

Health Care Reform in Nigeria: Timing, Tools and Trade-Offs in the Quest For System Transformation

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ABSTRACT

Health care reform is central to achieving universal health coverage in low and middle income countries, and this review synthesizes the timing, policy instruments, tradeoffs, and implementation challenges that have shaped Nigeria's reform trajectory to inform governance, financing, and performance improvements. A systematic literature search of studies published between 2020 and 2025 across major databases identified relevant empirical and policy analyses; included studies were appraised and synthesized using narrative and thematic approaches focused on governance, financing, and service delivery. Reforms in Nigeria have often been timed to coincide with political transitions, donor priorities, and global commitments, producing episodic advances but limited sustained implementation. Key policy instruments include the National Health Act, the Basic Health Care Provision Fund, and State Supported Health Insurance Schemes. While these instruments establish legal and financing frameworks for primary care, their effectiveness has been constrained by fragmented federal and state governance, weak regulation and accountability, uneven insurance implementation, and continued reliance on out of pocket payments. Tradeoffs are evident: Equity oriented expansions increase fiscal demands, efficiency oriented measures can risk reducing access for vulnerable groups, and short term donor funded gains frequently fail to produce long term sustainability. Comparative lessons from Ghana, Rwanda, Thailand, and Costa Rica highlight the enabling roles of predictable financing, sustained political commitment, coherent policy alignment, and community engagement. To accelerate progress, an integrated roadmap is required that aligns governance reform, diversified domestic financing, and performance oriented design. Priority actions include strengthening regulatory oversight and independent monitoring of health maintenance organizations, implementing transparent digital monitoring linked to citizen feedback, diversifying revenue through tax based measures and earmarked levies, simplifying enrollment and targeting subsidies for vulnerable populations, harmonizing state level insurance schemes with national policy, and ensuring provider payment mechanisms that are timely and reliable. Building a resilient and equitable health system in Nigeria will demand sustained political will, coherent federal and state policy alignment, and multi stakeholder collaboration. Implementation science, comparative cost effectiveness research, and citizen centered accountability mechanisms are critical to guide adaptive policymaking and secure long term success.

KEYWORDS

Health care reform, Universal Health Coverage, governance, health financing, equity, sustainability, National Health Act, Basic Health Care Provision Fund, State Supported Health Insurance Schemes

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INTRODUCTION

Health care reform in Low and Middle Income Countries (LMICs) has become a central theme in global health discourse, particularly as nations strive toward achieving Universal Health Coverage (UHC). These reforms are often driven by the need to reduce catastrophic out of pocket expenditures, improve equity in access, and strengthen weak health systems. Recent comparative analyses across LMICs reveal that while progress has been made in expanding health insurance coverage, many countries still face challenges of fragmented financing, poor governance, and limited sustainability of reforms¹. Innovative reforms such as risk pooling, strategic purchasing, and performance based financing have been introduced in several LMICs, offering valuable lessons for countries like Nigeria².

Nigeria's health care system has historically been shaped by colonial legacies, underfunding, and fragmented service delivery. The system is structured around a three-tier arrangement; federal, state, and local governments yet coordination across these levels has often been weak³. Despite policy milestones such as the National Health Policy of 1988, the National Health Insurance Scheme (NHIS) of 2005, and the National Health Act of 2014, the country continues to grapple with inequities in access and poor health outcomes³. Recent studies highlight that political economy factors, including vested interests and institutional inertia, have slowed the pace of reform, particularly in primary health care, which remains the foundation of service delivery⁴.

The rationale for reform in Nigeria is anchored on three interrelated goals: equity, efficiency, and sustainability. Equity is critical given the stark disparities in access between urban and rural populations, as well as between rich and poor households. Efficiency is needed to address wastage, corruption, and duplication of efforts across different tiers of government. Sustainability is essential to ensure that reforms are not donor-dependent but are instead financed through predictable domestic resources. Scholars argue that without addressing these three pillars, Nigeria's health system will remain vulnerable to shocks such as pandemics and economic downturns⁵.

