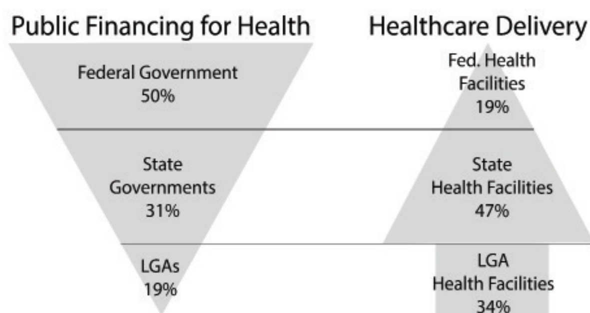
An Inverted Pyramid:

Three-tier Public Financing for Health in Nigeria

Yanfang Su
Harvard School of Public Health

Nigeria consists of 36 states and the Federal Capital Territory, as well as 774 local government areas (LGAs). Though healthcare delivery was decentralized to local governments in 1999, the main contributor of public financing for health continues to be the federal government, followed by state governments (see diagram below). In 2005, the federal government, state governments, and LGAs contributed 50%, 31%, and 19% of government expenditure on health, respectively.[1] This inverted pyramid structure of public financing presents critical challenges to delivering primary healthcare, especially because it enables leakage and corruption.

"Understanding the historical and political development of Nigeria's inverted pyramid of health financing is essential to grappling with modern-day inefficiencies in healthcare delivery."



How did the federal government become the main contributor of public financing for health in a decentralized system? In the 1970s, the state became the owner, producer, and marketer of oil. The oil sector now accounts for 85% of the government budget revenue and this revenue is clustered at the federal level.[2] The policy of distributing the Federal Account revenues to states and LGAs gives inadequate consideration to population needs. In the formula of resource allocation, only 30% of the Federal Account is distributed according to population base, and the least populous states often receive more revenues.[3]

At the state level, budget patterns have been systematically inequitable between the north and the south due to historical and political factors. Even though the Niger area was formally united in 1914, Nigeria remains divided into northern and southern parts, each distinct in their racial and ethnic makeup. Presidents Obasanjo (1999.5-2007.5), Yar'Adua (2007.5-2010.5), and Jonathan (2010.5-, Incumbent) were from the south, the north, and the south, respectively, and resource allocation fluctuates significantly depending on the president's regional background. Furthermore, studies show that the discrepancy in the distribution of resources against rural areas is largely influenced by existing political power, rather than by varying regional health needs.[4] Current state budgets for health remain far from the target established by the Commission for Macroeconomics and Health and agreed upon in the Abuja Declaration of 2001.

Understanding the historical and political development of Nigeria's inverted pyramid of health financing is essential to grappling with modern-day inefficiencies in healthcare delivery. Tracing health finances to the end-user, while difficult, can lead to high levels of efficiency in the health system. Even though the Auditor General of Local Governments presents both budget reports and expenditure reports to the state assemblies, the financial flow to

LGAs is not easily monitored.[5] From a political economy perspective, financial flows finally trickle down to health facilities and front line workers. Thus, one of the best ways to estimate efficiency of financial resource allocation is by collecting feedback from front-line workers. In 2002, 30 LGAs were sampled and more than 700 health workers were surveyed about salary payment. Evidence of large-scale leakage of public resources away from original budget allocations was found in this public expenditure tracing survey.[6 7]

These inefficiencies and corruption in the health sector have not escaped the public eye. Overall, government expenditure on health (GEH) in Nigeria remains low and has not been boosted by the growth in total government expenditure (TGE).[8] Even though Nigeria experienced economic growth with 2.5% annual growth rate from 2002 to 2006, the investment in health out of TGE remained around 5% to 7%. It is possible that the increase in public revenue was absorbed by other sectors, such as education, pension, and basic infrastructure, indicating that health investment was not prioritized in public financing. But a more plausible explanation is that public revenue leaked to the privileged elites due to corruption, which Nigerians experience in their daily lives and recognize in elite-sponsored programs. For instance, the program "Better Life for Rural Women" (BLRW), founded by first lady Maryam, was labeled "Better Life for Rich Women" by the Nigerian public.[9]

Ultimately, what steps can be taken to improve health financing and political accountability in Nigeria? Nigeria can come closer to achieving universal access to healthcare by establishing a permanent fund based on oil revenue to directly invest in health. Meanwhile, a matching mechanism between the three-tiers of the government will make local governments accountable for efficient allocation of financial resources to purchase healthcare. Last but not the least, Nigeria must fix its fundamental political and economic hurdles from a systematic perspective.[10] This includes mechanisms to empower political activists who will keep the federal government accountable for their resource allocation. Shaping financial flows in innovative ways is challenging but critical to the long-term health of the Nigerian population.

[1]Soyibo A, Olaniyan O, Lawanson A. National Health Accounts Of Nigeria, 2003 – 2005, Submitted to Federal Ministry of Health, Abuja, 2009
[2]Ejobowah J,Who Owns the Oil? The Politics of Ethnicity in the Niger Delta of Nigeria, Africa Today, Vol. 47, No. 1 (Winter, 2000), pp. 29-47
[3]Soyibo A, Olaniyan O, Lawanson A. National Health Accounts Of Nigeria, 2003 – 2005, Submitted to Federal Ministry of Health, Abuja, 2009
[4]Olaniyan O, Lawanson A, Health Expenditure and Health Status in Northern and Southern Nigeria: A Comparative Analysis Using NHA Framework, Paper presented at the 2010 CSAE conference held at St Catherine College, University of Oxford, Oxford, UK, March, 2010
[5]World Bank Group. Improving Primary Health Care Delivery in Nigeria: Evidence from Four States. 2010
[6]Gupta M, Gauri v, Khemani S. Decentralized Delivery of Primary Health Services in Nigeria: Survey Evidence from the States of Lagos and Kogi, Africa Region Human Development Working Paper Number 70, June 2004
[7]Khemani S. Local Government Accountability for Health Service Delivery in Nigeria, , Journal of African Economies, 2005
[8]WHO, Nigeria - National Expenditure on Health (Naira), http://www.who.int/nha/
[9]Smith, D. J. Development Seams: Donors, Dollars, and NGO Entrepreneurs, A Culture of Corruption: Everyday Deception and Popular Discontent in Nigeria. Princeton, Princeton University Press. 2007.
[10]Roberts M, Hsiao W, Berman P, Reich M. Getting health reform right: a guide to improving performance and equity. Oxford Univer-

Follow us at
www.hcghronline.org
for more web-exclusive coverage
and multimedia content

harvard college
global health review