeria, I accord particular attention to the BHCPF and on how its implementation is expected to improve primary healthcare delivery and access to healthcare in Nigeria. I discuss its proposed structure and set-up, the process of elaborating operational guidelines for its implementation and argue that Nigeria's federal structure, the country's economic performance, the dominance of the (non-for-profit and for-profit) private sector as well as the promotion of a narrow view of social policy and UHC by international development agencies (and parts of the interlinked political elite) heavily contribute to creating a policy landscape that allows for the continued fragmentation and underperformance of the country's healthcare system.

Finally, in the **Conclusion**, the main contributions and most significant findings of this research are summarised, while pointing at limitations as well as avenues for future research. I highlight that, from early on, a strong private sector lobby intervened to encumber more universal health policymaking and that continuous underfunding has left a vacuum for the private sector actors to fill. I maintain that, for Nigeria, as it is structured today, to improve its health outcomes sustainably and to tackle health inequities, sub-national level Governments need to work more closely with the Federal Government to create social policies focused on truly fostering **public** service delivery. This requires adequate funding and an effort to re-build trust in public service delivery. In this light, there is need to recognise that health policy, and social policies more generally, form an essential part of a coherent development policy for Nigeria and need to be integrated into economic policymaking and implementation. Lastly, it is essential to ensure the production of scholarship and evidence that backs the formulation and operationalisation of progressive and universal social policies in lieu of policies promoting more narrow forms of social protection.

CHAPTER 1 | Global ideas of welfare and the narrowing scope of social policy

1. Introduction

In the early 2000s, "social protection" re-appeared as a "buzzword" in the international development discourse, and became actively promoted as a new global public policy to address poverty (Hickey and Seekings, 2017, p. 9). In response, the dynamics and factors explaining the increased attention to social protection since the early 2000s have been discussed broadly in the scholarly debate. According to Barrientos and Hulme (2009), social protection evolved as a "quiet revolution" and, in line with Hanlon et al. (2010), social protection seems to have emerged as an alternative to "the neoliberal economic model", but also "the Northern model of social protection". Similarly, for (de Haan, 2011, p. 3), social protection appears to have served as the "ideal vehicle for addressing the critique of the impact of structural adjustment". Other scholars, for instance, Peck and Theodore (2015), point out that the rising popularity of social protection as a policy instrument is the consequence of "a global process of policy reform" led by the World Bank, highlighting the dominance of the World Bank in shaping development policy.

Yet, the newfangled global attention on scaling up social protection initiatives in low-income countries needs to be treated with caution. Upon closer inspection, the notion of what universal and integrated social policy entails seems to have narrowed significantly. Certain social policy dimensions such as free and affordable health care for all, which, in the 1950s and 1960s, were deemed essential to improving human well-being, only marginally figure in today's policy discussions. Today, projections of social policy, including by the International Financial Institutions (IFIs), tend to favour residualism. This promotes social protection programmes based on means-tested targeting, income transfers directed at the poor and the imposition of conditionalities. This differs from more universal transfers (such as universal pensions for the elderly, child grants or disability benefits) or policies (Lavinas, 2017). In many instances, social protection programmes take the shape of residual social assistance schemes, narrowing the initial universal scope of social policy. Today's focus is often on income-targeted social assistance schemes, such as conditional cash transfer (CCT) programmes, which have become "the primary – and sometimes the only – social protection instrument addressing poverty and vulnerability" (Barrientos, 2011, p. 243). Fine (2009, p. 3), for instance, emphasises the regressive impact of neo-liberalism "on income distribution and … [its] antipathy to social policy in deference to individual and market responsibility". As a result, all-encompassing social policies, addressing broader dimensions of human well-being, reaching beyond the immediate relief of poverty, are nowadays largely being disregarded. More broadly, this trend seems to reflect the "impoverishment" of the concept of development itself (Fischer, 2018; Harris-White, 2006). Today, development is understood as poverty alleviation and deliberations of wider social and economic transformation receive limited

attention. Adesina (2020) underscores that the "proclamation of social assistance, in the form of means-tested cash transfers, as a 'quiet revolution' in the global South or a 'development revolution' … is conclusive evidence of the 'impoverishment of the concept of development'".

Thus, while, more recently, there have been formal pledges to universalism, e.g. via the Social Protection Floors Recommendation and the adoption of the Sustainable Development Goals, such wider formal commitment to universal social protection seems to reflect the narrowing of the scope of social policy more generally (Adésínà, 2015; Lavinas, 2017; Martinez Franzoni and Sanchez-Ancochea, 2016; Mkandawire, 2011). According to Fine (2012, p. 23), the World Bank, in particular, is responsible for discrediting the welfare state, which had been characterised as "the embodiment of universalism". Similarly, Fischer (2018, p. 222) emphasises that "the strongest influence on this shift of meaning probably comes from the World Bank, which explicitly takes the position that universalism is achieved as long as everyone has access to something, **regardless of how this is provided**" (emphasis added). The World Bank is commonly perceived as opposed to a comprehensive welfare state and of "[falling] short of any commitment to universalism or social justice" (Kabeer, 2014, p. 339). However, nowadays, also the new policies of once traditional proponents of a human-rights based, comprehensive social security system and inclusive social policies that cover a multitude of contingencies (such as the International Labour Organisation, ILO) often disregard the broader range of available social policy instruments.

In this light, it becomes clear that in spite of the notion of social protection as an "ideal concept for the consensus-oriented aid industry" (de Haan, 2011, p. 3), there is no clear agreement on what exactly social protection, or social policy, is (according to whom) and how its functions can be defined. In addition, apart from differences between development actors, an internal consensus within different international organisations is often missing with each agency having both "a more 'economistic' and a more 'social' face, depending on who represents the agency" (Voipio, 2007, p. 54). Nonetheless, the disregard of the broader range of available social policy instruments has been criticised. And, in response to the tendency to focus on narrow forms of social protection, Adésínà (2015, p. 100) has called for a "return to a wider vision of social policy" and pleads for the "recognition of the multiple tasks of social policy – production, protection, redistribution, reproduction, and nation-building/social cohesion".

This chapter examines the rise of social protection in the international development discourse and reviews how social policy has traditionally been analysed within the literature (both within development studies and beyond). Against the backdrop of the shrinking scope of social policy, section 2 argues that to the present day, there is no consensus on what social policy is, which programmes, instruments and systems it should entail and to what extent and under which conditions it should be

offered. No commonly agreed definition of social policy prevails, and development actors continue to use a plurality of terms interchangeably (social protection, social assistance, etc.). Section 3 contends that the understanding of social policy and its functions strongly depend on underlying ideological positions as well as political and economic interests of development organizations and national governments, which implement different policies in practice. Notably, two distinct ideological positions are identified. On the one hand, proponents of the instrumentalist position consider social policy as a means to achieve economic growth and to manage socio-economic risks of the poor. On the other hand, advocates of an activist position comprehend social policy as a human right for all citizens and not only a residual group. Section 4 turns to an exploration of the existing literature on the evolution of welfare and social policy. The main aim is to review the existing scholarship in order to understand the possible elements that need to be taken into account when analysing social policy development in the Nigerian context. The section examines factors explaining the emergence of Keynesian welfare states in post-war Europe as well as their retrenchment with the ascendency of neo-liberalism throughout the 1980s. This is followed by a review of the literature analysing social policy trajectories and trends within countries of the Global South, and on the African continent especially. Against this backdrop, I single out the Systems of Provision approach as an apt analytical framework to guide my analysis of how social policy takes form in Nigerian in the context of health (section 5). In this sense, the analysis of health policymaking and implementation in Nigeria, which conditions (and is conditioned by) the Nigeran healthcare system of provision, serves as a lens on social policy making and implementation in an African context. I lay out the origin, theoretical background and key characteristics of the SoP approach, including an overview of the evolution of the SoP approach from a framework focused on private and commercialised consumption to a theory incorporating public consumption (previously often disregarded by consumption theorists as social policy). I discuss the five "fundamental" elements of SoP research and highlight its anchoring in Critical Political Economy. Section 6 concludes that, in practice, the scope of social policy has narrowed since the 1950s and that, in a broad field of theories exploring social policy developments, the Systems of Provision approach stands out, mainly due to its attachment to an investigation of system- and context-specific determinants.

2. Social policy and social protection: a contested terrain

Despite the rising popularity of social protection in the international development discourse, there is no consensus on what social protection refers to, nor on how it should be operationalized. No common definitions of social policy or social protection are available and several terms (such as social security, welfare, social entitlements, etc.) are in use. Midgley (2012, p. 8) highlights that "no generally accepted, standard definition of the term [social protection] has yet emerged. In addition, a large

number of synonyms for social protection are currently in use". The concept itself is elastic and employed differentially across a spectrum of stakeholders (Drolet, 2016, p. 76; Midgley, 2012, p. 8; Standing, 2007a, p. 521). Scholars, such as Standing (2007b, p. 512), emphasize the importance of distinguishing between different terms, arguing that e.g. welfare, social security and social protection should not be used interchangeably. According to him, social protection is the broadest term, encompassing the "full range of protective transfers, services, and institutional safeguards supposed to protection the population 'at risk' of being 'in need'". For Standing, social security only covers state-based entitlement systems guarding against unforeseen threats, while the term welfare state is used differently depending on the country context, but is generally understood to be targeted at promoting happiness, social justice, income equality or equal life chances (Standing, 2007a, pp. 512–513). He argues that in most low-income countries, the main focus has been on expanding social assistance programmes in order to remedy the gap in social insurance and contributory social security schemes, which primarily served civil servants in the formal sector who are able to contribute to these schemes (Standing, 2007a, p. 515). Another view is presented by Midgley (2012, p. 10), who highlights that that there is broad spectrum of terms in development discourses, including "social security, economic security, income security, income protection, income transfers, cash transfers, transfer payments, social transfers, tax funded benefits, entitlements, and welfare among others". He contends that social protection only gained popularity recently: "for many decades, social security was preferred and most academic literature as well as official documents and international conventions referred to social security rather than social protection" (Midgley, 2012, pp. 9–10).

In turn, according to Fischer (2018), social policy encompasses social protection, with the latter consisting of social insurance programmes, social assistance programmes and labour market regulations as proposed by Townsend (2009).[23] While social insurance is based on work-related contributions along the life-cycle, social assistance is financed by tax revenues and addresses the needs of selected segments of the population, subject to poverty, vulnerability and social exclusion most directly (Freeland, 2013, p. 25). In Western countries, social assistance programmes cover only a very small minority of the population. In developing countries, however, social assistance is the standard social protection instrument to address vulnerability and poverty (Barrientos, 2011, p. 243). Nonetheless, for Fischer (2018, p. 227), inspired by the body of work of Thandika Mkandawire, the prime focus on social protection in international development is misplaced, as it constitutes only a part of social policy. A similar view is reflected in the definition of social policy provided by Mackintosh

[23] Additionally, O'Brien et al. (2018) list social care, alongside social assistance, as a distinct form of non-contributory social protection.

and Tibandebage (2004, p. 143), who resort to a broad definition of social policy, conceiving it as the entirety of "governmental and non-governmental public action [shaping] social provisioning such as health and education". As a result of the vast variances in conceiving what social policy and/or social protection is and the interchangeable use of these different terms, there is no consensus on its scope, main objectives, instruments or best practices.[24] However, generally, an emphasis on public interventions to address poverty and vulnerability is reflected in most established definitions of social protection. Furthermore, many definitions of social protection propose measures to promote resilience against shocks. Often, this is based "on the understanding that a primary cause of persistent poverty is to be found in the constraints faced by the poor in taking advantage of economic opportunity, which can be explained, to a great extent, by their vulnerability to the impact of economic, social and natural hazards" (Barrientos, 2011, p. 2).[25]

Other scholars provide broader and far-reaching definitions of social policy. Mkandawire (2001, p. 1) has continuously criticised the conception of social policy as a residual social safety net, strongly advocating for the importance of social policy to address overall concerns of social development **in coherency with economic policy**. He urges caution regarding the tendency of making economic development the sole concern of social policy, which he deems "undercuts the intrinsic value of social policy" (Mkandawire, 2011, pp. 150–152).[26] Hence, while a multitude of existing definitions of social policy, social protection, social assistance, social security, etc. exist, I deem the United Nations Research Institute for Social Development's (UNRISD) understanding of social policy (based on Mkandawire (2001), and also more in line with Fischer's broader conception of social policy encompassing social protection) the most relatable. I hence adopt their definition of social policy as

> state intervention that directly affects social welfare, social institutions and social relations. It involves overarching concerns with redistribution, production, reproduction and protection,

[24] Notably, Midgley discusses the extent to which the variety of definitions and terms may be a challenge for research and policymaking. One the one hand, he reflects that "academics [may] need to agree on basic terminologies if they are to communicate effectively and undertake research that can inform policy" (Midgley, 2012, p. 10). On the other hand, "[t]here may be merit in using a broad umbrella term to connote a category of interventions rather than specific programs. In this sense, social protection refers not to a particular type of intervention but to a category of interventions. Attentions would then be focused specifically on particular programs that are easier to define. For example, there is much more agreement among scholars about the definition of social assistance, food for work, and tax credits than there is about the meaning of social protection" (Midgley, 2012, p. 11).

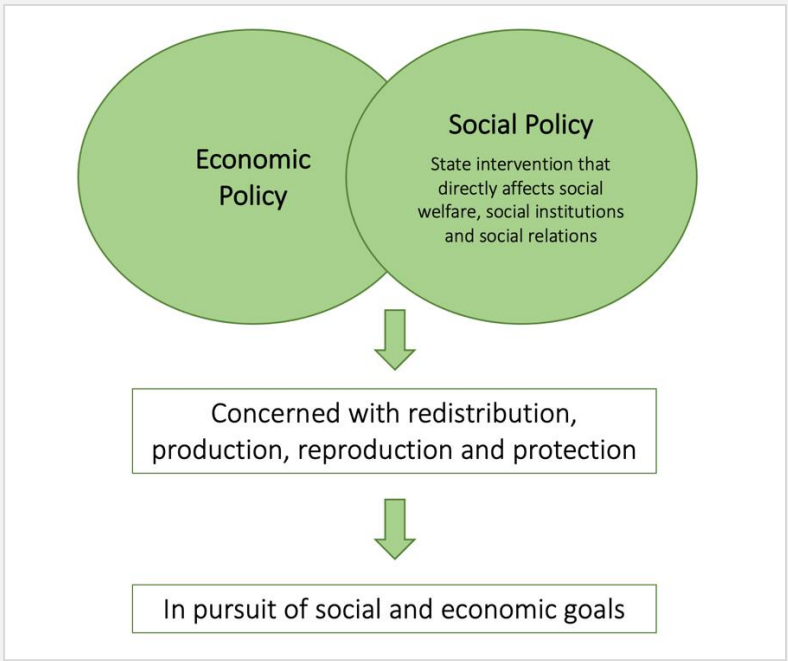
[25] Appendix A provides an overview of selected definitions.

[26] Yeates (2018, p. 1) adds that this entails "actions by governments and non-governmental organizations (NGOs) supportive of the right to the means of social participation. This right is underpinned by services and arrangements to ensure an adequate income, a relevant education, affordable housing, a healthy existence and a sustainable livelihood".

and works in tandem with economic policy in pursuit of national social and economic goals. Social policy does not merely deal with the "causalities" of social changes and processes; it is also a contribution to the welfare of society as a whole (UNRISD, 2006, p. 1).

Here, the criticality of the interplay between (and overlap of) economic and social policy for development (understood as social and economic transformation rather than poverty alleviation) is stressed, drawing on contributions by Elson and Cagatay (2000) and Chang (2004), who have highlighted that the dichotomy of social versus economic policy is misplaced altogether. As outlined by Mkandawire (2001, p. 6) and UNRISD (2006, p. 1), social welfare is concerned with access to adequate and secure livelihoods and income and requires social policy interventions, targeting redistribution, addressing unemployment and guaranteeing access to education and healthcare. At the same time, social policy interventions can also seek to transform class, race, or gender or other social relations. Lastly, social policies can also serve as instruments to determine social norms and institutions, shaping the "rules of the game"[27] that guide human interaction and regulate the roles of public and private agents involved in social provisioning. Figure 6 illustrates how social policy and its functions are understood in the context of this PhD research.

Figure 6: Definition and conceptualisation of social policy



Source: Own illustration (inspired by Mkandawire, 2001 and UNRISD, 2006)

[27] This term was coined by North (1990).

While I consider social policy to be the broader category, encompassing social protection measures (such as social insurance, social assistance, labour market regulations, and social care) alongside other interventions promoting well-being and social welfare, many scholars continue to use these terms interchangeably and, in today's international development discourse, the term "social protection" is employed more widely. This poses a difficulty to any effort to harmonise or standardise the use of terms across the next sections. I hence propose to use the terms interchangeably.

3. Social policy in practice: activism versus instrumentalism

With contested definitions and conceptualisations of social policy, different policies have been promoted in practice. Two particular positions stand out. On the one hand, advocates of social protection as a human right promote inclusiveness and universal schemes along the life cycle (the activist position). On the other hand, proponents of a charity-based paradigm conceptualize social protection as a residual and targeted approach to tackle poverty with the aim of furthering economic development (the instrumentalist position). This section turns to a discussion of these two positions and highlights how the trajectories of neo-liberalism have impacted how the conceptualisation and practices of social policy have evolved over time. I base my understanding of neo-liberalism on Brenner et al. (2010, p. 4), who assert that "in the most general sense, neoliberalization denotes a politically guided intensification of market rule and commodification" while highlighting the "variegated" character of neoliberalism.[28]

In principle, the integration of social protection within the 2030 Agenda for Sustainable Development as well as the broad support for the ILO's Social Protection Floors Recommendation and the ILO and World Bank co-headed Social Protection Interagency Cooperation Board (SPIAC-B) convey that a majority of development partners agree that the purpose of social protection exceeds smoothing consumption and alleviating short-term poverty. In practice, however, different ideological positions to social protection/social policy persist – "from macroeconomic stabilizer to humanitarian response; from risk management to promoting social justice" (Gentilini and Omamo, 2011, p. 329). Furthermore, within these different paradigms, the scope of social policy has narrowed.

[28] Similarly, Fine (2012b) highlights the "diversity and complexity across time, place and issue" and thus the "lack of distinctiveness" of neo-liberalism.

For Deacon (2007), development agencies that promote different practices of social protection have engaged in a so-called "Gramscian war of position".[29] In the 1990s and 2000s, this war over ideological hegemony has most distinctively been carried out between the World Bank and the ILO. Indeed, Devereux et al. (2015) identify two potentially contradictory directions within social protection debates. The activist and rights-based approach to social protection emphasizes that all citizens are entitled to social protection benefits. The instrumentalist and growth-oriented approach perceives social protection as a tool to reduce poverty and boost economic growth (Devereux et al., 2015, p. 7). Instrumentalists understand poverty as a hindrance to efficient development and, thus, see social protection as a way of managing risks – until the market allows for private insurance against such risk (Devereux and Sabates-Wheeler, 2007, p. 1). In contrast, rights-based approaches perceive poverty and vulnerability as symptoms of structural inequities and social injustices and advocate for the social protection as every citizen's right (Devereux and Sabates-Wheeler, 2007, p. 1). Indeed, for Barrientos and Hulme (2009, p. 5), the role of social protection is extended to "securing basic needs as a precondition for human and economic development". Along similar lines, Bangura (affiliated with UNRISD) states that universal social policy attempts to cover "the entire population with adequate benefits and is grounded in claimable entitlements, whether derived from rights or payments by institutions and individuals" (Bangura, 2010, p. 135).

In principle, these different viewpoints do not need to be mutually exclusive, but may affect what different development partners and policy makers highlight as the main function of social protection (Devereux et al., 2015, p. 7). As Ulriksen and Plagerson (2014) point out, the distinction between "neoliberal" social protection with an "emphasis on the fulfilment of duties", on the one hand, and social protection as a human right, on the other, is highly relevant in contemporary discussions on social policy design. Often, there is "little consensus on the basic principles" deemed relevant for the design of welfare systems, and "debates on the issue appear to have reproduced the long-standing divide between universal and residual approaches that has characterised social policy debates more generally" (Kabeer, 2014, p. 338). Thus, a position along the ideological dichotomy lays the foundation for what is perceived the ultimate objective of social policy and what form it should take: "is it primarily a means to achieve economic development targets (an 'instrumentalist' agenda), or is it a means to achieve social justice (an 'activist' agenda)?" (Devereux and Solórzano, 2016, p. 1). While instrumentalists may push for conditional cash transfers, proxy-means testing and narrow targeting,

[29] This alludes to Antonio Gramsci's distinction between the war of manoeuvre, the proletariat's military struggle against the bourgeoisie, and the war of position, the struggle for cultural and ideological hegemony (see, e.g. Morton (2007) for more details on Gramsci's social theory).

activists favour unconditional transfers that maximize freedom (Devereux and Sabates-Wheeler, 2007, p. 4). In the same vein, Kidd (2017) identifies two different social protection paradigms promoted by international organisations. While the citizenship paradigm is based on the premise that social protection is a right for all citizen, the charity paradigm conceptualizes social protection as "handouts" to the poor. According to Kidd, the citizenship paradigm is characterized by inclusive, lifecycle social protection systems, mainly built around conventional social security programmes, i.e. old age, disability, and unemployment transfer schemes, similar to the systems implemented in many of the high-income countries. The premise here is that social protection is perceived as a right of all "right holders" within a country. Such universal systems may be costly and will require adequate levels of taxation, but also need to be based on the consensus that redistribution is a public good, which contributes to more just and cohesive societies (Kidd, 2017, p. 1). In the following two sections, the origins of and shifts within the two positions are laid out in more detail.

3.1. The activist position and a human rights-based approach to social policy

Today, social security is enshrined in most human rights conventions as well as in the development strategies of major development organisations based on the understanding that "governments are – or at least should be – responsible to all of their citizens, not just to those below an arbitrary and uncertain poverty line" (Deaton, 2008, p. 109). Still, the notion that the State bears some degree of responsibility for the well-being of its citizens and the people living within its borders is not a recent viewpoint. Already in the 19th century, first attempts were made to introduce welfare policies in European countries. In 1834, the *New Poor Law Act* was adopted in the United Kingdom (Gough, 2008, p. 39). Later in the mid-1900s, William Beveridge – the "architect of the modern welfare state" (Ahmad, 1991, p. 107) – fuelled social and economic planning, including the promotion of full employment, and put in place a comprehensive social insurance system, entailing a National Health Service (NHS) for all and an universal children's allowance (Pedersen, 2018). In Germany, Chancellor Otto von Bismarck introduced a health insurance scheme in 1883. Throughout the 20th century, state activity in Western Europe considerably increased and after the end of the Second World War, welfare states – often combining universal benefits and contributory insurance schemes – were introduced in most Western European countries as a response to the emerging needs ensuing economic hardship in the late 1920s and 1930s (de Neubourg, 2009, p. 65).[30] Formal security systems in Europe materialised as "one set of policy responses" reflecting the "emergence of the modern nation-state

[30] Briggs (1961, p. 228) identified three main functions of the welfare state, namely to guarantee a minimum level of income, to reduce insecurities by providing support to sick, old or unemployed members of society and to enable access to social services.

and of 'self-regulating markets' as organising institutions of liberal economies was associated with dramatic economic transitions and social dislocation" (Devereux, 2013, p. 14). Social protection became "indisputably an inevitable part of the market economy" (Drahokoupil, 2004, p. 837). For Lavinas (2017, p. 9), the post-war period of Western Keynesian welfare states was marked by a "virtuous relationship" between social and economic policy and the "decommodification of a wide array of public services (housing, healthcare, education, professional training and the guarantee of monetary income)".

The ILO has traditionally been an advocate of a rights-based approach to social protection, seeing it as "grounded on basic rights" (Barrientos et al., 2005, p. 12). Accordingly, the conventions and recommendations adopted at the ILO in the first half of the 20th century reflected the intention to provide security benefits and social services, essential for maintaining a minimum standard of living, to all persons in need of protection (including non-nationals residing within the territory). The ILO adopted the first International Labour Convention on Social Security in 1919, and the mandate was later integrated in the ILO Constitution, and, in 1944, reaffirmed in the Declaration of Philadelphia. The historic Declaration of Philadelphia of 1944 underscored that "all human beings, irrespective of race, creed or sex, have the right to pursue both their material well-being and their spiritual development in conditions of freedom and dignity, of economic security and equal opportunity".[31] As per the declaration, the ILO committed to support the (Western) world's nations in their efforts to extend social security measures, including the provision of basic income to all people in need of protection, comprehensive health care, quality education, adequate protection for workers, child welfare, maternity protection, adequate nutrition, housing and facilities for recreation and culture to their citizens. The text reflected the spirit of the time: the provision of all-encompassing social services was the responsibility of the European welfare state, and its purpose was to guarantee a decent standard of living for all.

Only a few years later, the Universal Declaration of Human Rights was adopted, recognizing the right to social security. In 1952, the ILO adopted a detailed Social Security (Minimum Standards) Convention, outlining minimum standards for seven branches of social security: medical care; sickness benefit; unemployment benefit; family benefit; maternity benefit; invalidity benefit; and survivors' benefit. Subsequently, other human rights treaties have reflected the right to social security, notably, the 1965 International Convention on the Elimination of All Forms of Racial Discrimination, the 1966 International Covenant on Economic, Social and Cultural Rights and the 1979 Convention on the

[31] 1944 Declaration of Philadelphia, Article 3(f)

Elimination of All Forms of Discrimination against Women. While children are mentioned in most of these conventions and human right bodies, the 1989 Convention on the Rights of the Child (CRC) puts particular emphasis on their specific vulnerabilities. Moreover, within the 1996 revised European Social Charter, several articles highlight the importance of guaranteeing an adequate level of social protection to everybody. In the 1997 Treaty of Amsterdam of the European Union, the Community and the Member States are requested to aim to promote social protection.

Conventions between African countries have also acknowledged the right to social protection. The 2003 Protocol to the African Charter on Human and People's Rights on the Rights of Women in Africa, known as the Maputo Protocol, was signed, including provisions on economic and social welfare rights.[32] In 2004, Member States of the African Union formally recognized the "centrality of social protection for social policy enhancement" and the resulting Ouagadougou Plan of Action committed adhering Governments to "improving and strengthening the social protection schemes and extending them to workers and their families currently excluded".[33] The commitment to reinforce social protection systems across the continent was reconfirmed with the adoption of the Social Policy Framework for Africa in 2008, which entails clear recommendations on how to boost social policy across countries (African Union, 2008).

More recently, in 2012, the ILO formulated a new normative instrument as part of its strategy to extend social protection. The Social Protection Floors Recommendation offers non-binding guidelines on how to build and shape national social protection systems. [34] The ILO defines social protection floors as "nationally-defined sets of basic social security guarantees which secure protection aimed at preventing or alleviating poverty, vulnerability and social exclusion".[35] National governments are advised to enable (i) access to essential health care, including maternity care; (ii) basic income security for children, providing access to nutrition, education, care and any other necessary goods and

[32] 2003 Protocol to the African Charter on Human and People's Rights on the Rights of Women in Africa, Articles 22, 23 24

[33] Ouagadougou 2004 Plan of Action on Employment Promotion and Poverty Alleviation: https://www.tralac.org/documents/resources/african-union/1563-au-declaration-on-employment-and-poverty-alleviation-in-africa-september-2004/file.html (last accessed 23/06/2020).

[34] ILO Social Protection Floors Recommendation: http://www.ilo.org/dyn/normlex/en/f?p=NORMLEXPUB:12100:0::NO:12100:P12100_INSTRUMENT_ID:3065524:NO (last accessed 23/06/2020).

[35] On the homepage of the International Labour Organization, social protection floors are defined and annotated in more detail: http://www.ilo.org/secsoc/areas-of-work/policy-development-and-applied-research/social-protection-floor/lang--en/index.htm (last accessed 23/06/2020).

services; (iii) basic income security for persons in active age who are unable to earn sufficient income, in particular in cases of sickness, unemployment, maternity and disability; and (iv) basic income security for older people. The ILO recommendation was endorsed by most international organizations and many ILO Member States at the Cannes Summit end of 2011. Furthermore, the International Monetary Fund (IMF) agreed to work with the ILO on identifying funding for social protection in poorer countries and mid-2012, the SPIAC-B was put in place to facilitate coordination across agencies. The 2030 Agenda for Sustainable Development adopted in 2015 prominently featured social protection as a key instrument in promoting development.[36] At the same time, in Africa, the 2015 Addis Ababa Declaration on Transforming Africa Through Decent Work for Sustainable Development was approved, including a strong component on the establishment of national social protection floors.[37]

A widely used classification of the different instruments of social protection (understood as a human right) into four groups, was proposed by Devereux and Sabates-Wheeler (2004) in the early 2000s (see Table 2). Based on this framework, social protection performs (i) protective (ii) preventive (iii) promotive and (iv) transformative functions, albeit these functions may overlap. The first three functions are also known as the *PPP framework*: social protection schemes are designed with the objective of providing relief from deprivation, e.g. through the provision of social assistance and social services to people living in extreme poverty (protective measures). At the same time, a coherent social protection programme includes mechanisms that aim to prevent deprivation, e.g. social insurance systems, including informal mechanisms such as savings groups and risk diversification strategies (preventive measures). The social protection framework also includes a component aimed at enhancing livelihoods and promoting income stability, e.g. through microfinance (promotive measures). However, with time, the significance of social protection in supporting the transformation of lives by addressing unequal power relations that trigger vulnerability, was recognized, adding a fourth dimension to social protection (Mkandawire, 2004). Thus, inclusive social protection schemes also need to include measure that seek to promote social equity and social inclusion, like initiatives that encourage social cohesion and transform public attitudes and behaviours (transformative measures) (Devereux and Sabates-Wheeler, 2004, pp. 9–11). This last element is based on the understanding that not only economic risks, but also structural inequalities create vulnerability, and

[36] Social Protection within the 2030 Agenda for Sustainable Development: Target 1.3. (substantial coverage of the poor and the vulnerable); Target 3.8 (universal health coverage); Target 5.4. (provision of public services, infrastructure and social protection policies for unpaid care and domestic work); Target 8.5 (full and productive work and decent work); Target 10.4. (greater equality).

[37] See Appendix B for a chronological outline of selected key events, reports and declarations related to social policy/social protection/social security.

these structural vulnerabilities need to be addressed, requiring "a political approach to social protection, focusing on rights, duties, democracy and advocacy" (Devereux and Sabates-Wheeler, 2007, p. 1).

Table 2: Transformative Social Protection Agenda

Type	Poverty-focused social protection intervention	Types of instruments
Protective	Social assistance	Cash transfers, food transfers, fee waivers for social services, school subsidies, school feeding
Preventive	Social insurance	Health insurance, premium waivers, subsidies risk-pooling mechanisms
Promotive	Productive transfers, subsidies and work	Agricultural input transfers, fertiliser subsidies, asset transfers, public works programmes
Transformative	Social equity measures	Equal rights/social justice legislation, affirmative action policies, asset protection

Source: Holmes et al. (2012) adapted from Devereux and Sabates-Wheeler (2004)

Nonetheless, while notably the ILO has been influential in pushing forward an alternative to the neo-liberal understanding of residual social safety nets (Hickey and Seekings, 2017, p. 1), the publication of its 2012 Social Protection Floor Recommendation demonstrated that the organisation has become complicit in enabling the triumph of a "minimalist understanding of universalism" (Martinez Franzoni and Sanchez-Ancochea, 2016). For instance, Lavinas (2017, p. 80) highlights that the ILO is equally to be held accountable as "the scope of social protection was narrowed, and by the same institution [the ILO] which had conceived of it in the 1950s" as many conventions and recommendations seem no longer to reflect the principle of unconditional and universal provision of a wider array of social services. Lavinas (2017, p. 98) further highlights that the ILO's Social Protection Floors Recommendation does not clearly provide guidance on whether access to social services should be "public, free and universal". And, she stresses that the ILO's vigour to promote access to a wide range of social services to all people seems to have vanished as "all the other dimensions of the contingencies that made up a complex and integrated social security system back in the 1950s—housing, education, ongoing professional training, all on equal terms—have been tossed out" (Lavinas, 2017, pp. 81–82).

3.2. The instrumentalist position and the International Financial Institutions

Since the late 1960s, the World Bank has become the leading agency in guiding development policy-making (Van Waeyenberge and Fine, 2011, p. 26) and its shifts in ideology have been greatly influential for policymaking at the country levels. Prior to the Washington Consensus, state intervention was deemed essential for the coordination of extensive infrastructure investment projects and

governments were expected to provide for a "big push" to foster economic growth and employment creation and as a consequence poverty reduction (Saad-Filho, 2010, p. 2). While throughout the 1950s and 1960s, poverty reduction was not explicitly addressed but expected to be a by-product of trickle-down economic growth and productivity increases, the focus was expanded from "lending for infrastructure" to a more explicit form of "lending for poverty" in the 1970s (Van Waeyenberge, 2006, pp. 2–3). During the tenure of Robert McNamara as president of the World Bank, from 1968 to 1981, special emphasis was put on responding to people's basic human needs.

In parallel, however, from the 1970s onwards, concepts of state failure started to emerge in mainstream development economics and notably in the policy analysis of the IFIs. Rent-seeking theories (e.g. Krueger, 1974) as well as public choice and rational choice theories (e.g. Bates, 1988) became prominent, making the state's bureaucratic apparatus as well as incentives of people in power to maximize their own interests culpable for slow economic development. In 1981, a World Bank milestone report, the so-called Berg Report, was published, stating that "although internal constraints and changes in the world economy are heavily implicated in Africa's slow economic growth, domestic policy deficiencies and administrative constraints have also been important – in many cases, decisive – and will continue to block economic progress unless changes are made" (World Bank, 1981, p. 24). In other words, bad governance and poor policy choices of African governments were made responsible for limited economic performance.

The Washington Consensus[38] – a "consensus" across the World Bank, the IMF and the U.S. Treasury Department – marked by "a heavy attachment to universalist neo-liberal ideology, with absolute commitment to the free market at the presumption of the state as a source of both inefficiency and corruption" emerged as a response to these alleged weaknesses (Saad-Filho, 2010, pp. 3–4). The World Bank's "Finance Ministry Agenda" with its liberal market propositions gained the upper hand (Wade, 2002, p. 219), and neo-liberal policies, characterised by structural adjustment programming, fiscal austerity imposed through conditionalities led by the Bretton Woods Institutions (BWI), became dominant (Craig and Porter, 2006, p. 2) and the "readily accepted orthodoxy in the official donor community" (Van Waeyenberge, 2006, p. 5). These neo-liberal policies, however, resulted in high social and economic costs (Cornia and Stewart, 1990, p. 12). Craig and Porter (2006, p. 3) suggest that the IFI's failed structural adjustment programmes and adverse results from free and uncontrolled market rule caused "high street protests, public debunking of narrow neoliberal orthodoxies and calls

[38] Williamson (1990) coined the term Washington Consensus and he summarizes its underlying economic policies as "prudent macroeconomic policies, outward orientation, and free-market capitalism".

for re-regulation, strengthening governance and social protection". Hence, by end of the 1980s, the IFIs had to acknowledge the ambiguous and rather limited effect on economic performance and the negative social impact of their programmes, which had triggered calls for an "adjustment with a human face" (e.g. Cornia et al., 1987).

At the turn of the decade, the 1990 World Development Report reflected a first hesitant attempt of the World Bank to address social costs of structural adjustment in their development policy (Hickey and Seekings, 2017, p. 7). The report, announcing the World Bank's intention to put poverty back on the agenda, marked the beginning of "tentative moves to incorporate social protection within international development, including minimalist efforts to address the social costs of structural adjustment through social action funds and a largely rhetorical focus on safety nets" (Hickey and Seekings, 2017, p. 7). In reality, however, social concerns were merely added to the World Bank's basic policies of stabilisation, liberation and privatisation (Van Waeyenberge, 2006, p. 9). The IFIs fell short on scrutinizing their problematic fundamental assumptions of perfectly working markets and instead focused on promoting narrow safety nets for the poor and most vulnerable parts of population (Adésínà, 2010, p. 6). Other forms of non-contributory social protection were dismissed as too expensive and "likely to reinforce a culture of poverty" (Merrien, 2013, p. 90).

Subsequently, in the late 1990s, economic crises in Mexico (1994), East Asia (1997) and the Former Soviet Union (1998) prominently demonstrated the shortcomings of fast moving capital and comprehensive deregulation (Conway et al., 2000, p. 8; Craig and Porter, 2006, p. 3). Neo-liberalism had to give space to a "softer more inclusive poverty reduction and good governance agenda" as trust in free markets and self-regulation vanished and questions around the legitimacy of the IFIs arose (Craig and Porter, 2006, p. 2). As a result of "the negative consequences of unfettered market capitalism", ideology shifted "significantly enough to offer social protection in an ideological environment termed the Post-Washington Consensus" (Hickey and Seekings, 2017, pp. 7–8). Around the same time, Joseph Stiglitz was appointed chief economist at the World Bank, and called for a re-evaluation of the Washington Consensus, before being forcibly removed from the Bank, in response to his explicit criticism of the IMF and the U.S. Treasury Department (Bayliss et al., 2011, p. 3). Still, the World Bank introduced its Poverty Reduction Strategy Papers formally replacing the Structural Adjustment Programmes (SAPs), reflecting an awareness that poverty needed to be addressed directly through appropriate social and economic policy making (Saad-Filho, 2010, p. 8).

In the early 2000s, a team around Ravi Kanbur, an economist brought into the World Bank by Stiglitz to lead the development of the 2000/2001 World Development Report, presented their first draft of the World Bank's flagship publication, emphasizing that "liberalizing the economy and opening it to free international movements of goods, services and capital did not automatically help the poor; in

fact in sometimes worsened their condition" (Wade, 2002, p. 224). The 2000/2001 report, intituled Attacking Poverty, sought to signal the World Bank's shift towards a slightly softer policy agenda away from structural adjustment towards a policy of social protection and labour. Kanbur, though, resigned from his position, dissatisfied with the World Bank's stipulation to more aggressively promote privatisation and trade liberalisation (Van Waeyenberge, 2006). Besides, the World Bank also published its first Social Protection and Labour strategy in 2001 with a strong emphasis on social risk management.

Since then, the World Bank, promoting its "pro-market approach to combating poverty", has been a champion of social safety nets (Holzmann and Jørgensen, 2000). The residual approach to social protection of the World Bank reflected in its 2001 Social Protection and Labour Report further illustrated the prevailing differences in the understanding of social protection across agencies. While the ILO, at the International Labour Conference in June 2001, started its global campaign on social security and coverage for all, the World Bank put strong emphasis on social risk management and safety (Hickey and Seekings, 2017, p. 8). In the World Bank's Social Protection and Labor Strategy 2012-2022, it again positions itself as a proponent of a neoliberal and residual view of social protection, actively promoting conditional cash transfers, emphasizing social risk management, and adding macroeconomic stability and financial market development ambitions to their social protection understanding, stating that "conditional cash transfer programs have been especially successful at reducing poverty, along with improving both school attendance (especially for girls) and infants' and children's access to health services" (World Bank, 2012, p. xviii).

After the 2008 financial crisis, however, bids for a shift in paradigm intensified. In response, the SPIAC-B, co-chaired by the ILO and the World Bank, was established in 2012. The SPIAC-B has a long list of participating organizations[39] and its establishment may be perceived a key step in consolidating differing ideas within the international development community. In 2015, the World Bank and the ILO presented their shared mission and commitment to universal social protection[40] and in 2016, the Global Partnership on Universal Social Protection was launched.[41] However, despite these joint statements in favour of universal social protection, Kabeer (2014, p. 339), amongst others, argues that

[39] Full list of participating organizations: http://www.ilo.org/wcmsp5/groups/public/---dgreports/---nylo/documents/meetingdocument/wcms_211034.pdf (last accessed 23/06/2020).

[40] A shared mission for universal social protection (concept note): http://www.ilo.org/wcmsp5/groups/public/---dgreports/---dcomm/documents/genericdocument/wcms_378996.pdf (last accessed 12/08/2021).

[41] World Bank, ILO launch global partnership for universal social protection: http://www.ilo.org/global/topics/sdg-2030/latest/WCMS_525012/lang--en/index.htm (last accessed 13/02/2018).

the World Bank "still falls short of any commitment to universalism or social justice". Also, a background document commissioned by the Independent Evaluation Office (IEO) of the IMF states that "IMF staff contacted by this evaluation indicated that they have not seen a departure from the Bank's standard advice on designing and implementing social safety nets so far" (Zhou, 2017, p. 8). Along the same lines, Kidd (2017, p. 6) states that up until today the World Bank with its "long-standing commitment to structural adjustment and belief in low taxes and minimal social spending" seems to continue to pursue a so-called "charity paradigm" to social protection, offering social protection to the extreme poor mainly in the form of conditional or unconditional benefits.

Similarly, the commitment to universal, rights-based social protection of the World Bank's sister agency, the IMF, remains elusive in practice. In 2012, the IMF committed to supporting national Ministries of Finance, notably in Mozambique, in their efforts to increase domestic social protection expenditure to 40 percent of total government spending (ILO and IMF, 2012). However, the IEO (2017, p. 13) highlights that "some in the development community consider the Fund's preferred targeting approach to be inconsistent with the rights-based approach to social protection espoused by the UN and its related agencies".[42] Furthermore, the IMF has been criticised for not being an active participant (or merely present) in most of the SPIAC-B's meetings (Zhou, 2017, p. 8). Peter Bakvis of the International Trade Union and Kentikelenis et al. (2016) emphasize the IFI's reluctance to change their approach to social protection "at a time when global policy debates around the Sustainable Development Goals are overwhelmingly focused towards the universal provision of key welfare services" (Kentikelenis et al., 2016, p. 22). As a result of these concerns, an open letter was sent to Christine Lagarde and the former IMF's Executive Directors in December 2017 to voice alarm related to the Fund's policy advice and lending conditionalities, which force countries to pursue fiscal consolidation measures resulting in social expenditure cuts, since the IMF puts "fiscal objectives above the objective of ensuring respect for the right to social security as a human right".[43] In brief, while the **rhetoric** at the IFIs may have changed over time as they now position themselves as proponents of e.g. the universal social protection floor, their main focus – in practice – remains on poverty reduction and targeting on the basis of income. In reality, the IFIs, then, continue to promote narrow social

[42] Notably, Kidd et al. (2017) highlight that targeting approaches using proxy-means tests (PMT) are embedded within a neo-liberal paradigm and are in contrast to a human rights-based approach to social protection. Based on an extensive review of the literature, they emphasise that means-tested targeting approaches generates high exclusion errors, ranging between 50 and 93 percent (Kidd et al., 2017, p. ix).

[43] Open letter to the IMF on social protection:

http://www.ohchr.org/Documents/Issues/Development/IEDebt/Open_Letter_IMF_21Dec2017.pdf (last accessed 13/02/2018).

protection practices, despite the World Bank's commitment to universal social protection as well as the IMF's formal commitment to encourage social spending.

4. Scholarship and theories of social and welfare policy

This section looks at the scholarship concerned with attempting to put forward explanations for the development of welfare and social policies. First, different concepts that explain the development of extensive welfare policy across Western Europe after the end of the Second World War are discussed. It is laid out that while several scholars have suggested that welfare states were a consequence of industrialism, other theories point to the important role of class struggles, historical institutionalism, power relations, etc. However, no framework has received as much attention as Gøsta Esping-Andersen's attempt to classify welfare state into three different regime types. Second, the section touches on contributions that explore the link between the rise of neo-liberalism and the contraction of comprehensive social policy systems and decrease in social expenditure. Third, reflecting an awareness that Western concepts/theories of welfare are not necessarily transferable to the developing country context, alternative propositions seeking to provide explanations for social policy trajectories in countries of the Global South are reviewed. In this context, I emphasise that, while after independence many post-colonial African states were inclined to promote social policy as a way of facilitating nation-building and creating inclusive states, the rise of neo-liberalism significantly reshaped social policy making on the African continent.

4.1. Welfare state expansion theories

While a prominent notion in the literature is that welfare states emerged in response to industrialisation as a means to prevent social unrest and to ensure compensation of the working class for the negative consequences of capitalism, some stress a far more active role of the working class in promoting, driving and changing welfare policy. For Cousins (2005, p. 20), for instance, six different main drivers can be identified. He suggests that welfare states could have emerged (i) as part of the logic of industrialisation; (ii) in response to the needs of advanced capitalism; (iii) as a product of modernisation of societies; (iv) due to struggles over politics and social class; (v) due to social organisation of production; and/or (vi) as a consequence of structure and interests of the state or polity. Kpessa and Béland (2013) categorize social policy development theories into four main strands: (i) industrialism as the driving force for social policy development; (ii) the power resource approach, which is more attentive to the role of political forces; (iii) historical institutionalism, highlighting the shaping character of political institutions and policy legacies; and (iv) the role of ideas, culture, shared values and world view in shaping social policies. However, as Huber and Stephens (2001) emphasize, these theories are not necessarily mutually exclusive and various factors have interacted in the development of welfare states. For example, Gough and Therborn (2010) elucidate that, in their view,

industrial capitalism triggered social policy-making to respond to the requests of the industrial labour force – which organised in unions and parties – for adequate housing, insurance in case of unemployment, old-age, sickness or injury as well as access to basic social services. At the same time, political elites were interested in maintaining social order (Gough and Therborn, 2010, p. 743).

To organise my review of theories of the advent and expansion of welfare states in developed countries, I group these into three strands: those based on a "logic of industrialism"; those emphasizing the importance of politics, power and class; and Esping-Andersen's regime type approach.

4.1.1. The logic of industrialism

Industrial capitalism brought about new social challenges, but also additional resources for social spending, contributing to the foundation of welfare states in Europe (Gough and Therborn, 2010, p. 743). Scholars, such as Kerr et al. (1960), Rimlinger, (1971) and Wilensky (1975), have argued that industrialism increased the demand for public spending and, since it weakened family-based support networks, was the main root for the emergence of welfare states in European countries. Kerr et al. (1960, p. 152), for example, argue that the state with its enlarged responsibilities is charged with organizing and maintaining the newly emerged urban labour force. As a result, after the end of the Second World War and welfare policies expanded, for some, "economic security [was] transformed from 'charity' into a 'right' for which potentially every citizen was eligible" (Hemerijck, 2012, p. 34).

Nonetheless, while Myles and Quadagno (2002, p. 36) recognize that "industrialism and its correlates (economic growth, population ageing) are necessary to account for the common trend line in welfare state expansion", they query whether industrialism alone can account for the evolution of welfare policies in European countries. Instead, they highlight the important role of politics and power relations. In similar vein, Titmuss (1964, p. 34) argued that the "fear of social revolution, the need for a law-abiding labour force, the struggle for power between political parties and pressure groups, a demand to remove some of the social costs of change — for example, industrial accidents — from the backs of the worker, and the social conscience of the rich all played a part [in the emergence of the welfare state]". As such, the theories embedded within a logic of industrialism were seen to neglect elements such as preferences of political partners, party ideology as well as power relations between the working and the capitalist class.

4.1.2. Politics, power, and class struggle matter

Several theorists have looked into alternative explanations for welfare state expansion beyond industrialisation. While within Marxism, some scholars perceive the welfare state as a derivative of the capitalist system, necessary to maintain social order, others highlight the more active role of the

working class in requesting social protection, thus highlighting the importance of power dynamics. In contrast to theorists that highlight the role of industrialisation and disregard politics and power struggles as an explaining variable for welfare state expansion, Marxist theorists, notably O'Connor (1973), Gough (1979) and Offe (1984), argue that the welfare state was a necessary by-product of the capitalist system and that the main objective of welfare policies was to ensure the fitting reproduction and maintenance of a healthy and productive labour force, which was essential for capitalists to expand their surplus value. Notably, O'Connor (1973, p. 6) highlights how the industrial state needs to assure continued accumulation of capital while, at the same time, maintain its legitimacy and guarantee social harmony. For Watson (2000, p. 66) and Midgley (2012, p. 14), welfare is a form of social control that legitimizes capitalism and reduces the risk of a revolt of the working class, making social policy instrumental in maintaining the legitimacy of the exploitative capitalist system and allowing leaders to exercise social and political control.

For Mooney (2000, p. 168), these Marxist interpretations are relevant but do not sufficiently consider the importance of class as "collective agency, which may have a role in shaping and/or resisting policy developments". He and his colleague argue that while Marxist theorists often consider class struggle as a key feature of industrialised societies, they "fail to explore its specific relevance to social policy" (Lavalette and Mooney, 2000, p. 4). In the context of today's debates on social policy, Matthews (2018) stresses a similar point and argues that in most advanced capitalist societies, the workforce has not only been "a passive bystander", but labourers have actively requested and directed welfare policies (Matthews, 2018, pp. 1–2). Devereux (2013, p. 14) also makes reference to class struggle and expounds that "if 'self-regulating markets' serve the interest of capital, 'social protectionism' serves the needs of labour". And, Korpi (1989), the father of the Power Resource Theory, stresses that class is a major determinant of conflicts of interest in capitalist societies, able to push for social change and the materialisation of social rights of citizens. In his opinion, Marxist approaches underestimate the power of the working class to push for social reform (Korpi, 1989, p. 312).[44]

Besides theories that focus on class and power relations, other scholars have explored the organisation and structure of the state in an attempt to explain the emergence of welfare states. Skocpol (1985), for instance, argues in favour of "bringing the state back in". She highlights the importance of the make-up and organization of states, which need to be "conceived as organizations claiming control over territories and people may formulate and pursue goals that are not simply

[44] Korpi's work makes reference to the influential work of T.H. Marshall (1950), who identified three types of rights for the attainment of "citizenship", namely civil, political and social rights.

reflective of demands or interest of social groups, classes, or society" (Skocpol, 1985, p. 9). For Quadagno (1988), industrialisation in combination with other factors is held responsible for welfare state expansion in the mid-20th century. While welfare programmes may have evolved in response to the emergence of industrial capitalism, "the link between welfare state development and forms of social production may be modified in an advanced capitalist state if labor obtains the political resources to free welfare programs from market criteria" (Quadagno, 1988, p. 7). Similarly, in an effort to combine different theories, Gough (2008) identifies "five I's" as main drivers of welfare state development, namely, industrialization, interests, institutions, ideas and ideologies, and international influences.

While these theories continue to inform contemporary discussions on the welfare state or social policy, Gøsta Esping-Andersen's work on welfare state regimes has become a dominant reference within the scholarly debate on welfare state theories since the 1990s.

4.1.3. Esping-Andersen's "Three Worlds of Welfare Capitalism"

In the 1990s, Esping-Andersen made major contributions to the discussion on welfare states.[45] In *The Three Worlds of Welfare Capitalism,* he identifies three different types of welfare state regimes, classifying them on the basis of their level of social stratification and de-commodification.[46] He argues that "the outstanding criterion for social rights must be the degree to which they permit people to make their living standards independent of pure market forces" (Esping-Andersen, 1990, p. 3). Esping-Andersen defines a regime as "the combined, interdependent way in which welfare is produced and allocated between state, market and family" (Esping-Andersen, 1999, pp. 34–35) and distinguishes between the following three regime types: (i) liberal welfare state regimes, characterized by modest universal transfers and social insurance systems as well as means-tested social assistance programmes (such as the United States, Canada and Australia); (ii) conservative and strongly corporatist welfare state regimes, influenced by the Church and committed to the traditional family hood (such as Austria, Germany, France and Italy), and (iii) social-democratic welfare state regimes, devoted to universalism and the decommodification of social rights (such as the Scandinavian countries) (pp. 26–29). Esping-Andersen's welfare state regime approach became an important reference point within the scholarly debate (Powell and Barrientos, 2011, p. 73; Scruggs and Allan, 2006, p. 55).

[45] Prior to Esping-Andersen's work, the British Social Policy Specialist Richard Titmuss (1958, 1964, 1974) differentiated between more comprehensive institutional and residual welfare states.

[46] Decommodification can be understood as "the extent to which needs are to be satisfied through the labor market, or, as an alternative, through political mechanisms" (Esping-Andersen and Korpi, 1987, p. 40).

Nonetheless, Esping-Andersen's approach has been subject of vast criticism. Fine (2000, p. 15), for example, points out that "much of the literature has been concerned to question the legitimacy of Esping-Andersen's typology, both for the countries that he does include as well as for those that he does not, and, by the same token, for the characteristics that are nor are not included". Powell and Barrientos (2011, p. 70) conclude along similar lines that Esping-Andersen's approach has been

> criticized for being too centred on Scandinavian debates; ignoring the development of feminism as one of the most important and creative forces in social sciences over the past two decades; not being well-adapted to encompass the postmodern development of industrial society; being ill-adapted to understand the differences between welfare states in the politics of retrenchment; and not paying sufficient attention to the political differences between consensus and majoritarian regimes.

Trifiletti (1999, p. 9), as a feminist scholar, criticizes Esping-Andersen's neglect of women's role in and outside of the labour market and the regime approach's male centeredness. She proposes the inclusion of a Mediterranean regime to explain labour market and family policies in e.g. Italy or Spain. Alva and Gunnar Myrdal (1936) highlight the importance of women's participation in labour markets as well as public spending for education and health for economic development. Castles and Mitchell (1992, p. 2) suggests the inclusion of a fourth "radical" world of welfare capitalism for a more appropriate classification of Australia, New Zealand and the United Kingdom – countries that "depart at least somewhat from the expenditure-based orthodoxy that more social spending is the only route to greater income redistribution". Ferrera (1996, p. 18) proposes the consideration of a "Southern" or "Latin" welfare state-regime, as "the academic debate has so far largely neglected the study of the Southern European welfare state".

Even though Esping-Andersen (1999) addresses parts of this criticism in his follow-up essay *Social Foundations of Postindustrial Economies* (1999), by including the family into his analysis, acknowledging the existence of a fourth regime type and referring to Japan as an unique fusion of both liberalism and conservatism, "the welfare regime approach is insufficiently sensitive to differences between countries, and unduly neglects how those differences affect outcomes differentially across the different components that make up social policy" (Fine, 2012a, p. 12). Furthermore, for Jensen (2008, p. 151) and Powell and Barrientos (2011, p. 79), based on Powell and Hewitt (2002), the discussion of ideal types of welfare state regimes overly emphasizes transfers and cash benefits and excludes services, such as health care, pre-school care, elder care services, education, etc. Adésínà (2015) also points at the shortcomings of Esping-Andersen's decommodification index, which "ignores important social policy instruments such as (publicly) financed education, (universal) healthcare provision, labour market protection, equity or affirmative

action policies, land reform, social cohesion or nation-building instruments" (Adésínà, 2015, p. 100). In particular, Adésínà's criticism hints at the approach's lack of applicability for developing countries. Nonetheless, in spite of major shortcomings, Esping-Andersen's welfare regime approach remains prominent in today's debate on welfare states. The above theories focus on identifying explanatory factors for welfare state expansion. Other contributions have, however, analysed the cutback of social expenditure with the rise of neo-liberalism, which are discussed in the ensuing section.

4.2. Neo-liberalism and social retrenchment

While the post-world war II period was characterised by factors such as "a buoyant economy, the Keynes-Beveridge rationale for state intervention, theories of industrial society and post-capitalism, the promise of a science of society and the pursuit of socialism through welfare", the legitimacy of the welfare state had considerably weakened by the end of the 1970s (Mishra, 1984, p. 18). In that period, the general political and scholarly conversation shifted to a "discourse of welfare state crisis" (Wincott, 2013, p. 809). Economic laissez-faire liberalism started to blossom and privatisation and structural adjustment replaced post-war, more state-centred development strategies (Putzel, 2002, p. 1).

In the early-1970s, the Bretton Woods system of fixed exchange rates was replaced by a floating exchange rate scheme. Oil prices rocketed as a consequence of the two oil price shocks of 1973 and 1979. The volatile economic situation led to questioning of the compatibility of the welfare state and market liberalisation (Hemerijck, 2012, p. 40). Keynesian macroeconomic policy-making was made responsible for stagflation – a situation characterized by a combination of high inflation rates, increasing rates of unemployment and stagnant growth – and "from the early 1980s on, European political economies no longer seemed capable of guaranteeing industrial full employment while preserving generous social protection" (Hemerijck, 2012, p. 40). In 1981, Western economists came together in Paris at a conference hosted by the of the Organisation of Economic Co-operation and Development (OECD) and concluded that social expenditure for the welfare state "was out of control" and was stalling economic growth (Ringen, 2006, p. viii). With the rise of neo-liberalism, "with [its] absolute commitment to the free market at the presumption of the state as a source of both inefficiency and corruption" (Saad-Filho, 2010, pp. 3–4), the concept of universalism suffered and residualism gained grounds. As Bayliss et al. (2016, p. 25) highlight, the responsibility was put on individuals to cater for their own welfare and greater discrimination between "deserving" and "undeserving" poor called for means-testing, often designed to restrict eligibility. The expansion of neo-liberalism and monetarism challenged the post-war Keynesian welfare state, and "in the face of persistent stagflation Keynesianism has virtually collapsed as a theory and as a guide to action" (Mishra, 1984, p. 27).

The emerging neo-liberal ideas were backed by newly elected, neo-liberal, conservative governments, notably Margaret Thatcher's government in Britain and Ronald Reagan's administration in the United States of America. The rise of Thatcherism and Reaganonomics "sealed the political revival of self-regulating markets" and most Western countries started to reorient their policies, putting more emphasis on market solutions and monetary discipline (Hemerijck, 2012, p. 40). Neo-liberalism also meant cuts in social spending (Standing, 2007b, p. 30). And, while early empirical work substantiated a positive correlation between aggregate social spending and economic development (Wilensky, 1975), in the 1980s, German economist Herbert Giersch (1985) coined the term Eurosclerosis, making high social benefits responsible for economic stagnation and high unemployment – and ideas which was also taken up by other economists (e.g. Hansson and Henrekson, 1994). Others, however, have highlighted the importance of welfare policies for economic and social development (Korpi, 1996, p. 19; Vaughan-Whitehead, 2015, p. 1; Wood and Gough, 2006, p. 1697) and as Mkandawire (2011) points out: "the argument now is that, whatever merit the welfare state may have had in stimulating economic growth and in combating poverty, its time has passed – a point further reinforced by the collapse of socialism and of the ideologies of solidarity and equality that drove it" (Mkandawire, 2011, pp. 163; 165). Consequently, the rise of neo-liberalism resulted in many policy makers tightening their welfare programmes and replacing their comprehensive social policies, which focused on elements such as education, housing, etc. with more narrowly conceptualized social protection programmes (focusing on cash transfer schemes such as child benefits, unemployment benefits, etc.). From the 1980s onwards, many African policy makers cut back on social expenditure, and by the 1990s, neo-liberal policy-making had become the norm across a multitude of capitalist countries (Kus, 2006, p. 492).

However, for Pierson (1996, 1994), welfare state policies under Thatcher and Reagan, did not mean as drastic a retrenchment of the welfare state. He argues that due to the "institutional stickiness" of welfare states as well as widespread unpopularity of austerity policies, it was not as straightforward for conservative politicians to decrease welfare benefits, as these unpopular policy measures would need to "withstand the scrutiny of both voters and well-entrenched networks of interest groups" (Pierson, 1996, pp. 113–114). Along similar lines, Powell and Hewitt (1998, p. 11) note that "the welfare state is being redefined, but reports of its death have been much exaggerated".

Nonetheless, while conceding that right-wing governments may not have been able to reverse all introduced social services, Ringen (2006, p. xxxviii) insists that the function and responsibilities of welfare states are considerably changing and "what was a we-will-take-care-of-you welfare state is becoming a take-care-of-yourself welfare state". Related to this, Fine (2009) argues that neo-liberalism seems to favour individual and market responsibility over social policy and distinguishes

two different phases of neo-liberalism: a first phase of neo-liberalism with strong emphasis on markets and privatisation and a second phase that aimed at both addressing the social costs of unbound market forces, while at the same time sustaining the extensive expansion of financial activity. For Fine, the 2007 crisis and its consequences "are clearly a source of growing inequality and poverty and, by that token, provide a rationale for remedial social policy" (Fine, 2009, pp. 3–4). In like manner, Mkandawire (2016a) is of the view that neo-liberalism strongly affected social policy-making. He calls for a "fourth great transformation"[47], which will provide basis for a developmental, socially-inclusive and democratic new global order. According to him, "the current crisis of neo-liberalism provides us with the opportunity to seriously rethink the world order and the limits it imposes on nation states to pursue progressive and socially inclusive economic and social policies" (Mkandawire, 2016a, pp. 105–106).

4.3. Theories on social policy development in the Global South

The above review focused on the development and evolution of welfare states and social security systems in Western nations. However, in many developing countries, and particularly in the African context, theories of social policy development need to consider circumstances such as informal systems of mutual support, colonial legacy as well as efforts to re-build socially cohesive nations after independence. Over the years, several scholars have challenged the applicability of conventional welfare theories for developing countries and have attempted to formulate theories that explain social policy development in less industrialised countries, and notably in Africa.

Kpessa and Béland (2013, p. 332), for example, highlight how the "logic of industrialism" lacks explanatory power for less developed countries, by stressing that social policy was not only an instrument for industrial development, but also a nation-building tool. Similarly, according to Adésínà (2015, p. 113), in many post-colonial African countries, in spite of relatively stagnant development, leaders introduced ambitious social citizenship projects to boost education and to assure an adequate standard of health care and housing as part of their nation-building efforts. Thus, on the African continent, social policy was mostly about "enhancing functional citizenship which required public spending on education and health care" and was considered a pre-condition for economic development and growth (Adésínà, 2015, pp. 108-109). Also, Mkandawire (2009) notes that nationalist African leaders contemplated that "the holding together of the nation and the mobilisation of the population behind the new nation-building project demanded that the state embark on some

[47] The other three great transformations since Polanyi that Mkandawire (2016a) identifies are firstly, the period in Europe when the belief prevailed that belief that markets were the nature's way of managing exchange in an efficient way, secondly, society's reaction in defending itself against the ravages of the market and thirdly, neoliberalism's launch of a counter-movement giving the market primacy.

form of social policy even if only to establish the fact that its policies were inclusive" (p. 141). On that account, political ideologies emerged such as Kwame Nkrumah's conscientism in Ghana, Kenneth Kaunda's humanism in Zambia, Obafemi Awolowo's democratic socialism in Nigeria and Leopold Senghor's *négritude* in Senegal. As Kpessa et al. (2011, p. 2116) highlight, these ideologies were based on a "common humanistic narrative tied to the state provision of social benefits" . On this basis, African states were created that were "internally stronger and more cohesive in the first two decades after independence than in the post-1970s following the implementation of structural adjustment programmes (Kpessa et al., 2011, p. 2116). Chabal (2009, p. 6) argues that patrimonial states, which require legitimate rulers to be predominantly accountable to their followers and provide them with the necessary resources, were successful models of state in the 1960s.

Nonetheless, in the 1970s and 1980s, many African policy makers cut back on social expenditure under the pressures of the IFIs, which were promoting structural adjustment programming.[48] Neo-liberalism, with its high social costs, resulted in the disenchantment and disengagement of many African leaders with their nation states, but also, as social policy and nation-building were strongly intertwined in many African countries, impacted the national unity in these countries (Kpessa et al., 2011, p. 2128). In this context, Korpi's Power Resource Theory may seem as a good starting point to analyse why the World Bank and the IMF, while lacking "policy-making legitimacy in domestic policy circles", were able to mobilise against local constituencies, including organised labour movements, and push for structural adjustment programming and social policy retrenchment (Kpessa and Béland, 2013, p. 333). However, while factors such as economic growth, group mobilisation, culture and ideas and political power are important concepts to consider when analysing social policy development in African countries, the Power Resource Theory or theories focusing on historical institutionalism are not entirely apt to explain, for example, why social policies often serve an urban elite and not the informal sector, who pushed forward the anti-colonial movement; or why citizenship-based social programmes, introduced after independence, were replaced by fee-for-service programmes stressing individual responsibility later in the 20th century (Kpessa and Béland, 2013, pp. 328–330).

Also other scholars such as Bailey and Turner (2002, p. 8) highlight the importance of the colonial legacy as explanatory factor for social policy development in Africa, noting that "in the countries that were British colonies, social security programmes are generally more modest than in French-speaking Africa". Also for MacLean (2002, pp. 70–71), "different patterns of state formation established in the

[48] Some leaders, such as Burkina Faso's revolutionist Thomas Sankara, tried to resist neo-liberalism and promoted anti-imperialism and self-sufficiency, e.g. in his address to the African Union: "debt is a cleverly managed re-conquest of Africa […] Each of us becomes the financial slave, which is to say a true slave" (Sankara, 2007).

early part of the colonial era result in contrasting social policies" and while the French government seems to have been more a proponent of activist social policies, Great Britain's strategy was to "increase Africans' standard of living to enable them to support themselves and their extended families rather than to provide a public social safety net". Thus, as pointed out by Kraus (2007), social protection programmes in some countries may also have been weaker due to a strong traditional belief that the family is the first line of assistance and mainly responsible for the provision of support. According to Mkandawire (2016b, p. 3), it was widely assumed that "traditional forms of social protection would take the place of social security provided by the state". He accentuates that colonialism shaped "nationalist agendas and forms of mobilization and resistance, and on the ideological progression and the 'social pacts' that emerged" (Mkandawire, 2016b, p. 3).

Against this background, Mkandawire (2016b) makes the distinction between (i) concession economies where resources were exploited by private companies, notably the DR Congo, Congo and the Central African Republic, (ii) cash crop economies,[49] where local leadership, self-management and voluntary effort was at least partly enabled and measures to protect peasants from vulnerability were only introduced to complement traditional forms of social protection, and (iii) labour reserve economies,[50] where Africans were coerced in partaking in the capitalist, settlers-dominated labour market. He argues that, since colonialists in these exploitative labour reserve economies were cognisant of the necessity to ensure the reproduction of labour, their "solution was to transfer the burden of social security onto rural communities, most of whom were living at the subsistence level, deliberately maintained to force peasants into the capitalist labour market" (Mkandawire, 2016b, p. 6). However, in his opinion, these high intensities of economic inequality produced higher levels of labour militancy and political pressure to correct historical injustices. Additionally, because social welfare regimes were actually put into place in these labour reserve economies, although highly racially segmented, foundations for new initiatives were available.

For Devereux (2013), social protection in today's Africa was imported and is determined by its complex pre-colonial, colonial and post-colonial history. In his view, social protection in African countries manifests a merger between ideas of European social security systems and donor-driven humanitarian responses efforts. He contends that "attempts to graft these imported models onto domestic policy agendas have failed to recognise that the economic and social structures of African countries are

[49] Benin, Burkina Faso, Cameroon, Côte d'Ivoire, Gambia, Ghana, Guinea, Guinea-Bissau, Mali, Mauritania, Niger, Nigeria, Senegal, Sierra Leone, Tanzania, Togo, Uganda (enlarged West Africa)

[50] Angola, Botswana, Burundi, Kenya, Lesotho, Madagascar, Malawi, Mozambique, Namibia, Rwanda, South Africa, Swaziland, Zambia, Zimbabwe (East and Southern Africa)

fundamentally different from those of Europe, resulting in grossly inadequate coverage and programmatic responses that fail to meet the actual social protection needs of local populations" (Devereux, 2013, p. 13). In contrast, Gough and Therborn (2010, p. 741) argue that "a political responsibility for the well-being of a state's population is not a European invention", but have been part of religion and culture in other parts of the world as well. They concur that the welfare state "in its recent meaning" appears as an European intervention, but attribute the emergence of the European welfare state inter alia to the "unique Western European family system" characterized by much weaker kinship ties compared to other parts of the World (Gough and Therborn, 2010, p. 742). They furthermore emphasize that the international environment after the Second World War was particularly conducive for the emergence of welfare states in European countries, as, in spite of US imperialism, the "Marshall Aid had none of the conditionalities of the later IMF-World Bank structural adjustment programmes"(Gough and Therborn, 2010, pp. 743–744). Related, Gumede (2018) makes reference to selected radical scholars, such as Rodney (1981), Onimode (1988), Ake (1996), Amin (1997), and Shivji (2005), who highlight the responsibility of imperialism and colonialism for the "underdevelopment" of African countries, and are in favour of radical delinking from global capitalism (Gumede, 2018, p. 124). Bevan (2004) highlights the important role of external forces, and identifies five components that form part of African countries' so-called "rectification mix"[51] – namely, polity, market, society, kin and self. She stresses the important role of "external members of 'the mix', including international migrants and diasporas, the international financial institutions, UN organisations concerned with development and humanitarian aid, international development and humanitarian non-governmental organisations (NGOs), and bilateral and regional donors" (Bevan, 2004, p. 104).

Based on a similar understanding of limited opportunity to access basic social services, Gough and Wood (2004) develop a regime approach to explain social policy development across countries, with two new regime types seen as particularly relevant for developing countries: (i) welfare regimes as portrayed in Esping-Andersen's work, (ii) insecurity regimes characterized by no institutional arrangements that can provide for security and risk mitigation, and (iii) informal security regimes where family and community bonds serve as an important source of support. Strong family ties are seen as particularly relevant in developing countries, and "far more extensive in the developing than

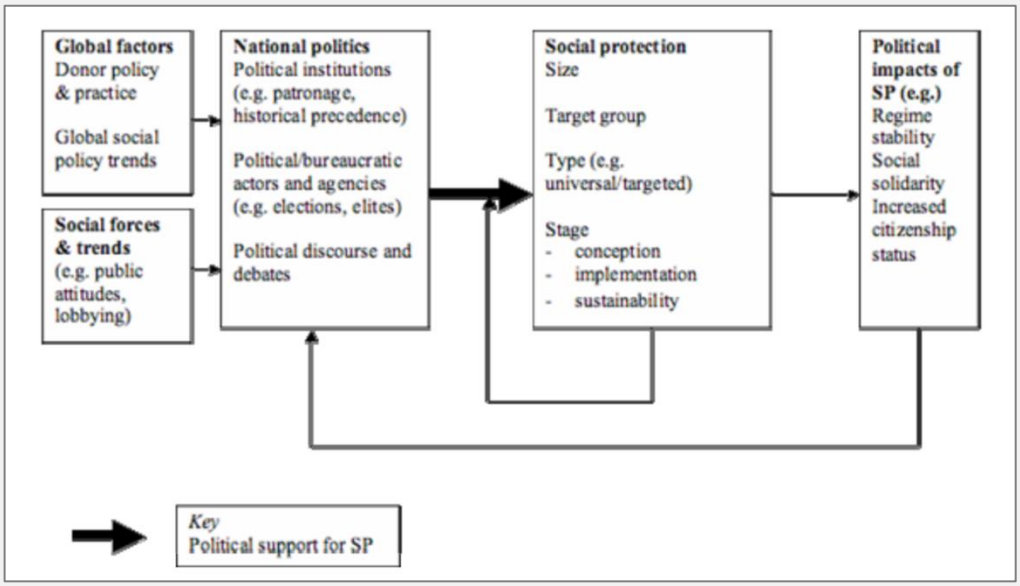
[51] Bevan (2004) states that "[she is] using the word 'rectification' since the adjective 'welfare' seems inappropriate to describe some of the activities in the mix, which, while they generate livelihoods and social protection for the perpetrators and their households, involve the adverse in- corporation or exclusion of some or all of the members and/or directly damage or remove the livelihoods, life chances and lives of others" (p. 103-104).

in the industrial world" (Gough, 2008, p. 59). In like manner, Niño-Zarazúa et al. (2012), while acknowledging the vast diversity across the continent, propose a taxonomy of sub-Saharan African states and identify two models of social protection: the so-called middle-income countries model characteristic of Southern Africa that focuses on age-based social transfers (e.g. universal social pensions or child grants) and the low-income countries model, which strongly relies on poverty-based transfers. For the authors, three key determinants help to explain future dynamics of these two models of social protection: (i) politics and the policy process; (ii) financial viability and (iii) institutional capacity (Niño-Zarazúa et al., 2012, p. 168).

The work of Niño-Zarazúa and his colleagues was influenced by the work of Hickey (2007), who identifies four key aspects relevant in the context of an analysis of the politics of social protection in Africa. These include: (i) political institutions, (ii) political actors and agencies, (iii) socio-economic forces, and (iv) the global dimensions (see Figure 7). Firstly, Hickey points at the importance of institutions, both formal and informal institutions, highlighting the significance of elections, policy legacies as well as patron-client relations throughout policy-making processes and defining "the rules of the game" as North (1990, p. 3) puts it.[52] Secondly, Hickey attributes considerable influence to political parties, agencies, elites, etc. in shaping ideology and political debate and thus determining the distribution of goods and power (Hickey, 2007, p. 3). Thirdly, socio-economic forces, according to Hickey, include public attitude, degree of social cohesion or fragmentation, level of citizens' voice and related urbanisation and economic inequality are highly relevant to social policy-making, although global actors, notably donors, may be equally influential in shaping policy (Hickey, 2007, p. 4).

[52] "Institutions are the rules of the game in a society or, more formally, are the humanly devised constraints that shape human interaction" (North, 1990, p. 3).

Figure 7: Basic Framework illustrating the links between politics and social protection



Source: Hickey (2007)

In similar fashion, Devereux and White (2010) identify three key elements that shape social protection in African countries. While "technocrats" base their policy making on an evidence-base, which is based on other countries social protection initiatives, "political" and "ideological" concerns evolve around the questions "what is popular?" and "what is right?". In the realm of the political, the authors argue that the interest of ruling elites may not necessarily result in the most effective allocation of available resources, and point at dangers such as nepotism and corruption (Devereux and White, 2010, p. 64). Furthermore, they observe that African politicians may favour to support "deserving" and economically-active poor people and be opposed to "handouts" to the "undeserving" population as this could create dependency (Devereux and White, 2010, p. 64). With regard to ideology, they highlight that depending on the depth of the social contract between a government and its citizens, claims for social protection as a right and their entitlement may become louder (Devereux and White, 2010, p. 65). Yet, some African scholars (see, notably, Adésínà (2020) and Ouma and Adésínà (2019)) have highlighted the negative role of Western donors and the damaging effect of their efforts of "policy merchandising" on Africa's democracy. The question raised by Adésínà (2020, p. 562) summarises the criticism well: "What, in the experience of Europe with social policy making, suggests that externally inducing policy makers in a country is the appropriate way to go about public policy making in Africa?"

In spite of these existing theories on social policy development in developing countries, e.g. Mkandawire (2012, 2011) or Kpessa and Béland (2013) stress that comprehensive theories on social

policy and welfare in developing countries are still lacking, particularly in the African context, noting that "there is little in social policy studies in developing countries as heuristically potent as Titmuss's and Esping-Andersen's work on welfare regimes" (Mkandawire, 2011, pp. 151–152). Yet, the literature on the Developmental Welfare State theory may present an alternative as it more closely looks at economic policies, notably industrial policy, and their nexus with social policies. The term "developmental state" was first coined by Johnson (1982), who was referring to the Japanese economic miracle and the country's use of industrial policy to achieve it. Later, Amsden (1989) and Wade (1990) highlighted the important role of state intervention in South Korea and Taiwan, respectively, and demonstrated that active industrial policy supported the process of structural transformation in these countries. The East Asian countries, characterized by accelerated export growth, solid agricultural sectors as well as a favourable demographic transition, prioritized industrialisation, which was identified as main factor for their economic development (Ikpe, 2008, pp. 4–5). Thus, the idea of the developmental state paradigm is based on the understanding that an active state facilitates economic growth while an economy transitions from an agricultural to an industrial base. Chang (2004), however, stresses that the experience of the East Asian developmental states has been used by free-market economists as proof that it is advantageousness for a state to ignore social policy and to merely focus on economic policy. Yet, Chang continues that "this is a fundamentally mistaken characterization of the East Asian developmental experience. The East Asian countries have used many policies and institutions to address social problems" (Chang, 2004, p. 247).

Nonetheless, while the focus on social policy as an important factor for development may have been disregarded at first, according to Mkandawire (2012), a second generation of developmental state literature puts stronger emphasis on the welfare and social policy aspect with regard to the developmental state. For instance, Kwon et al. (2017, p. 101) explicitly highlight that "social outcomes of the developmental welfare state were impressive in the East Asian countries". Also Fine (2014, 2009) argues that while the developmental state paradigm may have been inclined to neglect the role of welfare, placing the provision of welfare services within the framework of the developmental welfare state allows to acknowledge diverse causes, contents and consequences of elements of social policy.

In response to the shortcoming of existing theories that have tried to analyse the characteristic features of social policy development in various settings, Fine (2002) recommends an analysis of specific systems of provision that bear on social policy, which allows to take into account different contexts. The SoP approach opposes the categorisation of different welfare states into regimes but enables to unpack the diverse and complex determinants that drive a specific social policy intervention, here the NHAct, in a specific place, here Nigeria. In the following section, I introduce the

SoP approach, its comparative advantage for the purposes of my research and provide information on how it will guide my analysis of the Nigerian health policy reform process.

5. The Systems of Provision (SoP) approach

In the previous sections of this chapter, I surveyed different theories and frameworks, which seek to account for how social service delivery systems take form in different places, with the most popular one being Esping-Andersen's welfare regime approach. In addition, I reviewed the scholarship by African and other development scholars, who have advanced alternative theories seeking to provide explanations for social policy trajectories in African countries. Although these theories provide a wealth of potential explanatory variables for welfare system developments, a particular strength of the SoP approach to public service delivery is its emphasis on context- and system-specificities (Bayliss and Fine, 2020). As Fine (2004, p. 88-89; emphasis in original) puts it:

> [S]ocial policy is *programme-specific*. In other words, housing, education, health programmes, etc., have to do with housing, education and health … [I]mplicit in the previous point is the differentiation of social policy by country as well as by programme. Each country will be at its own stage of development, will have its own structure and dynamic of economic, political and ideological forces, and these will interact with, or be concretized through, the provision attached to particular programmes.

Since its inception, the SoP approach was concerned with understanding the context- and system-specific factors that determine consumption patterns and norms. Generally, the study of consumption has received considerable attention over past years across social science disciplines (see e.g. Daunton and Hilton (2001) for an overview of consumer history). The SoP approach was conceptualised in response to the shortcomings of neo-classical consumption theory, which sees consumption as a mere outcome of rational and individualised decision-making (Fine and Leopold, 1993). For Fine and Leopold (1993), post-modern theories and studies of consumption outside of economics, focusing on the "cultural lives of the consumers" (Daunton and Hilton, 2001, p. 6), were also inapt to assess adequately the complexities and diversities that generate consumption outcomes and to take into consideration structural shifts in notions and material practices of consumption and production with trends such as globalisation, neo-liberalisation, commodification and financialisation. In view of this, the SoP approach was presented as an alternative, coherent and robust approach to analysing consumption within social sciences, having been developed as a means to escape both "the devil of neo-classical economics and the deep blue sea of postmodernism" (Fine, 2013, p. 218).

In later years, the SoP approach shifted away from concentrating on private and marketized consumption only to also incorporate public consumption and public provisioning systems,

recognising that, in many places, the lines between public and private consumption have become diluted. This gave rise to the public sector systems of provision (PSSoP) approach (Fine, 2002b). According to Fine et al. (2018), consumer theory has long neglected to pay special attention to the provision of public goods and services, conveniently classing public consumption as social policy and leaving it untouched. Fine insists that "as soon as consumption becomes (recognizably) public, it tends to be redefined as something else, most notably as the welfare state, or, of course, social policy, putting it outside the realm of consumption studies" (Fine, 2014, p. 29). Yet, the commercialisation, commodification and financialisation of social services, over the past decades, have led to an increasing role of the private sector in previously public provision systems, while still requiring some form of state activity and regulation, as "even private provision cannot prevail in a totally disembodied market" (Bayliss et al., 2016, p. 9). The (PS)SoP puts emphasis on analysing the specificities of a good/service-specific public sector system of provision in a concrete location, as opposed to adopting an "Esping-Andersen-like" welfare regime approach of classifying welfare states into (ill-fitting) categories (Fine, 2009, p. 16). Moreover, the approach is committed to understanding the determinants that drive specific social policy interventions and how they impact citizens (Bayliss and Fine, 2020), which is at the core of what I aim to do with my research.

What is more, the SoP approach emphasises that the way in which a good or service is produced and provided influences whether individuals or groups of individuals will (and/or can) consume it. Such focus on production originates in Critical Political Economy, heavily concerned with the question of how societies produce the material conditions that enable their continued existence (Fine and Saad-Filho, 2016, p. 14). The logic of focusing on the sphere of production as starting point of an analysis appears meaningful, as goods and services need to be produced first before they can be exchanged or distributed; the production of a good or service – the process of workers putting their labour power towards creating value – is thus at the heart of the economy, while the way a production system is organised has implications for society (Choonara, 2009, p. 18). As Bayliss and Fine (2020) outline, the SoP approach is deeply concerned with understanding how the value of a product is created and seeks to comprehend the social relations that underpin its production. The SoP approach hence centres the fact that production processes are inherently linked with consumption outcomes.

