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The Political Economy of the Design of the Basic Health Care Provision Fund (BHCPF) in Nigeria: A Retrospective Analysis for Prospective Action

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ABSTRACT

Nigeria has instituted health financing reforms in the past, yet Universal Health Coverage (UHC) remains elusive and out-of-pocket spending accounts for over 70% of the country's total health expenditure. A current reform, the Basic Health Care Provision Fund (BHCPF), was established by the National Health Act of 2014 to increase the coverage of quality basic health services and promote UHC in Nigeria. However, there is limited knowledge of the political economy of health financing reforms in Nigeria and the impact on reform outcomes. This study applied the Political Economy Framework for Health Financing Reforms as described by Sparkes et al. in assessing the political economy of the BHCPF design. The study found that the BHCPF design was considerably influenced by the interplay of stakeholders' interests. The National Assembly was pivotal in ensuring the first BHCPF appropriation in 2018, and the Minister of Health, using donor-funded support, hastened the early BHCPF design. However, certain design elements were opposed by the legislature, bureaucratic and interest groups, which led to the suspension of the BHCPF and its subsequent redesign, led by bureaucratic groups. This produced changes in the BHCPF utilization, governance, pooling and counterpart funding arrangements, some of which increased the influence of bureaucratic groups and diminished the influence of the health ministry and external actors. These changes have implications for BHCPF implementation subsequently, including reduced accountability, potential stakeholders' conflicts, and fragmentation in external contributions. Understanding and managing these stakeholders' dynamics can create an accelerated consensus, minimize obstacles, and efficiently mobilize resources for achieving reform objectives.

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Introduction

Nigeria like many other low- and middle-income countries (LMICs) has subscribed to the principles of Universal Health Coverage (UHC) as its health policy vision.¹ The World Health Organization (WHO) 2010 World Health Report defined UHC as “ensuring that all people can use the promotive, preventive, curative, rehabilitative and palliative health services they need, of sufficient quality to be effective, while also ensuring that the use of these services does not expose the user to financial hardship.”² The UHC Service Coverage Index (SCI) measures the level of coverage of essential services. Nigeria's SCI—42 out of 100, which is below the African average (45.6)—indicates the low coverage of essential health services in the country.³ The low UHC SCI is largely attributable to the unfavorable health financing landscape in Nigeria. Public spending on health is suboptimal,

inefficient, and inequitable,⁴ and out-of-pocket spending accounts for over 70% of the total health expenditure, way beyond the 30% threshold recommended by the WHO.⁵ Meanwhile, it has been established that a predominant reliance on public financing for health is central to equitable progression on the path to achieving UHC, although different countries follow different trajectories and deploy differing mechanisms.^{6,7}

The Basic Health Care Provision Fund

The Basic Health Care Provision Fund (BHCPF), a specific-purpose inter-governmental fiscal transfer for health established by the National Health Act (NHAct) 2014,⁸ is one of Nigeria's responses to its unfavorable health financing landscape.⁹ The NHAct stipulates that the BHCPF is an earmarked fund for health to be

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financed with not less than 1% of the federal government's Consolidated Revenue Fund (CRF), in addition to contributions from donors, the private sector, and other sources. It also specifies that 50%, 40%, and 5% of the Fund should be allotted to and managed by the implementing gateways, i.e., the National Health Insurance Scheme (NHIS), National Primary Health Care Development Agency (NPHCDA), and National Emergency Medical Treatment Committee (NEMTC) 'gateways,' respectively, for the purchase of a Basic Minimum Package of Health Services (BMPHS) for Nigerians; purchase of drugs, PHC infrastructure and human resources for health; and the provision of emergency medical treatment (EMT).⁸

The fund flows through each gateway to their state-level counterparts, i.e., the State Social Health Insurance Schemes (SSHIS), State Primary Health Care Development Agencies (SPHCDA) and State Emergency Medical Treatment Committees (SEMTC), for implementation at the state level. As stipulated by the NHAct 2014, as a condition for BHCPF disbursement to states, state governments are required to provide counterpart funding, which is 25% of the total funds expected from the BHCPF disbursement.¹⁰

Beyond providing additional funding for expanding health access at the sub-national level, the BHCPF is expected to incentivize improved health spending by sub-national governments through counterpart funding. It is also expected to catalyze the sub-national implementation of key centrally driven health policy thrusts in the country, including the establishment of State Social Health Insurance Schemes (SSHIS) across the 36 states in the country and the Federal Capital, and the PHC Under One Roof (PHCUOR) policy.¹⁰

Political Economy of Health Financing Reforms

The growing realization that UHC and needed health financing reform efforts could be more political than technical gives prominence to the consideration of political economy in the design and implementation of health financing policies.¹¹ Political economy is defined as the study of politics and economics, specifically the interaction between them and their consequences for specific outcomes of interest.¹² It also includes the distribution of power and wealth between different groups and individuals, and the processes that create, sustain, and transform this relationship.¹³ Sparkes et al.¹⁴ highlighted the critical role of political economy analysis (PEA) in identifying strategies that enabled health financing reforms in Turkey and Mexico. As described by Sparkes et al.¹⁴ and Croke et al.¹⁵ in the case of health financing reforms in

Turkey and Mexico and Malaysia, respectively, the trajectories and ultimately the success or failure of the health financing reforms were driven by political economy factors. This emphasizes the importance of understanding the political economy of the BHCPF design, which will be instrumental in its successful implementation, since it is in the early stages of implementation. It will also guide the successful design and implementation of future health financing reforms in Nigeria and countries with similar contexts.