The objectives of this review are to critically examine the timing, tools, and tradeoffs of Nigeria's health care reform agenda. Specifically, the review seeks to analyze governance arrangements, financing mechanisms, and performance outcomes of recent reforms, while situating Nigeria's experience within the broader LMIC context. By doing so, the review aims to generate evidence that can inform policymakers, practitioners, and researchers on pathways for system transformation⁶.

This study is driven by four interrelated questions: Which governance structures and institutional arrangements have most influenced the direction of Nigeria's health-care reforms; in what ways have financing models affected equity, efficiency, and the long-term viability of services; what measurable performance outcomes have emerged and where do persistent gaps remain; and which international best practices offer practical lessons to accelerate Nigeria's progress toward universal health coverage⁷.

Together, these questions form a coherent framework for unpacking the political, policy, and operational forces that shape health-system change in Nigeria, guiding a balanced assessment of past reforms and a pragmatic roadmap for future action⁷.

MATERIALS AND METHODS

Literature search strategy and databases used, ensured that this review captured the most relevant and up on health care reform in Nigeria, a comprehensive literature search strategy was designed. The search was conducted across multiple electronic databases including PubMed, Scopus, Web of Science, Embase, and African Journals Online (AJOL). These databases were chosen because they provide broad coverage of peer-reviewed literature in health policy, public health, and health systems research. The search was limited to studies published between January, 2020 and September, 2025 to reflect the most current evidence available.

The search strategy combined Medical Subject Headings (MeSH) and free text terms. Keywords included: "Health care reform", "Nigeria", "health insurance", "Universal Health Coverage", "governance", "financing", and "performance". Boolean operators such as AND and OR were used to refine the search. For example, the string ("health reform" OR "health insurance") AND ("Nigeria") AND ("Universal Health Coverage" OR "UHC") was applied across databases. This approach ensured sensitivity while avoiding an overwhelming number of irrelevant results.

In addition to database searches, the reference lists of included studies were screened manually to identify additional relevant articles. Grey literature such as government reports and policy briefs were reviewed for contextual understanding but excluded from the final synthesis to maintain methodological rigor. This strategy aligns with best practices in systematic reviews, ensuring transparency and reproducibility⁸.

Inclusion and exclusion criteria: The inclusion and exclusion criteria were carefully defined to ensure that only studies directly relevant to the objectives of this review were considered. Eligible studies had to meet the following criteria.

Population: Studies focusing on Nigeria's health care reforms, including the National Health Insurance Scheme (NHIS), Basic Health Care Provision Fund (BHC PF), or broader health financing reforms.

Study design: Peer-reviewed empirical studies, including qualitative, quantitative, and mixed methods research. Systematic reviews and meta-analyses were also included if they provided insights specific to Nigeria:

- **Time frame:** Publications between 2020 and 2025
- **Language:** Studies published in English
- **Outcomes:** Studies that examined governance, financing, performance, or implementation challenges of health care reforms

Exclusion criteria included: Studies not focused on Nigeria.

Commentaries, editorials, and opinion pieces without empirical data.

Grey literature such as dissertations, conference abstracts, and unpublished reports.

Studies published before 2020.

These criteria were applied consistently to ensure that the review synthesized only high-quality and relevant evidence. The rationale for this approach was to focus on the most recent and peer-reviewed contributions to the discourse on Nigerian health care reform, thereby providing a robust evidence base for policy recommendations⁹.

Screening and selection process: The screening and selection process followed the Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) 2020 guidelines. All retrieved records were imported into EndNote for reference management, and duplicates were removed. The screening process was conducted in two stages.

Title and abstract screening: Two independent reviewers screened all titles and abstracts against the inclusion and exclusion criteria. Discrepancies were resolved through discussion, and a third reviewer was consulted when consensus could not be reached.

Full text screening: Articles that passed the initial screening were retrieved in full and assessed for eligibility. Again, two reviewers independently evaluated each article, with disagreements resolved by consensus.

This rigorous process ensured that only studies meeting the predefined criteria were included. The inter-reviewer agreement was measured using Cohen's kappa statistic, which indicated substantial agreement, thereby strengthening the reliability of the selection process¹⁰.