As such, the SoP is a structured analytical framework that offers a way of paying attention to different elements within a specific provisioning system. It does so by, on the one side, considering the entire vertical chain of activity (from production, to transformation, to distribution, to consumption). On the other side, it takes account of the horizontal context (the social and historical environment). The vertical investigation of a material system of provision of a specific good or service addresses the question of how a good/service is produced, distributed, consumed, in order to understand who gets

what. The approach does so by connecting the consumption of a product to the entire chain of activities within a provisioning system, recognising that such a system is shaped by different agents, their relation to each other as well as structures and processes within the SoP. Consumption, then, is seen as integrally interrelated with the production, transformation, provision and distribution of a particular good or service, themselves shaped by social, political, economic, geographic and historical factors (Bayliss et al., 2016b, pp. 1–2). Each SoP is different, consists of multiple factors, agents and institutions and is constructed by a plurality of parties, making it essential to analyse elements (and their relationships) such as the context, financing, policy design and the role of public and private actors, among others (Bayliss et al., 2016, p. 1).

At the same time, the SoP approach emphasises that consumption norms are also a product of personal experience and cultural/social dynamics (the horizontal context). Depending on their location, gender, class, race, social statues, etc. (and the intersections across these dimensions), people will give different meaning and attach different levels of importance to the consumption of a specific good/service. By way of illustration and borrowing from Bayliss et al. (2016a, p. 30): "although chemically the same, water in a drought is different from water in a flood. Bottled water is not the same as supply from a public water system. The culture of water consumption is therefore contextual". Moreover, over the years, the SoP approach has been adapted to more explicitly account for trends such as globalisation and neo-liberalisation and their impact on narratives and consumption outcomes. Evolving narratives impact not only policy, but also influence the culture and meaning attached with a particular good or service: for example, if the narrative is that private healthcare provision is of higher quality, Nigerians may feel unhappy if they have to seek publicly provided healthcare. Therefore, beyond looking at the vertical chain of activities from production to consumption, the approach puts emphasis on understanding what it "means" to an individual or group of individuals to consume a specific good or service. The "material culture" is not only affected by the way the good/service is being provided, but also contingent on differences in gender, age, income level, location, occupation, race, ethnicity, etc. (Bayliss et al., 2016, p. 3). The SoP approach hence considers the interconnected nature of the material system of provision of a certain good or service with the material culture, influencing consumers' needs, preferences and ability to consume a good or service (Bayliss et al., 2016).

In essence, the SoP approach seeks to combine the investigation of the vertical chain of activities with the horizontal context in which the provisioning system is located. The framework encourages the researcher to link the investigation of the material system of provision of a good/service with an analysis of the cultural meanings attached to the good/service in view of gaining a better understanding of why a good/service gets produced, provided and consumed. **Error! Reference**

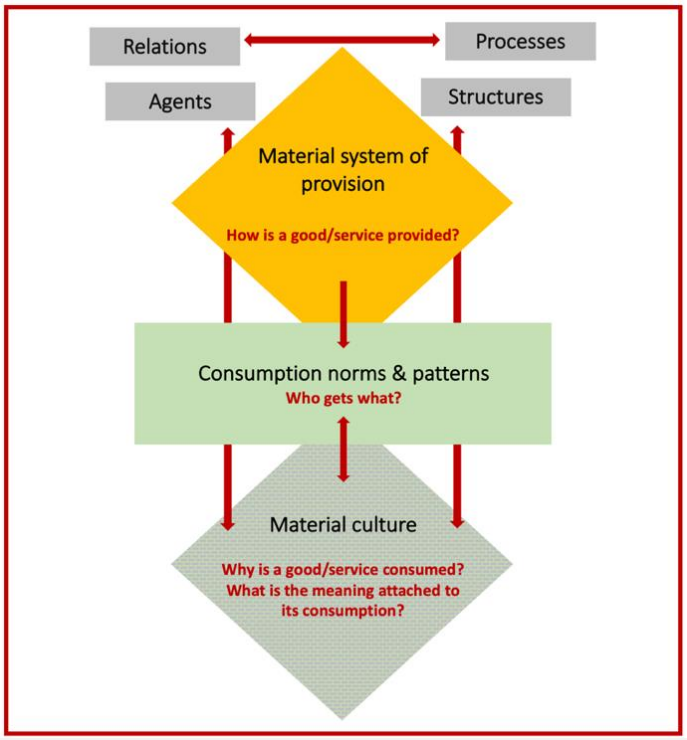
source not found. summarises the “five fundamentals” of the SoP approach. Figure 8 illustrates the central tenets of the SoP approach graphically.

Table 3: The five fundamentals of the SoP approach

Agents and agencies	First, systems of provision are determined by their participants, i.e. its consumers, producers, the state (which can take the role of a regulator, a policy maker, a consumer, a provider, etc.), global institutions, etc.
Structures	Second, these agents operate within a particular set of structures, which are highly context-specific and evolving.
Processes	Third, processes such as globalisation, trends of privatisation and financialisation etc. as well as processes linked to a specific activity impact “how things are done” within a system of provision.
Relations	Fourth, agents, structures and processes are related in particular ways: what is the structure of certain relations, what is the relation between different agencies within these structures and which processes are in place that reinforce and/or alter processes in place?
Material cultures	Fifth, the SoP approach emphasises the importance of material cultures and the meaning, norms and beliefs attached to the consumption of a particular good or service.

Based on Bayliss and Fine (2020)

Figure 8: Conceptualisation of the SoP approach



Source: Own illustration

6. Conclusion

In today's international development discourse, particular emphasis is put on promoting social protection systems as part of a country's development strategy. Yet, the form these social protection systems take in practice, e.g. in the African context, differ greatly from the generous welfare states that were put into place across most of Europe in the mid-20th century. This chapter argued that, over time, the focus shifted from the ambition to provide a wide range of social services universally towards the fostering of more narrowly conceived social assistance programmes, such as means-tested cash transfer programmes. As a consequence, since especially the IFIs endorse an instrumentalist approach to social protection, truly universal access to social services (provided through an integrated system) is not guaranteed and residual and targeted forms of social protection continue to be implemented in many countries.

The literature, aimed at analysing and understanding the different approaches to and practices of social policy, is vast, and a number of scholars have brought forward theories and ideas that help explain social policy trajectories and welfare practices, at different points in time and place. While many scholars have concentrated on theories of the European welfare state, development scholars have also presented their own notions on social policy development in the Global South. Still, the "Global South" is a diverse and broad category, making it difficult to develop a framework that allows to classify countries within specific groups. Yet, there have been scholarly contributions trying to imitate Esping-Andersen's regime approach as well as contributions, which identify determinants that have similarly affected social policy practices across a multitude of developing countries.

In the interest of taking into consideration various elements brought forward by an array of these scholars but maintaining the view that it is necessary to account for the heterogeneity of social policy systems of developing and emerging countries, Fine's SoP approach stands out as a practical and structured framework to guide the analysis of a specific social service delivery system and the elements that shape the policy landscape embedding it. In this sense, I have introduced the SoP approach as analytical framework to guide my research and have provided information on its origin as well as its evolution from a framework focusing on private consumption to a framework, incorporating public consumption and social policy. I have outlined its theoretical background and have presented the five "fundamental" elements of a SoP investigation (agents, relations, structures, processes, and material culture). However, before moving onto how the SoP approach can be applied to the study of the policy environment embedding the Nigerian healthcare system of provision, Chapter 2 provides a discussion of trends and tendencies that pertain to health policy development and practices of healthcare service delivery systems.

CHAPTER 2 | Health policy and changing perceptions of Universal Health Coverage

1. Introduction

Most social security and human rights declarations since the 1950s have made reference to the right to health, maintaining that physical and mental well-being are essential for human progress. Prominently, the 1978 Alma-Ata Declaration put emphasis on the universal human right to a comprehensive set of primary healthcare services, going beyond the right to receive medical treatment only in the case of sickness (Yi et al., 2017, p. 5).[53] Moreover, it was maintained that achieving *health for all* (by the year 2000) is only possible, if, simultaneously, global efforts are aimed at fighting imperialism and neo-colonialism and correcting international inequities and injustice (UNGA, 1974).

According to Koivusalo and Mackintosh (2005, p. 5), "health policies define the direction towards which health systems are geared, how health systems are resourced and on what basis these operate". Health policy, as an aspect of social policy, has been particularly exemplary of the impact that different interpretations of universalism have on the realities and practices of healthcare delivery. Moreover, the provision of healthcare, alongside educational services, are central to social policy, occupying, in most places, a large share of public budgets (Fischer, 2018). Furthermore, the intersections between health and social inequalities and other forms of discrimination (i.e. on basis of race/ethnicity, indigenous status, immigrant status, gender, sexuality, disability, age, etc.) are critical (Krieger, 2014; Navarro, 2007; Navarro and Shi, 2001). For instance, O'Laughlin (2016, p. 687) emphasises that "what was once the rather marginal specialized field of international health development has been transformed into a new field – global health – in which inequality is a central issue".

Drawing on the discussion of changing conceptions of social policy in the previous chapter, this chapter documents how health policy and healthcare delivery systems, in particular, have been impacted by shifts in views, priorities and practices of social policy. Specifically, I explore the effect of the diversity of interpretations of what social policy is in the context of health and healthcare provisioning systems. I highlight that the narrowing scope of social policy is particularly visible in the area of health. The rise of neo-liberalism, accompanied by the intensification of the commercialisation

[53] Commonly, three different levels of care are distinguished: (i) primary level (the first contact level with patients, including health posts, smaller healthcare facilities, dispensaries); (ii) secondary level (a more sophisticated hospital, e.g. at provincial level); and (iii) tertiary level (the most sophisticated hospital, such as teaching hospitals located in provinces' capitals); see here: https://2018.iupesm.org/wp-content/uploads/2014/06/WHO-LevelsofHealthServices.pdf (last accessed 15/07/2020).

and commodification of social services, has had significant implications for the distribution of roles between private and public sectors in health and has impacted the practices of universal provision of healthcare. Like the variety of positions and views on what social policy is and what functions it needs to fulfil, there are a multitude of perceptions of what universal health **care** (nowadays, universal health **coverage**) is and entails – and how it can and should be attained. Different actors understand and conceptualise universalism differently, and while the goal of UHC "has risen to the top of the global health agenda, even becoming one of the key pillars of the UN's SDGs …, [the] UHC cooptation story is illustrative of the fate of many progressive international and global health policy efforts in the context of neoliberal globalization over the past three decades" (Birn et al., 2016, p. 735). Ultimately, the way UHC is understood and the shape different countries' healthcare systems take depend on localised political struggles and processes (Fox and Reich, 2015; Greer and Méndez, 2015; McKee et al., 2013). Against this backdrop, I argue that the notion of comprehensive primary healthcare, previously considered a universal human right, has been replaced by a concept of universal health coverage, which pays less attention to integrated provisioning modalities or quality of services.

This chapter proceeds as follows. Section 2 presents how global health policies and perceptions of what universal healthcare service provision should entail have shifted over time and continue to differ across countries and regions. I emphasise that the vision of universal and comprehensive healthcare, that prevailed until the 1980s, was weakened with the emergence of neo-liberalism. Since then, cost-efficiency considerations were brought to the forefront and the door was opened to the commercialisation and privatisation of health sectors.

In section 3, I focus on how UHC is understood today and the political and economic factors that impact the varying degrees of universalism in different healthcare systems. I outline how more recent calls for UHC are not necessarily echoing the spirit of the Alma-Ata declaration – in spite of a (nominal) return to universalism and a (nominal) renunciation of selectivity. While existing characterisations of UHC are discussed and set out, it is also maintained that the definition of UHC remains "nebulous" (Stuckler et al., 2010, p. 8) and that, overall, the meaning of universalism has been diluted. Today, the focus seems to be on increasing the proportion of people "covered" with services, but discussions on who is responsible for guaranteeing and financing access to which health service as well as whether healthcare services are being provided in an integrated and equalising manner have been marginalised (Fischer, 2018, p. 241).

Section 4, then, turns to the different manifestations of healthcare delivery systems in practice more specifically. I provide an overview of (the lack of) progress made towards UHC on the African continent and appraise different health financing systems. I review the consequences of the commercialisation

of health sectors and the increased role of the private sector in healthcare systems in further detail, challenging the assumption that health services provided by the private sector are of superior quality.

Section 5 summarises the contributions of this chapter, including a review of shifts in global health policy, a discussion of concepts and theories of UHC and universalism, and an overview of practices of UHC.

2. Shifts in global health policy

This section emphasises that already in the 19th century, activists highlighted the important link between social conditions and health. Later on, the 1978 Alma-Ata Declaration, in particular, took aboard these reflections and promoted the reduction of societal inequities to be accompanied by efforts targeted at attaining health for all as a human right. I emphasise that in the aftermath of the Alma-Ata conference, the vision of universal and comprehensive primary healthcare was challenged and weakened. User fees were introduced as part of neo-liberal reforms and more responsibility was placed on the individual and the household to provide for their health. In particular, the World Bank and the Bill and Melinda Gates Foundation have (strongly) promoted this shift towards private responsibility and provisioning.

2.1. Social conditions, a fair international economic order and health

In 1845, Friedrich Engels published his famous essay on *The Conditions of the Working Class in England*, which described the disastrous link of a hazardous working environment and poor housing conditions with the state of health of members of the working class (Engels, 1845). Prominently, Engels highlighted the adverse effect that the industrialised, capitalist mode of production had on workers, considering illness, disease, work-related accidents as well as high levels of poverty to be "deliberate by-products of capitalism" (Sell and Williams, 2019, p. 3). Engels' observations were similar to the ones made by Edwin Chadwick at the time, who authored the UK's 1842 Sanitary Report (which is, every so often, considered as the beginning of modern public health), namely that "poverty was a conscious and deliberate part of a structure of accumulation associated with industrial capitalism, creating … a new system of wage slavery and inequality that had devastating impacts on health" (Sell and Williams, 2019, p. 3). Engels' assessment of the relation between the exploitative nature of capitalism and ill-health is also well-reflected in the body of work of the Prussian 19th century physician Rudolf Virchow. Virchow has become known to have popularised the concept of "social medicine", as he, too, considered societal problems to be the root cause of disease and illness (Waitzkin, 1978; Waitzkin et al., 2001). Virchow's view of how to counteract the spreading of epidemics was to avoid concentrating on medical solutions only – contrary to what the most prominent proponents of germ

theory of the time were advocating[54] – but to intervene in the political arena in order to compel economic and social change in favour of the working class (Waitzkin, 1978). Especially after the revolutions of 1848 against European monarchs, Virchow became an outspoken political advocate, pleading for improved working conditions, better remuneration and a more progressive tax system (Waitzkin, 1978). Krieger (2016) documents how Virchow was convinced that more focus needed to be put on actions addressing social conditions fostering illness and that doctors and medical facilities needed to be put under state control.

The perspectives of Engels and Virchow, however, did, at the time, not receive much traction within Europe, where responsibility for health or sickness was seen to rest with the individual and considered to be unrelated to the environment the individual lived and worked in (Navarro, 1976). Nonetheless, in the late 19th and early 20th centuries, public health initiatives (e.g. sanitation programmes) as well as forms of health insurance schemes were introduced, e.g. in Germany under Otto von Bismarck and in the UK under David Lloyd George. Also, during this period, in 1913, the US business magnate John Rockefeller founded a private charity, the Rockefeller Foundation, kickstarting the new American movement of scientific philanthropy, which, at the time, looked into applying technical solutions to specific health problems and disregarded underlying causes of sickness, such as poor housing conditions (Birn and Richter, 2018, p. 157).

In 1937, however, the Bandoeng conference under the leadership of the League of Nations Health Organisation (LNHO) took place, advocating for better rural hygiene as an important component of public health (Medcalf et al., 2015, p.4; Brown and Fee, 2008, p. 42).[55] Then, after the end of the two major European wars, welfare states, including platforms supporting health sectors, emerged across most European countries with the aim to ease the worst impact of industrial capitalism on the working class. Furthermore, the World Health Organisation was established in 1948, but initially had its primary focus on vertical health programmes (notably, malaria eradication) (see Litsios 2020).

Concerns related to mounting a health infrastructure in countries of the Global South, which was capable of providing basic healthcare services, only emerged from the 1960s onwards (Litsios, 2004, p. 1885; Cueto, 2004, p. 1864). Especially, African and Asian nations, newly decolonised and part of the non-alignment movement, criticised the WHO's narrow vertical approach, advocating for a broader social and political response to health crises (Birn and Richter, 2018, p. 161). Moreover,

[54] I.e., Louis Pasteur and Robert Koch.

[55] However, as Medcalf et al. (2015, p. 4) highlight: "as important as this conference was, there is little direct evidence that it had an impact on global health thinking following World War II".

outside of the European continent, Virchow's ideas had already been influential earlier.[56] Notably, Vladimir Lenin in the Soviet Union (which had a public health system since 1922), Salvador Allende in Chile (where social medicine was promoted since the 1920s), Mao Zedong in China (where a rural health system was introduced after the revolution in 1949), or Che Guevara in Cuba (where universal healthcare was adopted in the 1960s) were adamant to build strong public health systems, recognising the important relationship between politics, economics and health (Waitzkin, 1978). Especially, China's "barefoot doctors" (or, since the 1980s, "village doctors") are considered a "major inspiration to the primary health care movement leading up to the conference in Alma-Ata, in in the former Soviet Republic of Kazakhstan in 1978" (Weiyuan, 2008, p. 914). China's rural health system, put into place in the mid-19th century, prioritised PHC and played a vital role in facilitating access to preventive and basic healthcare services for people living in the rural areas of China (Hu et al., 2017).

By the 1960s, the importance of developing integrated health systems had moved to the forefront at the WHO (at the time, under the leadership of Marcolino Candau).[57] This culminated in the adoption of a resolution on basic health services in May 1973, which emphasised the importance of extending preventive and curative basic services to all people. A few months later, Halfdan Mahler, who had been instrumental in driving basic health services within the WHO in his role as one of five assistant directors-generals, became the director-general of the world's leading intergovernmental health agency. He collaborated notably with UNICEF as well as with the Christian Medical Commission (CMC) to reinforce health systems across the world (Litsios, 2004). At the same time, the WHO started engaging with the social determinants of health (although the formal Commission on the Social Determinants of Health (CSDH) was only founded many years later in 2005).[58] Notably, WHO senior staff member, Kenneth Newell, who spearheaded the formal creation of the organisation's PHC programme in 1975, highlighted that there are "studies demonstrating that many of the 'causes' of common health problems derive from part of society itself and that a strict health sectoral approach

[56] Even prior to Virchow, in the early 1880, a form of state-sponsored public health programme, comprising vaccination campaigns in order to reduce infant mortality and fight epidemics, had been introduced to Egypt under its ruler Muhammad Ali. However, as Esposito (2004, p.191) highlights: "The British occupation of Egypt in 1882 thwarted Ali's efforts, however. Colonial authorities introduced a Western form of medicine to the country. Furthermore, they privatized medical education and established English as the language of instruction".

[57] Health systems are understood as "activities whose primary purpose is to promote, restore or maintain health" (WHO, 2000, p. 5).

[58] As stated on the WHO website, the social determinants of health are the conditions in which people are born, grow, live, work and age. These circumstances are shaped by the distribution of money, power and resources at global, national and local levels. The social determinants of health are mostly responsible for health inequities – the unfair and avoidable differences in health status seen within and between countries; see: https://www.who.int/social_determinants/sdh_definition/en/ (last accessed 09/07/2020).

is ineffective, other actions outside the field of health perhaps having greater health effects than strictly health interventions" (Newell, 1975, p. xi).[59] Moreover, the role of the CMC, in particular, was influential and decisive in promoting comprehensive primary healthcare as an entitlement and universal human right and in reinforcing the fight against health inequities – ideas, which were taken fully aboard by the WHO by the mid-1970s:

> To do so, the CMC from its inception gave priority to what it termed comprehensive health care – "a planned effort for delivering health and medical care attempting to meet as many of the defined needs as possible with available resources and according to carefully established priorities." Such a program "should not be developed in isolation but as the health dimension of general development of the whole society" (CMC's letter of application for NGO relationship with the WHO from 3 February 1969, cited in Litsios (2004, p. 1888).

Thus, the combination of these experiences, influences and efforts aimed at promoting PHC service delivery, embedded in broader ambitions of addressing international inequities, resulted in the organisation of the land-mark international conference on PHC in Alma-Ata in the former Union of Soviet Socialists Republics (today, Almaty in Kazakhstan) in September 1978.[60] The enthusiasm for PHC as a corner stone of a fairer world order echoed the political climate of the time. Many African countries had newly gained their independence from colonial powers and were engaged with nation-building and actively advocating for anti-imperialism. A few years before the Alma-Ata conference, in May 1974, the United Nations General Assembly adopted its *Declaration on the Establishment of a New International Economic Order* (NIEO). The declaration, initiated by a group of developing countries that had formed part of the Non-Aligned-Movement during the Cold War, was meant to support the struggle against neo-colonialism and imperialism and to "correct inequalities and redress existing injustices [and to] make it possible to eliminate the widening gap between the developed and the developing countries" (UNGA, 1974)[61]. As Cueto (2004, p. 1865) contends: "[m]odernization was

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[59] In parallel, Marc Lalonde, Minister of National Health and Welfare in Canada, had published a report in 1974, making the similar argument that healthcare services themselves are not the most important determinants of health, but also lifestyle, environment and human biology (alongside healthcare organisation) are determinants of health (Glouberman and Millar, 2003; Hancock, 1986). Other influential works of the time, promoting similar perspectives, were Carl Taylor's work on rural medicine in India (Taylor, 1976) as well as the work by the British historian Thomas Mckeown (McKeown, 1976).

[60] 134 countries were represented at the conference; yet, the Chinese delegation, which had initiated the discussions around organising such a conference and whose rural health systems had inspired the notion of PHC, was absent because of worsening relations with the Soviet Union (Cueto, 2004).

[61] Declaration on the Establishment of a New International Economic Order; online available: https://digitallibrary.un.org/record/218450?ln=en#record-files-collapse-header (last accessed 03/07/2020).

no longer seen as the replication of the model of development followed by the United States or Western Europe. For example, Prime Minister Lester B. Pearson of Canada and Chancellor Willy Brandt of West Germany chaired major commissions on international development emphasizing long-term socioeconomic changes instead of specific technical interventions".

Against this backdrop, the Declaration of Alma-Ata emphasised the need for social and economic development on basis of the principles established in the declaration on the NIEO in order to attain "health for all".[62] At first, the commitments made in Alma-Ata (and endorsed at the 32nd World Health Assembly in Geneva in 1979), grounded in an understanding that health problems need to be addressed by correcting social and economic inequalities and by adopting an intersectoral and community-based PHC approach rather than focusing on "top-down, techno-biological campaigns", seemed to have been well-received by most governments (Birn et al., 2016, pp. 738–739). Nonetheless, the consensus achieved at the conference did not stand strong for long and critical voices emerged soon, worrying that the ideal of universal care for all by 2000 was not affordable (Stuckler et al., 2010).

2.2. From comprehensive to selective primary healthcare

In 1979, the Rockefeller Foundation,[63] with the assistance of the World Bank (Brown et al., 2007, p. 67), organised a meeting in Bellagio (Italy) to discuss more cost-effective disease control programmes, building on an idea brought forward by Julia Walsh and Kenneth Warren, who suggested the pursuit of an (interim) strategy of offering "selective" primary health care (SPHC):

> The goal set at Alma Ata is above reproach, yet its large and laudable scope makes it unattainable in terms of its prohibitive cost and the numbers of trained personnel required. … How then, in an age of diminishing resources, can we best attempt to secure the health and well-being of those trapped at the bottom of the scale long before the year 2000 arrives? We believe that a *selective* attack on the most severe public health problems facing a locality should be considered in order for us to have the greatest chance to improve health and medical care in less developed countries (Walsh and Warren, 1980, p. 145).

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[62] Declaration of Alma-Ata; online available: https://www.who.int/publications/almaata_declaration_en.pdf (last accessed 03/07/2020).

[63] As Martens and Seitz (2015, pp. 23-24) highlight, in the first half of the 20th century, the Rockefeller Foundation was one of the most influential actors shaping the discourse on global health governance, focusing on innovations on biomedical solutions to health problems. Yet, as Levich (2015, p. 709) emphasises, the Rockefeller Foundation's motive was not only altruistic and "as Rockefeller expanded its international health programs in concert with U.S. agencies and other organizations, additional advantages to the imperial core were realized. Modern medicine advertised the benefits of capitalism to "backward" people, undermining their resistance to domination by imperialist powers while creating a native professional class increasingly receptive to neocolonialism and dependent on foreign largesse".

The concept of SPHC was promoted by a multitude of actors, notably the World Bank. Also, UNICEF, which had co-sponsored the Alma-Ata conference only a short time earlier, started promoting and implementing its "GOBI-FFF" programme from 1982 onwards. The organisation deemed a focus on "**G**rowth; **O**ral rehydration therapy; **B**reast feeding; **I**mmunisation; **F**amily spacing; **F**ood supplements; **F**emale education" to be more cost-effective (Stuckler et al., 2010, p. 14). Thus, under the auspices of UNICEF's new executive director, James Grant, the son of a Rockefeller Foundation medical doctor, UNICEF made a U-turn, replacing PHC with SPHC, which it believed created the right balance between political opportunity, scare resources and outcomes (Cueto, 2004). Besides UNICEF, also other aid organisations favoured the SPHC approach, which was perceived to be "more measurable, rapid, and less risky than PHC" (Medcalf et al., 2015, p. x). Yet, the proponents of PHC were clear on the limits and shortfalls of turning away from PHC towards the SPHC approach. Notably, Newell (1988, p. 904) clearly articulated that "[t]o the convinced PHC advocate such SPHC proposals are not PHC at all but are the antithesis of it. They are disease control programmes which are ideologically similar to the malaria eradication disaster and are a regression to the very qualities of imposed systems which were described in the Organisational Study".

Subsequently, many governments turned away from the Alma-Ata principles with the rise to prominence of neo-liberal ideology and the ensuing push for budget discipline throughout the 1980s. For instance, as Birn et al., 2016 (p. 739) highlight, "most Latin American governments rejected, or in some cases coopted, the Alma-Ata approach, instead favouring SPHC, which fitted the ascendant strategies of targeted short-term programmes in the absence of rights, fragmentation of social policy, and increased community responsibility for health services delivery". In the African context, however, where a majority of countries had by now attained their independence and were hoping for favourable economic and political conditions to provide impetus to their development, PHC was seen as a way of improving the mainly curative and urban-centred health systems inherited from the colonial period. And, in spite of economic difficulty and high public debt levels throughout the 1980s and 1990s, there were "clear attempts to abide by the orientations of the PHC strategy" (Chatora and Tumusime, 2004, p. 297).[64]

Nonetheless, in 1987, on the initiative of UNICEF (and backed by the WHO), African ministers of health adopted the Bamako Initiative (to be implemented alongside UNICEF's GOBI-FFF programme). The Bamako Initiative sought to ensure drug availability and community participation but was rooted in

[64] The authors mention Botswana, Burkina Faso, DR Congo, Malawi, Guinea, Namibia and Tanzania (Chatora and Tumusime, 2004, pp. 297–298). Also, Nigeria launched its first comprehensive health policy based on the principles of PHC and Alma-Ata in 1988 and instituted the NPHCDA in the 1992 (Aregbeshola, 2017, p. 48).

individualistic presuppositions as it introduced "co-financing" responsibilities for health service users. Thus, the poorest members of communities were now asked to pay for services, which previously had been accessible for free, often leading to their exclusion from service delivery (Yi et al., 2017, p. 5). Already at that point in time, there were concerns that "[q]uite apart from the debatable long-term impact of the health strategy being advocated, the Bamako Initiative poses serious questions related to equity and the implementation of fee systems which must be answered" (Kanji, 1989, p. 110).

2.3. The rise of the World Bank and the Gates Foundation in global health policy

In 1988, Mahler handed over leadership at the WHO to the Japanese researcher Hiroshi Nakajima.[65] Nakajima "rapidly became the most controversial director general in WHO's history" being criticised for "his autocratic style and poor management, his inability to communicate effectively, and, worst of all, cronyism and corruption" (Brown et al., 2007, p. 68). Moreover, the WHO was confronted with a shortfall in funding, as the organisation's dependence on extrabudgetary resources from donors and multilateral agencies increased, replacing income generated from states' membership fees (Godlee, 1994; Walt, 1993). Especially, the reduction of US financial support – which is the WHO's largest donor, but against several of the WHO's positions (its stance on PHC; its support for generic essential medicines; its reluctance to promote breast-milk substitutes) – considerably weakened the organisation's position (Birn et al., 2016, pp. 738–739). Thus, while the WHO was still an important cradle of technical expertise, its leadership role in the global health policy area was contested, with the World Bank in particular taking advantage of the WHO's crisis, assuming the role of the lead agency in the global health space (Abbasi, 1999, p. 868). Brown et al. (2007, p. 68) highlight that "in the late 1980s and early 1990s, the World Bank moved confidently into the vacuum created by an increasingly ineffective WHO … The Bank maintained that existing health systems were often wasteful, inefficient, and ineffective, and it argued in favo[u]r of greater reliance on private-sector health care provision and the reduction of public involvement in health services delivery".

With the World Bank in the driving seat, the commercialisation and privatisation of health sectors, which had started in the 1970 as part of neo-liberal reforms, intensified (Yi et al., 2017, p. 4). As Adejumobi (1999, p. 88) highlights, "what is new in the present conjuncture is that the privatisation project hitherto confined to the areas of industry, manufacturing and agriculture, which the state participated in, is now being extended to the area of social welfare services and the state

[65] Interestingly, Nigeria's former Minister of Health, Dr. Olikoye Ransome-Kuti was amongst those contesting for the top position.

infrastructure sector".[66] And, with the new predominance of the World Bank on matters of global health, and the publication of the World Bank's 1993 report, *Investing in Health*, the shift away from provision of health as a public duty towards private responsibility, in favour of healthcare being seen as private good, was solidified (Laurell and Arellano, 1996). Since then, a pro-market stance has been the outspoken position of the World Bank, with the 1993 report promoting cost-effectiveness and policies for privatisation and commercialisation (Hunter and Murray, 2019, p. 4; Pfeiffer, 2019, p. 52). In essence, the role of the government is confined to offering basic services to the poorest members of society as provider of last resort and, if necessary, to performing a regulatory function (World Bank, 1993, pp. 5; 164). The Bank's main reasoning for their proposition was grounded in the view that government subsidies support richer rather than poorer segments of society, as articulated in the same report (World Bank, 1993, p. 11).

While a strong case can be made for integrated and well-funded public systems and, according to Ruckert and Labonté (2014, p. 1600), "full-scale privatisation of health was abandoned" by the mid-1990s, in reality, the emphasis on private sector engagement in the area of health continues – in particular as promoted by the World Bank, but also private foundations, such as the Bill and Melinda Gates Foundation (BMGF). Bill and Melinda Gates entered the global health arena, first with the establishment of the William H. Gates foundation and the Bill and Melinda Gates Children's Vaccine Programme and then with the launch of the BMGF in 2000, replacing the Rockefeller Foundation as the most powerful private foundation in global health governance[67] (Birn, 2014). The same year, the Global Alliance for Vaccines and Immunisation (GAVI) was founded by the Gates, operating as a private-public partnership.[68] Two years later, the Global Alliance for Improved Nutrition (GAIN) was launched (and co-founded by the Gates) and the Global Fund to Fight AIDS, Tuberculosis and Malaria

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[66] Commercialisation is defined to include "the provision of health care services through market relationships to those able to pay; investment in, and production of, those services, and of inputs to them for cash income or profit, including private contracting and supply to publicly financed health care; and health care finance derived from individual payment and private insurance" (Mackintosh and Koivusalo (2005, p. 3) cited in Yi et al. (2017, p. 4)). As Koivusalo and Mackintosh (2005, p. 18) argue, this makes commercialisation a broader category than privatisation (transfer of ownership of an asset from the public to the private) or marketisation (change from a government-led provisioning system to a market-led system of provision) and distinguishes it from commodification (creation of a sellable product). In the context of the latter, Fischer (2018) and Mackintosh (2006) make reference to Karl Polanyi, who speaks of fictitious commodification as healthcare or education are not like "normal" commodities, which are produced for market exchange.

[67] Levich (2015) makes an important point when stating the following: "**Global health governance,** the phrase typically used to describe health management in the era of Bill Gates, is perhaps too narrow to comprehend the character and ambitions of the project I have attempted to outline. It may be more useful to employ the term **global health imperialism**" (p.732; emphasis added).

[68] See, e.g. the description of their operation model on their website: https://www.gavi.org/our-alliance/operating-model (last accessed 06/07/2020).

(commonly known as the Global Fund) was initiated, also with the financial support of the Gates. Buse and Walt (2000) point at the emergence of a multitude of such global public-private partnerships – or global health initiatives (Languille, 2017; Storeng, 2014) – since the late 1990s, defining them as "a collaborative relationship which transcends national boundaries and brings together at least three parties, among them a corporation (and/or industry association) and an intergovernmental organization, so as to achieve a shared health-creating goal on the basis of a mutually agreed division of labour" (Buse and Walt, 2000, p. 550).

Since its inception, the BMGF has played a decisive and priority-setting role in the field of global health. It has become the second-largest donor to the WHO after the US (Martens and Seitz, 2015, p. 31). As of 31 December 2018, the BMGF had asset endowments of US$ 46.8 billion and provided direct grantee support of US$ 5 billion in 2018 only.[69] This compares to the WHO's 2018-2019 budget of US$ 4.4 billion.[70] Yet, little of their funding is consigned to entities located in the Global South as research conducted by McCoy et al. (2009) highlighted: between 1998 and 2007, 40 percent of the BMGF's resources were channelled via supranational organisations (global health initiatives and intergovernmental organisations), while, of the remaining share, 95 percent of grants went to organisations located in the US, Europe or other high-income countries. Moreover, most of the BMGF's grants directly channelled to the WHO are earmarked funds, leaving the WHO with limited scope to push forward its own priorities. Former director-general Margaret Chan observed: "[m]y budget [is] highly earmarked, so it is driven by what I call donor interests." (Martens and Seitz, 2015, p. 31 citing an interview Chan gave to the New York Times in 2014).[71] Therefore, like the Rockefeller Foundation in the first half of the 20th century, the BMGF has become "the most influential agenda-setter in the global health and nutrition arena (and in agriculture, development, and education)" (Birn and Richter, 2018, p. 155). Birn and Richter (2018) further contend that while both of these private foundations were created by the richest men of their times and on basis of a view that public health is a necessity for capitalism to thrive, the Rockefeller Foundation, still, emphasised the State's duty to provide healthcare, whereas the BMGF seems to prefer collaboration with corporate (and) non-governmental partners, having a less favourable view of and interest in the public sector.

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[69] See the foundation's fact sheet at: https://www.gatesfoundation.org/Who-We-Are/General-Information/Foundation-Factsheet (last accessed 06/07/2020).

[70] See annex of adopted resolution of the WHO 2018-19 programme budget: https://www.who.int/about/finances-accountability/budget/PB2018-2019_en_web.pdf?ua=1 (last accessed 06/07/2020).

[71] See: https://www.nytimes.com/2014/09/04/world/africa/who-leader-describes-the-agencys-ebola-operations.html?_r=0 (last accessed 06/07/2020).

Therefore, in line with the World Bank's promotion of the private sector, the BMGF favours a business-oriented and technology-driven approach to tackling a specific health problem instead of a broader health systems strengthening approach (Birn, 2005; Martens and Seitz, 2015; Storeng, 2014). Levich (2015, p. 706), for instance, insists that the Gates are only providing "brief lip service to the idea of strengthening public health services in poor countries". Along similar lines, an interview with a GAVI employee conducted by Storeng (2014, p. 868) uncovered the following:

> The Gates Foundation was 'a very loud, vocal voice, saying that we do not believe in the strengthening of health systems', said one of GAVI's strongest health systems proponents, recalling that Bill Gates often told him in private conversations 'that he is vehemently against health systems ... he basically said it is a complete waste of money, that there is no evidence that it works, so I will not see a dollar or cent of my money go to the strengthening of health systems'.

While more resources for health appear good and necessary, the caution that e.g. Birn and Richter (2018) maintain with regard to the scale and nature (and ensuing influence) of "selfless philanthropic generosity" seems justified (see also McCoy and McGoey, 2011; O'Laughlin, 2016, p. 20; Storeng, 2014). Firstly, so-called philanthro-capitalists'[72] often are motivated by their own concerns around their reputation and their corporate interests; secondly, there are issues of democratic accountability and transparency;[73] and thirdly, much of their profits made over the past decades were to the detriment of the working class, were the result of the exploitation of elaborate tax avoidance schemes and contributed to increasing inequality (Birn and Richter, 2018, p. 171; Curtis, 2016). As Curtis (2016, p. 8) expresses: "there is something wrong when any individual is allowed to accrue such a vast fortune while billions languish in poverty".

3. Universalism and Universal Health Coverage: how is it understood today?

In October 2019, following a high-level meeting on UHC, which had taken place the preceding month, the UN General Assembly adopted a political declaration, repeating the pledge of the world's national

[72] Birn and Richter (2018, p. 156) refer to the US business editor of the Economist, who first coined the term philanthrocapitalism, which refers to "both to infusing philanthropy with the principles and practices of for-profit enterprise and as a way of demonstrating capitalism's benevolent potential through innovations that allegedly 'benefit everyone, sooner or later, through new products, higher quality and lower prices'".

[73] See e.g. Erikson (2015) on clandestine financial dealings in global health.

leaders to achieve UHC[74] – praised as "the single most powerful concept that public health has to offer" by the former head of the WHO, Margaret Chan.[75] Accordingly, a 2019 UNGA resolution puts emphasis on health being a human right with the government being the primary duty bearer, contends that health is both a condition as well as an outcome of social and economic circumstances, and further highlights that attaining UHC, as part of efforts to attain the SDGs by the year 2030, is conditional upon improving PHC service delivery. This is stated in paragraphs 1, 5 and 13 of the declaration (UNGA, 2019).[76]

Thus, for proponents of a rights- and solidarity-based understanding of universal health care, embedded in broader economic and social policies promoting international equity and justice, the mention of the Alma-Ata conference in this new resolution is particularly encouraging. Seven years earlier, in December 2012, the UNGA had adopted a similar resolution, urging national decision-makers to accelerate efforts towards the attainment of UHC.[77] Yet, while the 2012 declaration makes mention of "comprehensive PHC" (once) and refers to the social determinants of health, there is no reference to the Alma-Ata Declaration nor global justice. It does, however, mention the Report of the 1994 International Conference on International Population and Development, which, in turn, refers to Alma-Ata. Other important resolutions at the UN since then, which make reference to UHC, include, most prominently, the 2030 Agenda for Sustainable Development (targets 3.8),[78] but also the 2015 Addis Ababa Action Agenda on development finance[79] and the 2016 resolution on global health and foreign policy, health, employment and economic growth.[80] Additionally, the International Health

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[74] Interestingly, these efforts were led by the Nigerian Tijjani Muhammad-Bande, who acted as President of the 74th session of the UNGA. It is also to note that the declaration was adopted without a vote.

[75] See: https://www.who.int/life-course/news/events/uhc-day/en/#:~:text=Dr%20Margaret%20Chan%2C%20WHO%20Director,based%20on%20primary%20health%20care.%E2%80%9D (last accessed 08/07/2020).

[76] The resolution adopting the political declaration of the high-level meeting on universal health coverage; online available: https://undocs.org/en/A/RES/74/2 (last accessed 08/07/2020).

[77] The 12 December, the day the resolution was adopted in 2012, was made the "UHC Day": https://undocs.org/a/res/72/138 (last accessed 08/07/2020).

[78] Target 3.8 of Sustainable Development Goal 3 "Good health and well-being" reads as follows: "achieve universal health coverage, including financial risk protection, access to quality essential health-care services and access to safe, effective, quality and affordable essential medicines and vaccines for all".

[79] Online available: https://undocs.org/en/A/RES/69/313 (last accessed 08/07/2020).

[80] Online available: https://undocs.org/A/RES/71/159 (last accessed on 08/07/2020).

Partnership for UHC 2030 (known as UHC 2030) was established in 2016, and over the course of the last few years, many other development agencies, partners, regional bodies and national governments, including in Africa, have adopted several declarations and agendas, committing themselves to support efforts targeting the improvement of PHC service delivery and/or the attainment of UHC by the year 2030.[81] Furthermore, in April 2020 – in the midst of the COVID-19 crisis – the heads of several West African states (of the Economic Community of West African States, ECOWAS) reiterated their commitment to the 2001 Abuja Declaration of spending at least 15 percent of their annual budgets on their health systems.[82]

Hence, a plethora of declarations on and commitments to UHC exists and assuring universal access to healthcare has been adopted as a global goal.[83] In reality, however, national health systems and reform proposals differ greatly, and countries are progressing at different pace towards assuring that people have access to the health services they require. Thus, while the formal commitment to UHC has been vast, it remains "primarily a normative concept" and views on how UHC should be achieved and can be operationalized are manifold (MacGregor, 2017, p. 61). Health policy trajectories and reforms across countries heavily depend on political processes as well as the balance of power between supporters of private service delivery and supporters of solidarity-based universalism (Yi et al., 2017). National debates on health system reforms aimed at paving the way to UHC have proven to be "intrinsically political" (Greer and Méndez, 2015, p. 637) and "highly politicised" (Koon and Mayhew, 2013, p. 1). While some view health care as a fundamental human right and rely on the core principle that "people should contribute according to their ability to pay and receive health care in response to their need" (MacGregor, 2017, p. 64), others view it "as a tradable commodity" (McKee et al., 2013, p. 39). Hence, as Lagomarsino et al. (2012, p. 933) put it, "there is little consensus about how low-income and lower, middle income countries should structure reforms aimed at moving

[81] These include the 2005 World Health Assembly resolution on universal coverage and social insurance, the 2006 Addis Ababa Declaration on Community Health in Africa, the 2008 Ouagadougou Declaration on PHC and health systems in Africa, the 2010 World Health Report on health systems financing and the path to UHC, the 2014 Luanda commitment to UHC, the 2016 World Bank-WHO Framework for Action for UHC in Africa, the 2017 G20 Berlin Declaration, 2017 Tokyo Declaration on UHC, the 2018 WHO-UNICEF sponsored Declaration of Astana, the 2019 Africa Health Agenda International Conference Declaration, etc. – alongside many national declarations on UHC.

[82] See: https://www.theafricareport.com/26912/coronavirus-ecowas-appoints-buhari-as-pandemic-response-champion/amp/?utm_source=twitter.com&utm_campaign=post_articles_twitter_27_04_2020&utm_medium=social&__twitter_impression=true (last accessed 09/07/2020).

[83] This includes the US: https://usun.usmission.gov/explanation-of-position-on-the-high-level-political-declaration-on-universal-health-coverage/ (last access 08/07/2020).

towards universal coverage". Yet, for Greer and Méndez (2015, p. 637), "it is a political victory that UHC is discussed at all".

3.1. Conceptualising Universal Health Coverage

The WHO definition of UHC is that

> all people receive the health services they need, including public health services designed to promote better health (such as anti-tobacco information campaigns and taxes), prevent illness (such as vaccinations), and to provide treatment, rehabilitation and palliative care (such as end-of-life care) of sufficient quality to be effective, while at the same time ensuring that the use of these services does not expose the user to financial hardship (WHO and World Bank, 2019, p. 7).

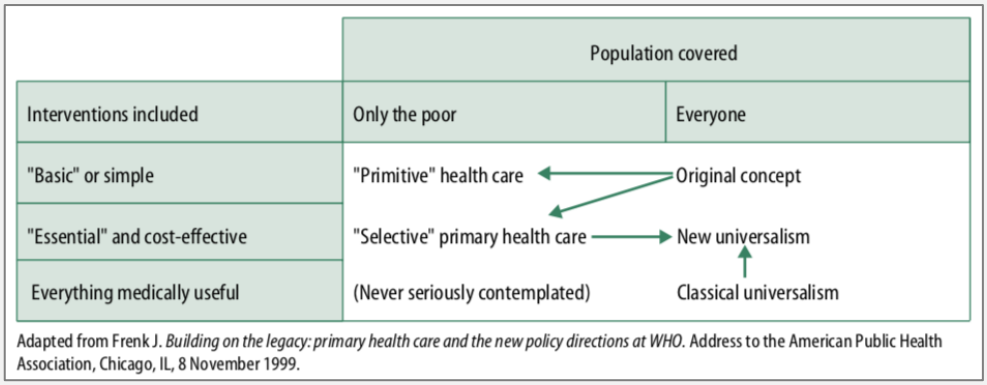
Nonetheless, the concept of universalism itself is vague. This may be a reason for the considerable range of different modes of operationalising some form of UHC in reality and the broad adoption of UHC in the first place (Stuckler et al., 2010, p. 8; Fischer, 2018, p. 225; MacGregor, 2017, p. 65). Overall, however, the tendency since the 1980s has been to mainstream a narrower understanding of universalism. While universalism may have once meant creating healthcare provisioning systems that are public, integrated, free/subsidized, equitably-accessible and socially-equalizing, today's focus seems to be on assuring universal coverage and guaranteeing access with less focus on who provides the services and at what price (Fischer, 2018). Fischer (2018, p. 222) further contends that "the strongest influence on this shift of meaning probably comes from the World Bank, which explicitly takes the position that universalism is achieved as long as everyone has access to something, regardless of how this is provided". In addition, the influence of the BMGF, who seem to have a similar understanding to World Bank-like "universalism", in promoting this view cannot be underestimated. Hence, while some organisations and actors, such as the UN and notably the WHO, may advocate for the institution of healthcare systems based on notions of inclusion, social cohesion and equity, the World Bank, the BMGF and others continue to argue in favour of more neo-liberal forms of health services delivery systems, with an enhanced role for the private sector. Furthermore, while at the time of Alma-Ata, a more just distribution of power and resources across the globe was seen as an integral part of efforts targeted at improving people's health status, more recent calls for UHC "are silent on social determinants of health and community participation" (Sanders et al., 2019, p. 619).

Scholars as well as international organisations like the WHO have proposed to evaluate national healthcare delivery systems based on their degree and/or depth of universalism as well as extent of elements of selectivity. Richard Titmuss (in Abel-Smith and Titmuss, 1987) and Skocpol (1991) have highlighted that some level of selectivity and targeting within universalism (e.g. on basis of age,

dis/ability or sex) may be important and justifiable. Thus, in order to appraise a national health system's degree of universalism, there is need to address questions such as: who should access which service? For free or at a subsidised price? Which interventions should be included? Who should be providing these services? Who is ultimately responsible for the quality of care and its accessibility?

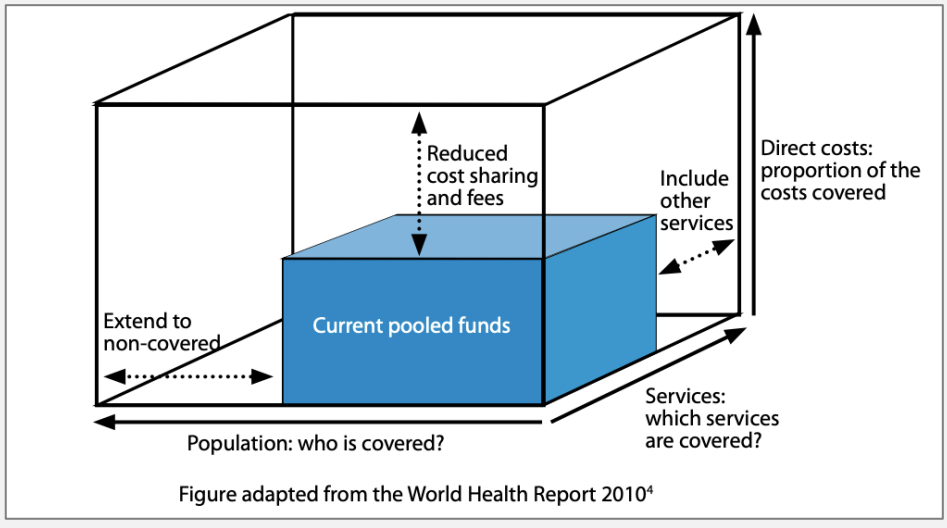
These question around what universal, comprehensive primary health care entails featured prominently in a 2000 WHO report (see Figure 9). The WHO conceptualises UHC on the basis of three key dimensions: (i) population: who is covered; (ii) services: which services are covered; and (iii) direct costs: proportion of the costs covered (see Figure 10). True universalism would imply that the entire population is covered, has access to all medically relevant services and all direct cost are covered and paid for from a pooled fund (older versions of the same graph of the WHO explicitly state "public health expenditure" in the place of "current pooled funds").

Figure 9: Coverage of population and of interventions under different notions of primary health care



Source: WHO (2000)

Figure 10: The three dimensions of universal health coverage



Source: WHO (2014)

Fischer (2018) suggests measuring the degree of universality on a spectrum and breaks down universalism into three components. These include: (i) provisioning modalities, concerned with expanding coverage and assuring equitable access to services, delivered in an integrated manner (no matter the ownership status of the service provider); (ii) costing and pricing, which in a strong universalistic system would be decommodified and independent of market behaviour; and (iii) the modality of financing, relating to the question of how services are being paid for (directly, e.g. via user fees, or indirectly, e.g. via progressive taxation). Inspired by Fischer (2012), Martinez-Franzoni and Sánchez-Ancochea (2014; 2016) propose the three dimensions of coverage, generosity (in level and quality) and equity, to measure the extent of universality of a country's social service delivery system. In line with Fischer (2012, 2018), they stress that universalism is a continuous variable, but put particular emphasis on the importance not to confuse policy instruments (e.g. how to meet UHC) with policy principles (i.e. what form of UHC do governments want to achieve) (Martinez Franzoni and Sanchez-Ancochea, 2016, p. 31).

Averill and Mariott (2013) have identified four "key ingredients" for UHC. They argue it is necessary to: (i) promote equitable access by removing financial barriers, especially direct payments; (ii) make prepayment compulsory; (iii) ensure that there is a large risk pool; and (iv) ensure that the Government covers the health costs of people who cannot afford to contribute. Also, MacGregor (2017) identifies three aspects which are important when discussing UHC: first, access to quality health services for all; second, interventions to promote a healthy society and individual well-being; and, third, sickness benefits to cover absence from the labour force due to acute or chronic conditions. Her principles seem to reflect the importance to promote UHC in accordance with addressing the social determinants of health. Similarly, Stuckler et al. (2010), aware of multiple definitions of UHC, have identified five themes that are commonly associated with UHC. These include: (i) access to care or insurance; (ii) coverage; (ii) package of services; (iv) rights-based approach of UHC; and (v) social and economic risk protection.

Lastly, Yi et al. (2017) have proposed a model to assess the degree of universality of a healthcare provisioning system. This is based on the following six dimensions:

(i) Entitlement, which refers to the importance of a legal basis as well as political and institutional mechanisms in place for citizens to claim their right to health

(ii) Eligibility, which, in universalism, means that every person regardless of gender, age, class, health status, etc. is allowed treatment

(iii) Access, which depends on enabling factors (i.e. availability, location, cost, etc.) and is the extent to which beneficiaries can actually consume and use services

(iv) Appropriateness, which relates to the extent of (quality) services and benefits being provided

(v) Distributive rules of benefits, impacting poverty and inequality

(vi) Organising principles, which addresses the question the extent to which the public should assume responsibility for welfare and social services

Therefore, while, perhaps pragmatically, universalism may be "best considered as an ideal, a vision and a goal, serving as a rallying call and aid to mobilization" (MacGregor (2017, p. 65), national policy-makers need to address these six dimensions when designing and operationalising health systems. The outcome will depend on processes of domestic negotiation, contestation and priority-setting, themselves influenced by the power of different actors (including "outside" actors), their views and ideological stance, existing norms and contextual factors, such as historical/colonial legacy, degree of social cohesion, organisation of the state including degree of decentralisation, economic standing, etc.

However, from a pro-universalism, rights-based perspective, policy makers, committed to attain UHC, should **strive** towards ensuring that healthcare services are provided in a comprehensive and integrated as opposed to a fragmented manner, with the responsibility lying with a unified institutional structure (the state), which guarantees that every person has access to quality services, regardless of their sex, age, dis/ability, ethnicity/race, etc. and financial situation, by assuring that healthcare is decommodified and mainly tax-funded. Thus, as Andersen (2012, p. 164) has summarised, a country's healthcare system would be only truly universal, if health is a human right, enforceable due to compulsory legislation, tax-financed, uniform throughout the country, designed for the entire population, which has equal access and most of them make use of these services. Nonetheless, the ultimate decision on the degree of universalism, which can be achieved within a specific country, depends on global political processes and interplays as well as distinctively context-specific factors – which is what SoP research is focused on.

3.2. Determinants of the degree of universalism in healthcare

Several scholars have put forward theories that help explain the practice of universalism and have further explored factors and determinants of universalization. Navarro groups these theories that aim to explain variation in healthcare systems reforms into four groups: first, pluralist theories (popular choice theories), which highlight the interplay and preference of multiple different actors and citizens and their impact on policy making (e.g. via voting systems or behaviour as a market participant); second, institutional theories (power groups theories), which focus on institutions and interest groups such as medical professionals, representatives of pharmaceutical enterprises, insurance providers, etc. and how they impact and are impacted by policy dynamics; third, development theories, which

suggest that when countries get richer, they will also increase their public social spending; and finally, class theories, which see healthcare systems of provision as an outcome of struggles between the capitalist and the working class (McKee et al., 2013; Navarro, 1989; Stuckler et al., 2010).

Inspired by such theories explaining health policy development, scholars have identified possible factors that determine the degree of universalism in a country's health system. For instance, according to Greer and Méndez (2015), democratization, partisanship and strong left-wing parties are enabling factors for successful UHC reform at country-level, although they highlight that political support at international level is equally important to avoid competing advocacy for e.g. single-disease focused programmes (Greer and Méndez, 2015). A comparative analysis of health insurance reforms in several African and Asian countries, conducted by Lagomarsino et al. (2012), draws a similar conclusion, namely that UHC reforms are political and country-context dependent, often correlated with the degree of domestic support, the power of donors as well as fiscal constraints and operational capacity. Along similar lines, Stuckler et al. (2010) as well as (McKee et al., 2013) have conducted an extensive literature review and have identified five main determinants, apt to explain cross-national variations in UHC. These include: (i) the existence of powerful left-labour coalitions, which prioritise redistribution and state intervention; (ii) the wealth of a nation, as richer nations seem more likely to have higher levels of universal coverage; (iii) political regimes, institutions and degree of social cohesion, as societies which are more divided and more unequal are less prone to put into place redistribute policies; (iv) initial social welfare conditions, assuming that existing health systems configurations influence future reform paths; and (v) the existence of a "political window of opportunity", e.g. in response to a natural disaster, social turmoil, or financial crisis. In similar fashion, Fox and Reich (2015) as well as Rizvi et al. (2020) refer to four explanatory factors (known as the "four I's"), which explain health outcomes and have been identified in classical political science frameworks, namely interests (all actors and interest groups that will benefit or lose out as a consequence of a certain policy change), institutions (both formal and information political institutions and norms influence policy change), ideas (i.e. specific policy solutions, concepts, information, etc.) and ideology (i.e. a particular world view used to justify policy change).

Researchers at UNRISD have specified six enabling factors, which have shown to facilitate progress towards universalism in healthcare delivery (UNRISD, 2017). First, they argue, an empowered civil society, which closely collaborates with the government, has played a major role in driving efforts towards UHC, notably in Thailand and Brazil. Secondly, they highlight the importance of political will and support as well as institutional capacity to make available the necessary financial resources for UHC reforms. Third, they contend that approaches to and concepts of universalism are often contested (as e.g. in the case of South Africa) and highlight the significance of finding ways to build

consensus (through democratic mechanisms) across a multitude of stakeholders and policy sectors in order to accomplish successful reforms. Fourth, the need to find ways to mitigate and reduce resistance in and from the private sector is highlighted, as in many emerging economies pro-market views are deep-rooted and may pose a hinderance to UHC reforms (e.g. Russia, China or South Africa). Fifth, their research has shown that efforts to decentralise service provision played an important role in expanding access to health services (e.g. in Brazil) but need to be part of a comprehensive and coherent national framework. And, sixth, they highlight the benefits of tax-financed healthcare systems, for instance, to people of the informal sector over e.g. employment-based contributory insurance systems. These enabling factors identified by UNRISD as well as by other scholars are helpful in theorising and explaining Nigeria's progress towards creating a policy environment conducive to attaining UHC.

4. Practices of Universal Health Coverage

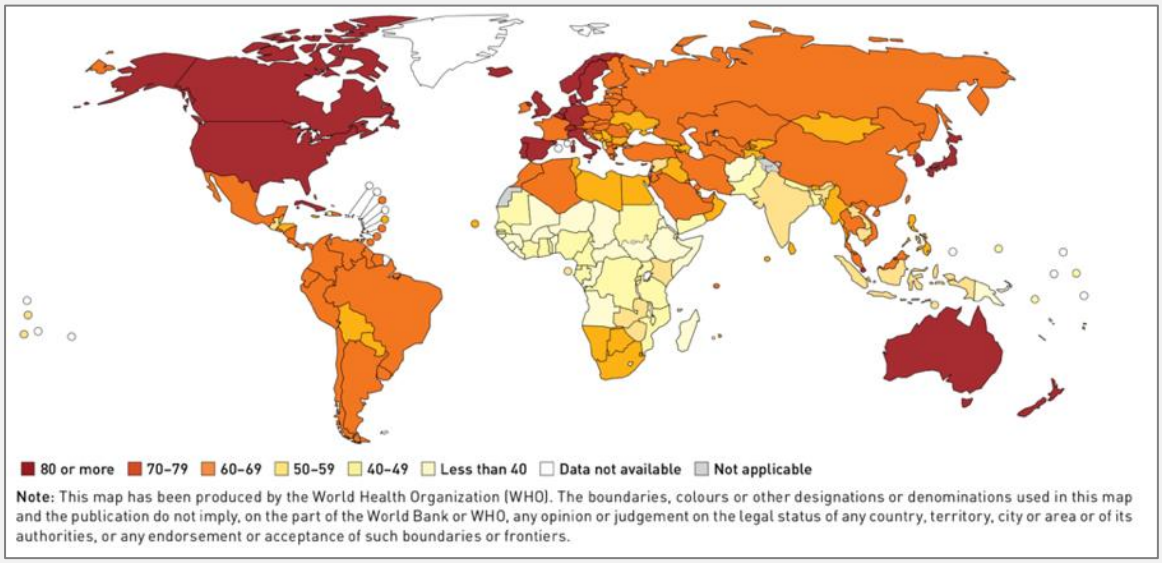
A number of developing/emerging countries in Latin America and Asia have made considerable advancements in putting into place health systems that are progressing towards increasing their degree of universalism. A 2013 Oxfam report mentions the success stories of Thailand, Malaysia, Sri Lanka and Brazil – which all "share a common understanding that entitlement to health care should be based on citizenship and/or residency and not on employment status or financial contributions" (Averill and Mariott, 2013, p. 8). Other nations and regions, too, have been lauded for their public-sector driven UHC reforms, including Cuba, Costa Rica or the Indian State of Kerala (Sen, 2015). On the African continent, the Seychelles provide free primary healthcare services to all its citizens (Workie et al., 2018, p. 364). Other countries, such as Burundi, Zambia or Niger provide some free health services to selected groups such as children under age five and/or pregnant women (Lagarde et al., 2012; Nimpagaritse and Bertone, 2011). Many other countries (or regions within countries) on the continent have adopted UHC or PHC strategies and policies, created budget lines and introduced or reinforced community-based and/or national health insurance schemes.[84] The WHO, with the support of the World Bank and others, monitors countries' progress towards the attainment of the UHC targets 3.8.1 and 3.8.2.[85] Yet, as can be seen in Figure 11 and Figure 12, in many African countries, coverage

[84] A 2018 report prepared by the WHO Africa programme features some of these programmes and strategies; online available: https://www.who.int/docs/default-source/primary-health-care-conference/phc-regional-report-africa.pdf?sfvrsn=73f1301f_2 (last accessed 13/07/2020).

[85] The targets are formulated as follows: (i) SDG indicator 3.8.1: Coverage of essential health services (defined as the average coverage of essential services based on tracer interventions that include reproductive, maternal, newborn and child health; infectious diseases; noncommunicable diseases; and service capacity and access; among the general and the most disadvantaged population); (ii) SDG

needs to be expanded further and the pressure on households relating to health expenditure needs to be relieved (with Nigeria performing particularly badly in terms of catastrophic and impoverishing health expenditure).

Figure 11: UHC service coverage index, 2017

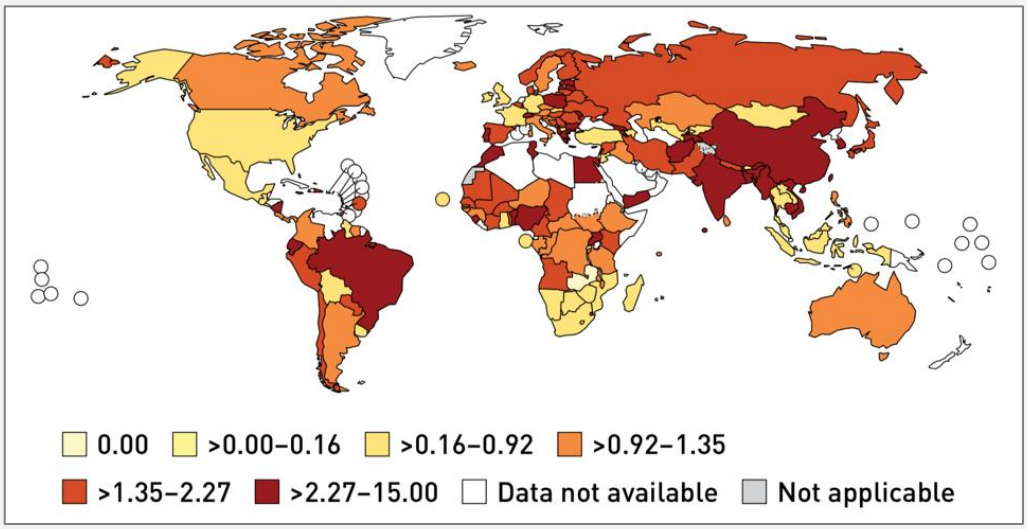


Source: WHO and World Bank (2019)[86]

indicator 3.8.2: Proportion of population with large household expenditures on health as a share of total household expenditure or income.

[86] The UHC service coverage index (SCI) is composed of 14 tracer indicators, covering four essential health services areas (reproductive, maternal, newborn, and child health, infectious diseases, non-communicable diseases, and service capacity and access).

Figure 12: Percentage of population with impoverishing health spending
(at the relative poverty line of 60 percent of median per capita consumption)



Source: WHO and World Bank (2019)

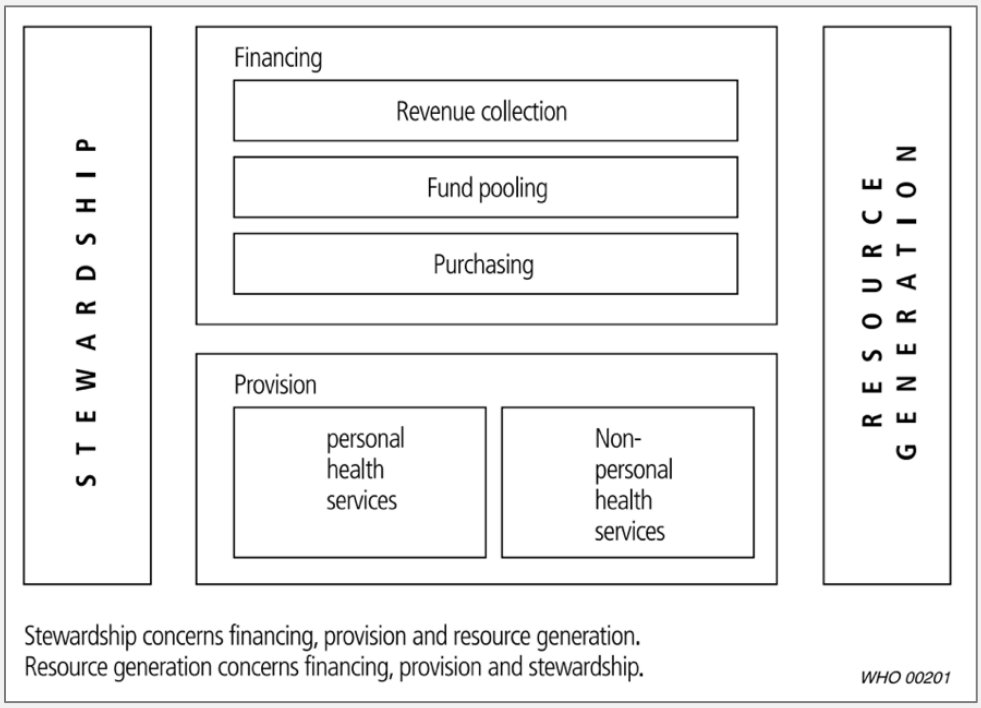
4.1. Health system financing modes

The approaches at country-level to achieve UHC are diverse and, as argued earlier, depend on political processes and a multitude of context-specific factors. In particular, health system financing or how to mobilise resources for service delivery is often subject to domestic contestation.[87] Murray and Frenk (2000, p. 724) define health system financing as "the process by which revenues are collected from primary and secondary sources, accumulated in fund pools and allocated to provider activities".[88] As they suggest, commonly three sub-functions are distinguished, namely revenue collection, fund pooling and purchasing (see Figure 13).

[87] According to the WHO, the six building blocks of a health system include service delivery, health workforce, health information systems, access to essential medicines, financing and leadership/governance.

[88] As Kutzin (2013) highlights, health financing arrangements are not the only component that influence the objectives of a health system, such as improving health outcomes and boosting social equity. Therefore, health policies and strategies need to be in concord with policies and aims of other economic and social sectors, as such other societal goals are interconnected with the health systems (Kutzin, 2013, p. 603; Murray and Frenk, 2000, p. 719).

Figure 13: Functions of a health system with financing at its core



Source: Murray and Frenk (2000)

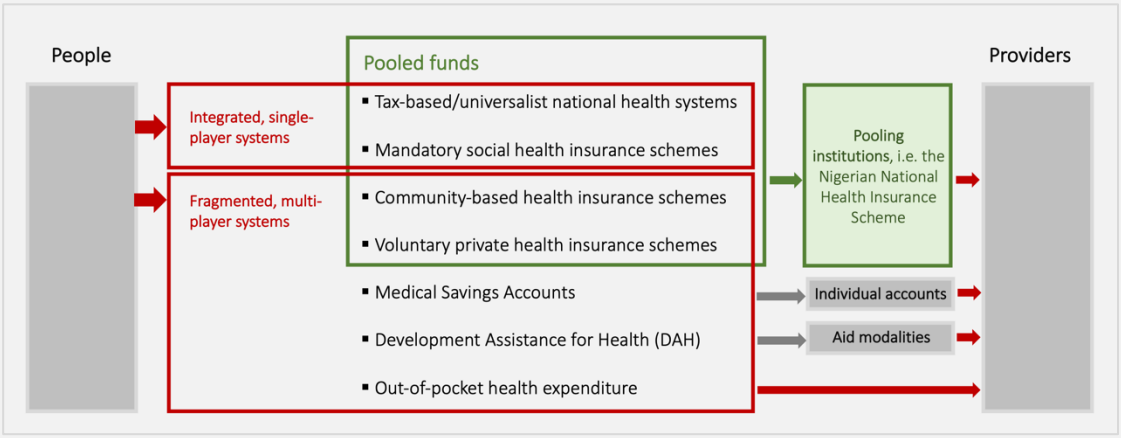
Revenue collection relates to the mobilisation of resources for healthcare e.g. from individuals, households, employers, governments or bi- and multilateral donors. Averill and Mariott (2013, p. 8), for example, stress that expanding mandatory national social insurance schemes has been identified as a crucial strategy to contribute to the attainment of UHC, while voluntary, private or community-based insurance schemes still need to be proven to be effective. Nonetheless, African countries have opted for a broad range of health financing policies and strategies; i.e. Ghana has been analysed for having expanded health coverage with the help of a national insurance scheme (Agyepong et al., 2016), whereas Rwanda has been promoting community-based health insurance (Chemouni, 2018). Notably, Gautier and Ridde (2017) have reviewed African country studies, which have addressed health financing options and policies as well as their enabling variables and varying degrees of success.

These different financing models can be differentiated on basis of several criteria, i.e. the nature of the scheme (public versus private), its compulsoriness (voluntary versus mandatory), its competitiveness (single- versus multiple player), its contribution method (tax-financed, social security contributions or insurance premiums) and its basis of eligibility (i.e. residency status, citizenship, only contributors eligible, etc.) as summarised by Toth (2016). In this context, there have been important scholarly contributions reviewing and categorising the different types of financing schemes, while acknowledging that in many countries a mix of financing schemes may co-exist (see for instance, Field, 1973; Frenk and Donabedian, 1987; Navarro, 1989; OECD, 1994; Lee et al., 2008; Savedoff, 2012;

Averill and Mariott, 2013; Toth, 2016; Onwujekwe et al., 2019). Based on a review of the existing literature as well as on an assessment of what is deemed relevant and applicable to the African context, Figure 14 schematises seven different types of financing modes, which are the following:

1. **Tax-based/universalist national health systems**, where healthcare is paid for through the Government's budget
2. **Mandatory social health insurance schemes**, which is an employment-based, contributory system, allowing for cross-subsidisation between the healthy and wealthy and the sick and the poor (Fenny et al., 2018), i.e. the Formal Sector Social Health Insurance programme in Nigeria, which is one of the country's programmes under the National Health Insurance Scheme
3. **Community-based health insurance schemes**, also known as *mutuelles de santé*, which are solidarity-based, not-for-profit, voluntary schemes, covering a small group of, most commonly, low-income people living in rural areas and working in the informal sector
4. **Voluntary private health insurance schemes**, which are for-profit arrangement, where individuals can opt to choose an insurance provider (i.e. managed care systems using Health Maintenance Organisations in the US as well as Nigeria)
5. **Medical Savings Accounts**, where individuals decide to put aside part of their own resources to be used to pay for healthcare services when they become necessary at a later time, but without the benefit of pooling resources and risks with other contributors (see e.g. Savedoff, 2012)
6. **Out-of-pocket health expenditure**, where individuals use their own financial means to pay for healthcare directly at point of service
7. **Development assistance for health (DAH)**, notably in form of grants of loans, disbursed on basis of the agreed-upon aid modality, i.e. project financing, technical assistance, budget support, etc.

Figure 14: Types of health financing schemes



Source: Own illustration based on Savedoff (2012)

Nevertheless, while there are several ways of mobilising resources to pay for health services, MacGregor (2017) highlights that the wider the pooling of resources and risks into one unified fund, with contributions no longer being tied to the particular contributor, the more universal the scheme. According to Savedoff (2012, p. 4), tax revenues (levied on income, consumption/value-addition, imports, etc.) as well as mandatory insurance contributions most commonly present the largest source of pooled funding for health. Voluntary private and/or community-based health insurance schemes also function as pooled funding; yet, countries, which largely rely on private health insurance schemes are often faced with considerable equity concerns and make it harder (and, even, hardly possible) to attain UHC (Averill and Mariott, 2013). Additionally, as e.g. Wagstaff (2007) has highlighted, so-called "purchaser-provider models", where the purchasers is a third party (such as an insurance scheme/company) kept separate from the health care provider, introduced to create competition and commonly promoted, have not been proven to be more effective than tax-financed purchasers.

With regard to purchasing, which is "a generic term that refers to the transfer of pooled funds to providers on behalf of a population" (Kutzin et al., 2017), different countries have also employed different purchasing mechanisms. Passive purchasing means that a government allocates funds to a health facility or service provider on basis of its last year's budget (and, in the better cases, its actual disbursement of it). In contrast, active or strategic purchasing – acclaimed to be the best way forward to achieve UHC (Etiaba et al., 2018; Hanson et al., 2019; Mathauer et al., 2017) – intends to improve quality and efficiency by basing purchasing decisions on thorough needs assessments and ample information relating to prices, quality and quantity of services, treatment choices and health staff performance (WHO, 2010, p. xviii). The purchasing of healthcare services from service providers, hence, is a crucial component of health financing systems, involving three sets of decisions as e.g. Figueras et al. (2005) point out: namely, the identification of the right benefits entitlements (what to

buy?), the selection of service providers, e.g. public, private for-profit, private not-for-profit or a combination of providers (from whom to buy?) and the choice of a mechanism/arrangement to purchase these services, so-called provider payment mechanisms (how to buy?). The purposefulness of adopting strategic purchasing strategies is to ensure that available resources are used in the most "cost-effective" manner while health gains are maximised, thus requiring continuous negotiation and interaction of governments, providers, patients and purchasers (Busse et al., 2007; Hanson et al., 2019; Sanderson et al., 2019).[89]

Yet, while it seems intuitive that governments should use their resources wisely and should pay for the health services that the population needs, the focus on allocative efficiency means that "medical needs" and "health gains" need to be quantified and made measurable. Today, often, the utility and cost-effectiveness of a health intervention is evaluated with the help of metrics such as the "disability-adjusted life year" (DALY) or the "quality-adjusted life year" (QALY). There are, however, considerable limitations in employing such measures (see e.g. Pettitt et al. (2016) for a literature review), most striking relating to concerns of valuing once individual's life over another's and incentive to neglect diseases of the few. In any case, today, many countries, including in Africa, are committed to make their purchasing of healthcare services more strategic in order to make their health systems more efficient, yet again employing a variety of different approaches, as Hanson et al. (2019) highlight.

While agreeing on the right benefits package is important, especially payment-provider mechanisms (PPM) – how to best pay the providers of services – are another significant point of contestation in many countries. Common ways to purchase healthcare services from providers include monthly salary payments to staff, capitation systems, fee-for-service (FFS) arrangements, diagnosis related groupings (DRG) or case-based payments, per-diem payments and advance payments to health facility to cover specific costs (line-item budgets) or aggregate costs (global budget). Appendix C provides an overview of these PPMs, including information on their strengths and shortcomings as identified in the literature. Countries like Thailand, considered a UHC success story, have pursued a capitation payment system for their social insurance scheme (Tangcharoensathien et al., 2019) and other African countries have seen animated debates on whether (and on ways of making) capitation systems work (see e.g. Atuoye et al. (2016) and Obadha et al. (2020) for Ghana and Kenya, respectively). Yet, the World Bank

[89] It has been pointed out that mainstream neo-classical theories (focusing on market competition) were particularly influential in shaping healthcare purchasing reforms for decades; today, the most common theories include principal-agent theory, transaction cost economics, and more recently, theories of inter-organisational relationships (Hanson et al., 2019, p. 501; Sanderson et al., 2019, p. 5). Notably, Hanson and colleagues have applied principal-agent theory to low-/middle-income countries (including in Nigeria) in view of analysing how the relationships between governments, providers, patients and purchasers are altered through incentives, available information, power and accountability (Hanson et al., 2019).

seems to have positioned itself in favour of a fee-for-service system, which they more frequently refer to as performance-based financing (PBF). Research conducted by Gautier and Ridde (2017), analysing government ownership and donor influence on different health financing policies in Africa, have found that "there is limited evidence that PBF policymaking processes were government-owned". Similarly, Barnes et al. (2015) have documented unbalanced power relations in negations on PBF scheme designs. As I will discuss in Chapter 6, this is reflective of the Nigerian experience, where it seems that the World Bank's preference for FFS is in opposition to national stakeholders' preference for capitation.

4.2. Private sector involvement in healthcare

In April 2019, the African Union member states came together in Egypt for the occasion of the 64th Ordinary Session of the African Commission on Human and Peoples' Rights.[90] Amongst the resolutions adopted during the session was a resolution voicing concern regarding the reality that "the growth of private actors' involvement in health and education services delivery often happens without the consideration of human rights resulting in growing discrimination in access to these services, a decrease in transparency and accountability, which negatively impact the enjoyment of the rights to health and education".[91] While the resolution calls upon national governments to assure appropriate regulation of private sector actors involved in the provision of social services, the resolution also highlights discontent about mounting pressure of "bilateral donors and international institutions […] to privatize or facilitate access to private actors in […] health and education sectors".

The privatisation of service delivery has been pushed forward by proponents, who are of the opinion that market mechanisms can more economically and efficiently provide public goods and services (Rondinelli et al., 1989, p. 59). And, today, many African Governments rely on private entities to support the provision of healthcare services (Mills et al., 1990, p. 23). A report by a consortium of progressive NGOs picked up on this reality, highlighting that discussions around strengthening public-private-partnerships are being held in 50 developing countries and in spite of absent proof of their advantageousness, "there has been a large push by the multilateral banks and the IMF […] to leverage private sector investments for development purposes" (Ortiz and Cummins, 2019, p. 43). Birn et al. (2016, p. 741) refer to several different channels through which private sector involvement materialises. These include:

[90] Nigeria is signatory of African Charter on Human and Peoples' Rights, known as the African Charter, and ratified the document in 1983.

[91] See: https://www.achpr.org/sessions/resolutions?id=444 (accessed 08/10/2019).

- the promotion of a private health insurance marketplace;
- support to private pharmaceutical companies instead of public drug manufacturers;
- encouragement of the provision of healthcare services in private hospitals and healthcare centres;
- and the outsourcing and subcontracting aspects of public health care systems (information management, human resource recruitment, support services such as patient transportation) as well as of service delivery (laboratories and pharmacies).

While it depends on the specific country-context whether some sort of private sector involvement in healthcare delivery may have benefit, it has been highlighted that, generally, the private sector's ambition to maximise profit has proven problematic for healthcare provision (Hanson et al., 2008; Mills et al., 2002; Oxfam, 2009).[92] Nonetheless, in spite of widespread concern, compelling evidence of the excluding effect of privatised health, the World Bank, in particular, continues its push for an increased participation of the private sector in healthcare systems (see e.g. World Bank, 2003, 2007, 2008, 2011, 2016). More recently, the World Bank as well as other pro-private sector proponents (such as the BMGF) actively endorse PPPs as a new way forward to collaboratively attain UHC (Lethbridge, 2017), in spite of contradictory evidence of their benefits (see e.g. Marriott, 2014).[93] For instance, Languille (2017), reviewing PPPs in health and education, Bayliss and Van Waeyenberge (2018), reviewing PPPs for infrastructure, and Romero (2015) and Eurodad (2018), reviewing PPPs in developing countries more broadly, have engaged thoroughly with the risks and problems associated with PPPs. These include high risks and costs for national Governments, a diversion of development aid towards the private sector, adverse effects on public sector administrative capacity, negative impact on equity, and limited transparency and, as a consequence, and a weakening of democratic accountability.

Generally, scholars have cautioned against a dominant private sector in healthcare delivery systems on the one hand. Reasons include that strong private sector involvement may result in overpriced and distorted provision and over-medication/diagnosis, marginalises high-risk groups (MacGregor, 2017, p.67), commonly excludes poorer people from accessing healthcare of a certain quality standard (Mackintosh et al., 2016b) and replicates social inequities (Oxfam, 2009; Wilkinson and Pickett, 2011).

[92] This has also become once more apparent in the context of the COVID-19 pandemic, which produced "mass market failures in private health services globally" (Williams, 2020, p. 1).

[93] Languille (2017, p.156) as well as Romero (2015, p.4) accentuate the heterogenous nature of PPPs and explain that there is no commonly agreed upon definition of what a PPP is.

Furthermore, it has been contended that market-based healthcare provision is “imperfect”, as this may cause localised monopolies (only one hospital serving a specific geographic area) and unethical rent-seeking, as for-profit private firms operate in their own interest and demand for healthcare is inelastic (health is a necessary pre-condition for human well-being) (Clarke et al., 2019; Fischer, 2018; Mooney, 2012). Also, research findings of a comparative study of private and public healthcare systems in low- and middle income countries conducted by Basu et al. (2012, p. 10) have shown that the private sector, contrary to claims by private sector advocates, appeared to be less efficient compared to the public sector, for reasons such as higher drug costs, the prescription of unneeded treatment and testing, higher risk of complications and weak regulation. And, McPake and Hanson (2016, p. 626) alert that investing in corporate, commercial providers may reduce the effective coverage of public primary care services – “whether because services become unavailable altogether or because fewer facilities can provide services of a basically adequate quality standard”.