However, there are very limited studies available on the political economy of specific health financing reforms and mechanisms in Nigeria including the BHCPF. Ananaba et al.¹⁶ described how politically salient health issues are related to control over financial resources at the three levels of governance in Nigeria, often blocking or delaying reforms such as in the enactment of the NHAct 2014, which took 10 years from the first hearing before it was passed into law. This is also shown in the subsequently slow progress in the implementation of the Act.¹⁶ Onwujekwe et al.¹⁷ identified that the success and sustainability of the BHCPF may be impacted by the level of willingness and ability of sub-national governments to pay the statutory counterpart funding to the BHCPF.

At the time of writing this paper, we were not aware of any detailed study on the political economy of the BHCPF design. Hence, this study aims to examine the political economy of the BHCPF policy design and the lessons learned, to provide evidence which can be prospectively used to shape the BHCPF implementation and future health financing reforms toward achieving intended outcomes.

Methodology

Theoretical Framework

Fox and Reich¹⁸ identified interests, institutions, ideas and ideology as the main political economy elements that shape the design and implementation of UHC. Campos and Reich¹⁹ further identified six stakeholder groups that influence the course of design and implementation of health policies. The Campos and Reich's Political Economy Framework for Health Financing Reforms as described by Sparkes et al.¹⁴ was used for this study, alongside the consideration of Nigeria's political context following the approach of Sparkes et al.¹⁴ and Shiffman²⁰ in the application of the framework. The framework was adopted based on the evidence of its use in assessing health financing reforms,^{14,20-23} and its relevance to stakeholders' and political economy analysis as it reflects the key stakeholders and institutions,

their influence, interests, ideas and ideologies in a health reform process.

Stakeholder Groups

The Campos and Reich Framework identified six stakeholder groups that influence the course of design and implementation of health policies, namely: leadership politics, bureaucratic politics, budget politics, external actor politics, interest group politics, and beneficiary politics.^{14,19} Leadership Politics include the position of the reform relative to other pertinent policy issues and the commitment and actions of individuals or institutions with political power (both executive and legislative political leaders) capable of promoting, enabling and supporting the position of the policy. Bureaucratic Politics are the dynamics of the multiple levels of government agencies and administrative bodies responsible for designing and/or implementing policy. Budget Politics are the dynamics of the interactions of the health reform team with the groups responsible for the allocation and redistribution of government financial resources, which may either enable or slow down the reform process. External Actor Politics examine the influence of donor and partner groups who often support in-country interventions with funding and technical expertise on the reform design. Interest Group Politics are groups with varying levels of organization and influence, that are likely to oppose or support policies based on the alignment with their shared interests to minimize losses or increase gains. Beneficiary Politics include the behaviors and mobilization of individuals or groups, who are existing consumers or stand to benefit from the policy, which can be leveraged to promote the reform.^{14,19}

Political Context

In addition to the dynamics of these stakeholder groups, the role of Nigeria's political context in the BHC PF design was also examined. As described by Shiffman,²⁰ the shaping of reforms is not only dependent on the roles and actions of stakeholders but is also heavily influenced by the political and social structures of a country which may not be easily influenced by stakeholders' actions. As described earlier, Nigeria operates a federal system of government and its three tiers of government have a relative policy and financing decision-making autonomy, including for health.²⁴ This impacts the arrangement and performance of the health system in Nigeria, as it shapes the financing and disbursement formulas that determine the volume and efficiency of health spending and health goals, ultimately.²⁵ Therefore, the political context of Nigeria, particularly the federal governance structure and the

implications for the BHC PF design at the federal and state level, was considered for this study.

Research Approach

This study uses a qualitative approach to examine and describe the key stakeholders' dynamics in the design of the BHC PF, employing evidence from policy documents, implementation progress reports, media reports, and key informant interviews with relevant stakeholders involved in the policy process. The stakeholders interviewed (N = 20) were purposively sampled along the six stakeholder groups in the Campos and Reich Framework (Table 1). The stakeholders were selected based on the active involvement of their institutions in the BHC PF design, and whether they held an active role and were present during the design of the BHC PF. These included health and finance policymakers, legislators, development partners, health interest groups, civil society, and other stakeholders that work and engage directly with the beneficiaries. The interviews were conducted by four authors between October 2020 and May 2021. Informed consent was obtained from each respondent and for the interviews to be recorded. The audio recordings were transcribed verbatim and proof-read following each interview. The interview data were coded manually and using ATLAS.ti; deductive and inductive analysis was conducted.

Information from the interview respondents was compared against one another to check for consistency and triangulated with secondary data from the review of

Table 1. Interview Respondents.

S/N	Stakeholder Groups	Interviewees
	Leadership Politics	Federal Ministry of Health (FMoH) National Assembly (NASS) Forum of State Commissioners for Health Nigeria Governors Forum (NGF)
	Bureaucratic Politics	Federal Ministry of Health National Primary Health Care Development Agency (NPHCDA) National Health Insurance Scheme (NHIS) State Ministries of Health (SMoH) State Social Health Insurance Schemes (SSHIS)
	Budget Politics	Federal Ministry of Finance, Budget, and National Planning Budget Office of the Federation (BoF)
	External Actor Politics	World Bank Bill and Melinda Gates Foundation (BMGF)
	Interest Group Politics	State Social Health Insurance Schemes (SSHIS) Nigeria Medical Association (NMA) Healthcare Reform Foundation of Nigeria (HERFON) - Civil Society
	Beneficiary Politics	The Advocates - Civil Society International Society of Media in Public Health (ISMPH) State Social Health Insurance Schemes (SSHIS) PharmAccess One Campaign

laws and policy documents, operational guidelines, implementation and media reports on the BHCPF design. Interview data was also analyzed independently by two members of the research team and their interpretations were compared.

