LAGOS STATE
MINISTRY OF HEALTH

SUB-NATIONAL HEALTH ACCOUNT

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Lagos State Ministry of Health

Sub-National Health Accounts 2020-2021

Final Report

February 2023

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Foreword

It gives me great pleasure to present this comprehensive and essential report on Subnational Health Account (SNHA). In an era of decentralized governance and growing regional disparities, understanding how health resources are allocated and utilized at subnational levels is crucial for effective health planning and equitable service delivery. This pioneering work is a testament to the commitment and collaboration of multiple stakeholders who share a common goal: improving the health and well-being of our citizens.

As we strive to achieve universal health coverage and sustainable development goals, it becomes increasingly evident that a one-size-fits-all approach is insufficient. Every region, state, or province within our nation has unique health challenges, resources, and priorities. Subnational Health Accounts offer a groundbreaking framework to assess health expenditures, resource allocation, and the overall performance of health systems at subnational levels. By providing granular insights into healthcare financing and utilization patterns, this report equips policymakers, planners, and healthcare providers with the tools they need to make informed decisions and allocate resources more effectively.

The data and analysis presented in this report enable us to identify disparities, inefficiencies, and opportunities for improvement in our healthcare delivery systems. Armed with this knowledge, we can formulate evidence-based policies that target the specific needs of each subnational region, fostering greater inclusivity and leaving no one behind in our journey towards better health outcomes for all.

This policy document would be widely disseminated to health and finance institutions, donors, Non-Governmental Organizations (NGOs) as well as interested parties in health care management, provision, and financing.

I encourage all stakeholders, from policymakers and health administrators to researchers and advocates, to engage with the findings of this report actively. Let us come together to chart a path that harnesses the potential of subnational health accounts to drive positive change and elevate the health and well-being of our citizens.

In closing, I sincerely hope that this report serves as a catalyst for meaningful dialogue and action, inspiring us all to collaborate and innovate in the pursuit of healthier, happier communities. Together, we can build a stronger, more resilient healthcare system that empowers individuals and enables our nation to flourish.

Dr. Olusegun Ogboye
Permanent Secretary, Health

Acknowledgments

The 2020-2021 Lagos State Subnational Health Account depicts the flow of resources in the health sector, including expenditures for all activities whose primary purpose is to restore, improve, and maintain public health.

This achievement was spearheaded by the Health Financing and Economics Unit of the Directorate of Health Care Planning, Research, and Statistics (HCPRS) under the Ministry of Health, with invaluable support from our esteemed partners, the German Corporation for International Cooperation (GIZ) and Global Fund.

The realization of this document's final form owes much to the commitment and unwavering support from a myriad of individuals, institutions, and organizations. The Ministry extends its sincere gratitude to the Enterprises, Donor Agencies, Implementing Partners, Non-Governmental Organizations, Health Facilities, and Ministries, Departments, and Agencies (MDAs). Their invaluable contribution of data was indispensable in ensuring the comprehensive execution of the SHA survey.

Equally deserving of commendation is the Federal Ministry of Health, the National Bureau of Statistics, and the State Bureau of Statistics. Their consistent support throughout every stage of the process was instrumental in transforming the vision of the SHA survey into reality.

We also express our profound appreciation for the technical support provided by CHECOD - Africa Team. Their guidance and expertise were pivotal in achieving the methodological precision required for a project of this magnitude.

Our success was further buoyed by the dedication of every individual who participated in the workshop; engaged in fieldwork; meticulously cleaned and mapped data; conducted thorough data analysis; and contributed to discussions surrounding the Subnational Health Account. Their collective diligence and perseverance played an indispensable role in shaping the final document.

In closing, the Ministry extends its deepest gratitude to Dr. Dayo Lajide and her team, including Dr. Oluwatosin Ijimakinwa, Dr. Chinyere Gift-Okorie, Dr. Olutomike Ajose, and others from the Directorate of Healthcare Planning and Research within the Ministry of Health. Their tireless efforts were pivotal in steering the process to its successful conclusion.