On the other hand, the reasoning and existing evidence in favour of strong public systems are compelling. For example, Martinez Franzoni and Sanchez-Ancochea (2016) provide a solid case for universalism on basis of their research findings in Latin America, demonstrating that countries’ governments that have pursued (seemingly, more expensive) universal policies, overall, made a net profit, as these social policies had a positive effect on economic growth and competitiveness (Martinez Franzoni and Sanchez-Ancochea, 2016, p. 42). Another argument in favour of strong government-led systems is that a public healthcare provision system may (re-)build trust in governments and enhance social cohesion and a sense of solidarity (MacGregor, 2017, p. 67). There is evidence from Latin America, Asia and Southern Africa that a drop in public health investment negatively impacts the state of public health infrastructure and further magnifies inequities in accessing healthcare services (Qadeer and Baru, 2016, p. 776; Oxfam, 2009, p. 36). Also, Jasso-Aguilar and Waitzkin (2015, p. NA) conclude that “between 1980 and 2010, the policies of privatization, deregulation, and liberalization led to a massive transfer of resources from the public to the private sector, the systematic elimination of the safety net, and the worsening of existing social and economic inequalities”. Also, the perspective of a restricted role for the state in healthcare delivery raises concerns about the danger of providing a too basic package of selected services via fragmented service delivery systems and of excluding the rest of the population (Koivusalo and Mackintosh, 2005; Laurell and Arellano, 1996).

In light of the continued promotion of the private sector, however, it is important to note that the private sector itself – defined by Mills et al. (2002) as “all providers who exist outside the public sector, whether their aim is philanthropic or commercial, and whose aim is to treat illness or prevent disease” – is diverse and heterogeneous. The WHO, for instance, makes the distinction between the for-profit (corporate) and non-for-profit private sector, the informal and formal private sector and the domestic

and international private sector.[94] Mackintosh et al. (2016) have identified characteristics and patterns that help to understand the extent, importance and dominance of the private sector in public healthcare systems in developing countries.[95] Their classification is compelling and is based on three metrics. These allow to identify five distinct types of public-private "mixed" health systems. The metrics include: (i) the size and pattern of the private share in overall health spending; (ii) the share of visits to privately-owned primary and secondary health facilities; and (iii) the extent to which the public sector relies on household's out-of-pocket health expenditure. The five types of health systems, as outlined by Mackintosh et al. (2016), are:

(1) a **dominant private sector** marked by high OOP and widespread private service delivery (like in Nigeria and India)

(2) a **non-commercialised public sector** and complementary private sector, with rather low shares of private expenditure and widespread public service provision which is largely user fee-free (like in Sri Lanka and Thailand)

(3) a **private sector at the top of a stratified system**, with relatively high shares of private and social insurance, widespread private service provision and low public sector reliance on user fees (e.g., South Africa and Argentina)

(4) a **highly commercialised public sector**, with a small private sector but a commercialised public sector, which relies on user fees (e.g., China before its most recent healthcare reform)

(5) a **stratified private sector**, shaped by low incomes and little public sector intervention, with the wealthier segments of the population visiting private hospitals and the poorer segments private medicine vendors (e.g., Tanzania, Ghana, Malawi and Nepal)

Many African countries operate mixed healthcare systems and, taking into account specific countries' realities, some form of engagement with the private sector, if well regulated, may be beneficial (Clarke et al., 2019). For instance, MacGregor (2017, p. 68) summarises that, at times, public sectors may be confronted with rising public expenditure and inflationary pressures, may have less opportunity to offer specialised service delivery, may be subject of vested interests and courruption within their civil service and their public good may be less-well appreciated. In this regard, McPake and Hanson (2016) signal that an extreme stance against any role for the private sector in a pluralistic healthcare system may neglect already very strong interlinkages between the public and the private sector in countries'

[94] See: https://www.who.int/publications/i/item/the-private-health-sector-an-operational-definition (last accessed 06/07/ 2020).

[95] E.g. Wendt (2009) has conducted a similar exercise for European countries.

health systems. While they state clearly that UHC does require the centralised pooling of funds and adequate levels of Government resources as well as "effective public stewardship", this may be compatible with granting certain roles to the private sector (McPake and Hanson, 2016, p. 628).

Nonetheless, as Mackintosh et al. (2016) argue, the behaviour and size of the public sector influence the behaviour and the role the private sector comes to play. They highlight that "[a] reinvigorated and accessible public sector, sometimes alongside major expansion of social insurance, can **reshape private sector roles and behaviour** within mixed health-care systems in low-income and middle-income countries to support moves towards universal health coverage" (Mackintosh et al., 2016, p. 603). In short, the privatisation of healthcare system has led to a reality in many countries, where (underfunded) public sectors (try to) cater for the poorest and the (highly variegated) private sector addresses the needs of the members of society with some financial means (Mackintosh, 2001).

5. Conclusion

The purpose of this chapter was three-fold. First, I illustrated that the tendency of a narrowing scope of social policy is particularly well-reflected in the area of health. My review of global health history has demonstrated that while in the 1970s, comprehensive primary health **care** was meant to be a public good and a human right, more recent calls for universal health **coverage** pay less attention to the way health services are being provided and the inter-connectedness of social inequities. Second, I argued that universalism and UHC themselves have been subject to their own contestations. Interpretations of what universalism entails are manifold, and context-specific factors determine how UHC is conceptualised and understood. Third, as a result of the fuzziness of the concept of UHC, healthcare systems across the world take distinctive shapes and forms. Healthcare systems differ, notably, with regard to who bears responsibility for financing and providing healthcare, to what segment of the population and under what conditions.

It is essential to be equipped with a profound understanding of changing conceptualisations and practices of universalism and UHC in order to better locate the health policy trajectory in Nigeria. The views on UHC of various interest groups, operating withing the Nigerian healthcare system, influence health policy and impact, ultimately, who can (and cannot) access healthcare in Nigeria. By adopting Ben Fine's SoP approach, I concentrate on scrutinising the impact of global processes (such as the privatisation of healthcare systems) on healthcare provisioning and consumption, apart from the effect of context-specific structures and the relations and contestations between agents on health policy and UHC. The following chapter outlines how the SoP approach has been applied to the study of the policy landscape that is conditioning the Nigerian healthcare system of provision. I also provide information on the methods and methodology that I have used in my endeavour to answer my research questions, including some reflections on my own positionality.

CHAPTER 3 | Deploying the Systems of Provision approach to analysing health policy in Nigeria: empirical strategies and methods

1. Introduction

The overall purpose of this dissertation is to identify and understand the agents, relations, structures, processes that influence health policymaking and implementation and, hence, healthcare provision and consumption, in Nigeria. It seeks to make a contribution to the social policy literature, by looking at a concrete case of policy making and implementation in an African context, singling out specific factors determining policy reform processes. It does so by drawing on the SoP approach as first developed by Ben Fine in collaboration with Ellen Leopold. With my interest in health policymaking and implementation, I focus on one specific element, which I deem "particularly decisive" in determining the shape of the Nigerian healthcare system (see Bayliss et al. 2016a, p. 14). Thus, my dissertation aims to uncover how the elaboration and design of health policy (with a focus on the NHAct) as well as efforts to implement it, affect who accesses healthcare in Nigeria, why and how. At the same time, I pay particular attention to the meaning Nigerians attach to healthcare consumption (the material culture), as consumption norms and patterns emerge from values, beliefs and practices associated with the provision of a good or service and are contingent on the specific context (Bayliss and Fine, 2020).

The focus of this research is not strictly on analysing the effectiveness of the Nigerian healthcare SoP itself, but on understanding the interconnectedness of the different dimensions of this SoP (including the nature of its agents, structures, processes and norms) with the scope and practice of health policymaking and implementation in Nigeria. I recognise that, while the Nigerian healthcare SoP affects policymaking and implementation, it is itself conditioned by the latter. By way of a SoP analysis, I then understand health policymaking and implementation in Nigeria to be both the backdrop to, as well as the fabric from which, the Nigerian healthcare SoP emerges and produces particular outcomes. The Nigerian healthcare SoP affects, and is in turn itself conditioned by, the policymaking and implementation sphere. As such, this PhD examines the role of historical and contemporary structures, processes, narratives and different agents in influencing and shaping the set-up of the Nigerian healthcare SoP by providing a deeper understanding of the various interests that bear **on social policymaking and implementation.**

This chapter has a twofold purpose. First, I turn to a presentation of how I apply the SoP approach to my analysis of the policy environment that is conditioning the Nigerian healthcare system of provision and describe how the approach adds value to my investigation (section 2). Second, I discuss the methods that I pursued, including the analysis of both qualitative and quantitative data, with a particular interest in issues of positionality implied by my fieldwork (section 3). I proceed in this order.

2. Operationalisation, scope and limitations of my SoP investigation

Several scholars have applied a SoP lens to their analysis of the consumption of a specific good or service, having used different entry points for their investigations. Looking at more recent work, Mattioli et al. (2020), for instance, have used the SoP approach to identify key political economy characteristics that determine and explain car dependence. Serrano and Brooks (2019) have focused on examining how an increase in global demand for avocados has affected livelihoods of farmers in Colombia. And, Bayliss and Pollen (2019) have looked at the effect of the global energy policy paradigm on the Zambian electricity system of provision. In line with the work done by Bayliss and Pollen, my research focuses on policy and attempts to dissect the impact of global and context-specific narratives, processes and structures specifically on UHC policymaking and implementation in Nigeria. The openness and non-prescriptive nature of the SoP approach permits to examine/analyse the political economy surrounding a specific provisioning system, which impacts the nature of service provision and consumption. Moreover, by conducting an assessment of contextual factors that shape access to healthcare in Nigeria and determine consumption norms, this research responds to appeals made by Mackintosh and Tibandebage (2004, p. 150) to employ "methodologically thicker", context-specific and localized policy analysis rooted in political economy and social theory: "[m]ore research on social sectors in low-income contexts, that combines detailed economic analysis of distributive processes and outcomes with historical and sociological analysis of institutional and policy evolution and the interaction of social policy with broader economic and political change, will strengthen the scope for social policy that draws upon local institutional strengths".

One way of operationalising an SoP investigation, according to Bayliss et al. (2016a, p. 13), is to "follow the action" and to scrutinise the entire chain of provision from production of a good/service to its consumption. The second method they propose is to "follow the chain of determinants across structures, processes, agents and relations" (Bayliss et al., 2016a, p. 14). Applying the latter approach to my analysis allows me to pay attention to the integral nature of the Nigerian healthcare system of provision, while focusing on the determinants shaping the **policy** sphere in particular, providing the eco-system within which the Nigerian healthcare system of provision takes form. My approach to operationalising the SoP approach, therefore, is to identify the key agents that influence the UHC policy environment in Nigeria, to analyse relations and contestations between them and to unpack how historical and contemporary structures and processes condition their position and importance with regard to UHC policymaking and implementation. At the same time, I pay attention to the material culture surrounding healthcare consumption. The SoP approach thus allows me to conduct a structured and focused contextual investigation of the policy environment that conditions healthcare

provision and consumption in Nigeria, enabling me to address questions of what is provided to whom, how, why, and with what meaning.

The key comparative advantage of the SoP approach is that it allows me to connect the healthcare consumption norms and patterns with how policy design and implementation impact (i) the material system of provision of healthcare services (an analysis of elements of the vertical chain), while (ii) paying attention to the historical, ideological, social and political environment (an investigation of the horizontal context). This is crucial to understand poor health outcomes and prevalent health inequities in Nigeria, which, following the SoP approach, are linked to and result from the way healthcare is provided in Nigeria (the material system of provision) and are influenced by how different agents feel about healthcare provision and consumption (the material culture). Both these elements are related to and contingent on the policy environment.

As Bayliss and Fine (2020, p. NA) accentuate, the investigation of a system of provision ("how to research?") is separate from the presentation of the empirical findings of the investigation ("how to present?"). With regard to the investigation, the authors emphasise that the SoP approach itself is grounded in inductive reasoning and urges the identification of an area of investigation rather than a fixed set of hypotheses as the starting point to engage in a "reasoned dialogue" between theory and evidence (Bayliss and Fine, 2020, p. NA). The approach is not prescriptive as to what research methods I need to employ in order to understand the dynamics of UHC policymaking and implementation in Nigeria, but it is strongly opposed to adopting a logic of understanding the consumption of healthcare as the outcome of a rational and optimising decision-making process. In contrast, the framework encourages the researcher to seek to understand the nature of consumption and the underlying currents that shape consumption norms and patterns.

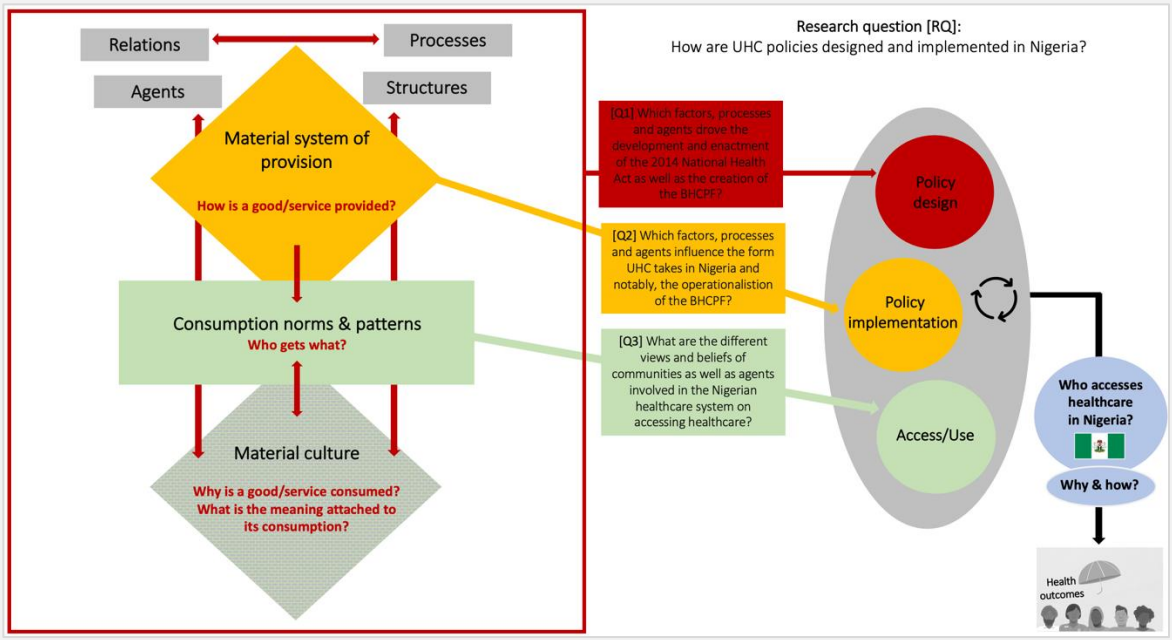
Concretely, the approach encouraged me to explore how different agents and their relationships to each other, conditioned by global processes (such as the trajectory of neo-liberalisation) as well as context-specific structures (such as Nigeria's federal character and its economic and security situation), impact UHC policy design/implementation. This is key to understand how universalism is interpreted in the context of Nigeria and in order to grasp the form UHC takes there. One important challenge of SoP research, however, is how to set boundaries. Health outcomes and health inequities in Nigeria are, most intuitively, linked not only to the healthcare system of provision, but to a variety of other provisioning systems (including education, housing, water and sanitation, infrastructure, etc.). My research not only draws a boundary by focusing on the Nigerian healthcare system of provision only, but also by putting policymaking and implementation at the heart of my investigation (in contrast to e.g., conducting an impact evaluation of the BHCPF).

With regard to the presentation of findings, the key challenge for SoP researchers is to establish how best to put forward the empirical evidence gathered from the SoP investigation: "what goes where and where to start"? (Bayliss and Fine, 2020, p. NA). In this context, I have decided to proceed as follows:

1. In Chapter 4, I start with a presentation of prevailing consumption patterns and norms and the actual, material Nigerian healthcare system of provision. I provide information on how it is constituted, on how it is funded and on who is actually accessing and using healthcare in Nigeria and with what effect. This allows me to single out and present the **agents** bearing influence on the operation of Nigeria's healthcare system. I furthermore discuss public attitudes towards health and healthcare, making the link between consumption patterns and norms and the meaning different agents attach to healthcare consumption. This allows to illustrate how the material system of provision is intertwined with the material culture.
2. I then move on, in Chapter 5, to discuss the key **structures** and **processes** that affect the **relations**, dynamics and contestations between these agents operating in Nigeria's healthcare system of provision, in order to understand the determinants of UHC policymaking. I describe in detail how global and Nigeria-specific structures, processes, agents, their relations and the meaning they attach to healthcare consumption influenced the development of a particular policy, via the NHAct.
3. I then take this one step further, by connecting the process of agreeing on the final text of the NHAct with the way the policy is currently being implemented. Once more, I concentrate on clearly outlining how relations and contestations between agents as well as structures and processes affect the operationalisation of the NHAct, and the BHCPF in specific, which was put into place in order to reduce catastrophic health expenditure and to mitigate current service delivery challenges at primary healthcare level.

All in all, to be able to draw meaningful conclusions on what form UHC is likely to take in Nigeria, the above dynamics and undercurrents relating to policymaking and implementation need to be understood in great detail. This is the centre piece of this PhD study, which relies on the SoP approach and its iterative nature and methodological and theoretical openness to do so. Figure 15 illustrates how I apply the SoP approach to answer my operational research questions. By gaining an in-depth understanding of the processes, structures, agents and relations that guide policy design and implementation as well as by unpacking the material culture that contribute to the manifestation of certain norms and patterns of healthcare use, this dissertation seeks to provide insights into the elements determining social policy trajectories in an African context. The following section describes the methodology and methods I have used in order to do so.

Figure 15: Connecting the SoP approach with my research questions



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3. Research methodology and methods

The choice of how to answer a research question is rarely an insular process. Instead it relates to and is informed by how a researcher deems that scientific knowledge can be generated, what reality is and how it should be studied (Jäger et al., 2016, p. 101; Bryman, 2012, p. 19). Thus, no social research project is unprejudiced (even if the prejudice is that objective meaning exists). Rather, social research is influenced by a researcher's ontological and epistemological standpoints, the theories selected as well as the researcher's value system (Bryman, 2012). Knowledge, then, is a "social product", impacted by how the researcher sees the world. Morgan (2016, p. 16), for instance, asserts:

> Taken in isolation the following can seem a ridiculous statement; ridiculous in the sense that it is so obvious it ought not to require such statement: Any science, including a social science such as economics, ought to be about reality, the nature of reality ought to make a difference to how we study it and what we then claim about it as a form of knowledge. However, when one considers that **knowledge is a social product** then the need to be reminded of the significance of the obvious becomes considerably less ridiculous. **Knowledge is a set of claims based on particular theories, and particular investigations, using particular methods.** These develop over time … Knowledge is a social product and can for various reasons lose sight of or become deformed in terms of its primary concern: the investigation of reality (emphasis added).

In this light, ontological considerations (relating to the question of what reality consists of) are closely associated with epistemological considerations (relating to the question of how we as human beings

can understand reality) and inform the adoption of a purposeful theory, research methodology and research methods (Crotty, 1998). To an extent, they also guide the motivation for doing research and the choice of the research object. As Jäger et al. (2016) emphasise, researchers engaging in Critical International Political Economy (CIPE) analysis own up to a fundamental commitment to an emancipatory perspective. In other words, the impetus to do research here is to better understand the world and critique injustices within the existing social order, with the explicit ambitions of tackling inequality, of supporting disadvantaged and oppressed groups and of advocating for transformations that result in a more solidaristic society (Cox, 1981; Sayer, 1997). Thus, methods and methodology are not neutral but are linked to our view of the world and how it can be studied.[96]

Therefore, working in the tradition of Critical Political Economy, the question follows what the appropriate methodology/research strategy entails, and which research method(s) are the most fitting to employ.[97] I have opted for a country case-study approach[98] and the use of quantitative and qualitative data in order to be able to take account of the complexity and particularity of the Nigerian healthcare system in as much detail as necessary. My thinking has been informed by existing theories that explain health system reforms and outcomes in different settings and I have analysed available survey and health expenditure data to understand better the links between health outcomes and e.g. levels of public finance, aspects of policy reforms (i.e. decentralisation) as well as group-based attributes such as gender, social location, etc. A significant proportion of my analysis, however, relies on information provided by more than 130 people in Nigeria, gathered via semi-structured interviews and focus group discussions (FGDs) with agents operating within the Nigerian healthcare system. Figure 16 links my research methods to my three operational subsidiary research questions.

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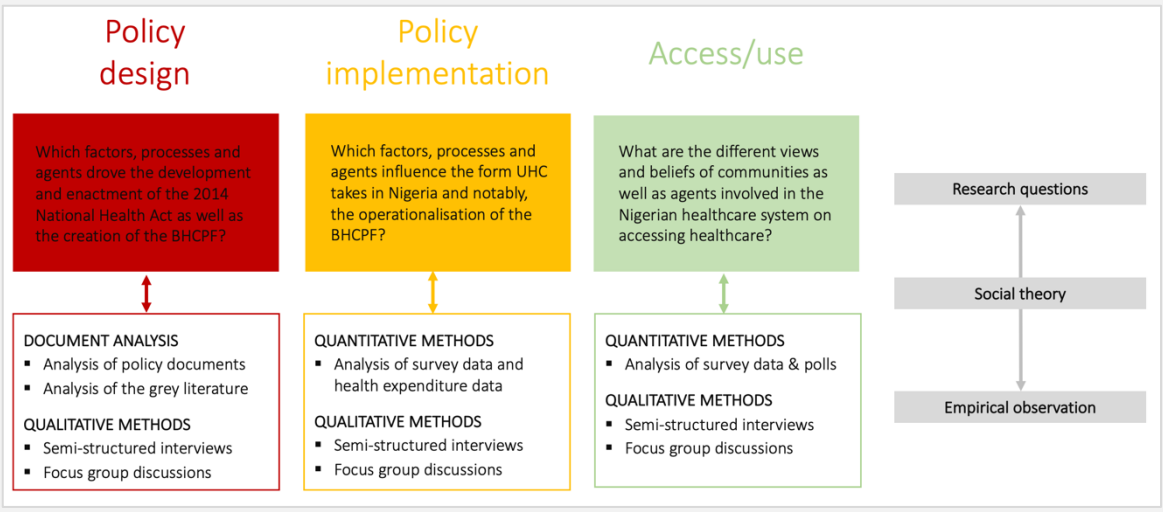
[96] Crotty (1998) defines methods as the "techniques or procedures used to gather and analyse data" and methodology as the "strategy, plan of action, process or design lying behind the choice and use of particular methods and linking the choice and use of methods to the desired outcomes".

[97] Most commonly, quantitative methods (i.e. analysis of statistical data, surveys, structured questionnaires, etc.) are more likely to be associated with the positivist paradigm, while qualitative methods (i.e. semi-structured interviews, focus group discussions, etc.) traditionally have been linked to the interpretivist paradigm (McEvoy and Richards, 2006). Yet, the debate on whether quantitative and qualitative methods can/should be combined when undertaking social research is long-standing. As Kaltenbrunner (2011, p. 182) summarizes, generally, proponents of a purist approach (which take an absolute stance and advocate against a mixing of methods as methods need to be coherent with the underlying ontology/epistemology) can be distinguished from proponents of a more pragmatic approach (which promote the use of the research methods, which will led to the best result). Yet, while, within critical realism, there may be some scepticism as to whether quantitative methods are an apt way of doing research (see e.g. Pratschke (2003, p. 18) on attitudes of critical realists towards statistical analysis), the opinion prevails that research methods (be it quantitative, qualitative or a mix) should be chosen on basis of the nature of the research question (McEvoy and Richards, 2006, p. 71).

[98] See e.g. Heale and Twycross (2018) for information on the case-study approach.

Figure 16: Research methods



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3.1. Primary data collection: fieldwork in selected States in Nigeria

In order to collect primary data, I spent four months in Nigeria between January and April 2019.[99] Prior to commencing my fieldwork, I requested and obtained ethical approval for my research endeavour from the National Health Research Ethics Committee. Nigeria, with a population of approximately 200 million, 36 States plus a Federal Capital Territory (FCT), 6 geo-political zones and a multitude of different ethnical and religious groups, is by no means a homogenous country, and it stretches over a surface of slightly more than 920,000 km^2 (for comparison purposes, the United Kingdom has a surface of just slightly more than 240,000 km^2). Therefore, financial and time constraints, but also a sometimes-volatile security situation in parts of the country, made it necessary to choose field research sites and interview partners purposefully and selectively. The below research sites were identified for the following reasons (a map of Nigeria is depicted in Figure 17):

1. **Abuja (North-Central region):** Abuja is located in the center of the country in the Federal Capital Territory. It has been the **capital city** of Nigeria since 1991 when Abuja took over from Lagos as the political and administrative center of Nigeria. I spent a considerable amount of my time in Nigeria in Abuja in order to exchange with policymakers within the Federal Government, the National Health Insurance Scheme (NHIS), the National Primary Health Care

[99] In the midst of my period of active fieldwork, in February 2019, Presidential elections took place. This did not substantially impact my data collection but meant that most people I interacted with articulated some political commentary, with many people referring to the need to "see what happens after the elections".

Development Agency (NPHCDA) as well as representatives of international organisations and civil society organisations (CSOs)/NGOs, which, for the most part, have their headquarters in Nigeria's capital city. Moreover, spending time in the capital city allowed me to have many formal/informal exchanges with other players within the Nigerian healthcare system (e.g., Health Maintenance Organisation (HMO) representatives, staff members working in the National Assembly (NASS), government officials working in departments other than health, etc.) and enabled me to participate in a two-day workshop, entitled "Nigeria Value for Money in Health" (upon invitation).

2. **Enugu State (South-Eastern region):** While often the Southern states of Nigeria have lower official poverty headcounts in comparison to Nigeria's Northern states, Enugu (alongside Ebonyi state) remains an outlier with a 58.13 percent poverty headcount (compared to neighbouring Anambra state's poverty rate of 14.78 percent in 2019).[100] Yet, under 5 child mortality rates are similar in Enugu and Anambra (61 percent in Enugu compared to 58 percent in Anambra according to 2018 DHS data). In 2007, Enugu State introduced a **free Maternal and Child Healthcare (MCH) programme** seeking to make essential healthcare services and drugs free at point of service at public facilities for pregnant women and children under age 5. The programme is tax-funded with monthly contributions by the Enugu State Government as well as local governments (Ogbuabor and Onwujekwe, 2019). I was interested to conduct interviews and FGDs in Enugu state due to its longstanding free MCH programme. Furthermore, most members of the Health Policy Research Group (HPRG) are based in Enugu (the capital city of Enugu State) at the Enugu Campus of the University of Nsukka, Nigeria (known as UNEC). They hosted me in their offices at the "Old UNTH" (the old campus of the teaching hospital of the University of Nigeria), which was immensely beneficial as it permitted me to have a multitude of informal conversations with colleagues and health workers. I furthermore had the opportunity to present some of my research ideas to the HPRG's extended network, generating valuable feedback.

3. **Anambra State (South-Eastern region):** Anambra State launched a State Health Insurance Scheme (SHIS) in September 2018 and, at the time of my fieldwork, had a functioning **state health insurance agency** in place – the Anambra State Health Insurance Agency (ASHIA). Anambra is one of the first states to operate a functioning SHIS, as recommended by the NHAct. As per their website, ASHIA envisages to cover all residents within the State, not just

[100] Based on the official latest poverty data; more detailed information will be provided in Chapter 4.

government civil servants, by making health insurance mandatory and pooling resources in order to allow for cross-subsidisation. I deemed it valuable to conduct interviews and FGDs in a state that already had a SHIS in place, to gather insights from State and Local Government officials as well as Anambra residents on the social health insurance scheme.

4. **Niger State (North-Central region):** In addition, I conducted FGDs and interviews in Niger State in Nigeria's North-Central region. A great share of healthcare facilities in Niger State are in public ownership (89.41 percent compared to 63.78 percent in Anambra and 8.19 percent in Enugu, according to the 2018 Health Facility Registry), yet more than a quarter of all non-food expenditure of households (28.6 percent according to 2018/2019 data of the Living Standard Measurement Survey, LSMS) is spent on health. Niger State was selected as one of the first three states to pilot the BHCPF (aside Abia State and Osun State). Interviews and FGDs with different participants in the healthcare system were expected to provide additional insights on how the on-going implementation of the BHCPF is perceived.

In addition, I spent time in two of Nigeria's major cities, **Lagos (in Lagos State in the South-Western region)** and **Ibadan (in Oyo State in the South-Western region)**, in order to engage in informal discussions, to learn more about the country-context and to participate in a conference, organised at the University of Ibadan. The participation in the conference allowed me to present some of my preliminary ideas and to get valuable feedback from others, researching and working on similar topics in the field of social and economic policy in Nigeria.

Figure 17: Administrative map of the Federal Republic of Nigeria

Source: Wikipedia

In addition, and crucially, my affiliation with the Enugu-based HPRG under the leadership of Professor Obinna Onwujekwe was decisive for the successful course of my fieldwork. The HPRG was founded in 2003 and, since then, has worked extensively with scholars across Nigeria (i.e., the University of Ibadan, Lagos State University, Ahmadu Bello University Zaria).[101] At the same time, it is part of several consortia, including the Consortium for Research on Equitable Health Systems (CREHS) as well as the Responsive and Resilient Health Systems (RESYST), both based at the London School of Hygiene and Tropical Medicine. The HPRG also has ties with SOAS, with members of their team contributing to the research endeavours of the Anti-Corruption Evidence (ACE) programme. HPRG's members have published extensively on many aspects of Nigeria's healthcare system and are or have been in high-level, policy-relevant positions within Nigeria's health policymaking landscape. The HPRG has produced evidence and policy recommendations pertaining to health systems reforms and initiatives, including the 2014 NHAct and the BHCPF. Moreover, thanks to the support provided by the HPRG, I was able to profit from the knowledge, expertise and skills of namely two colleagues, who assisted me in my data collection efforts. I was especially privileged to work with Dr Chinyere Mbachu and Ms Uche Ezenwaka, who were instrumental in organising and conducting the FGDs in Enugu and Anambra state. They furthermore supported me in making contact with key stakeholders in Nigeria's health sector. I wish to express my gratitude and emphasise how essential, both, my affiliation with them during my fieldwork as well as the research and knowledge that they have produced were for the realisation of my research project.

3.1.1. Semi-structured interviews

During four months of fieldwork in parts of Nigeria, I was able to interview 52 different individuals, who play different roles in Nigeria's healthcare system.[102] With the aim of gaining a comprehensive understanding of the Nigerian healthcare system and guided by my research questions, the selection of my interview partners was a result of purposive sampling.[103] Prior to the commencement of my fieldwork, after an extensive review of the literature and familiarisation of the policy landscape and functioning of Nigeria's health system, I identified five interest groups to target for interviews, as summarised in Table 4. Within these categories, I reached out to key representatives, then applied

[101] More information is available on the UNN website: https://www.unn.edu.ng/the-health-policy-research-group-hprg/ (last accessed 25/09/ 2020).

[102] See Appendix D for the full list of interview participants.

[103] According to Bryman (2012, p. 418), "the goal of purposive sampling is to sample cases/participants in a strategic way, so that those sampled are relevant to the research questions that are being posed".

snowball sampling, until theoretical saturation was reached.[104] Two points are noteworthy. First, the category of "healthcare providers and health insurance providers" is diverse, and the insights gathered from this important interest group in Nigeria's healthcare sector were complemented with information obtained during FGDs. Second, interviews with representatives of CSOs focused on organisations based in urban centres and are, thus, not necessarily representative of grassroot groups and views from communities, which were in turn an identified target for the FGDs.

I conducted all interviews myself (in English) and all interviews, except for one, were one-on-one interviews. One interview was conducted with three members of the same organisation at the same time, who were sharing their views and complementing each other. All interviewees received an information leaflet/consent form and were advised of the purpose of this research. All interviewees signed a research participation declaration, where I guarantee them anonymity. They all granted me the right to quote information they provided in anonymised form. I had prepared guidelines for semi-structured interviews, formulating questions rather broadly at the beginning to avoid asking leading questions and suggesting particular sets of answers (see Appendix E). I provided more prompts towards the end if some of the issues I was interested in had not yet been raised. During interviews, I took extensive hand-written notes, which I digitalised immediately after each interview and complemented with my own observations and information and background on the interview partner. I later transcribed all interviews verbatim using NVivo version 12. I then re-read and analysed each interview in detail to identify key categories, matching these categories with key direct quotes from interviewees.

Table 4: Sampling – interviews

Identified interest groups within Nigeria's healthcare system (semi-structured interviews)		**# of interviewees**
Federal Government and federal-level parastatals	Such as representatives of the Federal Ministry of Health, the Federal Ministry of Finance, the National Assembly, the National Health Insurance Scheme, the National Primary Health Care Development Agency, the National Social Safety Net Coordinating Office and the Nigeria Centre of Disease Control (NCDC)	10
State and Local Government and state-level parastatals	Such as representatives of the State Ministry of Health, State Houses of Assembly, state-supported health insurance schemes, State Primary Health Care Development Agencies and Boards, and Local Governments	12

[104] According to (Strauss and Corbin, 1998, p. 212), theoretical saturation is reached when "(a) no new or relevant data seem to be emerging regarding a category, (b) the category is well developed in terms of its properties and dimensions demonstrating variation, and (c) the relationships among categories are well established and validated".

Healthcare providers and health insurance providers (public and private)	Such as health personnel working in public establishments, notably primary healthcare centres (e.g., nurses, midwives, Community Health Extension workers), private healthcare providers as well as representatives of for-profit private HMOs	9
CSOs and research institutes/academia	Such as representatives of Health Foundation Reform of Nigeria, Nigeria Health Watch and the HPRG	10
International Organisations	Such as representatives of the World Bank, UN agencies (notably, the WHO, UNICEF, UNFPA and UN Women), the Bill and Melinda Gates Foundation (BMGF), the Clinton Health Initiative and Results for Development	11

3.1.2. Focus Group Discussions

In parallel to conducting semi-structured interviews, I gathered information via 12 FGDs, with a total of 83 participants,[105] assisted by two colleagues from the HPRG and an experienced researcher from the Ahmadou Bello University (ABU) Zaria.[106] Nine out of 12 FGDs were conducted in Igbo (in Enugu and Anambra States) with me present. These were led by a colleague on basis of a detailed FGD guide that I had prepared (which was translated into Igbo). Participants were encouraged to speak freely using Igbo, but many spoke a mix of English and Igbo. The remaining three FGDs were conducted in Hausa (in Niger State), with me introducing myself at the beginning, but then led by the researcher from ABU Zaria without my presence.[107] Similar to the approach taken for the identification of interview partners, the rationale behind identifying focus groups was purposive and aimed at generating vast insights that will help me in answering my research questions. Table 5 provides an overview of the different interest groups. Each FGDs had between 6 and 8 participants, except one group of only 5 participants.

There was no specification regarding participants' gender when people were invited to FGDs. Yet, FGDs with health services users turned out to be all-female groups (which is why I label them women's group going forward) and FGDs with village heads turned out to be all-male groups. In order to organise the FGDs in Enugu and Anambra States, I visited (most) selected facilities prior to the actual date of the FGDs to converse with the Officer in Charge (OIC), habitually the chief nurse, at the public primary healthcare facility and paid her a small lump-sum to cover for the phone calls she had to make to organise the sessions. The FGDs in Niger State were organised by the researcher from ABU Zaria and a colleague of his at the Niger State Ministry of Health (SMOH). I obtained additional ethical

[105] All FGDs are listed in Appendix F.

[106] ABU Zaria is a federal government research university based in Kaduna State in North Nigeria.

[107] See **Error! Reference source not found.** for the FGD guide.

clearance for the conduct of the FGDs in Niger State. All participants in the FGDs were reimbursed for their time. In a similar vein to my approach to analysing the semi-structured interviews, I re-read and analysed all English transcripts of the FGDs and identified/matched key information into categories.

Table 5: Sampling – Focus Group Discussions

Identified interest groups within Nigeria's healthcare system (focus group discussions)	# of FGD
Public healthcare providers, Ward Development and Health Facility Committees members	4
Health services users/women's group	4
Village heads	2
Youth groups	2

3.1.3. Collection of policy and advocacy documents and grey materials

Aside from the information gathered during interviews and FGDs, my presence in Nigeria also enabled me to obtain hard and soft copies of policy documents and reports, otherwise not available. These included previous iterations and drafts of policies, laws and operational manuals, consultancy reports prepared by international organisations, meeting minutes from some of the key meetings that have taken place over the last decade, advocacy material and letters addressed to stakeholders in the sector, etc. These have provided me with a wealth of additional information. To make best use of such grey material, it is important to understand underlying politics and positions of the writers/commissioning organisation. As O'Laughlin (2007, p. 135) highlights: "The production of policy documents, our reading of them and the construction of our own accounts are shaped by the politics of the policy-making process. What policy-oriented research tells us is not self-evident; it has to be interpreted politically to be understood".

3.2. Analysis of survey and budget data

While my research relies to a large extent on the primary data gathered during fieldwork, it is complemented by available household survey data sets as well as data on budget allocation and spending. By engaging in secondary data analysis, I am able to document some health outcome trends at disaggregated level. A magnitude of social, economic and budgetary data is made available by the National Bureau of Statistics (NBS) and the Central Bank of Nigeria (CBN). Other large survey data sets include the Demography and Health surveys (DHS), the Living Standard Measurement surveys (LSMS) as well as the Multiple Indicator Cluster surveys (MICS). Quantitative survey data was analysed using the statistical software Stata as well as Microsoft Excel.

Secondary household survey data analysis efforts were complemented with an analysis of budget allocation and expenditure trends over time as well as other macroeconomic data. Obtaining disaggregated expenditure data was particularly difficult with information being scattered across multiple platforms (e.g., the website of the budget office of the Federation, websites of States' Ministries of Budget and Planning, media reporting, reports of CSOs). National Health Accounts (2006-2009; 2010-2016; 2017) are available and were obtained from key contacts. Some information on spending trends of past decades is available in journal articles, books as well as policy documents such as the Colonial Welfare Acts. Moreover, especially national accounting work done by Pius Okigbo in the first decades after independence is a very valuable source. Also, international organisations, including the World Bank and the WHO (Global Health Expenditure database) provide information on public health spending trends.

3.3. Positionality

Social location and identity, upbringing and personal preconceptions influence a researcher's outlook on and appreciation of the world. For example, Abimbola (2019, p.2) points at the benefit of reflecting on one's own position and to explicitly declaring our "pose" (the viewpoint from which we write) as well as our "gaze" (our intended audience) when doing research:

> This authorial reflexivity can give permission to the foreign expert, who, **recognising the limits of what they can see or understand**, chooses to write for other foreign experts, primarily; and can expose the hubris of a foreign expert who does otherwise. But note that the local versus foreign pose can shift depending on the person and the topic; an anthropologist from the same West African country, but of a different ethnicity to the location of the outbreak, may be a foreigner in relation to burial practices – foreignness could be defined by ethnicity, race, caste, geography, socioeconomic status and the issue in question.

Therefore, authorial reflexivity means for me to acknowledge my personal biases and boundaries to grasping and understanding social phenomena, while also showing an awareness of the socio-economic realities, which determine who, in the first place, is in a position to generate knowledge and access platforms that allow for its dissemination. In this regard, for example, Walt et al. (2008) have highlighted the importance of making reflections on power and position of the researcher an explicit concern when engaging in HPSR in low- and middle-income countries. In my case, my biases and boundaries are informed by a variety of elements: I was raised in Austria (by an Austrian mother and a Nigerian father) and enjoy privileges associated with carrying an Austrian passport and socio-economic background. I visited Nigeria from an early age on, have a Nigerian name and also carry the Nigerian passport. I do, however, not speak Igbo, my father's native language. In my case, my Nigerian heritage opened doors and facilitated my research in many ways – I was able to enter the country

without a visa, my Nigerian name and roots in Enugu State meant that I had a family network supporting me whilst in the country and that, generally, interviewees and FGDs partners were well-disposed and amicable towards me. My Austrian heritage and education in the United Kingdom opened other doors – I am, in the first place, privileged enough to be able to pursue this PhD degree, am a self-funded student and, being enrolled at SOAS and having worked previously with UNICEF helped to get access to interviews, especially with representatives of international organisations. On the other hand, I relied on the support of other Nigerians to help me with the conduct of my FGDs as I have very limited proficiency in Igbo and none at all in Hausa.[108]

4. Conclusion

This research is conducted in the tradition of Critical Political Economy, which is committed to understanding and critiquing real-world injustices and inequality. In Nigeria, a majority of households need to pay for healthcare out-of-pocket – a reality which fosters systemic health inequities as it leaves many people without the necessary care and contributes to unnecessary ill-health or death. Against this backdrop, this chapter, first, discussed how the SoP approach, anchored in Critical Political Economy, guides my research and allows me to concentrate on identifying agents, processes and structures that are decisive in shaping UHC policymaking and implementation in Nigeria. Second, I have laid out my research methods and have provided background information on my fieldwork in Nigeria. I have also presented my reflections on my positionality as a researcher in Nigeria.

The following chapter provides information on health outcomes and prevalent health inequities and presents a mapping of the Nigerian healthcare system of provision. It identifies the agents that have an influence on the policy landscape, in which the Nigerian healthcare system is embedded in. It analyses healthcare consumption norms and patterns and perceptions of the material culture of healthcare.

[108] See, for instance, Deane and Stevano (2015), who highlight the importance to reflect and account for the role and influence of research assistants on research outcomes.

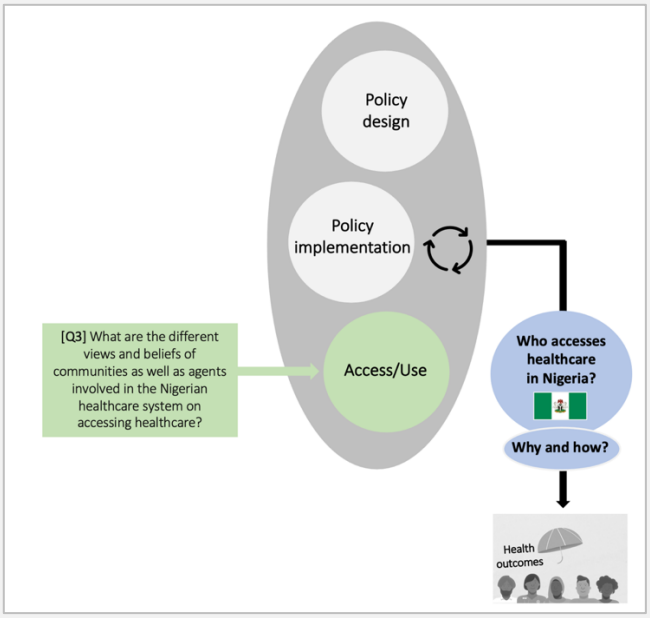
CHAPTER 4 | The state of health and healthcare in Nigeria

1. Introduction

As part of this thesis' ambition to account for country- and system-specific processes, structures and interests that underpin the way UHC is being implemented in Nigeria following the National Health Act, this chapter has a three-fold purpose. First, it documents health outcomes in Nigeria, including existing inequities. Second, it maps Nigeria's healthcare system underpinning these health outcomes and inequities. And, third, it highlights prevailing healthcare consumption norms and patterns and their interconnectedness with the meaning Nigerians attach to healthcare consumption. This allows me to identify the agents involved in Nigeria's healthcare system of provision who affect UHC policy design and implementation. It is the basis on which Chapters 5 and 6 proceed in their investigation of the development and implementation of the NHAct

The current chapter charts **how** healthcare is provided in Nigeria, **who** accesses it and with what result. Furthermore, it presents an overview of common expectations of the population with regard to healthcare provisioning in Nigeria, dissecting different views on the importance of health as a policy priority and on who should be accessing healthcare, where and how (see Figure 18). The chapter proceeds on the basis of a range of secondary data sources, including household surveys and databases of the national statistics office and international organisations. This combines with insights from my field research, in particular on how different groups of Nigerians assess their (and others') ability and willingness to use healthcare.

Figure 18: Accessing healthcare in Nigeria



Source: Own illustration

The chapter is structured as follows. Section 2 documents health outcomes across Nigeria, analysing temporal trends and illustrating regional and other disparities. While there have been positive trends in recent years in some key indicators, health outcomes in Nigeria remain poor and Nigeria tops the ranking of countries with the highest under-five mortality rate.[109] The bulk of morbidity and mortality in Nigeria can be attributed to (avoidable) communicable, neo-natal, maternal and nutritional diseases and conditions, with poorer households particularly badly affected.

Section 3 provides an overview of how the Nigerian healthcare system is constituted and funded, documenting how it gives rise to unsatisfactory and inequitable health outcomes. I analyse the structure of the healthcare system, for which the NHAct provides the legal basis, and highlight the different roles of the three tiers of government. In this context, I examine budgetary allocations to the public healthcare system, underlining that the Federal Government's budget for healthcare falls short of the "15 percent for health" threshold maintained in the 2001 Abuja Declaration. I depict how funding for healthcare has remained low, even after the NHAct was passed and made an annual budgetary allocation to the healthcare system via the BHCPF mandatory. Similarly, a majority of State Governments allocate low levels of public resources to their Ministries of Health, making donor support – albeit, overall, small compared to Nigeria's Gross Domestic Product (GDP) – vital for the health sector. As a result of inadequate Government health spending, access to healthcare in Nigeria is then, for the most part, tied to a household's capacity to pay for services out-of-pocket, putting additional pressure on especially poorer families. In conjunction with this, I review the role of the private sector in healthcare delivery, maintained in the NHAct as a key stakeholder within Nigeria's healthcare system, and emphasise the prevalence of private healthcare providers notably at secondary and tertiary levels of care. I discuss the implication of a substantial private sector for equitable access to healthcare and demonstrate that regional variation across the country includes higher levels of use of private service providers in the (richer) Southern States. This detailed review of who has influence on the operation of the Nigerian healthcare system allows me to provide a mapping of the agents of significance in shaping UHC policy design and implementation.

Section 4 discusses norms of healthcare consumption and public attitudes towards health and healthcare. I argue that because of high levels of poverty and multi-faceted deprivations, the perception prevails amongst Nigerians that public policy is confronted with the necessity to choose amongst competing priorities, with health and healthcare not necessarily explicitly projected as a

[109] According to estimates developed by the United Nations Inter-agency Group for Child Mortality Estimation (UNICEF, WHO, World Bank, UN Department of Economic and Social Affairs Population Division)

priority by the Government nor the citizenry. I furthermore highlight the widespread opinion that some form of private sector participation is necessary to facilitate wider access to healthcare in Nigeria and document the equally widespread scepticism towards and distrust in the Government and its preparedness to provide healthcare services.

Section 5 concludes with a summary of the most important features that characterise the state of health and healthcare in Nigeria.

2. Access to healthcare services, health outcomes and health inequities in Nigeria

In 2018, the Federal Government of Nigeria (FGON) presented and adopted its 2018-2022 National Strategic Health and Development Plan (NSHDP II), highlighting the following concerns:

> […] despite Nigeria becoming the largest economy in Africa and it being re-classified as a middle-income country, **health outcomes have stagnated** over the past two decades. The health system is characterised by gross underfunding, poor coordination of different stakeholders, inadequate numbers and skills of health care workers, poor infrastructure, limited availability of evidence for planning and decision-making, **inequities in distribution of health resources and poor access to services and limited financial protection at the point of care** (FMOH, 2018, p. 32; emphasis added).

Health outcomes in Nigeria are mediocre and the country's progress to assure healthcare for all Nigerians remains a policy ambition.[110] Since 2015, the WHO, jointly with the World Bank, has been monitoring countries' advancement towards attaining UHC. Nigeria's performance, if benchmarked against the SDG indicators, has been below average with a score of 42 in 2017 (and in 2015) relative to the SSA average of 46 (see Table 6). For comparison purposes, for example, South Africa's score is 69 in 2017; or, Malawi (where the GDP per capita is a fifth of Nigeria's GDP per capita) has a score of 46. Also, looking at the effective coverage index, an alternative measure published in *The Lancet*,[111] it becomes evident that Nigeria's performance is modest in comparison to neighbouring countries and countries within the same region and/or income group (see Figure 19).

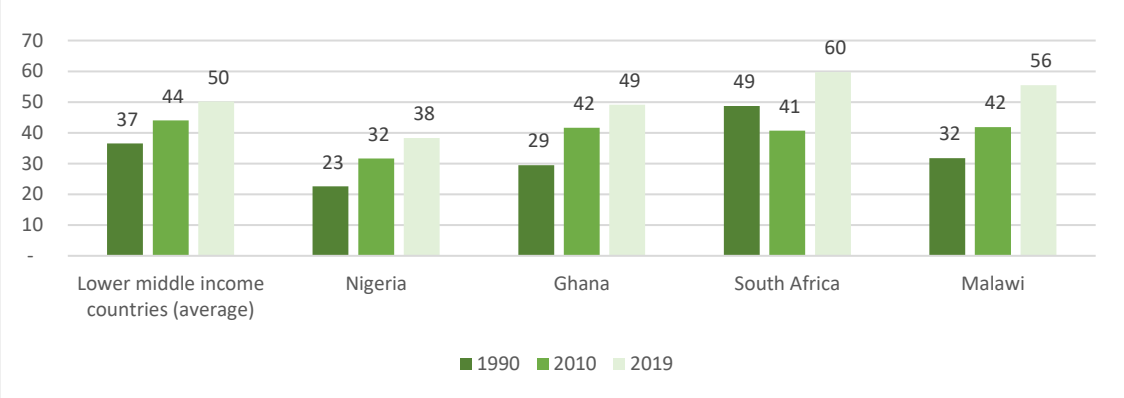
[110] As per the WHO definition, health outcomes are a "change in the health status of an individual, group or population which is attributable to a planned intervention or series of interventions, regardless of whether such an intervention was intended to change health status."; see here: https://www.who.int/healthpromotion/about/HPR%20Glossary%201998.pdf (last accessed 12/05/2021).

[111] See Lozano et al. (2020) for more details on their measure and its value added.

Table 6: Monitoring progress towards the attainment of UHC

SDG target 3.8: Achieve universal health coverage, including financial risk protection, access to quality essential healthcare services and access to safe, effective, quality and affordable essential medicines and vaccines for all	**Nigeria**	**Sub-Saharan Africa**
SDG UHC Indicator 3.8.1: Service Coverage Index, 2017[112]	42	46
SDG UHC Indicator 3.8.2: Population with household expenditures on health greater than 10% of total household expenditure or income (%)	15.1 (2012)	7.3 (2015)
SDG UHC Indicator 3.8.2: Population with household expenditures on health greater than 25% of total household expenditure or income (%)	4.1 (2012)	1.8 (2015)

Figure 19: UHC Effective Coverage Index



Source: Own illustration based on data by The Lancet/Institute for Health Metrics and Evaluation 2020

While there has been some progress – with Nigeria's UHC effective coverage index increasing since 1990 – health outcomes in Nigeria have failed to improve substantially. For instance, maternal and child mortality rates remain high and surpass national and international benchmarks (see Figure 20). According to the 2018 Demographic and Health survey, every tenth child in Nigeria dies before its fifth birthday (132 children under the age of five per 1,000 live births),[113] with much higher under-5-mortality rates (U5MR) in some of the Northern states of the country as illustrated in Figure 21. While the aggregate trend may be somewhat positive, Nigeria's U5MR is the highest in the world (jointly with Somalia) and compares to 47.9 children under the age of five out of 1,000 dying in Ghana.[114] Similarly, infant mortality rates are above average and only one Nigerian child out of five (aged 12-23

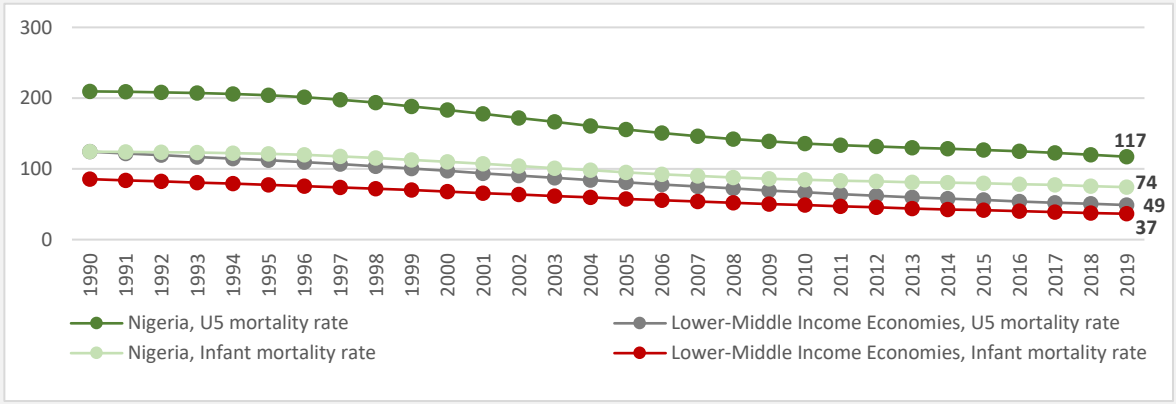
[112] The WHO and the World Bank have proposed a UHC measurement framework in 2014, taking account of a range of services, including promotion, prevention, treatment, rehabilitation, and palliation, to establish its service coverage index.

[113] In 2019, the UN Inter-Agency Group for Child Mortality Estimation (IGME), reports a value of 117 (per 1,000 live births).

[114] Data online available at: https://data.unicef.org/country/gha/ (last accessed 13/05/2021).

months) received all age-appropriate vaccinations in 2018. Moreover, two out of five deliveries did not take place in a health facility in 2018, potentially explaining why 31.3 percent of female deaths are maternal (National Population Commission Nigeria & ICF 2019: 223, 377). As a consequence, maternal and neo-natal disorders are the greatest contributor to mortality and morbidity in Nigeria (measured in disability-adjusted life years) at 16.3 percent.[115] These are followed by a range of communicable diseases (i.e., enteric infections at 14.6 percent, respiratory infections and tuberculosis at 12.8 percent and neglected tropical diseases and malaria at 12.5 percent – all affecting children disproportionally). In 2019, the main causes of death in Nigeria were neo-natal disorders, malaria, diarrheal diseases and lower respiratory infections. Figure 22 depicts the burden of disease in Nigeria in 2019, based on data by the Institute for Health Metrics and Evaluation (IHME).[116] Appendix H summarises some of Nigeria's key health outcome indicators.[117]

Figure 20: Trends in U5 and infant mortality rates in Nigeria (deaths per 1,000 live births)



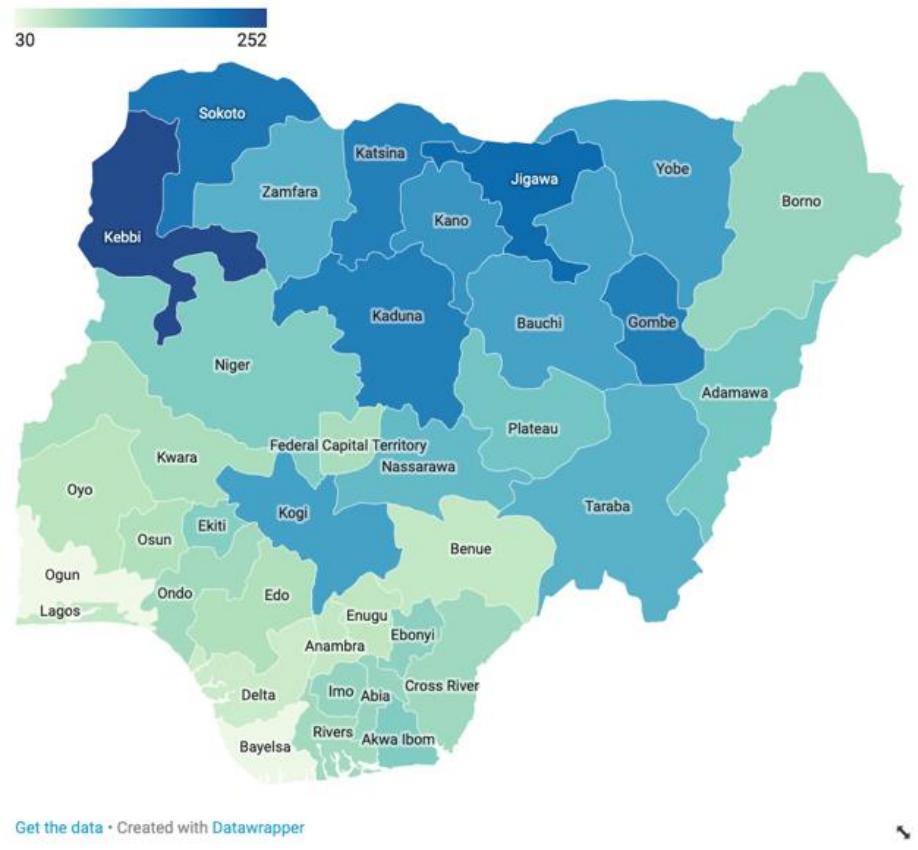
Source: Own illustration based on UN Inter-Agency Group for Child Mortality Estimation estimates, 2020

[115] Although a widely used measure, I would like to stress that focusing on national burdens of disease and interventions, which have the largest effect on changes in health status – as measured in DALYs or quality-adjusted life years (QALYs) – have been deemed problematic, as they are based on the notion that healthcare systems are only there to produce "health" as cheaply as possible (Mooney, 2009). Already at the inception of the DALY in the 1990s, its conceptual and technical basis was criticised and there have been warnings to avoid basing resource allocation decisions solely on attempts to minimise aggregate DALYs, as this has shown to be inequitable (Anand and Hanson, 1997, p. 685).

[116] See here for a critique of the IHME's estimates: https://www.thenation.com/article/society/gates-covid-data-ihme/ (last accessed 24/05/2021).

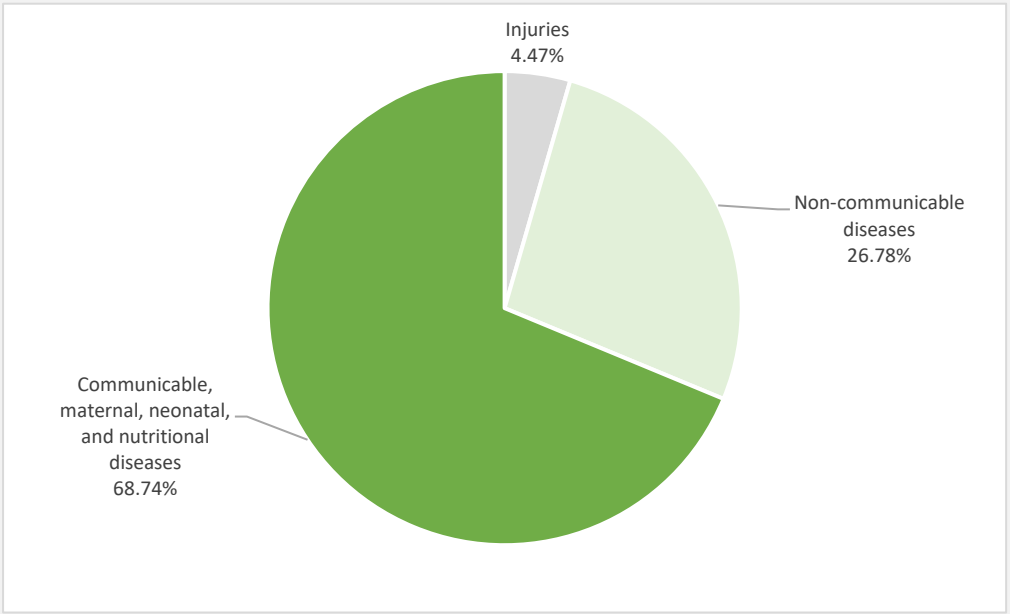
[117] I also want to emphasise that the delivery of non-healthcare services, such as water, sanitation and hygiene (WASH) services or climate change/pollution-mitigating measures have an important impact on mortality and morbidity and influence people's health status. Such services and measures, therefore, should be part of broader discussions on public policies for better health. However, an in-depth engagement with these determinants of health, and policy efforts to address and improve them, goes beyond the boundaries of this PhD research.

Figure 21: U5MR by State



Source: Own illustration based on DHS 2018 data

Figure 22: Leading causes of mortality and morbidity in Nigeria (DALY)



Source: Own illustration based on IHME data, 2019

Health outcomes in Nigeria depend on an individual's social location and reflect broader social inequalities. In 2019, two out of five Nigerians (approximately 80 million people out of an estimated population of 200 million; 40.1 percent) were living below the national poverty line according to data by the National Bureau of Statistics (NBS, see Appendix I for a summary of some of Nigeria's key demographic and macro-economic indicators). Despite considerable economic growth between 2000 and 2014,[118] the country (classified by the World Bank as a lower middle-income country, LMIC) has not been able to satisfactorily translate economic growth into social progress.[119] The COVID-19 pandemic further aggravates the situation, as the crisis-related disruption of education and health service provision (e.g., immunization campaigns) is negatively impacting human development. According to IMF data, the Nigerian economy contracted by 3.2 percent in 2020[120] and, based on World Bank estimations, an additional 15-20 million Nigerians are at risk of falling into "extreme poverty" by 2022 (World Bank, 2020, p. 2; 11). There is strong regional variation. Some Northern States report rates of poverty headcounts higher than 85 percent compared to 4.5 percent in Lagos State (see Figure 23). As illustrated in Figure 24, States, where poverty headcounts are higher, tend to have worse levels of child mortality.

Inequality (measured as the income share held by the richest 20 percent) increased from 2003 to 2009 (from 46 to 49 percent, based on World Bank data) and, in 2018, was still as high as 42 percent.[121] Consequently, aside the geographical North-South divide in terms of health outcomes, differences are even more substantial depending on an individual's socio-economic background. The 2018 DHS shows that the higher the wealth quintile and the better educated the mother, the lower neo-natal and child mortality rates. This means that children growing up in poorer households and in households, where caregivers are less educated, are at a higher risk of dying before they reach age five (see Figure 25). Similarly, the data shows that the proportion of children with a fever for whom treatment is being sought the same or the next day depends on the wealth quintile. 3 in 5 children living in the best-off households (the richest wealth quintile) receive treatment imminently after they have developed a

[118] On average, annual GDP per capital was 4.4 percent between 2000 and 2014 (according to World Bank data).

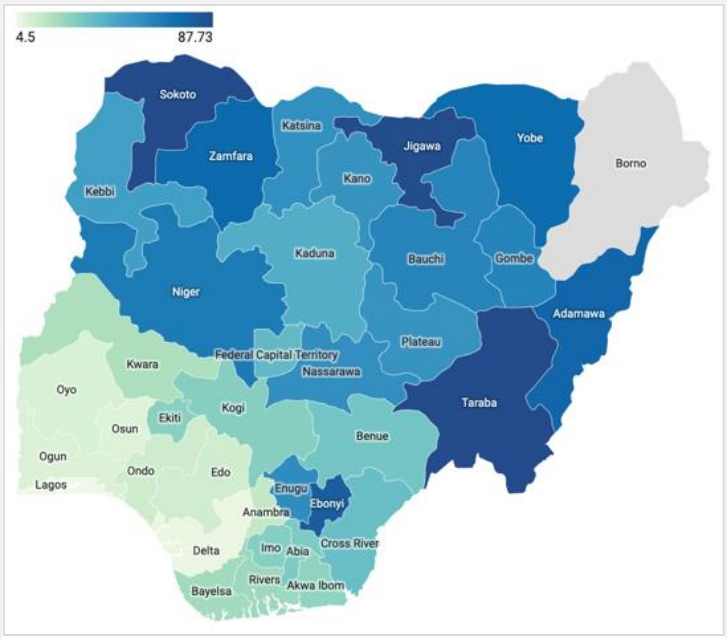
[119] The service sector has been the biggest contributor to GDP over past years (48 percent as of quarter 3 in 2020), followed by the agriculture sector (30.8 percent).

[120] World Economic Outlook, January 2021 data set; online available: https://www.imf.org/en/Publications/WEO/Issues/2021/01/26/2021-world-economic-outlook-update (last accessed 08/02/2021).

[121] For illustration, more than half of the population in Kano State live below the national poverty line, while one of their most famous co-citizens, Aliko Dangote, has a net worth of US$ billion 11.5, making him the richest man of the continent; see: https://www.forbes.com/profile/aliko-dangote/?sh=6690322a22fc (last accessed 29/04/2021).

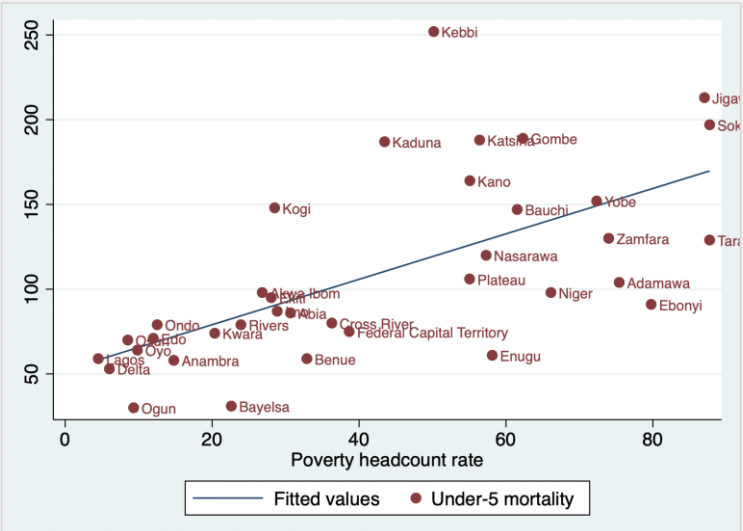
fever, compared to 1.25 in 5 children of the poorest 20 percent of the population (59.9 versus 25.2 percent, respectively). Children of mothers, who formally benefited from at least secondary education, are also more likely to be tested for malaria if they have developed a fever (24 versus 11 percent). Moreover, the DHS data shows that women of richer households are more likely to give birth in healthcare facilities, where they can receive birth assistance (79.5 percent in the highest wealth quintile versus 11.6 percent in the lowest wealth quintile).

Figure 23: Poverty rates, Nigeria (% people below poverty line)



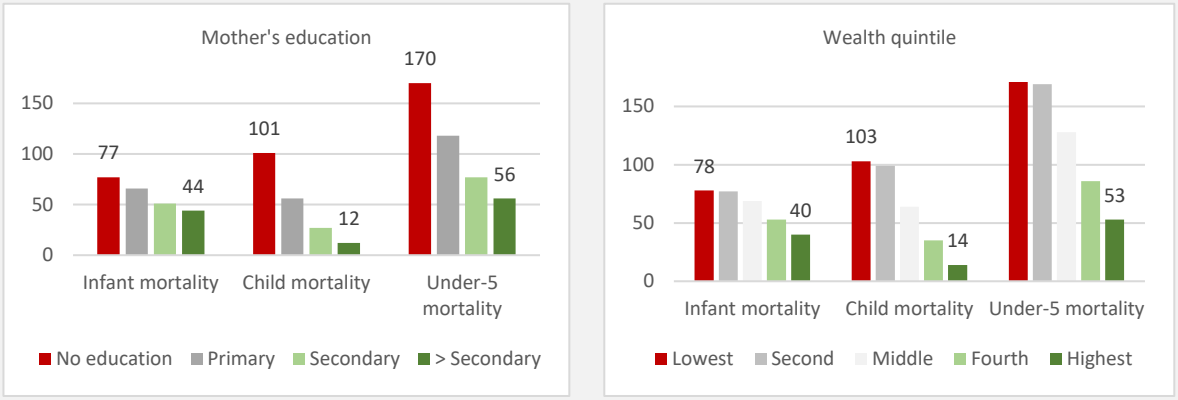
Source: Own illustration based on 2018-2019 Nigerian Living Standard Survey (NLSS) data

Figure 24: Poorer States have higher U5 mortality rates



Source: Own illustration based on 2018 DHS data (U5MR) and 2019 CBN data (poverty rates)

Figure 25: Child mortality rates depend on children's families' socio-economic background



Source: Own illustration based on 2018 DHS data

Ability to pay for healthcare services appears as the determining variable as to whether a Nigerian can access and use healthcare services and also affects **where** people access healthcare. DHS data shows that the richer the household, the more likely it is that the mother will deliver her child in a private healthcare facility (with 36.5 percent of women in the richest wealth quintile delivering in private facilitates compared to 1.7 percent of women of the lowest wealth quintile). Women in the South-East are the most likely to delivery in private sector healthcare facilities (44.5 percent of live births) followed by the South-West (30.8 percent), in contrast to the North-East and the North-West, where 1.6 percent and 1.8 percent of deliveries take place in private facilities, respectively (see Figure 26). Overall, the private healthcare sector caters for the health needs of approximately 60 percent of the Nigerian population (Alliance for HPSR and WHO, 2017, p. 17). People living in the richer regions of the South are more inclined to seek care in a private facility and the prevalence of private providers is higher (see Figure 27). This is in line with what an interviewee, a former CSO employee, now working at a UN agency, stressed:

> In some States in this country up to 60 percent of the population access their healthcare through the private sector. There is a distinct demarcation between if you are in the Northern part of the country, or Southern part of the country. If you are in Enugu for example, a lot of people go to private facilities and all of that. Compared to if you are in Lagos, most people go to private practice. If you come to Abuja, many people go to private healthcare. But if you go to Sokoto,

> Kano, certain parts of the country, or certain parts of Nigeria where it is rural and the private practice does not exist, you are only left with the public.[122]

Aptly, Asakitikpi (2019, pp. 3–4) distinguishes several categories of Nigerians in terms of their lieu of healthcare-seeking. These include: the extremely wealthy upper class, which travels abroad to seek medical treatment;[123] a lower upper class, which seeks care in international/foreign or local private establishments; the middle class, which seeks care exclusively in private health centres (upper middle class), in specialised hospitals (middle middle class) or in general hospitals (lower middle class); and lastly the lower classes, which seek care in a variety of places, including the general hospitals, chemist shops, drug vendors or traditional healers. According to DHS data, only 1.4 percent of caregivers of children with a fever sought treatment with traditional practitioners. This may, however, be the result of underreporting and, for instance, Chukwuma et al. (2015) list a whole range of medical plants still regularly in use in Nigeria for the treatment of various illnesses. Moreover, in an opinion poll, conducted by the UNICEF Nigeria Country Office, 42 percent of respondents say that children are being taken to a traditional healer when they are sick.[124] Along similar lines, a Local Government official highlights "that the only challenge is that many [people] still prefer local traditional services. And because of the modern life that we are living, some prefer to go to faith houses to receive treatment".[125] Still, according to DHS data, the largest number of Nigerians (46.5 percent according to 2018 DHS data) seek care for their children with a fever from private chemists and patent medicine vendors, followed by Government health centres (18.1 percent).

Against this backdrop, the following section provides an overview of the structure of the Nigerian healthcare system. It presents how the public healthcare system is constituted and funded and points to the dominance and prevalence of a (heterogenous) private sector in healthcare service delivery.

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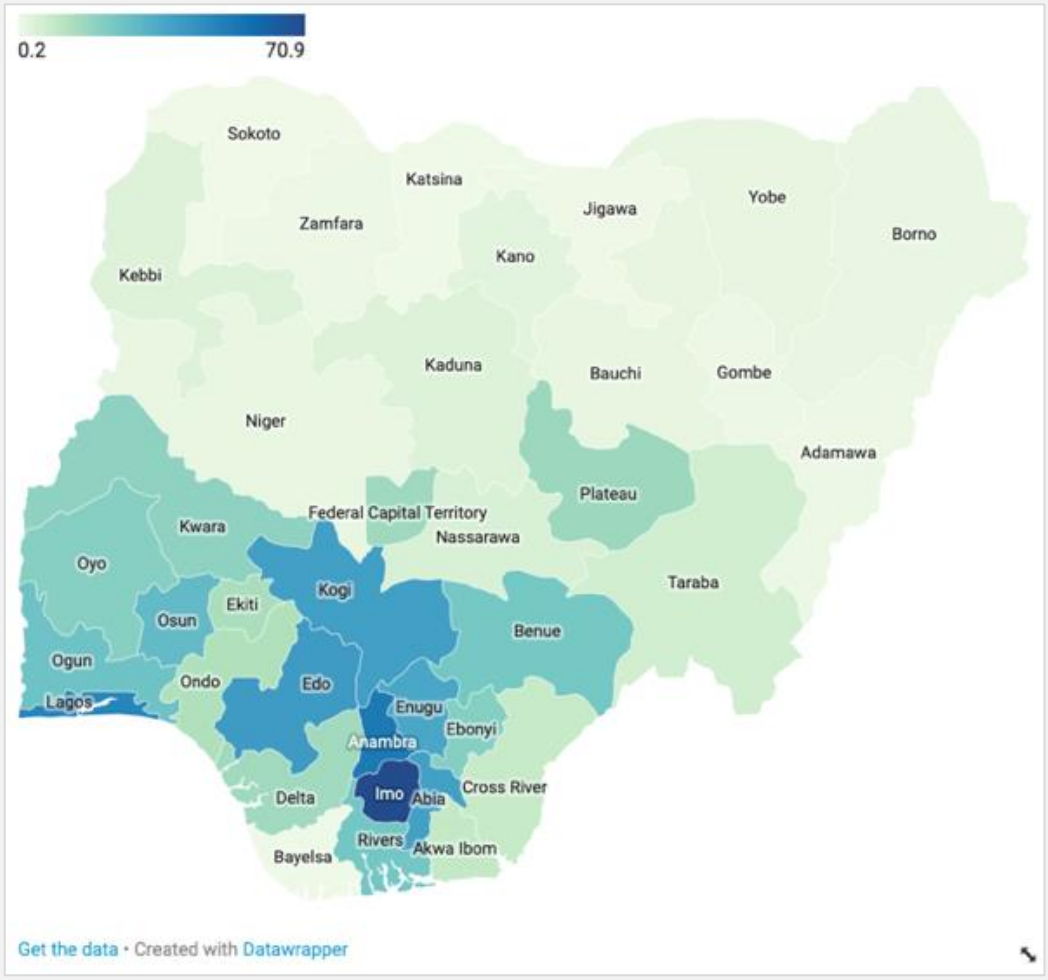
[122] Interview 42; 25/03/2019.

[123] A 2017 PricewaterhouseCoopers report citing the Nigerian Sovereign Investment Authority (NSIA), emphasised that Nigeria loses about US$ 1 billion annually due to outbound medical tourism (PricewaterhouseCoopers, 2016). The 2014 NHAct (Art. 46) is explicit in negating public officers of the Government of the Federation the privilege to be "sponsored for medical check-up, investigation or treatment abroad at public expense" (with some exceptions which would require the Minister's approval). At the time of writing, however, President Buhari has just returned from yet another trip to the UK for medical treatment. See, for instance, here: https://www.theafricareport.com/76967/nigeria-buhari-heads-to-uk-for-medical-treatment-as-doctors-strike-erupts-at-home/ (last accessed 17/05/2021).

[124] The results of the poll are available here: https://nigeria.ureport.in/opinion/106/ (last accessed 24/06/2021).

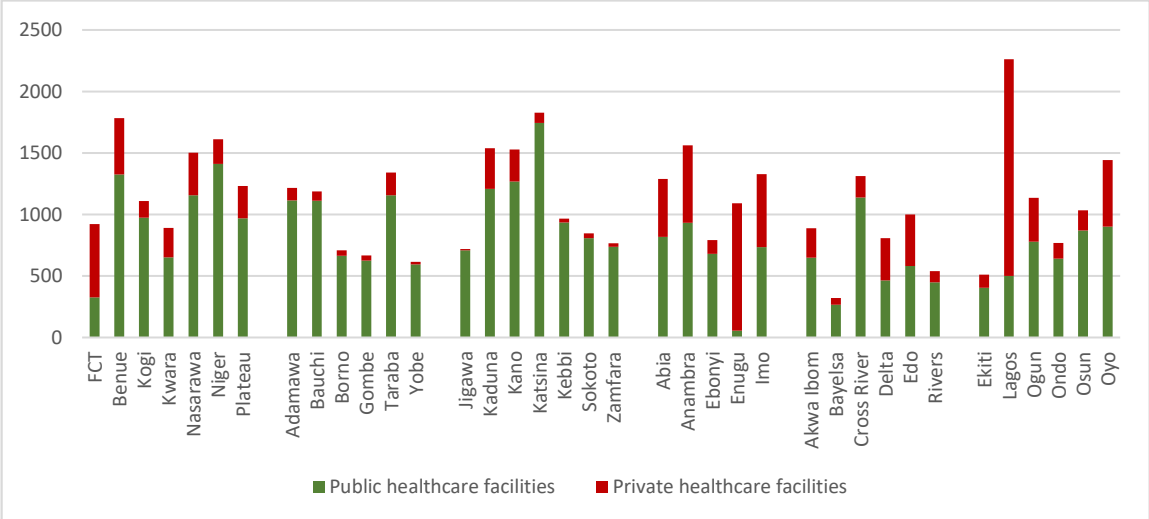
[125] Interview 8; 19/02/2019.

Figure 26: Share of deliveries having taken place in private sector facilities (%), by State



Source: Own illustration based on 2018 DHS data

Figure 27: Number of public and private healthcare facilities per State

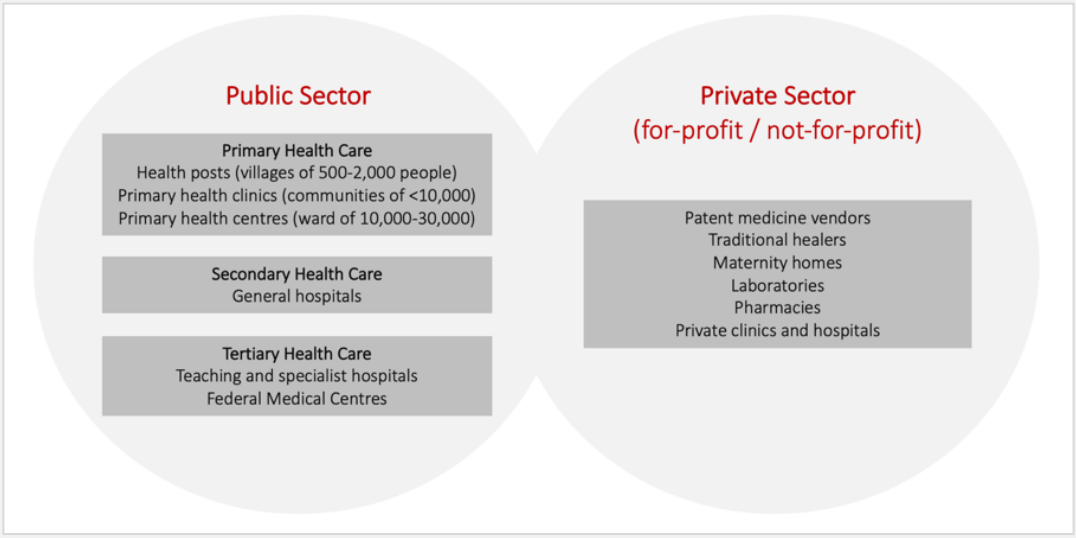


Source: Own illustration based on Health Facility Registry data (October 2019)

3. Nigeria's healthcare system and the interplay of the public and the private sector

As stipulated in the NSHDP II, Nigeria operates a pluralistic healthcare system, comprising the public and the private sector as well as modern and traditional providers delivering healthcare (FMOH, 2018a, p. 6). According to Onoka (2014, pp. 47–48), public health facilities, on the one hand, include "comprehensive health centres, and general, specialist and teaching hospitals". On the other hand, private health facilities include "general and specialist private hospitals (including for-profit and not-for-profit private hospitals), laboratories and pharmacies, and a significant number of informal providers including patent medicine dealers, maternity homes and traditional healers" (Onoka 2014, pp. 47–48). Figure 28 depicts these private and public sector healthcare providers.

Figure 28: Nigeria operates a pluralist healthcare system



Source: Own illustration based on NSHDP II, Onoka (2014), NHIS (2012)

The majority of healthcare facilities in Nigeria are owned by the three tiers of Government as summarised in Table 7. Overall, as of October 2019, 73.9 percent of all the 41,053 listed health facilities on the Health Facility Registry were in public ownership. There are, however, significant differences depending on the level of care (primary, secondary or tertiary healthcare).[126] According to the registry's records, 80.6 percent of primary healthcare facilities are in public ownership in contrast

[126] Primary healthcare facilities are entry-points/point-of-first-contact of individuals with the healthcare facilities, which provide preventive, curative and rehabilitative services; secondary healthcare facilities offer specialized services to referred patients (recourse to the HMOs necessary except for in some cases of emergency); tertiary healthcare facilities can be consulted if patients are in need of highly specialized services and have been referred to from secondary care level through the HMOs (NHIS, 2012, p. 5).

to only 24.6 percent of secondary healthcare facilities. Slightly more than half of tertiary healthcare facilities (52.5 percent) are publicly owned.[127]

Table 7: Health Facilities in Nigeria (%)

	% All levels	% Public ownership	% Private ownership
Primary	87.9	80.6	19.4
Secondary	11.6	24.6	75.4
Tertiary	0.5	52.5	47.5
All levels		**73.9**	**26.1**

Source: Own calculations based on Health Facility Register data (as of October 2019)

More generally, a range of different agents operate within the Nigerian healthcare system and/or influence, to different degrees, how it functions.[128] Most evidently, the Government across all three tiers, supported by technical agencies (such as the NPHCDA and the NHIS), plays a key role in shaping the healthcare system and assuring healthcare delivery via (public and private) healthcare facilities. In addition, development organisations, civil society organisations and community-based and religious groups are important actors within Nigeria's healthcare landscape. At the same time, the configuration of the private sector is particularly noteworthy. Aside from for-profit and not-for-profit healthcare service delivery entities, privately-owned Health Maintenance Organisations (HMOs) are a key characteristic of the Nigerian healthcare system – not found in many more places outside of Nigeria and the United States of America. HMOs were introduced to Nigeria in the mid-1990s by proponents of the U.S. "managed care" system (Onoka et al., 2015, p. 1109). At first, the purpose of these HMOs, operating as "private limited liability companies" (Eboh et al., 2017), was to supply private health insurance plans to private firms. However, the military decree mandating the establishment of the NHIS in 1999, introduced HMOs as operators of the social health insurance scheme (Onoka et al., 2016). This double-hat was made possible as the official accreditation system was weak and financial barriers low, encouraging the creation of many HMOs, perceived by policy

[127] A data set with details on ownership per health facility is available. An analysis of the data base showed that the Health Facility Registry lists only 56 public health facilities in Enugu State. This is by far the lowest absolute number across all States. However, it is not clear why the registry, for example, has classified the Enugu State University Teaching Hospital (ESUTH) as privately owned (see, for instance, Onwujekwe et al. (2019) who list ESUTH as State-owned).