Results

Political Context

The political context, including the governance structure of a country, tends to modulate the outcomes of the interplay of the influence and interests of actors and institutions on public policy design and implementation.²⁰ Nigeria operates a federal system of government and its three tiers of government (Federal, State, and Local Governments) have a relative policy and financing decision-making autonomy, including designing policies, legislation, and financing the health sector.²⁴ This has implications for the country's fiscal imbalances and contributes to the country's health financing challenges,²⁶ and the arrangement and performance of the health system.²⁵

The Nigerian health system is primarily funded from the federation account (i.e., federally collected revenue) allocation to the Federal, State, and Local Governments,²⁷ statutorily entitled to 52.7%, 26.7%, and 20.6%, respectively.²⁸ However, the fiscal and administrative capacity of LGAs to fulfill their responsibilities remains limited; the LGAs generate minimal revenue and depend on funding from the federation allocations which account for over 50% of LGA financing, in addition to donor funding and interventions.²⁹ The effective financing of PHC services by the Local Government thus is limited.³⁰ The impact is clearly shown in the share of General Government Health Expenditure (GGHE) where the Federal, State and Local Governments contribute 43.2%, 48.2% and 8.6% of the GGHE, respectively.⁵

The BHCPF, an inter-governmental fiscal transfer, was necessitated by this political and fiscal federalism arrangement in Nigeria. Inter-governmental fiscal transfers are widely used in politically decentralized settings to improve subnational health funding and facilitate intergovernmental policy diffusion, both of which the BHCPF seeks to achieve.³¹ Other countries with similar complex political and administrative structures, such as India, Brazil, China and Mexico, have used specific-purpose inter-governmental fiscal transfers to partly correct the vertical fiscal imbalance, expand fiscal space and create incentives for pro-UHC reforms for enhanced efficiency and equity at sub-national levels.^{32,33}

The BHCPF provides additional funding at the PHC level and has accelerated the implementation of national health policy thrusts such as the SSHIS and the PHCUOR at the sub-national level. However, as opposed to a unitary system of government, where the central government can mandate certain actions by sub-national governments,²⁰ Nigeria's federal system confers a relative political autonomy on State Governments. This means that States will move at their own pace; hence, the observed variations in the speed of BHCPF design and implementation across States. The BHCPF resource allocation to States also mirrors the existing mechanism for the federation revenue allocation to state governments, which is based on population size and poverty levels.

Stakeholder Groups

The stakeholders examined under each category are presented in [Table 1](#) and a summary of the influence and interests of the stakeholders analyzed, with the corresponding impacts on the BHCPF design presented in [Table 2](#).

Leadership Politics

After the enactment of the NHAct in 2014, it was not until 2018 before the BHCPF was first included in the national budget through the influence of the National Assembly (NASS). This delay is partly attributable to the stalled BHCPF design process, which has witnessed several evolutions owing to the interplay of stakeholders' interests and influence to date. The appropriation was preceded by the efforts of the Minister of Health, who as the health sector reform leader in Nigeria⁸ led several advocacies to the NASS alongside health advocacy groups. The advocacies led to the launch of the Legislative Network for Universal Health Coverage (LNU) in July 2017, during which the legislators committed to ensuring the BHCPF appropriation in the 2018 budget.³⁴ To hasten the BHCPF design and implementation, the Minister of Health also solicited donor support, which provided the leeway for the co-mingling of donor contributions with the BHCPF and led to the design of the previous BHCPF Operations Manual, the establishment of the BHCPF secretariat, and piloting of the BHCPF in three states, all of which were donor-funded.³⁵ The previous BHCPF Operations Manual, approved by the National Council on Health (NCH) in 2018, was silent on the 25% counterpart funding requirement for state governments for the implementation of the fund.

The approval of the manual in 2018 by the NCH, being the highest policy and decision-making body for

Table 2. Summary of stakeholders' roles, interests and influence in BHCPF design and implementation.

