Financing Sdg 3 (Good Health and Well-Being): Partnerships, Investment, and Accountability in Nigeria

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ABSTRACT

This study examines the financing architecture of Sustainable Development Goal 3 (Good Health and Well-Being) through the interconnected pillars of Partnerships, Investment, and Accountability, with specific attention to West Africa, using Nigeria as a case study and comparable developing economies. Despite global commitment to the 2030 Agenda, the financing gap for Universal Health Coverage (UHC) in Sub-Saharan Africa remains substantial, worsened by macroeconomic instability, currency depreciation, post–COVID-19 fiscal pressures, and, in some cases, a lack of accountability.

Using a qualitative descriptive design grounded in interpretivism, the study analyses secondary data from the World Health Organisation (WHO), the World Bank, and Nigerian fiscal policy frameworks. The theoretical foundation integrates the Human Capital Framework (World Bank, 2018), the Fiscal Space for Health Framework (Barasa et al., 2018), the Health Governance Model (Brinkerhoff & Bossert, 2020), and the Health Systems Resilience Framework (Thomas et al., 2020) to examine structural constraints in health financing.

Research shows that Nigeria's reliance on Out-of-Pocket (OOP) payments—exceeding 70% of total health expenditure—continues to expose households to catastrophic costs and undermines equity objectives (World Bank, 2024; Adewole et al., 2021). While Public-Private Partnerships (PPPs) and Foreign Direct Investment (FDI) offer potential pathways for infrastructure expansion, they remain constrained by exchange rate volatility, regulatory uncertainty, and political risk. The study also identifies weaknesses in domestic accountability systems, particularly in the administration of the Basic Health Care Provision Fund (BHCPF) at sub-national levels (Eboreime et al., 2020).

The study concludes that sustainable progress toward SDG 3 requires a shift from donor dependence to strengthened domestic resource mobilisation, mandatory social health insurance under the NHIA Act (2022), and institutionalised procurement transparency. Policy recommendations emphasise blended finance mechanisms, ring-fenced health taxes, Direct Facility Financing, and the adoption of Open Contracting Data Standards in health procurement.

Keywords: Sustainable Development Goal 3, Health Financing, Universal Health Coverage, Public-Private Partnerships, Out-of-Pocket Expenditure, NHIA ACT 2022.

INTRODUCTION

Sustainable development cannot occur without a healthy population. Contemporary development economics increasingly recognises health not merely as a social outcome but as productive capital. The transition from the Millennium Development Goals (MDGs) to the Sustainable Development Goals (SDGs) reflected this broader understanding. While MDGs 4, 5, and 6 focused on specific disease burdens and maternal-child health outcomes, SDG 3 adopts a comprehensive mandate: to ensure healthy lives and promote well-being for all at all ages (United Nations [UN], 2023).

Central to SDG 3 is Target 3.8—Universal Health Coverage (UHC)—which guarantees access to essential services without financial hardship. Achieving this target requires substantial and sustained reform of financing.

The World Health Organisation (WHO, 2023) estimates that low- and middle-income countries require an additional $371 billion annually to meet baseline health targets by 2030. In Sub-Saharan Africa, financing efforts are constrained by high disease burdens, limited fiscal space, and rising sovereign debt (Coulibaly & Gandhi, 2021).

Nigeria illustrates these tensions sharply. Although a signatory to the 2001 Abuja Declaration, which requires African countries to commit 15% of national budgets to health, federal allocations have remained between 4% and 6% over the past decade (Federal Ministry of Health [FMoH], 2022). As a result, health financing is dominated by Out-of-Pocket (OOP) payments. According to the World Bank (2024), OOP accounts for approximately 75% of Total Health Expenditure, one of the highest rates globally. Such reliance disproportionately burdens low-income households and increases the risk of catastrophic expenditure (Adewole et al., 2021).

Macroeconomic instability has compounded these structural weaknesses. Following COVID-19, fiscal pressures intensified due to subsidy cuts and exchange rate reforms. With over 70% of medical commodities imported, inflation has significantly increased healthcare costs (CSEA, 2024). Under these conditions, traditional aid flows alone cannot sustain SDG 3 commitments. Sustainable financing must integrate strategic partnerships (SDG 17), private investment, and enforceable accountability mechanisms.

Statement of the Problem

With fewer than five years remaining before 2030, progress toward SDG 3 in Nigeria remains off track. The central problem is structural: ambitious health targets are being pursued within financing systems that remain fragmented, underfunded, and weakly regulated.

Three interrelated challenges define this gap.

First, the investment deficit. Public capital expenditure is insufficient to close infrastructure gaps estimated in the tens of billions of dollars (IFC, 2022). Many Primary Healthcare Centres lack essential utilities and equipment, while private capital remains cautious due to macroeconomic volatility and regulatory uncertainty.

Second, the partnership paradox. Although Global Health Initiatives have financed disease-specific programs, they have often operated through parallel systems, raising sustainability concerns as donor transitions accelerate (Mathauer et al., 2017).

Third, the accountability gap. Even when funds are allocated, implementation weaknesses limit impact. The Basic Health Care Provision Fund (BHCPF) has faced bureaucratic delays, inadequate counterpart funding, and transparency challenges at sub-national levels (Eboreime et al., 2020).