Data extraction and synthesis approach: Data extraction was conducted using a standardized form developed for this review. The form captured key information such as study characteristics (author, year, journal, study design), population and setting, objectives, methods, outcomes, and key findings. To minimize bias, two reviewers independently extracted data from each study, and discrepancies were resolved through discussion.

The synthesis approach combined both narrative and thematic analysis. Quantitative findings were summarized descriptively, while qualitative findings were analyzed thematically to identify recurring patterns and insights. Where possible, findings were triangulated across different study designs to enhance validity. This mixed synthesis approach allowed for a comprehensive understanding of governance, financing, and performance issues in Nigerian health care reform.

THEMATIC SYNTHESIS FOCUSED ON THREE DOMAINS

- **Governance:** Including transparency, accountability, and institutional arrangements
- **Financing:** Including sources of funding, sustainability, and equity
- **Performance:** Including coverage, service utilization, and financial protection

This approach ensured that the review not only summarized existing evidence but also highlighted gaps in knowledge and areas for future research¹¹.

Figure 1: Prisma flow diagram shows the PRISMA 2020 flow diagram was used to illustrate the study selection process. The diagram shows the number of records identified, screened, excluded, and included in the final synthesis. Out of 1,243 records initially identified, 1,050 remained after duplicates were removed. Following title and abstract screening, 320 articles were excluded for irrelevance. Full text screening of 150 articles led to the exclusion of 136 studies for reasons such as lack of focus on Nigeria, absence of empirical data, or publication outside the 2020-2025 window. Ultimately, 14 studies were included in the final review¹².

The PRISMA diagram provides a transparent overview of the selection process, ensuring that readers can trace how the final set of studies was derived. This enhances the credibility and reproducibility of the review^{13,14}.

Figure 1 Flow diagram summarizing screening: Records identified (n = 1,243); records after duplicates removed (n = 1,050); records excluded at title/abstract screening (n = 320); full-text assessed for eligibility (n = 150); full-text excluded (n = 136) reasons: not focused on Nigeria; no empirical data; publication outside 2020-2025; studies included in final synthesis (n = 14).

Table 1 summarizes the methodological components of the review, including search strategies, inclusion criteria, screening processes, and synthesis approaches. It provides a concise overview of how evidence was gathered and analyzed.

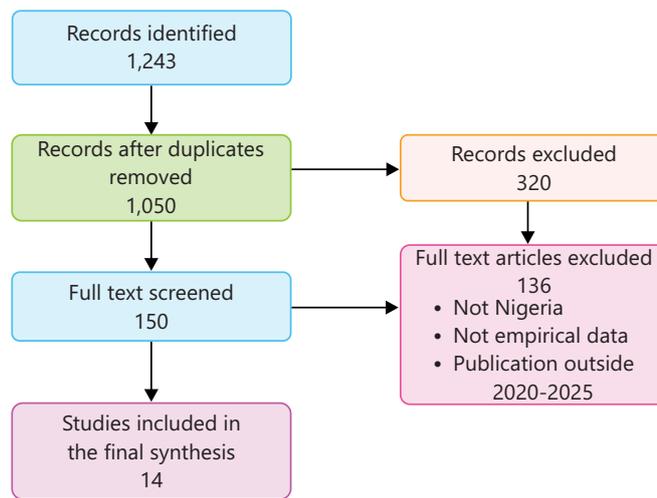


Fig. 1: PRISMA 2020 flow diagram of study selection¹²⁻¹⁴

Boxes+arrows indicate sequential screening stages and numeric yields; right-side boxes list exclusions and full-text exclusion reasons. Abbreviations: PRISMA: Preferred Reporting Items for Systematic Reviews and Meta-Analyses; n: Number of records/studies