Stakeholder group	Stakeholders analysed	Influence on BHCPF design	Interest in BHCPF Design	Impact of influence on BHCPF design
Leadership Politics	Honourable Minister of Health (HMH)	<ul style="list-style-type: none"> Steward and leader of health sector reforms Coordinator of the BHCPF policy processes Responsible for the approval of the BHCPF design 	<ul style="list-style-type: none"> Accelerating the design to hasten the commencement of BHCPF implementation Coordination of the BHCPF implementing agencies 	<ul style="list-style-type: none"> Led the initial design of the BHCPF which included the co-mingling of funds, waiver of states' counterpart funding and establishment of the BHCPF Secretariat, all of which were contested and contributed to the suspension of BHCPF implementation and its eventual redesign. Coordinated the implementing agencies in the BHCPF redesign. Facilitated the re-inclusion of the NCDC as a recipient and implementer of the fund.
	National Assembly (NASS)	Statutory functions of the NASS for Legislation, Appropriation, Oversight and Accountability	Compliance of BHCPF design with the NAct 2014	<ul style="list-style-type: none"> Facilitated the first BHCPF appropriation in the 2018 budget which rolled out the design Suspended BHCPF disbursements and ordered a redesign to comply with the law Enforced counterpart funding by States and ceded the BHCPF redesign to the federal implementing agencies (NPHCDA & NHIS) as stated in the law
	Nigeria Governors Forum (NGF)	Responsible for creating structures and providing counterpart funding for BHCPF implementation at the subnational level	Accelerating the design to hasten the disbursements of the BHCPF to states to commence implementation	Facilitated the BHCPF redesign by agreeing to contribute the 25% counterpart funding for the BHCPF.
Bureaucratic Politics	Forum of State Commissioners for Health	Health system steward at the subnational level	Oversight of BHCPF administration at the State Level	Establishment of State Oversight Committees for the BHCPF headed by the Commissioners.
	NPHCDA	Statutorily assigned by the NAct 2014 to implement the BHCPF and design the BHCPF operational guideline	<ul style="list-style-type: none"> Alignment of BHCPF with their existing PHC policy thrust, i.e. PHCUOR Autonomy to lead the BHCPF design and implementation 	<ul style="list-style-type: none"> Jettisoning of BHCPF Secretariat Removal of co-mingling of government and donor funds Harmonization of BHCPF with PHCUOR Design of the current BHCPF Operational Guideline
	NHIS	Statutorily assigned to implement BHCPF	<ul style="list-style-type: none"> Alignment of BHCPF with the existing NHIS policy thrust, i.e. decentralization into SSHIS Autonomy to lead the BHCPF design and implementation 	<ul style="list-style-type: none"> Jettisoning of BHCPF Secretariat Removal of co-mingling of government and donor funds Harmonization of BHCPF with SSHIS Design of the current BHCPF Operational Guideline
Budget Politics	NCDC	The NCDC Act 2018 claimed 2.5% of the BHCPF for public health emergencies	<ul style="list-style-type: none"> Receiving BHCPF disbursements and being a BHCPF implementing gateway 	<ul style="list-style-type: none"> Inclusion of the NCDC as a BHCPF implementing gateway
	Federal Ministry of Finance, Budget and National Planning (FMFBNP)	Responsible for funds appropriation and releases	<ul style="list-style-type: none"> Efficient utilization of earmarked funds through the waiver of states' counterpart funding Accountability for efficient management of the funds 	<ul style="list-style-type: none"> Facilitated the first appropriation for BHCPF in the 2018 budget which rolled out the design. Concerns of the FMFBNP on the efficient and accountable use of the fund prompted the initial hastened BHCPF design (and the counterpart funding waiver) by the HMH Made the BHCPF a Statutory Transfer
External Politics	Donors	Contribution of funds for BHCPF implementation	<ul style="list-style-type: none"> Accelerating the design to hasten the commencement of BHCPF implementation Efficient utilization of the Fund with transparency and accountability 	Initial BHCPF design including co-mingling of government and donor funds, setting-up of the BHCPF Secretariat and piloting of BHCPF implementation in three states, all of which were contested and contributed to the BHCPF suspension and its eventual redesign.
Interest group Politics	NMA	Critical professional group in the Nigerian health sector	Allocation of funds for medical emergencies from the BHCPF	<ul style="list-style-type: none"> Allocation of 5% of BHCPF to Emergency Medical Treatment Temporary removal of the NCDC as an implementer of the fund
	Forum of SSHIS Executives	BHCPF implementing gateway at the State level	Alignment of BHCPF with SSHIS operations	<ul style="list-style-type: none"> Alignment of BHCPF Provider-payment system to suit the SSHIS arrangement Using the BHCPF as to fund the SSHIS equity programs, hence, targeting of the vulnerable population as priority beneficiaries of the BHCPF

(Continued)

Table 2. (Continued).

Stakeholder group	Stakeholders analysed	Influence on BHCPF design	Interest in BHCPF Design	Impact of influence on BHCPF design
Beneficiary Politics	Civil Society Organizations & Media	Critical pressure group in Nigeria's health sector	<ul style="list-style-type: none"> Accelerating the design to hasten the commencement of BHCPF implementation Amplifying citizens' voice in the BHCPF design 	<ul style="list-style-type: none"> Enactment of the NHAAct 2014 and first BHCPF appropriation in the 2018 budget Mediated for resolutions of contentions including advocacies and support to sub-national governments Representation on critical BHCPF implementation committees including the Ministerial and State Oversight Committees
	Health consumers	Social accountability	Healthcare access and financial protection	<ul style="list-style-type: none"> Enactment of the NHAAct 2014 Raising the accountability bar for BHCPF Implementation

health chaired by the Minister and consisting of all the State Commissioners for Health, provided the leeway for the BHCPF disbursement to states without the provision of counterpart funding. Meanwhile, the Commissioners for Health across the 36 states created the Forum of Commissioners to enable effective engagement in the BHCPF design process with a strong and uniform voice. The lack of adequate involvement of the commissioners in the BHCPF design at the initial stage influenced the creation of the forum, and their key concern was to have a replica of the national oversight structure for BHCPF at the state level. This group was able to use its influence to address key concerns and actualize certain interests such as the drafting of the BHCPF operational guideline, the structure of the counterpart funding requirement, removal of the procedural bottlenecks in accessing the funds at the state level, and ensuring that the oversight role of the State Ministries of Health (SMoH) in the administration of the fund features prominently.

However, some of the BHCPF's initial design elements, particularly those that were not in alignment with the provisions of the NHAAct 2014, were contested by different stakeholder groups.¹⁰ The NASS opposed the waiver of states' counterpart funding, which was in contradiction to the provision of the law. In addition to other stakeholders' contentions with further aspects of the design, the NASS deployed their oversight role and suspended BHCPF disbursements between January to August 2020 to fix these misalignments.³⁶ This led to the jettisoning of the previous BHCPF operations manual and a new operational guideline was developed, with the enforcement of the payment of counterpart funding by states among other changes. The Nigeria Governors' Forum (NGF), consisting of the 36 State Governors in Nigeria, was majorly interested in ensuring the accelerated implementation of the BHCPF at the state level. Thus, they expedited the prerequisite State actions for BHCPF implementation, including the operationalization of the SSHIS, and reaching a consensus for the 25%

States counterpart funding which contributed to the lifting of the BHCPF suspension.

Bureaucratic Politics

The NHAAct 2014 made a provision to the BHCPF to purchase a basic minimum package of health care services, strengthen primary health care and provide emergency medical treatment to Nigerians. These functions, except the latter, aligned with the specific mandates of existing health agencies (i.e., NPHCDA and NHIS), hence, the Act conferred the administrative and implementing power of the Fund to these semi-autonomous health agencies, with the Federal Ministry of Health (FMoH) playing an oversight and coordinating role.