This study, therefore, examines how Nigeria can redesign its health financing architecture to attract sustainable investment, strengthen partnerships, and institutionalise accountability in pursuit of SDG 3.

Research Questions

1. What macroeconomic and structural barriers hinder the sustainable financing of SDG 3 in Nigeria?
2. How can PPPs and blended finance mechanisms reduce investment risk in health infrastructure?
3. How does reliance on OOP financing affect progress toward UHC?
4. What role do transparency and accountability mechanisms play in improving allocative efficiency?

Objectives of the Study

The study aims to analyse health financing reforms necessary to advance SDG 3 in Nigeria. Specifically, it seeks to:

1. Evaluate the effects of debt, inflation, and fiscal constraints on public health spending.
2. Examine multi-stakeholder partnerships in mobilising capital and expertise.
3. Assess the implications of transitioning from OOP to mandatory social health insurance under the NHIA Act (2022).
4. Propose policy measures to strengthen accountability in procurement and service delivery.

Significance of the Study

This study contributes to policy, investment strategy, and academic discourse.

For policymakers, it provides guidance on operationalising the National Health Insurance Authority (NHIA) Act and expanding domestic resource mobilisation.

For private investors, it identifies regulatory and financial mechanisms necessary to reduce risk in health-sector PPPs.

For academia, it links macroeconomic financing theory with practical governance realities in Sub-Saharan Africa.

Scope and Limitations

The study focuses on health financing reforms between 2017 and early 2026, capturing pre-pandemic trends, COVID-19 disruptions, and subsequent policy shifts. While referencing broader developing-economy experiences, Nigeria serves as the primary case study. The analysis centres on Partnerships, Investment, and Accountability.

Limitations include reliance on secondary data and possible reporting discrepancies across institutional datasets. However, triangulation across peer-reviewed and multilateral sources strengthens validity.

Operational Definitions

1. **Universal Health Coverage (UHC):** Access to needed health services without financial hardship.
2. **Out-of-Pocket (OOP) Expenditure:** Direct payments made at the point of service, excluding pre-paid insurance or tax-based financing.
3. **Basic Health Care Provision Fund (BHCPF):** A statutory fund under the National Health Act (2014), financed by at least 1% of the Consolidated Revenue Fund to support primary healthcare.
4. **Blended Finance:** Use of concessional or development finance to mobilise private capital by reducing risk exposure.
5. **Strategic Purchasing:** Evidence-based allocation of pooled funds based on performance and health system priorities.
6. **National Health Insurance Authority (NHIA) Act (2022):** A Nigerian health policy reform that transformed the previous voluntary health insurance framework into a more comprehensive national system aimed at expanding coverage to all citizens and legal residents. The Act seeks to strengthen financial risk pooling and improve access to healthcare by integrating both formal and informal sector populations into a national health insurance scheme.

LITERATURE REVIEW AND THEORETICAL FRAMEWORK

Analysis of SDG 3 financing requires disaggregation of health financing into its three established functions: revenue collection, risk pooling, and purchasing (WHO, 2020).

Revenue Collection

Revenue collection refers to the mobilisation of funds from households, firms, governments, and donors to finance health services. In many developing economies, including Nigeria, revenue generation remains fragmented and heavily dependent on out-of-pocket (OOP) payments and external aid.

Transitioning toward SDG 3 requires shifting from voluntary and point-of-service payments to predictable, compulsory prepayment mechanisms, particularly through general taxation and mandatory insurance contributions (Olakunde, 2020). Such restructuring enhances equity and stabilises funding flows.

Risk Pooling

Risk pooling involves the accumulation and management of prepaid funds to spread financial risk across populations. Fragmented pools—where private insurance covers high-income groups, formal workers are insured separately, and informal workers remain excluded—limit cross-subsidisation between income and health risks.

Achieving Universal Health Coverage (UHC) requires consolidating pools at the national or state level to enable redistribution from higher-income to lower-income groups and from healthier to sicker populations (Barasa et al., 2018). Without large, integrated pools, financial protection targets under SDG 3 remain unattainable.

Strategic Purchasing

Purchasing refers to the allocation of pooled funds to providers for service delivery. Passive purchasing—characterised by historical budgeting or fee-for-service arrangements—often leads to inefficiency and cost escalation.

Strategic purchasing, in contrast, aligns provider payment mechanisms with system objectives by determining what services to buy, from whom, and how to pay (e.g., capitation or performance-based financing) (Mathauer et al., 2017). Strengthening purchasing mechanisms is therefore central to improving efficiency and accountability in health financing.

CONCEPTUAL FRAMEWORK

Achieving Sustainable Development Goal 3 (SDG 3), which seeks to ensure healthy lives and promote well-being for all at all ages, requires a multidimensional financing architecture that integrates governance, investment, and institutional partnerships. Health financing is not solely a matter of public expenditure but involves a complex interplay among fiscal capacity, governance structures, and collaborative arrangements across the public and private sectors. In the Nigerian context, these dynamics are particularly important due to persistent fiscal constraints, high out-of-pocket health expenditure, and systemic inefficiencies in resource allocation (Olakunde, 2020; McIntyre et al., 2017).