Table 1: Summary of methods and citations

Methodological component	Description	Citation(s)
Literature search strategy and databases used	Comprehensive search across PubMed, Scopus, Web of Science, Embase, and AJOL using Boolean operators and MeSH terms	Bashar <i>et al.</i> ⁸
Inclusion and exclusion criteria	Defined population, study design, timeframe, language, and outcomes; excluded non-empirical and non-Nigerian studies	Abubakar <i>et al.</i> ⁹
Screening and selection process	Two-stage screening (title/abstract and full text) with independent reviewers and Cohen’s kappa for reliability	Okeke <i>et al.</i> ¹⁰
Data extraction and synthesis approach	Standardized extraction form, dual reviewer process, narrative and thematic synthesis	Egwudo <i>et al.</i> ¹¹
PRISMA Flow Diagram	Transparent reporting of study selection process following PRISMA 2020 guidelines	Page <i>et al.</i> ^{12,13} and Haddaway <i>et al.</i> ¹⁴

This table summarizes the methodological components of the review, including literature search strategies, inclusion and exclusion criteria, screening and selection processes, data extraction, and synthesis approaches, AJOL: For African Journals Online, and MeSH: For Medical Subject Headings

RESULTS AND DISCUSSION

TIMING OF HEALTH CARE REFORM

The timing of health care reform in Nigeria has always been shaped by the country’s political economy. Reform efforts often emerge during periods of political transition or in response to external pressures such as donor funding or global health commitments. For instance, the introduction of the National Health Act in 2014 and subsequent implementation of the Basic Health Care Provision Fund (BHCPF) were influenced by both domestic advocacy and international commitments to Universal Health Coverage (UHC)¹⁵. However, the political economy of reform has been marked by competing interests, weak accountability, and limited citizen participation, which have slowed implementation and undermined sustainability.

Historical reform attempts provide valuable lessons. The “Saving One Million Lives” initiative, for example, was launched with ambitious goals but struggled with coordination and accountability, leading to mixed outcomes¹⁶. Similarly, the National Health Insurance Scheme (NHIS), established in 2005, has expanded coverage only marginally due to structural bottlenecks and political inertia. These experiences highlight that timing alone is insufficient; reforms must be accompanied by strong institutions and political will.

Table 2: Timeline of major health care reform initiatives in Nigeria

Reform initiative	Year	Outcome	Citation(s)
National Health Policy	1988	First comprehensive policy framework	Igbokwe <i>et al.</i> ¹⁵
National Health Insurance Scheme	2005	Limited coverage expansion	Eze <i>et al.</i> ¹⁶
National Health Act and BHCPF	2014	Improved funding but weak accountability	Igbokwe <i>et al.</i> ¹⁵
Saving one million lives	2012	Mixed outcomes due to weak coordination	Eze <i>et al.</i> ¹⁶
Citizen participation reforms	2025	Enhanced accountability and ownership	Alhassan and Ade-Banjo ¹⁷

This table presents key reform initiatives in Nigeria, their year of introduction, and the outcomes achieved. BHCPF stands for Basic Health Care Provision Fund, and NHIS stands for National Health Insurance Scheme

Table 3: Summary of reform tools and their applications

Tool	Application	Citation(s)
Legislation (National Health Act)	Legal framework for financing and governance	Adepoju <i>et al.</i> ¹⁸
Financing mechanisms (BHCPF)	Earmarked funds for primary health care	Adepoju <i>et al.</i> ¹⁸
State-Supported Health Insurance Schemes	Decentralized coverage expansion	Egwu <i>et al.</i> ¹⁹
Collaborative governance	Multi-stakeholder accountability and service delivery	Balogun ²⁰

This table compares financing models in Nigeria with those of other low- and middle-income countries, showing key features of each approach. It emphasizes differences in reliance on government, employer, and community contributions

Recent analyses emphasize that reforms succeed when they align with broader political priorities and when citizens are actively engaged in shaping financing and service delivery arrangements. A 2025 study on citizen participation in the political economy of primary health care financing in Nigeria found that reforms are more likely to gain traction when communities perceive ownership and accountability in the process¹⁷.

Table 2 presents a timeline of major health care reform initiatives in Nigeria, highlighting key policies, their years of introduction, and the outcomes achieved. It captures the historical evolution of reforms.