[128] Appendix J summarises the principal institutions and interest groups which I have identified as being the key influential agents within Nigeria's healthcare system of provision and in creating the environment, which embeds it.

makers as the best alternative to the weak public health system for the implementation of the social health insurance scheme (Onoka et al., 2016, p. 12).[129]

The following section (section 3.1) presents the administrative architecture of Nigeria's public healthcare system as, technically, Nigeria runs a system that is mainly driven by the public sector. I make reference to the role of the significant agents and describe the organisation of the system as it is outlined in the 2014 NHAct, which became the first law to formally establish and govern Nigeria's national health system and sets standards for rendering healthcare services. In then turn to an analysis of health financing in Nigeria, illustrating the various channels through which the healthcare system is funded (section 3.2). I highlight that Government funding allocated to the public healthcare system is little and continues to be little, even after the NHAct mandated the establishment of the Basic Health Care Provision Fund, which should be financed from an annual grant of the Federal Government (see also Chapter 6). I furthermore present information on the existing social health insurance scheme, the National Health Insurance Scheme, which covers only a small percentage of the Nigerian population. Because of limited public health financing and insufficient financial risk protection schemes, the largest proportion of total health expenditure are borne directly by households, who pay to access services, in either the private or public healthcare sector, out-of-pocket. In section 3.3, I discuss the role and heterogeneity of the private sector, which, in reality, dominates considerable parts of service delivery, despite varying degrees of quality.

3.1. Organisation and governance structure of Nigeria's public healthcare system

In 1999, Nigeria formally returned to democratic rule after more than 15 years of military rule.[130] The same year saw the introduction of the *1999 Constitution of the Federal Republic of Nigeria* and the declaration of the Fourth Republic, headed by then-President Olusegun Obasanjo. According to the constitution, the State is responsible to assure that all Nigerians have access to adequate medical and health facilities (chapter II, paragraph 17, 3).[131] The provision and maintenance of health services is

[129] Section 3 of Chapter 5 discusses the entrenchment of the private sector in Nigeria's healthcare system of provision, including the role of HMOs, in more detail. The NHIS will be discussed as a health financing mechanism in Nigeria in the following sections of this chapter.

[130] In 1993, M.K.O Abiola was elected President of Nigeria's Third Republic. However, military leader Sani Abacha annulled the results the same year and Abiola was imprisoned.

[131] The constitution is available online: http://www.nigeria-law.org/ConstitutionOfTheFederalRepublicOfNigeria.htm#ExclusiveLegislativeList (last accessed 08/02/2021). To date, there were several alterations to the constitution; see: https://www.ilo.org/dyn/natlex/natlex4.listResults?p_lang=en&p_country=NGA&p_count=242&p_classification=01.01&p_classcount=21 (last accessed 08/02/2021).

listed as a function of the local government council (schedule IV, paragraph 2).[132] Yet, while the constitution emphasises that it is the Government's duty to assure that all Nigerians can access healthcare and suggests a role for the Local Government to provide healthcare services, it does not provide any guidance on the exact responsibilities of the Federal, State and Local Governments in financing and assuring access to the different levels of care. As was stated in the 2004 revised health policy: "There is no health act describing the national health system and defining the health functions of each of the three tiers of government" (FMOH, 2004a, p. 4). Accordingly, the NHAct was expected to fill these gaps of the constitution and to "help to better identify roles and responsibility" of the three tiers of government.[133] However, while the NHAct echoes the "right of the people of Nigeria to have access to health care services" (Art. 1e), it does not "properly address[ed] the gaps in the Constitution" as stipulated in the (most recent) 2016 national health policy (FMOH, 2016a, pp. 11–12).[134] The NHAct does not specify which tier of government is responsible to finance and facilitate access to which level of care, but posits that patients should formally be referred to a higher level of care in the case that a health establishment of lower level is "not capable of providing the necessary treatment or care" (Art. 17.2).

Nonetheless, while the law may not have been entirely successful in filling the void of the constitution, it is the first legislative framework to govern the Nigerian national health system and orients its organisational structure and architecture. As stipulated in the NHAct, Nigeria's Federal Ministry of Health (FMOH), currently headed by the Federal Minister of Health, Dr. Osagie Emmanuel Ehanire, a surgeon, has the overall responsibility for the health sector coordination and regulation, the development of health policies and their implementation in collaboration with State and Local Governments as well as for strategic planning and budgeting.[135] The organ within the FMOH acting on these responsibilities is the National Council on Health (NCH), which is the "highest policy making body in Nigeria on matters relating to health" (Art. 5.1) and is in charge of formulating national and state health plans. The NHAct also instructs the NCH to "ensure the widest possible catchments for the health insurance scheme [NHIS] throughout the Federation and any part thereof" (Art. 40). The NCH

[132] Besides that, health is mentioned on other occasions in the constitution but related to aspects of health and safety (and not healthcare).

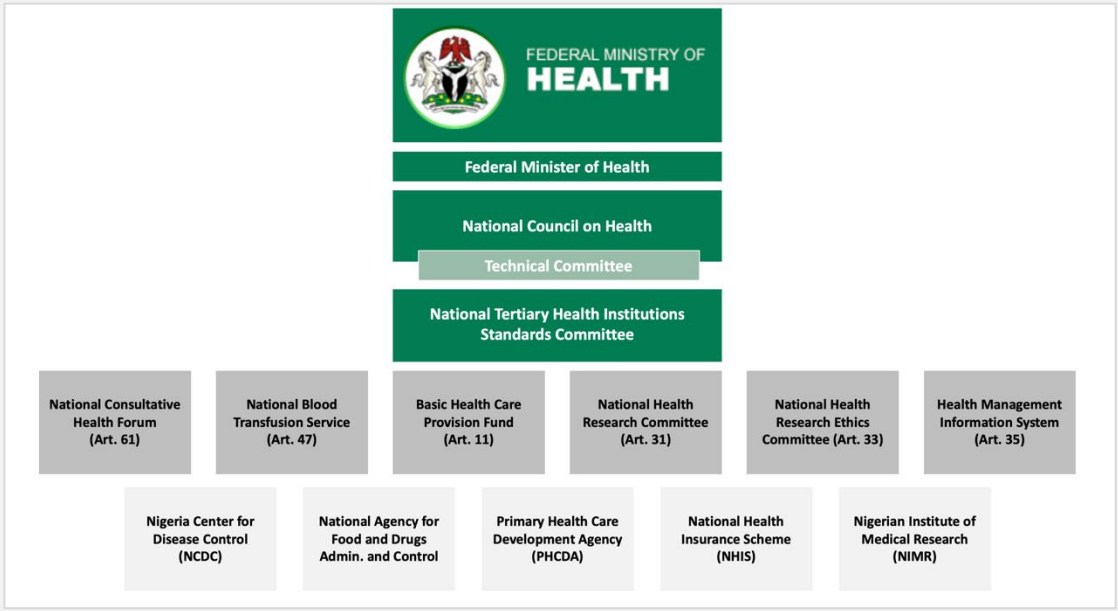
[133] Interview 33; 17/03/2019.

[134] The document is not available online, but a soft copy has been shared with me during fieldwork.

[135] Ehanire took over the position of Federal Minister in Health from Prof. Isaac Adewole, a Nigerian professor of gynaecology and obstetrics, after the 2019 elections. He had already worked in Buhari's first cabinet as Federal Minister of State for Health (2015-2019).

brings together State Commissioners of Health (which are some sort of "Ministers of Health" at the State level) and the Federal Minister of Health and serves as the main platform for Federal and State Governments to coordinate and exchange on matters related to health and to adopt binding decisions. At federal level, there is furthermore a National Tertiary Health Institutions Standards Committee (which allows for representation from other Ministries), which is in charge of "matters affecting the establishment of tertiary hospitals in Nigeria" (Art. 10.1a). Figure 29 illustrates the structure of the Federal Ministry of Health and also lists the agencies instituted at federal level, which are the National Primary Health Care Development Agency (NPHCDA), the National Health Insurance Scheme (NHIS), the National Center for Disease Control (NCDC), the National Agency for Food and Drugs Administration and Control (NAFDAC) and the Nigerian Institute of Medical Research (NIMR).

Figure 29: Structure of the Federal Ministry of Health



Source: Own illustration (based on the 2014 National Health Act)

At State level, State Ministries of Health, advised by State Health Councils, are expected to develop their own state health policies and plans with the support of the Federal Ministry of Health (Art. 2, 3a). Although not specified in the NHAct, the (non-legally binding) NSHDP II clarifies that while the Federal Government is responsible for tertiary level care, State Governments bear responsibility to provide secondary level care, such as curative care and basic medical specialities in State-Government run hospitals and health facilities (FMOH, 2018a, p. 6). In turn, the Departments of Health (DoH), located within Local Governments, carry the responsibility to deliver primary healthcare services in PHC centres and facilities such as i.e. community health posts, clinics and dispensaries, and rely on

Ward Development Committees (WDC)[136] as a way of institutionalizing community participation (World Bank, 2018, p. 19). Figure 30 depicts the organisation of Nigeria's public healthcare system and summarises the responsibilities which the three different tiers of government are expected to perform in practice.

Figure 30: Organisation of Nigeria's public healthcare system

Level of Governance	Primary Care	Secondary Care	Tertiary Care	Responsibilities	Facilities
FEDERAL MINISTRY OF HEALTH National Council on Health	* Minimally responsible	** Partly responsible	*** Mostly responsible	Mainly responsible for health policy-making, planning and budgeting; the determination of salary scales; resource generation; quality assurance of the health workforce (sets the curricula, licenses practitioners and facilities) and controlling the location of public facilities	Teaching & tertiary hospitals
State Governments State Health Council	** Partly responsible	*** Mostly responsible	** Partly responsible	Participates in health policy-making; supports resource generation; and mirrors the roles and responsibilities of the Federal Ministry of Health at the state-level	District hospitals, comprehensive health centers, specialist and general hospitals
Local Government Areas Wards / Village Development Committees	*** Mostly responsible	– Not responsible	– Not responsible	Mainly responsible for the appropriation of specific budget items for health; and capacity building for the PHC workforce	Dispensaries, health posts, health centres, clinics

Source: Own illustration based on World Bank (2018a), Okpani & Abimbola (2015), National Health Policy

Since 2011, efforts have been on-going to bring "PHC under one roof" (PHCUOR) and guidelines were developed and adopted that year, putting more responsibility on States with regard to the provision of primary healthcare services:

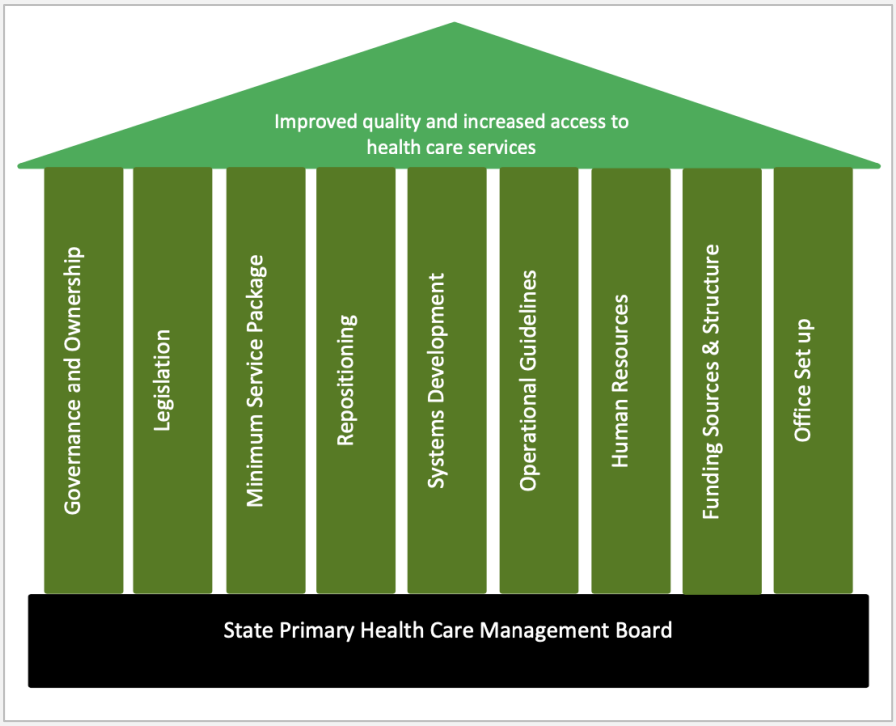
> Key elements of the policy called for specific structural changes … a single management body with control over services and resources (human and financial); an enabling legislative framework; decentralized authority, responsibility, and accountability with appropriate span of control; an integrated supportive supervisory system managed from a single source; the integration of all PHC services under one authority; and an effective referral system between/across different levels of care (Odutolu et al., 2016, p. 292).

Thus, proposed in 2011, and made mandatory with the 2014 NHAct (as a pre-condition to receive BHCPF funding), States had to put into place so-called State Primary Health Care Agencies or Boards

[136] Local-level Ward Development Committees were introduced in 2000 by the NPHCDA and are made up of volunteer community members that advocate for the health and social needs of their communities (World Bank, 2018, p. 19).

(SPHCDA/Bs; or a structure, carrying any other name as States may see fit), in a move to assure the integration of all PHC services under one authority (see Figure 31). As outlined in the 2018 Ward Health Policy, the PHCUOR strategy was adopted in order to reduce the fragmentation of PHC service delivery, to ensure sustainable funding and to better plan and manage human resources needs (FMOH, 2018b, p. 43). Therefore, as of today, State-level organs oversee the management of primary healthcare service provision (i.e., paying healthcare workers) to support the delivery of PHC services. However, despite the concentration of PHC management at State-level, a substantial degree of responsibility to deliver PHC services remains devolved to local governments (see also Abimbola et al. 2015). Unfortunately, Local Governments often only have limited capacity to efficiently implement PHC policies with available resources, while also struggling to mobilize necessary additional funding (Tilley-Gyado et al., 2016, p. 277). The BHCPF is expected to make more money available to support the equipment and maintenance of PHC facilities, in order to ensure that at least one PHC facility per Ward is functional (as stipulated in the 2018 Ward Health System report and rolled out under the banner of the "PHC Vitalisation Programme" launched by President Buhari in 2017). In 2018, 800 out of 9,556 Wards in Nigeria were without a PHC facility and out of the 30,000 existing PHC facilities only 6,000 were functional (FMOH, 2018b).

Figure 31: The nine pillars guiding the operationalisation of the PHCUOR Policy



Source: 2018 Report "Ward Health System" (FMOH, 2018b)

Furthermore, other major programmes have been introduced by successive Governments (often with donor-support) and include the following:

- *Free Maternal and Child Health program (FMCHP), known as NHIS-MDG-FMCHP*: the programme was implemented in 12 Nigerian States between 2009 and 2015 with funding from debt relief gains that were granted to Nigeria by the Paris Club to support the nation's efforts to attain the Millennium Development Goals (MDGs).
- *National Midwives Service Scheme (MSS)*: as part of the programme, which started in 2009, midwives were recruited in order to increase the use of antenatal services of women in rural public sector clinics.
- *Subsidy Re-investment and Empowerment Programme (SURE-P)*: the programme was started in 2012 with the aim of improving maternal and child health via a range of supply- and demand side components (i.e., recruitment of human resources for health, upgrading of PHC facilities, conditional cash transfers targeted at pregnant women).
- *Saving One Million Lives (SOML)*: the initiative is being implemented across the whole of Nigeria since 2012, with the aim of expanding access to PHC services for children and women. It is supported by the World Bank.
- *Nigerian State Health Investment Project (NSHIP):* this World Bank-supported programme ran between 2012 and 2020 with the objective to improve the quality of care in health facilities in participating States. It operated a Performance Based Financing (PBF) system as well as a Decentralised Facility Financing system and has been presented by the Bank as the pilot programme to the BHCPF.

Apart from these "healthcare-focused" programmes, the healthcare sector benefits from other Government-driven projects such as the *N-Power* initiative (a programme put into place in 2016 to address youth unemployment and foster social development) or the *National Youth Service Corps (NYSC) Health Initiative for Rural Dwellers*[137] (a long-running programme instituted in the 1970s, requiring young graduates to undertake national service in a State that is not their home State), as they make additional human resources for health available. Moreover, a range of donors and national/international organisation support healthcare delivery through a variety of other initiatives and projects, often targeted at specific diseases in line with their organisation's mandate, and sometimes blurring the line between public and private healthcare delivery. Yet, before turning to a

[137] See here for more details on the programme: https://nysc.gov.ng/downloads/HIRD_PROFILE.pdf (last accessed 18/05/2021).

presentation of the role of the private sector in Nigeria's healthcare system, the following sections inquires how the public healthcare system is funded and how Nigerians pay for their healthcare more generally.

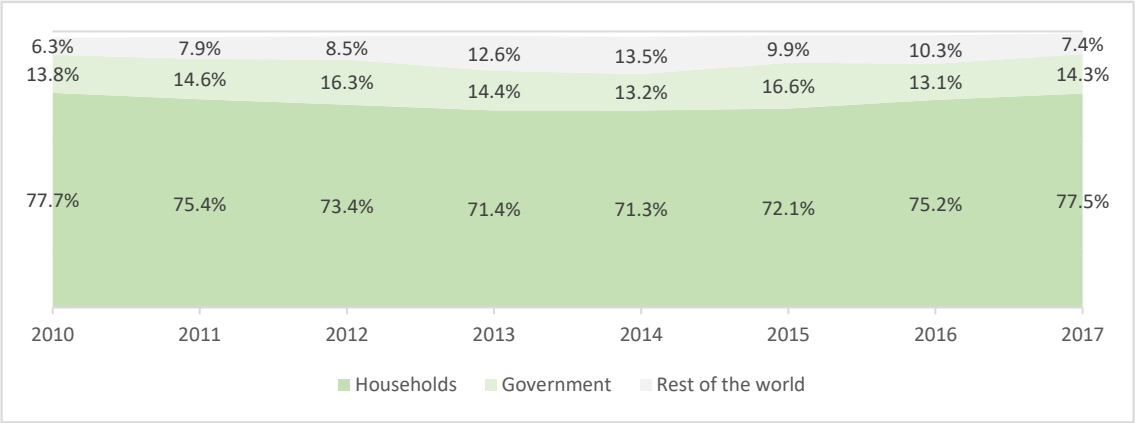
3.2. Health financing in Nigeria

In Nigeria, according to the official latest National Health Accounts (NHA 2017 report, published in April 2019), the institutional sources of funding for the healthcare system are the Government (via its three tiers and the social insurance agency), corporations (employers), external donors, non-for-profit organisations and, most importantly, households. Presently, the burden on Nigerian households to cater for their own health needs is enormous and private out-of-pocket (OOP) health spending is the main source of current health expenditure (CHE; see Figure 32). In 2017, according to the NHA, 77.5 percent of CHE were OOP payments at point of consumption, while only 14.3 percent of health financing was sourced from the Government.[138] In the years of 2013, 2014 or 2016, donor funding (managed by donor agencies themselves) constituted close to the same share of CHE as Government funding, demonstrating that the Nigerian state still relies significantly on external support in the area of health. Donors also contribute to capital health expenditure (investments in healthcare).[139] However, such investments – small overall (3.6 percent of total health expenditure) – are mainly financed by the Government (87.5 percent in 2017). Table 8 summarises selected health financing indicators.

[138] As defined by the WHO, health financing is the "function of a health system concerned with the mobilization, accumulation and allocation of money to cover the health needs of the people, individually and collectively, in the health system"; see: https://www.who.int/healthinfo/systems/WHO_MBHSS_2010_section5_web.pdf (last accessed 04/05/2021).

[139] Capital health expenditure consist of "other and unspecified gross fixed capital formation" (37.1%) followed by expenditure on machinery and equipment (27.5% of capital health expenditure), building and structures (20.7%) and education, training and research (12.7%).

Figure 32: Main institutional sources of health financing (% of current health expenditure)



Source: Own illustration on basis of data from the 2016 NHA & 2017 NHA

Table 8: Key health financing indicators

	Target	Nigeria
General resource mobilisation		
Total health expenditure in absolute terms (NGN billions)		4,455.5
Current health expenditure in absolute terms (NGN billions)		4,297.1
Capital health expenditure in absolute terms (NGN billions)		158.4
Out-of-pocket (OOP) expenditure in absolute terms (NGN billions)		3,332.3
Per capita total health expenditure (NGN) - OOP (NGN) - Government (NGN) - Donors		22,311 16,687 (USD 55) 3,786 (USD 12) 1,692
Government-funded health expenditure as percentage of GDP	4-5% (WHO)	0.7%
General government health expenditure as percentage of general government expenditure	15% (Abuja)	6.6%
Current health expenditure financing schemes		
OOP expenditure as percentage of current health expenditure	30-40% (WHO)	77.5%
Government spending as percentage of current health expenditure - Federal Government as percentage of current health expenditure - State Government as percentage of current health expenditure - Local Government as percentage of current health expenditure		14.3% 6.2% 6.9% 1.2%
Health insurance as percentage of current health expenditure - Social insurance as percentage of current health expenditure - Voluntary insurance as percentage of current health expenditure		1.2% 0.7% 0.5%
Donor funds (managed by their agencies) as % of current health expenditure		7.4%
Services		

Curative service expenditure as percentage of current health expenditure		37.2%
Preventive service expenditure as percentage of current health expenditure		12.5%
Primary Health Care spending as percentage of current health expenditure		8.6%
Investments in healthcare		
Government spending as percentage of capital health expenditure		87.5%
Donor spending as percentage of capital health expenditure		12.2%

Source: 2017 National Health Accounts

3.2.1. Government health spending

High levels of OOP expenditure are linked to low levels of Government funding for health as shown in Figure 33, comparing government health spending of African countries with levels of OOP expenditure. According to NHA data, in Nigeria, domestic general government health expenditure as a percentage of general government expenditure (meaning, public health spending as share of the budget) was only 6.6 percent in 2017. The value is even lower according to the WHO Global Health Expenditure database at 4.4. percent, which allows for international comparison and ranks Nigeria amongst the worst-performers in sub-Saharan Africa (SSA). Overall, most sub-Saharan African countries are underperforming with regard to public health spending. Based on the WHO database, no single country meets the 15 percent Abuja target in 2018 (with Botswana being the closest at 14.3 percent).[140] South Africa, for example, spends 13.3 percent of its general government expenditure on health – more than four times Nigeria's health spending (see Figure 34). WHO data further shows that Nigeria only spent 0.6 percent of its GDP on health in 2018 – distinctly below the (low) SSA average of 1.7 percent.[141]

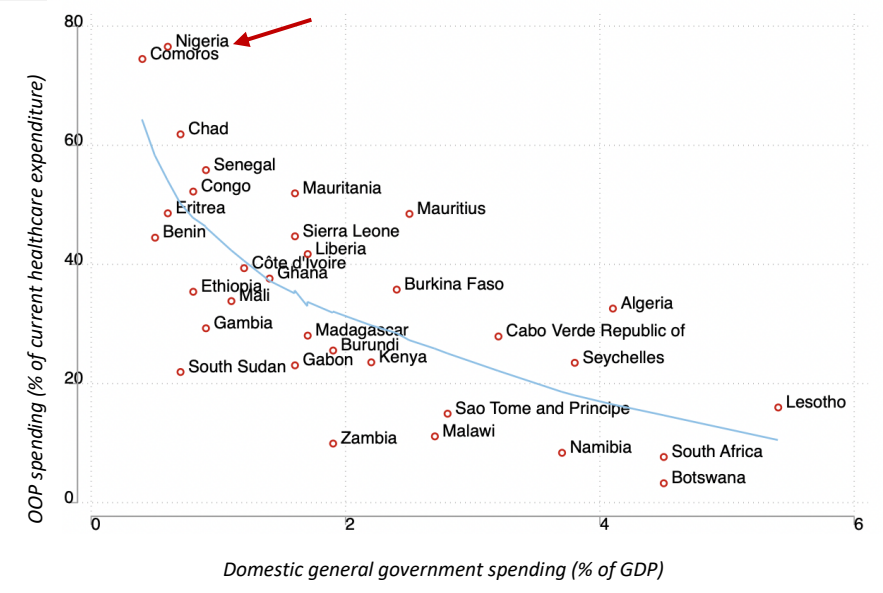
On the whole, government revenues as a share of GDP increased sharply in 2000 (the year after Nigeria had returned to democratic rule) but have continuously been decreasing since then, from 28.8 percent in 2000 to 7.8 percent in 2019 (see Figure 35). Thus, the level of resources available for health spending is affected by Nigeria's difficulty to mobilise revenue to fund its public budget more generally. Specifically, a decrease in oil prices in more recent years meant that oil revenues have lost importance vis-à-vis non-oil revenue (with the latter constituting 46 percent of total federally collected revenues in 2019 compared to an average of 25 percent between 1981-2014 until the most recent oil price crash). At the same time, Nigeria has one the lowest tax-to-GDP ratios in the world

[140] The Abuja Declaration is online available at: http://www.who.int/healthsystems/publications/Abuja10.pdf (last accessed 03/10/2018).

[141] According to the 2017 NHA, Nigeria spent 0.7 percent of its GDP on health in 2017.

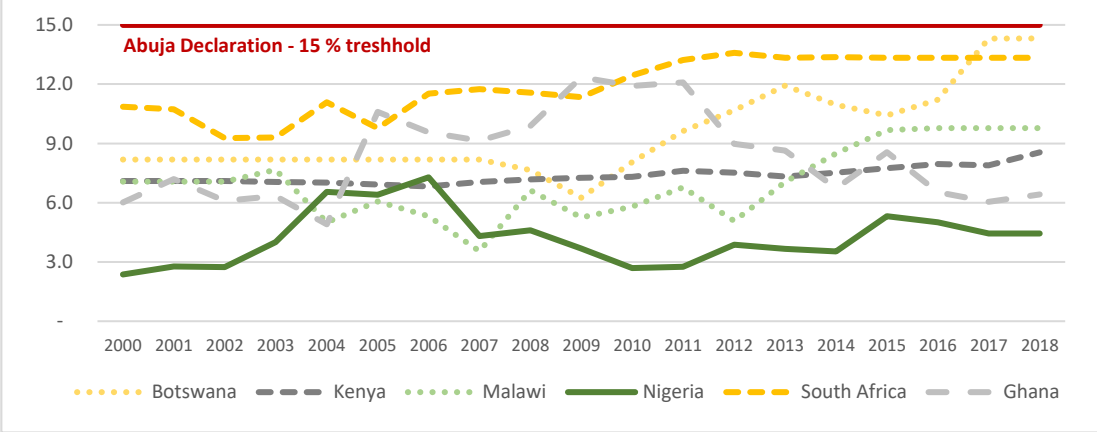
(6.3 percent in 2018 compared to an African average of 16.5 percent, according to OECD data).[142] Nigeria is also one of the most affected African countries in terms of illicit financial flows (IFF) and heavily impacted by capital flight in event of "unfavourable" monetary policy conditions, such as the depreciation of the Nigerian Naira (UNCTAD, 2020).

Figure 33: Government health spending versus out-of-pocket spending in Africa, 2018



Source: Own illustration based on WHO Global Health Expenditure data

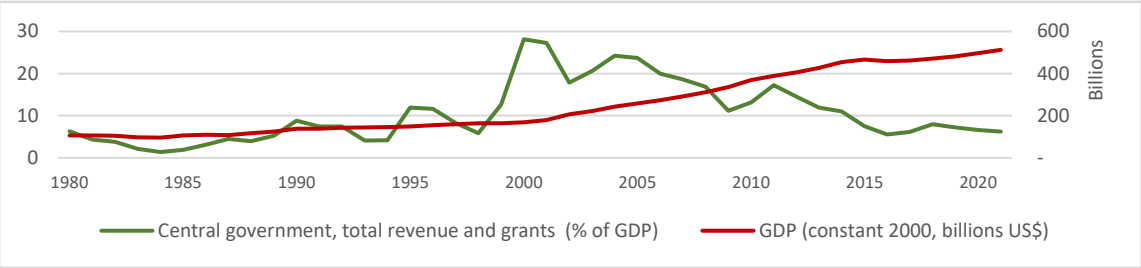
Figure 34: Trend in domestic health spending (% of total Government spending), selected African countries



Source: Own illustration based on WHO Global Health Expenditure data

[142] This prompted the adoption of a national tax policy (NTP) in February 2017, highlighting as its key goal to improve Nigeria's low tax-to-GDP ratio. The document is available online: https://pwcnigeria.typepad.com/files/fec-approved-ntp---feb-1-2017.pdf (last accessed 12/04/2021). The OECD data is online available: https://www.oecd.org/tax/tax-policy/brochure-revenue-statistics-africa.pdf and https://www.oecd.org/tax/tax-policy/revenue-statistics-africa-nigeria.pdf (last accessed 12/04/2021).

Figure 35: Government revenue as % of GDP



Source: Own illustration based on African Bank Development Group 2021 data

Several scholars have pointed to Nigerians' negative colonial experience of taxation as well as long-running controversy around the distribution of resources between different regions and States as explanatory variables for prevailing anti-tax sentiment and tax resistance in Nigeria (Ekpo and Ndebbio, 1996; Meagher, 2018; Ovwasa, 1995).[143] Notably Meagher (2018, p. 4) has highlighted that, during colonialism, taxation was regarded across most of Africa as being a means to cover "the costs of administration and extracting labor and cash crops from the African population" and "less about service provision and political voice". Considering that both the Western and Eastern regional governments had implemented an agenda of vast investment in the socio-economic development of their respective regions, the imposition of a Federal Government, led by the North, which was positively inclined towards the British, may have impacted tax discipline from the very beginning. Meagher (2018) further contends that "owing to negative colonial experiences of taxation, political autonomy and democracy in many African countries has been associated with the abolition of direct taxation"; she highlights the abolition of head taxes in Southern Nigeria in the 1970s as an example. Gatt and Owen (2018, p. 1200), having conducted research in Lagos State, found community members not *per se* being opposed to contributing financially to community development (which is done, e.g. via donations to organised religious groups), but critical of direct taxation if "the benefits of paying were not seen or because the state was not seen as deserving".[144] Odusola (2006, p. 5) highlights that

[143] Anti-tax sentiment and tax resistance was prevalent from early on and transcended all ethnic groups (see Adeniran (1974) on taxation in the South-West; Naanen (2006) on taxation in the South-East; and Smith (1964) on taxation in the North). To give one example, in 1947, market women in the South-West of the country, led by women's right activist Funmilayo Ransome-Kuti, protested unfair taxation laws imposed by the British colonial government – events, which became to be known as the Abeokuta Women's Revolt (Byfield, 2003).

[144] A recent online article, seeking to analyse cultural and historical reasons for Nigeria's limited success to mobilise domestic resources, also points at a link between civic participation (measured in terms of turnout rate for presidential elections) and tax compliance. The article is available here: https://republic.com.ng/december-20-january-21/why-is-tax-collection-low-nigeria/ (last accessed 28/04/2021).

many Nigerians seem to perceive the Nigerian taxation system as unfair. Meagher (2018, p. 11) emphasises that at the level of the informal economy,[145] a sentiment of dissatisfaction and distress with taxation prevails, as informal traders and workers are often also subject to illegal forms of money extraction.

A survey conducted in 2019 to gather insights into attitudes of Nigerians regarding tax compliance showed that 22.1 percent of respondents think it is "not wrong at all" not to pay taxes on income and an additional 54.3 percent found that it is "wrong but understandable".[146] Additionally, Adésínà (2012) and Ochonu (2017) draw attention to the fact that, after independence, the power set-up Nigeria was left with by the British, was unstable and concentrated the power in the hands of the Northern ruling elite.[147] As Nigeria operates a federal system of governance, including a system of fiscal decentralisation, the distribution of power between the center and the regions (and, today, the States) and the appropriate formula to distributing public revenues between different levels continue to be points of contestation.[148] Fiscal decentralisation entails that taxation and expenditure functions are divided and, thus, that also sub-national levels of government can levy taxes (Odusola, 2006, p. 1). In the 1950s, this meant that Nigeria's three regional governments (of the Eastern, Western and Northern region) enjoyed considerable fiscal autonomy and operated in a noticeable decentralised system (Akpan, 2011; Salami, 2011; World Bank, 2002). However, according to Ovwasa (1995, p. 76), the military regimes between 1966 and 1979 were characterised by a "centralizing tendency", inclined to concentrate a majority of fiscal power at the central level, while also known for widespread corruption.[149] Over time, these so-called vertical and horizontal allocation formulas have changed

[145] According to the World Bank, Nigeria is home to Africa's largest informal workforce (World Bank, 2020).

[146] The presentation of findings is available here: https://www.ictd.ac/dataset/nesg-nigeria-tax-subsidy-perception-dataset/ (last accessed 27/04/2021).

[147] This is also highlighted in the racist writings of Frederick Lugard, the first Governor-General of Nigeria: "But there can be no doubt that such races [referring to the Fulani in the previous paragraph] form an invaluable medium between the British staff and the native peasantry. Nor can the difficulty of finding any one capable of taking their place, or the danger they would constitute to the State if ousted from their positions, be ignored. Their traditions of rule, their monotheistic religion, and their intelligence enable them to appreciate more readily than the negro population the wider objects of British policy (see p. 220), while their close touch with the masses with whom they live in daily intercourse mark them out as destined to play an important part in the future, as they have done in the past, in the development of the tropics (Lugard, 1922, p. 237).

[148] See, for instance, here: https://www.thisdaylive.com/index.php/2021/06/15/again-pdp-govs-push-for-review-of-revenue-sharing-formula/ (last accessed 24/06/2021).

[149] In response to widespread corrupt practices within public offices, in 1999, after an return to democracy, newly-elected President Obasanjo introduced an extensive anti-corruption programme (Enweremadu, 2013).

several times with the result that, nowadays, States depend to a large extent on the Federation Account to finance their budgets. This is the case as a considerable share of high-income sources, such as revenue from petroleum profit taxation, are now collected and retained at the level of the Federation (see Appendix K for information on tax collection and retention by tier of government).

As a consequence, currently, States' capacity to mobilise their own internally generated revenues (IGR) is limited and they remain dependent on a grant from the federation account (Gatt and Owen 2018; see Figure 36). Lagos State has been cited as the only state in Nigeria that has achieved true fiscal independence, having mobilised enough IGR via channels such as collection of personal income taxes, land sales taxes, car licenses and transfer fees (Gatt and Owen, 2018; RESYST, 2015). A few other states, i.e. Rivers, Akwa Ibom and Kano, have been praised for the progress they have made in strengthening their IGR positions (BudgiT, 2019).[150] Still, despite a narrower scope to mobilise revenues, State Governments contribute the largest share to government spending on health (48.2 percent compared to 43.2 percent Federal Government spending and 8.6 percent of Local Government spending in 2017). However, States' health budgets differ vastly across Nigeria. For instance, in 2019, Kwara and Kano States were able to meet the health spending criterion agreed upon in the Abuja Declaration (with 17.8 and 15.2 percent, respectively). Overall, the average of States' health budgets (as share of their total budgets) is only 8.7 percent and this falls as low as 2.1 percent in Akwa Ibom (see Figure 37). An analysis of State health budgets and selected service delivery indicators (i.e., Primary Health Facility with Basic Medical Equipment or health workers who have received training in Integrated Management of Childhood Illnesses) shows no link between more money and better service delivery. On the contrary, States with higher shares of their budgets dedicated to health tend to be States with higher under-five child mortality rates (see Figure 38). This, therefore, seems to suggest that there is at least a tendency for investments in health to be highest, where need is the greatest and where improvements are required most urgently. This, however, is not what Onwujekwe et al. (2019) observe, who emphasise that "there is no system to ensure financial resources are fairly distributed across geographic regions in the country considering their different poverty and vulnerability levels".

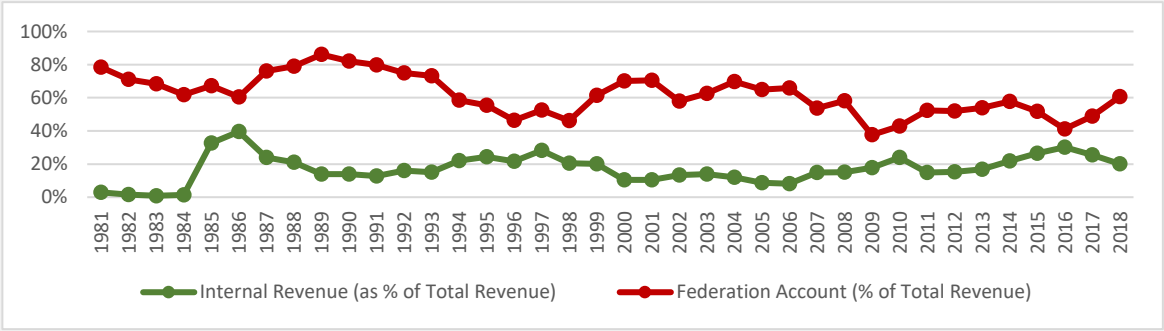
[150] See page 129 for the States' Financial Sustainability Index ranking: https://yourbudgit.com/wp-content/uploads/2019/10/2019-State-of-States.pdf (last accessed 28/04/2021).

Generally, the healthcare system in Nigeria itself appears to contribute to perpetuating social inequality and exacerbating health inequity.[151] Notably, Mackintosh (2001, p. 175) stresses that much of the literature on health reforms concentrates on the impact a healthcare system has on health outcomes. Yet, the focus on changes in health status often happens to the detriment of understanding how healthcare systems themselves are a space that reinforces existing social inequalities (see arrow C in Figure 39). This seems to be the case in Nigeria, with e.g. Oxfam highlighting how the structure of Nigeria's healthcare system maintains existing social inequality (Martin et al., 2020):

> Towards the bottom of the ranking are Nigeria, India and Pakistan, which are spending too little to meet the needs of a majority of their populations; they are essentially abandoning their people to the vagaries of a **hugely unequal system**, characterized by crumbling and **under-resourced public health services**, or a highly **commercialized and unregulated private healthcare sector** (Martin et al., 2020, p. 27; emphasis added).

In their recent assessment of governments' efforts to respond to the COVID-19 crisis and to tackle inequality – through improving public service delivery, reforming tax systems, and ameliorating labour conditions – they rank Nigeria second-to-last out of 158 countries in 2020, which is only performing better than South Sudan (where a civil war took place between 2013 and 2020). As the above quote emphasises, a key contributor to the perpetuation of social inequality is the low level of Government health spending and the high reliance on out-of-pocket spending as a means to finance healthcare.

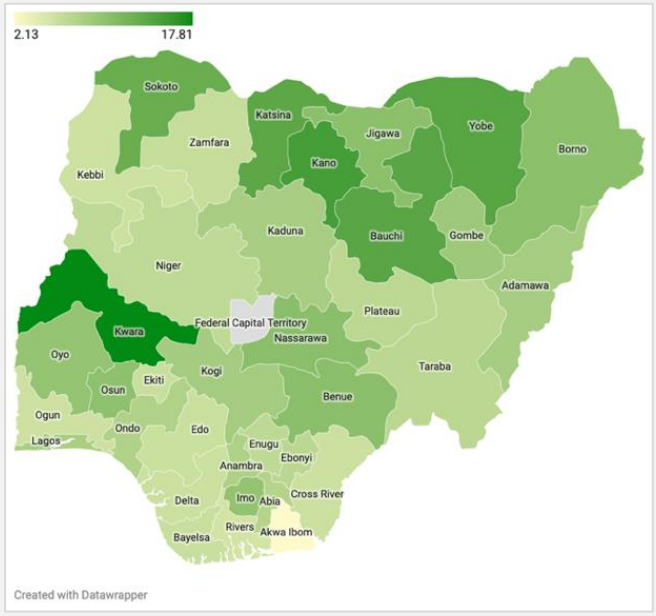
Figure 36: Revenues of States' Governments



Source: Own illustration based on 2019 CBN Statistical Bulletin data

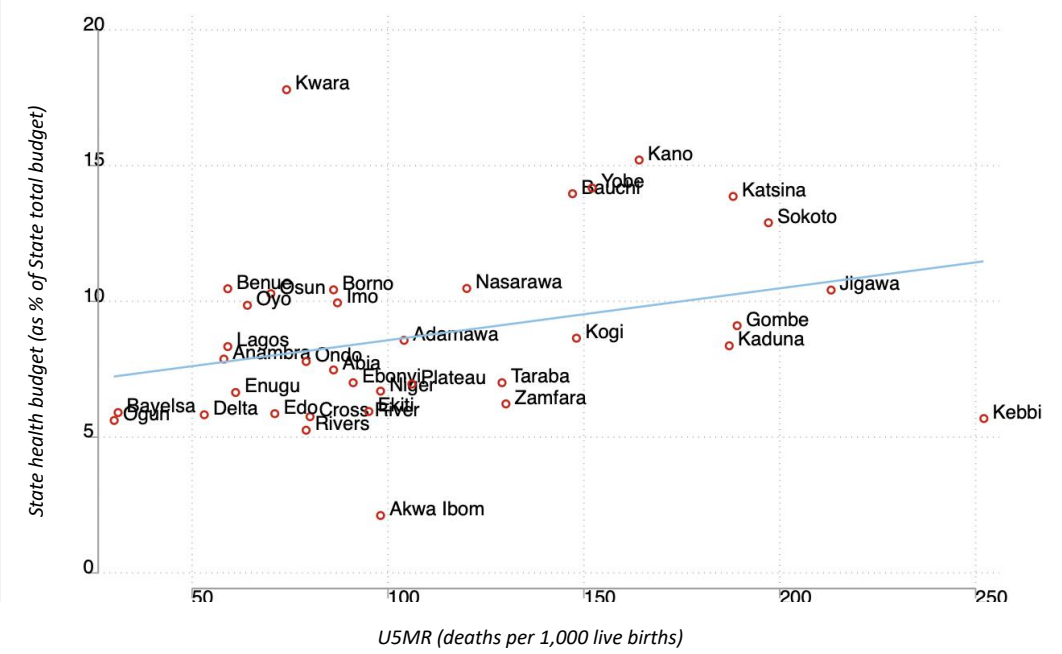
[151] Health inequities (or disparities) are systemic differences in the health of certain individuals or groups of individuals, avoidable and unjust, stemming from inequalities in the social conditions in which people live, work, grow and age (Arcaya et al., 2015; Marmot and Wilkinson, 2005). Also, see chapter 2, which touches upon the concept of the social determinants of health.

Figure 37: State health budget (as % of State total budget), 2019



Source: Own illustration based on data compiled by BudgIT Research[152]

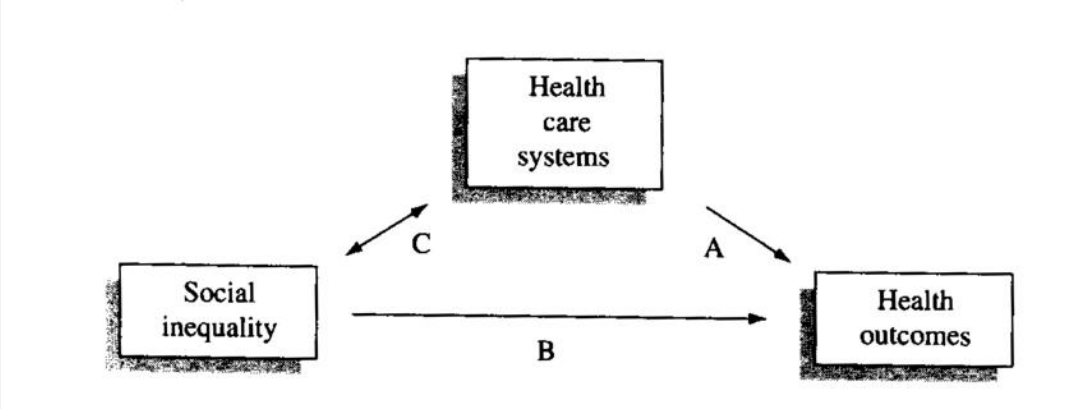
Figure 38: More health spending where child mortality is highest



Source: Own illustrated based on DHS data (U5MR) and BudgIT data (health budget)

[152] Their full 2020 report "State of States" is available here: https://yourbudgit.com/wp-content/uploads/2020/11/State-of-States-2020-Revised-Edition.pdf (last accessed 06/05/2021).

Figure 39: Health/inequality interactions



Source: Mackintosh (2001)

3.2.2. Social health insurance

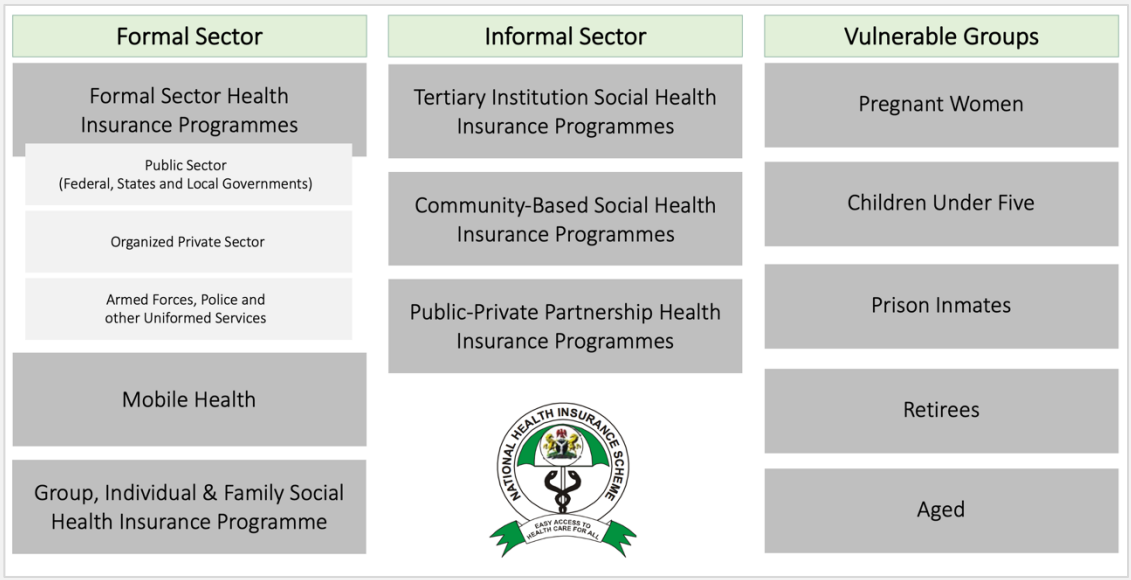
According to Nicholson et al. (2015), experiences from other countries indicate that an increase in levels of public finance for health **in combination with** an effective system of pooling of all resources in one fund are crucial prerequisites for the attainment of UHC. In theory, Nigeria introduced a social insurance scheme in 1999, which became operational in 2005. However, social insurance revenues as a share of current health expenditure are negligible (0.7 percent) and social health insurance coverage remains low (at "less than 10 percent" or "about 5 percent"; NHIS, 2020). Moreover, the scheme primarily benefits Federal Government employees and their dependants, as the only truly functional programme of the NHIS is the Formal Sector Social Health Insurance Programme for (FSSHIP). The FSSHIP relies heavily on Health Maintenance Organisations, to act as intermediaries between healthcare providers and the organisation (the Federal Government, in this case) seeking to provide healthcare to their employees.[153] As enrolment in the FSSHIP is only mandatory for Federal Government employees, but voluntary for employees of private, formal-sector firms, the latter often chose private health insurance plans over the national social insurance scheme (Onoka, 2014; Onoka et al., 2016). The private formal sector in Nigeria is small though and, hence, private health insurance coverage is limited to only 0.3 percent of the population (Onoka et al., 2016, p. 11). There are other

[153] In principle, the activities of these HMOs are regulated by the council of the NHIS (Asoka, 2011; Okebukola and Brieger, 2016).

social insurance programmes, which were introduced within the NHIS gradually and target specific groups in society, but they do not perform well (see Figure 40).[154]

In general, the idea is that the NHIS, which has the overall responsibility to set guidelines and standards, accredits HMOs and tasks them with the collection of contributions from employer and employee (a concept often referred to as "managed care" or "integrated care"). These HMOs then enter into a contract with a public or private healthcare provider, which also needs to be accredited by the NHIS and which takes on the responsibility to provide primary healthcare services to the employee in case of need. The HMO pays a regular "capitation" (an advance payment) to the primary healthcare provider regardless of whether the employee requires its services or not. Referrals to higher-level healthcare facilities have to be approved by HMOs prior to receipt of service (except for in emergencies). In theory, there is no additional payment required from the person in need of service, if enrolled in the NHIS. Yet, it is questionable if this is really the case, as in 2016, 77 percent of health facilities (and 98 percent of private health facilities) across Nigeria were still charging user fees (FGON, 2016, p. 124). Figure 41 illustrates the organization of the NHIS and the interplay between the involved stakeholders.

Figure 40: Programmes of Nigeria's National Health Insurance Scheme

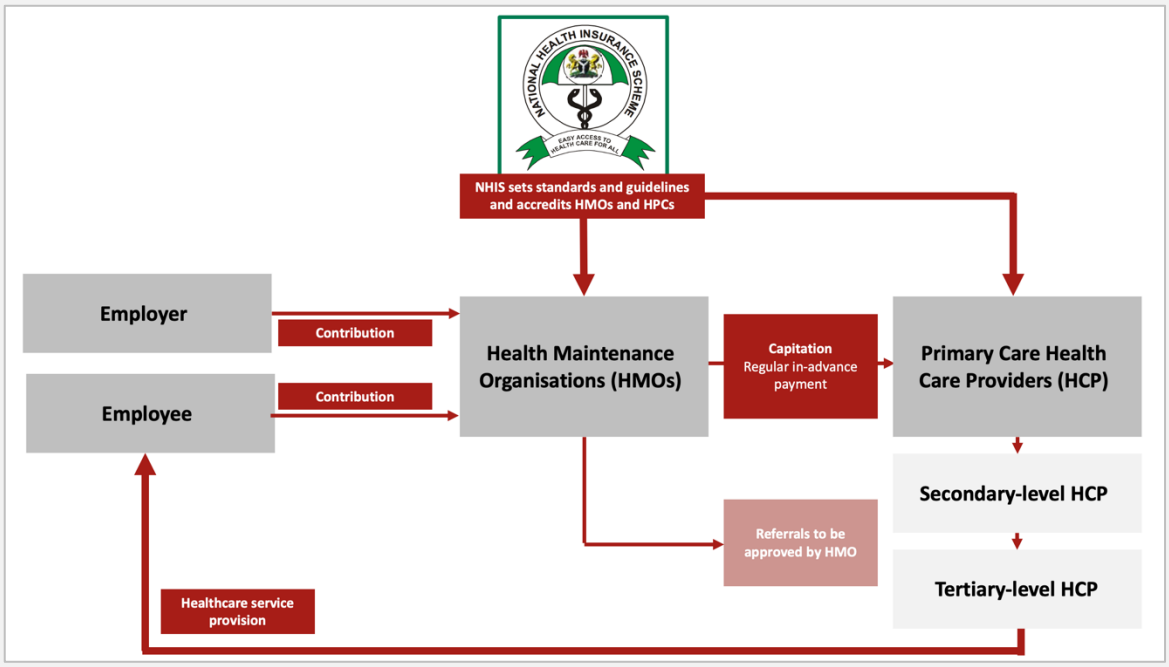


Source: Own illustration based on the programmes listed on the NHIS Website[155]

[154] In 2020, the Government introduced the "Group, Individual and Family Social Health Insurance Scheme", which, in essence, only replaced the existing voluntary health insurance scheme.

[155] See: https://www.nhis.gov.ng/our-services/ (last accessed 22/06/2021.

Figure 41: Organization of the National Health Insurance Scheme



Source: Own illustration based on the 2012 Revised NHIS Operating Guidelines

In November 2020, the Senate passed new NHIS legislation, which seeks to make health insurance mandatory for all Nigerians.[156] It remains to be seen, if and how this will be put into practice and enforced. In parallel, the Federal Government and the NHIS have been working on a "Health Insurance Under One Roof" policy, which highlights the important role that the NHIS, at federal level, is expected to play in coordinating the decentralised State/State-supported Health Insurance Schemes (SHISs). The latter were only instituted in 2015, on recommendation of the NHAct and as part of the BHCPF, which foresees to channel parts of its resources via the NHIS, via the SHISs, to service providers. The SHISs are separate social insurance schemes and operate at State-level only. The exact roles that the NHIS and SHISs are expected to play as part of the BHCPF will be discussed in detail in Chapter 6.

3.2.3. Out-of-pocket healthcare spending

As Government healthcare funding is small and social health insurance coverage limited, households are by far the main source of health financing in Nigeria. As illustrated in Figure 42, WHO statistics, dating back to the early 2000s, document the persistently high levels of OOP spending in Nigeria and illustrate that the situation continues to worsen. The problem is striking as OOP expenditure are

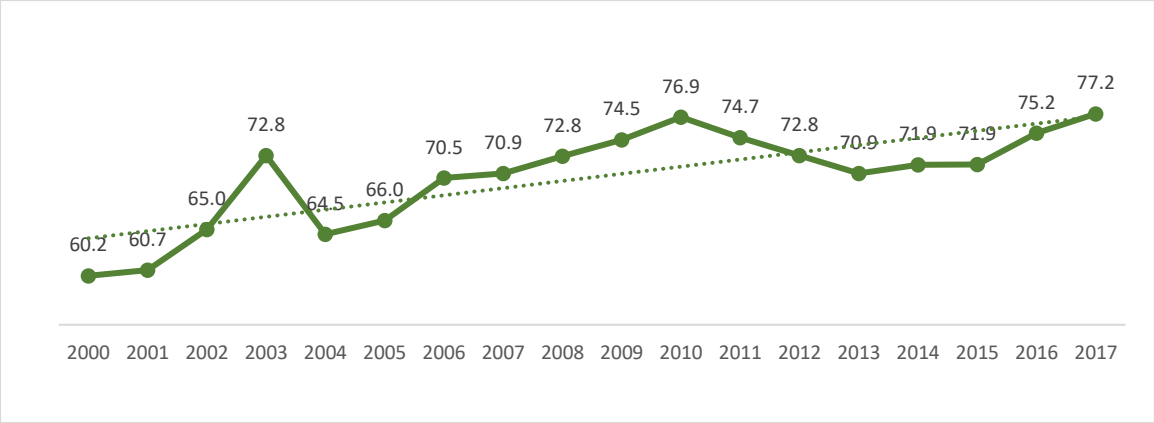
[156] See: https://www.vanguardngr.com/2020/11/senate-passes-bill-to-make-health-insurance-mandatory-for-all-nigerians/ (last accessed 22/06/2021).

regressive, affecting the poorest people disproportionally (Murray and Frenk, 2000). As pointed out by Uzochukwu et al. (2015, p. 441), in Nigeria, "on average, about 4% of households spend more than half of their total household expenditures on healthcare and 12% spend more than a quarter." According to Martin et al. (2020), one in ten Nigerians incurs catastrophic healthcare expenditure, meaning that more than 10 percent of households' income is used to pay for health services – a threshold considered to be high enough to risk pushing people (further) into poverty. An exercise conducted by Wagstaff et al. (2018) found the incidence of catastrophic health spending at the 10 percent threshold in Nigeria to be 25 percent. The WHO, in its World Health Statistics 2020 report, states that 15.1 percent (2010-18 average) of the Nigerian population incur health expenditure higher than 10 percent of their total household expenditure (compared to a value of 7.3 percent for the entire WHO Africa region).[157] According to Onwujekwe et al. (2012), 27 percent of Nigerian households spend more than 40 percent of their non-food expenditure on health services. An analysis of data of a recent consumption pattern survey (commissioned by the Central Bank of Nigeria in 2019) shows that health expenditure makes up 6.1 percent of total expenditure and 14.1 percent of non-food expenditure (making it the second-highest financial burden after cost for transport at 14.9 percent). Differences are vast across States, and also depending on whether households reside in rural or urban areas of the country. In rural areas, health expenditures are the most important non-food expenditure, with household spending on health accounting for approximately a fifth of non-food disposable income (18.9 percent). In urban areas, health spending amounts to 9.9 percent of non-food expenditure after spending on education, transport, services such as telecommunication services, rent and fuel/light (in order of priority).

As illustrated in Figure 43, the burden of health expenditures varies by State, ranging from shares higher than 28 percent in Adamawa and Niger States to a share of only 7.2 percent in Lagos State. These high levels of healthcare spending at household level continue to be a contributing factor to high levels of poverty across Nigeria as can be seen in Figure 44. States with higher poverty headcounts are also States where households spent higher shares of their household income on healthcare services. This is illustrative of the close link between poverty and high household-level healthcare spending and translates into a reality where the high reliance of Nigerian households to self-cater for health needs means that people are not able to access the necessary healthcare (Onwujekwe et al., 2009, p. 195).

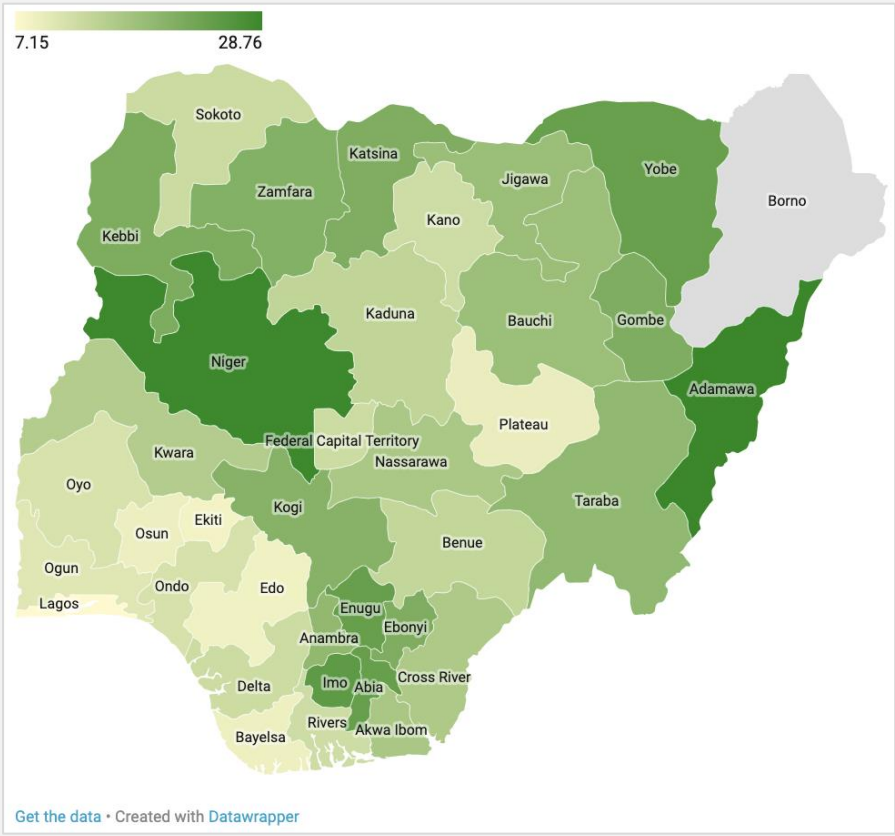
[157] See, for instance, Okedo-Alex et al. (2019) for a review of existing studies on the incidence and determinants of catastrophic health expenditure in Nigeria.

Figure 42: Out-of-pocket spending as % of current health expenditure



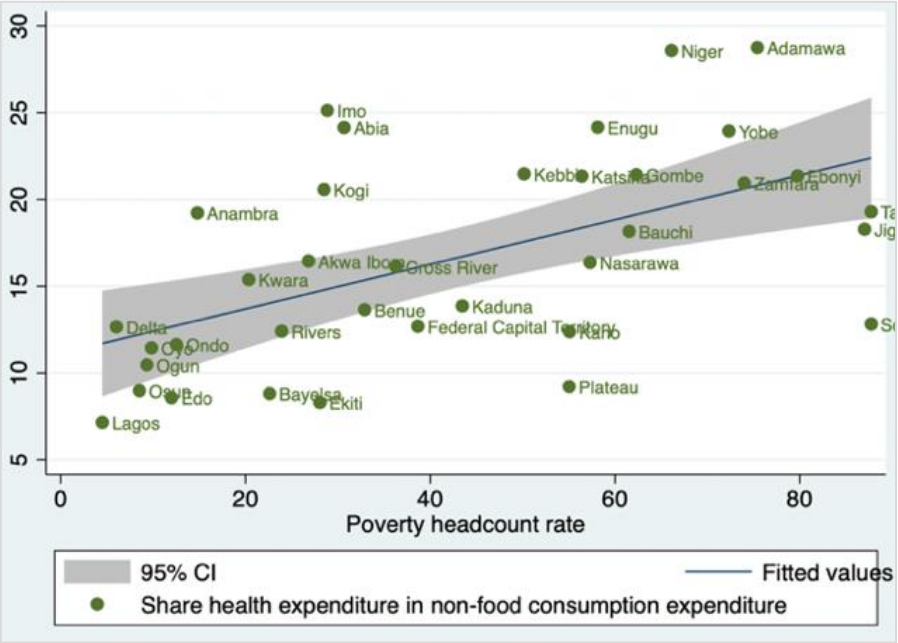
Source: Own illustrated based on World Health Organisation data

Figure 43: Share of health expenditure at household level (as % of non-food consumption expenditure)



Source: Own illustration based on 2019 Consumption Pattern Survey/Nigerian Living Standard Survey data

Figure 44: Poverty rates and health expenditure at household level



Source: Own illustration based on 2019 CBN data

3.3. The role of the private sector in healthcare service delivery in Nigeria

While there is an operative government-run, public healthcare system in Nigeria, many Nigerians access healthcare via the private sector. Accommodating this reality, close to all government documents make reference to the need for stronger collaboration with the private sector. This is apparent in the 2012 Revised NHIS Operational Guidelines[158] ("improve and harness private sector participation in the provision of healthcare services"); in the 2016 Draft Health Policy ("[the] Government shall provide policy support and funding and take active measures to involve all private health care actors and other stakeholders"); as well as in Article 18 of the 2014 National Health Act ("the Federal Ministry, any State Ministry, Local Government of any public establishment may enter into an agreement with any private practitioner, private health establishment or non-governmental organization in order to achieve any objective of this Act"). By the same token, one State Government official states that, going forward, the private sector will play an important role in healthcare service delivery in Nigeria:

[158] The revised NHIS Operating Guidelines are available at:

http://admin.theiguides.org/Media/Documents/NHIS_OPERATIONAL_GUIDELINES.pdf (last accessed 24/06/2021).

> We surely recognise the private sector health delivery as key. A majority of Nigerians, a majority of Enugu State indigents are treated by private hospitals. It is a fact. We recognise it, we respect it and we carry that information along in all the designing … Our agency will definitely work together with the private sector.[159]

There is, however, need for caution, as the private sector is not a homogenous category. For example, an analysis conducted by Oxfam established that 40 percent of providers that where classified as "private" by the World Bank's International Finance Cooperation (IFC), were actually "just small shops selling drugs of unknown quality" (Oxfam, 2009, p. 2). Similarly, Mackintosh et al., (2016, p. 7) maintain that the private sector in Nigeria includes "unlicensed sole practitioners, shops and medicines vendors". The 2018 DHS data for Nigeria confirms that while 36.6 percent of respondents have reported to have sought advice or treatment for their child with diarrhoea in the private sector (compared to 24.1 percent having consulted a public facility), they mostly refer to chemists or patent medicine stores or private mobile clinics with only two percent of respondents, actually having sought care in a private **hospital**. In the same vein, the 2018 Living Standards Measurement Survey highlighted that, in case of illness, close to half of respondents report to have visited a private chemist (47.9 percent of male and 46.2. percent of female respondents), who may not be subject to any quality assessment. The quality of services in the private sector is thus not always guaranteed. Rather, because of a "highly deteriorated" and "commercialised" Nigerian public health sector, which relies on user fees, the private sector has kept growing in spite of "low quality private provision for the low income population" (Mackintosh et al., 2016b, p. 7).

Yet, as problems within the public system are vast and reach from non-availability of drugs and medical equipment to poor infrastructure and understaffing, private clinics tend to provide better services than public primary health centres as an analysis of the 2013-14 Service Delivery Indicator survey showed. According to the World Bank, provider knowledge (on a selection of conditions) appears to be higher in private facilities (see Table 9). Moreover, 46.2 percent of public facilities indicate to not have electricity in their establishment (compared to 15.9 percent of privately owned health facilities). In a WHO-World Bank-OECD report, it is cited that "less than one quarter of facilities in Nigeria had reliable water, sanitation and electricity" (WHO et al., 2018, p. 45). And, Onoka (2014, p. 48) further highlights that "although 88 percent of doctors in Nigeria work in hospitals, 74 percent of these doctors work in private hospitals".

[159] Interview 17; 05/03/2019.

Table 9: Provider knowledge at primary health care centres

On average, providers correctly diagnosed condition X, X percent of the time?	Public	Private
Diarrhoea	26%	43%
Pneumonia	42%	64%
Diabetes	36%	71%
Tuberculosis	60%	77%
Malaria	11%	26%
Post-partum haemorrhage	59%	79%
Birth asphyxia	37%	62%

Source: World Bank (2018) based on 2016 Health Facility Survey data

Reliance on private provision, however, means an exacerbation of health inequities as services provided at private facilities appear to be more costly than in public primary healthcare facilities and, hence, add additional financial pressure on already vulnerable households (Asakitikpi, 2019; Onwujekwe et al., 2010; Onwujekwe and Uzochukwu, 2005). For instance, in 2016, average drug charges (the largest component of user fees) were NGN 1,090 in private facilities compared to NGN 432 in public primary health centres (FGON, 2016, p. 124). Also, across many of the FGDs, high costs at private facilities were a recurring theme with one community member stressing that:

> Sometimes, when you are sick and go to the government hospital, you won't see a doctor to take care of you, they may now ask the person to go to a private clinic, and the person may not have the money to go to private clinic because we all know that the **bills are high in the private facilities**. When the person gets there, they may start asking the person to do one thing or the other, and before you know it, the amount they will call at the end will be so much that the person may not be able to provide the money, and if the person is unfortunate, he may die from the sickness because he did not receive proper care as he ought to. [160]

Along similar lines, another community member highlighted that seeking care in the public healthcare system is cheaper than seeking care in the private sector, but that, often, quality care is not available via the public healthcare system:

> When a woman is pregnant, our women here patronize the TBAs [traditional birth assistants] because when they come here [the public healthcare centre], they don't find the things they need. They may decide to go to the TBAs in the villages to deliver since it is almost the same

[160] FGD 1; 19/02/2019.

thing, and they will go there, while some will go to the private hospital, **but it is cheaper here than the private hospital because it is the government. Sometimes, it is free**.[161]

In the next section, I build on the above by delving into norms of healthcare consumption as well as public perceptions of and degrees of satisfaction with private and public healthcare delivery.

4. Material culture, views on healthcare and norms and patterns of healthcare consumption

A major (and distinct) element of the Systems of Provision approach is its commitment to explore the meaning attached to the consumption of a specific good or service (in a specific place). This is because consumption decisions – rather than being the outcome of a rational decision-making process – are affected by social interactions, value systems, cultural associations, discourses as well as actual practices attached to provisioning (Bayliss and Fine, 2020). For Bayliss and Fine (2020), material culture (as defined for the purpose of a SoP investigation) is the link between the material good/service and the social and cultural relations associated with it, and thus shapes the norms related to providing and consuming a specific good or service, in a specific context. *Ipso facto*, the material culture attached to the consumption of healthcare in Nigeria gives rise to a specific set of norms of healthcare consumption.

In this light, this section focuses on three major themes. First, the one, all-dominating sentiment amongst a majority of Nigerians seems to be a general dissatisfaction with the high costs associated with using healthcare services in Nigeria. The view prevails that the Government should demonstrate political commitment by taking action to improve healthcare delivery. It needs to prioritise increasing its financial support to the sector in order to assure that every Nigerian can access healthcare without suffering financial hardship. Second, two main aspects shape healthcare seeking behaviour in Nigeria. First there is an inclination to feel/be compelled to seek healthcare privately, because the public healthcare system is perceived to be dysfunctional. Second, if care is sought in the public healthcare system, there is a tendency to "skip" levels of care as especially the **primary** healthcare infrastructure is dysfunctional. The consequence of this reality is that there appears to be general agreement that **some form** of private sector participation is necessary to facilitate access to healthcare in Nigeria. Third, and from a broader perspective, while there is a general frustration with the current results the Nigerian healthcare system produces, Nigerians seem to be even more concerned with other policy priorities, such as job creation or tackling security challenges. Nigeria's political economy is complex, and the country faces a variety of different challenges, with health and healthcare not specifically seen as a priority by the general public nor the ruling class.

[161] FGD 5; 20/02/2019.

4.1.1. Financial barriers to accessing healthcare

During many of the focus group discussions as well as interviews conducted during field work, financial pressure at the level of the individual, as a result of the need to pay for healthcare privately, was emphasised. The general tenor was that "payment should not be a barrier to accessing health care".[162] In this light, and borrowing from an interviewee, who is researching healthcare service delivery in Nigeria, the central take-away is that any discussion of improving healthcare delivery in Nigeria is considered void, if financial barriers to accessing healthcare are not addressed as a matter of urgency:

> We can talk about improving service delivery, quality, building more health centres, providing, making services available, putting it all there. **But if people don't have financial access, you know, we cannot solve the problem of utilisation, of people actually using the health centres**. You can do every beautiful thing, you know, you want to do with the supply side, but if you haven't addressed the barriers to access, particularly financial barriers to accessing healthcare on the demand-side, I mean, then it will just be... it will be useless. Sorry, to use that... but yeah, it will be useless.[163]

Reflecting the reality of the health financing indicators presented in section 3, one Ward Development Committee member highlighted that many people, especially those living in rural communities, do not have enough financial resources to access healthcare and, thus, do not consume healthcare:

> They should consider those people in the village because there are people there who have nothing to eat and they can't go to the hospital when they are sick, and they can't borrow because whoever they go to borrow money from for health care, the person will say there is no money. So, they should have mercy on the people and make the drugs and services free. There is money in Nigeria, they should use the money and produce the drugs and give to the people.[164]

While the NHAct (Art. 20.1) stipulates that a healthcare provider cannot refuse a person emergency medical treatment, another respondent of the same FGD made the explicit point that the lack of financial resources at household-level, in reality, may mean the difference between life or death:

> The government should make it to be affordable so that no matter the amount the mother has, she will bring the child to the hospital. The common cause of child death is lack of money by the parent. If they have the required money, they wouldn't be losing their children, but when they

[162] FGD 6; 20/02/2019.

[163] Interview 15; 05/03/2019.

[164] FGD 1; 19/02/2019.

> make it affordable, even if the mother is having as low as five hundred Naira, she can rush to the hospital.[165]

At the same time, both these quotes emphasise that it is seen as the **responsibility of the Government** to ensure that also people with no or little financial means can access the necessary healthcare in Nigeria. In an opinion poll conducted in 2015 by the UNICEF Nigeria Country Office, asking citizens if they have heard about the NHAct and who they think should be responsible for providing access to health services, only three percent out of the more than 64,000 respondents (replying to the latter question) maintained that it is the individual's responsibility to assure access to healthcare. Close to half of the respondent saw it as one of the tiers of Government's sole responsibility to provide care. Another 41 percent answered that it is the responsibility of all tiers of Government together with the individual to assure access to healthcare.[166] Similar views were communicated during the FGDs: while some people were of the opinion that healthcare services should be funded entirely by the Government free at point of access, others highlighted that the Government should pay for the largest share of healthcare costs, but that individuals and the community can make a **reasonable contribution**. For instance, one woman, participating in a FGD in Anambra State, stated that the Government should "consider the current condition of Nigeria [and] should see how to reduce the cost for the people, so that the cost of payment will not make people to stay at home rather than coming to the health facility".[167] Similarly, in a FGD conducted with women in Niger State, views were that the Government should increase its funding to healthcare, but that also "community financing options" should be encouraged.[168] In several FDGs, respondents were supportive of an expansion of social health insurance schemes, which would require a (adequate) premium payment from their side:

> Yes, I support the introduction of health insurance schemes in the state, but enrolment issues should be encouraged, and the premium should be moderate for all to afford.[169]

> To me, the rate that the individuals will pay is not much, at least they can afford it, if you register. You can afford it since the government is paying ninety percent of your bill, you can afford ten percent, so you cannot rush to chemist again, you cannot go to any herbal home to

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[165] FGD 1; 19/02/2019

[166] The results are available here: https://nigeria.ureport.in/opinion/300/ (last accessed 24/06/2021).

[167] FGD 8; 11/03/2019.

[168] FGD 12; 16/03/2019.

[169] FGD 10; 16/03/2019.

go and buy drugs. You can go to the hospital with your smart card and get yourself treated. I think it is good.[170]

In addition, in some instance, FGD participants also pointed to the **duty of the private sector to financially contribute** to making healthcare accessible. Proposed ways included:

- "introducing joint funding of healthcare by both the government and the organised private sector";[171]
- encouraging "members of the society" to "generously donate" to healthcare funds;[172]
- having non-for-profit community solidarity groups or private persons providing financial support to communities, as "community funding mechanisms and involvement of philanthropists within communities will go a long way in financing health";[173]
- "pooling NGO funding";[174]
- obliging the private sector to pay "some money to help the poor masses".[175]

It was maintained that private individuals and organisations/corporations, financially supporting the healthcare system, does not diminish the importance of increased Government spending. Philanthropists – "big men … like private company owners" – may want to support the healthcare provision system, but "they won't go round, but the people who can go round are the government".[176] In short, private philanthropy and contributions do not replace the role the Government has in financing and guaranteeing the delivery of healthcare.

Several other FGD participants also highlighted their preference for government-funded healthcare – free or subsidised – **over a system of direct cash transfers**. Since 2015, the FGON has pushed to advance its social protection agenda, notably by introducing a new cash transfer programme, the

[170] FGD 9; 11/03/2019.

[171] FGD 10; 16/03/2019.

[172] FGD 10; 16/03/2019.

[173] FGD 11; 16/03/2019.

[174] FGD 12; 16/03/2019.

[175] FGD 2; 19/02/2019.

[176] FGD 4; 20/02/2019.

National Social Safety Net Project (NSSNP), and by signing a Social Protection Policy framework.[177] Yet, for example, two members of a FGD with village community leaders were concerned that a cash transfer scheme could take precedent over the provision of free/subsidised healthcare services. They highlighted that high levels of poverty may mean that people receiving a direct cash transfer will use this to fulfil their needs in other pressing areas (such as buying food) rather than taking care of their (and their families') health: [178]

> *Respondent A:* Like I had already said, our poverty level is too high here. An average black man will prefer to die if he is sick than spending the money you have given him to treat that sickness. But for us to fight good health, I am of the opinion that cash should not be dispensed to patients, let him just go to the health facility, be diagnosed and be treated, and then he is taken care of because I know quite well that sometimes you can say that you are giving him money because he is sick, he will tell you this sickness remain, I am hungry, let me go and eat food, and that sickness will be abandoned and he will die. So, I think if the government is giving direct free medical care to people, they will save more lives.
>
> *Respondent B*: What they said is correct because if you give money to ten sick people, hardly will you get up to four among them that will utilize the money for health, they may use it for food while some will use it for drink. So, giving proper treatment is correct.

Similar views were communicated in other FGDs by a person working at a health facility (respondent A) and a younger member of the community (respondent B):

> *Respondent A:* If they start giving the money cash, some people may take the money to solve those other family problems and say that the sickness should wait, that he would go later, and this sickness will be getting worse. But I think it will be better if the person goes to the hospital and receives the treatment, and then government will bear the cost of the health services the person received. Nobody will say he used his money for other life problems, everybody will utilize it on health care. If the Nigerians agree to channel the money God has blessed us with into health, you'd see that everyone in Nigeria including the immigrants would have good health

[177] See here for an overview of more recent steps of the FGON relating to social protection: http://documents1.worldbank.org/curated/pt/612461580272758131/pdf/Advancing-Social-Protection-in-a-Dynamic-Nigeria.pdf (last accessed 11/02/2021).

[178] FGD 7; 22/02/2019.

> care. Let that be what we boast of, because someone that is healthy can work for what to eat, but a sick person cannot even eat food given to him. [179]
>
> *Respondent B:* It is not for the government to give us cash … So, it does not mean that they will just count money and give to the people. It is through supports like drugs. The government can supply the drugs and we will be sure that calculation is accurate.[180]

Several women in Niger State proposed to maintain cash transfers alongside the provision of free healthcare services, with one woman stressing that "health care should be made free at point of care" but proposing that conditional cash transfers should be maintained as well – however, in a restricted manner, "made available only for vulnerable members of the society" such as "women and under-fives".[181]

In summary, the predominant opinion emerging from the FGDs was that more Government spending is key to ensuring that all Nigerians – no matter their socio-economic background – can access healthcare for free or at a reasonable, low price. Along the same line, a high-level stakeholder at the NHIS emphasized the importance of increasing public spending on health in Nigeria in order to achieve UHC.

> The essence of UHC is on public spending. It is not for individuals to come and make contributions to source for their healthcare needs, it is on public spending. So, the Government should spend more on health.[182]

In some instances, increased public spending on health was perceived to be merely a question of political will. For example, one Ward Development Committee member stated outright that "the government is strong and is up to the task. It only requires the political will"[183]. A community leader in the same village stated along the same line: "I think the government can pay for healthcare, especially if we remember that the government is rich. Unfortunately, however, this is not the situation on ground. Little is made available to health due to inadequate budgetary allocation."[184] A

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[179] FGD 1; 19/02/2019.

[180] FGD 3; 19/02/2019.

[181] FGD 12; 16/03/2019.

[182] Interview 14; 01/03/2019.

[183] FGD 10; 16/03/2019.

[184] FGD 11; 16/03/2019.

participant in another FGD, conducted with a women's group, similarly stressed that Nigeria is a rich country – with poor people:

> If we are to look into how health care should be financed in Nigeria, you will agree with me that what Nigeria as a nation has enough to take care of the healthcare of the Nigerian populace, the government is supposed to take care of the financing of any sick person in Nigeria due to what we have in this country, because if we are to look into what this country has, everyone is supposed to be living big in this country, but when you look at the realities in this country, you will see that when someone is sick, even for the very poor people that the government is supposed to take care of, the person will die of the sickness due to poverty. **But if the government can look into this and act based on the wealth of this country, people shouldn't be dying of poor health care due to lack of money to take care of them**. When you visit some hospitals you will see that some people die because of lack of money, but if the government should look into all these things, people shouldn't be dying like that. **So, in my own opinion, I will say that what this country has is enough to take care of everybody's healthcare**. The sick people should go to the hospital and receive their medication and live after treatment. That is my opinion, because this country is rich.[185]

Sharing the opinion that the public budget is a reflection of what the Government truly values, a medical doctor and university lecturer, also emphasised the importance of "political will":

> I think it is majorly political will, because you make money available for what you prioritise. And you know – health – I don't think that we push in health as much as other sectors do. You know, like advocacy for funding, for attention, is not usually as strong as other sectors. I mean, some other sectors will tell you "everything is health, is health, everything is going to health". I don't think we are pushing enough. … Yes, it is majorly political will.[186]

Strong political will and committed leadership, at the highest level, have been singled out as a key driver of UHC reforms (see e.g. Nicholson et al., 2015, p. 29). A recent example often brought forward is Thailand's introduction of a public health insurance scheme in 2001, championed by President Shinawatra, which now covers the entire Thai population (via three different programmes) and brought down catastrophic health spending from 6 percent in 1996 to 2 percent in 2015 (Tangcharoensathien et al., 2020, 2019). The concept of "political will" and/or the lack thereof, associated with corrupt leaders not wanting to do the "right thing", is however difficult to define and

[185] FGD 4; 20/02/2019.