This study adopts a conceptual framework that positions **partnerships, investment, and accountability** as the core drivers of sustainable health financing. Partnerships—particularly public-private collaborations—facilitate the mobilisation of additional resources, technical expertise, and infrastructure development within the health sector. Empirical evidence from health system reforms in developing countries suggests that well-structured partnerships can improve healthcare service delivery and expand access to quality medical services (Inuwa et al., 2021; IFC, 2022).

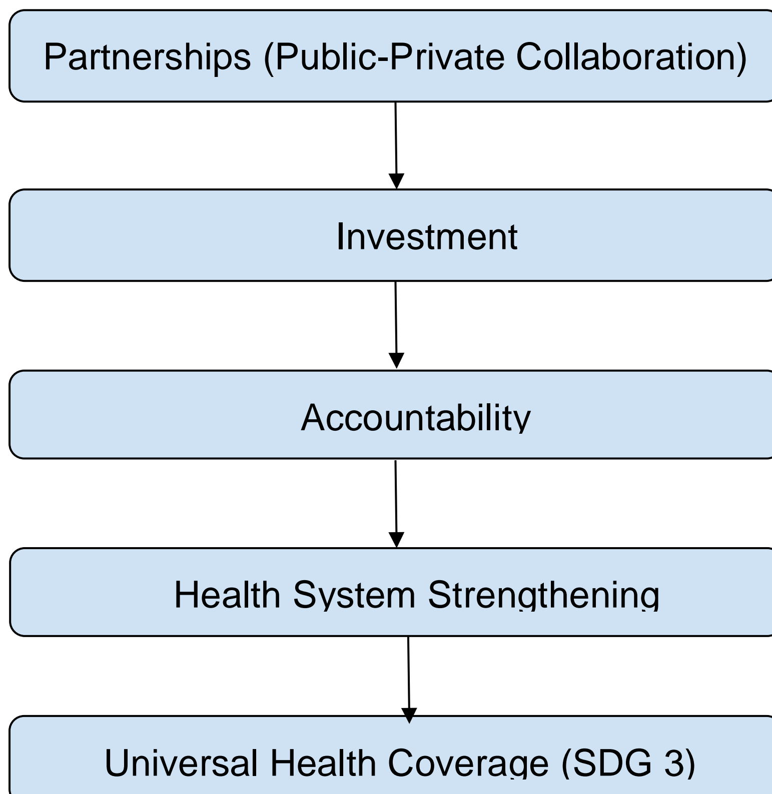
Investment represents the financial commitment required to build resilient health systems capable of delivering Universal Health Coverage. These investments include public budgetary allocations, international development assistance, private capital inflows, and innovative financing mechanisms. Strategic investment in health infrastructure, medical technologies, and human capital strengthens system capacity and enhances healthcare outcomes (WHO, 2020; World Bank, 2018).

Accountability mechanisms ensure that mobilised resources are allocated efficiently and managed transparently. Strong governance systems, regulatory oversight, and institutional transparency are essential to prevent corruption, improve efficiency in health spending, and ensure that financial resources translate into tangible health outcomes (Brinkerhoff & Bossert, 2020; Nigeria Health Watch, 2023).

Within this framework, the interaction of partnerships, investment, and accountability directly influences the performance of the health system. Effective coordination among these factors reduces financial barriers to healthcare access, strengthens service delivery, and enhances financial risk protection for households. Ultimately, these outcomes contribute to the realisation of Universal Health Coverage and the broader objectives of SDG 3.

The framework, therefore, conceptualises sustainable health financing as a dynamic process in which partnerships mobilise resources, investment strengthens health system capacity, and accountability ensures efficient and equitable utilisation of funds. When these elements function effectively, they collectively improve access to healthcare, reduce out-of-pocket expenditures, and enhance population health outcomes in Nigeria.

Figure 2.1: Conceptual Framework Linking Partnerships, Investment, and Accountability to SDG 3 Outcomes in Nigeria.



THEORETICAL FRAMEWORK

This study draws on four contemporary frameworks that reflect current fiscal and institutional realities of Nigeria. First, the **Human Capital Framework for Health (World Bank, 2018)** which reconceptualises health expenditure as investment rather than consumption. It models the impact of health outcomes—such as stunting, adult mortality, and untreated chronic disease—on long-term productivity and GDP growth. This framework provides macroeconomic justification for prioritising SDG 3. Health investment enhances labour productivity

and long-term growth potential, supporting arguments for mobilising domestic capital and attracting private investment into health infrastructure.

Secondly, there is the **Fiscal Space for Health Framework (Barasa et al., 2018).** This identifies five sources of fiscal space for health: Macro economic growth, Budget reprioritization, Health-specific domestic revenues, External assistance and Efficiency gains. Barasa et al. (2018) posit that in fiscally constrained contexts characterised by high debt servicing and low tax-to-GDP ratios, expanding fiscal space through domestic revenue reforms and efficiency improvements becomes essential. For Nigeria, sustainable health financing depends less on donor inflows and more on expanding health-specific taxation and improving expenditure efficiency

Thirdly, there is the Health Governance and Accountability Model (Brinkerhoff & Bossert, 2020). This model examines principal–agent relationships in decentralised health systems, emphasising accountability linkages between policymakers, providers, and citizens. Explaining that financing reforms may fail where monitoring systems are weak and incentives are misaligned. The model explains why expanded funding through mechanisms such as the Basic Health Care Provision Fund (BHCPF) or the National Health Insurance Authority (NHIA) Act requires strong fiduciary oversight and citizen accountability to translate financial inputs into service delivery outcomes.