The NPHCDA was designated by the NHAAct 2014 to design the BHCPF guidelines, subject to the approval of the Minister.⁸ However, this statutory responsibility was usurped by the FMoH at the initial stage of design and contributed to the opposition and subsequent delays in implementation. According to a respondent, *"When the Ministry of Health did not recognize the role of NPHCDA, it created a body within the Ministry which they called Secretariat of the Fund, and that Secretariat produced a Manual which was not acceptable to all the gateways including the States and that is why we have that setback for 2 years."*

The NPHCDA and NHIS, assigned as BHCPF implementing entities by the NHAAct 2014,⁸ contested the establishment of the donor-funded BHCPF Secretariat in the FMoH, as they believed the secretariat diminished their roles in the reform process, including in the initial BHCPF operational guideline design. This resulted in the jettisoning of the Secretariat and the removal of comingling of donor funds, following the BHCPF suspension in 2020 by the NASS. Therefore, the NPHCDA and NHIS led the design of the subsequent BHCPF guidelines, with supervision by the FMoH.¹⁰ Through this, both agencies leveraged the BHCPF to advance their existing policy thrusts, i.e., the NHIS decentralization policy and the NPHCDA's PHCUOR policy.¹⁰ This also

increased the overall influence of both agencies over the BHCPF design and their subsequent roles and power in the implementation processes. Nonetheless, the FMoH, being the supervisory entity, ensured that they maintained a coordinating role in the BHCPF implementation through the establishment of the Ministerial and State-level BHCPF Oversight Committees chaired by the Minister of Health and the States' Commissioners of Health respectively.

Although the NHAct 2014 did not list the National Center for Disease Control (NCDC) as an implementing entity for the fund, the NCDC Act 2018 claimed 2.5% of the BHCPF under the 5% EMT gateway allocation, owing to the mandate of the NCDC to handle public health emergencies.³⁷ Thus, in the first cycle of the BHCPF disbursement in 2019, NCDC received 2.5% of the BHCPF as an implementer of the fund.³⁸ However, the role of the NCDC as an implementer of the Fund was disputed by interest groups who argued the differences between public health emergencies (NCDC's mandate) and emergency medical treatment (the NHAct provision). These disputes eventually led to the removal of the NCDC as a recipient of the fund in the revised BHCPF Operational Guidelines approved in 2020.^{10,38} However, the NCDC was reintroduced as an implementer of the fund in 2022 following consultations of the Minister of Health with the Attorney General of the Federation (AGF) on the legality of the NCDC Act 2018 vis a vis the provisions of the NHAct 2014.

Budget Politics

During the drafting of the NHAct 2014, health sector stakeholders made a case for 2% of the CRF to be earmarked for the BHCPF, mirroring the existing earmarked Universal Basic Education (UBEC) Fund, which was equally 2% of the CRF. Following several back and forth in the ten-years journey for the NHAct 2014 enactment, 1% of the CRF was successfully earmarked for the BHCPF.

However, the finance ministry harbored concerns about the operationalization of the BHCPF, which also contributed to the delays in the BHCPF implementation. The Minister of Finance had concerns that with the counterpart funding requirement, the BHCPF would follow the same pattern as the UBEC funds, which were lying dormant in accounts without being used productively, due to the inability of state governments to provide the matching counterpart funding.³⁹ This concern and the need to speed up the BHCPF implementation preceded the decision by the NCH to waive states' counterpart funding, to assure the immediate productive use of the BHCPF to provide services to the

beneficiaries. This was accepted by the finance ministry and enabled the BHCPF disbursement to eligible states in 2019 before the NASS stepped in to ensure conformity with the law and enforced the counterpart funding requirement.

Also, following the appropriation of the BHCPF in 2018, the Budget Office of the Federation (BoF) was initially very skeptical about making the BHCPF a statutory transfer for the same reason. They were equally keen on ensuring that the fund is used per the provisions of the NHAct 2014 and disbursed to the appropriate channels and beneficiaries. Thus, the ministry of finance demanded the availability of the disbursement guidelines before the appropriated funds could be released. These concerns contributed to the hastened design of the initial BHCPF manual and other necessary financial management requirements. A respondent revealed, *“So that’s part of the reason why the DG said it’s not going to be a statutory fund; you need to demonstrate how you want to use this money before releases could be done. At that point there were no accounts, the appropriation was done even before they started creating the accounts and there were just so many things that hadn’t been done yet.”*

External Actor Politics

External actors formed part of the advocacy group that pushed for the NHAct enactment and the BHCPF provision within the Act. They also advocated alongside other pressure groups for the first BHCPF appropriation in 2018. The NHAct made provisions for donors' contribution to the BHCPF,⁸ and with their initial funding, they held significant influence in the early stages of the BHCPF design.³⁵ The interests of the external actors included ensuring that the funds were spent efficiently, with a high level of transparency and accountability, hence their vested interest in the co-mingling of government and donor funds. As stated by a respondent, *“That itself provided an attraction for institutions like the World Bank and other development partners, because it then meant that if you have a co-mingled account, you are going to have a high level of transparency and accountability.”* However, the BHCPF implementing agencies opposed the co-mingling as they believed it yielded undue influence to external actors in the BHCPF design. Thus, the co-mingling of funds was eventually removed.

Also, external funding supported the set-up and staffing of the BHCPF secretariat and the development of the initial operational guideline. These facilitated the BHCPF disbursement by the Ministry of Finance and the BHCPF piloting in three states.³⁵ However, this support was met with strong opposition from the

implementing agencies, with questions about the legality and role of the secretariat. The opposition led to the disbandment of the secretariat, which external actors believe has eroded the over-arching platform for accountability and oversight of BHCPF implementation. *“The main gap is the role of the secretariat as the over-arching coordination structure for BHCPF implementation. Right now, implementation is so fragmented. It is one agency on its own,”* said a respondent.