This document stands as a testament to the power of collaboration, innovation, and dedication. It is a reflection of the collective resolve to advance public health in Lagos State.

Dr. Olusegun Ogboye
Permanent Secretary, Health

Acronyms

CHE	Current Health Expenditure
CHECOD	Centre for Health Economics and Development
CSOs	Civil Society Organizations
FCT	Federal Capital Territory
FMOH	Federal Ministry of Health
GDP	Gross Domestic Product
HAAT	Health Accounts Analysis Tool
HAPT	Health Accounts Production Tool
HEFAMAA	Health Facility Monitoring and Accreditation Agency
HFG	Health Finance and Governance Project
HMOs	Health Maintenance Organizations
HNLSS	Harmonised Nigeria Living Standard Surveys
HSC	Health Service Commission
ICT	Information Communication Technology
IGR	Internally Generated Revenue
LASHMA	Lagos State Health Management Agency
LASUTH	Lagos State University Teaching Hospital
LBS	Lagos State Bureau of Statistics
LCDA	Local Council Development Areas
LGAs	Local Government Areas
LSACA	Lagos State AIDS Control Agency
LSHS	Lagos State Health Scheme
LSMOH	Lagos State Ministry of Health
MDAs	Ministry/Department/Agency
NBS	National Bureau of Statistics
NGN	Nigerian Naira
NGOs	Non-Governmental Organizations
NHA	National Health Accounts
NHIS	National Health Insurance Scheme
NCDs	Non-Communicable Diseases
NTDs	Neglected Tropical Diseases
OECD	Organisation for Economic Co-operation and Development
OOP	Out of Pocket
PPP	Public Private Partnerships
SDG	Sustainable Development Goals
SHA	System of Health Accounts
SNHA	Subnational Health Accounts
THE	Total Health Expenditure
UHC	Universal Health Coverage

UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
US$	United States Dollar
WHO	World Health Organization

Executive Summary

The National Health Account (NHA) describes the sources, uses, and channels for all funds spent in the production and consumption of healthcare goods and services in the country. Although the Federal Ministry of Health (FMoH) has conducted several NHA studies, there are methodological concerns regarding representativeness of the national health system at the state level, and these challenges minimize the utility of NHA for decision-making at the subnational levels. Thus, Lagos State Ministry of Health (LSMoH) conducts Subnational Health Accounts (SNHA) studies in order to generate evidence for policy at the state level.

The Lagos SNHA study for 2020-2021 was carried out in accordance with the accounting framework of 'System of Health Accounts (SHA) 2011' and proceeded in accordance with the national guidelines on health accounts production. The study was based on data systematically collected from households, health insurance institutions, enterprises other than health insurers, health facilities, government ministries, departments, and agencies (MDAs), donors and non-governmental organizations (NGOs).

Estimated Total Health Expenditure (THE) was 870.2 billion in 2020 and N990.0 billion in 2021 of which N851.2 billion (97.8%) and 963.0 billion (97.3%) respectively were Current Health Expenditures (CHE).

- Estimated household health expenditure was N746.0 billion in 2020 and N839.4 billion in 2021 accounting for 87.6% and 87.2% respectively of CHE. The burden of health financing on households is considerably too high.
- Expenditure by government (at all levels) was N72.2 billion (2020) and N92.5 billion (2021). Expenditure by corporations, Nonprofit Institutions and Donors reduced from 3.9% (2020) to 3.2% (2021) of CHE occasioned primarily by decrease in donor financing from N11.0 billion to N9.2 billion. Public financing of healthcare (sum of government budgetary funding, donor budget support and social insurance) increased from 8.9% to 9.8% of CHE. Limited public financing raises vulnerability of households to financial risks.
- Secondary hospitals received the largest share of CHE at 55.5% in 2020 and 2021. Notably, more funds were channeled through PHCs- 9.7% (2020) and 9.8% (2021) than tertiary hospitals- 6.1% (2020), 6.4% (2021). Curative care received the highest shares of CHE at 78.5% (2020) and 78.1% (2021). Next was preventive care at 12.0% each year.