Finally, the Health Systems Resilience Framework (Thomas et al., 2020) emphasises a system's capacity to absorb shocks, maintain core functions, and adapt to changing conditions. **Thomas et al. (2020) explained that s**ustainable financing must support resilient infrastructure, diversified supply chains, and domestic production capacity to withstand macroeconomic and public health shocks.

Empirical Review

This section reviews empirical studies published since 2017, organised by thematic relevance.

OOP Expenditure and Catastrophic Costs

Empirical evidence consistently links OOP financing to poverty and financial hardship. Aregbeshola and Khan (2018) found that OOP payments contribute significantly to catastrophic health expenditure in Nigeria, pushing millions into poverty annually.

Sparkes et al. (2019) further demonstrate through cross-country analysis that progress toward UHC requires legislated transitions from voluntary and OOP systems to mandatory prepayment schemes.

These findings support the restructuring of Nigeria's financing architecture toward pooled, prepaid mechanisms.

Social Health Insurance and the National Health Insurance Authority (NHIA) Act

Before the 2022 National Health Insurance Authority (NHIA) Act, voluntary insurance schemes in Nigeria recorded limited coverage. Adewole et al. (2021) found that, 15 years after the National Health Insurance Scheme (NHIS) was introduced, coverage remained below 5%, concentrated among federal civil servants.

Comparative studies from Rwanda and Ghana show that mandatory enrollment significantly expands risk pools and enhances financial protection (McIntyre et al., 2017). The NHIA Act aligns with this evidence by institutionalising compulsory coverage.

Public–Private Partnerships (PPPs) in Healthcare

Empirical evidence on PPPs is mixed and highly dependent on regulatory capacity. The Garki Hospital Abuja concession has been cited as a notable example. Inuwa et al. (2021) report improvements in service utilisation, technology upgrades, and industrial relations under private management.

However, Hunter and Murray (2019) caution that without regulatory safeguards, profit-oriented models may compromise equity by excluding low-income populations.

The literature suggests that PPPs can enhance efficiency but require pro-poor regulation and targeted subsidies to support SDG 3 equity objectives.

Sub-National Health Financing

Given Nigeria's federal structure, state-level implementation is central to financing reform. Eboreime et al.

(2020) found that states integrating State Health Insurance Schemes (SHIS) with the federal BHCPF through Direct Facility Financing experienced improved utilisation of maternal and child health services.

This evidence indicates that coordinated federal funding, combined with decentralised accountability structures, improves service delivery outcomes.

Debt Sustainability and Health Expenditure

Post-COVID-19 studies increasingly examine the relationship between sovereign debt and social spending. A study by the Centre for the Study of the Economies of Africa (CSEA, 2024) found a negative correlation between Nigeria's rising debt-service-to-revenue ratio and real health sector capital allocations.

These findings support the debt overhang hypothesis: elevated debt servicing constrains fiscal space for health investment, limiting progress toward SDG 3.

METHODOLOGY

This study is grounded in an interpretivist research philosophy. Interpretivism recognizes that policy processes, including health financing and accountability systems, are socially constructed and shaped by institutional behaviour, political economy dynamics, and stakeholder interactions.

Unlike positivist approaches that prioritise quantification, interpretivism is well-suited to examining how and why financing reforms succeed or fail in complex governance environments. Understanding Nigeria's health financing architecture requires analysis of institutional relationships among policymakers, donors, and service providers.

Research Design

The study adopts a qualitative descriptive research design. Given the macro-level, policy-oriented focus of health financing, qualitative analysis enables in-depth examination of the systemic relationships among fiscal policy, governance structures, and investment mechanisms.

Rather than estimating funding gaps alone, the design facilitates exploration of the structural and institutional factors shaping SDG 3 implementation.

Data Sources and Collection Strategy

The study relies exclusively on peer-reviewed and institutional secondary data. Documents were selected through purposive sampling based on relevance to macroeconomic policy, governance, and health financing reform.

Data on expenditure trends, OOP levels, and debt indicators were obtained from: WHO Global Health Expenditure Database, World Bank Health, Nutrition and Population Statistics, UN Sustainable Development Goals Reports (2023), NHIA Act (2022), National Health Act (2014) provisions on the BHCPF, Budget implementation reports from the Nigerian Budget Office (2023–2024).

Method of Data Analysis

Data were analysed using Reflexive Thematic Analysis as outlined by Braun and Clarke (2021). The process involved six stages:

1. **Familiarisation** – Repeated review of documents to gain an overview of recurring issues in health financing.
2. **Coding** – Identification of key patterns (e.g., OOP-related impoverishment, fiscal constraints, PPP regulation gaps).
3. **Theme Development** – Grouping codes into broader themes aligned with the study's analytical pillars: Partnerships, Investment, and Accountability.
4. **Reviewing Themes** – Comparing themes against source material to ensure coherence and accuracy.
5. **Defining Themes** – Refining thematic boundaries and clarifying conceptual relationships.
6. **Synthesis** – Integrating empirical findings with the theoretical framework to structure Chapter Four.