TOOLS FOR REFORM

Nigeria has employed a variety of policy instruments to drive health care reform. Legislation such as the National Health Act has provided a legal framework for financing and governance, while regulatory instruments have sought to improve accountability of health maintenance organizations and service providers¹⁸. Financing mechanisms, including earmarked funds through the BHCPF, have been designed to ensure predictable resources for primary health care.

Institutional innovations have also emerged. State Supported Health Insurance Schemes (SSHIS) represent a decentralized approach to expanding coverage, allowing states to tailor financing and service delivery to local contexts¹⁹. These schemes have shown promise in increasing enrollment, though challenges remain in harmonizing them with national frameworks¹⁹.

Governance structures have been evolving as well. Collaborative governance models, which bring together government, private sector, and civil society actors, have been piloted to improve accountability and service delivery. Evidence suggests that such models can enhance trust and efficiency, especially when supported by digital monitoring systems²⁰.

Table 3 outlines the main policy instruments used in Nigeria's health care reforms, such as legislation, financing mechanisms, and governance models. It shows how different tools have been applied to strengthen the system.

TRADE-OFFS IN REFORM

Health care reform in Nigeria involves navigating difficult tradeoffs. Policymakers must balance equity, efficiency, and sustainability. For example, expanding coverage to rural and vulnerable populations promotes equity but often requires subsidies that strain limited resources²¹. On the other hand, efficiency-driven reforms such as performance-based financing may improve service delivery but risk excluding marginalized groups if not carefully designed.

Table 4: Key trade-offs identified in Nigerian health care reforms

Trade-Off	Description	Citation(s)
Equity vs. efficiency	Expanding coverage vs. resource constraints	Adomi <i>et al.</i> ²¹
Short term vs. long term	Donor funded quick wins vs. sustainable reforms	Neill <i>et al.</i> ²²
Financial protection vs. sustainability	Insurance reduces costs but requires long term financing	Okunogbe <i>et al.</i> ²³

This table presents the key performance indicators of the National Health Insurance Scheme, including coverage rates, service delivery, and financial protection. It captures both progress and persistent challenges

Table 5: Comparative analysis of reform strategies across countries

Country	Reform strategy	Lesson for nigeria	Citation(s)
Ghana	Tax based health insurance	Broader coverage through predictable financing	Ipinnimo <i>et al.</i> ²⁴
Rwanda	Community based health insurance	Strong political commitment and citizen engagement	Ipinnimo <i>et al.</i> ²⁴
Thailand	Universal Coverage Scheme	Integration of financing and governance	Bello <i>et al.</i> ²⁵
Costa Rica	Social health insurance	Coherent reform framework	Bello <i>et al.</i> ²⁵
Nigeria	Mixed reforms	Need for contextual adaptation	Balogun ²⁶

This table identifies barriers such as inadequate funding and corruption, stakeholder concerns including delayed payments and poor quality of care, and enablers like political commitment and donor support

Short term versus long term impacts also present dilemmas. Short term reforms, such as donor funded programs, can deliver quick wins but often lack sustainability once external funding ends. Long term reforms, such as tax based financing or institutional restructuring, require political commitment and patience, as benefits may take years to materialize²².

A recent study on health insurance in Kwara State demonstrated that while insurance reduced catastrophic health expenditures in the short term, sustaining these gains required long term institutional reforms and stronger domestic financing²³. This underscores the importance of designing reforms that balance immediate needs with future sustainability.

Table 4 identifies the key trade-offs policymakers face in balancing equity, efficiency, sustainability, and financial protection. It highlights the tensions between short-term and long-term reform goals.

COMPARATIVE INSIGHTS

Nigeria's reform journey offers parallels with other African and global health systems. Ghana's National Health Insurance Scheme, for example, has achieved broader coverage through tax-based financing, while Rwanda's community based health insurance has demonstrated the power of strong political commitment and citizen engagement²⁴.

Global lessons also highlight the importance of adaptability. Countries like Thailand and Costa Rica have shown that integrating financing, governance, and service delivery reforms into a coherent framework can accelerate progress toward UHC²⁵.