Beneficiary Politics

Civil Society Organizations (CSOs) and the Media gave the needed push that led to the enactment of the NHAct 2014. The media played a pivotal role in educating the public and galvanizing public support for the NHAct 2014 before it was passed into law. The Market Women Association in the Federal Capital Territory also mobilized a mass visit to the National Assembly to raise the sense of urgency in enacting the NHAct 2014.³⁵ However, in the design of the BHCPF, beneficiaries have not been directly involved. As potential beneficiaries of the fund, CSOs form the core beneficiary politics that have engaged directly in the BHCPF design at the Federal and state levels. *“Civil society groups are the voices for those vulnerable persons and at every stage of the development of the policy (BHCPF), civil society groups were involved and had grassroots presence. So, to that extent, they (beneficiaries) were involved, not directly, but by proxy,”* a respondent echoed.

CSOs are represented on key health reform implementing committees such as the National Health Financing Technical Working Group (TWG), National Health Act Implementation Group, NHIS forum, NPHCDA TWG and the BHCPF Oversight Committees at the national and state levels.¹⁰ Thus, they have bridged the gap between the policymakers and citizens and contributed to promoting the interests of the citizenry in the BHCPF reform process. The major interest of these groups is ensuring that the Nigerian populace, particularly the vulnerable population, gets increased access to quality health care at no cost. They advocated to state governments and supported state entities to set up the prerequisites for the implementation of the BHCPF in states, such as the SSHIS. They also played a mediation role among contending stakeholder groups at the national level, and are promoting citizens' awareness of the BHCPF, to enhance transparency and accountability. The media has also continued to amplify the voice of health advocates on the BHCPF and provide design and implementation updates to the public to increase awareness and influence the utilization of the fund by beneficiaries.

Interest Group Politics

The major interest groups that have featured prominently in the BHCPF reform process include the Forum of the SSHIS Chief Executives Officers (CEOs) and the Nigeria Medical Association (NMA). The NMA's interest was founded on ensuring that the BHCPF catered for medical emergencies and their repeated advocacies led to the 5% allocation of BHCPF to emergency medical treatment in the NHAct 2014, supported by the premise of the proliferation of road traffic accidents and no emergency medical treatment system in the country at the time. Also, the NMA, in 2016 threatened to take legal action against the Federal Government for the delayed implementation of the NHAct, particularly the BHCPF.⁴⁰ Following the BHCPF appropriation, the NMA protested the disbursement of 2.5% of the EMT fund to the NCDC for public health emergencies. *“The initial consideration was to have half of that 5% allocated to the NCDC for public health emergencies, and we protested! because that particular provision is not for that, it is not for biosecurity, it is not for epidemic preparedness and response,”* according to a respondent.

On the other hand, the Forum of SSHIS CEOs was concerned about the BHCPF governance arrangement and ensuring that the insurance-related operations of the BHCPF aligned with the SSHIS structures. The forum pushed for the BHCPF to be an additional fund for financing the existing SSHIS equity programs, rather than become a parallel fund in states. The Forum also successfully ensured the BHCPF benefits package and provider-payment system aligned with those already employed by the SSHIS. The forum was able to achieve these based on the extension of the power as the state replica of the NHIS gateway.

Discussion

The roles, influence and interests of stakeholders immensely shaped the BHCPF design both positively and negatively in varying magnitudes. The six stakeholder groups played critical roles at different points that led to the progression of the policy design, but also stalled the process at other times when stakeholder interests overrode the common consensus. While budget and external actor politics set the tone for the initial stage of the BHCPF design, leadership, bureaucratic and interest group politics ultimately had the greatest influence and beneficiary politics held the least influence in the BHCPF design process.

Critical Political Economy Dynamics in the BHCPF Design

The leadership politics as influenced by the Minister of Health, being the overarching steward of the BHCPF policy, waived some requirements for States' qualification in the initial BHCPF design. This was in response to the influence and demands of budget actors regarding the modalities for effectively utilizing the fund before disbursing it and making it a statutory transfer. External actor politics provided the funding that aided this initial design phase, hence, their significant influence at the time. However, the initial BHCPF design was overturned by bureaucratic politics (NPHCDA and NHIS) who, although empowered by the NHAct 2014 to lead the BHCPF design process, felt sidelined due to their ineffective participation in the early stages of design.

There were also tensions between the external actors and bureaucratic politics that ensued from the perception that the FMoH was deferring too many policy decisions to external actors because of the funding they contributed. This decision space tension eventually led to the removal of the co-mingling of donor and government funds, as part of the efforts to reduce the influence of external actors. The mobilization of the bureaucratic groups to protect and promote their interests coupled with the misalignments of the early BHCPF design with the provisions of the NHAct 2014 led to a debate that necessitated the national legislature (leadership politics) to deploy their statutory role in upholding the provisions of the law. Thus, they reversed the policy waiver to States, dissolved the BHCPF Secretariat and gave the bureaucratic groups the power to lead the redesign of the BHCPF.

These dynamics show clearly that although high political power and influence can increase the speed of policy implementation, inadequate representation and inclusiveness of critical groups can result in an overturn of tides. It also emphasizes the need for the health ministry to respect the mandate and territories of their health agencies by conferring the rightful autonomy to these agencies in shaping the design of health reforms directly related to their mandates.

At the initial stage of the BHCPF design, the FMoH, in an attempt to establish its coordinating role in the BHCPF implementation, did not cede the needed autonomy to the BHCPF implementing agencies, despite the power conferred on both agencies by the NHAct as the administrators and implementers of the BHCPF and its design. This action by the FMoH left room for different contentions, delays and the ultimate redesigning of the policy by the federal bureaucratic agencies. With the BHCPF redesign, some stakeholders view the oversight

role of the federal and states' ministries of health on BHCPF implementation as diminished under the current structure where the federal health bureaucracies (NPHCDA and NHIS) communicate directly with their state replicas (SSHIS, SPHCDA).