Ethical Considerations

The study relies solely on publicly available secondary sources and does not involve human subjects. All materials were cited in accordance with APA 7th Edition standards. Data were presented objectively to preserve analytical integrity.

DISCUSSION AND ANALYSIS

Achieving SDG 3 requires governance models that extend beyond isolated state action. The analysis indicates a gradual shift from donor-dependent programming toward system-integrated and capacity-building partnerships, investment and accountability.

Partnerships: Re-Engineering Collaborative Health Governance

This examines the major structural factors shaping the financing of Sustainable Development Goal 3 (SDG 3) in Nigeria. While financial resources remain central to achieving Universal Health Coverage, the effectiveness of these investments is strongly influenced by broader systemic factors within the health sector. In addition to fiscal constraints, governance structures, and investment frameworks, the sustainability of health financing is closely linked to the availability and retention of skilled healthcare professionals. Consequently, this also examines the implications of the ongoing medical workforce migration crisis, highlighting how the loss of trained human capital undermines the effectiveness of public health investments and weakens the health system's capacity to deliver quality services.

To address these multifaceted challenges, achieving SDG 3 requires governance models that extend beyond isolated state action. Applying the Health Systems Resilience Framework (Thomas et al., 2020), it becomes clear that a health system cannot withstand economic shocks or severe workforce reduction if it relies on isolated actors. The analysis indicates that the current paradigm of global health partnerships must undergo a gradual shift from donor-dependent programming toward system-integrated and capacity-building partnerships to build true systemic resilience.

Fragmentation of Global Health Initiatives (GHIs)

Vertical global initiatives such as the Global Fund and Gavi have significantly improved disease-specific outcomes across Sub-Saharan Africa. However, evidence suggests that these programs often operate parallel systems—separate supply chains, reporting platforms, and incentive structures—focused narrowly on specific diseases.

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While HIV or immunisation programs may be well-funded, other essential services, such as maternal or primary care, remain under-resourced. This verticalization weakens horizontal primary healthcare (PHC) systems. An example will be my recent visit to the Neurology department of University of Abuja Teaching Hospital (UATH) Gwagwalada, that uses The Diabetes and Endocrine Treatment Centre, specially funded by the Office of the senior Special Assistant to the President on Sustainable Development Goals (OSSAP-SDGs), the structure being dedicated to a specific area of medicine, is well structured and looks a lot different compared to other Out-Patient departments in the hospital.

As Nigeria approaches potential donor graduation, sustainability requires integration of vertical programs into national financing structures. Donor resources should increasingly align with domestic pooling mechanisms,

including national health insurance schemes, rather than remain siloed (Mathauer et al., 2017).

Public–Private Partnerships (PPPs) in Service and Supply

Given fiscal constraints, PPPs are frequently deployed to expand infrastructure and service capacity. Beyond full-facility concessions, recent models include diagnostic services, pharmaceutical logistics, and health technology management. These arrangements have reduced stock-outs and supply inefficiencies in several states.

However, outcomes depend heavily on the allocation of risk. PPPs are unsustainable when governments absorb excessive financial risk or when regulatory instability discourages private participation. Conversely, weak regulation can compromise equity and affordability.

Effective PPPs require predictable regulation, timely payment under public insurance schemes, and clear assignment of operational risks to private partners.

Diaspora Engagement

Health workforce migration continues to affect domestic service delivery. Rather than viewing diaspora outflows solely as a loss, policy can facilitate structured re-engagement.

Telemedicine collaboration, temporary service return programs, and diaspora bonds targeting health infrastructure offer mechanisms to leverage remittance flows and professional expertise (World Bank, 2024). Such approaches reframe migration as a potential site for the circulation of capital and knowledge.

Investment: Closing the Health Capital Gap

The scale of financial resources required to achieve Universal Health Coverage (UHC) cannot be met through conventional public budget allocations alone. Viewed through the lens of the World Bank’s Human Capital Framework, population health should be regarded as a long-term national investment rather than merely a social welfare expenditure. Closing the health capital gap therefore requires diversified and blended financing strategies. Furthermore, applying the Fiscal Space for Health Framework (Barasa et al., 2018) highlights the importance of expanding domestic fiscal capacity through innovative taxation mechanisms and improved revenue mobilization, rather than relying predominantly on external borrowing.

Domestic Resource Mobilisation and Health Taxes

Progressive excise taxes on tobacco, alcohol, and sugar-sweetened beverages offer dual benefits: revenue generation and reduced non-communicable disease (NCD) burden. Nigeria’s SSB tax (introduced via the 2021 Finance Act) represents a step in this direction.

However, without legal earmarking, revenue fungibility limits health-sector impact. Ring-fencing such taxes to subsidise insurance premiums for vulnerable populations would strengthen financial protection and align taxation with SDG 3 objectives (Adewole et al., 2021).