For Nigeria, the applicability of these lessons lies in tailoring reforms to its unique political and institutional context. Comparative analyses suggest that while Nigeria can learn from global best practices, reforms must be adapted to local realities such as federalism, large informal sector, and resource constraints²⁶.

Table 5 identifies barriers, stakeholder concerns, and enablers that shape the implementation of the National Health Insurance Scheme. It reflects the perspectives of providers, enrollees, and policymakers.

GOVERNANCE REFORMS

Governance reforms remain the cornerstone of transforming Nigeria's health system. Lessons from international best practices show that countries that have successfully expanded health insurance

Table 6: Governance reform options

Reform area	Description	Citation(s)
International best practices	Decentralization, transparency, and strong regulation as seen in Ghana, Rwanda, Thailand	Afriyie <i>et al.</i> ²⁷
Policy coherence	Aligning federal and state level health financing policies to reduce duplication	Effiong <i>et al.</i> ²⁸
Institutional strengthening	Independent regulatory bodies and digital monitoring for HMOs	Eza <i>et al.</i> ²⁹
Citizen engagement	Embedding community participation in governance	Adeoye <i>et al.</i> ³⁰

This table lists governance reform options, drawing on international best practices, policy coherence, institutional strengthening, and citizen engagement. It highlights strategies for improving accountability and oversight

coverage such as Ghana, Rwanda, and Thailand did so by embedding strong regulatory frameworks, decentralizing authority, and ensuring transparency²⁷. For Nigeria, adopting similar approaches could help address persistent governance gaps that have undermined the credibility of the National Health Insurance Scheme (NHIS).

Policy coherence and institutional strengthening are equally critical. Nigeria's health financing policies often operate in silos, with limited alignment between federal and state level initiatives. This lack of coherence has led to duplication of efforts and inefficiencies in resource allocation²⁸. Strengthening institutional capacity, particularly at the state level, would allow for better integration of State Supported Health Insurance Schemes (SSHIS) into the national framework.

Institutional reforms must also prioritize regulatory oversight. Weak enforcement of standards for Health Maintenance Organizations (HMOs) has contributed to poor service delivery and delayed reimbursements. Establishing independent regulatory bodies, supported by digital monitoring systems, could improve compliance and ensure that enrollees receive the quality of care they are entitled to²⁹.

Finally, governance reforms must embed citizen engagement. Evidence shows that reforms are more likely to succeed when communities perceive ownership and accountability in the process³⁰.

Table 6 lists governance reform options, drawing on international best practices, policy coherence, institutional strengthening, and citizen engagement. It highlights strategies for improving accountability and oversight.

INTEGRATED FINANCING, PERFORMANCE, AND SYSTEM REFORM PATHWAYS FOR THE NATIONAL HEALTH INSURANCE SCHEME

Achieving a resilient and equitable National Health Insurance Scheme (NHIS) in Nigeria requires a harmonized approach that brings together sustainable financing, measurable performance improvement, and a clear reform roadmap. These elements are deeply interconnected, as progress in one area reinforces outcomes in others.

From a financing perspective, Nigeria's continued dependence on out-of-pocket spending remains a major barrier to universal health coverage. Diversifying revenue sources through tax-based financing, including earmarked levies and carefully designed sin taxes, has been widely recognized as a viable pathway for reducing household financial burden and improving access to essential health services³¹. Alongside public funding, structured engagement of the private sector, particularly through public-private partnerships, offers opportunities to expand service coverage, improve efficiency, and reach underserved populations³². While donor funding cannot serve as a long-term solution, strategic and well-governed external support can play a catalytic role in piloting innovations and strengthening institutional capacity, provided it aligns with national priorities and avoids dependency³⁰.