[186] Interview 15; 05/03/2019.

pinpoint. Drivers for what may be perceived as "lack of political will" are often context-specific and complex.[187] While the implication and motivation of political leaders is an important factor determining UHC reform in Nigeria, chapters 5 and 6 pay attention to the complexity of policymaking and implementation and the many conflicting interests of different agents and contestations that influence health policy reform.

4.1.2. Seeking healthcare in the private versus the public sector

As illustrated in section 2, the inequities that for-profit private sector healthcare delivery in Nigeria produces and replicates are vast. Nevertheless, the narrative prevails that the Government cannot assure the availability of healthcare services for all Nigerians – on its own, without the support of the private sector. However, the narrative is nuanced: while community members tend to say that they cannot **afford accessing healthcare services** without the financial assistance (or in-kind donations) of the private sector and/or private persons, the narrative amongst politicians, civil servants and members of the international community and formally organised civil society organisations is that Nigeria cannot **deliver healthcare services** without the private sector.

Two main opinions with regard to the role of the public versus the private healthcare sector emerged during FGDs and interviews at community level. First, the prevailing view was that the public system is underperforming and not delivering quality healthcare. High levels of healthcare-seeking in the private sector are, then, often the consequence of poor service delivery at public facilities and the notion that the "private sector [is] … assumed to be better".[188] For instance, one female FGD participant emphasised that "we are all saying the same thing. I am thinking of attributing the women's suffering to the government because when you get to the private hospitals, they are clean, and you will see all the required drugs there".[189] On the contrary, "when you come to the government hospital, you don't see drugs until you move out to [the] private hospital before you get it", another FGD participant reports.[190] It thus seems that Nigerians do not want to seek care in the for-profit private sector, but feel that they have to do so, in order to get adequate care. Yet another FGD participant made a similar statement:

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[187] See e.g. here: https://blogs.lse.ac.uk/africaatlse/2021/02/08/transparency-international-african-corruption-perceptions-index-role-the-global-north-critics/ or here: https://www.aljazeera.com/opinions/2014/2/1/flipping-the-corruption-myth (last accessed 05/05/2021).

[188] Interview 43; 27/03/2019.

[189] FGD 2; 19/02/2019.

[190] FGD 9; 11/03/2019.

> In a private hospital, the owner has money … so when you come, he will call any amount he likes for you and **you cannot do anything because you don't have other options**. For instance, if he carries out surgery on you, he will not loosen the wire until you have made your complete payment, and he doesn't care how you make the money, even if you are selling your land. **But you will have to do it because there is no other place you can go**. [191]

Therefore, often, healthcare is sought in a private facility although, also there, an adequate standard of quality of care is not guaranteed. A member of the Enugu State Committee on Health stressed:

> At the moment, over 60 percent of our healthcare service provision is in private sector. But this private sector is largely unregulated. The current state health law prescribes an expanded joint inspectory division of the Ministry of Health to support the regulation of the private sector … But, I am not sure ... the first quarter is nearly over, and in fact, the last two quarters I am not aware that the MOH has conducted any such inspection of private facilities.[192]

A second concern raised during FGDs and interviews was that for-profit private hospitals are too costly ("people are not actually going there [the private hospital], because of the cost"[193]), while crowding out support and motivation to assure good quality in the public healthcare system. For instance, it was articulated that doctors in public facilities would ask patients to come back later to see them in their private clinics, where they then provide services to patients privately at a higher rate. Another example is that government-financed drugs are being channelled into private healthcare centres, where they are being sold at a higher price. One FGD participant stressed that:

> It is better the government [does] something to improve their facilities. But it is worse still for them to supply drugs and the drugs are dumped or shared to their private hospitals, and they abandon the government hospital which the poor people patronize more. Just like my sisters have said, the drugs brought by the government that should have been sold for five hundred Naira here, they will have the drugs, but they will lie that they don't have it and will refer you to their private facility and when you get there, they will call a huge amount of money to you. And they will even have the drugs they claimed they don't have in the government facility.[194]

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[191] FGD 6; 20/02/2019.

[192] Interview 22; 07/03/2019.

[193] FGD 9; 11/03/2019.

[194] FGD 1; 19/02/2019.

On the contrary, the support provided by **not-for-profit** private institutions to the healthcare system, notably at PHC level, is appreciated as, for instance, a stakeholder working with a CSO accentuates:

> So, I don't think we should see private health facilities as people that should be excluded. After all, they are caring for the citizens. Some may be there for profit, but there are a lot of privately-owned facilities that are not there for profit, like the missionaries, and the faith-based ones, they are also private in a sense, they are not state actors.[195]

In summary, the preference of the respondents seems to be that the private sector should step back from providing its own (costly) services, but should support the government in delivering healthcare via the public healthcare system. This was clearly articulated by communities in, both, Anambra (respondent A) as well as in Enugu State (respondent B), where private healthcare provision is rampant:

> *Respondent A:* So that it will not be that we must go to a private hospital and get the health care. When you come to the government hospital, you don't see drugs until you move out to private hospital before you get it. If the government can assist the hospital and equip the hospital with the necessary drugs and necessary equipment, like when you go to Amaku and you want to do a X-ray, you will have to go to a private hospital, whereas this is a general hospital that is supposed to have it, so that is the areas that the government can assist us.[196]
>
> *Respondent B:* I think they also need to look well into the doctors that open private hospitals. In my opinion, I would advise they even shut down all these quack and mushroom hospitals everywhere, because some of them open the facilities at their backyard and be doing what they want. So, they need to look into it and close down such hospitals, while they **promote the government hospitals**, because if they do not close down such hospitals, people may not regard government hospitals at all, **but that is when the government has accepted to take care of the ones owned by them**.[197]

This discourse, however, differs significantly from the prevailing opinion raised of Government officials, where the basic tenor, here citing a LGA official, is that:

> **There is no way that Government facilities will provide everything**. The private sector has a role to play but should be strictly monitored by Government agency. Should be strictly

[195] Interview 36; 20/03/2019.

[196] FGD 9; 11/03/2019.

[197] FGD 1; 19/02/2019.

> monitored. Because if it is not strictly monitored, certain things that are not conducive for health may be going on, and we may not know.[198]

This was re-emphasised at State level, with one State Government official highlighting that they are in the process of further intensifying their collaboration with the private sector (for service delivery) as part of the on-going health reform initiated by the NHAct:

> We did the initial assessment. We are thinking of using a focal facility in each of the wards, political wards in the State. That is about 274 focal facilities. And then there is also this provision to also use the private health facilities. So, we were thinking of about 20 percent of the 274 will also be the private facilities.[199]

The view that the Government "can never finish all of it" was also perpetuated in conversation with Federal officials, with one interviewee highlighting that the private sector is "very involved in this. Because the intervention from the design and even in the implementation will be using both public and private health facilities".[200] Also, interviews with stakeholders working at donor agencies and with civil society organisation showed an inclination to facilitate the participation of the private sector in "the provision side in the States" and emphasised that, since private sector delivery is so widespread, it is a requisite to have the private sector facilities continue supporting healthcare delivery.[201] One interviewee stressed that "I don't see what they're going to do with those type of States, if they're not enrolling the private sector, cause the private sector is really buoyant there".[202] Another interviewee similarly voiced that "the missionaries and in fact the catholic missionaries brought health care to Nigeria. Right, it is on record. And up until today the private sector plays a very large role. … what it means is that private sector has a very large role to play in terms of service delivery".[203] This was similarly echoed by another interviewee, active in the CSO space: "we just have to involve them. People have more confidence in private facilities".[204] At the same time, many interviewees emphasised other important roles that the private sector can/needs to play, including providing

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[198] Interview 28; 12/03/2019.

[199] Interview 30; 16/03/2019.

[200] Interview 38; 22/03/2019.

[201] Interview 41; 25/03/2019.

[202] Interview 44; 27/03/2019.

[203] Interview 48; 03/04/2019.

[204] Interview 37; 21/03/2019.

financial support to the BHCPF – "when I talk about the private sector, it is their money we need"[205] – as well as supporting the establishment of a functional insurance system and supporting drug and commodities procurement and supply.

For-profit private healthcare practitioners welcomed stronger collaboration with the Government and a larger role for them in healthcare service delivery, seeing it as an opportunity to boost their profits, while expanding access to care to Nigerians:

> They are partnering with us here, subsidising the care for patients who are able to come and use here. When theirs is out-of-service, people will just come here, and … all we say is: how much would you have paid at the teaching hospital? 20,000? Bring the 20,000, we will just cover it. Government, at the end of the month, [would reimburse] us. Yes![206]

The same doctor, who is working at a private clinic in Enugu State, emphasised that if the Government would extend its support to private facilities, this would help curb medical tourism and would stop Nigeria's wealthy elite to fly abroad, in turn, raising more income:

> And, like I said, it will help curb that health tourism. People will not want to be going out again, because there are private hospitals that can run certain things and Government is helping them boosting their ability to run those things, at good rates. Good rates, across the board.[206]

Still, a project manager at a for-profit HMO, who has vast experience in partnering with private healthcare service providers, concedes:

> If it is a PHC [facility] sponsored and supported by the Government, then you can say that the patient alone is at the centre and the core, since the Government takes care of reimbursement of the staff, reimbursement of the drugs, and fixing of the equipment and fixing of all necessary resources. But if it is from the privately paying hospitals, owned by private individuals, you will see that there might be some problem. Because profit begets sustainability. So, that means, there may be a problem and that will be one of the challenges.[207]

So, while on the surface a strong discourse that "the Government cannot do it all alone" prevails, views on the role of the private sector in Nigeria are more nuanced and can be summarised as follows. First, the majority of participants in focus group discussions (i.e., community members, village heads, members of ward development committees, etc.) were wary of the high cost at for-profit private

[205] Interview 43; 27/03/2019.

[206] Interview 20; 07/03/2019.

[207] Interview 24; 08/03/2019.

healthcare facilities, but still frequent them (if they can afford to do so), because public facilities may not be well-staffed or -equipped and/or require co-payments for expectedly worse service delivery. There is limited trust that the Government can enable access healthcare at community-level for the better, without tapping into philanthropy and donor- and private sector funding. The understanding is that the Government cannot assure access to quality healthcare services on its own, but should aim to strengthen its delivery system with the financial/in-kind support of the private sector. For-profit private sector healthcare delivery is not celebrated, as it is recognised as costly and is drawing away attention from improving the public healthcare system. Second, there seems to be a disconnect between the prevailing view within the community and the views of different stakeholders within Government, the international community and formally organised civil society. The latter groups' starting point is the current dominance of the private sector in healthcare service delivery, being the basis for the notion that the Government, going forward, cannot deliver healthcare services on its own.

4.1.3. Health and healthcare: a priority in a complex political economy setting?

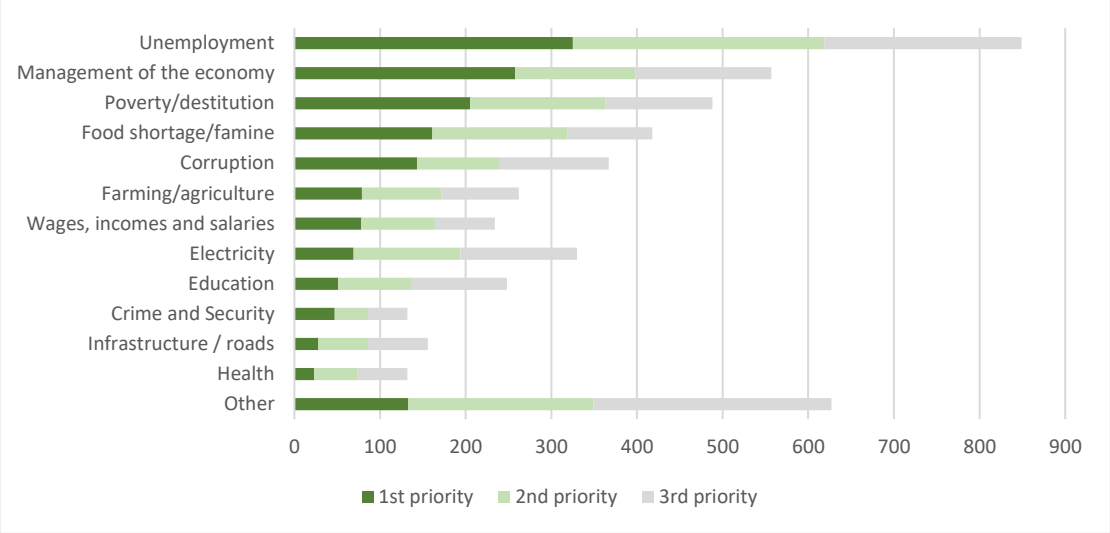
In 2018, Afrobarometer conducted the 7th round of its pan-African surveys, evaluating public attitudes towards democracy, governance and society. 1,600 respondents across Nigeria were asked to indicate what they deem is the most important problem, requiring the attention of the Nigerian government. An analysis of the available data shows that, in 2018, more than half of Nigerians (53 percent of respondents) identified unemployment as a major problem requiring government attention; according to the survey, 1 in 5 Nigerians think that addressing unemployment is the **most pressing** issue (see Figure 45). "Health" has been identified by 1.4 percent of respondents as the most important problem; 8 percent of respondents mention health in their top three. A 2016 stakeholder opinion survey conducted by the World Bank, asking respondents to indicate their top three most important development priorities for Nigeria, paints a similar picture, with only 16 percent of respondents mentioning health.[208] And, a more recent opinion poll conducted in December 2020 shows that health *per se* is not one of the top areas that Nigerians want the government to focus its attention on (see Figure 46).[209] Areas such as security, education, the economy or infrastructure take precedence. In this regard, four key points can be made: first, more tangible projects (such as road infrastructure) receive more attention than an intangible target such as "improving healthcare";

[208] The report is online available: http://documents.worldbank.org/curated/en/2016/09/26823595/fy16-nigeria-country-opinion-survey-report (last accessed 11/02/2021).

[209] Data is based on telephone interviews of a nationwide sample of 1,000 randomly selected (phone-owning) adult Nigerians across all regions of the country; see: https://noi-polls.com/new-year-poll-result-release-2/ (last accessed 10/02/2021).

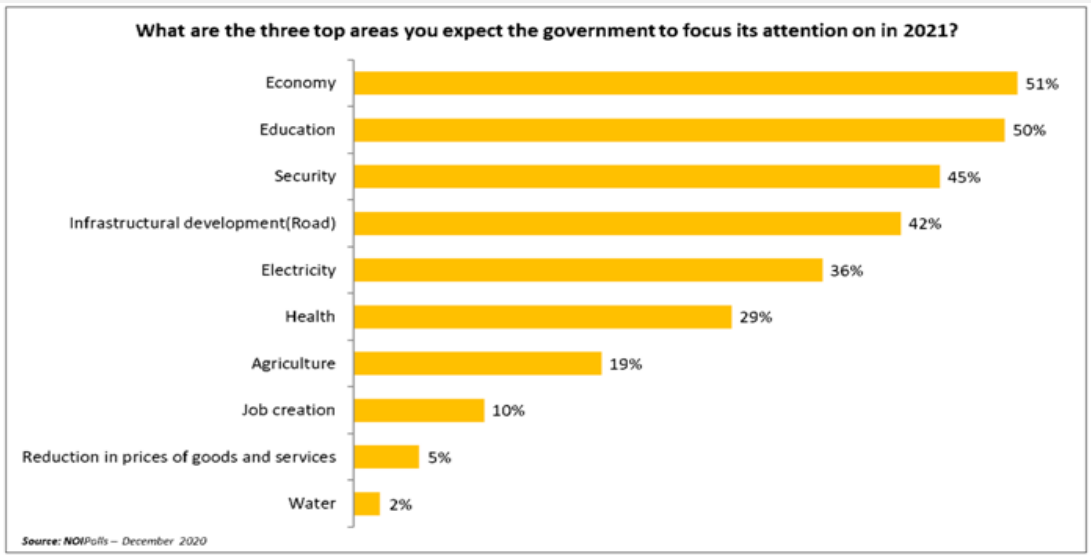
second, health is tendentially considered to be a “female domain” but women’s opinions are of lesser importance in a patriarchal society; third, especially Nigeria’s many security challenges distracts from other domains of social life; and, fourth, Nigerians show concern and appear frustrated with the inequity in access to healthcare in Nigeria. Let me address each in turn.

Figure 45: In your opinion, what are the most important problems facing this country that the Gov. should address?



Own illustration on basis of an analysis of Afrobarometer data (2017)

Figure 46: Healthcare not a top-five priority in Nigeria for 2021



Source: NOI Polls, December 2020

First, the notion that healthcare is less important than more tangible areas of concern was echoed in several interviews conducted during my field research. For instance, a high-ranking official within the FMOH supports the view that health is not seen as the most important priority in Nigeria:

> Typically, health is, at least in sub-Sharan Africa, not your number one or number two priority. Because also it is intangible – the results, right? If I tell you that I have deployed 400 million to build a road, you can say that this is the road, it is 16 km [long], the grading is XYZ. Or we spent 100 million and then we were able to reduce maternal mortality. Sorry, what does that mean? Do you get [it]? And, more important[ly] is that it takes a bit of time. It is not a two/three years, it is a five/ten years-landscape that we are talking about. So, health requires a little bit more patience … to demonstrate results … If you are going to engage somebody in Finance and Budget and National Planning … you really want to show what success looks like [and you need to] move away from [highlighting that] "we have now bought 400 bowls, or we bought 5000 anti-malarial drugs". You need to move into "we have treated … 600,000 patients, we delivered one million women". Those are numbers that anybody can probably verify. And it makes sense to them. So, I have spent 55 billion and they have been able to address 60 million people for XYZ. Then it makes sense.[210]

Similarly, a former Government official, now working at a UN agency, highlights how health is not being "marketed" the right way:

> It is difficult to say that it is ideology that is challenging our fashion of UHC. It is very difficult. It is very difficult to say it … It is a matter [of] not being [a] priority to the Government. It is an issue of prioritisation. Will the Government prioritise UHC above the security and funding the army? Will you prioritise it over infrastructure and all those [other areas]. And again, it is the poor knowledge of actually the benefits of UHC ... The way we market health is wrong … We need to market health as [product] with a return on investment. When we sell it as a consumption good, the Ministry of Finance will not like to fund it ... So, one way to go about is that we need to develop key messages, using very strong analysed data, showcasing health as an investment that is increasing GDP actually.[211]

And, a budget officer working in the office of the Senate President, highlighted the issue of "competing priorities" stating that:

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[210] Interview 47; 29 March 2019

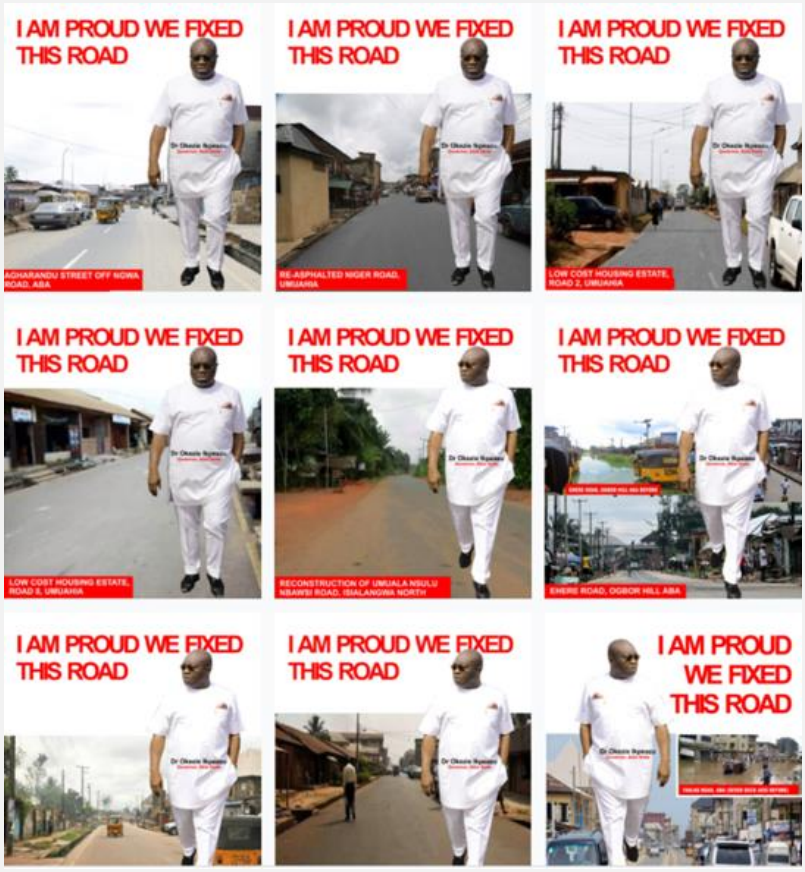
[211] Interview 1; 30 January 2019.

> Actually, when the budget is released – because, you know, short for the revenues and all – we tend to have priority projects, which are paid attention to. Priority projects like the construction of roads, you know, power, all of this that will enhance the economy. These are priority projects that the Government looks at, when there is shortfall of revenues.[212]

Figure 47 (anecdotally) demonstrates that, for example, "building roads" seems to be perceived as a better strategy to win the support of the electorate. This corresponds to a comment made by a member of a civil society organisation, stressing that politicians have their own priorities, and in the case of change of power at government level, priorities thus change:

> Because State Governments have priorities. In some of these States power may change hands, new Governors are coming into place, they may not take this as a priority for them. So, there may also be delays from that angle.[213]

Figure 47: "I am proud we fixed this road"



Source: Website of the Government of Abia State (https://abiastate.gov.ng/projects/)

[212] Interview 40; 24 March 2019.

[213] Interview 37; 21 March 2019.

Second, a culture of patriarchy and the ensuing social division of labour have been identified by feminist scholars as highly relevant to justice and public health ethics. For instance, Rogers (2006, p. 353) stresses the importance of considering the distribution of power across all processes of public health, including health policy making, and emphasises that "many preventive aspects of public health occur in the domestic sphere, such as diet, exercise, and regulation of children's activities. The domestic sphere is traditionally the area for which women are considered responsible". This seems also true for Nigeria and extends to a general responsibility of women for (child) health more broadly. In Nigerian society, gender expectations prevail and provide material advantages to men and also mean that their opinions count more (Aina, 1998; Makama, 2013). This was raised in an interview as well:

> It's not only in Nigeria, it's just that [health] is often seen as women's issues, which I'm not sure why. I think the idea of care is often associated with women and it's true that in Nigeria, it's usually women who would take the children to the doctor and so on … I would definitely think that if it's seen more of a "man-issue" it'd be a priority. I guess men also have health issues in Nigeria. There's also the problem that this society is so patriarchal, so men always have to show that they're strong. So, if you have health issues then you're kind of weak and that's probably more for women.[214]

This has been reiterated in FGDs conducted with different groups. For instance, one woman stated:

> My reason is that times are hard now, and like my sister has said, most women are responsible for virtually all financing in their households, some men are not even bothered about all these, and the woman will not abandon her child like that. But the man may leave and go to bar to enjoy himself, and when everything calms down, he will come back, but the woman will be there from morning till night. At times, some women will not even sleep because they are either attending to pregnancy stress or to a sick child.[215]

Another person highlighted that:

> we lack a lot of things, because the community people are seeing this health center as women and children's health care because when we come, we actually don't have a doctor and when somebody comes to a hospital and you see only the nurses, you may feel that this place is not

[214] Interview 45; 27 March 2019.

[215] FGD 2; 19/02/2019.

capable to take care of you, that is why you will see some of the members of this community who are sick going outside to attend to their health need.[216]

The third important feature of Nigeria's political economy is its multiple security challenges and their effect on the country's prospect for development. Since 2009, the Boko Haram sect, under the leadership of Abubakar Shekau, has been increasing its insurgency operations in the North of Nigeria (being mainly active in the North Eastern States of Nigeria, but also having conducted attacks in the North-West, Abuja and neighbouring countries).[217] In some Northern States of Nigeria, Boko Haram stepped in as a social service provider and created a parallel system, undermining and subverting state-led social delivery systems (Dele-Adedeji, 2020). At the same time, in the States of the North-Central region, a herder-farmer conflict intensified over the last years, with a rising number of disputes over access to natural resources and/or land, e.g. to allow livestock to graze on farmland (NBS and World Bank, 2018). In the South-East region of the country, tensions between secessionist movements, such as the Movement for the Actualization of the Sovereign State of Biafra (MASSOB) and security forces persist, while militancy groups continue to display their frustration with oil-drilling activities in the Niger Delta in the South-South region (e.g., in the form of killings and/or kidnappings of workers of international companies). In addition to terrorism, disputes over land and resources and ethnic frictions stemming from the legacy of colonialism (see Figure 48), criminal activity including banditry, armed robberies and kidnappings for ransom occurs in many parts of Nigeria. As a result, Nigeria was added to the list of fragile and conflict-affected situations in 2020.[218] Furthermore, more recently, in October 2020, enduring violence against the civil population by security forces as well as rampant frustration with the lack of opportunity within Nigeria sparked protests across the whole of Nigeria (and the diaspora).[219] The movement, known as the #EndSARS [Special Anti-Robbery Squad] movement, was brought to an end, when the army was ordered to Lekki tollgate in the city of Lagos, where they opened fire on peaceful protesters, killing at least 12 people. [220]

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[216] FGD 9; 11/03/2019.

[217] Since 2009, more than 40,000 fatalities have been reported; see: https://acleddata.com/crisis-profile/boko-haram-crisis/ (last accessed 10/02/2021).

[218] Nigeria is classified as a medium-intensity conflict; see: http://pubdocs.worldbank.org/en/888211594267968803/FCSList-FY21.pdf (last accessed 10/02/2021).

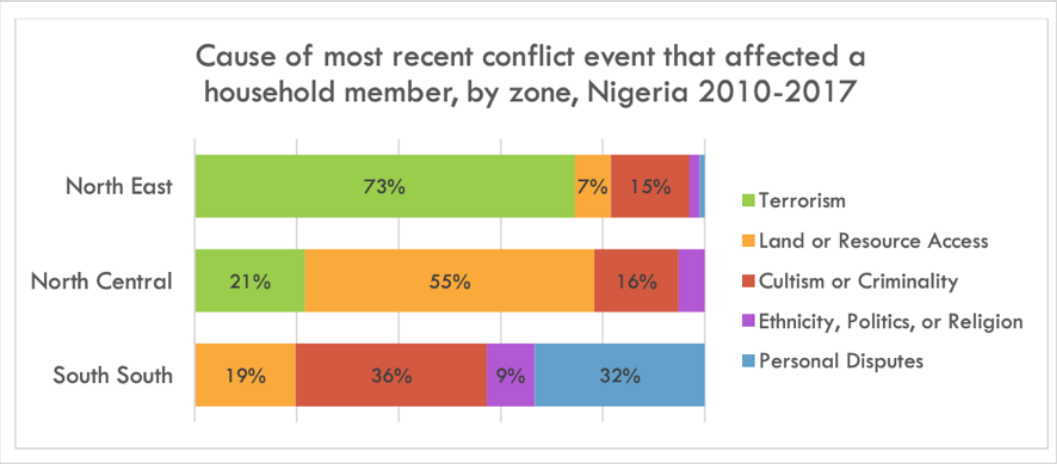
[219] See, for instance: https://www.boell.de/en/2020/10/23/endsars-protests-might-be-birth-new-nigeria (last accessed 10/02/2021).

[220] See: https://www.amnesty.org/en/latest/news/2021/01/nigeria-denials-and-cover-up-mark-100-days-since-lekki-shooting/ (last accessed 10/02/2021).

Security concerns, therefore, are a main feature of Nigeria's political economy and impact access to and delivery of social services, including of healthcare, as nicely summarised during an interview:

> And, they [the Government] could make a case that is very compelling: for instance, security is one area that Nigeria has been challenged with lately. Think of Boko Haram, kidnapping, banditry, herdsmen... All those things continue across different areas of Nigeria. So, when they have issues of security, they tend to have a very good excuse to go into the budget of social services and divert that to make sure that there is law and order and stuff like that. There is a balancing act, or trade-offs, if you ask me, from the Government. You tend to sympathise with them, but then you also question why it is social services that have to suffer more, instead of other things. Why don't they go to that road construction and buildings? Why do you focus on the school feeding or the immunisation services?[221]

Figure 48: Causes of conflict affecting households in Nigeria



Source: NBS and World Bank, 2018

Forth, concerns of equality and social justice more broadly also inform the meaning Nigerians attach to healthcare, with Nigerians appearing frustrated with the inequity in access to healthcare. This sentiment is reflected in a comment made by a respondent of a FGD conducted with members of the Health Facility and Ward Development Committees in a small town in Enugu State:

> What I am trying to add is that Nigeria should throw more of their weight in health, this is very important, if they want to do allocation, let health take a reasonable amount of money because it is somebody that is alive that will enjoy his money, so if they are doing their budget, they

[221] Interview 2; 20/01/2019.

> should put health in the first or the second priority because it is very important. And the government of Nigerian should know very well that many of them … are … usually flown abroad when they are sick, to London or America to go and access medical treatment and [then] come back to Nigeria. **They should put every other person in their shoes, that it is not everybody that has the money to go to London or America to access medical facility**, so if Nigerians can equip their own hospitals, they don't need to go to London or America.[222]

Another FGD participant, conducted with a women's group, also highlighted the prevailing problem of health inequity in Nigeria, stating that:

> They can't do it because they don't do the things they are supposed to do, they are not sincere. Even if they say they will do it, they will end up not doing it, and even if they start, they will not do it the way they are supposed to. And even when they start, they will still make it available for only they, the rich, and their families that will benefit from it, **it will not get to the poor masses**.[223]

This relates to what e.g. Mooney (2009, p. 45) stresses, namely that "often informed citizens demand more than simply 'health' from their health care services". This view is echoed by Mackintosh and Koivusalo (2005, p. 6), who stress that a health system's performance cannot be measured exclusively in terms of health outcome, but "health services must aim for universality of access according to need, and solidarity in provision and financing, and that health systems should be judged against these objectives. Solidarity here is about robust redistribution and cross-subsidy to sustain access on the basis of need.'' Therefore, the attention of a healthcare system should not only be on assuring the efficient use of resources to facilitate changes in health status of the individual, but needs to include concerns around equity and social justice (Birn et al., 2017). Improving health may still be a priority, but it goes hand in hand with the demand of assuring health equity – reducing health differences, which are the result of economic or social disadvantage (Braveman, 2014). As Birn and colleauges (2017, p. 550) put it, "[i]n the end, any tradeoffs that seek to pit equity against either efficiency or overall health improvements are fallacious: the more useful challenge is developing an efficient health care system that is also equitable (*and* leads to overall health gains)."

This furthermore demonstrates the importance of deploying a social justice/political economy approach to health systems research more broadly and highlights, at the same time, one of the limitations of my study and the boundaries that I have chosen to draw. In this sense, and as the SoP

[222] FGD 5; 20/02/2019.

[223] FGD 2; 19/02/2019.

approach suggests, it is important to focus on underlying causes, structures and processes of ill-health and disease as well as the linkages between health, other social dimensions (such as housing, education, clean water, etc.) and the economy. Having this in mind may help explain why "health" as such is often not singled out as the top priority, but closely interwoven aspects of life – such as better infrastructure, allowing people to get to work; electricity and clean water, improving people's living conditions; or equal opportunity to access employment and education, allowing people to live decent lifestyles – are, as they have a valuable impact on the quality (and length) of people's lives.

5. Conclusion

In this chapter, I have sought to lay out several important features that characterise the state of health and healthcare in Nigeria. These can be summarised as follows:

First, I showed that health outcomes in Nigeria are poor. At the same time, health inequities are extensive and people living in certain States, coming from lower socio-economic backgrounds and with less educational opportunity are the worst off. Also, income/wealth levels influence where a person seeks access to healthcare. While richer people tend to seek healthcare in higher-quality private facilities, in the absence of a functional public facility, the poorest have no option but to seek support in low-quality private chemist stores or smaller, unregulated practices.

Second, I provided an overview of how the Nigerian healthcare system is constituted and funded. Most notably, in a first step to operationalise my SoP investigation, I highlighted the key agents that operate directly within the healthcare system of provision or the policy sphere that it is embedded in. While there are a range of social determinants that impact the health of individual Nigerians, the healthcare system itself contributes to existing social inequalities. Two key factors for this are low levels of public funding to healthcare and an unclear distribution of roles and responsibilities within the Government-run healthcare system. States and Local Governments are, in principle, in charge of managing and delivery primary healthcare, releasing the Federal Government of its responsibility to guarantee the right to health to all Nigerians. Nigeria's fiscal federalism implies, in practice, that different States allocate different levels of financial resources to healthcare. At the same time, the Federal Government – overall – spends little on health, requiring households to take care of their healthcare needs themselves, which, for many, is an additional burden. Households, then, often have to resort to accessing primary healthcare via the private healthcare system, which oftentimes is more expensive, but also not necessarily of good quality. As a consequence, levels of impoverishing out-of-pocket health expenditure are high and large segments of service provision are privatised.

Third, and in line with the SoP approach, I have outlined how the material culture attached to the consumption of healthcare in Nigeria gives rise to a specific set of norms of healthcare consumption,

by having shed light on some of the existing norms and patterns of healthcare consumption in Nigeria and public attitudes towards health and healthcare. I emphasised that the financial barriers to accessing healthcare are considered the main burden to healthcare use in Nigeria. Moreover, I have stressed that a narrative, hailing stronger collaboration with the private sector as the solution to improving healthcare service delivery, prevails, but with its nuances. While communities communicate the belief that the private sector needs to financially support the Government to improve public service delivery, the Government, in particular, is of the view that the private sector needs to continue taking over part of its service delivery responsibility, albeit amidst better regulation. Lastly, I highlighted that Nigerians' view on healthcare tends to be influenced by the many "competing priorities" alongside healthcare, which, characterise today's Nigeria.

The 2014 National Health Act, if properly implemented, is anticipated to improve health outcomes. It seeks to reform Nigeria's healthcare system and to make more funding available for ameliorated service delivery, notably through the implementation of the BHCPF. The passing of the NHAct as well as the potential to deploy it as a driver for change, however, need to be understood in the broader context of health policymaking in Nigeria. The next chapter turns to an analysis of social policy trajectories in Nigeria and sheds light on the development of the National Health Act. For this purpose, the SoP approach allows me to draw particular attention to the relations between agents, structures and processes that have contributed to key contestations during the policymaking process.

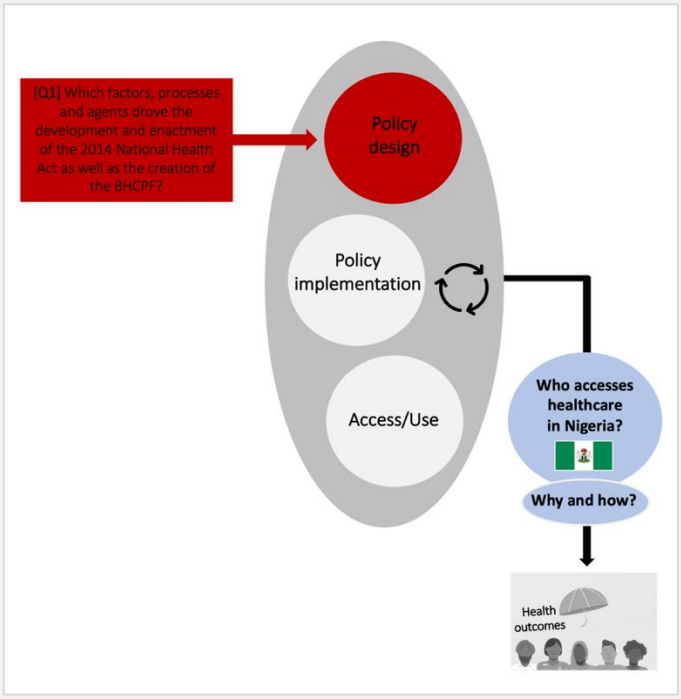
CHAPTER 5 | Interrogating health policymaking in Nigeria

1. Introduction

This chapter addresses the broad question of which underlying dynamics affect health policy design in Nigeria. Concretely, this chapter analyses and discusses how different priorities of, and relations between, agents as well as the meaning they attach to healthcare consumption (as documented in Chapter 4) affected the process of designing the National Health Act (see Figure 49). Today, the NHAct is the principal legal framework, steering the operation of the Nigerian healthcare system of provision. At the same time, the way the Nigerian healthcare SoP itself operates (and has operated over time) underpinned and pre-conditioned the genesis of the NHAct.

Efforts to reform Nigeria's disjointed health system have been long-running and, as demonstrated in the previous chapter, there have been some gains. Yet, health outcomes in Nigeria have failed to improve substantially and regressive out-of-pocket healthcare expenditures remain consistently high contributing to health inequity. This has been acknowledged by Nigeria's Government and, in March 2014, the then-President of the Federation, Jonathan Goodluck, pledged the administration's commitment to make quality healthcare accessible to all Nigerians and to strengthen mechanisms to protect the Nigerian people from financial hardship relating to health expenditures. A few months later, the NHAct was adopted.

Figure 49: Designing the National Health Act



Source: Own illustration

While the enactment of the NHAct can be considered an encouraging milestone, health policymaking in Nigeria is a complex process. It is affected by a variety of stakeholders with different degrees of power. In this chapter, I assess the effect of interactions between agents, structures, processes and norms on policymaking, analysed from a historical perspective. This is done on the basis of the material that was collected through fieldwork interviews and FGDs. By way of a SoP analysis, I place the genesis of the NHAct within the country's socio-economic, political and historical context and identify four principal structures and processes that have had a significant effect on Nigeria's health policymaking trajectory, including the design of the NHAct. These are the following:

- First, Nigeria's **federal character** has impacted health policymaking since before independence and severely influenced the final text of the NHAct. The organisation of Nigeria as a Federation has meant that State Governments have objected to the concentration of power at the Federal level and insisted that the NHAct would not infringe on their autonomy. At the same time, **election cycles** have meant that changing compositions of the National Assembly have distorted and delayed the process of adopting the NHAct.
- Second, the **socio-economic context of Nigeria**, at different points in time, has significantly impacted the volume of resources put towards social policy more broadly, and health policy in particular. Until the 1980s, oil revenues were used to fund public healthcare delivery systems. However, in the run-up to the enactment of the NHAct, volatile global oil prices, paired with low levels of tax income, made the Minister of Finance wary of the financial implication of committing a higher share of the public budget to funding healthcare.
- This leads to the third point, which is that the NHAct, with its emphasis on **private sector participation**, is the result of path-dependency. Since the mid-1960s, private healthcare providers were able to lobby against a mandatory health insurance scheme and for their inclusion in the publicly funded social insurance scheme. The attachment to the private sector in healthcare service delivery was further fueled by the emergence of neo-liberalism in the late 1970s as the dominant ideology in global policymaking. Both these factors contribute to today's prevalence of private healthcare providers and explain the role of Health Maintenance Organisations as private agents in the implementation of the NHIS. The NHAct was markedly influenced by interests in the private sector and the prevalent opinion that the private sector is needed to improve healthcare delivery in Nigeria.
- Fourth, and intertwined with the (global) ascendancy of neo-liberalism since the late 1970s, the **conception of what UHC should look like in practice** has, also in Nigeria, shifted away from assuring access to a broad range of necessary healthcare services (universally and for free) to providing a selective package of healthcare service. The inclination in Nigeria to rely

on private sector healthcare provision and a general distrust in the capacity of the public sector, including from within Government, are reinforced by leading agencies within the international community promoting a distinct set of ideas of what an equitable healthcare system should look like. Correspondingly, the NHAct proposes the provision of a Basic Minimum Package of Health Services. The small amount of funding reserved for its provision, as per the NHAct, makes it furthermore likely that its provision will be targeted at certain groups of the population (as will be discussed in detail in Chapter 6).

Figure 50 schematises the core context-specific structures and global processes as well as the agents, norms and patterns that affect the health policy landscape in Nigeria, which provides the eco-system within which the Nigerian healthcare SoP materialises. In the following sections of this chapter, the relations between these depicted agents and the contestations that the system gives rise to are discussed in detail. I explore the history of health system reform in Nigeria, highlighting how imperatives to institutionalise social policy, with healthcare provision at its core, have developed over time.[224] I analyse the progression of relevant health policies in Nigeria, including the newest law, the NHAct, and embed these in the broader context of evolving ideologies, policy discourse and practices of social service provision. I emphasise how Federalism in Nigeria and the country's economic performance, largely influenced by the inconstant profitability of crude oil sales, had an impact on health policy reforms. Moreover, I highlight the authority and relevance of private sector actors over time and describe how neo-liberal thinking furthered the privatisation process of Nigeria's healthcare system. I identify three major episodes to guide my analysis and proceed as follows.

In section 2, I address intentions and motives for health policymaking during the period of colonial rule and the first two decades after Nigeria's independence. Especially, in the years leading up to independence in 1960 and in the first few years after independence (prior to the on-set of the first military junta in 1966), Nigeria's regional governments were determined to provide social services to their people. Notably, economic and social policymaking in Nigeria's Western region between 1953 and 1961 has been hailed as a success story and is illustrative of African leaders' commitment to invest in their citizens, to enable them to contribute to their country's development (Adésínà, 2012, p. 286). Also, throughout the 1970s, the social policies put forward by Nigeria's (civilian and military) Governments envisaged the expansion of social service provision with the aim of fostering national unity.

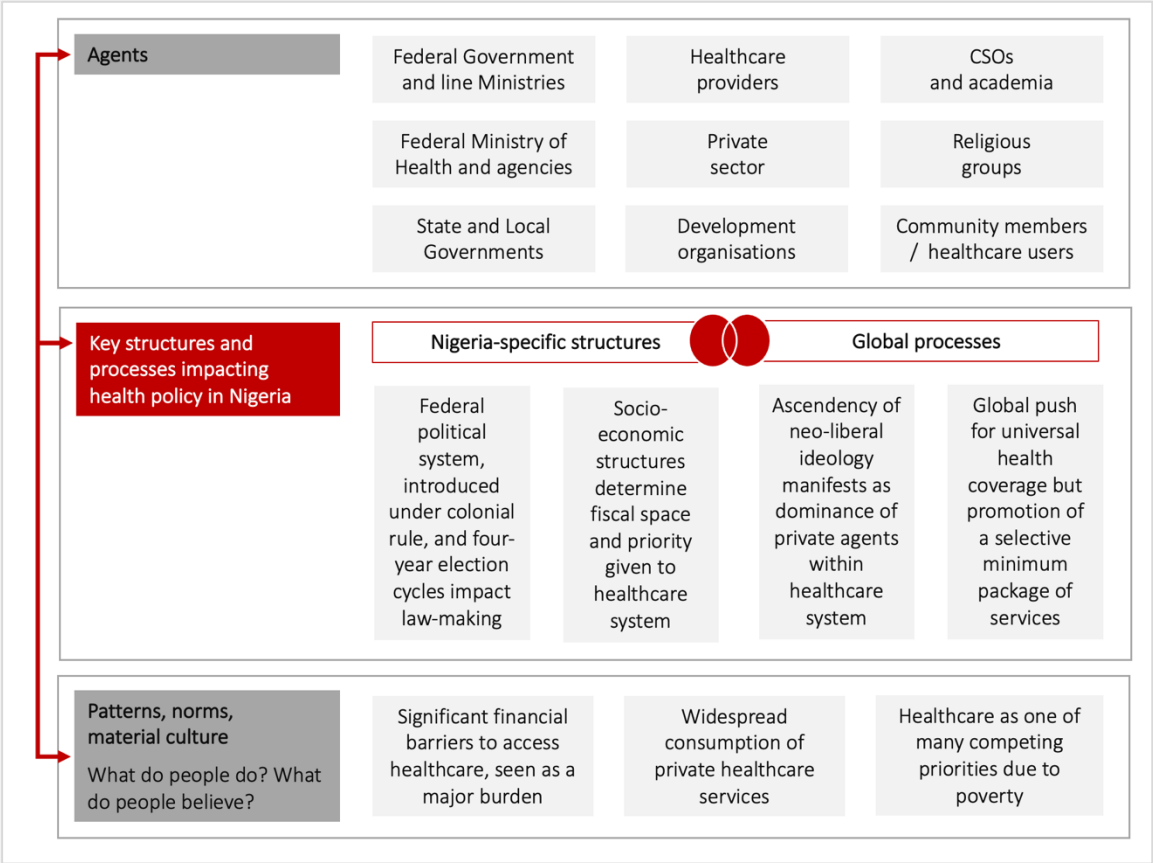
[224] Appendix L summarises the key health policy milestones in Nigeria as well as the political events that embed them.

In section 3, I turn to health policymaking form the 1980s onwards, a period characterised by the ascendency of neo-liberalism. While (free) public service provision had expanded after independence, public spending decreased subsequently and user fees for health services were introduced in Nigeria as part of neo-liberal reforms promoting fiscal consolidation and privatisation (Orubuloye and Oni, 1996). In Nigeria, the spread of neo-liberal ideology coincided with a massive reduction in revenue inflow due to declining global oil prices. This translated into significant cuts in Government social spending, weakened the country's public health infrastructure and provided grounds for arguments against the public and for the private sector (Adésínà, 2012, p. 305). Also, after the failure of neo-liberal stabilisation and adjustment programmes had become apparent in the 1990s, policymaking continued to be subjugated to a heavy emphasis on strengthening the role of the private sector in social sectors.

It is against this broader historical backdrop of changes in social policymaking that the development of the 2014 NHAct need to be understood, which is part and parcel of section 4. In section 4, I examine the more recent developments that led to the enactment of the 2014 NHAct. Once more, the complexity of policymaking processes is highlighted, showcasing how the distribution of power across various stakeholders in Nigeria influenced the design of the NHAct. I outline how agents and interest groups such as the Minister of Finance, the President, the organised civil society and its allies, development organisations, religious groups and government officials within the Federal Ministry of Health and its parastatals, used their position to curb or impel the enactment of the law. I once more highlight the States' role, as federating units, in influencing the NHAct.

Section 5 concludes and recapitulates the channels through which different agents, affected by surrounding structures and processes, influenced the Nigerian health policy landscape.

Figure 50: Schematic of agents, structures, processes & norms affecting health policy studied through a SoP lens



Source: Own illustration

2. From colonial health policymaking to healthcare as an investment by Nigerians for Nigerians

Nigeria's healthcare system has been subject to manifold transformations, ranging from more traditional forms of healthcare provision, making use of locally available remedies for disease prevention and treatment, to "westernised" forms of healthcare service delivery (Adefolaju, 2014a; Orubuloye and Oni, 1996; Schram, 1971; Scott-Emuakpor, 2010). According to some scholars, "the earliest form of modern medical services in Nigeria was introduced by various European explorers", but only with the spread of church missionaries, notably the Roman Catholic mission, Anglican church missionary society and the American Baptist mission, these forms of healthcare services became accessible to the Nigerian population (Ogaji and Brisibe, 2015; Schram, 1971). In 1880, a first dispensary was established by the Church Missionary Society in Obosi, and the first hospital in Nigeria, put into place by the Roman Catholic Mission in Abeokuta, started its services in 1885. In 1889, the Nigerian Government built its first hospital, St. Margaret's Hospital, in Calabar (Ogaji and Brisibe, 2015, p. 80). At the same time, European settlers disapproved of traditional medicine and labelled its practitioners "witch-doctors" (Adefolaju, 2014a, p. 121). Traditional forms of medicine were further

ostracised when Southern Nigeria formally became a British protectorate in 1901,[225] which in 1914 amalgamated with Northern Nigeria to become the "colony and protectorate of Nigeria" (Adefolaju, 2014a; Adésínà, 2012; Anyanwu, 1982).[226] While church missionaries made some health service available to the Nigerian people, the British colonial government paid limited attention to expanding medical services to the general population (Nkwam, 1988, p. 321).

This only slowly started to change from the 1930s onwards. Notably, on basis of the 1929 Colonial Development Bill, the British provided some aid to colonial development, as, both, "its duty and its interest" (Bourdillon, 1944, p. 370). However, the bill was considered inadequate to tackle colonial poverty from its inception (Bourdillon, 1944; Utietiang, 2015). Similarly, Wicker (1958, p. 178) assessed that the 1929 bill did not really diverge from the principle that colonies needed to be self-supporting. Moreover, as Walter Rodney (1981, p. 179) highlighted, economic crises and war time spending meant less resources for the colonies and "in all colonial territories, wages were reduced during the period of crisis". Only the passage of the Colonial Development and Welfare Act of 1940 – adopted as a measure of promoting capitalist expansion and in order to "inoculate Britain from the United States' critique of colonial rule" (Utietiang, 2015, p. 6) – resulted in some increased welfare funding for British colonies. As Onokerhoraye (1984) stressed, during the 1940s, welfare policies promoting the provision of education, healthcare and housing services (to some Nigerians) were introduced by the British administration to Nigeria to complement customary family support systems. The introduction of colonial development plans were aimed at providing basic support to the Nigerian population, while allowing the colonial power to continue to pursue its commercial and economic interests at the same time (Onokerhoraye, 1984, p. 4). Also Adeyeri and Adejuwon (2012) highlight that Britain's colonial policies were mainly designed to serve their own economic ambitions. And, while some resources were channelled from Britain to the colonies, there were restrictions regarding the use of these resources, reflecting the self-interested nature of the policy: "Grants in aid of educational projects, other than technical education were, for example, not allowed. …Three things are necessary in the producer if we are to have increased production; physical capacity, knowledge, and the desire to produce" (Bourdillon, 1944, pp. 372; 377).

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[225] A year later, the West African Medical Service was established (Schram, 1971) and in February 1902, it is written as follows in the British Medical Journal: "We are informed by Mr. Chamberlain, Secretary of State for the Colonies, that it has been decided to amalgamate the medical services of the British West African Colonies and Protectorates into a single service, to be known as the West African Medical Staff" (see: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2511964/pdf/brmedj08208-0031.pdf; last accessed on 10 October 2019).

[226] The Colony of Lagos had been incorporated into the Southern Nigeria protectorate in 1906.

As a consequence of the limited financial aid to the British colonies at the time, Nigeria's three regional Governments took to mobilising their own revenues (Adésínà, 2012, p. 291).[227] Notably, from 1954 onwards, regional governments were allowed to collect their own taxes (Rupley, 1981, p. 259). Moreover, as Salami (2011) highlights, prior to 1959, regional governments were allowed to retain 100 percent of their mining rents and royalties. At the same time, the Federal Government's grant to the regions become a statutory allocation based on need, national interest and derivation, rather than being a discretionary decision taken solely by the central Government.[228] Later on, the 1958 Raisman-Tres Commission made the "derivation principle" its main formula for the sharing of the nation's revenues (Akpan, 2011), elevating it over other criteria i.e. need or national interest.[229] The principle of derivation allowed regions that were mobilising higher levels of resources, to also benefit accordingly. Precisely, most of the total revenue mobilised by the regions were kept at regional level (50 percent), and only 20 percent went to the federal government to support its executive and legal functions while the remaining 30 percent were re-distributed (via the Distributable Pool Account, DPA) (Sarumi, 1982). As Rupley (1981, p. 259) explains, these developments meant that the central Government, at the time, was foregoing considerable amounts of revenue, while the imbalances between the regional governments exacerbated. All in all, while there was controversy around the distribution of resources via the DPA, notably as the North – allegedly more populous – was deemed to receive proportionally too little resources, the operationalisation of the derivation principle at that point in time meant that Nigeria's three regions enjoyed considerable fiscal autonomy and operated in a noticeable decentralised system. In a report on the role of State and Local Governments in Nigeria, the World Bank (2002, p. 5) summarises that "until the late 1950s regions retained a high degree of control over their revenues. ... The result is that as Nigeria approached independence, it consisted of

[227] Three regional governments (of the Northern, Western and Eastern region) had been instituted in 1939. The 1946 Arthur Richards Constitution reflected the federal character of the nation and the same year saw the institutionalisation of the Phillipson Commission, which decided to grant each of the three regions autonomy to mobilise its own resources and, to a large extent, to make use of it as it deemed best (Salami, 2011). The 1954 Oliver Lyttleton Constitution (which followed the 1951 MacPherson Constitution) solidified federalism in Nigeria, creating the position of Premier in the regions. See Suberu (2019) for an overview of the different constitutions in Nigeria.

[228] In 1946, the East received 24 percent, the West 30 percent, and the North 46 percent of national revenues (Ekpo and Ndebbio, 1996). In 1958, the revenue allocation of pooled resources in the DPA changed to 40 percent to the North, 31 percent to the West and 24 percent to the East and 5 percent to Southern Cameroons on basis of the principle of derivation, but also of need (Ovwasa, 1995, p. 75).

[229] The 1958 commission also made personal income tax a regional tax to further strengthen the regions' own tax base (Ahmad and Singh, 2003).

a federation of three autonomous political entities, each with a different ethnic base, and each with its own revenue base".[230]

The institution of the derivation principle by the colonial Government contributed to the different pace of development of Nigeria's regions, which also impacted healthcare service delivery. As Fine's theoretical framework suggests, access to a service is linked to the way it is provided, which in turn is impacted by global narratives, tendencies and the relationship between different actors involved in a provisioning system. In this light, as stressed in the literature (Bailey and Turner, 2002; MacLean, 2002; Mkandawire, 2016b), the impact and legacy of the diverse systems of colonisation have been identified as an important variable in explaining the variance of social policy trajectories across African nations, including in Nigeria. With reference to Nigeria, for example, Ananaba et al. (2018, p. 8) opines that:

> The health sector is also influenced by the legacy of British colonialism, under which the formal system provided better access to health in the South. The extension of healthcare in the post-colonial era followed the British-model centred on hospitals, doctors and treatment, with greater access in urban areas and poor provision in rural areas where trained professionals did not want to live.

Moreover, early negotiations in Nigeria over the form and scope of social policy are illustrative of the importance of understanding the relative power of different agents as well as their underlying motivation to promote one form of social policy over another. For example, already in the 1940s, views of colonial and of Nigerian leaders on the functions of welfare policy diverged and ideological discussions on what public social policy should entail emerged, including debates evolving around the question whether "social welfare [leads] to greater economic development or vice versa"(Utietiang, 2015, p. 9). Utietiang (2015, p. 10) continues:

> Smith's view [in charge of the development department] was based on the basic needs ideology […]. In order to unleash the productive capabilities of the colonial people, it was important that the populace be provided with basic needs. If the people were contented and prosperous, then you could require more from them and this would have a positive impact on the economy. On the contrary, Caine's view [financial advisor to the colonial office in 1942] was that the foundation of development was economic growth and productivity. Through these, resources

[230] While it is true that the three regions all had a dominant ethnic group (the Hausa-Fulani in the North, the Yoruba in the East and the Igbos in the East), at the time, the main political parties themselves were "regional" rather than "ethnical" parties, with all regions being home to Nigerians from many different ethnical groups (Adésínà, 2012, p. 288).

are produced that will allow the colony to invest in social services such as education, health, etc. The question is, what comes first: welfare or development? For Caine, it is development and for the Nigerian officials, it was welfare.

In 1951, the Action Group, led by Chief Awolowo, introduced free universal education and healthcare for children in Nigeria's Western region and adopted "democratic socialism" as its official party ideology (Ayoade, 1985, p. 171). In 1957, the Eastern and Western regions obtained the right to govern themselves, followed by the Northern region in 1959. While the two regions of the South were producing "scores of graduates and professionals … the North had produced hardly a single graduate and no more than a couple of professionals" (Awa, 1960, p. 101). Similarly, Falola (2004, p. 74) accentuates the emergence of regional disparities, with the South developing more rapidly than the North due to a higher number of people in wage employment as well as missionary influence. In particular, the Western region had implemented a successful social and economic programme (Adésínà, 2012). There, the government was committed to assuring universal access to publicly-funded primary education, in spite of limited fiscal space (Adésínà, 2007; Awolowo, 1960). In the East, Nnamdi Azikiwe (commonly known as Zik), having become Premier in 1954 of the region on the platform of the National Council of Nigeria and the Cameroons (NCNC), had inspired the emergence of the so-called "Zikist movement", committed to implement a similar welfarist and anti-imperialist programme (Abdulraheem and Olukoshi, 1986).[231] As Lynn (2002, p. 97) notes, Azikiwe was committed to drive economic development in the East without having to rely on the support of the British colonial office.[232] In the North, however, the conservative Northern Peoples' Congress (NPC), under the leadership of the powerful and conservative (and non-secular) Ahmadu Bello, known as the Sardauna of Sokoto, enjoyed the support of the British colonial power, who were explicit in their aim to supress any empowerment of the alternative political party, the Northern Elements Progressive Union (NEPU) led by Aminu Kano, keen to implement a more socialist agenda and more aligned with the political ideology of notably the South-West (Ochonu, 2017).

More generally, from the beginning of their invasion, the British had deemed the Muslim Hausa-Fulani people to be "better prepared for indirect rule" than the non-Muslims and "negroid autochthons of

[231] Initially, the NCNC was not really the party of the "East", but a party committed to bringing together Nigerians opposing British colonial rule. It was founded in 1944 in Lagos (in the Western region) by Herbert Macaulay, who became the party's first President, and Nnamdi Azikiwe, an ethnic Igbo from the East, who became the party's first secretary. Azikiwe only later went on to become Premier of the Eastern region in 1954.

[232] Lynn (2002, p. 96) further highlights that the Colonial Office considered Azikiwe to be the most "dangerous" leader in Nigeria, as he was committed to the project of radical decolonialisation.

the Middle Belt" and had built close ties with Hausa-Fulani Muslim "aristocrats" as their proxy in Nigeria (Ochonu, 2017, p. 233). The British's strategic interest to ensure that their long-standing and "more collaborative" Northern ally would lead the nation after independence was thus twofold: first, they were worried about socialist ideas emerging and gaining traction in Nigeria, similar to the successes of Kwame Nkrumah in neighbouring Ghana; and secondly, they were cautious of the more pronounced anti-imperialist sentiment in the South and hopeful to mobilise their close ties with the Hausa-Fulani to their (economic) advantage in the future (Adésínà, 2012). In this context, federal elections took place in Nigeria in 1959 with three major parties competing – the AG, the NPC and the NCNC. As Adésínà (2012) notes, the constitution was set-up in a way to favour the Northern region from the outset, and, hence, the NPC won, forming a coalition government with the NCNC under the leadership of Abubakar Tafawa Balewa (NPC) as Premier, supported by Nnamdi Azikiwe (NCNC) as (ceremonial) President of Nigeria.

After Nigeria gained independence in 1960, the political situation in Nigeria was volatile, with political instability marking the Western region and non-unanimity prevailing between the ruling parties.[233] Still, the country continued to use its revenues and tax income to fund "universal and free health care in predominantly public facilities" (Odeyemi and Nixon, 2013, p. 2). At this point in time, investments in social domains were considered crucial in order to nurture a productive citizenry, deemed necessary for the post-colonial development of the country (Adésínà, 2012, p. 299). Moreover, the general spirit of the time was to reject colonial exploitation and to facilitate the integration of the newly/soon-to-be independent nations into the international system on equitable terms. These ideas were discussed at the 1955 Bandung Conference, which represented an important step towards the establishment of the Non-Aligned Movement in 1961 and the United Nations Conference on Trade and Development in 1964 (and later, the adoption of the Declaration on the Establishment of a New International Economic Order in 1974).

Also, as outlined in chapter 2, at the World Bank, which had become the leading agency in guiding development policymaking, in the 1960s, State intervention had become an essentiality for the

[233] Markedly, in 1962 Awolowo was jailed and in 1964, the Mid-Western region seceded from the Western region as a consequence of demands raised by minority groups within the Western region (Adésínà, 2012). Moreover, Nigeria's unsustainable power set-up became especially apparent in the 1964/1965 elections and its aftermath. The AG had broken into two rivalry segments: parts of the party, unhappy with Awolowo's and his allies' pro-socialist course, seceded in 1964 to form their own political movement (named the Nigerian National Democratic Party, NNDP) under the leadership of Samuel Ladoke Akintola and aligned themselves more closely with the NPC. As Diamond (1988, p. 94) highlights: "as Chief Awolowo positioned the Action Group in increasingly explicit advocacy of socialist development policies and radical ideological themes, many of the Yoruba businessmen and merchants at the party's financial core became nervous (as did conservatives and business interests in the other two parties)." The NPC won the elections in 1965.

coordination of extensive infrastructure investment projects (Van Waeyenberge and Fine, 2011, p. 26). The spirit of this position appears to be somewhat reflected in Nigeria's first (World Bank co-authored) development plan, introduced in 1962 (World Bank, 1962). Ibietan and Ekhosuehi (2013, p. 300) highlight that the plan put main emphasis on increasing the standard of living of the population through public investments in agriculture, industry, transport and human development. And, according to Onokerhoraye (1984, pp. 2–3), the plan reflected "the belief that if the economy can be made to grow rapidly, the social benefits of such growth will accrue equitably to all members of the society both as individuals and in the various strata, social groups and regions to which they belong".

In the same year, in the field of health, then-Minister of Health, Dr. Majekodunmi, supported by his "Halevi" Committee, proposed a parliamentary bill for a social health scheme, the Lagos health bill. Onoka et al. (2015, p. 1108) reflect that "the plan included a pre-paid contributory element of a 'health financing arrangement', which led some analysts to reference it as the first recognition of the need for health insurance". The bill represented a first attempt to introduce a social health insurance scheme in Nigeria. Yet, it was unsuccessful, as the bill was rejected. According to Awosika (2005), the main reasons for its rejection were two-fold. On the one hand, the strong opposition of the Nigeria Medical Association (NMA), which was "heavily influenced by private medical practitioners in Lagos", opposed the use of salaried doctors for service delivery and the banning of private practice. On the other hand, the "compulsory nature of the scheme" was rejected (Awosika, 2005, p. 42;44). Another view is that the bill was rejected as there was apprehension whether enough quality service providers were available (Adefolaju, 2014b, p. 155). These discussions around the introduction of social health insurance as well as publicly-funded social service provision in Nigeria's early years illustrate that in Nigeria, like in many other post-colonial African countries, social policy was not perceived as a mere instrument for the promotion of industrial development, but was conceived as a nation-building tool and part of a social citizens project (Adésínà, 2015; Kpessa and Béland, 2013; Mkandawire, 2009).

While at the beginning of the decade, civilian leaders engaged in discussions around promoting social policies, from the mid-1960s onwards, the country was subject to a series of coup d'états. In January 1966, the first military coup took place, and the Prime Minister as well as other senior politicians were killed.[234] Within months a counter-coup d'état followed, which made Yakubu Gowon the head of the

[234] The coup was led, amongst others, by two ethnic Igbos, Chukwuma Nzeogwu and Emmanuel Ifeajuna, which is why the coup was often attributed to be an "Igbo mutiny", perpetrated on basis of ethnic division. Yet, Adewale Ademoyega, one of the leading mutinous soldiers (and *not* an ethnic Igbo) highlighted in his book "Why we struck" that their main motivation to unseat the government was their dissatisfaction with the abuse of power of the ruling elite and their reluctance to proceed with a process of true (and merit-based) "Nigerianisation" rather than any incentive related to ethnicity (Ademoyega, 1981, p. 24). See e.g. Abdulrahman and Mang (2017), who highlight that the "Nigerianisation" – the replacement of foreigners by Nigerians – of the army, especially, was viewed by the Northern

military state and kickstarted Nigeria's first military junta (1966-1979). Subsequently, a pogrom against the Igbo population unfolded in the Northern parts of the country (Ekwe-Ekwe, 2012). This, in turn, elicited a three-year civilian war between the self-proclaimed Republic of Biafra (in the Igbo-dominated South-Eastern part of the country) and the remainder of Nigeria.[235] The civil war, fought between 1967 and 1970, plunged the country into recession.[236] As a result, the second development plan (1970-74), launched after the end of the civil war, put heavy focus on the reconstruction of the country. A strong inclination of the Nigerian government to promote private sector-driven economic development was also reflected in the plan, while the importance of local ownership of the economy and investments in public infrastructure were emphasised at the same time (Adésínà, 2012, p. 293). As a result, the extent of healthcare service provision to the Nigerian people was the outcome of a negotiation between the "business bourgeoisie" (i.e. private companies/individuals) and the "bureaucratic bourgeoisie" (i.e. the Government) as Ityavyar (1987) contends. For instance, in 1970, the strong position of the NMA, representing private physicians, impacted policymaking considerably. They liaised with the State, impersonated by the then-chief Medical Advisor (himself a physician), with the aim of promoting privatised medicine with an emphasis on curative care, opposing the suggestion to expand preventive healthcare service provision and to train mid-level health personnel (Ityavyar, 1987).

Still, while the first and second development plans may have paid less attention to inequalities in terms of access to health, particular focus was put on the redistribution of wealth, notably by promoting social elements, such as housing, free education and a basic health service scheme (BHSS), as center pieces of the third development plan (1975-80) – introduced with the aim of fostering economic growth and improving social well-being (Ogaji and Brisibe, 2015, p. 80). Particular attention was given to improving the health status of the poorer classes of society in the mid-1970s. Ityavyar (1987, p. 292–293) maintains:

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ruling elite with caution, as "the army, unlike other bureaucracies thrived on discipline, experience, order and merit", which would have meant an advantage for officers from the better educated South.

[235] The war resulted in mass famine in Biafra and, ultimately, a victory of the military government in Nigeria, which was supported by the British favouring a "One Nigeria" solution, committed to protecting their oil interests (Uche, 2008).

[236] Falola (2004, p. 182), for instance, described the situation as follows: "During the war, various aspects of the economy slowed down. The economy grew at the rate of 0.8 percent between 1965 and 1970, the country lost over N600 in physical damage, and the component of agriculture to the GDP fell by 5 percent during the war. External countries, such as the United States, Britain and France, calculated their interest from the point of view of the oil market and not necessarily from the desirability, or otherwise, of the unity of Nigeria".

> Though poverty does not necessarily lead to political unrest, in Nigeria it may have been motivated by the sudden wealth that oil brought to a few… The degree and frequency of social strife by peasants, workers and unemployed in rural and urban areas of Nigeria may have been responsible for some of the health reforms in the Third National Development Plan. The military leaders, in spite of their guns, found it difficult to rule in an atmosphere of many demonstrations, strikes, and riots. For this reason they thought of social policies that would contain discontent.

Thus, the third development plan was introduced with the aim to foster economic growth and to improve social well-being by putting an emphasis on the redistribution of wealth and by including social elements, such as housing, free education and quality health services. In that respect, Lambo (1982) states that the third development plan was designed with the goal of "health for all" already in mind (as later stipulated in the 1978 Alma-Ata Declaration). Along similar lines, Ogaji and Brisibe (2015, p. 80) stress that the plan "appears to have given the greatest impetus to the improvement of the Nigerian health system. They also report that, already then, the plan lacked the "policy framework for sharing responsibility for health among the three tiers of government". Ogaji and Brisibe (2015, p. 80) further highlight that:

> This era witnessed massive investment in health infrastructure and the development of auxiliary health manpower under the 'Basic Health Service Scheme' (BHSS) [introduced in 1976]. This scheme commenced three 3 years before the Alma-Ata declaration of Primary Health Care and continued long afterwards; aimed to increase the health coverage, correct mal-distribution of facilities between urban and rural areas; return emphasis on preventive care and establish an appropriate healthcare delivery system for the country.

Therefore, while especially the third development plan, covering the second half of the 1970s, focused on expanding the provision of specifically preventive healthcare services, the 1980s were, more so, characterised by the emergence of a neo-liberal pro-market, anti-welfare state discourse at the global level.[237] During this period, the general tenor (notably promoted by the International Financial Institutions) was to cut back social expenditure (Craig and Porter, 2006; Hemerijck, 2012; Holmes and Lwanga-Ntale, 2012; Mishra, 1984; Ringen, 2006). The emergence of neo-liberal ideology coincided with the collapse in oil revenue in Nigeria, having profound implications for healthcare service delivery in the country. This brings me to the following section.

[237] Notably, in 1981, the World Bank's Berg Report, was published, making bad governance and poor policy choices of African governments responsible for limited economic performance (World Bank, 1981, p. 24).

3. The entrenchment of the private sector in Nigeria's healthcare system of provision

While the private sector was already able to exert some influence on health policymaking in Nigeria in the two decades following independence (notably with its opposition to a mandatory social insurance scheme), particularly from 1985 onwards, its interests were (both im- and explicitly) promoted by the Nigerian Government and the IFIs. This created a form of path-dependence and resulted in private providers as well as for-profit HMOs being incorporated in the law that established the NHIS in 1999. Consequently, the entrenchment of the private sector in the second half of the 1980s and 1990s, as a key agent shaping policy, led to an arrangement in Nigeria, where a poorly regulated private sector dominates the Nigerian healthcare SoP today. Yet, as explained in the previous section and noted by several interviewees, this has not always been the case and the market-centric turn in public policymaking of the late 1980s and the power it accorded to the private sector contributed decisively to today's set-up. For example, one interviewee pointed at the more equitable nature of healthcare service provisioning in the 1970s:

> If you look at health indicators, we have not made any progress in three decades or so. It hasn't always been the case and if you speak to some people, who have been in Government in the 1970s, you get a totally different perspective. UHC, for example, in Nigeria, was 70, 80 percent. Now we are looking at 33 percent. … So, I mean, we have a lot of not-so-positive news, when it comes to the health sector.[238]

In a similar vein, a former Government official, reiterates the view that, prior to the neo-liberal reforms of the 1980s and 1990s, public policies were fostering the maintenance of a functional public healthcare infrastructure:

> The Governments of the 1960s and 1970s, up to the early 1980s, were even more serious with healthcare. You were able to find poly clinics in every State capital. And also, during that period, the 1960s and 70s, teaching hospitals were established. Each Federal University had a teaching hospital attached to it. Let me name them: University of Ibadan, University of Nigeria in Enugu, University of Ahmadu Bello in Zaria, University of Calabar, University of Jos, University of Port Harcourt, University of Ilorin, University of Lagos. All these Federal Universities had their own teaching hospitals to train doctors, to have home-grown doctors. And medical students were attending these courses and learnt in these hospitals. And up until today, many States have their own teaching hospitals. It was during that time that they were built. During that period,

[238] Interview 3; 30/01/2019.

> we had huge and ambitious, gigantic dreams for the country. These teaching hospitals were flourishing, and Nigerians were attending.[239]

Their views are confirmed by the data and the literature. While in the 1960s, 1970s and early 1980s, public investments included investments in education and health, from the mid-1980s onwards, public policies in Nigeria turned to relying on individuals to cater for their social needs privately and started promoting the privatisation of social service delivery (Adésínà, 2012, 2007; Ichoku and Fonta, 2006; Odeyemi and Nixon, 2013; Orubuloye and Oni, 1996). For instance, Ichoku and Fonta (2006, p. 2) summarise this shift in public policymaking as follows and highlight its adverse effect especially on people of lower socio-economic classes:

> Since the mid-1980s, economic and social development policies in Nigeria have been marked by structural shifts from state-dominated to market-driven paradigms. … [T]hey have … heightened the prevailing elitist orientation in the country's political economy: in which privilege and socioeconomic advantages have joined to create large inequalities between the affluent and powerful few, and the poor and powerless majority. … The end result is that the majority of people are excluded from these services or obtain them at great opportunity costs.

Correspondingly, Adésínà (2007) contends that education and health expenditure were the dominant forms in which social policy was expressed in Nigera prior to 1985. However, when global oil prices dropped in the early 1980s, Nigeria was faced with an economic crisis and public resources to fund the budget plummeted. The government's difficulties to generate revenues heavily affected the health care sector and it introduced several cost recovery mechanisms such as user fees and accelerated the privatization of healthcare (Odeyemi and Nixon, 2013, p. 2).[240] Also for Orubuloye and Oni (1996, p. 303) this was a "major departure from the welfare philosophies of the pre- and post-independence eras". The fall in revenue for healthcare and education is also acknowledged in the World Bank's 1994 SAP report (World Bank, 1994, p. 26) and demonstrated in Figure 51:

> There has been a marked decline in real per capita expenditure on health and education since 1981. … [R]eal federal expenditure on health fell from ₦9.4 per capita in 1981 to ₦3.1 by 1985 … There were huge investments in health-care infrastructure in the wake of the oil boom of the 1970s, with the construction of hospitals, the purchase of medical equipment and drugs and the training of health-care personnel. During the first half of the 1980s, real federal government

[239] Interview 4; 30/01/2019.

[240] The introduction of charges for health services recurred not only in Nigeria, but across many of the low- and middle-income countries and public healthcare sectors became more commercialised in the 1980s and 1990s (Mackintosh et al., 2016b, p. 4).

health expenditure declined rapidly in real terms reaching a pre-SAP low in 1985. The share of health expenditure in total federal expenditure in total federal expenditure was about the same in 1990 as it was in 1981, yet the real value of health expenditures was only about half of that in 1981.

Figure 51: Federal Government spending on health and education, 1981-1992

	Health		Education	
	(₦ M)	(₦)	(₦ M)	(₦)
		(1987 Naira)		
1981	692.2	9.4	2,137.9	29.1
1982	658.1	8.7	2,017.3	26.6
1983	476.0	6.1	763.1	9.8
1984	266.6	3.3	926.1	11.5
1985	261.8	3.1	968.7	11.6
1986	419.6	4.9	974.6	11.4
1987	354.7	4.0	448.6	5.1
1988	321.6	3.5	1,156.4	12.7
1989	215.8	2.3	1,462.6	15.6
1990	362.5	3.8	1,129.9	11.7
1991	385.6	3.9	550.8*	5.6*
1992	-	..	505.0*	5.0*

* Primary education expenditures were transferred to state and local governments in these years.

Source: Federal Ministry of Health and Human Services, CBN Annual Reports and Statements of Accounts, 1981-91 and World Bank Staff Estimates.

Source: World Bank (1994, p. 26)

Hand in hand with budget cuts to social sectors, the privatisation of healthcare was encouraged on the platform of structural adjustment (Olaopa et al., 2012). In the early 1980s, the IFIs started urging Nigeria, as other governments in Africa, to introduce neo-liberal SAPs (Holmes and Lwanga-Ntale, 2012, p. 12). While, in Nigeria, there was some resistance at first to introduce the SAP,[241] the military regime of General Babangida that had seized power in 1985 in a military coup "opted, against public

[241] At first, Nigeria was reluctant to introduce these programmes, but the Government led by Shagari entered into negotiations with the IMF in 1983. The IMF insisted on severe austerity conditionalities, resulting in the consultations ending in a stalemate, mainly due to the FGON's "unwillingness to accept an exchange rate-led adjustment programme" (Olukoshi, 1995, p. 142). Buhari's regime, which took over in 1983 introduced some of the IMF's austerity measures (such as reducing the budget deficit and the size of the public service) but dismissed others, i.e. devaluation, across-the-board privatization of public enterprises, trade liberalisation, and petroleum subsidy removal (Olukoshi, 1995, p. 143). The resistance of the Buhari government to fully introduce the SAP resulted in the World Bank rejecting several of Nigeria's loan applications, including for water supply and health projects (Olukoshi, 1995, p. 144). The FGON, "in [the] face of a continually growing problem of external debt service […] sought without success to achieve a Paris Club rescheduling without recourse to the IMF" (Mosley, 1992, p. 228).

opinion, for loaning from the IMF, breaking the deadlock of the previous administration" (David et al., 2015, p. 47). The SAP was launched in 1986 by the military administration (Lewis 1996, p. 94). As part of Nigeria's SAP, the Government reduced its subsidies to health centres and expected households to cater for their needs privately (Anaemene, 2013, p. 52). Similarly, Adésínà (2012, p. 311) accentuates that "[i]n the areas of education and health care the emphasis in public policy has been on the active policy of private provisioning, through the licensing of private providers, and the passive policy assuming that citizens can and should rely on private service providers".[242]

The promotion of the private sector reflected an arrangement between the State and private physicians. As, for example, Alubo (1986, p. 469) highlights, the profession of the medical doctor was prestigious since colonialism.[243] And, after, independence, the relationship between the State and medical doctors was "cordial and complementary because each side obtains some benefits from the relationship. For example, health care policies in Nigeria are designed to favour the more privileged social class in which members of the state belong" (Ityavyar, 1983, p. 56). Ityavyar (1987, p. 293) further observes that doctors were not enthusiastic of para-medics being trained to perform some of their duties but approved after "the state made some concessions by liberalizing laws on private medicine. … Physicians could not have been more pleased. They opened a lot of hospitals and clinics in towns and cities thereby again compounding the problem of urban concentration of health services". In 1992, the NMA secured an exemption for the medical profession from the Private Practice Prohibition decree of 1984. [244] This meant that medical doctors, who were in full-time Government employment, were allowed to also operate their own private practices in parallel. While the 1999 constitution, superior to any act or code, prohibits government-employed professionals to run their own practices privately, this is still habitually done in Nigeria, with the NMA defending their actions

[242] In summary, in Nigeria, like in other African countries, the social costs of implementing the SAPs were high and average economic growth rates do not positively reflect on these austerity measures (Cornia and Stewart, 1990, p. 12). The policies aggravated poverty in Nigeria and economic growth did not translate into adequate levels of social progress (Momoh, 1995, p. 20; Odey, 2018, p. 146; Orewa, 1997, p. 6). The Nigerian SAP created strong discontent amongst the population due to declining real wages, culminating in a series of anti-SAP protests supported by students, traders, and organised labour. This prompted some compensatory measures (Lewis, 1996, p. 84).

[243] And, up until today, medical care receives disproportionate attention compared to other healthcare services, such as public health and nutrition programmes (Alubo and Hunduh, 2017, p. 779).

[244] See here for the 1984 decree: https://gazettes.africa/archive/ng/1984/ng-government-gazette-supplement-dated-1984-12-19-no-70-part-a.pdf; and here for media reporting on the 1992 exemption: https://www.pressreader.com/nigeria/thisday/20171128/282024737577781 (last accessed 09/08/2021).

with reference to the 2008 Code of Medical Ethics in Nigeria.[245] This, however, continues to be a point of contestation.[246]

In the midst of the general climate of pro-private sector social policymaking throughout the second half of the 1980s and the 1990s, the NCH set up two successive committees to discuss on how to best institute a national health insurance scheme: the Koshoni Committee in 1984, named after the then-Health Minister Admiral Koshoni and the Committee on National Health Review in 1985 under the leadership of the incoming Minister of Health Dr Nsan. These committees concluded that the introduction of a NHIS is "desirable" and "feasible" (Onoka, 2014, p. 73). Subsequently, consultations regarding how to implement the proposed national health insurance scheme continued and a preliminary model was proposed in 1988 during the tenure of Dr Olikoye Ransome-Kuti, who had succeeded Nsan as Minister of Health.[247] As Onoka (2014) outlined, the blueprint of the NHIS, proposed under the leadership of Ransome-Kuti, foresaw the use of health insurance boards, managed by the States, as intermediary operators of the scheme.[248] However, while the NHIS was supposed to be made operational straight away, political will at the time appears to have been limited and rivalries between different groups of health professionals hindered progress (Awosika, 2005, p. 42; Onoka et al., 2015, p. 1108). Nonetheless, while under Ransome-Kuti's tenure no social health insurance scheme was made operational, he successfully led efforts to launch Nigeria's first comprehensive national health policy. In 1988, the National Health Policy and Strategy to Achieve Health for All Nigerians was promulgated and had made PHC its cornerstone (Aregbeshola and Khan, 2017, p. 1).[249] Congruously, a few years later, in 1992, the National Primary Health Care Development Agency was established.[250]

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[245] See here for the 2008 Code of Medical Ethics in Nigeria: http://www.mdcnigeria.org/Downloads/CODE%20OF%20CONDUCTS.pdf (last accessed 09/08/2021).

[246] See here: https://dnllegalandstyle.com/2017/position-law-govt-doctors-engaging-private-practice/ (last accessed 09/08/2021).

[247] Ransome-Kuti was considered to have been a "social crusader" (Raufu, 2003, p. 1400) and was the son of activist Funmilayo Ransome-Kuti.

[248] The report proposing this blueprint of the NHIS is known as the Eronini-report, named after the chair of the committee elaborating the preliminary model, Dr Umez-Eronini.

[249] The policy is available online: https://thedocs.worldbank.org/en/doc/929691562140346971-0240021988/render/WorldBankGroupArchivesFolderD204877.pdf (last accessed 10/08/2021).

[250] Ransome-Kuti's tenure as Minster of Health ended in 1993 due to another military regime's government takeover. He did, however, remain the chairperson of the NPHDA until his death in 2003 (Raufu, 2003).