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De-Risking Pharmaceutical Investment

Nigeria's dependence on imported pharmaceuticals exposes the system to foreign exchange volatility and supply disruptions. Expanding domestic manufacturing capacity is therefore both an economic and a health security priority.

Recent exits by multinational firms reflect structural barriers including foreign exchange constraints, energy costs, and regulatory delays (Aluh et al., 2024).

Blended finance instruments—such as credit guarantees, concessional loans, and first-loss capital from Development Finance Institutions—can reduce investor risk and support compliance with WHO Good Manufacturing Practice standards (IFC, 2022).

Mandatory Health Insurance as Institutional Pooling Reform

The National Health Insurance Authority (NHIA) Act (2022) establishes mandatory health insurance coverage. If effectively enforced, this reform can significantly expand prepaid risk pools and reduce reliance on catastrophic out-of-pocket payments (Olakunde, 2020).

Large pooled funds enhance purchasing power, enable price negotiation, and support quality enforcement. However, implementation challenges remain, particularly within the informal sector, where premium collection mechanisms are weak.

Human Capital Investment and the Medical Brain Drain Crisis

Any discussion of financing **Sustainable Development Goal 3 (SDG 3)** remains incomplete without addressing the human capital required to deliver healthcare services. In recent years, Nigeria's health sector has experienced an escalating workforce crisis characterised by the large-scale migration of trained medical professionals to high-income countries. According to data from the Coordinating Minister of Health and Social Welfare, more than **16,000 Nigerian doctors emigrated between 2018 and 2025** in search of better remuneration, improved working conditions, and safer clinical environments (Adejoro, 2025). Consequently, the national **doctor-to-population ratio has declined to approximately 3.9 per 10,000 people**, significantly below the threshold required to achieve effective Universal Health Coverage (Adejoro, 2025; Zakir, 2025).

From a macroeconomic perspective, the ongoing migration of healthcare professionals represents a substantial loss of public investment. The estimated cost of training a medical doctor in Nigeria exceeds **US$21,000**, with much of the cost subsidised by public funds. Longitudinal evidence suggests that nearly half of medical graduates emigrate within fifteen years of qualification to destinations such as the **United Kingdom, Canada, and the United States**. This trend effectively transfers publicly funded human capital to advanced healthcare systems without compensation, thereby weakening the domestic health sector and undermining national development objectives (Adejoro, 2025; Zakir, 2025).

Several structural factors drive this persistent migration. Zakir (2025) notes that resident doctors frequently endure excessively long shifts, sometimes ranging from **24 to 72 continuous hours**, often without adequate rest or institutional support. These conditions are compounded by delayed salary payments, inadequate hazard allowances, limited training infrastructure, and the psychological strain of managing patients in resource-constrained environments. Under such circumstances, migration becomes a rational response to professional burnout and economic insecurity. At the national level, this workforce attrition threatens the attainment of **SDG 3** by weakening specialist services, reducing maternal and child healthcare capacity, and widening disparities in rural health access.

Addressing this crisis, therefore, requires deliberate policy intervention and sustained investment in healthcare human resources. Although the Federal Government has recently introduced the **National Policy on Health Workforce Migration**, which aims to manage health worker mobility through bilateral cooperation agreements, long-term retention requires broader structural reforms. Effective investment in SDG 3 must include enforcing

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regulated duty hours, improving clinical infrastructure, and competitive remuneration structures that reflect the occupational risks faced by healthcare professionals. Strengthening workforce welfare will not only improve retention but will also protect Nigeria's existing investments in medical education and healthcare delivery.

Strategic Purchasing and Efficient Health Resource Allocation

Achieving Sustainable Development Goal 3 requires not only more funding but also the more efficient use of existing health funds. A key reform is **strategic purchasing**: the intentional use of pooled health funds to pay providers in ways that maximise health outcomes, improve quality, and ensure cost-effectiveness. Unlike passive budgeting, strategic purchasing links funding to measurable health outputs and population needs (Mathauer et al., 2017).

Historically, public health financing in many developing nations, including Nigeria, relied on rigid line-item budgeting based on past spending rather than on service outcomes. This system undermines accountability and provider incentives, resulting in inefficiency, resource wastage, and unequal service distribution (Sparkes et al., 2019).

Strategic purchasing reforms tackle inefficiencies through performance-based funding, contractual payments, and data-driven resource allocation. Purchasing agencies (e.g., national health insurance) prioritise services, select providers, and structure payments, such as capitation, case-based payments, and performance bonuses, to incentivise quality care while controlling costs (Mathauer et al., 2017).

In the Nigerian context, the successful implementation of the **National Health Insurance Authority (NHIA) Act of 2022** provides an institutional platform for operationalising strategic purchasing. By shifting from fragmented, facility-based budget allocations toward pooled insurance financing and outcome-based payments, Nigeria can significantly improve the efficiency of its limited health resources. Furthermore, integrating strategic purchasing with **Direct Facility Financing (DFF)** mechanisms and digital health information systems would enable policymakers to monitor provider performance, track service utilisation, and allocate funding in ways that reflect real population health needs.