Similar to the bureaucratic politics, the mobilization of interest group politics also yielded significant influence in the BHCPF design, as they were able to defend their respective interests, leveraging on the power of their coalitions for a strong voice. Interest group politics (particularly the NMA) during the process of the NHAct 2014 enactment led to the allocation of 5% of the BHCPF to medical emergencies in the Act. This group also vigorously opposed the allocation of half of the medical emergencies funding to the NCDC at the inception of the BHCPF design. This opposition resulted in the temporary removal of NCDC as a beneficiary of the fund before its eventual re-inclusion.

Beneficiary politics played a key role in expediting the enactment of the NHAct 2014 which established the BHCPF, and beneficiaries, as represented by civil society organizations, are represented on all key BHCPF decision-making platforms. However, beneficiaries have not been directly involved in the BHCPF design and there is low awareness among the citizenry on the BHCPF. Hence, there were no key beneficiaries-led interests which featured prominently both at the initial and subsequent stages of the BHCPF design.

In addition, the political context of Nigeria, particularly the federal structure of governance played a significant role in shaping the BHCPF design for sub-national level implementation. Although the BHCPF is an inter-governmental fiscal transfer created to augment PHC funding at the sub-national level, the federal level stakeholders as empowered by the NHAct 2014 held the most influence in the design of the BHCPF. The resultant design elements have yielded some positive impacts, such as the accelerated implementation of national health policy thrusts at sub-national levels. These include the establishment of State Social Health Insurance Agencies, State Primary Health Care Development Agencies and Local Government Health Authorities (LGHA), all of which are designed as prerequisites for the implementation of the BHCPF in states.

The limited influence of these state and local government stakeholders, however, may impede the successful implementation of the BHCPF subsequently. Achieving early stakeholders' consensus in a politically decentralized setting could be difficult and the considerable gaps in stakeholders' management in the BHCPF design contributed to the contentions recorded. These gaps in addition to the diminished influence of sub-national stakeholders in the BHCPF design decision-making

space may foster implementation challenges. More so, federalism allows significant policy autonomy for sub-national governments. This, therefore, necessitates effective dialogue and consensus-seeking in making critical decisions on the policy direction that has implications for all tiers of government.

Implications of the Political Economy of the BHCPF Design on Its Implementation

The political economy dynamics of the design of the BHCPF as detailed above have led to its evolution from the initial design phase with critical changes in some design elements—which have implications for BHCPF implementation subsequently. Chief among these are the changes in the governance arrangements, unmingling of donor funds with government funds, the conformity with the requirement of counterpart funding by states, and the allocation of funds from the BHCPF for medical and public health emergencies.

The changes in the governance arrangements, particularly the disbandment of the BHCPF secretariat, have implications for reduced transparency and accountability in BHCPF implementation across all levels. The BHCPF secretariat previously served as the central coordination point for BHCPF implementation, data gathering and dissemination across all gateways. The secretariat helped boosted transparency and accountability with easy accessibility of BHCPF implementation data for all stakeholders. However, with the jettisoning of the secretariat, there is an observed gap in central data processing and dissemination for BHCPF implementation, which may result in reduced transparency and accountability for the fund implementation across all levels. The Ministerial and State Oversight Committees for the BHCPF implementation may be able to assuage this challenge if the platforms are effectively leveraged to enshrine transparency and accountability across all levels.

Also, with the direct correspondence of the federal health bureaucracies (NPHCDA and NHIS) with their state replicas (SSHIS, SPHCDA), there is a perceived reduction in the influence of the federal and state ministries of health. This poses a threat of potential friction among the state health entities in the implementation of the fund at the state level. Similarly, the limited influence of state and local government entities in the BHCPF decision-making space may hinder the adequate implementation of the fund at the state and local government levels. Therefore, the BHCPF reform team must consider this context and manage the dynamics and ensure all relevant stakeholders are effectively engaged in decision-making to achieve a smooth and successful policy implementation.

The modifications to the counterpart funding waiver in the BHCPF redesign also pose a significant threat to the successful implementation of the fund. If state governments are unable to produce matching counterpart funds for the implementation of the BHCPF, then the funds may also continue to lay dormant in states' accounts without being put to productive use. Thus, mirroring the same pattern as the UBEC funds, which was a key concern of the budget actors before the commencement of the BHCPF disbursement.

Another key change is the unmingling of donor funds with the 1% of the FG CRF, which has introduced fragmentation into the BHCPF pool and may ultimately reduce the size of the fund available for direct BHCPF implementation. With the previous arrangement, donors could contribute directly to the BHCPF pool which then flows directly to health service delivery at the PHC level. As a result, donors were a key part of the BHCPF governance arrangement and held significant influence in the decision-making of the BHCPF design and implementation. However, with the current unmingled arrangement, there is a reduced influence of donors in the governance and oversight of the BHCPF implementation and donors have become less enthusiastic about contributing to the BHCPF.

Also, at the time of writing the paper, the entire size of the BHCPF pool relies solely on the 1% of the FG CRF, while donor contributions have become fragmented, which is less efficient. More so, external actors expressed the preference for co-mingling as a means to ensure a high level of transparency and accountability in the fund implementation. However, other stakeholders thought the influence of external actors in the BHCPF governance should be minimized to ensure a high level of local ownership in the BHCPF implementation and reduce the vulnerability of the BHCPF to external influence. Hence, the unmingling could promote increased government ownership and reduced vulnerability of the BHCPF management to external influences.

A prominent outcome of the political economy of the BHCPF design is the eventual allocation of funding to the NCDC, which has implications for financing health security in Nigeria. Prior to its temporary removal as a recipient, the initial funding received by the NCDC from the BHCPF was very instrumental in bridging key health security funding gaps and can be linked to Nigeria's improved Joint External Evaluation (JEE) Score to 46% in 2019 from 39% in 2017.^{38,41} With the re-inclusion of NCDC as a recipient of the fund, although at a lower proportion of the BHCPF, there will be more available funding to bridge health security gaps and prospectively further improve Nigeria's JEE score further down the line.