Later on, throughout the 1990s, General Abacha's military regime introduced rolling development plans and showed some commitment to improving the healthcare system. This included an emphasis on the need for adequate funding to rehabilitate healthcare facilities as outlined in the national Nigeria Vision 2010 document. This also, and crucially, included an effort to institute the NHIS and, in 1999, the NHIS was signed into law. However, once more the interests of the private sectors gained traction and a strong pro-private sector lobby ensured that the NHIS Decree (No. 35 of 1999) integrated private healthcare providers and profit-oriented HMOs as intermediaries for the financing and purchasing of healthcare (Odeyemi and Nixon, 2013; Onoka et al., 2015). Notably, during a National Health Summit, organised under the auspices of the Abacha's regime in 1995, policy makers aimed to build consensus around the intensification of collaboration with the private sector. Onoka (2014, p. 75) highlights that "[T]his was facilitated by the strong participation of HMO enthusiasts with previous exposure to the managed care system in the United States of America, and lobbyists from the insurance industry that had struggled with previous attempts at providing health insurance." Along the same lines, one interviewee stressed that HMOs were persuasive in influencing the 1999 law establishing the NHIS in their favour and

> They were dominant because they helped to develop the law, the health insurance law in 1999. So, they wrote themselves into [the law]. Because before 1999... you know, these managed care companies that were in Lagos – because, you know, they understand health insurance – so they were called to write the law. So, they just wrote themselves into the law. But so many people have seen that they are just collecting money. … But not all HMOs are bad. Let me make this point clear. When they started, they had few HMOs, and those were real, good HMOs, Total Health Trust, Hygeia... Some of them were very good.

While the decree was passed in May 1999, formally established the NHIS, it took another six years for the NHIS to become operational. As underlined in Chapter 4, only in 2005, the Formal Sector Social Health Insurance Programme, which to date only covers Federal Government employees, was rolled out. As a result of the above developments, the supposedly State-led health insurance boards had been replaced with for-profit HMOs and the private sector had been included as service provider in the NHIS, in response to a perceived inability of the public sector to implement the NHIS (Onoka, 2014, p. 75).[251] Accordingly, the model of health insurance introduced in Nigeria in the 2000s meant that each enrolee would be expected to contribute a certain amount on a monthly basis to a health facility

[251] Moreover, the National Health Financing Policy proposed that there "shall be a split between funding and purchasing and the powers for both shall not reside in same agency" (FMOH, 2006, p. 16); and, HMOs were seen to secure this envisaged purchaser-provider split and to increase the efficiency of the NHIS (Obikeze and Onwujekwe, 2020).

of their choice via an HMO. As elaborated in Chapter 4, under the NHIS scheme, HMOs would enter into an agreement with health facilities and would then collect employers' and employees' contributions on its behalf. According to Onoka (2014, p. 107), the first HMO emerged in 1996, with eleven more following until 2004 before the FSSHIP started. The commencement of the FSSHIP in 2005, and its inclusion of HMOs meant that, from 2005 onwards, the HMO business became distinctly more attractive (Eboh et al., 2017). According to Onoka et al. (2016, p. 17), the NHIS even proved "life-saving" for some HMOs, which saw the "FSSHIP capitation payments which they received regularly from the NHIS as 'guaranteed income'". Consequently, as emphasised during an interview, the profitable nature of the HMO business encouraged more and more people to establish HMOs:

> But, you know, because of the money that was now coming from health insurance, almost everybody now had a HMOs. ... So, it then diluted the whole process. I am sure that if you are stuck with a few good ones, I am sure that it would have been better. [But then, they started] expanding the market, and allowing all kind of rich people, all Generals, all Governors [to participate]. They all had HMOs.[252]

The lucrativeness of the HMO business also stems from the fact that HMOs – besides collecting contributions and payments and providing healthcare services to the insured through healthcare providers they have contracts with as part of the FSSHIP – also offer private insurance plans in parallel (Onoka, 2014). This was made possible as the private sector had lobbied for the NHIS to be made voluntary, which a NHIS employee criticised:

> [The] NHIS was really established in 1999, but … it was only in 2005, following real political [will] by the Obasanjo government, that they moved it. And that was a major, a major, a major financial reform in the country. [The NHIS] was given the mandate to attain UHC in ten years. … But the law that set up the NHIS was faulty. You cannot talk about UHC [and use] a system that is voluntary. … It must be mandatory and there should be [a] subsidy. So, the Government did not make available all these tools for us to move [to] UHC.[253]

Moreover, the HMOs' double-hat was also made possible as, according to Onoka et al. (2016, p. 12), the official accreditation system was weak and a share capital requirement of Nigerian Naira 100 million was waived, encouraging the creation of many HMOs, perceived by policy makers as the best alternative to the feeble public health system for the implementation of the NHIS. Since 2011, the accreditation process has allegedly become more difficult, but even after the most recent re-

[252] Interview 12; 28/02/2019.

[253] Interview 13; 01/03/2019.

accreditation exercise in April 2018, the role of the 52 re-accredited and recommended HMOs remains substantial.[254] In 2021, the NHIS website lists 58 different HMOs.[255] Therefore, as stipulated in the 2012 Revised NHIS Operating Guidelines, today's NHIS operates as a public-private partnership with the HMOs supplying both private and social health insurance to a small portion of Nigeria's formal sector:

> [The] National Health Insurance Scheme is a body set up by Decree 35, of 1999 (now Act 35) operating as **Public Private Partnership** and directed at providing accessible, affordable and qualitative healthcare for all Nigerians … Health Insurance can be defined as a system of advance financing of health expenditure through contributions, premiums or taxes paid into a common pool to pay for all or part of health services specified by a policy or plan. Health Insurance can be broadly categorised as social or private health insurance (NHIS, 2012, pp. 10, 13; emphasis added).

In summary, the integration of HMOs into the NHIS reflected the government's broader ambition to pursue a private-sector driven economy as well as their belief that the private sector could implement the social health insurance scheme more effectively than the public sector (Asoka, 2011, p. 3; Onoka et al., 2016, p. 12). And, ultimately, particularly the use of HMOs as operators of the NHIS as well as providers of private insurance plans has markedly influenced the healthcare landscape in Nigeria up until today (Onoka et al., 2015, p. 1114). Since its inception, the implementation of the NHIS, as it was put into place in 1999, has proven to be challenging for two main reasons. First, State governments, especially, felt excluded from the scheme as the health insurance boards never materialised (Asoka, 2011, p. 6; Onoka et al., 2015, p. 1109). As a consequence, and because the ambiguous language of the decree gave States as federating units the leeway to either opt in or out of the scheme, most States opted against its implementation (Onoka et al., 2015). Second, due to the voluntary nature, popular interest in the scheme is limited. As a result, the NHIS still only covers less than five percent of Nigeria's population (Aregbeshola and Khan, 2018).[256] All in all, the consequences of turning from social healthcare provisioning towards the private sector and towards responsibilising individuals to cater for their own healthcare in the 1980s, part and parcel of the neo-liberal agenda, were

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[254] See: https://doctorsquarters.com/nhis-full-lists-of-re-accredited-hmos/ (last access 12/10/2018)

[255] See: https://www.nhis.gov.ng/hmo-contacts/ (last accessed 09/08/2021).

[256] In theory, the NHIS has several other programmes; however, these programmes, such as community-based health insurance schemes, which were gradually introduced and target other groups in society (notably the informal sector), do not perform well. Also, see Onoka et al. (2015) for a systematic analysis of the stakeholders and interests involved in the development of the NHIS.

"disastrous" and "cost human lives" (Adésínà, 2007, p. 15) and explain the underperformance of the Nigerian healthcare SoP of today and ensuing health inequities.

As a result of these two decades of neo-liberal public policymaking, the WHO, in its 2000 report, identified Nigeria's healthcare system as one of the four worst healthcare systems in the world. This, in turn, drove a group of like-minded Nigerians, dedicated to improving Nigeria's healthcare system, to come together to discuss possible ways to ameliorate access to primary healthcare services. In 2001, the Change Agents Programme (CAP) was formed. Members of the CAP included health professionals, policy makers, members of Government, of labour unions and of civil society organisations, who were adamant to "initiate and sustain country-led health reforms […] and policy development in Nigeria".[257] The following section outlines the healthcare system reform process that took place throughout the 2000s and early 2010s and resulted in the adoption of the 2014 NHAct. I review the course of events leading to the enactment of the new law and unpack how the various agents, operating within the defined structures and processes, influenced its content.

4. The genesis of the 2014 National Health Act

In Nigeria, the adoption of the 2014 NHAct can be considered a milestone in health policy development. Remarkably, the principal novelty of the 2014 NHAct is that it mandates the establishment of the BHPCF as an arrangement to sponsor a basic minimum package of health services with the goal of fast-tracking the attainment of UHC in Nigeria. The BHCPF is expected to be funded through multiple sources, but with the main source being an annual allocation of the Federal Government of Nigeria of "not less than 1 percent" from the Federal Government's public budget.[258] This newly-introduced BHCFP is perceived as an opportunity for the informal sector and people with limited financial means to access (primary) healthcare, as high payments are an important hindrance for people to access the necessary healthcare (Onwujekwe et al., 2009, p. 195). The constitution of a (predominantly) publicly financed basket fund for healthcare seems like a major achievement. Nonetheless, the process of elaborating the NHAct has proven difficult and various stakeholders were able to influence its final text and, in consequence, shape the form UHC can take in Nigeria. Appendix

[257] See: https://www.herfon.org.ng/#about-us (last accessed 13/10/2019).

[258] As will be discussed in Chapter 6, these resources are expected to be complemented with counterpart funding from State Governments (Uzochukwu et al., 2018, p. 2) as well as revenues generated from 'any other source' such as additional taxation on e.g. temptation goods i.e. alcohol or tobacco (FMOH, 2016b, pp. 6; 18). In addition, the NHAct explicitly encourages philanthropists and donors to place supplementary resources into the BHCPF.

M summarises the most influential contentions and developments that have shaped the design of the NHAct.

In the early 2000s, in a first step, the CAP, after having pro-actively sought (and obtained) funding from the Department for International Development (DfID),[259] aimed to produce a diagnosis of the Nigerian health care system and its shortcomings. Therefore, they organised knowledge exchange missions to Ghana, to gain knowledge on best practices related to policy making, and to South Africa, in order to learn from the nation's approach to health service delivery. Comparing the performance of the Ghanaian and South African healthcare systems to the Nigerian healthcare SoP prompted one (former) change agent to say: "when we came back to Nigeria, we were ashamed of ourselves".[260] Borne out of the CAP, which operated between 2001 and 2004, the NGO, "Health Reform Foundation of Nigeria" (HERFON), was founded in 2004 and took over efforts targeted at pushing for a new legal framework for the country, which was expected to form the basis of a substantive health reform in Nigeria. HERFON, as a representative agent of the civil society, has decisively contributed to formulating the text of the NHAct and to ensuring its adoption.

Around the same time HERFON was founded, Professor Lambo was appointed as Minister of Health by the President Chief Obasanjo, after the latter had been re-elected as the head of Government in May 2003. The incoming Minister was the first and (so far) only health economist to hold the position of Federal Minister of Health in Nigeria. He looked back on a career at the WHO as Regional Advisor and, hence, had expert knowledge in the areas of health systems reforms and health financing.[261] Furthermore, Lambo – a (self-proclaimed) technocrat,[262] "real reformer and change agent"[263] and "key figure"[264] – had acted as the director of the CAP prior to his appointment as Minister and had previously advocated for improvements in the Nigerian healthcare sector. Thus, under his auspices, the health policy of 1988 was revised in order to enable actions towards reforming the health sector. A revised health policy was adopted in 2004 with the aim of taking account of the "recommendations

[259] DfID initiated and established the Partnership for Transforming Health Systems (PATHS Phase I) programme in 2002, which ran until 2008. The second phase of the programme ran between 2008 and 2014 (PATHS Phase II).

[260] Interview 46; 27/03/2019.

[261] Lambo has a PhD degree in Operational Research applied to Nigeria's healthcare sector.

[262] See: https://thenationonlineng.net/feel-fulfilled-70-says-lambo/ (last accessed 15/10/2019).

[263] Interview 46; 27/03/2019.

[264] Interview 36; 20/03/2019.

that emerged from the [1995 National Health] summit" as well as of the inputs of and experiences made by the change agents" (FMOH, 2004a, p. iii). The 2004 policy reiterated the importance of PHC and the objective of health for all. While the 2004 National Health Policy contends that "the publicly funded health service alone cannot provide the services required by the populace especially with regard to the provision of quality care and universal coverage", it refers to "especially the non-governmental organizations (NGOs) and the community based organizations (CBOs)" as important private partners for healthcare service delivery (FMOH, 2004a, p. 50).

Apart from efforts to finalise a (non-binding) health policy, efforts were spearheaded in parallel to develop a legal/binding framework for the healthcare sector. During his time in office, Lambo oversaw the implementation of the 2004-2007 Health Sector Reform Programme (HSRP), which formed part of the National Economic Empowerment and Development Strategy (NEEDS) – Nigeria's version of the World Bank's Poverty Reduction Strategy Paper.[265] The inaugurating report of the HSRP emphasises the need to strengthen the stewardship role of the Government and to improve the management of the national health system. It gives (public) health finance and expenditure considerable attention, but also highlights the importance of private companies "such as pharmaceutical companies and medical equipment manufactures … in the production of health-related goods and in making health care more affordable". Specifically, one of the main action points of the HSRP was the "development of an effective public-private partnership policy" (FMOH, 2004b, pp. 34, 35).[266] At the same time, the HSRP report features the '[e]nactment of a National Health Act that re-defines the National Health System as well as the **functions of each level of government**' alongside a "revised, updated and harmonized" health policy as one of its main ambitions (FMOH, 2004a, p. 3; emphasis added). It, notably, points at the shortcomings of the 1999 Constitution to clarify the exact responsibilities of the three tiers of Government with regard to healthcare provisioning (FMOH, 2004b, p. 3). As indicated above, the new law was expected to fill the gap in the 1999 Constitution, which does not provide clear guidance on the roles and responsibilities of the three different tiers of governance, from federal to state to local government, with regard to healthcare service delivery (Adegboye and Akande, 2017).

[265] The *National Economic Empowerment and Development* focused on four areas of national development, namely value orientation, poverty reduction, wealth creation, and generation of employment, and was introduced as *State Empowerment and Development Strategy* (SEEDS) and *Local Empowerment and Development Strategy* (LEEDS) at state and local government levels (Odey, 2018, p. 147).

[266] The National Policy on Public-Private-Partnership for Health in Nigeria, adopted in 2005, speaks of a "public-private mix", recommending the participation of both, the private for-profit and not-for-profit sector – stating, however, that "while for-profit institutions have a right (or an obligation) to make a profit, this has to be balanced against the equally important considerations of ensuring safety quality, and equity" (FMOH, 2005, pp. 5, 7).

The shortcoming of the Nigerian constitution to outline exact roles and responsibilities for the three different tiers of government appears to have been a main reason for the push for a legal framework for the national health system. It has been cited extensively during interviews and FGDs as one of the explanatory factors for the poor performance of Nigeria's healthcare SoP of today. Several interviewees highlighted that the constitution "mentions health just in passing"[267] and "doesn't really guarantee a right to health… and the constitution says health is one the concurrent list. So, anybody can literally do health and all that".[268] When the constitution mentions health, "it is more [geared] towards health and safety"[269] or "industry".[270]

In this spirit, the change agents and, later on, HERFORN continued to push for a new legal framework for Nigeria as the basis of substantive health system reform. This included support for the drafting of a first national health bill. A preliminary version was to be presented and distributed for inputs at the 2003 Annual Meeting of the NCH in Bayelsa State's capital Yenagoa. However, its dissemination was stopped at the last minute by the Federal Minister of Health. One agent who was part of the effort to distribute the bill explains:

> And the thing [the copies of the health bill] was very bulky, so it could not be flown. So, we had to send it by way – sending it through trucks from Abuja first to Port Harcourt. Then we got another truck to take it to Yenagoa, which is the capital of Bayelsa. And I arranged the thing – 10 copies per State, and Directors and everything. And, the meeting was in progress, so I was sitting at the side – the Minister waved to me. I came, and I went up to the Minister [who said]: "You can't distribute that". I said: "what?". "So, the Director was asking what [this is]" – this is the Minister [speaking]. I said: "This is just the draft, but everybody can go and look at [it], so we can then move forward". He said: "No, the director said, it cannot be distributed.". So, wherever it came from, we should take it away … And I said: "Minister, can't you…?" He said: "No, no". That thing wasn't distributed. So I carried it back all the way back from Bayelsa capital Yenagoa.[271]

[267] Interview 12; 28/02/2019.

[268] Interview 36; 20/03/2019.

[269] Interview 47; 29/03/2019.

[270] Interview 43; 27/03/2019.

[271] Interview 46; 27/03/2019.

Consequently, a first advanced draft of the bill was tabled much later, during the 2005 session of the NCH, which endorsed the 2004 National Health Bill (Obi, 2014). This 2004 National Health Bill outlined clear responsibilities of States and Local Governments. It brought about a fundamental shift, from a contributory to a publicly financed scheme, as it suggested the establishment of a tax-funded National Primary Healthcare Development Fund (NPHDF), the forerunner of the present-day BHCPF.

Following the NCH's acceptance of the 2004 version of the bill, hopes were high that the bill would gain the necessary approval of the House of Representatives and the Senate before the end of the year, notably, because members of the National Assembly had already discussed the bill during a retreat in Kaduna and voiced their accord. However, the health bill was not adopted for two main reasons. First, dissatisfaction from sides of the States interfered with the policymaking process. Matters did not proceed smoothly and in spite of prior approval of the NCH, as selected State Commissioners of Health felt the Act would interfere with the autonomy of States. Specifically, the Edo State Commissioner of Health led "a coup against the Minister and against the Act".[272] To solve the issue, the Minister decided to put into place a committee to give representatives of the States another opportunity to provide input into the bill, with the outcome being that "everything related to the States was taken out".[273] This is a demonstration that Nigeria's federal character, and the power of (some of the) State Governments, have hampered progress towards attaining UHC – rather than that it/they improve decentralised healthcare service provision.

Second, the bill was not adopted by the National Assembly in time, demonstrating how law adoption procedures impact policy development.[274] The reason for "delays in sending the Bill to the National Assembly by the Executive arm before the end of 2005" (Obi, 2014) seemingly was "a powerplay" between two key people within the Federal Ministry of Health, who were both sub-ordinates to the Minister:

> We could have passed the Act already in 2006. … [The two people] were both supposed to take notes during the retreat and then harmonize them after the retreat. However, one of them

[272] Interview 46; 27/03/2019.

[273] Interview 46; 27/03/2019. The draft version of the health bill is available.

[274] In 2006, the bill would have been approved by the National Council of State and the Federal Executive Council via the National Economic Council, an advisory committee on economic affairs (Obi, 2014). Their support was relevant, taking into consideration that the health bill foresaw the Government to be the main financier of the health bill. The 2004 version of the health bill did not specify the value of the grant of the Federal Government of Nigeria nor the necessary counterpart funding from States, but rather highlighted that the fund shall receive resources from taxes on alcohol, tobacco, road traffic insurance schemes as well as contributions from VAT and other existing taxes.

> refused to take notes and to give the Minister a clean copy of the report of the retreat. Because of these discussions, the effort was taken beyond the December deadline … The civil-service is not structured for results-orientation … Even within the system, many people did not actually believe what they were doing.[275]

Then, when the bill was reviewed by the NASS, the health bill was only approved by the House of Representatives at the beginning of 2007 but failed final passage in the Senate. The second tenure of President Obasanjo ended in May 2007 and with it, the appointment of the Senate Health Committee cohort of 2004-2007, which was in the process of harmonising the bill (Adegboye and Akande, 2017; Obi, 2014). This meant that the review process had to be restarted by the incoming NASS after the 2007 elections. That year, Professor Grange replaced Lambo as Minister of Health and Iyabo Obasanjo-Bello (former-President Obasanjo's daughter) took over the chairpersonship of the Senate's Health Committee. In her function as chair of the Senate Health Committee, she attempted to expedite the adoption of the national health bill, in the form that it had been prepared by the previous Senate cohort. This attempt failed. Both women, Obasanjo-Bello and Grange, received unwanted media attention, when the Economic and Financial Crimes Commission (EFCC) commenced to investigate their alleged participation in the embezzlement of public funds. [276] Grange resigned, was arrested on orders of President Yar'Adua and stood trial (but was, in the end, not convicted). Obasanjo-Bello continued in her role as Chairwoman and organised a retreat in Ghana for members of her Senate Committee on Health with the aim of agreeing on a version of the national health bill. After positive reviews by the Senate in May 2008 and the House of Representatives in February 2009, the harmonised 2009 National Health Bill was passed in August 2009. It, however, no longer clearly outlined responsibilities of States and Local Governments, but still spoke of a National Primary Healthcare Development Fund (rather than of the BHCPF), now clearly stating that it shall be funded through an annual 2 percent allocation from the Federal Government's budget. Still, the many changes made to the health bill between 2004 and 2009 appeared not to be in conformity with the constitution and the bill was referred back to the National Assembly after review by its legal department (Okoghenun, 2014).

In 2010, Dr Chukwu took over as Minister of Health and, under his leadership, the National Strategic Health Development Plan (NSHDP 2010-2015) was developed as part of the Nigeria Vision 20:2020

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[275] Interview 46; 27/03/2019.

[276] The scandal received broad media attention, see for instance: https://allafrica.com/stories/200804070050.html and https://allafrica.com/stories/200803260005.html (last accessed 16/10/2019).

strategy. The document, generally, did not put much emphasis on social policy, but restated the Government's mission to strengthen the Nigerian health system (FMOH, 2010, p. 18). As Holmes et al. (2012, p. 17) highlight the document, pleading to make Nigeria one of the World's twenty largest economies, was enacted with "only one explicit reference to a specific social protection instrument – the National Health Insurance Scheme and the Community-based Health Insurance Scheme – to provide free health services to vulnerable groups including women and children across the country". The document also acknowledged that previous attempts to cover larger parts of the population via community-based schemes have been "unsustainable". It refers to pilot schemes with the private sector as an alternative way of extending healthcare coverage, notably mentioning the Hygeia Community Health Plan in Kwara State.

Furthermore, the publication of the WHO (2010) report on health system financing seems to have given additional impetus to Nigerian lawmakers to move forward with the country's health systems reform. After the two chambers of the Assembly had made minor amendments to the text (in terms of assuring the appropriate wording) as proposed by the legal department, the revised version of the health bill was passed by the Assembly in May 2011. The Senate gave its assent only days before the term of the 2007-2011 cohort ended, compelled by a demonstration by "a coalition of several CSOs in health, [formed in order] to amplify their voice".[277] HERFON in collaboration with the Market Woman Association "mobilised market women and a lot of people. They went to protest at the national assembly; and [the Senate] passed [the bill]."[278] Thus, the civil society's efforts were a success as, this time around, the health bill passed in both the Senate and the House of Representatives. One interviewee drew attention to the importance of the women's protest:[279]

> Women in masses are feared, and they were heading towards the National Assembly, ready to take their rappas off. These women started fighting with the security people and the women found their way into the Senate and insisted that they wanted to speak to the Senate President. Two days later, the national Assembly passed the law and sent it to Jonathan.[280]

However, while the National Assembly gave its endorsement to the health bill, other concerns emerged in parallel and put further obstructions in the way of establishing a new legal framework for

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[277] Interview 43; 27/03/2019.

[278] Interview 36; 20/03/2019; see: https://www.worldpulse.com/community/users/vivian/posts/3236 (last accessed 17/10/2019).

[279] See media reporting on the demonstration: https://www.worldpulse.com/community/users/vivian/posts/3236 (last accessed 17/10/2019).

[280] Interview 46; 27/03/2019.

Nigeria's healthcare sector. Notably, the Catholic Church, the Muslim community, professional groups as well as the Minister of Finance continued to lobby against certain elements of the health bill (Obi, 2014). Especially, formulations in the draft of the bill that did permit the sale of human ovarian eggs and did not make donor consent a precondition for human organ transplantation raised red flags for the Catholic Church (which, at the same time had also become a concern for the Muslim community), as reiterated by CSO representatives:

> There was one medical doctor, a crazy person, [who] was busy writing everybody in the World – the UN Secretary General, the Pope, ECOWAS, Heads of State – saying that [the national health bill] is all a conspiracy and will open doors for someone to come and harvest organs in Nigeria, clone people, do abortions. […] The Catholic Church had picked up on it and started working from behind.[281]

Moreover, other health professionals had voiced concern that the bill would sustain a "hegemony of doctors" (Obi, 2014). As one interviewee highlights, the question was: "The Tertiary Hospital's Committee – who is going to head it? So, the initial wording was, it must be a doctor. So, they said, no it must not be a doctor, it just has to be a health personnel. Everybody works in a T[ertitary] hospital, so why must it just be a medical doctor that will head the Tertiary Committee?"[282] Finally, the Minister of Finance (Dr. Ngozi Okonjo-Iweala, now Director General of the World Trade Organisation while also serving as a board member of GAVI)[283] was wary of the financial implications that the health bill would have for the public budget, writing "so many memos against the Fund".[284] The Minister of Finance was particularly worried that the BHCPF would reproduce the failures associated with the Universal Basic Education Commission (UBEC), where States failed to utilise the ear-marked funding for education. One interviewee highlighted:

> So, the BHPCF was modelled after UBEC. But while UBEC is two percent, BHCPF is one percent. But UBEC had significant implementation problems. Under its implementation arrangement, State Governments were meant to provide counterpart funding. So, to say, if you have a project of a million, you will provide about 50 percent of those funds for you to be able to leverage the

[281] Interview 46; 27/03/2019.

[282] Interview 12; 28/02/2019.

[283] See here an article, outlining some of the neo-liberal policies that she has promoted in her different roles within Nigeria as well as at the World Bank: https://africasacountry.com/2021/02/black-faces-in-high-places (last accessed 25/05/2021).

[284] Interview 12; 28/02/2019.

> federal funds. As at this time, and as of today, the UBEC funds has accumulated up to 150 billion at the central bank. Why? Because States were not leveraging on the UBEC funds as expected. … So, for UBEC, money was taken off the top, it wasn't returned to the Treasury, because States were not taking it up as they should be accessing it. So, it just sat there. And you cannot spend it on anything else, because it is a constitutional requirement.[285]

This view was re-affirmed during an interview with an official working at the National Primary Health Care Development Agency:

> The thing is, the problem is looking at UBEC, UBEC was a case study for the fund. I actually feel that UBEC might have – let me not say totally, but in a way – negatively impacted on BHCFP. Because UBEC has so many unexpended resources that the government was now a bit sceptical about the ability of the health sector to absorb the fund. Because it was meant to be 2 percent and the reduced it to 1 percent. And now the release of the 1 percent was not done the way it was supposed to as well. So, that is another fight that needs to be going for.[286]

HERFON actively tried to clarify and convince different stakeholders of the advantages of the health bill by organising workshops and consultations to create awareness and spread information. The CSO also encouraged trusted people as well as international figures to reach out to Jonathan Goodluck, who had assumed the office as President of Nigeria after Yar'Adua's demise in office, to convince him of the importance of the health bill. [287] Nonetheless, the President did not sign the bill in 2011.

Furthermore, 2011 was an election year and, once more, the representation in the Senate and the House of Representatives changed, meaning that new persons were in charge of reviewing and adopting the health bill. The chairpersonship of the Senate health committee changed hands from Obasanjo-Bello to Dr Okowa, who was "very conversant with the Act as a former Commissioner of Health and a progressive health advocate". [288] Thus, with a former change agent in the Senate and

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[285] Interview 33; 17/03/2019.

[286] Interview 49; 04/04/2019.

[287] HERFON, who had formed a coalition with other NGOs with an interest in health sector reform, elaborated a detailed action plan, including reaching out to personalities such as Obasanjo, the Sultan of Sokoto, Ngozi Okonjo-Iweala, the Archdeacon of Aso Rock Cathedral, Gordon and Sarah Brown, Bill Clinton, Desmond Tutu, Bill Gates, etc. to ask for their support in convincing Jonathan to sign the health bill. They further organized press conferences, drafted an open letter to the President, partnered with telecom companies to send out bulk text messages with information on the health bill and organized the collection of signatures of citizens, doctors, pharmacists, nurses, etc. supporting the bill (action plan available).

[288] Interview 46; 27/03/2019.

Chukwu as Federal Minister of Health, who was the former HERFON chairperson of Ebonyi State, two progressive health reformers were in seats of power in Abuja and supportive of the health bill. Between 2011 and 2014, HERFON continued its efforts to convince religious leaders, professional groupings, politicians and the general public of the advantages of the national health bill. In February 2014, Okowa organised a public hearing in the National Assembly, after which the bill was accepted by the National Assembly and passed on to Jonathan for his signature. In March 2014, the President pledged the administration's commitment to making quality healthcare accessible to all Nigerians. At a Presidential Summit on UHC under the theme "UHC… a vehicle for sustainable growth and development", he committed to strengthen mechanisms to protect the Nigerian people from financial hardship related to health expenditures and to promote access for all Nigerians to a defined bundle of basic health services.[289] And, a few months later, President Goodluck finally signed the NHAct into law in October 2014.

The signing of the Act took place more than a decade after discussions had started, and ten years after a first draft of the document had been made available, showcasing the complexity of policymaking in a context characterised by a multitude of agents, structures, and processes. Moreover, the many backs and forth over the years resulted in significant changes to the final text of the NHAct. Table 10 lists key changes, which include the following three pertinent amendments with future implication for the potential of UHC in Nigeria to be attained. First and foremost, the public basket fund for primary healthcare (the NPHDF), which, at first, had been conceptualised to be disbursed in full via the NPHCDA in order to strengthen the PHC delivery system, was replaced by the BHCPF, which was to be disbursed via three gateways. Second, the earmarked Federal government annual allocation was reduced from "at least two percent" to "at least one percent". Third, a provision was made to divert five percent of the basket fund, initially supposed to focus on PHC only, towards emergency response. This appears to have occurred on initiative of the FMOH, which is overseeing this proportion of the resources, and against the will of most of the agents involved as highlighted in a consultancy report by Oloriegbe and colleagues (2011), commissioned by UNFPA and DfID:

> The amendments were proposed by the FMOH and it is that the 5% of the PHC fund (from the 50% allocated to the NPHCDA) should be allocated for "epidemics and emergency response" and this component shall be given to the FMOH to manage. […] These FMOH proposed amendments are not acceptable to majority of the stakeholder in the sector. The belief is that

[289] The outcome document, a 23-point declaration, is available at: http://www.msh.org/sites/msh.org/files/presidential_summit_declaration_on_universal_health_coverage_in_nigeria.pdf (last accessed 25/09/2019).

the amendments are not evidence based and would not add value to the system. […] The long gestation period of the bill and its various amendments create confusion among stakeholders. Knowledge of the contents of the bill is limited and many are not aware of the implications the bill would have on health care provision in the country. The bill being a framework would require further details in operational guidelines to ensure that it is implemented smoothly and effectively.[290]

Table 10: Content analysis of the drafts of the national health bill and the final NHAct

Subject of Bill	Drafts of the health bill	2014 NHAct
Clarification on roles and responsibilities of the three tiers of Government	Outline that the Federal level is responsible for tertiary, the State level for secondary, and the Local level for primary healthcare	No longer clearly assigns clear responsibilities by tier of Government
Establishment of a dedicated fund for PHC	Propose the establishment of a National Primary Health Care Development Fund	Mandates the establishment of the BHCPF
Federal block grant	Propose a 2 percent deduction from the Consolidated Revenue Fund	Stipulates that the BHPF shall be funded via a 1 percent deduction from the Consolidated Revenue Fund
Emergency medical treatment	Make no provision for emergency medical treatment	Stipulates that 5 percent of the funds are allocated for emergency medical treatment via a committee appointed by the National Council on Health
Counterpart funding	Proposes that States and Local Government provide 10 percent and 5 percent, respectively, in counterpart funding as an eligibility criterion to access the federal grant	Requires States and Local Governments to provide 25 percent in counterpart funding
Chairpersonship of the National Tertiary Health Institutions Standards Committee	Suggested that the committee shall be chaired by a professor of not less than 10 years of experience and the person must be a medical doctor	Suggests that any experienced person in the health sector with skills in service delivery and planning
Control of use of blood, products, tissue and gametes in humans	Does not stipulate the waiver of the consent clause for the use of blood and tissue products from living persons for medical investigations and emergency treatment	Stipulates that the consent clause for the use of blood and tissue products from living persons may be waived for medical investigations and emergency treatment
Cloning	Prohibits the reproductive and therapeutic cloning of humankind, but stipulates that the Minister can approve exceptions	Prohibits the reproductive and therapeutic cloning of humankind; there is no exemption possible.

Source: 2004, 2008, 2011 (partial) drafts of the guidelines and advocacy material provided by CSOs

[290] The soft copy of the consultancy report available.

Generally, the NHAct is expected to rectify some of the Nigerian healthcare SoP's most pressing deficits (notably in terms of health financing) and address the difficulties caused by the constitution's oversight to provide a clear set-up of the national health system. However, asked the question of whether the NHAct corrected for the shortcoming of the constitution, a leading figure of the health sector reform process responded: "I wouldn't say yes, but I wouldn't completely say no. … But, notwithstanding, some of the provisions of the law try to address that to date.[291]

5. Conclusion

In light of the above, President Goodluck was in the world-wide spotlight in March 2014, when he pledged the Nigerian administration's commitment to making quality healthcare accessible to all Nigerians, and even more so, when he finally signed the NHAct into law half a year later. Yet, as laid out in this chapter, although the enactment of the NHAct may be considered a breakthrough in Nigeria's journey towards reforming its health system, the different positions and interests of the various stakeholders, election cycles, law adoption procedures and Nigeria's federal character have severely influenced the final text of the NHAct and, consequently, influence the form UHC implementation is taking in Nigeria. From this point of view, I have attempted to make two key arguments in this chapter.

First, I highlight how the persistent influence of the private sector over the process leading to the NHAct can be accounted for in terms of the existence of a pro-private sector lobby from independent-Nigeria's beginnings, but notably in terms of an explicit market-centric turn in social policymaking in the mid-1980s. While in the 1950s, 1960s and 1970s, public policies promoted public investments in healthcare and education as a way of investing in citizens and fostering social cohesion and national unity, social spending for health (and education) declined significantly in the early 1980s as a result of a global oil price crush and a shift in policymaking. Notably, the adoption of the neo-liberal reform structural adjustment programme in 1986 was accompanied with an emphasis on privatising healthcare delivery systems as well as the introduction of user fees. The latter demonstrate the policy of making individuals responsible to cater for their health needs privately. The path-dependency of the strong emphasis on private provisioning and private responsibility was that when Nigeria's National Health Insurance Scheme was enacted in 1999, private Health Maintenance Organisations were invited to serve as interface between the beneficiaries of the social insurance scheme and the (public or private) health providers. As a consequence, solid private sector involvement in Nigeria's healthcare system remains a governance reality also today and private providers continue to be an

[291] Interview 36; 20/03/2019.

important component of Nigeria's healthcare SoP. Furthermore, while the NHAct was initially expected to constitute a radical shift from high OOP spending to a publicly funded healthcare system, Government resources envisaged for the provision of healthcare services are little and insufficient to assure access to quality healthcare for a population of around 200 million people (see also Chapter 6).

Second, I have demonstrated the complexity of health policymaking in the Nigerian context by showcasing how various agents impacted the final text of the NHAct and thus the policy environment that the Nigerian healthcare SoP is embedded in. Specifically, I have outlined the effect of Nigeria's federal structure on policymaking, as States are federating units and have significantly altered the NHAct (notably, by insisting that exact roles and responsibilities are deleted from its final version). I have also highlighted the impact of election cycles and law-making procedures on health policymaking, having narrated how changes in Government have led to delays of getting the NHAct passed into law. And, lastly, I have laid out how Nigeria's socio-economic context and the prevalent narrative that public resources are scarce and public capacities limited have resulted in a NHAct that only earmarks a small annual allocation for primary healthcare delivery and encourages the private sector to support efforts to improve service delivery.

In conclusion, while the enactment of the NHAct may be a landmark, close attention now needs to be paid to whether and how the NHAct will be implemented. For instance, Holmes and Akinrimisi (2011) have highlighted the important role that State and Local Governments play in adequately translating regulatory policies into practice. And, Aiyede et al. (2015) have pointed at Nigeria's weak track-record of implementing social policies. Similar views were raised during interviews and the concern appears to prevail whether the NHAct will be properly implemented: "we [Nigerians] do not have problems with developing policies. Where the problem lies is implementing the policy."[292] In the following chapter, I focus on the on-going implementation of the NHAct, and notably on the concurrent efforts to operationalise the BHCPF, as one of the main contributions of the NHAct. I present a thorough analysis of how the BHCPF is organised. And, I highlight the many contestations between different agents, operating with a specific set of structures and processes that characterise the Nigeran healthcare SoP and which affect its operationalisation and the shape UHC is taking in the country.

[292] Interview 9; 27/02/2019.

CHAPTER 6 | Implementing health policy in Nigeria: the BHCPF as catalyst for achieving UHC in Nigeria?

1. Introduction

When a decade after a first draft of the health bill was initially tabled and the NHAct was finally adopted in 2014, article 11 of the Act received wide-spread attention. This was, in particular, because it mandated the establishment of a novel health financing mechanism: the Basic Health Care Provision Fund (also known by its name "Huwe").[293] The Fund was created to provide sustainable resources for the fast-tracking of UHC and is intended to be predominantly funded through an annual block grant from the Federal Government. Concretely, the BHCPF, as instituted by the NHAct, has a three-fold purpose. First and foremost, the Fund seeks to encourage and broaden access to social health insurance in order to reduce out-of-pocket healthcare expenditure. Half of the BHCPF's resources are expected to be channelled via the NHIS to decentralised State Health Insurance Schemes or State Health Insurance Agencies (SHIAs), in order for these to provide a Basic Minimum Package of Health Services (BMPHS) to the people living in their States (the "NHIS implementation gateway"). Second, 45 percent of the BHCPF's money is to be used to reinforce the public primary healthcare delivery system. The NPHCDA has been charged with the responsibility of overseeing that at least one fully functional PHC facility per political ward is accredited to serve as a service delivery point for the BMPHS. While private sector participation is allowed as part of the BHCPF roll-out, the resources via the "NPHCDA gateway" are reserved for public facilities in order to allow them to upgrade their standard of service. Third, the remaining 5 percent of BHCPF resources are reserved for emergency medical treatment and administered by the National Emergency Medical Treatment Committee (via the "EMT implementation gateway").

Therefore, in December 2014, when the NHAct became law, hopes were high that the establishment of the BHCPF would swiftly lead to a considerable increase in public funding for healthcare to improve access to healthcare for the Nigerian people. Yet, the Federal Government of Nigeria did not make its first allocation to the BHCPF until 2018. Only four years after the formal passing of the NHAct 55.1 billion Naira (worth approximately US$ 150 million at the time) were allocated to the BHCPF. The BHCPF was formally launched on 10 May 2019 in just three pilot States (Niger, Abia and Osun States).[294] And, only in September 2019, the incoming Federal Minister of Health of Nigeria, Dr.

[293] Huwe is a word in the language Ebira (spoken in North-central Nigeria), which means life. See, for instance, here: https://nigeriahealthwatch.com/will-the-1-be-a-game-changer-in-nigerias-2019-elections/#.XZ7cG0ZKjIU (last accessed 08/07/2021).

[294] See: https://twitter.com/fmohnigeria/status/1126814038216855552?lang=en (last accessed 12/07/2021).

Ehanire, announced the first disbursement of 5.6 billion Nigerian Naira (approximately US$ 15.7 million) via the gateways of the BHCPF to the NHIS and the NPHCDA. However, a few months later, the implementation of the BHCPF was put to a halt again.[295] The interruption followed objections by the Committees on Health of the National Assembly that the BHCPF's 2018 Operations Manual was not in compliance with the NHAct.[296] Since then, new implementation guidelines have been adopted and the BHCPF has re-started operations. However, due to the shortfall in revenue amidst the COVID-19 pandemic, the allocation to the BHCPF in 2021 amounted to only 35 billion Nigerian Naira (approximately US$ 85 million). With Nigeria's (estimated) population of 200 million, this represents an allocation of around US$ 0.42 per person.

This chapter focuses on the implementation of the NHAct and places an analysis of how the BHCPF can contribute to UHC in Nigeria at its center (see Figure 52). In this respect, my aim is not to assess the BHCPF's effectiveness or its direct impact on changes in health status of the Nigerian people. Instead, I aim to unpack the contestations that are characterising the on-going process of operationalising the BHCPF, with implications for transformations of the Nigerian healthcare system of provision as a whole. Specifically, I discuss how the four key structures and processes I have introduced in Chapter 5 continue to impact the way in which different agents within Nigeria's healthcare SoP affect policy implementation, here of the NHAct (by proxy of the BHCPF):

- First, **Nigeria's federal structure** continues to impact the policy sphere decisively, affecting how the BHCPF is operationalised. Most prominently, Federalism in Nigeria has translated into the **decentralisation of social health insurance** in Nigeria and the establishment of 38 different health insurance schemes in the country. At the same time, State Primary Health Care Agencies (SPHCDAs) were made primarily responsible for the management of primary healthcare delivery (with the support of Local Government Health Authorities and Ward Development Committees).
- Second, the **socio-economic context of the country**, in the first instance, influences whether and how much resources are being made available for the implementation of the BHCPF and for the healthcare system more broadly. This has a direct impact on the different dimensions

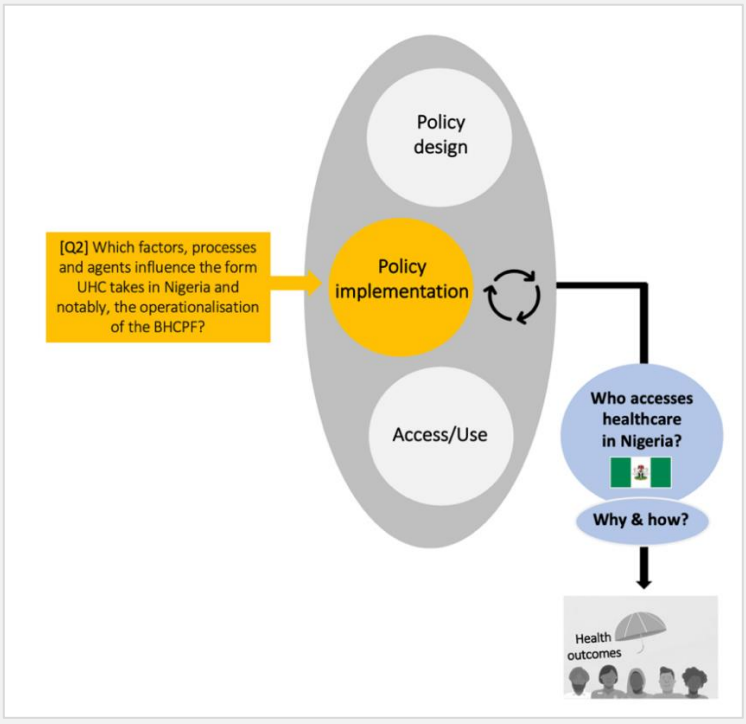
[295] See: https://www.premiumtimesng.com/health/457060-basic-health-care-provision-fund-a-slow-start-to-a-long-journey.html (last accessed 26/07/2021).

[296] See presentation made by the Minister of Health in January 2021 (footnote 304) as well as here: https://sydani.org/the-journey-towards-health-for-all-in-nigeria-is-the-bhcpf-the-way-forward/ (last accessed 12/07/2021).

of UHC: which services will be included as part of the benefits package; who will be allowed to access them; and to what extent will there be cost sharing?

- Third, the **dominance of neo-liberal policies**, globally and in Nigeria, manifests as an attachment to **private sector inclusion in healthcare delivery**. Private healthcare providers are invited to partake in the BHCPF and deliver the BMPHS and some States have decided to contract Health Maintenance Organisations to administer portions of their insurance business process.
- Fourth, in Nigeria, we observe a concrete example of the way in which a globally promoted shift from universalism (free, comprehensive primary healthcare for all citizens) to focusing on the delivery of selective services for the few materialises. As of now, a limited **Basic Minimum Package of Healthcare Services** is being delivered to specific **target groups**.

Figure 52: Implementing the National Health Act



Source: Own illustration

This chapter is structured as follows.

In section 2, I outline the current set-up of the BHCPF and provide a detailed overview of how its three gateways operate.

In section 3, I provide an in-depth analysis of how the above set of structures and processes affects the potential of the BHCPF to serve as a catalyst for UHC in Nigeria. I shed light on the controversies

surrounding the elaboration of the BHCPF operational guidelines and analyse how these contestations affect the on-going operationalisation of the BHCPF through the prism of the SoP approach. This proceeds on the basis of careful examination of three different versions of the guidelines (2016, 2018, and 2020), with the latest version now serving as the main roadmap for the implementation of the BHCPF. This is combined with data collected during fieldwork, which allows to investigate how the position of different agents influenced modifications made to the different iterations of the guidelines. I single out the most pertinent changes to the guidelines and analyse their (potential) implication for access to healthcare in Nigeria. Concretely, three major areas of contention stand out, with significant implications for the healthcare SoP in Nigeria. First, agents' viewpoints differ with regard to how BHCPF resources should be secured, used and disbursed. Second, the division of power and responsibility between Federal and State organs as well as between the Ministry of Health and its agencies remains contested. Third, there is contestation around whether/how to enrol and target beneficiaries and what the service package should entail.

Section 4 concludes and summarises how the various agents, structures and processes are influencing the implementation of the BHCPF and how this affects Nigeria's UHC reform.

2. General administration, financial management and implementation gateways of the BHCPF

The NHAct establishes the BHCPF in article 11.1 and provides direction on how the fund should be financed (NHAct, 11.2.), how the money should be used (NHAct, 11.3 and 11.4) as well as on criteria for State and Local Governments to qualify for a block grant (NHAct, 11.5 and 11.6). The BHCPF operational guidelines build on the NHAct and provide a more detailed account of how the BHCPF should be administered, managed, implemented and monitored. Since 2016, multiple versions of the guidelines have been published and in September 2020, the FMOH published its latest version of the guidelines (the *Guideline for the Administration, Disbursement and Monitoring of the Basic Health Care Provision Fund*). Currently, the 2020 guidelines serve as the basis for the on-going implementation of the BHCPF and stipulate the following objectives (FMOH, 2020, p. 25):

- to achieve at least 1 fully functional public or private primary facility in each political ward (within 7 years);
- to achieve at least three fully functional public or private secondary health care facilities, benefitting from the BHPCF in each State (within 5 years);
- to establish an effective emergency medical response in 36 States plus the Federal Capital Territory in 5 years, including a national ambulance service;
- to reduce OOP spending by 30 percent in 5 years and to increase financial risk protection through health insurance;

- to increase life expectancy to at least 60 years over the next 10 years.

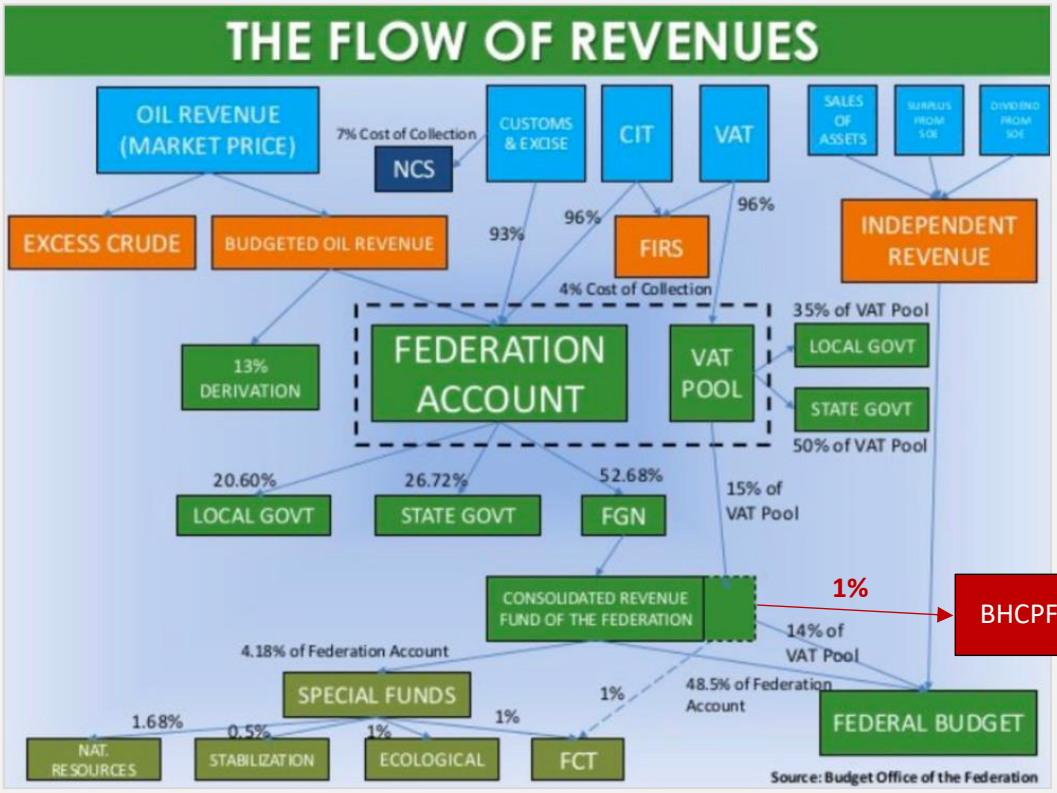
As stated in article 11.2 of the NHAct, the BHCPF is expected to be predominantly financed from a Federal Government annual grant of not less than one percent of its Consolidated Revenue Fund (CRF). As per the constitution, the CRF combines "all revenues, or other monies raised or received by the Federation (not being revenues or other monies payable under this said constitution or any Act of the National Assembly into any other public fund of the federation established for a specific purpose)" (NHAct, 80.1; also see Figure 53). In addition, grants from donors as well as resources from any other source are expected to increase the available resources via the BHCPF. With regard to funding from "any other source", no detailed information is provided in neither the Act nor the 2020 guidelines. However, revenues from taxes on cigarettes and alcohol (Uzochukwu et al., 2015), taxes on refined sugar-based beverages[297] or a mobile phone tax[298] have been discussed in the literature and the media. As per the 2020 guidelines, donor funding should be pooled into a dedicated Treasury Single Account (TSA) at the Central Bank of Nigeria (CBN), in like manner as the 1 percent CRF funding, and also disbursed following the same criteria.[299] The guidelines, however, stipulate that "if donors have specifications for disbursement of their contributions, those funds will be domiciled in a separate account and disbursed by the MOC [Ministerial Oversight Committee] according to the donor stipulations" (FMOH, 2020, p. 36). The guidelines also allow partners to select a specific recipient State and implementation gateway and to provide dedicated support in accordance with their mandate (e.g., financial support for infrastructure development or equipment or technical support to assist programme implementation). In this case, they would not be required to channel their resources via the general BHCPF pool. Hence, the 2020 guidelines give some leeway to donors to bypass the BHCPF and to attach conditions to their funding.

[297] See here: https://www.premiumtimesng.com/health/457060-basic-health-care-provision-fund-a-slow-start-to-a-long-journey.html (last accessed 08/07/2021).

[298] See here: https://www.vanguardngr.com/2018/12/csos-to-fg-introduce-mobile-phone-tax-to-fund-healthcare-in-nigeria/ (last accessed 08/07/2021).

[299] The Treasury Single Account (TSA) policy was implemented in 2015 by the Buhari regime in a move to increase budget transparency and prevent mismanagement of public resources. Since then, all federal Ministries, Department and Agencies are required to pay all government income into a unified pool at the Central Bank (Bashir 2016).

Figure 53: The flow of revenues in Nigeria



Source: Twitter Account of user "TMZ" based on the Budget Office of the Federation[300]

To date, little public resources have been allocated to the BHCPF and even less, only 27.55 billion Naira (approximately US$ 75 million) of Federal Government funding, have been actually disbursed (see Table 11). Some donors have contributed to the BHCPF. In 2018, the Bill and Melinda Gates Foundation (BMGF) approved a US$ 2 million grant to be disbursed over a period of 31 months in order to "test a new Government-sanctioned primary health care funding mechanism by (a) providing operational budgets for 898 rural primary health care facilities in Abia, Niger and Osun States; (b) purchase a set of basic but high impact services".[301] The same year, the World Bank committed to support the roll-out of the BHCPF implementation in these three states with a US$ 20 million Global

[300] See: https://twitter.com/busanga/status/1210847996797173760 (last accessed 26/04/2021).

[301] The "Committed Grants Database" of the BMGF is available for download here: https://www.gatesfoundation.org/about/committed-grants?country=Nigeria&page=5 (last accessed 08/07/2021).

Financing Facility (GFF) grant.[302] According to media reports and also re-iterated during interviews, DfID as well as the Dangote Foundation have signalled eagerness to support the BHCPF financially.[303]

Table 11: Allocations to the BHCPF and disbursements to date

Years	Funds appropriated (in NGN)	Funds released (in NGN)
2015, 2016, 2017	0	0
2018	55,150,000,000	27,550,000,000
2019	51,219,751,964	0
2020	44,498,247,834	0
2020 (revised budget)	26,457,743,000	0
2021	35,025,926,586	n/a

Source: Appropriation bills 2015-2021; Presentation by the Federal Minister of Health held on 21st January 2021[304]

In line with the NHAct, the BHCPF funds, pooled at the Central Bank, are expected to be disbursed via three gateways:

- 50 percent of resources are channelled via the "NHIS gateway" for the provision of a basic minimum package of health services to citizens in eligible primary or secondary health care facilities through the National Health Insurance Scheme (NHAct, 11.3.a).
- 45 percent of resources are channelled via the "NPHCDA gateway" in order to provide essential drugs, vaccines and consumables for eligible primary healthcare facilities [20 percent] (NHAct, 11.4.b); for the provision and maintenance of facilities, equipment and transport for eligible primary healthcare facilities" [15 percent] (NHAct, 11.4.c); and for the development of human resources for primary healthcare [10 percent] (NHAct, 11.4.d).

[302] According to the World Bank's latest implementation report, US$ 11.5 million have been disbursed so far. See here: https://documents1.worldbank.org/curated/en/798791624997945892/pdf/Disclosable-Version-of-the-ISR-BASIC-HEALTHCARE-PROVISION-FUND-PROJECT-HUWE-PROJECT-P163969-Sequence-No-05.pdf (last accessed 08/07/2021).

[303] Interviews 2, 14, 41, 49; also see, for example, here: https://www.thisdaylive.com/index.php/2019/01/10/fg-wbank-bmgf-commit-180-million-to-fund-universal-health-coverage/ (last accessed 08/07/2021).

[304] The presentation is available here: https://ngfrepository.org.ng:8443/bitstream/123456789/2777/1/UPDATE%20ON%20IMPLEMENTATION%20OF%20THE%20BHCPF%20for%20NEC.pptx (last accessed 08/07/2021).

- 5 percent or resources are channelled via the "EMT gateway" to be used for emergency medical treatment (NHAct, 11.4.e) and administered by the National Emergency Medical Treatment Committee (NEMTC).

The NHIS and NPCDA gateways channel their resources onwards to (the TSA accounts at the Central Bank) of the respective SHISs and SPHCDAs. The NHAct (11.5.a) and the 2020 guidelines (FMOH, 2020, pp. 27–28) stipulate that these State-level organs can only draw from the Federal pool after they have provided 25 percent of the total cost of projects as counterpart funding to match the grant from the Federal level. The SHISs and SPHCDAs are then responsible to channel the resources onwards to accredited healthcare facilities.

As part of the NHIS gateway, the SHISs will purchase a defined benefits package – currently actuarially determined to cost NGN 12,000 (worth around 30 USD in July 2021) – from enlisted and accredited **primary** healthcare facilities for the number of persons that they have enrolled (using a capitation provider payment modality). This means that SHISs will pay a monthly advance payment to these health facilities to ensure that enrolled individuals can access services that are part of the BMPHS fee-free at point of delivery.[305] If PHC facilities refer patients onwards to **secondary** healthcare providers, the SHISs will reimburse these secondary facilities on basis of actual tariffs of the services rendered (using a fee-for-service provider payment modality). Public and private, primary and secondary healthcare facilities can participate in the programme but need to apply for enlistment into the BHCPF and undergo certification and accreditation.[306]

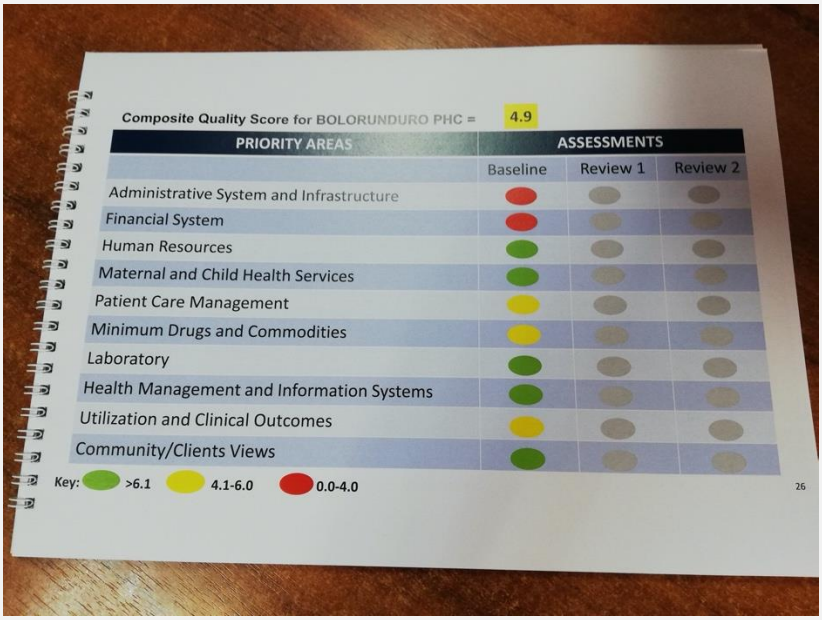
As part of the NPHCDA gateway, the BHCPF supports the objective of putting into place at least one functional PHC facility per political ward, which can serve as service delivery point for the BMPHS. On the basis of a baseline needs assessment, beneficiary public PHC facilities are selected and are then eligible to receive funds from the SPHCDA on a quarterly basis (see Figure 54 for an example of a scorecard, determining eligibility). Concretely, SPHCDAs make a direct transfer to the commercial bank accounts of selected PHC facilities. This payment modality is known as Decentralized Facility Financing (DFF) and was piloted as part of the World Bank's Nigeria State Health Investment Project. The reception of direct payments allows facilities to purchase medicines, medical consumables and

[305] As clarified in Art. 64 of the Act, "basic minimum package means the set of health services as may be prescribed from time to time by the Minister after consultation with the National Council on Health". The BMPHS should include preventative, protective, promotive, curative and rehabilitative health services. A detailed list of services currently included as part of the BMPHS is available in the 2020 guidelines (FMOH, 2020, pp. 46–53).

[306] The NHIS is primarily responsible for accrediting private primary and secondary healthcare facilities, and public secondary healthcare facilities. The NPHCDA is primarily responsible for accrediting public primary healthcare facilities (FMOH, 2020, p. 44).

other health commodities (with 20 percent of the resources) as well as to renovate and maintain the PHC facility infrastructure and support transportation of vaccines, community outreach activities and other operational costs (with 15 percent of resources). PHC facilities need to use the resources on the basis of a business plan that they submit to the SPHCDAs. The remaining 10 percent of resources disbursed via the NPHCDA gateway are maintained at the level of the SPHCDAs and utilised to fund interventions such as training midwives and community-based health workers. Both State agencies as well as Local Government Health Authorities (LGHAs) are expected to match the BHCPF grant (providing 25 percent counterpart funding each) and, in parallel, are strongly compelled to continue providing their routine funding to public PHCs (FMOH, 2020, p. 53).

Figure 54: Quality Scorecard for PHC facilities



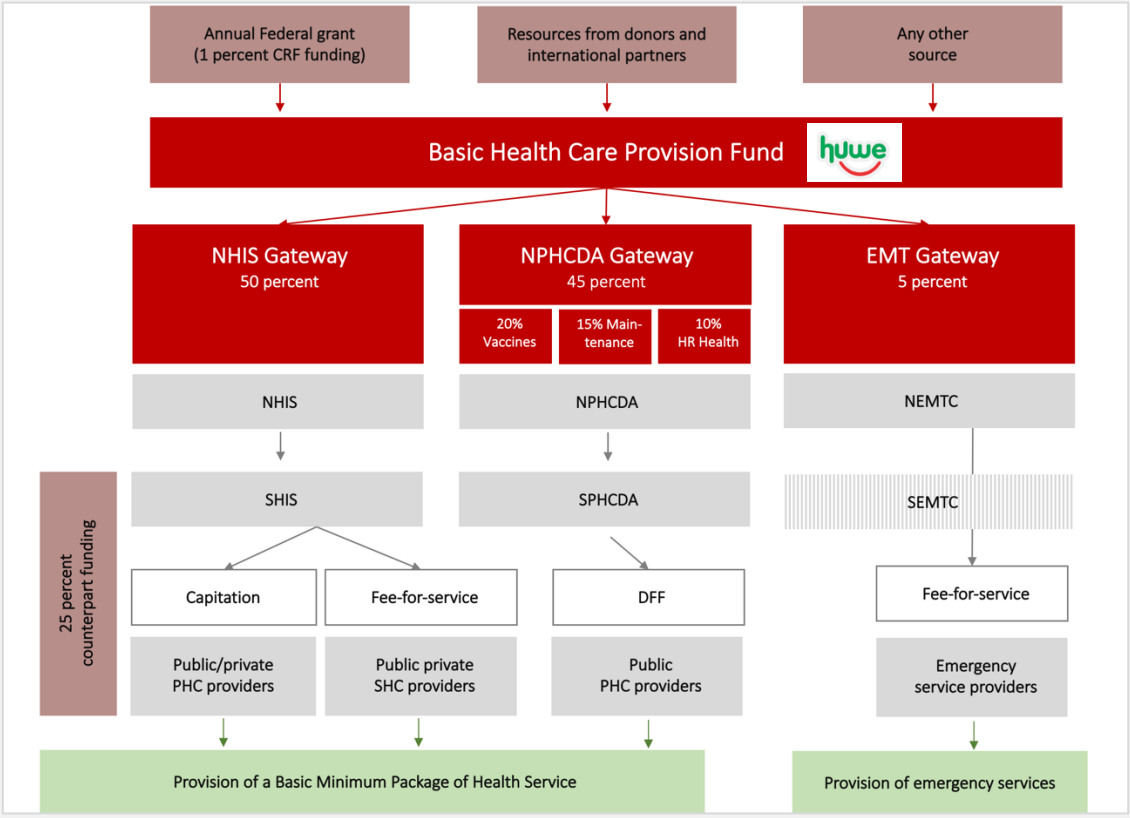
Source: Photo taken during fieldwork on 29 March 2019

Finally, the resources disbursed via the EMT gateway are administered by the NEMTC with the aim of establishing a functional National Emergency Medical Services and Ambulance System (NEMSAS). The NEMTC directly reimburses providers for emergency medical treatment services (emergencies, trauma or accidents, disaster and mass casualty situations) using a fee-for-service payment modality. At State level, State Emergency Medical Treatment Committees (SEMTCs) are currently being instituted,[307] and States are expected to provide 25 percent counterpart funding for this gateway.

[307] In May 2021, Anambra State became the first State to put into place a SEMTC: https://www.absradiotv.com/2021/05/08/anambra-govt-inaugurates-emergency-medical-treatment-committee/ (last accessed on 27/08/2021).

However, the responsibility of SEMTCs is restricted to feeding the NEMTC with data on providers and to expediting the verification of claims. They do not handle any payments. Figure 55 represents the implementation structure of the BHCPF with its three implementation gateways.

Figure 55: Implementation structure of the Basic Health Care Provision Fund



Source: Own illustration based on NHAct and the 2020 guidelines

The Federal Minister of Health, who is supported by a Ministerial Oversight Committee (MOC),[308] bears ultimate responsibility for the effective implementation of the BHCPF and approves annual plans and budgets for the three gateways. The MOC is the main coordination and oversight organ. At State level, the State Commissioners for Health and State Oversight Committees (SOCs) support the BHCPF implementation and assure that counterpart funding is provided. They, furthermore, support existing Local Government Area Primary Health Care Advisory Committees, which were put into place as an integral part of the PHCUOR initiative and the Ward Health System. These Local Government organs

[308] The MOC is headed by the Minister of Health and its members include the heads of the NHIS, NPHCDA and the NEMTC, the Minister of Finance, representatives of the SHISs and SPHCDAs as well as representative of CSOs, development partners and private sector organisations contributing to the fund. The full list of membership of the MOC is available on page 31 of the 2020 guidelines.

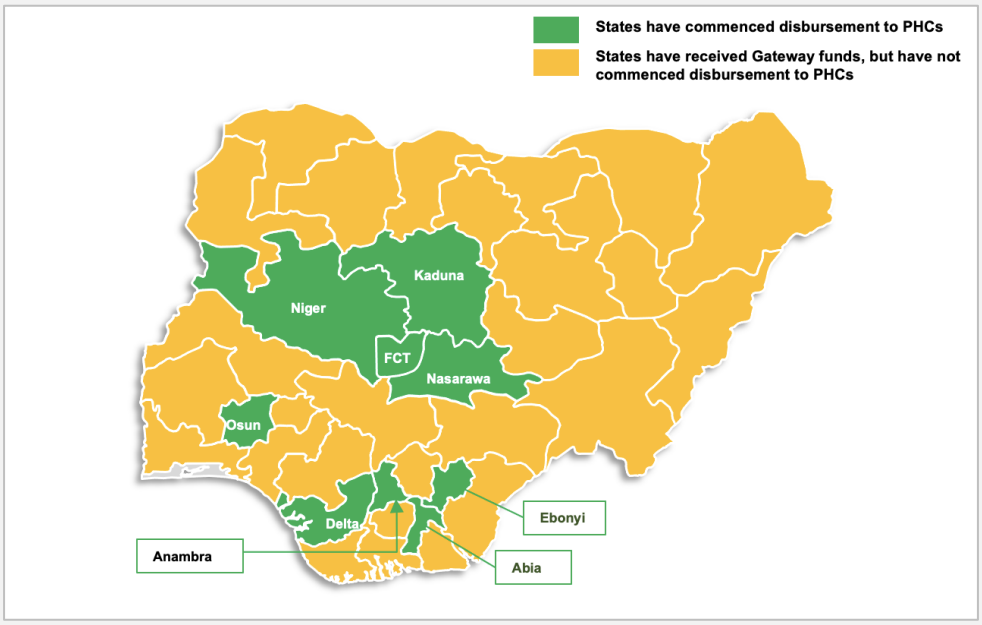
closely collaborate with Ward Development Committees, who support the health facility leadership in identifying and planning for health needs. The WDCs are also co-signatory to the commercial bank accounts. The 2020 guidelines, moreover, stipulate the establishment of so-called gateway fora at Federal and State level to assure interaction between the agencies and organs in charge of implementing the three gateways. Operations cost at Federal and State level are financed by having each gateway deduct 5 percent of their share and pool them in a designated account (FMOH, 2020, p. 40). For each of the gateways, a monitoring and accountability component is outlined in the 2020 guidelines and CSOs are explicitly encouraged to provide an oversight function.

As of January 2021, BHCPF funds have been released to all 36 States and FCT via the NHIS gateway according to a presentation given by the Federal Minister of Health (see footnote 300). Nonetheless, only 13 States and FCT have started enrolling beneficiaries to the BHCPF.[309] The Minister's presentation further summarised that NGN 13.2 billion of BHCPF funds have been released via the NPHCDA gateway to all 36 States and FCT, with eight States and FCT having already met all readiness criteria, including the baseline assessment and capacity building activities, and have started to disburse funds to PHCs (see Figure 56).[310] At the time of the presentation, another 19 States had been authorised to start disbursement to facilities. On the contrary, two States (Akwa Ibom and Rivers) had not yet started their baseline assessment and another four additional States (Kogi, Cross River, Enugu and Lagos) had not yet commenced the necessary capacity development training of health facility workers, which are both pre-conditions for a State to be "verified" and authorized to commence paying health facilities. The following section highlights some of the contestations that contribute to the rather slow implementation of the BHCPF.

[309] Based on the Minister's presentation, these States are Kaduna, Kano, Niger, Sokoto, Kwara, Nasarawa, Yobe, Cross River, Anambra, Ebonyi, Abia, Kogi and Ogun.

[310] Based on the Minister's presentation, these States are Abia, Ebonyi, Osun, Anambra, Delta, Niger, Nasarawa and Kaduna.

Figure 56: Disbursements to States and PHCs via the NPHCDA gateway



Source: Presentation by the Federal Minister of Health held on 21st January 2021 (see footnote 300)

3. Contestations concerning the implementation of the BHCPF

During the 62nd meeting of the National Council on Health in September 2019, State Governments raised concerns regarding the implementation structure of the BHCPF as well as the process that had led to the adoption of the 2018 BHCPF implementation guidelines (the *2018 Operations Manual*). Concretely, they signalled dissatisfaction with the extent to which development organisations had influenced the BHCPF implementation guidelines and the fact that they had not been consulted sufficiently.[311] In particular, the World Bank's role in influencing the 2018 guidelines and structuring the BHCPF as a **project** instead of a sustainable funding stream was singled out as a problematic issue. In response to the criticism raised during the 62nd session of the NCH, an independent consultancy report was commissioned. The consultant was tasked with assessing the course of events that had led to the adoption of the 2018 Operations Manual. According to a civil society member, the consultant's report found that the BHCPF implementation structure had indeed been overly influenced by the World Bank and that the guidelines were not entirely in accordance with the NHAct.[312] As a

[311] See for example here a report on the 62nd session of the NCH: https://southsaharan.org/wp-content/uploads/2020/08/Report-on-the-62nd-National-Council-on-Health.pdf (last accessed 12/07/2021.)

[312] Follow-up phone call to interview 36; 08/05/2021.

consequence, a process was initiated to revise the 2018 implementation guidelines. The mandate to oversee this process was given to the Executive Director of the NPHCDA (Dr Faisal Shuaib), which is in accordance with Art. 11.7 of the National Health Act.[313] In due course, a committee, with the NHIS, the NPHCDA and the FMOH as main patrons, revised the implementation guidelines in consultation with the States. The 2020 guidelines were approved by the NCH in September 2020.[314]

The World Bank's influence on the BHCPF implementation process and the broad discontent with the IFI's power to do so, is illustrative of how a number of contestations between the various agents in Nigeria's healthcare SoP affects the implementation of the BHCPF and its contribution to UHC in Nigeria. In this sense, the preface of the 2020 guidelines highlights that the revision of the 2018 BHCPF Operations Manual was necessary in order to "better align [the implementation guidelines] with the NHAct and address fundamental issues with the mechanism for administration of the fund, among other concerns". A careful analysis of the three (approved) versions of the BHCPF guidelines (adopted in December 2016, November, and September 2020, respectively) as well as detailed background information gathered during fieldwork, follow-up conversations after fieldwork and through the media allows me to group the most pressing concerns into the below three intertwined categories.

- First, there seem to be difficulties relating to the **BHCPF's funding sources, the use of its resources as well as its disbursement modalities**. Although the NHAct appears to be prescriptive as to how to secure funds for the BHCPF and how these need to be used, the views of some agents differ with regard to: (i) whether the Federal annual block grant needs to be a statutory allocation; (ii) the extent to which States' counterpart funding should be a pre-condition to receive federal funds; (iii) how donor funding should be pooled and used; (iv) whether parts of the resources of the EMT gateway should be used to prepare and respond to infectious disease outbreaks; (v) whether resources earmarked for the BHCPF can be diverted back to the national level for national vaccine procurement ; (vi) whether funds can be used for the construction of new PHC facilities; (vii) the share of resources that can be used to cover for administrative costs; and (viii) which provider payment mechanisms appear to be the most appropriate for disbursing funds to end users.

[313] The article outlines that the responsibility to develop "appropriate guidelines for the administration, disbursement and monitoring of the Fund with the approval of the Minister" lies with the NPHCDA.

[314] See: https://www.health.gov.ng/index.php?option=com_k2&view=item&id=743:national-council-on-health-meeting-approves-2020-basic-health-care-provision-fund-guideline (last accessed 12/07/2021).

- Second, agents operating within the Nigerian healthcare SoP show different preferences regarding how the **control and responsibility to implement the BHCPF** should be allocated. This has been illustrated by (i) the shift from a technical Management Secretariat of the Fund (TMSoF), responsible for oversight and coordination only, to a high-level National Steering Committee (NSC) with more power and control over the operations of the BHCPF, and finally back to a Ministerial Oversight Committee; (ii) the approach States are taking to operationalise their SHISs and their discontent with the NHIS for enrolling citizens in "their" States; and (iii) concerns as to whether the collaboration between SMOHs, SPHCDAs and LGHAs will be harmonious.
- Third, controversy surrounds the **actual practice of delivering healthcare services** concerning (i) the groups targeted to access the benefits package; (ii) the choice of healthcare services that will be part of the BMPHS; (iii) the enrolment procedure preceding the consumption of healthcare services as part of the BHCPF; and (iv) whether the BHCPF is set-up to address major service delivery challenges, such as the inadequate state of infrastructure, the lack of qualified healthcare personnel, the non-availability of drugs, and corruption.

In the following three sections, I discuss these three major areas of contestation in detail. I highlight and signpost how the interplay between different agents, Nigeria's federal structure, the country's socio-economic context, processes of neo-liberalisation and privatisation and a global push for UHC cut across these areas of controversy and affect the process of operationalising the BHCPF. Concretely, I discuss how such contestations have been reflected in the changes made to the operational guidelines and outline how the various agents operating within Nigeria's healthcare SoP have had different levels of influence and power (and interest) to influence policy implementation. Appendix N summarises the most pertinent changes to the operational guidelines and Appendix O maps the role and influence that the identified agents of significance have on shaping the implementation of the BHCPF in Nigeria.

3.1. BHCPF funding sources, use and disbursement

If properly implemented, the BHCPF is expected to secure a sustainable funding stream to the healthcare system. This is because the NHAct makes an annual Federal allocation mandatory and requires State and Local Governments to provide counterpart funding as a pre-condition to benefit from the BHCPF. At the same time, the NHAct encourages donors to contribute to the fund and invites policymakers to be "innovative" and think of further avenues to secure funding. Yet, in reality, different agents' interpretations of these stipulations influence the outlook and, likely, the sustainability of the BHCPF. In the following, I highlight eight concrete areas that have proven to be contentious.

First and foremost, the envisaged statutory annual 1 percent CRF allocation to the BHCPF has not materialised as planned. The first disbursement only happened in 2019, and, as a CSO representative highlighted, only after the elections had brought in a new chairman of the Senate's health committee (Senator Yahaya Ibrahim Oloriegbe). The new chairman heavily advocated for its launch and "was one of our people [a former founding member of HERFON]".[315] The Buhari-led Government, on the contrary, appears to have shown little motivation to allocate any resources to the BHCPF and fell short to do so in 2015, 2016 and 2017, in spite of it being a legal requirement, as highlighted by a State official:

> This Government in office delayed the implementation of this BHCPF. They came in in 2015, the law was signed in October 2014, they came in [on] May 29th, 2015. And they just flagged it off [in] January 2019. So, you see, four years … a whole tenure of not implementing it.[316]

Furthermore, as a World Bank employee notes, in 2018, the allocation to the BHCPF was not made on initiative of the Federal Government (the executive), but was only included in the budget proposal after public health reformers within the National Assembly (the legislative) highlighted the oversight:

> The first time the BHCPF was implemented was in 2018 … This is the budget process: the executive submit proposals to the legislature, then the legislature sends it to the President to sign the appropriation into law. In 2018, the BHCPF was not included in the proposals from the executive. Like the previous years … the executive was not ready to implement the BHCPF. It was the legislator that inserted the BHCPF into the budget.[317]

Moreover, another interviewee, a civil society representative, pointed explicitly at the shortcoming of the Federal Minister of Health himself to ensure that funding is being apportioned to the BHCPF as mandated by the NHAct. He stressed the important background work of the civil society, who urged for the Senate President (Bukola Saraki) to alter the budget proposal in 2018:[318]

> The Ministry was never involved, the Minister was never interested. Because all the Minister needed to do – it is a law – is budget for it! He went and brought [the excuse that] the Minister for Budget and Planning … kept on telling [him] … that he doesn't have [the] money. It is not

[315] Follow-up phone call to interview 36; 08/05/2021.

[316] Interview 18; 07/02/2019.

[317] Interview 33; 17/03/2019.

[318] Notably, the Nigerian Medical Association and the Health Sector Reform Coalition were essential driving forces and had also approached the Senate's president's wife, a known health advocate (and SOAS alumni), Toyin Ojora-Saraki, to gather her support.

> your right to tell us, you can't put money that is a law. So, we kept on pushing, pushing, pushing, pushing ... For where![319] It was the Nigerian Medical Association that got that thing on … We have primed [the Senate President] enough to [get his] commitment … that he is going to put that thing into the budget. That is how that thing came into the budget. By that time, the President had submitted the budget. But, it hadn't left the National Assembly ... And they put it.[320]

Nevertheless, when in 2018 the first appropriation to the BHCPF was made, the appropriation was not made a **statutory** allocation. The NHAct, though, was intended to mirror the law that established the Universal Basic Education Commission – a law that made six years of compulsory primary and three years of compulsory junior secondary school education free. Similar to the NHAct, the 2004 Compulsory, Free Universal Education Act states that nine years of universal basic education shall be financed from "a Federal Government block/annual grant" of – in the case of UBEC – not less than 2 percent of the Federal Government's CRF (see Appendix P comparing the exact wording of the UBEC Act and the NHAct).[321] As outlined in the previous chapter, the Minister of Finance, in particular, pushed for a more conservative approach and replaced the proposed 2 percent allocation to the BHCPF with a 1 percent allocation. However, another moot point is that in the first two years of the BHCPF implementation, the budget allocation to the BHCPF was treated as a "service-wide vote". As Inyang et al. (2019) explain, a service-wide vote is a budget reserved for contingency and emergencies, normally constituting 5 percent of the annual budget and used to pay for items not included in the annual budget. Statutory transfers, in contrast, are backed by law and cannot be denied by the Presidency and the executive government. The important difference is that the latter do not have to be returned to the treasury at the end of the year, unlike funds channelled to Ministries, Departments and Agencies (MDAs). Still, the States' difficulty to make use of the UBEC resources led to the "political decision"[322] to hold off making the BHCPF allocation a statutory allocation. Only the 2020 version of the implementation guidelines clearly states that the Federal block grant needs to be treated as a statutory first-line charge. In 2020 and 2021, appropriations to the BHCPF, consequently, were

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[319] "For where" is an expression in Nigerian pidgin which means "talk" or "lie".

[320] Interview 46; 27/03/2019.

[321] Currently, efforts are on-going to amend the NHAct and increase the CRF allocation to the BHCPF from 1 percent to 2 percent; see, for instance, here: https://guardian.ng/features/health/gbajabiamila-seeks-buharis-assent-to-bill-seeking-to-make-health-insurance-mandatory/?mc_cid=e19ca5f91c&mc_eid=724b5c5719 (last accessed 30/07/2021).

[322] Interview 47; 29/03/2019.

statutory allocations. Still, the reluctance from sides of the Government to secure the relatively small allocation to the BHCPF demonstrates two things. On the one hand, it shows how the economic downturn that Nigeria was experiencing since 2015 affected their readiness to invest in a social sector. On the other hand, it also reflects that in times of crisis, health/healthcare is not seen as a priority. This, once again, underscores the significance and importance of the BHCPF allocation being a statutory allocation in order to ensure sustainability.

Second, the negative experience with the UBEC not only impacted the decision relating to the nature of the annual BHCPF allocation. It also incited a debate whether it was prudent to enforce the stipulation of the NHAct that requires State Governments to provide counterpart funding as a pre-condition for them to benefit from the BHCPF. As was elaborated in Chapter 5, States did not access UBEC funding and the resources remained sat at the Central Bank. The negative experience with the UBEC is openly described in the 2016 version of the guidelines, and the 2016 guidelines left room for interpretation as to whether States have to provide counterpart funding. As a consequence, one insider reported that, in reality, States have not been paying their counterpart funding:

> Now, States are not paying counterpart. What they are doing is just straight – bring 100 million and you are qualified. They are not really paying that 25 percent, just 100 million – you put it down – 100 million, and then ...[323]

A stakeholder working at the NHIS explains why their agency's position with regard to the counterpart funding was to show some leniency towards States regarding the matter of counterpart funding:

> Well, we are looking at it from the compassionate disposition. Because if you say that they wouldn't get [the money] – and this thing is meant for the citizens – and the Governors are not ready to bring the money: are you going to deny the citizens what is due for them because their Governor has refused to bring the counterpart fund? Some of the Governors consider health as priority, some say, that security is their priority, some will say education, infrastructure and all that. So, but what we intend to do is to go ahead and implement and use the "carrot-and-stick" approach to still be telling them: "Please come and bring your counterpart funding".[324]

Concisely, the debate and reality surrounding States' duty and (lack of) ability to financially contribute to the BHCPF illustrate the direct effect Nigeria's federal structure has on the implementation of UHC in Nigeria. For the case that States do not mobilise the necessary counterpart funding, two possibilities

[323] Interview 12; 28/02/2019.