Ultimately, strengthening strategic purchasing mechanisms represents a critical bridge between **health financing and health system performance**. While mobilising additional resources remains essential, ensuring that those resources are spent efficiently and transparently is equally important for achieving Universal Health Coverage and the broader objectives of Sustainable Development Goal 3.

Accountability: Strengthening Fiduciary and Clinical Oversight

A central argument of this study is that increased financial investment in healthcare systems is ineffective without strong accountability mechanisms. This perspective aligns with the Health Governance and Accountability Model proposed by Brinkerhoff and Bossert (2020), which emphasizes that financing systems function effectively only when there is a triangular accountability relationship linking policymakers, service providers, and citizens. Given the technical complexity of medical procurement and service delivery, the health sector is particularly vulnerable to financial leakages and governance failures. Consequently, establishing robust oversight mechanisms across these three actors becomes essential for ensuring that health financing translates into improved health outcomes.

BHCPF and Direct Facility Financing (DFF)

The Basic Health Care Provision Fund (BHCPF) allocates 1% of federal consolidated revenue to primary care. Implementation, however, has been uneven due to delays in counterpart funding and administrative bottlenecks at sub-national levels.

Direct Facility Financing (DFF) reduces these constraints by transferring funds directly to primary health centres. Linking disbursements to performance audits and community oversight mechanisms strengthens accountability (Eboreime et al., 2020).

Sub-National Pooling and Local Oversight

State-level health insurance agencies play a central role in decentralised service delivery. Agencies such as the Enugu State Universal Health Coverage Agency demonstrate how localised pooling improves monitoring of provider accreditation, fraud prevention, and capitation oversight.

Proximity to service providers enhances responsiveness and strengthens the link between pooled funds and community-level outcomes.

Procurement Transparency

Public procurement of medicines and equipment is particularly vulnerable to price inflation and substandard supply. Adoption of digital procurement platforms and alignment with the Open Contracting Data Standard can enhance transparency and reduce corruption risks (Brinkerhoff & Bossert, 2020).

Transparent procurement systems also improve investor confidence and reduce perceived risk premiums.

Regulatory Accountability and the Threat of Substandard Medicines

A critical but often overlooked dimension of health financing accountability is the regulatory oversight of medical commodities. Mobilising financial resources for Universal Health Coverage becomes fundamentally counterproductive if the medicines procured within the health system are falsified or substandard. The World Health Organisation (2024) estimates that countries globally lose approximately $30.5 billion annually to substandard and falsified medical products. Low- and middle-income countries bear the greatest burden of this crisis, where at least **one in ten medical products fails to meet acceptable quality standards**. Across Africa, this challenge has evolved into a silent epidemic that directly undermines decades of progress in disease prevention and treatment. Wada et al. (2022) note that the proliferation of these dangerous products contributes to hundreds of thousands of preventable deaths each year, including an estimated **450,000 deaths associated with ineffective or toxic antimalarial drugs**.

This regulatory crisis is closely connected to the broader macroeconomic financing challenges previously discussed in this study. Because Nigeria’s health system continues to rely heavily on catastrophic out-of-pocket expenditure, many households are structurally compelled to seek lower-cost alternatives from informal and poorly regulated pharmaceutical markets, including patent medicine vendors and illicit street drug sellers (Wada et al., 2022). In addition, weak regulatory enforcement capacity, systemic corruption at ports of entry, and fragmented pharmaceutical import supply chains create substantial vulnerabilities that sophisticated counterfeit networks can exploit (World Health Organisation, 2024).

Addressing this significant clinical and financial leakage requires a fundamental shift in both regulatory accountability and strategic investment in pharmaceutical governance. From an investment perspective, financing must prioritise modern supply chain integrity systems such as **track-and-trace technologies, blockchain-enabled verification platforms, and handheld spectrometer devices** capable of rapidly detecting counterfeit medicines in field operations. From a governance perspective, national regulatory agencies must also strengthen international collaboration. By domesticating the regulatory frameworks of the **African Medicines Agency (AMA)** and actively participating in the **WHO Global Surveillance and Monitoring System (GSMS)**, Nigeria can enhance cross-border intelligence-sharing and intercept falsified medical products before they enter domestic pharmaceutical markets (Wada et al., 2022; World Health Organisation, 2024). Ultimately, ensuring the integrity of medical commodities is essential to the broader objective of financing Sustainable Development Goal 3, as effective health financing must guarantee that every public or private investment results in the procurement of safe, authentic, and life-saving medicines.

Strategic Purchasing and Clinical Accountability

Financial oversight must be complemented by outcome-based accountability. Passive budgeting mechanisms weaken incentives for quality improvement.

Strategic purchasing—through capitation or performance-based financing—aligns provider reimbursement with service-quality, patient-outcome, and efficiency targets. Linking payments to measurable indicators strengthens system performance and supports SDG 3 objectives.

Accountability in Social Determinants Programs

Health outcomes are closely tied to poverty reduction and nutrition interventions. Programs such as Conditional Cash Transfers and school feeding initiatives aim to reduce vulnerability and prevent catastrophic health expenditure (Oweibia et al., 2024).