Table 7: Integrated reform dimensions, key focus areas, and expected contributions to NHIS goals

Reform dimension	Key focus areas	Expected contribution to NHIS goals	Citation(s)
Tax-based financing	Earmarked levies and sin taxes to broaden revenue base	Reduced out-of-pocket spending and improved financial protection	Uguru <i>et al.</i> ³¹
Private sector engagement	Public-private partnerships in service delivery and management	Expanded coverage and improved efficiency	Onyedima <i>et al.</i> ³²
Strategic donor support	Time-bound catalytic funding for pilots and capacity building	Strengthened systems without long-term dependency	Adeoye <i>et al.</i> ³⁰
Performance-oriented design	Alignment of financing with service quality and accountability	Improved provider responsiveness and enrollee satisfaction	Alawode and Adewole ³³
Coverage expansion strategies	Simplified enrollment and targeted subsidies	Reduced inequities and improved access, especially in rural areas	Adeniran and Tayo-Ladega ³⁴

Financing reforms must be matched with performance-oriented strategies to ensure that expanded resources translate into tangible health gains. Evidence suggests that insurance coverage expansion has improved access to care in several states, yet persistent disparities remain, especially in rural and hard-to-reach areas^{33,34}. Addressing these gaps requires simplified enrollment processes, targeted subsidies for vulnerable populations, and strengthened provider payment mechanisms that promote efficiency and accountability. Design and implementation challenges within the NHIS, particularly those affecting service quality and provider responsiveness, highlight the importance of aligning financial incentives with performance outcomes³⁴.

An integrated reform pathway, therefore demands a systems-oriented roadmap that links financing sustainability with service delivery improvements and institutional strengthening. Such an approach emphasizes coordinated planning, stakeholder engagement, and adaptive learning to ensure that reforms remain responsive to Nigeria's evolving health needs. By embedding financing, performance, and reform priorities within a single framework, the NHIS is better positioned to deliver equitable, high-quality care and advance the national goal of universal health coverage.

Table 7 maps core reform dimensions to concrete focus areas and the expected contributions toward NHIS goals. It condenses five reform strands tax-based financing, private sector engagement, strategic donor support, performance-oriented design, and coverage expansion into a single comparative view.

A simple four-column layout: Reform Dimension, Key Focus Areas, Expected Contribution to NHIS Goals, and Citation; five content rows correspond to the reform strands described in the subsection. Visually, the table is a compact reference grid designed for quick comparison across policy levers and their intended effects on access, quality, and financial protection. Abbreviations: NHIS: National Health Insurance Scheme; PPP: Public-Private Partnership; sin taxes means taxes on products like tobacco and alcohol.

CONCLUSION

Nigeria's path to universal health coverage hinges on translating sound policy into sustained, coordinated action across federal and state levels. Strengthening governance, regulatory oversight, and transparent accountability must precede and accompany major financing reforms. Predictable domestic financing, including diversified revenue sources and timely provider payments, is essential to reduce out-of-pocket spending and protect the poor. Harmonizing state-level insurance schemes with national policy will improve equity, reduce fragmentation, and increase administrative efficiency. Digital monitoring systems linked to citizen feedback can strengthen performance oversight and make implementation more responsive. Future research should prioritize implementation science to test which delivery models scale best in Nigeria's political and fiscal context. Comparative cost-effectiveness studies of financing and provider payment models will guide efficient allocation of scarce resources. Investigation of political economy barriers and incentives at the state and federal levels will help design more durable reform

strategies. Operational research on community engagement and demand-side approaches can reveal practical ways to increase trust and uptake of services. Sustained political commitment, paired with evidence-driven policy adjustments and inclusive stakeholder engagement, will be required to secure long term, equitable gains in Nigeria's health system.

SIGNIFICANCE STATEMENT

This study discovered that Nigeria possesses strong legal and programmatic foundations for universal health coverage, yet persistent fragmentation in governance, unstable financing, and uneven implementation hinder equitable access to essential health services. The findings can be beneficial for policymakers, health system planners, and development partners in designing reforms that align federal and state actions, secure predictable domestic funding, strengthen regulatory oversight, and implement transparent monitoring systems linked to citizen feedback. By highlighting these gaps and trade-offs, this study will help researchers uncover the critical areas of governance, financing, and performance that many prior studies have not fully explored. Thus, a new theory on integrated, context-sensitive health system reform in low- and middle-income countries may be arrived at.

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