[324] Interview 14; 01/03/ 2019.

appear plausible: first, State Governments may not have enough financial resources to provide counterpart funding, which is a result of how revenue is mobilised and re-distributed in Nigeria (a point raised in Chapter 4). As one interviewee put it bluntly: "Another thing also that is hindering the States to run with the Federal Government agenda on UHC is the issue of counterpart funding. So, where will this money come from?".[325] Or, second, State Governments may not want to prioritise the BHCPF. One of the main criticisms from State-side with regard to the 2018 Operations Manual was that it was too prescriptive as to how States have to run the BHCPF. A member of Nigeria's academia, who was involved in the discussion around the 2018 version of the guidelines, summarised:

> Because the guideline is not strictly following the law. Because if the guideline was following the law, a State may decide to have HMOs help them to implement, you know what I mean. Because the law actually says that the States will come up with whatever they want to do. And then the funds are merged – the States will provide 25 percent counterpart. So, a State may decide to use HMOs, you know. But now everything is centralised – all the guidelines from Abuja. So, States almost have not so much autonomy. Well, they have autonomy when the money comes, but not so much when it comes to [the] design they want to implement. What they should implement is almost coming down from Abuja.[326]

The dissatisfaction of States Commissioners for Health did contribute to the development of the newest guidelines. The new 2020 guidelines clearly highlight the necessity for all state-level organs to pay the designated 25 percent of the total cost as counterpart funding as per the NHAct. The 2020 guidelines furthermore emphasise the need for Local Governments to provide their counterpart funding. At the same time, the 2020 guidelines also emphasise that BHCPF funds are not to crowd out State and Local Governments' **routine funding** to public PHCs. On the contrary, the guidelines are less prescriptive as to how States are to implement the BHCPF. While the 2018 Operations Manual had a section outlining the exact roles and responsibilities of the State Health Insurance Agencies, this is no longer the case in the 2020 guidelines.

Third, another addition to the 2020 guidelines is that they stipulate that donors can attach specifications as to how they want their financial support to be used and, if they want, they can circumvent the common BHCPF pool. These concessions appeared necessary as, allegedly, the view was that "donor money is quite important to get things happening. If there is no donor money, nothing

[325] Interview 1; 20/01/2019.

[326] Interview 12; 28/02/2019.

is happening".[327] Moreover, the BHCPF originated during a time, where donors, operating actively in Nigeria's healthcare system, were openly challenging the Nigerian Government for having misappropriated financial support. This was highlighted by an interviewee, working in the FMOH:

> [The BHCPF] came in at a time where GAVI, Global Fund were threatening to pull out of Nigeria, because of the scams, you know – there have been some issues with fund misappropriation. World Bank had its own issues as well.[328]

Consequently, as a consultant working with the World Bank accentuates, development organisations, at least at the onset, appeared underwhelmed by the idea of having their finances pooled into a government pot:

> And I remember speaking to a specific donor – the head of one of the agencies, which I'll keep nameless – and asking them if they would be willing to come and put money in the BHCPF. And they said that there is not a chance in hell that money will go to [the] Government of Nigeria. But that's changed. That perspective has changed in less than four years, because … at least there are talks of different donors putting in money into that Fund.[329]

In response to donors' concerns relating to the embezzlement of funds, the Federal Ministry of Health – perceived by some as "not strong with its development partners" but "romanc[ing] and danc[ing] with the development partners"[330] – insisted on pooling all BHCPF resources at the Central Bank of Nigeria in order for the BHCPF to gain donor support and confidence. This was reiterated by an employee of the FMOH:

> In the future we will then have conversations with GAVI, we will have conversations with the Global Fund: "this is a platform for you to deploy your resources, don't put it into a different pot" … [But] if I put this pot in my Ministry of Health account, I am not giving confidence to the partners given the issues that I have had in the past. Right? If I put [all money in a] pot and say, well, the access is divided [with the] NPHCDA and [the] NHIS, partners [will ask]: "Huh? … [The] NPHCDA that had issues with GAVI? I am not dealing with this" … So, the Minister said, I will put this pot at the Central Bank of Nigeria. But not just that I [will] put this pot at the Central Bank

[327] Interview 12; 28/02/2019.

[328] Interview 47; 29/03/2019.

[329] Interview 3; 30/01/2019.

[330] Interview 1; 30/01/2019.

> of Nigeria, I will commit [that the] NPHCDA and [the] NHIS … [and] the State agencies also open their accounts at the CBN.[331]

Despite this attempt to foster transparency, the 2020 guidelines no longer insist on having donor support to the BHCFP collected in and disbursed via the same common resource pool. Allowing donors to circumvent the common pool and to attach conditions to their funding, which likely will reflect their mandates and own priorities, seems to defeat parts of the purpose of the BHCPF. These include: firstly, to have a bulk of resources available that is dedicated to strengthening the primary healthcare service delivery systems **horizontally**; and, secondly, to avoid further fragmentation of healthcare service delivery. The issue of fragmentated and uncoordinated support to the healthcare system is a widely discussed problem within Nigeria's healthcare system of provision, including by development agencies as highlighted by a UNICEF representative:

> You have a partner, for instance, handling the malaria programme, another partner handling the TB [tuberculosis] programme, another partner handling immunisation programme and they are all moving supplies through different channels, at different times to the same end user.[332]

Donors' behaviour and willingness to contribute to a common Government-owned pool remains to be evaluated. In any case, the way that the NHAct is now being interpreted seems to give development organisations leeway to proceed with addressing their own priorities under the appearance of contributing to the BHCPF.

Fourth, apart from controversy surrounding the use of donor funds, the use of resources reserved for emergency medical treatment surfaced as a point of dispute. While the inclusion of the EMT gateway as one of three implementation gateways was already a compromise made during the policymaking process in order to appease the FMOH (see Chapter 5), the 2018 version of the guidelines introduced further confusion. It proposed to split the 5 percent allocation, reserved "to take care of all those road accidents and all those things"[333] into two, and to channel 2.5 percent of the resources to the Nigeria Centre for Disease Control for it to prepare its response to epidemics. A civil society member highlighted that:

> It was also that day that the medical doctors extracted that five percent of emergency medical services, because the question was... that money was supposed to be for road traffic accident,

[331] Interview 47; 29/03/2019.

[332] Interview 23; 08/03/2019.

[333] Interview 43; 27/03/2019.

> but the way they are applying it now is beyond road accident. They are taking it into epidemics, but it shouldn't be, because there is a budget line for epidemics in the Federal Ministry of Health. It is because they are not funding it, they are now going to take money that is not budgeted for epidemics. There is a budget line annually for epidemics, so they shouldn't take that money, this money for emergencies.[334]

The 2020 guidelines reverse this decision, and the entire 5 percent are now again managed by the NEMTC and intended to be used for medical emergencies (and not epidemics). In hindsight, this has been interpreted as the Federal Government cutting funding for epidemics preparedness and response in the midst of a global pandemic.[335] However, the issue rather lies with the Government's shortcoming to allocate adequate resources to the appropriate budget line for epidemics in the first place. The earmarked resources to the BHCPF are small and insufficient to cover the entire Nigerian population. The politics as to who else within the health system could/should benefit from this statutory allocation distract from the original intention for which the BHCPF was created, i.e. to facilitate access to and strengthen primary healthcare.

Fifth, a similar point can be made with regard to vaccine procurement. The shortcoming of the Nigerian Government to prioritise and make available the necessary financial resources for its **routine** national vaccine procurement programme now further cuts into the BHCPF pot. Introduced to the 2018 guidelines and maintained in the 2020 guidelines, 10 percent of the funding reserved for the NPHCDA gateway can now be redirected back to the national level for vaccine procurement. This is different from what is stipulated in the NHAct, which is that eligible PHC facilities can use 20 percent of their allocated BHCPF resources to procure essential drugs, vaccines and consumables, **if they see fit** on the basis of their own business plans that they agreed with the SPHCDA. Once more, this shows the friction that emerges by virtue of Nigeria being a Federation. Instead of respecting the stipulation of the NHAct, the guidelines now allow for resources intended for State-level to be diverted back to the Federal level, because the latter is falling short on its obligation to fund its routine national vaccination programme.

Sixth, another item of contestation was that the FMOH, at the time led by Minister Adewole, proposed to use part of the NHIS gateway's funding, strictly envisaged to be used for the strategic purchasing of the BMPHS, for the construction of PHC facilities. As one informant, working with a CSO, states:

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[334] Interview 46; 27/03/2019.

[335] See, for instance: https://www.thisdaylive.com/index.php/2020/09/17/bhcpf-and-the-defunding-of-ncdc-during-a-pandemic/ (last accessed 23/07/2021).

"Professor Adewole didn't really know what the BHCFP was about. He was distracted and more focused on the 'One PHC per Ward' initiative … He wasn't connected with the BHCPF, and he wanted to draw money from the NHIS to fund his "PHC per Ward" initiative."[336] He explained that this resulted in an open conflict between the FMOH and the NHIS, necessitating the Ministry of Finance to step in to rule that PHC facilities cannot be built with the resources earmarked for the NHIS gateway. It is to note that the 2016 version of the guidelines explicitly stated that the BHCPF resources cannot be used for the construction of new facilities. However, this provision is no longer part of the 2020 version of the guidelines. This leaves room for future contestation and alternative interpretations and demonstrates how Nigeria's organisational structure combined with its election cycles may impact the implementation of UHC in Nigeria. As one World Bank consultant put it: "I think one challenge that Nigeria has faced is … a lack of continuity between changing regimes … You know, if it is seen as something that the current President, or the current regime is doing, then it might have a higher risk of not being continued."[337]

Seventh, Nigeria's federal structure and general underfunding of its healthcare system also contributed to a broad discussion related to the share of the BHCPF funding that can be justifiably held back to pay for the administration of the BHCPF.[338] The 2016 guidelines summarise that a maximum of 5 percent of the entire BHCPF funds can be used to pay for administration expenses. They, however, do not outline which institutions and which level of government is to benefit from these resources. When the guidelines were revised, it appeared that this created tension for two main reasons. The first reason was that the newly proposed high-level National Steering Committee (NSC) was perceived as adding an extra (unnecessary) layer of control, while absorbing parts of the operational costs. This was highlighted by a university employee:

> So now they have a National Steering Committee, which we had suggested, but they wanted to have a Secretariat running this Fund, outside of the Ministry of Health. With funding, with vehicles, with a lot of money – with almost 10 percent of the money. And with the provision

[336] Follow-up phone call to interview 36; conducted on 8 May 2021. Also, in the 2020 guidelines, it is stated that "the healthcare agenda of the administration of Pres. Buhari is centred around the establishment of at least 1 fully functional primary health care centre in every political ward, with the ultimate objective of ensuring UHC; the BHCPF is key to accomplishing this agenda" (FMOH, 2020, p. 23).

[337] Interview 35; 18/03/2019.

[338] As highlighted in a hard-copy report evaluating the NHIS [available], discussions on overhead costs appear to have been a long-standing point of debate in Nigeria. The NHIS budgets an administrative overhead cost of 20 percent, which apparently are shared half-half between the NHIS and the HMOS. The report mentions that this compares to other countries' administrative overhead costs of 5 % (Germany) or 7-8% (Switzerland).

> that the Minister of Health can actually increase it, if it is not enough. So, that one... you know... So that was a big problem. And it included also a lot of running cost in the Ministry.[339]

The second reason was that there was contestation between the agencies and Federal versus State level, as the NHIS and NPHCDA would have preferred to keep the entire funds for administrative cost at their level. As highlighted during an interview with representatives of HERFON:

> So, this is the bulk money here, 5 percent for operations … One of the facts that they were fighting for was that [they] wanted to control the entire operational costs. They didn't want to give these people operational cost. They want to do all operations. And now they have agreed again, because they have now realised – what happens with the States level money? How are those people at the State level now [going to] implement? They have now said "Okay, the Federal Government will hold 60 percent". But we are still on that contention.[340]

The 2020 guidelines do no longer include a National Steering Committee (which is a point I will discuss in more detail in the next section). The most recent version of the guidelines, too, provide some guidance on how much of the BHCPF funding can be held back by the different administrative structures to pay for their operational costs and caps them at 5 percent per gateway. However, it remains to be evaluated how this will actually play out in practice and how much of the BHCPF's funds will go towards paying for operational cost and at which level.

Eighth, and last, a major point of contestation was to find an agreement on the modality of disbursing the funds, the provider payment mechanism. Especially, the World Bank's predisposition and authority to impose its view caused discontent, especially with the NHIS. The World Bank wanted to adopt a performance-based financing mechanism for the NHIS gateway. This means that they wanted to include a mechanism that "incentivises health workers based on how much services they are able to deliver".[341] The World Bank pointed to their Nigeria State Health Investment Project as the blueprint for the BHCPF. The NSHIP "made use of the disbursement indicators method to distribute money to all the states in the country based on their performance around certain health indicators, a lot of which are PHC", as one NPHCDA official explained the World Bank's approach.[342] A consultant, working at the World Bank consultant, further details that:

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[339] Interview 12; 28/02/2019.

[340] Interview 43; 27/03/2019.

[341] Interview 33; 17/03/2019.

[342] Interview 49; 04/04/2019.

> … a lot of the BHCPF is built on a project based on evidence from a project called the Nigerian State Health Investment Project, which had two arms. It had a performance-based financing arm, which is designed around 25 primary healthcare services and 20 services provided at secondary level. And I am sure you know a lot about PBF, but I think **the sweetener there was that - one - health workers for the first time were getting incentives for delivering results**. The second is it came as a package, and was not only focused on service delivery, but there were also systemic reforms that were being put in place. For example, it was facilitating the primary healthcare management by fast ... So, for you to implement basic proponents of the PBF, you have to have done the Primary Healthcare Under One Roof integration, which is brought to all the health centres, which were under the management of multiple Ministries, Ministry of Local Governments, Ministry of Health, you know ... brining them together under this Primary Healthcare Agency in the State and have a single management structure. As part of that you are transferring the staff health workers under the management of this Agency, which means that **you can then start to discipline health workers, you can start to rationalise, which has always been an issue, especially in remote areas**. So, I think that the PBF structure comes with that sort of reform.[343]

The NPHCDA official, in turn, highlighted that the impact evaluation report did not necessarily show that the incentive structure yielded any noteworthy results:

> The only thing that the manual did not really accept – everything else they tried to modify – but the only thing that they didn't really take was incentives to health workers. Because there was an impact evaluation done on NSHIP that showed that the difference between giving incentives to worker and not giving incentives to worker wasn't that much. So, they felt a cost-effective way of improving health service delivery is not giving health workers incentives.[344]

Along similar lines, another key stakeholder, involved in the process of developing the guidelines and of implementing the BHCPF, hinted at the ideological proclivity of the World Bank to explain the institution's push for PBF, in the absence of any evidence of its advantageousness:

> Well, I think the World Bank is a business organisation ... They can still go to somebody in Okolom-Dogondaji. This is where the gold mine is – and [they will] give you a loan to buy [your own] gold [laughs...]. [The] World Bank has so many programmes – they have the NSHIP, which

[343] Interview 3; 30/01/2019.

[344] Interview 49; 04/04/2019.

> is performance-based financing in some States. They have this Saving One Million Lives. What they were pushing actually is that this BHCPF should become like a performance-based financing model ... When that loan ends for NSHIP, because the NSHIP is a loan, this PBF – what happens? So, they had this idea that the BHCPF should be used as the PBF in the country. But there is no evidence that the PBF is cost-effective. Where is the evidence? There is no evidence. So, if there is no evidence, how can you scale-up. We keep asking them, where is the evidence? Is it cost-effective?[345]

Although it appears that many different agents within Nigeria's healthcare SoP were suspicious of the World Bank's performance-based financing proposition, the NHIS, especially, showed opposition to the World Bank's proposition to have (their) NHIS gateway operate using a PBF approach:

> Now, the World Bank and the FMOH agreed to use modified-fee-for-service, what they call the bundle payment for payment of claims. Well, we – some of us – argued [against it]. **Because we believe that our level of ICT development and our e-claims processes have not developed to manage the volume of claims that will arise from this.** … **For us researchers, we think that this will be a Herculean task, it will be difficult, likely being an impediment to the implementation.** Because when claims begin to come, processing will become difficult, and providers don't get reimbursement. It will become not just a quality issue; it also becomes a serious programmatic issue. So, the way-forward will become difficult. Because providers will not be rendering services, except [for if] they are paid. And if you have huge claims you will rush to pay, and you can overpay, and exhaust the entire pool in the fund. **So, we felt that capitation should have been the best for the payment of primary healthcare services.** Since all over the world and global studies have proven to be the best for payment of primary healthcare services. And there is a consensus recently in Nairobi … I was also there … And the Nairobi consensus on provider-payment-mechanisms adopted [was] that primary healthcare should be paid for by capitation – based on evidence.[346]

The outcome of this conflict, in 2018, was that, on the one hand, the World Bank had to concede the element of "incentivising" health workers to deliver care. On the other hand, the claims-based reimbursement system (entitled modified fee-for-service) found its way into the 2018 Operations

[345] Interview 12; 28/02/2019.

[346] Interview 14; 01/03/2019.

Manual against the wish of and albeit the scepticism of several other stakeholders.[347] This "compromise", however, has proven to be unstable and the World Bank's modified fee-for-service proposition short-lived. The 2020 guidelines replaced the fee-for-service mechanism with a system of capitation as the primary provider payment mechanism under the NHIS gateway. Only secondary level healthcare providers will be reimbursed using a fee-for-service mechanism going forward.

At the same time, the World Bank, pointing once more at the design of their NSHIP programme, had proposed to pay primary healthcare facilities directly under the NPHCDA gateway. This system, now termed Decentralized Facility Financing, was adopted and maintained throughout all versions of the guidelines. The BHCPF was designed with the World Bank's NSHIP project in mind, but the NSHIP profited from systematic technical implementation support, which the BHCPF lacks. This was highlighted by a World Bank consultant:

> So, if we lean on the evidence that we have from NSHIP, then the BHCPF will work and it will deliver services. But the thing with innovation is always scaling, right? So, we did NSHIP in three States. It took a lot of technical assistance, which I don't think a lot of the actors in this space are remembering … We had technical assistance from Rwanda, who have been doing PBF for ten odd years. And they pretty much hand-held the States on every step of the ways. The BHCPF does not have that technical assistance structure. And people are always sceptical about technical assistance and say "why are you bringing in foreigners or other Africans to do what we can do ourselves". But the reality, there is a uniqueness to this system and to having implemented this system successfully, which we have to recognise with the NSHIP model. So, when we are talking to the sceptics of technical assistance, I think we need to realise that component a bit.[348]

Essentially, the role of the World Bank in shaping the implementation of the BHCPF, through its contribution to defining the provider payment mechanisms, is profound as much as it is emblematic of how major global players can impact policy implementation, and thus shape the practice of social policy in an African country. While the BHCPF implementation was put to a halt in 2019 to change the payment modality under the NHIS gateway from fee-for-service to capitation (amongst other things),

[347] The fee-for-service modality was already part of the 2016 guidelines. However, in the earlier drafts of the version this was not the case, as highlighted by a NHIS official, who was part of the initial Committee working on the development of the first implementation guidelines (Interview 14; conducted on 1 March 2019).

[348] Interview 3; 30/01/2019.

the dissatisfaction with especially the World Bank extended beyond its attempts to impose a fee-for-service modality.

The following section discusses how different views on who should control the BHCPF's operations caused/cause further disruptions to the implementation process. At the same time, additional tensions emerged as a result of Nigeria being a federal nation and because of the country's economic performance, the attachment to the private sector and a prevalent narrow view of how UHC should take form in practice.

3.2. Allocation of control and responsibility for managing the BHCPF implementation

Apart from discussions on how to ensure the BHCPF's fiscal sustainability and on how to disburse and use its earmarked funds, another substantial area of controversy relates to how to best manage the BHCPF. While not clearly stated in the final text of the NHAct, today, States and Local Governments bear the main responsibility for primary healthcare delivery. The BHCPF, however, is a Federal initiative addressing primary healthcare. A World Bank consultant highlighted:

> The Federal Government supposedly should be [responsible for] tertiary care. Yet, here we are establishing a Federal fund for primary healthcare, which [is the responsibility] of the local Government level. So, there are all those dichotomies that we have to sort out.[349]

In theory, the responsibility of the Federal Government, primarily, is to mobilise resources for the BHCPF and to provide an oversight function and platform for exchange. It, then, should delegate responsibility (and transfer financial resources) to the State-level, for these, one, to provide the BMPHS via the NHIS gateway and, two, to strengthen the public primary healthcare service delivery system by providing direct payments to selected PHC facilities. In reality, however, the Federal level has tried to maintain more control, as pointed out by several stakeholders. For instance, the same World Bank consultant states:

> The second element I think – shall I call it potential risk or threat to the BHCPF – … is that we are in a Federal state. And we keep uttering the works "fiscal federalism", but we are not really doing it. So, this fund was supposed to be devolved to States to respond bottom-up to their specific needs … These funds should be channelled towards fast-tracking every States' progress towards UHC. But in reality, when the discussion around the design of the BHCPF started …

[349] Interview 3; 30/01/2019.

there was a lot of hassle between the **Federal agencies on who should manage the funds, and between the Federal Government and the States**.[350]

In the first place, there were serious discussions with regard to the general administration of the Fund and on the organ that should exert management control over the entire BHCPF operation. The 2016 guidelines had introduced "The Management Secretariat of the Fund" (TMSoF), tasked with coordinating the administration, disbursement, monitoring and financial management of the BHCPF. The TMSoF, as proposed then, was an organ in charge of coordination and oversight, while the agencies at Federal level were the actual implementing bodies, in control of the disbursement of resources to their respective State-level organs. However, the 2018 Operational Manual introduced an additional (more powerful) management mechanism into the BHCPF management structure, by putting into place a high-level National Steering Committee. This was supposed to be headed by the Federal Minister of Health and supported by a Secretariat. The NHIS and the NPCHDA strongly opposed this plan, as they saw their control and responsibility shrink. As a WHO representative notes:

> Now initially, what was a challenge with [the] Secretariat, was how the Secretariat would be managed, especially as the Act has given the NPHCDA and the NHIS the rights to manage various aspects of the fund. So, getting the two agencies to agree with the Federal Ministry of Health on the role, on their roles and the role of the Secretariat and the dynamics of the various roles took some time. And you will agree with me that it is obvious why that was the case, because of the provisions of the Act.[351]

Also, the World Bank, who had positioned themselves in favour of the creation of the NSC and the Secretariat, acknowledged that the institution of the Secretariat was "a big challenge, because the two agencies felt, if you have a secretariat, this secretariat will more or less have more influence than [they] will have. And that will be a major issue. ... So, I think the issues around the guidelines where mainly around this."[352] Still, in the end, the NSC and the Secretariat were introduced in the 2018 guidelines on recommendation of the World Bank and supported by the then-Federal Minister of Health. As an NHIS stakeholders highlighted: "he [Health Minister Adewole] is the person who is driving with the World Bank this thing".[353] The NSC and its Secretariat were, thus, instituted despite

[350] Interview 3; 30/01/2019.

[351] Interview 48; 03/04/2019.

[352] Interview 33; 17/03/2019.

[353] Interview 13; 01/03/2019.

strong objections from the officially assigned implementing agencies, the NHIS and the NPCHDA, and despite concerns of other stakeholders that the Secretariat is costly, if not superfluous. For example, one key informant, who was part of the Committee elaborating the guidelines, highlights his strong opposition to the proposed NSC and its Secretariat. The person emphasised that it would create a parallel structure and would unnecessarily absorb resources for running its operations:

> So, everybody kicked against it, I kicked against it. I said no, it does not make sense … For me and the Committee members, this is routine money coming in. It is not a project. This money will be coming forever. And they already have a way to disburse them through the NPHCDA and the NHIS. So, what do you need something else for? In fact, it is a good way to strengthen the system. If there are things in the NPHCDA and NHIS that are not strong. The Federal Ministry of Health [can] strengthen them, [so that they can] perform the functions. But not to have a parallel structure.[354]

In essence, various stakeholders were, one the one side, apprehensive of an international organisation, like the World Bank, **exercising undue influence over the implementation** of the NHAct. The NHAct is seen as "a creating of Nigerian people"[355] and the World Bank was seen as "high-jacking the process, doing their thing"[356]. A NHIS official explained the power of the World Bank to actually do so: "The World Bank has a lot of overbearing influence of this. Probably because they are bringing money. You know, donors when they bring money, they go with all their arrows and... they bring all the TAs [Technical Assistants] and whatever to assist in the implementation."[357] Furthermore, these stakeholders were alarmed by the **substance** of what the World Bank appeared to be proposing, namely the adoption of a "project approach". This was reiterated by a second NHIS employee:

> They [the World Bank] are the ones driving the process for Nigeria. That is what we are seeing. We just watch and leave them. There are these people designing, writing everything … You will just sit down, the next day you will see a World Bank consultant. I don't understand. We don't know what is going on … If you look at the Act, the Act never envisaged using the World Bank Project approach to run the funding. Because it is a fund.[358]

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[354] Interview 12; 28/02/2019.

[355] Interview 13; 01/03/2019.

[356] Interview 12; 28/02/2019.

[357] Interview 14; 01/03/2019.

[358] Interview 13; 01/03/2019.

Also, another stakeholder, although overall positively inclined towards the NSC and the Secretariat, explains the widespread apprehension with regard to the World Bank's approach:

> So, there are limitations of making it separate, independent. **Because then it gives the connotation of [a] project [that] has an end-term.** And people will come and go. Like World Bank PIUs [Project Implementation Unit], which then are short term, given a loan for the process, and then either staffed by consultants, or hired with a few people from the Government seconded there. But then, they are not quite main-streamed, cannot influence practices, thinking. **Because at the end we should be seeing the BHCPF as part of a sustainable financing strategy for our State, for Nigeria. But if you start making it a stand-alone [project], then it becomes a programme, or just a mechanism, and then it dies.** But if you put it as a mandate and a function within, say, the Department of Planning, Research and Statistics in the Ministry, then the leadership of it and the discussions there should be seeing BHCPF as part of overall health financing, as a strategy for Nigeria. So that these big issues of strategic purchasing can be discussed broadly, but also within the context of the BHCPF for that matter.[359]

In any case, the main issue with the NSC and its Secretariat was that the NHAct did not stipulate to have this extra layer of management added to the administrative structure of the BHCPF. This ultimately led to its downfall as a civil society representative highlighted:

> So, as you see, the way the thing is loaded: National Steering Committee has a Secretariat. The Secretariat, it has a coordinator, who is the Director of Health Planning and Research of the FMOH. **Well, that thing was never in the bill**. In fact … there is nothing there for the FMOH, except to approve what ... [is discussed at] the National Council of Health, the plans and this things.[360]

In this way, the institution of the NSC and its Secretariat presented one of the central points of contestation that prompted the commissioning of an independent consultant and, subsequently, the review process of the guidelines. Today, the NSC and its Secretariat are no longer part of the 2020 guidelines. Instead, a Ministerial Oversight Committee was put into place and the NHIS and the NPHCDA re-gained their authority to manage the gateways, with the MOC serving as an oversight organ. Still, the interference by the World Bank resulted in the interruption of the BHPCF's

[359] Interview 41; 25/03/2019.

[360] Interview 46; 27/03/2019.

implementation. This demonstrates how (power) relations between agents, operating within a SoP, are decisive in shaping its material structures by virtue of their influence over policy.

While the discussions around the NSC and its Secretariat were significant, another crucial element, affecting the implementation of UHC in Nigeria, is the division of responsibility between the NHIS at Federal level and the SHISs at State-level. As mentioned earlier, the 2020 guidelines (reflecting the intention of the NHAct) accord considerable freedom to States to decide on how they wish to implement their social health insurance schemes. In an attempt to reflect Nigeria's federalist governance structure, social health insurance was decentralised in 2015 and the "National Council on Health … approved for States to begin to sign their own health insurance laws".[361] The rationale was that this may permit to tackle governance and enforcement challenges caused by federalism, to bypass the challenge of voluntary membership and to mobilise States' resources to subsidise insurance for the poor and vulnerable, as highlighted in a presentation given by the NHIS.[362] As a consequence of this process of decentralisation, States have progressed at different pace depending on their degree of capacity and prioritisation. This was repeatedly highlighted during interviews. For example, a representative of the Clinton Health Access Initiative (CHAI) notes:

> So, the biggest problem with the BHCPF now is that States don't have the required level of readiness to actually implement. I think that the biggest issue is that a lot of States have a lot of different systems going on. Like I said, States are very decentralised … So, I think the biggest problem would be to get States to actually all adopt the same system. It's a very political space and also, it's really difficult to convince states to start to setup a system that they can't see happening.[363]

Indeed, the leeway that was accorded to States regarding the implementation of social insurance in their States has, in practice, meant three things. First, Nigeria now has 38 different insurance "pools"[364] with States' insurance schemes being very dissimilar. Notably, some States rely on the support of private Health Maintenance Organisations, although the latter were deliberately excluded from the NHAct and the 2020 version of the BHCPF implementation guidelines. Second, some States'

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[361] Interview 37; 21/03/2019.

[362] See a presentation by the NHIS on the topic (slide 8): https://www.slideshare.net/HFGProject/decentralizing-health-insurance-in-nigeria-legal-framework-for-state-health-insurance-schemes (last accessed 27/07/2021).

[363] Interview 44; 27/03/2019.

[364] These are the 36 pools of Nigeria's 36 States, the pool of the FCT insurance scheme and the NHIS pool.

interest in the BHCFP appears to be limited, as they are more committed to continue the implementation of their own "home-grown" state health insurance schemes. And, third, in 2021, the NHIS, to some extent, "back-tracked" on the decentralisation of social health insurance and elaborated a "Health Insurance Under One Roof" (HIUOR) policy, attempting to harmonise processes and practices of health insurance across Nigeria.

With regard to the use of HMOs, there seems to be broad consensus amongst agents within the Nigerian healthcare SoP that HMOs are not fit for purpose as third-party players and that there is "a lot of dishonesty with the HMOs".[365] In 2017, the House of Representatives launched an investigation to establish whether HMOs are a necessary intermediary in Nigeria's healthcare system.[366] At a public hearing in June 2017, organised by the House of Representatives' Committee on Healthcare Services, the role of HMOs in Nigeria's healthcare system was heavily challenged:

> Balami [the Director of Hospital Services] noted that the Federal Government has paid about N351 billion to HMOs, without seeing appreciable results in health care delivery and insurance coverage … The Executive Secretary [of the NHIS at the time, Prof. Usman Yusuf] had no qualms about his desire to end any system that included using HMOs for service delivery. "The one thing countries doing better at achieving UHC have done is to do without HMOs. I see a potential of NHIS to directly fund healthcare in Nigeria," he said, adding that "NHIS handed over enrolment, money and regulation to HMOs."[367]

Also, during interviews, many negative experiences with HMOs were cited, which may be the reason why none of the versions of the BHCPF implementation guidelines openly mentions HMOs as implementing partners:

> There were a lot of reasons why they didn't want them again. One, HMOs, a couple of them have been owing health facilities. After being paid upfront by the NHIS. So, this is why the NHIS as an organisation became wary of HMOs. And I can actually confirm: in the guidelines they gave States for health insurance … they only mentioned third-party agents … States are not under obligation to use HMOs. And I don't think that for the BHCPF the Government is under obligation to ask HMOs to play a role in this. They are private organisations … If you want to do enrolment or registration, if you don't have the capacity or you don't really want to, you want

[365] Interview 27; 11/03/2019.

[366] See: https://healthnewsng.com/hmos-health-insurance-nigeria-future/ (last accessed 12/10/2018).

[367] See: https://nigeriahealthwatch.com/lost-in-the-debate-five-questions-no-one-is-asking-about-the-national-health-insurance-scheme-in-nigeria/?relatedposts_hit=1&relatedposts_origin=5633&relatedposts_position=0#.W8DNqhNKjOQ (last accessed 12/10/2018).

> to contract this function or task [it] out, then you define the TOR [Terms of Reference] for who would provide that service. If it is enrolment, it could be an NGO, it could be a local CSO that has that capacity.[368]

The view that disadvantages of using HMOs outweigh advantages includes voices from private sector healthcare providers. For example, a health center manager of a private clinic in Enugu stressed their preference to have HMOs excluded from the new SHIS:

> When I went to the State-branch of the NHIS, I asked them, what about the SHIS? So, they said that they are very slow here, and in other States it is already functioning, but here nothing ... If they can do it directly with the hospitals, actually, it would be better, because people are complaining about these HMOs … The HMOs are holding the money, and the doctors are doing the work. That is the opinion.[369]

As was highlighted in Chapter 2, the private sector's profit-orientation has been shown to be problematic for equitable healthcare provision and to replicate social inequality (Hanson et al., 2008; MacGregor, 2017; Mackintosh et al., 2016b; McPake and Hanson, 2016; Mills et al., 2002; Oxfam, 2009). A similar sentiment is expressed by a NHIS representative, highlighting the incompatibility of a for-profit entity to perform functions that seek to address a social cause. The person stressed that most States, as a consequence, have opted to avoid any collaboration with HMOs:

> You know, in the NHIS we are talking about HMOs in a social system. Alright? You collect the money, you want to take care of people, you are talking about poor, poor, poor, poor... and you carry it and give it to a private, profit-oriented person? And it will take it and will be drinking champagne and are not covering people. So, we are trying to use another approach to get the States [run the insurance schemes]. Close [to] 90 percent of the States didn't mention the HMOs in their law.[370]

Despite widespread apprehension amongst most agents within Nigeria's healthcare SoP of the use of HMOs, the 2018 Operations Manual made reference to so-called third-party agents/administrators (TPAs). These TPAs are commissioned to support States with e.g., enrolment or claims management and, in principle, do not have to be HMOs. However, in reality, they often are "HMOs … in another

[368] Interview 36; 20/03/2019.

[369] Interview 19; 07/03/2019.

[370] Interview 13; 01/03/2019.

colour".[371] Although the 2020 guidelines removed any reference to TPAs, some States have still opted to rely on the support of HMOs. The main reason for this is that HMOs are seen to have the necessary expertise and capacity to conduct key components of the insurance business process (such as enrolment or claims management). An HMO operator highlighted this:

> Well, really … **the people who have the technical expertise to implement any health insurance scheme in Nigeria are the HMOs, or people who are working in the HMOs** … In some of the States now that have started the SHIS, well, they actually do not have clear provision to use HMOs ... But they want to engage the services of HMOs to be able to implement some of those things, where they don't have the technical competences … At the initial state, the HMOs have to really participate in that. One technical area that has a serious concern is the claims administration … Enrolment, I know, with a good IT solution, the enrolment can pass through. But the administration of the scheme and the claims administration is actually a very technical and complex system.[372]

Along similar lines, another HMO employee proposed that "there should be a form of public-private-partnership in attaining UHC" with HMOs having the "direct responsibility of enrolling the participants, monitoring and sensitising the healthcare facilities and … vetting the claims and the bills that are generated from these clients from the scheme and making sure that they are appropriate with the Government tariff".[373] He summarises that "HMOs will play a very key role in attending to these issues. One, we have the experience and two, we can attend to these issues while the Government plays an oversight function".

In practice, we have seen this materialise, with e.g., Edo[374] and Lagos States[375] having opted for the use of HMOs as part of their SHISs. Other States, for example, Anambra State, have contracted other private sector entities to support e.g., their outreach activities:

> [The SHIS recruitment process] works centrally and there are a lot of outreachers out. … It opened up to the private providers, who actually move into communities to scout for enrolees,

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[371] Interview 41; 25/03/2019.

[372] Interview 34; 18/03/2019.

[373] Interview 24; 08/03/2019.

[374] See: http://nigerianobservernews.com/2021/05/health-insurance-scheme-subscribers-get-hmos-in-edo/ (last accessed 30/07/2021).

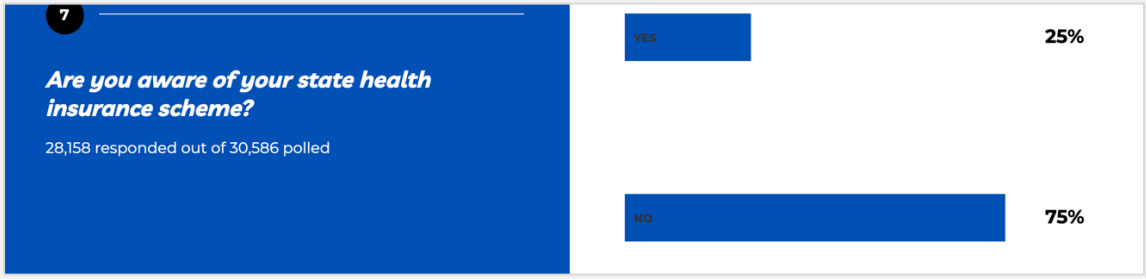
[375] See: https://thenationonlineng.net/lagos-to-accelerate-access-to-health-insurance/ (last accessed 30/07/2021).

by so doing bringing them into the scheme. As I am speaking with you, a lot of private providers have agents in the different communities in Anambra State, scouting.[376]

How well these 36 different SHISs and the FCT Health Insurance Scheme will work as a component of the BHCPF remains to be evaluated. As all States and FCT have adopted their own laws, it has yet to be determined how the stipulations of these various policies will be implemented in practice and, also, how much uptake there will be by the population. For illustration, in Rivers State, civil servants have already spoken out against the new contributory healthcare law.[377] Moreover, in April 2020, a poll indicated that a majority of respondents were not even aware of a state health insurance scheme in their States (see Figure 57). Also, close to all the participants in the FGDs had not heard of any plan to institute a SHIS, with the exception of a couple of members of the HFC and the WDC in Anambra State, where the SHIS is already operational. In the words of one CSO employee:

> One thing that I believe in Nigeria is that Nigerians over the years have lost trust in Government. So, and that is why it is a bit difficult for people to kind of take [the] Government serious. And you won't blame them for that, because they have been beaten several times. And they are like, well, we need to be very sure that this thing is for real.[378]

Figure 57: Poll – Are you aware of your state health insurance scheme?



Source: U-Report Nigeria, UNICEF, April 2020

Besides the differences in approach to health insurance taken by States, some interviewees explained that they fear that States may not be interested to participate in the BHCPF altogether but may prefer to focus on improving and expanding their own SHIS without Federal-level intervention. A similar

[376] Interview 27; 11/03/2019.

[377] See: https://dailypost.ng/2021/07/03/rivers-civil-servants-reject-new-contributory-healthcare-law/?mc_cid=a077609ef6&mc_eid=724b5c5719 (last accessed 30/07/2021).

[378] Interview 37; 21/03/2019.

concern is stipulated in the NHIS Strategic Plan 2020-30 that acknowledges the challenging political landscape and highlights that: "political issues also affect the establishment of State Social Health Insurance Scheme (SSHIS) and equity funds at the State level. The advancement of UHC is also negatively impacted by party politics, the ideological leaning of the political party in power and electoral cycles" (NHIS, 2020, p. 25). Such disparity in degrees of buy-in by State Government was emphasised by a CSO employee, who said that "State Governments have priorities. In some of these States power may change hands, new Governors are coming into place, they may not take this [the BHCPF] as a priority for them. So, there may also be delays from that angle".[379] Another interviewee stressed that some States have shown little interest in the BHCPF and prefer to implement their own schemes independently from the Federal initiative:

> So, I see that some of the States that have started implementing, like say Kano State, implementing their own State health insurance laws. Delta State. **They may not be too interested in the BHCPF.** Because already on their own, they have set aside some money for the agency to start, they are deducting funds, money from the salary of civil servants. So, they are building a pool, and gradually, who knows what will happen, if confidence builds in the system. People will be much more interested in their scheme … **And if I am a Governor, I rather bring my own health insurance than bother about the Federal Government really** … Except, obviously, if the Governor in the State is in the same political party with the Federal, the President – maybe it is easy to lobby and get things [done].[380]

Also, within the NHIS, there is an awareness that some State Governments may not prioritise participation in the BHCPF, but, potentially, could change their minds, if they see other States doing well: "Because if you say that some States are facing reluctance of some Governors – if you see other States doing well that might give motivation to the other States as well", states a civil society representative.[381]

In the end, it remains to be seen to what extent SHISs will attempt to align themselves with the requirements of the NHIS and the BHCPF. The reason for this is also because the Federal Government is currently introducing new laws and policies, whose potential impact will need to be evaluated. First, the Federal Government of Nigeria is in the process of finalising a new "Health Insurance Under One

[379] Interview 37; 21/03/2019.

[380] Interview 37; 21/03/2019.

[381] Interview 14; 021/03/2019.

Roof" policy. Second, it is in the process of introducing new legislation, the National Health Insurance Commission bill, that seeks to make health insurance mandatory for all Nigerians.[382] And third, it is in the midst of passing the National Health Insurance Authority Act establishing the National Health Insurance Authority (NHIA).[383] The NHIA is supposed to be the authority overseeing the NHIS and all SHISs and it aims to roll out the "Groups, Individuals and Family Social Health Insurance Scheme", which covers Nigerians who are not enrolled in the NHIS or any SHIS. According to a CSO representative, this effort has not necessarily been well received by the States, who "want their autonomy" and see the NHIS as competition. [384] They wish for the NHIS to play the role of a regulating agency only and not an implementing agency. This includes the transfer of enrolees from the NHIS to the States to avoid any operation of the NHIS at State-level.

A last point of contestation with regard to the management structure of the BHCPF relates to concerns as to whether the collaboration between the different organs at State level as well as between the State and Local Governments will be successful. This is decisive for the success or failure of the BHCPF's ambition to strengthen the primary healthcare delivery system. Two main issues appear important here. First, the BHCPF channels resources from the State level directly to PHC facilities, skipping the local level, which is illustrative of the lack of power of Local Governments, but also a reflection of their underperformance relating to PHC service delivery. A health professional, working in a hospital in Abuja, summarises that "Local Governments are not autonomous. So, they are not government. We call them Local Government – they are not autonomous. They are tied to the States. Their finances go to the States."[385] This reality is also highlighted by a World Bank employee:

> Another point in terms of political economy … is … that these Local Government authorities don't even do what they should be doing … So, ideally, the Federal sends allocations to Local Governments. The State Governments are so powerful, that actually the State Governments control all of the resources that gets to the Local Government. So, Local Government don't even

[382] In May 2021, a new NHIS law was passed into law, which will make social health insurance mandatory, but is still awaiting Presidential assent. See: https://guardian.ng/features/nhis-act-passed-into-law-awaits-presidential-assent/ (last accessed 25/05/2021).

[383] See: https://www.nhis.gov.ng/2020/11/25/formal-flag-off-of-group-individual-and-family-social-health-insurance-programme-gifship/ (last accessed 25/05/2021).

[384] Follow-up phone call to interview 36; 08/05/2021.

[385] Interview 39; 23/03/2019.

have the financing to do what they should be doing, you know. But this is a big, big problem of Federalism in Nigeria.[386]

The BHCPF explicitly keys into the initiative of establishing SPHCDAs to ensure that the management of PHC service delivery is concentrated at State-level, by endorsing the Primary Health Care Under One Roof initiative. An official working in the Federal Ministry of Health outlined the logic of implementing the PHCUOR initiative as follows:

> Government, at some point then said: we now know that given that PHC is the gateway to the health system, we are not sure that these guys [the LGAs] have the capacity, whether human resource wise, whether financial, to address these issues. So, we want to consolidate this under the State PHCUOR [Primary Health Care Under One Roof]. Which essentially say: one management, one framework, and one M&E. That is, we will consolidate everything that is done on PHC under the State, and we set up things called the State Primary Health Care Development Agencies to drive and implement PHC. [387]

Yet, an employee at an international organisation is also cautious as to whether States have the drive to push for the improvement of the PHC system, as "States have known about it for years, and it still hasn't been done. We have the PHC revitalisation program where one PHC per ward is supposed to be revitalised across the country. We've known about that for years, still it hasn't happened."[388]

The second issue relates to the distribution of power between the State Ministries of Health and the newly established SPHCDAs. Interviewees have highlighted that the installation of SPHCDAs has made them the largest public sector employer at the State level, providing them with an important position vis-à-vis State Ministries of Health. A Federal Government official emphasised that this has led to some controversy within some States:[389]

> At the time that was done, I am not sure that people considered that that would make that new organisation, devoid of clear structure or organisational profile, the largest public sector employer of labour. Do you understand what I am talking about? So, almost, you are creating an organisation that has almost 4,000 to 5,000 people at once. There is no other public sector [entity], whether it is your SUBEB [State Universal Basic Education Board] or whether it is the

[386] Interview 33; 17/03/2019.

[387] Interview 47; 29/03/2019.

[388] Interview 44; 27/03/2019.

[389] At the time of fieldwork, most States were only in the process of transferring the nominal payroll to their SPCHDAs.

> Ministry or Commission of Health, or Works, there is none of that. And it is an agency, and it is not even … it is not the Ministry in itself. So, the political economy around the SPHCDA would then be: someone wants to fight to be the boss here. Chances are that this person will have issues with this Commissioner [State Commissioner on Health]. Do you understand?[390]

Similarly, one member of academia, engaged in research on Nigeria's health system, echoed these concerns:

> My concern now is that State Governments are setting up the SPHCD Agency or Board that is supposed to oversee the implementation at the State level. In some States, most States that I am aware of, there has been that struggle between the State Ministry of Health and the SPHCDA, because the SMOH also has a Directorate for Primary Health Care. And now, you are setting up a parallel SPHCDA ... But you know the thing is that because of the way that healthcare is structured in Nigeria – we have the Federal level, State level, LGA level – the Local Governments have actually been the ones primarily responsible for PHC in Nigeria, not even the Directorate for PHC at the State level. So, we have had that fragmentation that has been causing problems. Now you are adding this SPHCDA. And they are having it at the State level. And I am concerned that this fund [the BHCPF] is going to end up being something that is just at the State level, and not actually reaching the community – getting down to the community, being used effectively for PHC.[391]

In conversation with officials at the State level, however, a positive view of the establishment of SPHCDAs prevailed. In Enugu, a representative of the SPHCDA stated that:

> There is evidence that the State is going in favour of functional PHCUOR. We have an office space, we have an Executive Secretary, we have staff pooling – it has started coming in from both the State Ministry of Health and the Local Government. The State was handling a District Health System before. Enugu State has now repealed the District Health System law and has come onboard the Ward Health System in line with the BHCPF. So, we are now operating a Ward Health System. So, the District Health System has collapsed in Enugu State, because that is not the kind of system that keys into the NHAct. Then, the State has started revitalising the various PHCs to achieve one functional PHC centre per ward … The collaboration with the LGA is designed to be very effective, because in this new law [Enugu State Health Sector Reform Law], there [are] no longer different departmental structures, like a HOD [Head of Department]

[390] Interview 47; 29/03/2019.

[391] Interview 15; 05/03/2019.

> Health, and all of that … The Local Health Authorities … have submitted to my office the nominal roll of all health workers in all the health facilities in the State.[392]

Similarly, in Anambra State, an official of the respective SPHCDA highlighted that:

> The whole PHC workers are now staff of the agency. They are no more with the Local Governments. So, with that it is now easy to handle. You now don't deal with individual local governments. Anything you want in PHC in Anambra State, this is where to find it. In fact, this table [referring to the Anambra SPHCDA] is in charge of all the PHC centres and even the workers. So, anything you want, you will drop here – you can rest assured.[393]

When asked whether LGAs have been reluctant to support the transfer of competency, the official responded that "this thing was sold to the political body, and they [the LGAs] bought into it. And since they bought into it – and the funny thing in this State is that most things they buy into – they look at it as a competition. Everybody wants to outdo the other – though positively". [394] Also, the assessment of the State official working at the SPHCDA agency in Niger State was similarly positive, even more so as Niger State had been selected as one of the first pilot States for the implementation of the BHCPF. The official stated that:

> Actually, some of the conditions that were considered for choosing the States was to have a PHC system that is up to date. We had this policy of "Primary Health Care Under One Roof", whereby all the various component of the PHC system should be managed by a PHCDA. Niger State has gone far in implementing those reforms, before the coming of the BHCPF. And, I am sure, this was one of the things that ensured that Niger State now get nominated among the initial three States. We have a robust PHCUOR [system]. All the governance and leadership issues ensured that all the health workers at the LGA level, they have been administered by the agency. We have gone far, but we are not yet there ... The payroll is not yet fully transferred to the healthcare agency board. All other administrative issues have been handled by the agency, just the financial aspect has not been transferred fully.[395]

In like manner, at LGA level, not much opposition to the PHUOR policy and the transfer of the PHC management responsibility from Local to State level was communicated. However, concerns were

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[392] Interview 18; 07/03/ 2019.

[393] Interview 27; 11/03/2019.

[394] Interview 27; 11/03/2019.

[395] Interview 30; 17/03/2019.

raised as to whether States have the capacity to take on board this extra responsibility. A LGA spokesperson highlighted:

> Yeah, actually, it is the right thing. It is a welcomed decision. It is a welcomed idea. You see, here in Niger State, the health workers at the LG: there was a time, they talked about moving the health workers form the LG to PHCDA at the State level, so that everything of the health at the LG should go uniformly ... There will be fast-track of sending information and getting feedback. If really the agency is fully in place… But can you believe up to now, the agency could not take off. They are still complaining of the funds. That the State Government does not have the funds to bring all the LG health workers under one roof.[396]

In brief, it remains to be seen whether the BHCPF can serve as a catalyst for the PHCUOR policy to be implemented and whether State and Local Governments and State agencies will work together to support the objective of strengthening the PHC provisions system. Nigeria's federal character, in particular, is proving decisive in shaping Nigeria's healthcare SoP and the form UHC potentially can take in the country.

3.3. Providing a Basic Minimum Package of Healthcare Services: how, to whom and what exactly?

A last area of discussion surrounds the actual practice of delivering healthcare services to the Nigerian people as part of the BHCPF roll-out. Who is eligible to receive services? Which healthcare services will Nigerians be able to access? What do Nigerians need to do in order to access healthcare services? And, to what extent will Nigerians be receiving healthcare in spite of the many existing service delivery challenges? The NHAct only answers the first question: "**all Nigerians** shall be entitled to basic minimum package of health services" (NHAct, Art. 3.3; emphasis added).[397] The Act does not provide details on how all Nigerians can access the BMPHS and what it entails. It does, however, acknowledge that the successful delivery of a BMPHS requires investment in the PHC system by virtue of earmarking BHCPF funds for the strengthening of the public PHC delivery system. The BHCPF implementation guidelines provide more details on who can access the BMPHS, whether/how these eligible citizens have to enrol to become beneficiaries, and what the BMPHS entails. It also pre-empts one of the main challenges that characterises the Nigerian healthcare SoP, namely corruption, by having put forward an elaborate accountability mechanism.[398] Moreover, the NHAct via the BHCPF makes resources

[396] Interview 31; 16/03/2019.

[397] In article 11.3(a) the NHAct refers to "citizens".

[398] See Onwujekwe et al. (2018) on common practices of corruption in the Nigerian (and other Anglophone West African) healthcare sector.

available for drugs, human resources and the upgrading of infrastructure. And, the BHCPF guidelines make a baseline assessment mandatory for PHC facilities to participate in the BHCPF, putting further emphasis on the quality of service delivery.

Yet, neither the Act nor the BHCPF guidelines provide substantial input on how the most prevalent service delivery challenges can be addressed. An analysis of all 12 FGDs shows that, for FGD participants, following four areas appear to be the most pressing service delivery impediments. First, one of the most pertinent problem relates to the availability of qualified health personnel. On the one hand, community members highlight an often bad and abrasive attitude of health workers as well as their lack of qualification. On the other hand, (some) health workers state to have little incentive to perform well, because of an imperfect salary structure, a deprived state of infrastructure at PHC level (i.e., lack of running water or electricity) and the lack of the necessary medical equipment to perform their duties. This links to the second challenge, namely the state of infrastructure of primary healthcare facilities and the need for them to be better maintained and equipped. Third, FGD participants have reported that Nigeria appears not to be in a position to ensure the adequate supply of required medication. Non-availability and/or high price of essential drugs as well as the proliferation of counterfeited drugs have been raised as major challenges. Fourth, the problem of corruption in Nigeria also extends to the health system. On the one hand, what is perceived as too low pay by health workers may often encourage corruption in the form of acceptance of gifts and/or money or entice medical doctors to refer patients to their own private hospitals. One the other hand, lack of accountability of officials holding positions within Local, State and Federal Government as well as within the health agencies has been raised as an issue.

In what follows, I discuss how the role and views of various agents as well as Nigeria's federal structure, its socio-economic context and the global push for a watered-down version of UHC are impacting: (i) who can access the BMPHS in Nigeria; (ii) the services which are entailed in the BMPHS; (iii) how beneficiaries can access the BMPHS; and (iv) the policy measures which are being implemented to assure that these key service delivery challenges do not obstruct the delivery of the BMPHS.

The first and second points are heavily intertwined and relate to two of the key dimensions of the WHO's "UHC cube" (as introduced in Chapter 2): what part of the population is covered (x-axis); and which services are covered (z-axis)?[399] While the NHAct stipulates that all Nigerian citizens should be

[399] The y-axis reflects the proportion of cost that is covered. In the Nigerian case, the BHCPF is expected to fund the entire BMPHS to make it free at the point of service.

able to access a BMPHS, the 2016 version of the BHCPF guidelines was explicit in stating that priority should be given to rural areas. In the 2018 guidelines, the target group was restricted further, stipulating that beneficiaries have to be part of specific groups in targeted regions in order to access the BMPHS. These are children of age 5 and younger, pregnant women and all people for malaria treatment, hypertension and diabetes screening within priority rural communities. The 2020 version of the guidelines appear more inclusive and state that all Nigerians are eligible to access the BMPHS under the NHIS gateway. However, they propose to prioritise rural public PHC facilities under the NPHCDA gateway as a way of targeting poor households and populations in the lowest wealth bracket (FMOH, 2020, p. 53).

Furthermore, while the 2020 guidelines stipulate the need to target specific areas of concern such as maternal, newborn and child health and non-communicable diseases (FMOH, 2020, p. 28), the actual list of services that are included as part of the BMPHS is more extensive. The listed surpasses the proposed BMPHS of the 2016 and 2018 versions of the guidelines by large. In the 2016 version of the guidelines, the BMPHS was designed to target interventions addressing maternal and under-five morbidity and mortality, as these are seen to contribute massively to Nigeria's disease burden and are considered "cost-effective".[400] In addition, blood pressure screening and urine analysis were included in the BMPHS. A World Bank representative explains that adding blood pressure screening and urine analysis to the BMPHS was a political choice to ensure that the text of the NHAct is respected and the BMPHS does include services for **all** Nigerians, not only women and children:

> Just to point out, there is also some political economy issue even with the package itself. Which is always a political issue anyway. So, section 3.3 states that this should be for all Nigerians. So, to address the issue of all Nigerians, the package includes measurement of your blood pressure and urine analysis. So that if there is a constitutional issue there – so you will be saying, look, you are not just taking care of children and women, you are also taking up men. So, we have measurement of BP [blood pressure], which is nothing, and urine analysis, which is nothing. But at least, that addresses that.[401]

[400] The 2016 guidelines explicitly stipulated that the "[d]eterminations on actual interventions for the BMHPS content were informed by inclusion criteria such as: (a) most prevalent disease burden (b) cost-effectiveness and/or (c) equity. The World Bank has designated health interventions that cost less than US$100 per year of life saved as highly cost-effective for low and middle- income countries" (FMOH, 2016b, p. 16).

[401] Interview 33; 17/03/2019.

Later, malaria treatment for the entire Nigerian population was added to the 2018 version of the guidelines. This allegedly transpired on initiative of the Federal Minister of Health and the World Bank, as highlighted during several interviews, e.g., by a NHIS employee:

> So, at the heat of all this, a lot of technical committees were set up to guide the implementation, because the essence of this fund is to ensure that it gets [down], more specially, to the vulnerable population. So, for us here, vulnerability was classified to be those in under five and pregnant women – who were the ones that were contributing to the abysmal health indices we were having in Nigeria. However, some other morbidities were added like malaria and screening of non-communicable diseases [on initiative of] the Federal Minister of Health and the World Bank.[402]

As pointed out by a second employee of the NHIS, adding malaria to the BMPHS was met with concern, as providing malaria treatment for an estimated population of 200 million people (with 76 percent of the population living in high-transmission areas)[403] was perceived as too costly and likely to take up a huge share of the BHCPF's resources:

> So, we started to target pregnant women, children under 5, and then, we added the elderly. But when they started this thing that they are doing, they changed that and now even added malaria for all Nigerians … With the BHCPF money … You do the costing, you do an actual costing for covering the whole population against malaria – I hope it is not going to take more than half of the whole money.[404]

The 2020 guidelines continue to include malaria treatment as a service provided as part of the BMPHS, and according to the guidelines, the price to purchase the BMPHS is now calculated to be Nigerian Naira 12,000 per person. This compares to an initial costing exercise conducted by the NHIS, which put the price of the BMPHS at Nigerian Naira 6,000.[405] As highlighted in the media[406] and during interviews, the resources allocated to the BHCPF are little. One NHIS employee highlights that based on their calculations and modelling, the cost of achieving UHC in Nigeria is "not 55 billion, it goes into

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[402] Interview 14; 01/03/2019.

[403] See: https://www.severemalaria.org/countries/nigeria (last accessed 02/08/2021).

[404] Interview 13; 01/03/2019.

[405] Interview 13; 01/03/2019.

[406] See, for example, an article stating that Nigerian Naira 2.3 trillion are needed to purchase the BMPHS on behalf of all Nigerians: https://sydani.org/the-journey-towards-health-for-all-in-nigeria-is-the-bhcpf-the-way-forward/ (last accessed 02/08/2021).

trillions".[407] Also another interviewee, an researcher, highlighted that the funds are by far too little to deliver on the promise of providing the BMPHS to all Nigerians:

> It will not be enough. We – my group – we have done a financial feasibility of the BHCPF. It is not enough. That 1 percent will cover like 20 percent of the population. So, it is not enough. So even if all the money is released, it is still not enough. Just to cover maternal [health]. So, we did the financial feasibility of using that Fund to cover pregnant women and under-fives, just pregnant women and under-fives, and they cannot cover 20 percent of the population in Nigeria. So, we are not talking about the whole population, old people, trauma and all that... and this is on the condition that the whole money, 55 [b]illion comes out, and the States also pay their complete counterpart.[408]

Along the same line, a World Bank representative accentuates that States have only been targeting a very small group:

> At the minimum … what the BHCPF is funding is the BMPHS. Now, most States do not actually have funding to do anything beyond the BMPHS. They don't. They think they have the capacity. They are not financially buoyant to do so. So, what [they] should … realise is that some States have expanded the package of services they are delivering beyond what the BMPHS suggests … **A good State will ignore these other things and just simply offer the basic package across the board for all its citizens. And that will be the State that will achieve UHC first.** But, I haven't seen. So, a lot of State Governments are still wallowing in this, trying to satisfy a very minor population – not more than 20,000/30,000 people who are contributing something and then they want to offer them an enhanced package. Which to me is, living in fool's paradise.[409]

As a consequence, the reality of UHC in Nigeria, as of now, is that not all Nigerians realistically can benefit from the BHPCF as there is not enough money available to provide the BMPHS to all Nigerians. Rather, the beneficiaries of the BHCPF will be a targeted segment of the population, in principle consisting of the "poorest of the poor and other vulnerable groups".[410] As outlined in the presentation that the Minister of Health gave in January 2021, targeting options include State level targeting and to make use of the National Social Register (NSR), which was set up as part of Nigeria's newest

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[407] Interview 13; 01/03/2019.

[408] Interview 12; 28/02/2019.

[409] Interview 33; 17/03/2019.

[410] See footnote 300 for the link to a presentation given by the Minister of Health in January 2021.

conditional cash transfer scheme, the National Social Safety Nets Project.[411] The use of the NSSNP's National Social Register, in combination with verification and community identification, for the identification of beneficiaries of the BMPHS was confirmed by a CSO employee.[412]

The real-world practice of UHC in Nigeria, namely the choice of policymakers to use the NSR and target beneficiaries of the BHCPF on basis of income, demonstrates that decades of neo-liberal policymaking have cemented the notion that there is not enough fiscal space to provide healthcare to everyone.[413] The version of UHC in today's Nigeria, in practice, translates into a limited package of healthcare services for a targeted group – far removed from the 1970s-conception of comprehensive primary healthcare for all. This is also reflected in the World Bank's policy practice: it supports the national cash transfer programme with US$ 500 million compared to its support of US$ 20 million for the BHCPF. Moreover, instead of increasing its financial commitment to the BHCPF, in January 2020, the World Bank started the implementation of a new initiative, the *Immunization Plus and Malaria Progress by Accelerating Coverage and Transforming Services Project*.[414]

Targeting, however, brings up the question of how eligible beneficiaries can access the BMPHS. While the 2016 guidelines stipulated that all Nigerians should be able to receive the BMPHS completely free at the point of delivery, without any user fees whatsoever, this no longer holds true. The 2020 guidelines state that beneficiaries need to be enrolled into the programme by the NHIS/SHIS prior to

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[411] The NSSNP was initiated in December 2016, with the aim of providing income support to some of the poorest households in Nigeria. The programme's design and financing received significant support from the World Bank (notably, a US$ 500 million loan) and operates via direct cash payments to beneficiary households across Nigeria. The programme imposes conditionalities on its beneficiaries, who are required to attend skills training on financial literacy, nutritional practices, tree planting, etc., have to attend medical appointments and to enable their children to stay in school. The NSSNP also relies on a variety of targeting mechanisms to identify beneficiary households: (i) geographical targeting in order to identify the poorest Local Government Areas and communities, followed by (ii) community-based targeting where community members identify the poorest households in their community, and (iii) proxy-means-testing in order to validate the list of identified households. See pages 104-108 of the World Bank's project appraisal document: https://documents1.worldbank.org/curated/en/813221467989481643/pdf/PAD1687-PAD-P151488-IDA-R2016-0107-1-Box394887B-OUO-9.pdf (last accessed 27/08/2021).

[412] Follow-up phone call to interview 36; 08/05/2021.

[413] The 2016 guidelines explicitly state the following: "Health spending rarely matches demand and overall disease burden. This means that the demand for health services does not equal the supply of health services. As resources are always finite, there is no country that can provide health services to meet all the possible needs of its population therefore countries have to select which services to provide" (FMOH, 2016b, p. 16). Also, the Health Financing Policy as well as the NSHDP II highlight that the BHCPF is insufficient to finance UHC in Nigeria but can serve as a catalyst to leverage additional domestic and external investments.

[414] See here: https://documents1.worldbank.org/curated/en/102621580321213128/pdf/Nigeria-Immunization-Plus-and-Malaria-Progress-by-Accelerating-Coverage-and-Transforming-Services-Project.pdf (last accessed 28/08/2021).

being able to access services free at point of delivery. In Anambra State, for instance, beneficiaries are expected to pay a fee at enrolment, but are then able to access services for free for a year.[415] One FGD participant provides information on the process of enrolling into the SHIS in Anambra State:

> It covers everybody living in Anambra state, whether you are a citizen of Anambra state or just residing in Anambra state. Once you are in Anambra state and you take that policy, you register for it, it is not costly, it is just for you to go to the Anambra state health insurance scheme after Aroma junction, you go there and register and pay the stipend, the money is about twelve thousand Naira for registration, when you pay the money, they will give you a smart card, with the smart card you can obtain the facility from your preferred hospital, because you have to register the hospital too, you have to mention your preferred hospital so that they will work with that hospital.[416]

The Minister's presentation further clarifies that all enrolment will now need to be validated using the National Identification Number (NIN). Only in 2017, the use of a NIN was made a mandatory requirement to register for the use of health and medical services in public facilities.[417] This requirement will likely become an impediment for many people to access healthcare. As of July 2021, only "more than 60 million" Nigerians had been captured by the National Identity Management Commission (NIMC) in charge of registering Nigerians for the unique NIN.[418] According to UNICEF, only one Nigerian child in three is registered at birth, illustrative of the current practice and capacity of the Government to register its citizens.[419]

Finally, the last matter that needs to be investigated is whether PHC facilities will be apt to provide the BMPHS to targeted and enrolled citizens. Concretely, the questions are: will there be enough well-trained health personnel available to deliver the BMPHS at PHC level? Will the necessary drugs be available? Will PHC facilities be adequately maintained and equipped? And, what measures are in place to ensure that eligible citizens do not need to be/are not being asked to provide any co-payment

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[415] In Anambra, the "adoption model" is promoted, where wealthier members of the community are encouraged to pay the annual fee for vulnerable members; see here: https://nigeriahealthwatch.medium.com/be-your-brothers-keeper-anambra-s-adoption-model-for-health-insurance-479dcae72029 (last accessed 28/08/2021).

[416] FGD 8; 11/03/2019.

[417] See here: https://nimc.gov.ng/docs/MandatoryNIN_Gazetted_2017.pdf (last accessed 02/08/2021).

[418] See, for example, here: https://thenationonlineng.net/nimc-captures-more-than-60-million-nigerians/ (last accessed 02/08/2021).

[419] See here: https://www.unicef.org/nigeria/reports/birth-registration-nigeria (last accessed 02/08/2021).

at point of delivery? These questions are crucial when evaluating whether the policy environment, in which the Nigerian healthcare SoP is embedded, is adequately preparing the material system of provision for the successful delivery of PHC, as access to PHC has been long recognised as the central component for improving people's health (Friedberg et al., 2010; Kruk et al., 2010; Macinko et al., 2003; WHO, 2008).

Therefore, first and foremost, it appears as a strength of the BPHCF design that it incentivises the reinforcement of the public PHC system, with the NPHCDA gateway making resources available for drugs procurement, the training of health personnel and the upgrading of PHC facility infrastructure. Hence, while the BHCPF aims to extend social insurance coverage as a way of improving the "demand-side" of the Nigerian healthcare system, it is also structured in a way to serve as a lever to improve public primary healthcare delivery and to address existing "supply-side" challenges. Second, other sections of the NHAct explicitly seek to address healthcare service delivery challenges (see Table 12).

Table 12: Policy response to main service delivery challenges

Service delivery challenges	**NHAct/BHCPF response:**
HR Health	▪ More funding to health personnel (NPCDA gateway) ▪ Endorsement of the PHCUOR initiative (SPHCDAs responsible for payment of salaries)
Corruption	▪ Accountability framework and clear funding flow of BHCPF
Drugs	▪ Funding for drugs (NPHCDA gateway)
Medical equipment and infrastructure	▪ Funding for medical equipment & maintenance/upgrading of PHC facilities (NPHCDA gateway) ▪ Endorsement of the One PHC per Ward strategy ▪ Introduction of a Certificate of Standards for PHC facilities

However, as the goal of UHC was adopted on the global stage and it was stressed that health financing is key to achieving UHC,[420] it appears that the BHCPF received a disproportionate amount of attention, often to the detriment of other important sections of the Act. This was articulated by a World Bank consultant who emphasised that:

> The BHCPF is part of a Health Act, which should be part of an effort to reshape the health sector in its totally. **But here we are only focused on one article, one section of the Act, because there is money tied to it.** So, we are not talking about the whole sections on the national health

[420] Notably, the 2010 WHO's report on health systems financing put emphasis on the importance of adequate funding for UHC.

> system. … Also, when you are thinking of UHC, are you more thinking about coverage? You know, people accessing care? **Or are you also thinking of quality of care?** And the Act provides a whole section on accreditation and establishment of standards for health facilities. And that is just not being done … So, just to give you a sense, of how much importance is attached to the rest of the sections of the Act.[421]

Notably, in part II of the Act ("Health Establishments and Technologies"), the law makes it a prerequisite for any establishment providing healthcare to obtain a Certificate of Standards in order to operate and provide prescribed health services (NHAct, Art. 13.1). The NHAct clearly states that these Certificates of Standards should have been obtained by **all health facilities** within 24 months from the date the Act took effect (regardless of their participation in the BHCPF). This implies that in 2019, when interviews took place, all health facilities in Nigeria were in non-accordance with the law as the certification process had not yet started. As a CSO employee highlighted:

> If you ask me, my critique about the NHAct implementation is that it seems to be too BHCPF focused. **Because the NHAct is a reform, a holistic reform that covers different aspects of the health system.** It has provisions, for instance, about the rights of a patient. It says a lot about, you know, having standards for health facilities, categorising them and all of that, so that each year, or every two years, health facilities are supposed to be re-accredited and issued a certificate of standards. So, but, this sort of [things] seem to have fallen [through the] cracks. In the sense that the law says, two years after the signing of the Act that all health facilities operating in Nigeria must have the certificate of standards. So, in principle, almost every health facility in Nigeria is operating illegally or breaking the law in a sense.[422]

As a consequence of both the relatively modest BHCPF funding allocation and the lack of attention to quality aspects of the public healthcare system, two outcomes appear likely. First, private facilities, for the time being, may be better placed to provide the BMPHS, as they may be more likely to meet the criteria, allowing them to participate in the NHIS gateway. Second, donor support may be perceived as a necessity to assure adequate PHC service delivery, but may contribute to further the fragmentation of the Nigerian healthcare SoP. Incidentally, as with the private sector, the expectation is that the donor community should "key into" the Government programme: "Well, the government cannot do it alone, development partners can key into the government health financing policy through

[421] Interview 3; 30/01/2019.

[422] Interview 36; 20/03/2019.

basket funding rather than running parallel programs."[423] However, while donors should not bypass the Government structures when providing support to the PHC service delivery system but provide their assistance in a coordinated way, this is not always the case, as stressed by a State representative in Enugu:

> They always sign a Memorandum of Understanding with the Ministry of Health. With the State. And the State will give them the facilities they are supposed to, that they need to support for them. But, you know, time goes on. The donors – some of them stay five years, some of them stay four years. **As time goes on, they shift somehow and start working directly – sometimes, not always – directly with the facilities. Some of them are also items donated by communities, some are items donated by philanthropists that may not need to go through the Ministry of Health.** They say, we want to support this facility, and so we support them.[424]

The consequence of such reliance on philanthropy and donor support, especially if uncoordinated, is the fragmentation of healthcare service delivery and the unequal distribution of support across Nigeria, as highlighted by the same State-level official:

> If you go to most of our public health facilities, you may not find a weighing scale for children. And you know, growth monitoring is one of the things we do**. You may not find weighing scales, you may not find some other basic equipment, while there are so many lying to waste in some facilities**. … You see this big, big, big equipment, packed in their cartoons. So, I am thinking, the health sector needs to do a lot. **We need to do a lot, even redistribution of equipment. Because some of this people got this equipment through donors, partners that will just go straight and give them**. And when you ask them: "you don't need these things, you can shift it to other places", they will say "no, it is our own". Something like that. So, we need to work very hard, we need to work very hard. But that does not mean that health is not working, we are doing a lot, but there are areas we need to improve.[425]

Moreover, there is a chance that NGOs and international organisation may refrain from channelling their resources to the BHCPF but will continue to promote their own priorities – focusing on implementing "cost-effective" initiatives responding to a specific health condition as per their

[423] FDG 11; 16/03/2019.

[424] Interview 9; 27/02/2019.

[425] Interview 9; 27/02/2019.

mandates[426] or on expediting other (narrower) forms of social protection. For instance, the NSSNP (the conditional cash transfer scheme introduced to Nigeria in 2015), with the support of the World Bank, is ostensibly in opposition of the promotion of universalism, but requires a significant commitment on behalf of the Government.[427] Therefore, in short, the actual, practice of service delivery is dependent not only on Nigeria's economic performance and the Government's ability to mobilise revenue, but also on which parts of the NHAct and aspects of the BHCPF are being implemented as a priority. In order for the BMPHS to be delivered, more focus needs to be put to implement policy measures seeking to eliminate some of the most challenging service delivery impediments.

4. Conclusion

In this chapter, I highlighted how interactions between agents, Nigeria's federal structure and the country's economic context impact the progress of implementing the BHCPF. At the same time, I have illustrated the discrepancy between the global promotion of UHC and the actual practice of providing a package of selected services to a targeted group of people. These context-specific structures and global processes affect how the various agents that operate within Nigeria's healthcare SoP have attempted to shape the operationalisation of the BHCPF, notably by moulding the implementation guidelines.

In particular, three aspects of policy implementation have been especially affected. First, these include discussions pertaining to the BHCPF's funding sources and the use and channels of distribution of these resources. While it appears, at first sight, that the NHAct is rather prescriptive as to how the sustainability of the BHCPF can be guaranteed and how resources shall be used, different interpretations of the relevant section of the NHAct have shown that this is not necessarily the case. Also, in terms of agreeing on adequate modalities to disburse the funds, especially the World Bank's attachment to use a PBF model collided with the NHIS's preference for a capitation provider payment modality. Second, Nigeria's federal governance system, in particular, allowed for the emergence of debates on how to best distribute management control and responsibility over the BHCPF operation.

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[426] See, for instance, this document, where DfID is making its aim explicit to influence the Nigerian Government to adopt a HIV/AIDS programme, which it considers cost-effective and good "value for money": https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/67716/health-influencing.pdf (last accessed 03/06/2021).

[427] The World Bank's financial support to the FGON is a credit, and not a grant, of US$ 500 million. In addition, the FGON is required to make available US$ 1.33 billion between 2016 and 2022. See: https://projects.worldbank.org/en/projects-operations/project-detail/P151488 (last accessed on 03/08/2021).

Most notably, the decentralisation of social health insurance means that, in practice, 38 different health insurance schemes – 36 SHIS, one FCT health insurance scheme and the NHIS – are currently in place in Nigeria. This raises not only questions of efficiency but also equity, as there is no common pool of resources, which would allow for fair cross-subsidisation (from the healthy to the poor, from the rich to the poor). Third, the impact of neo-liberalism's attachment to fiscal consolidation and privatisation means that, in reality, not enough resources are being made available in Nigeria to provide all necessary PHC services universally via the public PHC delivery system. Instead, a package of selective services is targeted to a small group of Nigerians, often via private sector facilities, while public facilities are in the process of upgrading their standard.

CONCLUSION

Since December 2019, the COVID-19 pandemic has laid bare existing social inequalities and has amplified vulnerabilities, across and within countries and regions as well as within households, families and work relationships (Kabeer et al., 2021; Stevano et al., 2021). In Nigeria, children from poorer socio-economic backgrounds have had less opportunity to continue their learning during the pandemic and low-income families continue to be disproportionally affected by a decline in household income, a drop in remittances, and roaring price inflation (and food price inflation, in particular) (World Bank, 2021; World Bank and NBS, 2021a). In terms of health, existing inequities in Nigeria are being further aggravated by the pandemic. In July 2020, 78.4 percent of households, surveyed by the World Bank and the NBS, stated that they were not able to access healthcare due to lack of money (World Bank and NBS, 2021b). At the same time, the provision of essential maternal and child health services, such as antenatal care and child immunisation programmes, was reduced further, notably due to government-imposed movement restrictions (Ahmed et al., 2020; Oke et al., 2020). Vulnerable populations in Nigeria are yet to be vaccinated,[428] and Nigeria's reliance on imported medicine has proven to aggravate medicine security, affecting the poorest families especially (Akande-Sholabi and Adebisi, 2020; Elebesunu et al., 2021).

The pandemic is prominently demonstrating the consequence of the structural shortcomings of our contemporary capitalist global world order and its attachment to neo-liberal policymaking (Navarro, 2020; Stevano et al., 2021). Concretely, the crisis has shown that countries with robust and universal health systems as well as more functional re-distributive and protective social systems fared markedly better during the crisis (Williams et al., 2021; Williams, 2020). Moreover, the pandemic has distinctively highlighted how health and healthcare are intimately linked to other dimensions of social and economic well-being, underscoring the exigency of conceptualising purpose-driven social and economic policies *in coherency*. This requires an in-depth understanding of the agents, relations, processes, structures and material cultures that influence policymaking and implementation in a specific context. By having engaged in a SoP investigation – concretely, an investigation of how UHC polices are designed and implemented in Nigeria – I have sought to contribute to the strand of the social policy literature that is committed to gaining such a detailed understanding of determinants and factors shaping social policy (and, in direct consequences, social policy outcomes).

[428] As of 23 August, only close to 4 million vaccine doses had been administered; see: https://covid19.who.int/region/afro/country/ng (last accessed 24/08/2021).

From this point of view, the main contribution of my PhD thesis is my original and thorough examination of the factors that shape health policymaking and implementation in Nigeria, affecting the form UHC is taking in the country and, thus, who can access quality healthcare. I have employed the SoP approach in order to go beyond the mere *description* of the Nigerian healthcare system and the actors, processes and structures operating within it. It has allowed me to understand the ways in which different degrees of power of and relations between agents have been influenced by global processes, country-specific structures, material culture and meaning associated with healthcare. And, notably, I have concentrated on the shifts of these vectors over time. Simultaneously, I have provided an analysis of the effect of interactions and contestations between agents on health policy in Nigeria, and, hence, on the state of the Nigerian healthcare system as well as health outcomes and health in/equality.

Thus, while there has been a considerable amount of research on the Nigerian healthcare system, including on policy and health system reforms, this PhD research is the first study that applies Ben Fine's System of Provision approach to the analysis of Nigeria's health policy environment. Conducting a SoP investigation of the policy environment, which embeds the Nigerian healthcare SoP (while being conditioned by it at the same time), allowed me to pay particular attention to the most pertinent structures and processes that affect the development and influence the on-going implementation of a specific policy – the NHAct. At the same time, I was able to single out the various agents operating within the Nigerian healthcare SoP and to examine their influence on the elaboration and implementation of the NHAct, and the BHCPF in particular. To date, little research on the BHCPF, particularly drawing on qualitative data, has been conducted. This is in part because the BHCF has only recently been rolled out.

In this spirit, the conclusion in this chapter aims to succinctly recapitulate the nature of the complexity of health policy making and implementation in Nigeria, while abstaining from making blanket recommendations in the manner of increasing public resources for primary healthcare or strengthening the coordination between the different tiers of Government. Although these are important proposals (evidently already broadly discussed within Nigeria[429]), this PhD thesis provides a historical and analytical account of *why* a specific policy (the NHAct) has taken a particular form and *why* its on-going implementation (with focus on the BHCPF) is taking a particular path. In this PhD thesis, I have outlined why it has not been "that simple" to increase public resources for primary

[429] See, for instance, here: https://www.premiumtimesng.com/health/457060-basic-health-care-provision-fund-a-slow-start-to-a-long-journey.html (last accessed on 25/08/2021).

healthcare or to ameliorate the coordination of healthcare delivery across the three tiers of Government. I argue that we need to understand these grounds in order to navigate future health policy making and implementation in Nigeria in an effort to promote the attainment of health for all. In the following section (section 1), I provide a summary of my main findings. Section 2 concludes this PhD thesis with a discussion of the limitations of my research and potential avenues for future investigation.

1. Summary of main research findings

In my PhD thesis, I have sought to uncover how UHC policies are designed, implemented, and put into practice in Nigeria. I have used the case study of policymaking and implementation in Nigeria (by proxy of the National Health Act and the Basic Health Care Provision Fund) to illustrate the complexity of social policy development in an African country and the multitude of elements which affect the process. In this light, I have provided a detailed account of the nature of this complexity, having unpacked how the current set-up of the Nigerian healthcare system, with its heavy reliance on private provisioning and individuals' out-of-pocket spending, contributes to health inequities and poor health outcomes. I have furthermore highlighted the effects of path-dependency as well as contestations between different agents (which include the Federal, State and Local Governments, medical professionals, international organisations, the civil society and private sector organisations, to mention a few) on health policymaking and implementation. Different views on social policy and different conceptualisations of universalism influenced the content of the NHAct and continue to impact the on-going operationalisation of the BHCPF.

Effectively, four key factors, having influenced the final text of the NHAct and which continue to influence the implementation of the BHCPF, stand out. First, Nigeria's economic performance, at different points in time, has significantly impacted the volume of resources put towards social policy more broadly, and health policy in particular. Levels of public funding to healthcare are very low and the proposed "at least one percent" annual allocation from the Federal Government's budget is too little to cover the primary healthcare needs of all Nigerians (if it is released). Until the 1980s, public revenues were used to fund public healthcare delivery systems. However, in the run-up to the enactment of the NHAct, volatile global oil prices, paired with low levels of tax income, made the Minister of Finance wary of the financial implication of committing a higher share of the public budget to funding healthcare. As a consequence, notably, the Minister of Finance pushed against committing a larger share of public resources to the BHCPF.