The preponderance of OOP expenditures by households was observed in the financing of priority intervention areas (diseases)

- Expenditure on HIV/AIDS in 2021 was N35.4 billion (3.7% of CHE). Households contributed approximately N24.2 billion (68.4%), Government at all levels provided N5.0 billion (14.2%), Corporations provided N90.9 million (0.3%), and Donors provided N6.0 billion (17.0%).

- Expenditure on Tuberculosis (TB) in 2021 was N78.8 billion (8.2% of CHE). Households contributed N70.0 billion (88.9%), Government (all levels) funded N6.8 billion (8.6%), Corporations provided N498.1 million (0.6%) and Donors - N1.5 billion (1.9%).
- Expenditure on Malaria in 2021 was N235.9 billion (24.5% of CHE). Households contributed N216.1 billion (91.6%), Government (all levels) provided N18.2 billion (7.7%), Corporations provided N1.6 billion (0.7%) and nonprofit institutions provided N1 million.
- Expenditure on Reproductive Health in 2021 was N137.4 billion (14.3% of CHE). Households contributed N120.9 billion (88.0%), Government (all levels) provided N14.2 billion (10.3%), Corporations provided N1.1 billion (0.8%), Donors provided N1.0 billion (0.8%), and Non-Profit Institutions provided N105.2 million (0.1%).
- Expenditure on Non-Communicable Diseases (NCDs) in 2021 was N83.0 billion (8.6% of CHE). Households contributed the highest share of N71.0 billion (85.5%), Government (all levels) provided N11.5 billion (13.9%), and Corporations provided N540.6 million (0.7%).
- Expenditure on Nutritional Deficiencies in 2021 was N66.3 million (0.01% of CHE). Government contribution of N10.8 million (16.3%) was provided by the Federal Government only. Households contributed N55.4 million (83.5%) and Corporations provided N0.1 million (0.1%).
- Expenditure on Neglected Tropical Diseases (NTDs) in 2021 was N23.8 billion (2.5% of CHE). Households contributed the highest share of N20.8 billion (87.2%). Government (all levels) provided N3.0 billion (12.4%). Corporations provided N90.3 million (0.4%).

Per capita THE increased from N31,897.7 (2020) to N35,162.7 (2021). Out-of-Pocket (OOP) household spending as a proportion of CHE declined slightly from 87.3% (2020) to 86.8% (2021) but is still very high compared to the benchmark of 30-40%. Although there is marked progress in resource pooling into the Lagos State Health Scheme (LSHS) and National Health Insurance Scheme (NHIS), payments through the schemes remain very low at 0.6% of CHE. Improvements in coverage of prepayment and financial risk protection mechanisms are needed to reduce the burden of healthcare financing on households, increase utilization of preventive services and improve household welfare.

On the part of government, health budget performance has not been optimal at an average of 76% between 2017 and 2021. Budget allocation to the health sector averaged 8% of total budget, leaving a gap of 7% relative to the Abuja declaration target of at least 15%. These are indicative of potential for increases in government spending.

Public financing of current expenditures increased from 6.8% in 2017 to 9.8% in 2021, reflecting progress in state health insurance scheme coverage, government budgetary spending and Basic Healthcare Provision Fund (BHCPF). However, progress toward universal health coverage (UHC) by 2030 requires that this share grows very rapidly. Although there is no specific benchmark for public financing, it is expected to reach a minimum of 50% of current expenditures for the purpose of UHC.