Lessons for Stakeholders' Management in the Design of Health Financing Reforms in Nigeria

The interplay of stakeholders' influence and interests in the BHCPF design provides valuable lessons that reform teams can take into account when planning the design of a future health financing reform in Nigeria.

Firstly, the successful design of a health financing policy reform requires striking a balance between the speed of design, stakeholders' participation and consensus, especially where strategies not backed by the law are being proposed. In the case of the BHCPF, the Health Minister's efforts to speed up the BHCPF implementation through waivers of certain requirements and donor funding was opposed due to a lack of consensus by bureaucratic groups, which led to the suspension of the policy implementation. As a consequence of this, certain stakeholders' interests, particularly the external actor politics, had to be sidelined to achieve consensus. Therefore, it is important for reform teams to recognize which stakeholders' interests must be captured and which interests can be sidelined in the reform design, without threatening its survival. Such trade-offs were made in the BHCPF design, as consensus was not reached with all stakeholders.

Secondly, the ability of the leadership structures to create and manage coalitions with other actors and interest groups to promulgate policy implementation is essential. The collaborative efforts of the Ministry of Health and other advocacy groups including external actors led to the BHCPF appropriation by the NASS in 2018. However, the ineffective collaboration between the Ministry and the NHIS and NPHCDA at the inception of the BHCPF design led to the contentions of the bureaucratic groups.

Another key lesson is that the alignment of new policy reform design with the existing policy direction of key institutions (especially the health sector bureaucracies) is an important determinant of their interest in health financing policy reforms. The NHIS and NPHCDA saw the BHCPF as a potential tool for advancing their health insurance decentralization and PHCUOR policies, respectively. Likewise, other stakeholder groups had specific interests that they strongly protected. This has important implications for future health policy design, which could receive support from health sector bureaucracies if such reform will create an impetus for accelerated implementation of their existing policies. Policy entrepreneurs should, therefore, explore win-win opportunities and alignments while canvassing health financing policy reforms. In this study, it was seen

that a wide range of actors very favorably supported the BHCPF implementation, however, they wanted their interests to be well protected in the design and the subsequent implementation.

Finally, the BHCPF design process highlighted the need to deepen the understanding of stakeholders on the technical aspects of the new policy reform to minimize tension and ensure a more seamless policy adoption and design. The minimal understanding of the concept of inter-governmental fiscal transfers, which underpins the BHCPF, made different actors perceive the BHCPF in diverse ways, which contributed to the contentions and delays encountered. Reform teams need to make deliberate efforts to deepen the knowledge and build the capacity of a wide array of stakeholders on the policy subject matter.

Conclusion

The design dynamics of the BHCPF policy in Nigeria were outcomes of the interaction of the varying interests and the influence of different groups. Our analysis of this process shows that health policy design processes can be more political than technical. The findings underscore the importance of understanding the political economy of designing health financing policy reforms, including the powers, roles, and interests of key stakeholders (the six stakeholder categories) and how these can support or delay and prevent the reform design. The analysis also emphasizes the need to understand the extent of stakeholders' consensus attainable and the need to sideline certain interests and forge ahead toward ensuring the reform design is not truncated. In addition to the importance of stakeholder consensus, this study highlights the important role of context and legal frameworks in designing and implementing policy reforms. The development of laws should be highly participatory and include a mechanism for direct participation by the populace. This could have affected how actors prioritized progress over interests. Political actors need to be cognizant of the changing dynamics of political power while negotiating for interests and should seek mutual benefits.

Understanding and applying the political economy knowledge will play a crucial role in the further redesign and implementation of the BHCPF, especially as it is still in an early implementation stage. It will also facilitate the design and implementation of future health financing reforms in Nigeria. A good understanding and real-time application of the political economy within appropriate contextual factors can create a win-win consensus, accelerate the pace of implementation, and mobilize the

needed resources to achieve health financing reform objectives while ensuring that windows of opportunity are effectively leveraged and optimized.

Recommendations

- For the success of health financing reforms in Nigeria, at the inception of the design, there is a need for stakeholders mapping, effective engagements with all identified stakeholders and deploying a more participatory approach.
- It is important to strike a balance between speed of the policy design and effective stakeholders' participation.
- It is important to deepen the knowledge on key stakeholders in Nigeria on the concept of health financing and Universal Health Coverage reforms to expedite the design and implementation process.
- There is a need to align health financing reforms with existing policy thrusts of health agencies in the country for a better buy-in of stakeholders, synergy and seamless implementation.
- Due to the federal nature of Nigeria, it is important to effectively engage the subnational authorities to maximize the input and buy-in of subnational governments in the policy design and implementation.
- Disbursement of the BHCPF should be based on performance rather than population size and poverty levels.
- Health sector actors should take advantage of pandemics and other crises to attract more political attention toward needed health financing reforms.
- The BHCPF requires improved coordination mechanisms among implementing gateways, to fill the vacuum created with the jettisoning of the BHCPF secretariat.
- Nigeria's health financing landscape will benefit from fiscal devolution, especially to further correct the vertical fiscal imbalance.

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Contributors

GA conceptualized the study. All authors participated in the design of the research. AA, ABA, GA and CC collected the study data. ABA and GA conducted data analysis and wrote

the draft with key input from AA. CC, FI, ZM and AA provided edits and feedback. All authors revised and approved the manuscript.

Data Availability Statement

All literature used in this study are publicly available, while interview data are kept confidential.

Informed Consent

Informed consent was obtained from all individual participants in the study and additional informed consent was obtained to audio record respondents.

Ethical Approval Statement

The National Health Research Ethics Committee (NHREC) in the Federal Ministry of Health, Nigeria approved this research (NHREC/01/01/2007-02/09/2020).

Patient and Public Involvement Statement

Patients or the public were not involved in the design, conduct, reporting, or dissemination plans of this research.

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