Second, Nigeria's federal character has been and continues to be a pivotal factor in shaping health policy and implementation and, hence, healthcare delivery in Nigeria. On the one hand (and related to the above first point), the NHAct only makes an "at least 1 percent" annual allocation to the BHCPF

mandatory, because a similar (but higher) commitment was made for the education system. In the case of the education system, States were not willing/able to provide the legally required counter-part funding, and, thus, did not access Federal public funds. This meant that the funds remained unused at the Central Bank. On the other hand (and more generally), the distribution of responsibility between the Federal, State and Local Governments means that no tier of Government really steps up to assure the adequacy of public primary healthcare delivery. The NHAct sought to address this issue, but a provision outlining clear responsibilities was taken out of the final version of the Act. Currently, a reform, aiming to put "Primary Health Care Under One Roof" at State-level, is on-going. However, States, as federating units, have considerable leeway to prioritise healthcare in their budgets as they see fit. At the same time, the Federal Government especially, arguably the level of Government with the largest fiscal space, has provided/continues to provide only little support to the primary healthcare system. This has resulted in the dilapidation of public health infrastructure and means that households, in reality, have to resort to accessing primary healthcare via the private healthcare system. Moreover, the decentralisation of social health insurance means that, in practice, 38 different health insurance schemes – 36 SHIS, one FCT health insurance scheme and the NHIS – are currently in place in Nigeria. This raises not only questions of efficiency but also of equity, as there is no common pool of resources, which would allow for fair cross-subsidisation (from the healthy to the sick, from the rich to the poor). Therefore, in today's Nigeria, access to healthcare is effectively still treated as an individual's responsibility and depends on a person's financial capacity to pay. Financial barriers are the main impediment to healthcare consumption in Nigeria, which has major implication for health inequity and social inequality as it deprivileges especially people of a lower socio-economic background and vulnerable groups such as young children and mothers.

Third, in response to the problems the public healthcare delivery system faces, the narrative that foregrounds collaboration with the private sector as the solution to improving healthcare service delivery, prevails in Nigeria. Today's dominant private sector in healthcare delivery is the product of path-dependency. The persistent influence of the private sector over the process leading to the NHAct can be accounted for in terms of the existence of a pro-private sector lobby from independent-Nigeria's beginnings, which petitioned against a mandatory health insurance scheme and for its inclusion in the publicly funded social insurance scheme. At the same time, an explicit market-centric turn in social policymaking in the mid-1980s has impacted healthcare system reform in Nigeria markedly. And, also in Nigeria, the dominance of neo-liberalism manifests as an attachment to private sector involvement which continues to be promoted up until today. As per the NHAct, private healthcare providers are invited to partake in the BHCPF and deliver a basic minimum package of health services and some States have decided to contract Health Maintenance Organisations to

administer portions of their insurance business process. Still, the narrative that "the private sector is needed" is nuanced. While communities communicate the belief that the private sector needs to financially support the Government to improve public service delivery, the Government, in particular, is of the view that the private sector needs to continue taking over part of its service delivery responsibility, albeit amidst better regulation. At the same time, international organisations – notably, the World Bank – continue to propagate that the private sector needs to be a key partner to achieve UHC in Nigeria and position themselves pro-marketisation.

Fourth and intimately interlinked with the above factors, today, the global discourse on UHC centres "coverage" and side-lines considerations as to how healthcare is provided. Neo-liberalism, with its attachment to fiscal consolidation and privatisation, shapes the conception of what UHC should look like in practice, including in Nigeria. As highlighted above, by design, the National Health Act does not make enough resources available to assure the provision of necessary healthcare services via the public primary healthcare delivery system to all Nigerians. Moreover, it maintains the private sector as a key actor, needed for the provision of a previously public good, such as healthcare. As a consequence, the BHCPF is operationalised by using public resources for the delivery of a basic minimum package of selective healthcare services to a small, targeted group of Nigerians, including via the (often for-profit) privatised healthcare delivery system. The ascendency of neo-liberalism, thus, has left its marks. While in the 1950s, 1960s and 1970s social spending was seen as an investment in nationhood, social cohesion and development, with the Government being the prime responsible for this, there was a rupture to such thinking and policymaking in the mid-1980s, notably with the introduction of the structural adjustment programme by Babangida's military regime in 1986.

Overall, my research underscored the complexity of health policymaking and implementation in the Nigerian context. It showed how a broad range of various agents – which include Federal, State and Local Governments, health professionals, communities, the civil society, the private sector and international organisations – impacted the final text of the NHAct (to different degrees) and influence the on-going operationalisation of the BHCPF. Moreover, the combination of Nigeria's federal structure, the dominance of the private sector, the widespread disenchantment with the Government in Nigeria as well as competing views and priorities of international organisations continue to influence Nigeria's perspective in terms of attaining UHC.

I am grateful to the 83 community members and 52 key informants who have shared their views on and knowledge of the Nigerian healthcare system and the policies shaping it, which formed the main empirical basis for my analysis.

2. Limitations and avenues for further research

The above highlights how complex policymaking and implementation is and how the success or failure of a policy is the result of multifaceted realities. In this light, the most significant limitations of my research are the following:

- First, in my research, I have focused on the elaboration of the NHAct and its implementation with a particular focus on the BHCPF. I have thus concentrated on scrutinising the policy environment that embeds and conditions the Nigerian healthcare system of provision. However, also other systems of provision (such as housing, water and sanitation, transport infrastructure, etc.) contribute to health outcomes, health inequities and social inequalities in Nigeria. In the future, it may be interesting to explore how other public policies affect the Nigerian healthcare system of provision, health inequity and health outcomes.
- Second, I have limited my analysis to policy aspects, but have not paid thorough attention to understanding and examining service delivery challenges and the effectiveness of different health programmes in Nigeria. Especially during FGDs, aspects such as the non-availability of drugs, the lack of qualified health personnel, lack of electricity or water in healthcare facilities and corruption in the healthcare system have been repeatedly raised. I hope to pursue these elements in future research.
- Third, it appears useful to further explore the voices of FGD participants with regard to the material culture of consumption of healthcare in Nigeria, scrutinising differences across different groups and anchoring meaning and material culture of healthcare consumption in Nigeria in the literature on health-seeking behaviour.
- Fourth, I was not able to pay adequate attention to a particular important link between health policy and economic policy, namely the production of medicines. By promoting the local production of drugs and medical equipment, Nigeria could not only improve availability of essential drugs, but also improve its productive capabilities in an important industry. The localised production of medical supplies and drugs lies at the "interface of industrial/economic development policy and public health policy" (Kaplan et al., 2011). A government's vow to assure access to quality healthcare comes with the commitment of guaranteeing availability of, and access to, essential medicines for citizens and residents (WHO, 2014b, p. 121). Hence, as claimed by Mackintosh et al. (2016, p. 3), "African governments have responsibility for their populations' health needs, and cannot address them without industrial expertise".
- Fifth, especially the effect of decentralision on access to healthcare services merits further research. Since the 1980s, many African countries have pursued a policy of decentralisation – defined as "the transfer of public authority, resources, and personnel from the national level

to subnational jurisdictions" (Ndegwa, 2002, p. 1) – in view of improving localised (healthcare) service delivery and participatory governance (Inkoom and Gyapong, 2016). However, the impact of these reforms on the Nigerian (as well as other African) healthcare system deserves more attention.

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Appendices

Appendix A: Summary of selected definitions of social protection or policy (most recent to least recent)

Source	Definition
Fischer (2018, p. 227)	"Social policy generally refers to the **range of publicly or collectively provided, funded and/or regulated forms of services and interventions** in a society, such as schooling, health care and social protection. The function or purpose is not only to provide these public or social goods, but also **to affect various social outcomes** through such provisioning (such as learning or health) or else to influence the access to and the incidence of adequate and secure livelihoods and income (as per Mkandawire 2004, p. 1). It is also generally considered to include several other areas such as housing policy, as well as more legal or regulatory aspects such as in child protection or labour market regulation. Within this broad understanding, **social protection** has received most of the recent attention as a more narrow view of social policy, whereas it is properly understood **as a subset of social policy**."
ILO (2017, p. xxix)	"Social protection, or social security, is a **human right** and is defined as the set of policies and programmes designed to reduce and prevent poverty and vulnerability throughout the life cycle. Social protection includes **child and family benefits, maternity protection, unemployment support, employment injury benefits, sickness benefits, health protection, old-age benefits, disability benefits and survivors' benefits**. Social protection systems address all these policy areas by a mix of contributory schemes (social insurance) and non-contributory tax-financed benefits, including social assistance."
Fiszbein et al. (2013, p. 3) (World Bank)	Social protection as the "collection of programs that address **risk, vulnerability, inequality, and poverty** through a system of transfers in cash or in kind."
World Bank (2012, p. 101)	"Social protection and labour systems, policies, and programs help individuals and societies **manage risk and volatility** and protect them from **poverty and destitution** – through instruments that improve resilience, equity, and opportunity."
UNICEF (2012, p. 14)	"Social protection is the set of public and private policies and programmes aimed at preventing, reducing and eliminating economic and social vulnerabilities to poverty and deprivation. Social protection is essential to UNICEF's commitment to the **realization of the rights of children, women and families to an adequate standard of living and essential services**. […] Within this broad set of policies, UNICEF's work on social protection concentrates on […] social transfers; programmes to ensure economic and social access to services; social support and care services; legislation and policies to ensure equity and non-discrimination in children's and families' access to services and employment/livelihood."
European Union (2012)[430]	"Social Protection refers to nationally defined systems of policies that provide **income security and access to health services** for all people, and equip and protect them throughout their lives to protect them against **poverty and risks** to their livelihoods."
Barrientos, 2009 (p. 253)	"Social protection is commonly taken to include **social insurance, social assistance and labour market regulation**. Social insurance normally covers schemes financed by contributions from employees, employers and the state; and protecting contributors and their dependents from contingencies associated with the life course, employment and health. Social assistance is predominantly tax-financed and aims to support those in poverty. Labour market regulation enhances security and protection of workers and ensures rights to participation and voice."

[430] See here: https://europa.eu/capacity4dev/results-and-indicators/social-protection-0 (last accessed 12/08/2021).

UNRISD (2006, p. 1)	Social policy defined as "**state intervention** that directly affects **social welfare, social institutions and social relations**. It involves overarching concerns with redistribution, production, reproduction and protection, and **works in tandem with economic policy** in pursuit of national social and economic goals. Social policy does not merely deal with the "causalities" of social changes and processes; it is also a contribution to the welfare of society as a whole."
Cichon and Hagemeijer (2006, p. 5) (ILO)	"Social security is a set of institutions, measures, **rights** and obligations whose primary goal is to provide – or aim to provide – according to specified rules, income security and medical care to individual members of society."
Mackintosh and Tibandebage (2004, p. 143)	"We employ a broad definition of 'social policy', to include governmental and non-governmental **public action to shape social provisioning such as health and education**, including influencing the distributive outcomes of social sector market processes. Indeed we argue that understanding the **mutual interaction of public policy and market behaviour** is key to designing effective developmental policy in health care as it is in other social sectors."
Devereux and Sabates-Wheeler (2004, p. 9) (IDS)	"Social protection describes all public and private initiatives that **provide income or consumption transfers to the poor, protect the vulnerable against livelihood risks and enhance the social status and rights of the marginalised;** with the overall objective of reducing the economic and social vulnerability of poor, vulnerable and marginalised groups."
Mkandawire (2001, p. 6)	"Social policy as **collective interventions** directly affecting transformation in **social welfare, social institutions and social relations**. Social welfare encompasses access to adequate and secure livelihoods and income. Social relations range from the micro to the global levels, encompassing intra-household relations of class, community, ethnicity, gender, etc. Social institutions are the 'humanly devised constraints that shape human interactions' or the 'rules of the game' in a society (North, 1990)."
Holzmann and Jørgensen (2000, p. 9) (World Bank)	Social protection "consists of public interventions (i) to assist individuals, households, and communities better manage risk, and (ii) to provide support to the critically poor This definition combines the traditional SP tools, including labor market interventions, social insurance programs and social safety nets, under a unifying theme."
Norton et al. (2001, p. 7)	Social protection refers to "the public actions taken in response to levels of **vulnerability, risks, and deprivation**, which are deemed **socially unacceptable** within a given polity and society."
United Nations (2000, p. 4)	"Social protection is broadly understood as a set of public and private policies and programmes undertaken by societies in response to various contingencies to offset the absence or substantial reduction of income from work; to provide assistance for families with children as well as provide people with health care and housing."
Van Ginneken (2000, p. 36)	Social protection can be defined as "**entitlement** to benefits that society provides to individuals and households – through public and collective measures – to protect against low or declining living standards arising out of a number of basic **risks and needs**."

Source: Own compilation

Appendix B: Timeline of key events, declarations and reports related to social protection

Time	Selected key global events	Selected human rights declarations	ILO declarations, recommendations, etc.	World Bank / IMF reports, periods, etc.
1919	World War I (1914-1918)		ILO International Labour Convention on Social Security	
1944	World War II (1939-1945)		Declaration of Philadelphia	Bretton Woods Conference
1948		Universal Declaration of Human Rights		
1952		Social Security Minimum Standards Convention		
1955	Bandung conference			
1961	Establishment of the Non-Aligned Movement			**1950s/1960s Lending for infrastructure** Ideas of trickle-down economic growth and convergence
1964			Employment Injury Benefits	
1965		Internatinal Convenant on the Elemination of All Forms of Racial Discrimination		
1966		International Covenant on Economic, Social and Cultural Rights		
1967			Invalidity, Old-Age and Survivors Benefits	
1968				
1969			Medical Care and Sickness Benefits	
1973	First oil-price shock End of fixed-exchange rate regime			**1968-1981 Pre-Washington Consensus** State coordination of large-scale investment projects (‘big push’) and elementary version of welfare
1974		Declaration on the Establishment of a New International Economic Order (NIEO)		
1978		Declaration of Alma-Ata on Primary Health Care		
1979	Second oil-price shock	Convention on the Elimination of All Forms of Discrimination Against Women		

1981				**1981-1997 Washington Consensus** Neo-liberal ideology with strong commitment to the free market and lending for structural adjustment ▪ *Berg Report* (1981) ▪ *WDR Poverty* – tentative moves to incorporate social safety nets (1990) ▪ '*East Asian Miracle' Report* published casting doubt on effectiveness of the IFI's SAP policies ▪ Negative social impact of SAP prompts calls for 'adjustment with a human face'
1982	Start of debt crisis		Maintenance of Social Security Rights	
1987				
1988			Employment Promotion and Protection against Unemployment (1988)	
1989		Convention on the Rights of the Child		
1996		European Social Charter		
1997				Joseph Stiglitz appointed as Chief Economist and calls for a **Post-Washington Consensus**
1999			World Labour Report*: "Income Security and Social Protection in a Changing World"*	Comprehensive Development Framework Introduction of PRSP
2000		Millennium Development Goals	Maternity Protection	*WDR Attacking Poverty* – triggers pro-poor growth debates
2001			Global Campaign on Social Security and Coverage for All	Report on "*Social Protection and Labour*" – strong focus on social risk management
2003		Protocol to the African Charter on Human's and People's Rights on the Rights of Women		
2004		Ouagadougou Plan of Action		
2005				Report "*Economic Growth in the 1990s: Learning from a Decade of Reforming*"
2008	Onset of the Global Financial Crisis – triggered rapid extension in the global-level-attention to social protection	Social Policy Framework for Africa		"*The Growth Report: Strategies for Sustainable Growth and Inclusive Development*" elaborated by the World Bank's newly established Commission on Growth and Development
2010			"*Extending Social Security to All*" "*World Social Security Report"*	

2012			Social Protection Floors Recommendation (No. 202)	"*The Cash Dividend*" – review of social protection in Africa 2012-2022 *"Social Protection and Labour Strategy"* IMF Fiscal feasibility assessment – commitment to increase social protection expenditure by 40 per cent
			Establishment of a Social Protection Inter-agency Coordination Board (chaired by the ILO and the World Bank; the IMF becomes member of the Board)	
2014			World Social Protection Report	Report on "State of Social Safety Nets"
2015		Sustainable Development Goals Addis Ababa Declaration on Transforming Africa Through Decent Work for Sustainable Development	Joint-statement of the ILO and the World Bank in favour of universal social protection	
2016			Establishment of a Global Partnership on Universal Social Protection	
2017			World Social Protection Report 2017-2019	
2018		Astana Declaration on Primary Health Care		
2019	Onset of the global COVID-19 pandemic	United Nations Declaration on UHC		

Source: Own compilation

Appendix C: Definitions of common provider payment mechanism

Provider-payment mechanism	Definition	Incentives for healthcare providers
Salaries	Regular payment to staff	No (monetary) incentive for health staff to improve performance, potentially reducing quality or resulting in underprovision of services
Capitation	Advanced, fixed payment to service provider on behalf of an enrolee	Incentive to improve efficiency, to attract more enrolees, but to select the healthier ones and to underprovide services or refer them to onwards to control costs
Fee-for service (FFS)	Payment for each individual service provided	Overprovide services above necessary and increase costs
Global budget	Advanced payment to a facility to cover aggregate expenditures for service delivery	Incentive to refer patients to other providers and to underprovide services, but to improve efficiency
Line-item budget	Advanced payment to a facility to cover specific line item such as expenditure related to staff, supplies, drugs, etc.	Incentive to spend all the money before the end of the financial year, to refer patients to other facilities and underprovide services and no incentive to improve efficiency
Per diem payments	Daily fixed payment for service delivery	Incentive to increase the number of days that a patient is admitted, to improve efficiency but no incentive to improve quality
Case-based payments / diagnosis related group (DRG)	A specific amount paid to provide all services per episode of illness	Incentive to increase the admissions more than necessary and to then discharge the patients early

Source: Obadha et al. (2019)

Appendix D: List of interview partners

#	Date	Organisational affiliation of interview partner
1	30-Jan-19	UNFPA
2	30-Jan-19	World Bank
3	30-Jan-19	World Bank
4	30-Jan-19	Ministry of Finance
5	1-Feb-19	Nigeria Center for Disease Control
6	18-Feb-19	PHC Center Agbani, Enugu State
7	18-Feb-19	PHC Center Okpanku, Enugu State
8	19-Feb-19	Local Government of Nkanu West, Enugu State
9	27-Feb-19	State Ministry of Health, Enugu State, Agency for UHC
10	27-Feb-19	State Ministry of Health, Enugu State, Department of Panning, Research and Statistics
11	27-Feb-19	State Ministry of Health, Enugu State
12	28-Feb-19	University of Nigeria Nsukka, Department for Health Administration & Management
13	1-Mar-19	National Health Insurance Scheme
14	1-Mar-19	National Health Insurance Scheme
15	5-Mar-19	Health Policy Research Group; University of Nigeria, Nsukka
16	5-Mar-19	Health Reform Programme (HERFON), Enugu
17	5-Mar-19	State Ministry of Health, Enugu State
18	7-Mar-19	State Primary Health Care Development Agency (SPHCDA), Enugu State
19	7-Mar-19	Coal Camp Medical Center
20	7-Mar-19	Coal Camp Medical Center
21	7-Mar-19	Coal Camp Medical Center
22	7-Mar-19	House Committee on Health, Enugu State
23	8-Mar-19	UNICEF Enugu Field Office
24	8-Mar-19	Green Field HMO
25	8-Mar-19	HPRG
26	11-Mar-19	PHC Center Okpuno, Anambra State
27	11-Mar-19	State Primary Health Care Development Agency (SPHCDA), Anambra State
28	12-Mar-19	Local Government of Aninri, Enugu State
29	15-Mar-19	National Social Safety-Net Coordinating Office (NASSCO), Office of the Vice President
30	16-Mar-19	Niger State Contributory Health Agency (NGSCHA)
31	16-Mar-19	Local Government of Chanchaga, Niger State
32	16-Mar-19	Local Government of Chanchaga, Niger State
33	17-Mar-19	World Bank

34	18-Mar-19	Healthcare International (HMO heading HMCAN)
35	18-Mar-19	World Bank
36	20-Mar-19	Results for Development
37	21-Mar-19	Nigeria Health Watch
38	22-Mar-19	Department for Health Planning, Research and Statistics, Federal Ministry of Health
39	23-Mar-19	National Hospital Abuja & Nigeria Medical Association
40	24-Mar-19	Office of the Senate President of the National Assembly
41	25-Mar-19	Bill and Melinda Gates Foundation
42	25-Mar-19	UNICEF Abuja Office
43	27-Mar-19	HERFON Abuja *(Interview conducted with three employees at the same time)*
44	27-Mar-19	Clinton Health Initiative (CHAI)
45	27-Mar-19	UN Women
46	27-Mar-19	Health Sector Reform Coalition & HERFON Abuja
47	29-Mar-19	Minister's Office at the Federal Ministry of Health
48	3-Apr-19	WHO
49	4-Apr-19	NPHCDA
50	5-Apr-19	NPHCDA

Appendix E: Guiding questions for semi-structured interviews

Main operational research question	
How are universal health coverage policies designed and implemented in Nigeria?	
Subsidiary operational research questions	
Policy design	Q1.) Which factors, processes and agents drove the development and enactment of the 2014 National Health Act as well as the creation of the BHCPF?
Policy implementation	Q2.) Which factors, processes and agents influence the form UHC takes in Nigeria and notably, the operationalisation of the BHCPF?
Access/use	Q3.) What are the different views and beliefs of communities as well as agents involved in the Nigerian healthcare system on accessing healthcare?

Guiding questions for interviews

Policy design:

- What is your opinion on the NHAct?
- What do you think was the main motivation to introduce the NHAct and the BHCPF?
- Which interest groups were in favour/against its introduction?
- Do you think the BHCPF is the right instrument to reduce the financial burden of rural communities and protect them from health-expenditure related risk?
- Would you prefer another way of financing healthcare?
- In what way shall the private sector be implicated in the BHCPF set-up?

Policy implementation:

- To what extent do you think will HMOs be affected by the introduction of the BHCPF?
- To what extent will States be implicated in implementing the BHCPF set-up?
- Will States willingly introduce State Health Insurance Schemes?
- Will States be able/willing to mobilize the 25 percent counterpart-funding for the NPHCDA gateway?
- When will it be funded?
- Will HCPs accept being reimbursed post-service provision?

Access/use:

- What could hamper the success of the implementation of the NHAct and the BHCPF?
- What do you think is the best way to finance and provide healthcare?
- In your opinion, what role should the private sector play in providing and financing healthcare services?

Appendix F: List of Focus Group Discussions

#	Date	Community	Group	Participants
1	19-Feb-19	Agbani, Nkanu-West, Enugu	HFC/WDC	8
2	19-Feb-19	Agbani, Nkanu-West, Enugu	Women's Group	6
3	19-Feb-19	Agbani, Nkanu-West, Enugu	Youth Group	6
4	20-Feb-19	Okpanku, Aninri, Enugu	Youth Group	7
5	20-Feb-19	Okpanku, Aninri, Enugu	HFC/WDC	7
6	20-Feb-19	Okpanku, Aninri, Enugu	Women's Group	8
7	22-Feb-19	Agbani, Nkanu-West, Enugu	Village Heads/Community Leaders	6
8	11-Mar-19	Okpuno, Akwa-East, Anambra	Women's Group	6
9	11-Mar-19	Okpuno, Akwa- East, Anambra	HFC/WDC	5
10	16-Mar-19	Minna, Chanchaga, Niger	HFC/WDC	8
11	16-Mar-19	Minna, Chanchaga, Niger	Village Heads/Community Leaders	8
12	16-Mar-19	Minna, Chanchaga, Niger	Women's Group	8

** HFC – Health Facility Committee; WDC – Ward Development Committee*

Part 1 – Introduction

#	Sequence
1	**Welcome participants as they arrive.**
2	**Greet them in Igbo and please inform them that the discussion will take place in Igbo, but that they can also speak English if they wish to do so.**
3	**Once everyone has arrived, ask people to take a seat.**
4	**Once people are sat down, thank and welcome them again.**
5	**Introduce yourself.** We would like to invite you to participate in this focus group that is being organized by researchers from the School of Oriental and African Studies / University of London and the Health Policy Research Group / University of Nsukka.
6	**Ask them to briefly introduce themselves (what is their name? what they do in their lives?)**
7	**Then ask them to pick a name (that is not a human name) that they will use for the focus group (to protect their identity) – write it on name cards.** **Note – the reasons for asking them to choose other names are:** ▪ To protect their identity and to ensure that everything they say is confidential. ▪ To make them feel comfortable to say what they think.
8	**Introduce the project and tell participants why they have been selected.** ▪ Inform participants of the aim of the focus group: The purpose of this focus group is to discuss the different views of community members on how healthcare should be provided and financed in Nigeria. ▪ Inform them why we are doing this: The focus group discussion is conducted as part of a PhD study, which aims to uncover how health policies are conceptualised and implemented in Nigeria. ▪ Inform the participants that they have been chosen based on their membership in one of the five below group:

	○ Female health service users; Village heads; Ward Development Committee; Health Facility Committee; Grassroot / youth group **Note – if participants ask how the research will benefit the community, explain:** ▪ Understanding better and learning more about how communities feel about how healthcare should be provided and financed may enable to make context-relevant policy recommendations, aiming to improve access to healthcare services in Nigeria. ▪ However, we accept that some of the work that we will do here may not have immediate direct benefits – we are grateful for their participation.
9	**Explain the focus group rules:** ▪ Duration of discussion: Between 45 and 90 minutes ▪ We want you to do the talking: Let's hear from everyone! Encourage people to speak that have not yet spoken. One person at a time. ▪ There are no right or wrong answers: Everyone's ideas and experiences are valuable. It is important to hear all sides – including both positives and negatives. We will not always agree, but we must always show respect for one another. ▪ What is shared in this room stays in this room: Please keep everything you hear today confidential. We will summarize themes without identifying individuals by name. We would like to record this session, so we do not miss anything.
10	**Explain tape recorder, ask them permission, and explain why we want to record them.**
11	**Switch on tape recorder and read consent form out loud:** The purpose of this focus group is to discuss the different views of community members on how healthcare services should be provided and financed in Nigeria. The purpose of the consent form is to provide you with information for you to decide whether to participate in this study. Any questions you may have will be answered by the researchers. During the focus group, we would like to take some notes to help us with our work. We would also like to audio-record our discussion to help us with our research. Everything that you say in the focus group will be confidential. When we say confidential, this is what we mean: ▪ Everything you say will only be listened to by researchers and assistants working on this project; ▪ Notes made during the focus group will only be read by researchers working on this project; ▪ We will not keep records of your names; ▪ We will not record your names on our tape recorder; ▪ The name of you or your village will not appear in any reports that we write; ▪ Any other details that may make it possible for you to be identified will also be removed. We would also like you to give us permission to use the information you provide in our reports. You do not have to agree to this. Any quotes that we publish

	will also be confidential. Your participation is entirely voluntary. We understand if you do not want to take part.
12	**Ask them to give consent and sign the consent form. Ask if there any questions.** **Note – if participants are reluctant to consent:** ▪ Researchers will also explore, in a sensitive way, reasons for non-consent, and will re-emphasise that discussions will be confidential, and that no quotes from the focus groups will be used without their permission. ▪ Discuss the purpose of the focus group – this focus group does not aim to collect personal/sensitive information, just to understand some of the views of people on healthcare provisioning and financing. ▪ Reassure the group that anyone who does not want to participate can leave at any time.

Part 2 – Discussion

13	**Introduce the general question:** The people in Government in Nigeria and many other organisations such as civil society organisations and international organisations are continuously discussing and looking into ways of how to best improve access to healthcare services in Nigeria, particularly for people living in rural parts of the country.
14	**Then ask the first guiding question. Do not make suggestions – ask them what they think:** ▪ **How do you think healthcare services should be provided in Nigeria? Why?** ▪ **How should healthcare be financed? Who should pay for what? Why?** ▪ **How would your ideal healthcare system in Nigeria look like? Why?**
15	**Encourage participants to share their views and see that everybody who wants to speak has time to speak. Encourage participants who are reluctant or shy to share their opinion too.** **Note – during discussion:** ▪ Make sure that you allow discussion. ▪ Probe to clarify the reasons for one choice over the other. ▪ Ask people to explain what they mean (why? for what reason?) and do not assume.

16	**Thank the group for their participation so far, and all the interesting reasons and arguments that they have suggested, then introduce the below follow-up questions (if necessary):** ▪ **What is the preferred option: to receive a cash transfer and then pay for healthcare privately or access public healthcare services at point-of-service free of charge?** ▪ **Should healthcare services be free for everybody? What are reasons for and against providing healthcare free-of-charge for everybody?**
17	**Thank the participants for all their efforts, and all the interesting things they have told us. But then ask:** ▪ **We have asked many questions that we thought are important, but we may have missed something. Is there anything else that we should know?**
18	**Ask the participants if they have any questions that they want to ask.**
19	**Switch off tape-recorder.**
20	**Thank them for coming and offer refreshments.**

Appendix H: Key health indicators of the country

Indicator	Source	Nigeria	SSA	LMIC
Health status				
Live expectancy at birth	World Bank, 2018	54.3	61.3	68.4
Total Fertility Rate (children / woman)	World Bank, 2018	5.4	4.7	2.8
Malaria incidence (per 1,000 people at risk)	WHO, 2018	291.9	219.1	
Road traffic mortality rate (per 100,000 people)	WHO, 2016	21.4	26.6	
New HIV infections (per 1000 uninfected people)	WHO, 2018	0.65	1.07	
Adult aged 15-49 HIV prevalence rate (%)	UNAIDS, 2019	1.3	3.72	
Top five contributors to deaths in Nigeria				
1. Neonatal disorders	IHME, 2019	12.3%		
2. Malaria	IHME, 2019	12.0%		
3. Diarrheal diseases	IHME, 2019	11.4%		
4. Lower respiratory infections	IHME, 2019	10.9%		
5. HIV/AIDS	IHME, 2019	5.2%		
Child health and nutrition				
Birth registration (%)	DHS, 2018	42.6	45	43
Infant mortality (deaths per 1,000 live births)	IGME, 2019	74	52	49
Under-5 mortality (deaths per 1,000 live births)	IGME, 2019	117	76	37
Prevalence of stunting in children under 5 (%)	WHO, 2019	36.8	32.5	
Prevalence of wasting in children under 5 (%)	WHO, 2019	6.8	6.4	
Prevalence of overweight in children under 5 (%)	WHO, 2019	2.1	3.1	
Children (12-23 months) who received all age-appropriate vaccinations (%)	DHS, 2018	19.1		
Children (24-35 months) who received all age-appropriate vaccinations (%)	DHS, 2018	4.0		
Children <5 with fever in the last two weeks for whom no advice or treatment was sought (%)	MICS, 2016-17	32.4		
Children <5 with symptoms of acute respiratory syndrome in the last 2 weeks for whom no advice/treatment was sought (%)	MICS, 2016-17	15.9		
Children <5 with diarrhoea in the last two weeks for whom advice or treatment was sought (%)	MICS, 2016-17	16.7		
Anti-malarial treatment of U5 children (%)	MICS, 2016-17	36.8		
Reproductive and maternal health				
Maternal mortality ratio (per 100,000 live births)	WHO, 2017	917	525	

Proportion of women of reproductive age who have their need for family planning satisfied with modern methods (%)	WHO, 2019	35.6	56.5	
Prevalence of anaemia in women (15–49 years) (%)	WHO, 2016	49.8	39	
Live births delivered in a health facility (%) - Public sector; private sector	DHS, 2018	39.4 (26.4; 13.0)		
Births attended by skilled health personnel (%)	MICS, 2016-17	43.0		

Appendix I: Key demographic, macroeconomic and health indicators of the country

Indicator	**Source**	**Nigeria**
Population	NPC, 2016 (projection) World Bank, 2019 (estimate)	193,392,517 201 million
Gross Domestic Product	World Bank, 2019 (current US$)	US$ 448.1 billion
Gross Domestic Product per capita	World Bank, 2019 (current US$)	US$ 2,230
Inflation rate (%; all items; annualized)	Central Bank of Nigeria, February 2021	17.3
Inflation rate (%; food; annualized)	Central Bank of Nigeria, February 2021	21.8
Government revenues (as % of GDP)	IMF, October 2020	7.9
Net Government debt (as % of GDP)	IMF, October 2020	25.4
Unemployment rate (%)	Labour Force Statistics, Q2/2020	27.1
Underemployment rate (%)	Labour Force Statistics, Q2/2020	28.2
Human Capital Index Score	World Bank, 2020	0.36
Human Development Indicator Rank	United Nations Development Programme, 2019	161 / 189 countries
Poverty headcount rate	Poverty and Inequality Report, CBN, 2019	40.09
Multidimensional poverty headcount ratio (% of total population)	World Development Indicators, 2017	53.70
Gini coefficient	Poverty and Inequality Report, CBN, 2019	35.13
Income share held by highest 20%	World Bank, 2018	42.4

Appendix J: Agents involved in defining the Nigerian healthcare system of provision

Category of agents	Key agents	Roles
Federal Government and line Ministries	President	Responsible for assenting and singing bills into law
	Federal Ministry of Finance	Advises the Federal Executive Council to ensure financial implications of laws align with the macro-economic realities of the country
	Federal Executive Council	Approves policies that have macroeconomic and financial implications
	National Assembly (NASS)	Reviews bills and amends them to ensure their compatibility with the constitution; responsible for the appropriation for the appropriation of health budgets and monitors the disbursement of the budget through its standing committees (Senate and House Committees on Health)
Federal Ministry of Health and agencies	Federal Ministry of Health	Responsible for the development of health policies and guidelines for their implementation as well as for developing annual budget proposals in accordance with national health plans
	NHIS	Mandated to provide social health insurance in Nigeria and to administer 50 percent of the BHCPF funding via the "NHIS gateway"; runs the Formal Sector Social Health Insurance Programme and oversees the operations of HMOs
	NPHCDA	Mandated to pursue and oversee interventions targeted at improving the primary healthcare delivery system in Nigeria (i.e., the Midwives Service Scheme, the Subsidy Reinvestment Programme, etc.) and to administer 45 percent of the BHCPF funding via the "NPHCDA gateway"
	NEMTC	Newly instituted with the NHAct to oversee the administration of emergency medical treatment services with 5 percent of the BHCPF funding ("EMT gateway")
State and Local Governments	State Ministries of Health	Responsible for the domestication of Federal health policies and overseeing their implementation; support Local Governments in their efforts to manage health plans and programmes
	SPHCDA	Introduced as part of the "Primary Health Care Under One Roof" policy and responsible for managing efforts targeted at improving quality and increasing access to essential healthcare services in their respective States; implementation partners of the NPHCDA gateway
	SHIS	Put into place in 2015 as part of an initiative to decentralise health insurance and responsible to extending social health insurance coverage in their respective States; implementation partners of the NHIS gateway

	Local Government Health Authorities	Responsible for operating the primary healthcare system, community mobilisation and ensure equitable access to healthcare services across the Local Government Area
Public healthcare providers	Public healthcare providers	Provide a broad range of healthcare services in health establishments across the country
Private sector	Health Maintenance Organisations	Interface between government and providers of healthcare in the social insurance scheme
	Private foundations and corporations	Support the healthcare system as part of their Corporate Social Responsibility activities or as investors
	For-profit private healthcare providers	Likely to overlap with the category of public healthcare providers, as more than 60 percent of health services are delivered by the private sector in Nigeria and it has been reported that many healthcare providers in the public sector also provide healthcare services privately
	Non-profit private healthcare providers	Include community-based organisations and NGOs, which support healthcare delivery at community level (technically, financially or with in-kind donations)
Development organisations	World Bank	Highly influential multilateral donor whose involvement in the health sector and other social sectors is substantial
	DfID	Contributed to Nigeria's health system reform process considerably through its "Partnership for Transforming Health Systems" programmes (PATHS I and II)
	UN (WHO & UNICEF)	UN agencies active in the domain of (child) health
	BMGF	Most important private donor to Nigeria's healthcare system and implements a variety of different health interventions; committed to support the BHCPF with US$ 2 million
Civil society organisations and academia	Civil society organisations and academia	Responsible for influencing and shaping the formulation and execution of public policies in favour of the broader public
Religious groups	Christian churches	Missionaries are reported to have introduced "modern" healthcare to Nigeria and different Christian churches remain influential and may affect public attitude towards healthcare, especially in the Southern States of the country
	Muslim Community Jama'atu Nasril Islam	Umbrella group for the Nigerian Muslim community (approximately half of Nigeria's population), led by the Sultan of Sokoto as their spiritual leader; influential and may affect public attitude towards healthcare
Community members	Community members	Diverse group of healthcare users

Source: Own compilation; based on Onwujekwe et al. (2019)

Appendix K: Tax collection and retention according to tier of governance in Nigeria

Tax		Collection	Retention
Import duties	High effective duty rates on imports into strategic sectors: i.e. wheat (85 percent), sugar (75 percent), rice (70 percent), tomato paste (50 percent), salt (70 percent), cement (55 percent)	FIRS	Federation Account
Luxury and excise duties	Dependant on goods: i.e. yachts, motorboats and other vehicles for pleasure (75 percent), alcohol (75-95 percent), tobacco products (95 percent)	FIRS	Federation Account
Export duties		FIRS	Federation Account
Mining rents & royalty		FIRS	Federation Account
Petroleum Profits Tax [PPT]	Joint ventures: 65.75 percent of chargeable profit (first 5 years) afterwards 85 percent; companies under production sharing contract: 50% of chargeable profit	FIRS	Federation Account
Company Income Tax [CIT] Tertiary Education Tax Withholding Tax	30 percent of profit 2 percent of profit Varying rates between 5-10 percent	FIRS	Federation Account
Personal income tax: armed and police forces, external affairs officers, non-residents, residents of the FCT		FIRS	Federation Account
Value Added Tax [VAT]	7.5 percent (since 2020)	FIRS/SBIRs	Federal/State
Capital gains tax [CGT]	10 percent on chargeable assets	SBIRs	State
Personal income tax [PIT] (other than listed below)	Progressive – highest: 24 percent (annual income of > NGN 3,200,00)	SBIRs	State
Capital Transfer Tax (CTT)		SBIRs	State
Stamp duties		SBIRs	State
Gift tax		SBIRs	State
Pools betting & other betting taxes		SBIRs	State
Entertainment tax		SBIRs	State
Land registration and survey fees		SBIRs	State
Property tax and ratings	15% of the transfer value of the land	SBIRs/LGA	State/Local
Licenses and fees		LGA	Local
Motor park dues		LGA	Local
Motor vehicle		LGA	Local
Market and trading license & fees		LGA	Local

Source: Adapted from Salami (2011);
Acronyms: FRIS (Federal Inland Revenue Service); SBIRs (State Boards of Internal Revenue)

Appendix L: Health policy milestones and their context in Nigeria

Year	Ministers of Health	Health (and social) policy milestones	Selected political events in Nigeria
19th cent.		Prevalence of traditional forms of medicines Church missionaries (Roman Catholic mission, Anglican Church Missionary Society, American Baptist Mission) introduce earliest forms of "modern" medical services with the first health care facility in the county being a dispensary (opened in 1880 by the Church Missionary Society in Obosi), followed by others in Onitsha and Ibadan in 1886 First hospital in Nigeria was the Sacred Heart Hospital in Abeokuta, built by the Roman Catholic Mission in 1885 and first government-built hospital was the St. Margaret's Hospital in Calabar (1889)	Sokoto Caliphate founded by Usman dan Fodio in 1804
1902		West African Medical Service introduced	
1903			Sokoto Caliphate conquered and integrated into the Norther Nigerian British protectorate
1914			Amalgamation of the British colonial protectorates of Northern Nigeria, Southern Nigeria and the Colony of Lagos into Nigeria
1922			Hugh Clifford Constitution adopted
1929		1929 Colonial Development Act	
1939			Nigeria is split into three regions: North, East, West
1940		1940 Colonial Development and Welfare Act	
1944		Asquith Commission Report becomes the blueprint for British policy in higher education in colonial territories until 1959	
1945		1945 Colonial Development and Welfare Act	
1946			Arthur Richards Constitution adopted and anchors federalism in Nigeria
1948		Yaba Higher College upgraded to University of Ibadan	
1951		Nigerian Medical Association established	Action Group established by Chief Obafemi Awolowo MacPherson Constitution adopted

1952	S. L. Akintola (1952-56)		
			Oil drilling starts in today's Bayelsa State
1957	Ayo Rosiji (1957-59)		
1959	Waziri Ibrahim (1959-61)		Parliamentary elections take place resulting in a victory of the Northern People's Congress (NPC)
1960	M. Majekodunmi (1961-65)		Nigeria gains independence from Britain Coalition government is formed with Abubakar Tafawa Balewa (NPC) as Prime Minister and Nnamdi Azikiwe acting as Governor-General (National Council of Nigeria and the Cameroons, NCNC)
1962		First Development Plan (1962-1968) adopted focusing on increasing the standard of living of the population through investment in agriculture, industry & infrastructure and education First proposition of parliamentary bill for a health insurance scheme elaborated by Halevi Committee (provision of health services through salaried doctors in Lagos area), but rejected by Nigeria Medical Association	
1963			First republic (1963-1966) established with Azikiwe as first President of Nigeria Fourth region, the Mid-Western region, introduced
1966			Begin of the first military junta (1966-1979) Coup d'état makes Johnson Aguiyi-Ironsi the head of the military government, followed by a counter coup d'état, which puts Yakubu Gowon in power Anti-Igbo pogrom
1967			Start of the civil war (1967-1970) and official declaration made by Chukwuemeka Ojukwu establishing the Republic of Biafra Creation of Lagos State, which becomes the capital A military decree replaces the 4 regions with 12 States
1970		Second Development Plan (1970-1974) launched focusing on the reconstruction of the country	

1971			Nigeria becomes a member of the Organisation of the Petroleum Exporting Countries (OPEC)
1972	Aminu Kano (1972-74)	Social Development Division established within the Federal Ministry of Labour Independent Ministry of Social Development, Youth and Sport set up	
1975	Dan Sulaiman (1975-77)	Third Development Plan (1975-1980) launched focusing on GDP growth and the distribution of wealth, considered the most ambitious plan launched so far (including social elements such as housing, free education, etc.), giving impetus to the improvement of Nigeria's health system	Coup d'état makes Murtala Mohammed the new head of State
1976		Basic Health Services Scheme (BHSS) as part of the 1975 – 1980 development plan introduced (included guidelines for PHC)	Coup d'état making Olusegun Obasanjo the interim head of State Second Republic (1976-1979) established with Shehu Shagari as President 7 new States are established taking the total to 19 States
1977	Peter Ogbang (1977-79)		
1978			
1979	D.C. Ugwu (1979-83)		
1981		Fourth Development Plan (1981-1985) launched promising more commitment to appropriate use of petrol resources and industrialisation	
1983		Negotiations with the IMF start, but end in stalemate as austerity conditions considered too severe and unacceptable	Begin of the second military junta (1983-1999) Coup d'état makes Muhammadu Buhari the head of State
1984	Patrick Koshoni (1984) Emmanuel Nsan (1984-85)	Committee set-up recommending a national insurance scheme as a desirable option for financing healthcare Introduction of user fees	
1985	**Olikoye Ransome Kuti** (1985-92)	Negotiations with IMF result in acceptance of the proposed Structural Adjustment Programme Committee on National Health Review, headed by Mr. L. Lijadu, set-up recommending NHI as an urgently needed and feasible option for financing healthcare	Coup d'état makes Ibrahim Babangida the head of State Nigeria enrols in the Organization of the Islamic Conference

		Consultative Committee on National Health Insurance Scheme introduced later by Ransome-Kuti becomes Minister of Health	
1986		Structural Adjustment Programme launched in September	
1987			Two new States are established taking the total to 21 States
1988		First official national health policy is introduced, the National Health Policy and Strategy to Achieve Health for All Nigerians Minister Ransome-Kuti commissions study, led by Dr. Emmanuel Umez-Eronini, which developed the template for the present-day National Health Insurance Scheme	
1989		Eronini-Report is published and approved for immediate implementation, but political will for implementation is lacking	
1990		Development of Rolling Development Plans begin (1990-1999) Maiden National Drug Policy (CDP) introduced Nigerian Health Transition research program initiated	Failed attempt to overthrow the Babangida regime
1991			9 new States are established taking the total to 30 States Abuja is made the Federal Capital Territory
1992		National Primary Health Care Development Agency established as a parastatal of the FMOH with the mandate to develop national primary health care policy	
1993	Julius Adelusi-Adeluyi (1993) Dalhatu Tafida (1993-95)		Third Federal Republic established after elections take place with Moshood Abiola being elected President; but the results of the elections are annulled and Abiola is thrown into prison Coup d'état takes place making Sani Abacha the head of the State
1995	I.C. Madubuike (1995-97)	National Health Summit takes place in Abuja with the aim of building consensus related to the role of the private sector and HMOs in Nigeria's health system	Olusegun Obasanjo is arrested for allegedly having supported a secret coup d'état Activist Ken Saro-Wiwa is hanged
1996		Nigeria Vision 2010 is adopted aimed at "making basic needs of life affordable for everyone" First HMO commences operations	Six new States are established taking the total to today's 36 States Kurdirat Abiola, Moshood Abiola' wife, is assassinated

1997	Jubril Ayinla (1997-98)	Second HMO commences operations (owned by owners of large of large HCP facilities, health management firms and individuals with a background in commercial insurance)	
1998	Debo Adeyemi (1998-99)	Health and Managed Care Association of Nigeria (HMCAN) formed by managers of HMOs (industry trade group)	Sani Abacha dies of a heart attack and Abdulsalami Abubakar becomes the head of State
1999	Timothy Menakaya (1999-2001)	Passage of Decree 35 establishing the National Health Insurance Scheme (NHIS): voluntary scheme launched nation-wide (adoption for states not obligatory); private sector participation with Health Maintenance Organizations, paid by the NHIS to manage new enrolees and pay capitations and reimbursements	Fourth Republic established and Olusegun Obasanjo elected President
2000		Public hearing on the NHIS Act organized by the parliament Abuja Declaration – heads of state of African Union countries met and pledged to set a target of allocating at least 15% of their annual budget to improve the health sector	
2001	Alphonsus Nwosu (2001-2003)	NHIS Governing Council inaugurated, but lacks capacity to implement the programme Ward Health System established, and Ward Minimum Health Care Package developed with the aim to improve PHC delivery	
2003	Eyitayo Lambo (2003-2006)	Child's Rights Act introduced	Olusegun Obasanjo is re-elected as president Extractive Industries Transparency Initiative adopted
2004		National Economic Empowerment and Development Strategy (NEEDS) adopted with focus on wealth creation, employment generation, poverty reduction ("*creating an environment where businesses can thrive*") Draft Social Protection Strategy developed Health Sector Reform Policy Programme (HSRPP) encapsulated in the NEEDS launched to guide the activities of the FMOH between 2004 and 2007 Revised 2004 National Health Policy adopted	
2005		Debt Relief Gain and MDGs Conditional Grant Scheme established (administered by the Office of the Senior Special Assistant to the President on the MDGs)	

		Actual implementation of the NHIS commenced on 6 June 2005 through the Formal Sector Social Health Insurance Programme (FSSHIP) with the President as its first enrolee; established to cover employees of federal, state and local governments, and those of private institutions employing at least ten workers; mix of public and private service provision and financing schemes	
2006		National Health Financing Policy developed – encourages states to commence state-level health insurance schemes (not the adoption of the NHIS programme by states)	
2007	Adenike Grange (2007-2008)	Seven Points Agenda introduced National "In Care of the People" (COPE) Pilot Conditional Cash Transfer Programme launched as part of the National Poverty Eradication Programme New NHIS Executive Secretary appointed by the President	Umaru Yar'Adua elected President
2008	Osotimehin Babtunde (2008-2010)	Draft National Social Protection Bill introduced ("The National Social Security Policy for Inclusiveness, Solidarity and Sustainable Peace and Prosperity") Maternal and Child Health programme launched as part of the NHIS (financed through funds from the MDGs office of the President) National Health Insurance Act of 2008	
2010	Onyebuchi Chukwu (2010-2015)	Nigeria Vision 20:2020 adopted, including its First Implementation Plan (2010-2013) National Strategic Health Development Plan (NSHDP 2010-2015 – approved in March 2010 by the 53rd National Council on Health meeting) developed as the health component of the government's poverty reduction policy Nigeria Vision 20:2020 NHIS started a rural community-based social health insurance program (RCSHIP)	President Yar'Adua dies in office and Vice-President Johnathan Goodluck takes over Presidency
2011		Draft 2011 National Health Bill proposes a radical shift in health financing through the establishment of the National Primary Healthcare Development Fund (NPHDF) financed from the Federal Government (2% of the consolidated fund of the federation), international donor partners, and funds from any other innovative sources and establishes State Primary Care Development Boards	Presidential elections confirm Goodluck in office

		Blueprints for the Tertiary Institutions Social Health Insurance Programme (TISHIP) and voluntary participants SHI schemes were launched Development of stricter guidelines for HMO	
2012		Petrol subsidies are removed and the "Save One Million Lives" Initiative is started focusing on health and nutrition interventions	
2014		Second Implementation Plan (2014-2017) of Vision 20:2020 adopted Health Care Act 2014 enacted with clear goal of achieving UHC; establishes the Basic Health Care Provision Fund (BHCPF) equivalent to at least 1% of the Consolidated Revenue of the Federation. The BHCPF will provide additional revenue to fund primary healthcare services and help Nigeria to achieve universal health coverage	
2015	Khaliru Hassan (2015) Isaac Adewole (2015-2019)		Muhammadu Buhari elected President
2016		2016 National Health Policy adopted (draft available) National Social Safety Nets Project introduced (conditional cash transfer programme)	
2018		Third Implementation Plan (2018-2020) of Vision 20:2020 adopted Basic Health Care Provision Fund (BHCPF) formally put in place Kwara State launches compulsory health insurance for all	
2019			Presidential elections confirm Buhari in office

Appendix M: Mapping of the contestations/relations of different agents & impact on health policy design

Category of agents	**Key agents**	Contestations/relations, structures, processes and norms affecting agents' position and influence regarding **the elaboration of the NHAct (through a SoP lens)**
Federal Government and line Ministries	President	- Nigeria's Presidential system made the signature of the President a necessary condition for the health bill to be made a law (the National Health Act). - The President (Jonathan Goodluck at the time) only showed commitment to drive UHC efforts the year before the 2015 elections, reported to have been a driving factor for his support to the Act. - The President's plea to support the objective of UHC and to sign the NHAct were preceded by considerable civil society driven advocacy efforts, which targeted his person. - As a Catholic, the President was influenced by concerns raised by the Catholic Church relating to the cloning of human cells.
	Federal Ministry of Finance	- The Minister of Finance (Ngozi Okonjo-Iweala, a Harvard-trained World Bank economist, in office between 2003 and 2006 and 2011 and 2015) was wary of the financial implications of a commitment to fund the BHCPF with an "at least 2 percent of the CRF" annual Federal grant and intervened to reduce the allocation. - The Minister of Finance's position was influenced by the "UBEC experience": resources earmarked for the education sector lie idle at the Central Bank, as States are not willing/able to provide the necessary counter-part funding to draw from the UBEC pot and statutory allocations do not flow back to the Treasury once untapped and cannot be used for anything else.
	Federal Executive Council	- The FEC needed to approve the NHAct, as the law has macro-economic and financial implications for the country as it proposed to make an annual Federal grant a statutory allocation - The critical role of the Minister of Finance in advising the FEC meant that the Minister of Finance was able to push through the reduction of the annual Federal allocation to the BHCPF from "at least 2 percent" to "at least 1 percent" of the CRF
	National Assembly (NASS)	- Existing law-making processes contributed to delays to the enactment of the NHAct as the two chambers of the NASS (the Senate and the House of Representatives) both needed to approve the national health bill before it came to be an Act. - The composition of members of the standing Committees on Health changed continuously during the period of elaboration of the NHAct because of four-year electoral cycles, which set the process of review back. - The degrees of power/influence of the respective persons heading the Senate and House Committees on Health as well as of the Senate President and their view on health policy (and their affiliation with notably the CSO, HERFON) influenced the attention given to the NHAct.

Federal Ministry of Health and agencies	Federal Ministry of Health	- The FMOH is statutorily responsible for the elaboration of health policies and programmes, and it led the technical working group (with members of the civil society) that elaborated the NHAct. - The constitution's omission to clarify roles and responsibilities of the three tiers of Government with regard to healthcare was a key driver for why the elaboration of a law to guide and govern the national health system was deemed necessary; while previous iterations of the bill stipulated exact responsibilities of Federal, State and Local Governments, this passage was taken out of the final text after resistance from State Governments. - The FMOH's ambition to expedite health policy reform depended vastly on the differing degrees of power, influence and interest of the respective Federal Ministers of Health; a considerable impetus kickstarting the reform process that culminated in the enactment of the NHAct was given by Professor Lambo (in power between 2003 and 2007).
	NHIS	- The opposition of the private sector to making the social health insurance scheme mandatory as well as the lobbying power of HMOs at the time of the elaboration of the NHIS Act, impacted the importance that the NHIS plays in today's Nigerian healthcare system; enrolments rates are low, and HMOs play a dominant role in spite of accounts of corruption and inefficiency. - The NHIS had an interest in passing the NHAct, as it stipulates that 50 percent of the BHCPF's resources shall be channelled via the NHIS for the agency to support efforts to increase social insurance coverage in Nigeria. - The President has the authority to appointment and dismiss the NHIS Executive General (which Buhari has done amidst corruption allegations, by dismissing Usman Yusuf and appointing Nasir Sambo).
	NPHCDA	- Poor maternal and child health indicators across the whole of Nigeria (yet with considerable disparities related to socio-economic background and geographical location) as well as a global push for Universal Health Coverage provided a clear incentive to strengthen Nigerian healthcare system, with primary healthcare delivery as its "backbone" - As the agency superintending the PHC delivery system in Nigeria, it had an interest in passing the NHAct, primarily to make more financial support available to boost PHC service delivery; the NHAct places 45 percent of BHCPF funding in the hands of the agency.
	NEMTC	- The NEMTC is a newly instituted organ, which was put into place as the FMOH also wanted to retain at least a small share of the BHCPF resources at its level. - An increase in prevalence of trauma patients (mainly as a result of road traffic accidents) provided a defendable reason to keep part of the BHCPF funding at levels of the FMOH.
State and Local Governments	State Ministries of Health	- A system of federal governance was introduced to Nigeria during colonialism (but weakened during military rule); the degree of power of States as federating units meant that States – using the platform of the National Council on Health – had the capacity to push back on having some of their responsibilities anchored in the law

		- Some State Commissioners on Health were afraid that the Act would interfere with the autonomy of the States and impose responsibilities on them
	SPHCDA	- The process of installing SPHCDAs had already been initiated in 2011 as part of the PHCUOR policy; the NHAct made their institution a necessary pre-condition to receive BHCPF funding via the NPHCDA gateway - As LGAs are habitually held responsible for the delivery of PHC services, but have limited financial means and technical capacity, the PHCUOR policy stipulated that the management of PHC should be pulled together at State-level
	SHIS	- The NHAct does not speak to the decentralisation of social health insurance; however, in 2015, a policy of decentralisation of health insurance implementation to the States was introduced
	Local Government Health Authorities	- As part of Nigeria's federal system, it is customary that Local Governments are responsible for PHC delivery; they, however, have quite limited capacity and often the appointment of the LGA chairperson, who could push for improvements, is subject to interference from State Governors, who have their own political motives. - Local Governments Health Authorities are represented by their State Commissioners of Health, but appear to have been quite powerless/non-essential in influencing the NHAct
Public healthcare providers	Public healthcare providers	- Not a homogenous category but includes medical doctors/dentists, nurses & midwifes and community health extension workers and other health professionals - The long-standing professional rivalry between medical doctors on one on side (represented *inter alia* by the Nigerian Medical Association) and other health professionals on the other side (represented by the Joint Health Sector Unions, JOHESU) surfaced - Notably, other health professionals were in opposition to the proposition that the National Tertiary Health Institutions Standards Committee had to be headed by a medical doctor, which needed to be changed in the NHAct
Private sector	Health Maintenance Organisations	- At the 1995 National Health Summit, interest groups from the insurance industry as well as persons who had previously been exposed to the managed care system in the US proposed the inclusion of HMOs and private healthcare providers as part of the NHIS (with the result that HMOs took the place of public Health Insurance Boards as intermediary of the scheme) - HMOs (backed by powerful individuals) positioned themselves as a solution to the incapacity of the public system to implement the NHIS and spread notably with the roll-out of the FSSHIS - As their current status as intermediary between the government and providers in the NIHS is profitable for them, they would have wanted to ensure that they continue in that role to maintain a stream of profit, but there was widespread opposition from healthcare providers and policymakers to continue using HMOs as stakeholders of the BHCPF

	Private foundations and corporations	- A capital-favouring/regressive tax system has allowed private companies and persons to amass wealth, while a majority of Nigerian remain poor - Many of Nigeria's largest corporations engage in philanthropy and have their own private foundations, such as the Dangote Foundation, Jim Ovia Foundation or the TY Danjuma Foundation; they may have an interest in engaging in Corporate Social Responsibility to promote their image and are thus potential private donors to the BHCPF - Notably, Aliko Dangote, as an "ally" of Bill Gates, has been supportive of the NHAct
	For-profit private healthcare providers	- Economic downturn (resulting in a degradation of public infrastructure and delivery systems) combined with the promotion of a stronger role of the private sector in social service delivery as part of neo-liberal reforms (notably by international organisations such as the World Bank and the IMF), led to an increased reliance on private providers in the 1980s - Many medical professionals have their own private practice (instead or in addition to their employment with the public healthcare system) and had an interest to ensure that private practitioners are permitted to also provide healthcare services as part of the BHCPF
	Non-profit private healthcare providers	- NGOs and community-based organisations have stepped in and have supported healthcare service delivery (financially and in-kind) in the absence of a functional public healthcare delivery system - Their interventions are oftentimes targeted at specific communities and may bypass the Federal or State Government, which makes their task to coordinate healthcare service delivery more difficult
Development organisations	World Bank	- Has not been very involved in the process of developing the NHAct, but has technically and financially supported important healthcare initiatives (such as NSHIP) and provided a credit to the Federal Government in order for it to introduce a conditional cash transfer programme taking away some fiscal space for the healthcare sector
	DfID	- Financially supported the "change agents" and later HERFON in their efforts to strengthen the national health system and to develop a legal framework for the Nigerian national health system
	UN (WHO & UNICEF)	- Important technical partners with an interest in seeing the NHAct passed into law as it is in line with their organisational mandates
	BMGF	- Bill Gates himself was one of the "powerful individuals" asked to speak with the President to advocate on behalf of the civil society for his assent to the NHAct
Civil society organisations and academia	Civil society organisations and academia	- Led by a group of "change agents" and later on the CSO "Health Reform Foundation of Nigeria" (HERFON) and advocated and lobbied massively for a health sector reform law to improve poor health outcomes and reduce high out-of-pocket spending - The publication of the 2000 World Health Report, highlighting Nigeria's inadequate healthcare system, compelled a group of dedicated Nigerians to come together to start advocacy efforts to reform the healthcare

		system; a key figure driving the reform process was Professor Eyitayo Lambo, a Nigerian health economist who worked as Regional Advisor for health sector reforms, health care financing and health in socioeconomic development at the WHO Africa Regional Office
Religious groups	Christian churches	- The arrival of European settlers and missionaries in the South of Nigeria in the 19th century resulted in an expansion of the Christianity in Southern Nigeria - The Catholic Church was worried that the NHAct would allow cloning and uncontrolled handling of organ transplantation
	Muslim Community Jama'atu Nasril Islam	- The Sokoto Caliphate was founded in the early 19th century by Usman dan Fodio and the Sultan of Sokoto remains an influential figure amongst Fulani and Hausa people in Northern Nigeria - The Sultan of Sokoto has voiced concern over the NHAct, worried that the NHAct would promote abortion
Community members	Community members	- The passing of the NHAct with an emphasis of increasing funding for health is in the interest of citizens - As the main "financiers" of the healthcare system via out-of-pocket expenditure, their consumption norms and patterns, dependent on their personal experience and existing social structures, inform and justify policymaking - Many healthcare users have to seek care in private facilities as the public healthcare system is (perceived as) dysfunctional, which feeds into a discourse of policymakers that healthcare delivery requires private sector participation - A majority of community members, however, seem to have been unaware of the elaboration of the NHAct; some groups (e.g., market women's groups) were mobilised by civil society organisation to demonstrate for the enactment of the NHAct

Appendix N: Summary of significant changes across different versions of the operational guidelines

	2016 Guidelines	**2018 Guidelines**	**2020 Guidelines**
	Harmonized Guidelines for the Administration, Disbursement, Monitoring and Fund Management of the Basic Healthcare Provision Fund, December 2016	2018 Operations Manual, November 2018	Guideline for the administration, disbursement and monitoring of the Basic Health Care Provision Fund, September 2020
Funding			
Federal annual grant	Do not specify the statutory nature of the annual grant from the Federal Government	Do not specify the statutory nature of the annual grant from the Federal Government	Clarify that the CRF funding shall be deducted as a statutory first-line charge
Counterpart funding	Acknowledge that the NHAct stipulates that States need to contribute 25 percent counterpart funding in order to obtain funding from the BHCPF but highlights that the "use of counterpart funding as a mechanism to engender State participation, inclusion and ownership of federally led programs have in the past not yielded the desired results" and mentions the experience with the UBEC. The guidelines thus call for "innovative solutions" and to ease the conditions for disbursement	Adopt a stronger stance on counterpart funding and stress the necessity for States to allocate a 25 percent matching grant (no mention of UBEC)	Once more highlight the necessity for state level organs to designate 25 percent of the total cost of projects as counterpart funding as stipulated in the NHAct (no mention of UBEC); also makes explicit that Local Governments are required to pay 25 percent counterpart funding; emphasise that the BHCPF does not replace the routine funding of public PHCs by state and local governments
Donor contributions	List grants from international donor partners as one of three funding sources of the BHCPF, but do not specify any further	List grants from "donors, international partners and others who wish to either donate or contribute to the fund" as a funding source and specifies that such contributions to the BHCPF shall be included in the BHCPF account at the CBN.	List donor contributions as a source of BHCPF funding and stipulate that donor funds "shall be pooled in a dedicated TSA managed by the FMOH and disbursed in the same proportion to the gateways as the 1 percent CRF"; however, stipulate that donors can bring forward their own conditions and can also select to support specific States and gateways.
Governance & administration			
Oversight function	The Management Secretariat of the Fund (TMSoF) is put into place to coordinate the administration, disbursement, monitoring and financial management of the BHCPF; it is a technical organ	A high-level National Steering Committee (NSC) is introduced, which is headed by the Federal Minister of Health, and is granted extensive responsibility beyond the coordination and oversight of the	The Ministerial Oversight Committee (MOC), chaired by the Minister of Health, replaces the NSC and serves as the main platform for stakeholders to brief each other on the implementation of the BHCPF. The NHIS and the NPHCDA re-gain a higher level of control and the MOC is predominantly in

	and includes technical experts from the FMOH, NHIS, NPHCDA. "The TMSOF is to (i) ensure adequate stewardship, regulation, governance and oversight of the Fund … (vii) serve as the Secretariat for Fund activities." (p. 20)	BHCPF implementation; it is supported by the Secretariat of the NSC: "The NSC shall meet at least quarterly and provide cross-functional leadership, strategic operational direction, oversight, ensure programme visibility and serve as an advocacy group for increased resource mobilisation." (p. 14)	charge of coordination and oversight of BHCPF implementation: "[The MOC shall] function as a national oversight group promoting robust collaboration among implementing agencies (NPHCDA, NHIS and NEMTC) in the evolution and implementation of the BHCPF." (p.32)
Healthcare services			
Emphasis of importance of Primary Health Care	Explicitly recognise that PHC is the "foundational basis for the provision of healthcare services in Nigeria", which is recognised by the NHAct and the sections which are designated to strengthen PHC service delivery	Do no longer make mention of PHC as the foundational basis of Nigeria's healthcare system	Re-introduce the paragraph on the importance of PHC and highlight that PHC is the "foundation for the provision of health care" as reflected in the NHAct
Basic Minimum Package of Healthcare Services (BMPHS)	Specify that a set of nine interventions are part of the BMPHS (4 maternal health interventions, 2 child health interventions and 3 interventions for all Nigerians, namely urine analysis, blood pressure screening and malaria treatment	Specify the same nine interventions and highlight that States can opt to expand the benefit package via top-ups (funded by SHISs and not by the BHCPF)	List many health interventions as part of the BMPHS at both primary and secondary healthcare levels
Cost of services	Highlight the challenging economic climate in Nigeria, stating that only about NGN 225 per capita are being made available via the BHCPF (2016)	Describe the approach to costing and the determination of the BMPHS, but do not provide any details; highlight that the BHCPF is designed as a low-cost universal health programme	Define a premium rate of NGN 12,000 for the benefits package; acknowledges that the additional fiscal space created by the BPHCP will be insufficient to finance a comprehensive health care package for all Nigerian
Complementary of other Government efforts, community efforts and vertical programmes	Stipulate the need to ensure that "other initiatives, vertical programmes, private or community efforts" should be designed in a way to complement and not substitute the interventions contained in the BMPHS.	Not mentioned	Highlight that PHCs need to continue to conduct all PHC actions and provide all routine PHC services based on the Ward Minimum Health Care Package as published by the NPHCDA
Beneficiaries of funds			
Targeting of beneficiaries	Highlight that sole preference shall be given to healthcare providers in rural areas to participate in the NHIS gateway for the first five years	Specify that in first five years, priority will be given to the "rural poor" and clearly stipulate that beneficiaries have to be part of certain target groups to access care: children of age 5 and younger, pregnant women and all people for	Encourage to prioritise to support rural public primary health care facilities (via the NPHCDA gateway) in order to target poor households and populations in the lowest wealth bracket

		malaria treatment, hypertension and diabetes screening within priority rural communities	
Enrolment procedures	Stipulate that all Nigerians should be able to receive the BMPHS completely free at the point of delivery, without any user fees whatsoever	Stipulate that the BMPHS will "piggyback" on existing formal and informal identification mechanisms in addition to limited registration; registration shall be facility based and implemented at or prior to the first utilisation	Stipulate that beneficiaries need to be enrolled into the programme with enrolment activities carried out by SHISs in collaboration with the NHIS
Distribution across States	Explicitly stipulate that all States plus FCT receive an equal share of the Fund (irrespective of land mass, population and disease burden)	Emphasise the importance to maintaining a "pro-poor" focus and propose geographically targeting of rural LGAs within States with higher poverty rates	Stipulate that the formula for calculating the disbursement of available funds will be the same for all States (that fulfil the obligations for participation) for equity and fairness reasons; the formula is not specified
Disbursement of funds and operationalisation			
Administrative cost	Stipulate that all administration expenses shall be paid for through the delineation of an annual allowance of maximum five percent of the funds accruing to the BHCPF	Stipulate the following administrative cost (as share of BHCPF funding), but states that the NSC can permit to an increase: - NSC: 0.5% of BHPCF funds - NHIS & SHISs: 2.0% - NPHCDA & SPHCDAs: 2.0% - NEMTC: 0.5%	Stipulate the following with regard to operational and administrative cost: - MOC and SOC: each gateway transmits 5% of remittances to MOH - NHIS and SHISs: 5% of remittances to gateway - NPHCDA and SPHCDA: 5% of total accrued funds for operational costs - NEMTC: responsibility to fund the operational cost of the NEMTC through its counterpart funding
Use of funds for the EMT gateway	Stipulate that 5 percent of BHCPF funding shall be deployed towards emergency medical treatment, notably following road traffic injuries	Stipulates that 2.5 percent of BHCPF funding shall be deployed towards emergency medical treatment, while the remaining 2.5. percent shall be deployed towards the Nigeria Centre for Disease Control for the management of pandemics	Retrack and stipulate that the entire 5 percent of BHCPF funding shall be for emergency medical treatment
Alternative use of funds for vaccine procurement	Not mentioned	Stipulate that if there are not enough financial resources available to fund the national procurement of routine bundled vaccines, up to 10 percent of funding dedicated to the NPHCDA gateway can be redirected to the national level for vaccine procurement	Stipulate that if there are not enough financial resources available to fund the national procurement of routine bundled vaccines, up to 10 percent of funding dedicated to the NPHCDA gateway can be redirected to the national level for vaccine procurement

Provider payment mechanism (NHIS gateway)	Stipulate that funds are to be disbursed using the traditional "fee-for-service" principle; the provider makes a claim for payment after the treatment has already been provided (global payment)	Stipulate that pre-selected public and private sector providers shall be paid retrospectively a bundled fee (global payment) for providing designated services at no cost to the target population; need to make a claim	Change provider payment mechanism for PHC service delivery to capitation; maintain fee-for-service as provider payment mechanism for services rendered at the secondary level
Use of Third-Party Agents/Administrators and HMOs	Do not mention HMOs except for in the glossary, but indicates that either SHISs or for-profit or not-for profits Third Party Agents (TPA) can carry out the day-to-day operations of the NHIS gateway	Do not foresee TPAs to act as alternative to SHISs (make mention of HMOs and TPAs e.g. in the glossary and in the section on compliance)	No reference to TPAs whatsoever; HMOs are only referred to as part of the EMT gateway – if a person is registered with a HMO, it has to cover the cost of the medical treatment
Accreditation of facilities	Stipulate that SHISs or TPAs are responsible to accredit primary and secondary healthcare facilities to participate in the NHIS gateway	Stipulate that public and private primary and secondary healthcare facilities need to be accredited/approved on basis of both NPHCDA and NHIS criteria	Stipulate that primary public healthcare facilities need to be accredited by SPCHDAs; public secondary and private primary and secondary facilities need to be accredited by SHISs

Appendix O: Mapping of the contestations/relations of different agents & impact on health policy implementation

Category of agents	**Key agents**	Contestations/relations, structures, processes and norms affecting agents' position and influence regarding **the implementation of the NHAct and the operationalisation of the BHCPF (through a SoP lens)**
Federal Government and line Ministries	President	- The President in office has changed since the enactment of the NHAct, with the new President (Muhammadu Buhari, in power since 2015) being more devoted to promoting the Ward Health System policy and building functional healthcare centres, rather than supporting the BHCPF more globally - The change in Presidency also meant a change in ruling party at the Federal level; however, State Government elections follow a different schedule. This means that some Governors from the now opposition party may be less inclined to support Federal initiatives.
	Federal Ministry of Finance	- It took additional advocacy efforts from the civil society to ensure that the allocation to the BHCPF was made a statutory allocation (and not a service-wide vote) although the wording of the UBEC Act was close to identical to the wording of the NHAct; this shows that the Minister of Finance has some discrepancy, and it raises questions around the sustainability of the funding to the BHCPF.
	Federal Executive Council	- If, in the future, it becomes apparent that the resources allocated to the BHCPF are too low, any sustainable (in the case of changes in power) and legally binding increase to the BHCPF funding would require an amendment to the NHAct, which requires approval by the FEC.

	National Assembly (NASS)	- The NASS Committees on Health are responsible to ensure that the envisaged financial resources for the BHCPF are adequately appropriated and adequately disbursed; the degree to which they may or may not take this role seriously largely depends on the chairs of the Committees on Health and the Senate President and the importance they attribute to healthcare.
Federal Ministry of Health and agencies	Federal Ministry of Health	- Changes in Government also imply changes in the position of Federal Minister of Health; while the Minister of Health in Buhari's first cabinet (Adewole) has been reported to collaborate closely with the World Bank and was instrumental in granting them space to re-write the 2018 Operations Manual, the current Minister of Health (Ehanire) is less influential and has accommodated the propositions made by the agencies and other stakeholders within the Ministry of Health (such as the Department of Health Planning, Research and Statistics). - The power/influence of the Federal Ministry of Health to advocate for the allocation of adequate resources to the healthcare system is decisive in assuring a sustainable funding stream to the BHCPF and the healthcare system more broadly. For instance, in 2020, during the COVID-19 pandemic, funding to the BHCPF was cut and immunisation campaigns suspended.
	NHIS	- The NHIS had shown strong interest to ensure that the provider payment mechanism of the NHIS gateway for the purchasing of the BMPHS is a capitation system; the World Bank opposed this suggestion and included a fee-for-service system in the 2018 Operations Manual; this decision was however partly reversed with the adoption of the 2020 guidelines. - The NHIS started to disburse funds to SHIS in order for them commence with the delivery of the BMPHS; however, the NHIS' capacity to support the SHIS is questionable, as much of the "insurance business" had previously been outsourced to HMOs. - Moreover, it was agreed that the beneficiaries of the BMPHS will be a targeted group ("the most vulnerable") that will be identified with the use of the social register that was put into place as part of efforts to distribute cash transfers. - The NHIS adopted a new Strategic Plan in 2020, introduced a "Group, Individual and Family Social Health Insurance Programme" and developed a "Health Insurance Under One Roof" policy; however, this is not being well perceived by the States, who do not see it as the role of the NHIS (a federal agency) to enrol citizens in their States.
	NPHCDA	- The NPHCDA, too, was unimpressed with the World Bank's involvement in the elaboration of the 2018 Operations Manuel; it was notably concerned with the World Bank's proposition to insert a high-level National Steering Committee (NSC) and a Secretariat in the administrative structure of the BHCPF, which would exert more influence on the operationalisation of the BHCPF than just coordination and oversight. The new 2020 guidelines have replaced the NSC with a Ministerial Oversight Committee and the Federal agencies have regained their degree of control. - The NPHCDA is supporting the SPHCDAs to assure that healthcare facility baseline assessments take place; the process is progressing, but slowly as it depends on the capacity and willingness of the States to drive the process.

	NEMTC	- During the elaboration process of the manual to the BHCPF, the NCDC also advocated to be included in the scheme, and 2.5 percent of resources for emergencies were dedicated for the response to pandemics (this was prior to the commencement of the COVID-19 pandemic); however, there is already a separate budget line for pandemics, which meant that there was controversy as to why the NCDC should receive BHCPF funding; the new 2020 guidelines does no longer stipulate and BHCPF support for pandemics (a move which is now, in midst the COVID-19 pandemic, being decried as wrong).
State and Local Governments	State Ministries of Health	- States are expected to domesticate health policies and to ensure their adequate implementation; factors reported that determine the likelihood for this to happen include ability/capacity of State Ministries of Health and their Commissioners, the degree to which healthcare is a priority for State Governors and the (non-)affiliation of the ruling party at State level with the ruling party at Federal level.
	SPHCDA	- SPHCDAs (headed by an Executive Secretary) were newly introduced but given significant responsibility, including compared to the State Ministries of Health (headed by the Commissioner on Health); notably, the transfer of responsibility for the payroll of health personnel from Local Governments to the SPCHDA made it the largest employer in the sector at State-level. - The SMOH exert an oversight function via the State Oversight Committee, but it remains to be seen how the relation between the SMOH, the SPHCDA and the LGHA play out.
	SHIS	- The guidelines to operationalise the BHCPF make the establishment of SHISs are pre-condition for the implementation of the NHIS gateway; in the first version of the guidelines, Third Party Agents/Administrators were listed as an alternative to SHIS, but this is no longer envisaged by the latest version of the guidelines; still there are some States that draw on HMOs, as they are considered to be the entities within Nigeria knowledgeable to conducting the “insurance business” - As States are federating units, SHISs are not uniform and SHIS have the autonomy to expand the service package they want to provide to the beneficiaries - The “Health Insurance Under One Roof” policy seeks to provide guidance to harmonise SHISs to a certain extent; it appears, however, that this initiative is not necessarily well received by the States, who feel responsible for enrolling their citizens and providing them with social insurance.
	Local Government Health Authorities	- As only selected PHC facilities can benefit from the BHCPF funding (via the NPHCDA gateway), Local Governments remain with the responsibility to provide routine funding to the PHC system; however, they often do not have the necessary resources to do so. - With the transfer of the management responsibility to the SPHCDA, Local Government no longer have to pay healthcare workers at PHC level.
Public healthcare providers	Public healthcare providers	- Public healthcare providers (alongside private healthcare providers) are the ones that are required to provide the BMPHS and are expected to benefit from BHCPF resources via the NPHCDA gateway (resources earmarked for HR Health development)

		- Community members have highlighted that healthcare providers in public PHC are sometimes unavailable, unmotivated or ask for incentives/co-payments - Public healthcare providers have reported frustration with inadequate and unfair remuneration and the deprived state of infrastructure at PHC level
Private sector	Health Maintenance Organisations	- There appear to be widespread consensus amongst agents that HMOs shall no longer play as prominent a role in Nigeria's healthcare system - However, HMOs (as well as others) are aware that the expertise and capacity of the insurance business process lies with these HMOs (e.g., in terms of claims management, enrolment) - Consequently, some States have already opted to include HMOs as part of their SHIS (notably Edo and Lagos State) - At the same time, the World Bank is supporting one of the largest HMOs financially.
	Private foundations and corporations	- Private foundations are encouraged to support the BHCPF by contributing to the common pool; while the Dangote Foundation has suggested that it will contribute to the BHCPF, it remains to be seen who, in reality, will make regular contributions to the BHCPF
	For-profit private healthcare providers	- Private healthcare providers are expected to deliver the BMPHS to Nigerians via the NHIS gateway; they, too, have to first seek accreditation by the NHIS - It remains to be seen how involved the private sector will be in the BHCPF, as the for-profit private sector in and of itself is heterogenous ranging from low- to high-quality service provider)
	Non-profit private healthcare providers	- In the 2016 version of the BHCPF guidelines, particular reference was made to ensure that "other initiatives, vertical programmes, private or community efforts" should be designed in a way to complement and not substitute the interventions contained in the BMPHS - As the implementation of the BHCPF is delayed, it appears that NGOs and community-based organisations continue to provide support to the PHC system; this support, however, is often uncoordinated, contributing to the fragmentation of healthcare service delivery
Development organisations	World Bank	- Has intervened decisively in the process of elaborating BHCPF implementation guidelines, which was met with discontent from a range of agents within the Nigerian healthcare SoP and has led to the temporary suspension of the BHCPF - Has committed to financially support the BHCPF (US$ 20 million via the GFF) - Engages in a discourse of promoting universal health coverage, but advocates for a stronger involvement of the private sector in healthcare service delivery and sees the healthcare "industry" as an investment opportunity, demonstrated e.g., by financially supporting an HMO in Nigeria (Hygeia)
	DfID	- Has allegedly not been very involved in the process of implementing the BHCPF, but has signalled willingness to financially support it

	UN (WHO & UNICEF)	- The conception of social policy at both the WHO and UNICEF has narrowed over time; notably, the WHO's position with regard to the form universal health care should take has shifted from a strong focus on primary healthcare for all to promoting universal health coverage including via the provision of a basket of essential health services - They have not shown any opposition to the approach of delivering a BMPHS that Nigeria is currently taking
	BMGF	- The Gates Foundation is historically known to promote a vertical/technical approach to specific health conditions and appears to be wary of horizontal health systems strengthening interventions - Has committed to financially support the BHCPF (US$ 2 million for kickstart the BHCPF operations in three pilot States)
Civil society organisations and academia	Civil society organisations and academia	- Have been pleading for the first allocation to the BHCPF and for the allocation to become a statutory allocation - Expected to play an important oversight role with regard to monitoring the operationalisation of the BHCPF - Continue their advocacy pleading for an increase of the annual Federal block allocation (2 percent CRF funding instead of 1 percent CRF funding)
Religious groups	Christian churches	- Religious organisations seem to continue to support the primary healthcare delivery system in their communities; their support is not always channelled via the Government, which may mean that they contribute to the fragmentation of the healthcare delivery system
	Muslim Community Jama'atu Nasril Islam	- Religious organisations seem to continue to support the primary healthcare delivery system in their communities; their support is not always channelled via the Government, which may mean that they contribute to the fragmentation of the healthcare delivery system
Community members	Community members	- Citizens are supportive of any initiative that would increase their financial risk protection and reduce their burden of out-of-pocket spending - However, there is general scepticism as to whether an initiative such as the BHCPF will be properly implemented.

Appendix P: Comparing the 2004 Compulsory, Free Universal Education Act with the 2014 National Health Act

2004 Compulsory, Free Universal Education Act **(Part III, paragraph 11.1 and 11.2)**	(1) The implementation of the Universal Basic Education shall be financed from– a. Federal Government block grant of not less than 2% of its Consolidated Revenue Fund; b. Funds or contributions in form of Federal guaranteed credits; and c. Local and international donor grants. (2) For any State to qualify for the Federal Government block grant pursuant to sub-section 1(1) of this section, such State shall contribute not less than 50% of the total cost of projects as its commitment in the execution of the project.
2014 National Health Act **(Part I, paragraph 11.2)**	(2) The Basic Health Care Provision Fund shall be financed from– a. Federal Government annual grant of not less than 1% of its Consolidated Revenue Fund; b. Grants by international donor partners; and c. Funds from any other source. (3) For any State of Local Government to qualify for a block grant pursuant to sub-section (1) of this section, such State and Local Government shall contribute a. In the case of a State, not less than 25 per cent of the total cost of projects; and b. In the case of a Local Government, not less than 25 per cent of the total cost of projects as their commitment in the execution of such projects.