However, implementation gaps—including diversion of funds and weak oversight—have limited effectiveness. This underscores the broader finding of the study: financing mechanisms must be paired with enforceable monitoring systems to translate expenditure into measurable health gains.

Multi-Tiered Accountability for Health Equity

Effective accountability operates across multiple levels: political leadership, administrative execution, professional regulation, and citizen oversight (Nigeria Health Watch, 2023).

Evaluation frameworks should prioritise measurable health outcomes rather than financial inputs alone. Given contextual variation across states and regions, accountability mechanisms must be locally adapted rather than externally imposed.

FINDINGS, CONCLUSION, AND RECOMMENDATIONS

The analysis of contemporary health financing literature and policy frameworks yields four principal findings:

Persistent Out-of-Pocket (OOP) Burden

Heavy reliance on OOP payments—estimated at approximately 75% of Total Health Expenditure—remains a central barrier to achieving SDG 3. This financing structure exposes households to catastrophic expenditure and undermines equity within the health system.

Debt Constraints on Fiscal Space

High debt-servicing obligations significantly restrict fiscal capacity for health investment. Under current macroeconomic conditions, meeting international commitments such as the Abuja Declaration target remains unlikely without fiscal restructuring or sustained revenue expansion.

Partnership Fragmentation and PPP Opportunities

Global health partnerships remain partially fragmented, creating sustainability risks as donor support declines. Domestic PPPs offer potential for expanding infrastructure and pharmaceutical capacity, but outcomes depend on effective regulation and pro-equity safeguards.

Institutional Accountability Gaps

Administrative bottlenecks, weak procurement transparency, and inconsistent sub-national oversight limit the translation of allocated funds—particularly through mechanisms such as the BHCPF—into improved service delivery at the primary healthcare level.

CONCLUSION

This study concludes that achieving SDG 3 in developing economies requires structural reform of health financing systems, not incremental budget increases alone.

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Historical dependence on out-of-pocket payments and external donor funding has led to fragmented financing structures that undermine equity and sustainability. Transitioning toward mandatory pooled domestic financing—supported by effective insurance enforcement—offers a more stable pathway toward Universal Health Coverage.

The NHIA Act (2022) provides a legal foundation for expanding prepaid risk pools. However, legislative reform alone is insufficient. Implementation capacity, enforcement within the informal sector, and regulatory consistency will determine its effectiveness.

Private capital, including blended finance and PPP arrangements, can supplement public resources, particularly in pharmaceutical manufacturing and infrastructure development. However, these mechanisms require transparent procurement systems, predictable regulation, and strong fiduciary oversight to ensure alignment with public health objectives.

Overall, sustainable progress toward SDG 3 depends on integrating three pillars: expanded domestic resource mobilisation, institutionalised risk pooling, and enforceable accountability frameworks that link financial inputs to measurable health outcomes.

POLICY RECOMMENDATIONS

Policy actions are organised by implementation horizon.

Short- to Medium-Term (1–3 Years)

Strengthening the Implementation of the NHIA Act (2022) for the Informal Sector

State governments should prioritize the effective implementation of the NHIA Act by expanding health insurance coverage to the large informal sector workforce through accessible and low-barrier contribution mechanisms.

Practical Example: State Health Insurance Agencies could collaborate with telecommunication companies to introduce micro-contribution systems linked to mobile airtime purchases. For instance, a small deduction of approximately ₦50 from periodic airtime recharges could serve as a micro-premium contribution for registered informal sector participants. Such a system could facilitate the inclusion of millions of citizens in the national health risk pool without requiring complex administrative procedures.

Ring-fencing and Expanding Pro-Health Sin Taxes

The federal government should consider legislating the ring-fencing of revenues generated from health-related sin taxes, including those on sugar-sweetened beverages, alcohol, and tobacco, to ensure that these funds are dedicated exclusively to health financing initiatives.

Practical Example: Rather than channeling revenue from the Sugar-Sweetened Beverage tax into the general government treasury, these funds could be directly allocated to the **Vulnerable Group Fund under the NHIA**. This mechanism could help finance health insurance coverage for vulnerable populations, particularly pregnant women and children under the age of five, thereby strengthening financial protection within the health system.

Scale Direct Facility Financing (DFF)

Expansion of DFF can reduce administrative bottlenecks in BHCPF implementation. Disbursements should be linked to transparent reporting and facility-level performance audits.

Long-Term (3–5 Years)

De-Risk Pharmaceutical Investment

Targeted fiscal incentives, regulatory streamlining, and foreign exchange stabilisation mechanisms can encourage domestic pharmaceutical manufacturing. Collaboration with Development Finance Institutions to provide risk-sharing instruments would support investment viability.

Institutionalise Digital Procurement Systems

Mandatory adoption of e-procurement platforms aligned with open contracting standards can improve transparency in medical supply chains and reduce cost inflation.

Contributions to Knowledge

This study contributes to health economics studies by integrating recent macro-fiscal financing frameworks with governance and accountability models in decentralised systems.

It extends the discourse beyond quantifying financing gaps to examining institutional mechanisms that determine whether mobilised funds translate into service delivery improvements. In doing so, it highlights the role of

Direct Facility Financing and strategic purchasing as operational tools within broader fiscal reform.

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