Given the position of Lagos state as the largest industrial economy in Nigeria and the outstanding leader in internal revenue generation, employment-based healthcare benefits by private employers, government budgetary financing and earmarks are key potential sources of predictable and sustainable financing of healthcare in the state. Although limited, data on employment-based healthcare benefits indicate potential for sustainable healthcare resource mobilization in the state. In the sample of enterprises used for health account estimation, 60% of sampled employers that provide healthcare benefits are small enterprises (10-49 employees). However, only 20% of small enterprises offering healthcare benefits do so through health insurance, indicating a large room for expanding health insurance pools. Thus, the state government needs to engage the private sector on provision of employment-based healthcare benefits, while the state health management agency also needs to engage them on embracing health insurance mechanisms. The plans offered by the state insurance scheme are currently limited to government employees, individuals, and families with a view to expanding coverage of households. The focus needs to scale up coverage of private sector employees and the informal sector.

The three leading consumers of current spending – vaccine preventable diseases (VPDs), malaria and reproductive health – accounting for 64% of current spending are dominantly primary care level issues. However, secondary hospitals provide the leading share of services suggestive of expensive primary care services which contribute to the high level of OOP spending. Given the strength of health insurance institutions and employers in negotiating service tariffs to the effect of bringing down the cost of care, this phenomenon necessitates rapid expansion of health insurance coverage at the level of individuals, households, and employers.

Donors' current expenditure dwindled from N11.8bn in 2017 to N9.2bn in 2021. Of these, the amount provided as budget support, which is more likely to align with the state government's priorities, increased from N900m in 2017 to N1.5bn in 2021. In percentage terms, donor budgetary support as a share of total support increased from 8% in 2017 to 16% in 2021. Further progress in alignment of donor support with the priorities of the state government should translate to increases in this measure.

Providers of health financing include 49 HMOs and the state social health insurance agency (LASHMA). There are indications that private health insurance companies are more successful with enterprises than households and may explain the predominant focus of the social health insurance agency on households and individuals. Notwithstanding, there is ample opportunity for LASHMA to upscale coverage of enterprises across all sectors, especially microenterprises. Through partnership with insurance companies, banks and other financial institutions are making inroads into health insurance under the bancassurance guidelines provided by the National Insurance Commission (NAICOM). Efforts are needed from a broad spectrum of stakeholders to address the weaknesses in the health financing landscape in the state and make progress toward universal health coverage (UHC).

1. Introduction

National Health Account

The National Health Account (NHA) documents and characterizes the flow of resources in a country's health sector, including expenditures for all activities whose primary purpose is to restore, improve, and maintain health. The NHA describes the sources, uses, and channels for all funds used in the production and consumption of healthcare goods and services. Expenditures towards production of healthcare are explored along with the main funders in a health system. These are primarily the public sector (government), the private sector (employers and households) and development partners.

Health accounts deliver lessons from past expenditure to support effective planning, efficient resource allocation and accountable resource utilization. The NHA is an important input in the planning processes of a country as it:

- traces how resources are mobilized and managed, who pays, and how much is paid for healthcare;
- tracks the provision of goods and services, and how resources are distributed across these goods and services;
- provides policymakers with information (such as the overall resource envelope in the sector and the resource outlay among the various actors) for policy and dialogue on health financing;
- can be used to validate data and evidence from other sources in the country (triangulation).
- enables a country to track the outcomes of health sector reforms and general changes in health financing.
- can be used to compare trends in expenditure across different countries and measure performance against international benchmarks.

Time and space boundaries are important for the accurate production of health accounts. Estimates are based on cash accounting, that is, actual health expenditures incurred during the fiscal year under review, from 1st January to 31st December. The NHA includes health expenditures for the Nigerian 36 States, the FCT and the Federal level.

The Federal Ministry of Health (FMoH) adopted NHA to inform effective implementation of interventions by decision-makers tasked with delivering the best possible combination of healthcare services to the populace. The FMoH has learned from NHA studies throughout the years, and these lessons have informed health financing policy and strengthened the government's position as steward of the health sector.

Policy Objectives of the NHA

The major objective of the health accounts is to show how health resources are used, on what services, by which providers, through which schemes and for whom. Health Accounts will be used to track health spending trends and offer the necessary data to help decision-makers better understand health system issues and boost system performance. Specifically, the NHA is expected to answer the following policy questions:[1]

1. How are resources mobilized and managed for the national health system?
2. Who pays and how much is paid for health care?
3. Who provides goods and services, and what resources do they use?
4. How are health care funds distributed across the different services, interventions, and activities that the health system produces?
5. Which health providers benefit from health care expenditure?
6. What is the comparison between funds released to and funds received by benefiting entities within the national health system?
7. What is the level of resources mobilized for health within the country by development partners?
8. What is the Total Health Expenditure (THE) for the country?
9. What is the level of expenditure for preventive and curative health care?

The NHA provides answers to these questions and others through the lens of health financing functions – revenue generation, resource pooling and purchasing of services, as seen in Figure 1.

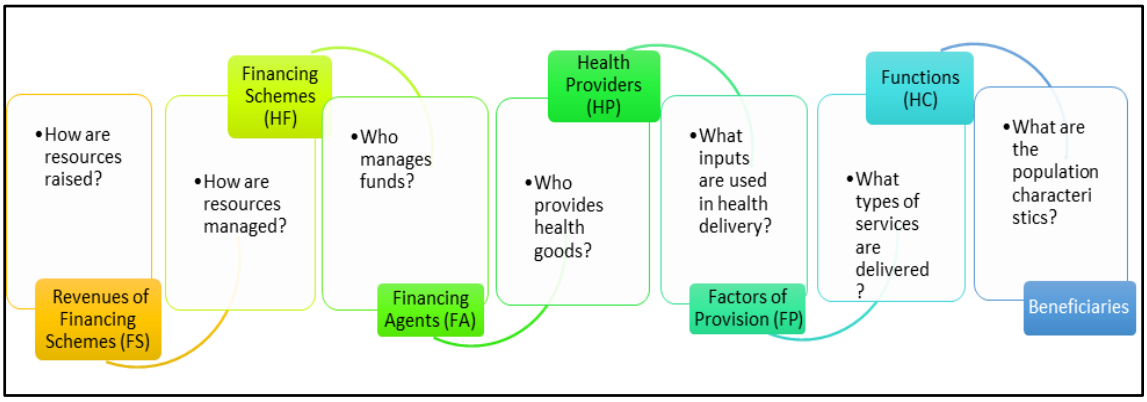

Figure 1. Questions Lagos SNHA seek to answer

In addition, expenditures on priority health interventions are estimated. These include reproductive health, human immunodeficiency virus/acquired immune deficiency syndrome

[1] Federal Ministry of Health, National Health Account (NHA) Implementation and Training Manual; 2010.

(HIV/AIDS), tuberculosis, malaria, non-communicable diseases (NCDs) and neglected tropical diseases (NTDs).

History of Health Accounts in Nigeria

NHA studies have been successfully conducted and reported by the Federal Ministry of Health (FMoH) for the years 1998-2002, 2003-2005, 2006-2009, 2010-2014, 2015-2016, 2017, 2018, 2019 and 2020 in order to provide information for health policy and resource mobilization from internal and external sources, and to reform public financial management frameworks. Through financing sources, financing agents, types of health providers, and types of health services, the NHA estimates provided thorough overviews of the nation's health expenditure trends (health care functions).

Rationale for Sub-National Health Accounts

NHA estimates are considerably limited in answering policy questions at the subnational level. Health policy and planning in the country is based on fiscal federalism and autonomy of the federating states. Health expenditures aggregated in the NHA are not completely amenable to disaggregation at subnational levels. Where disaggregation is possible, there are methodological concerns regarding representativeness of the national health system at the level of federating states. These challenges minimize the utility of NHA for decision-making at the subnational levels. Thus, the FMoH adopted the strategy of guiding States in the conduct of their State Subnational Health Accounts (SNHA) and subsequently aggregating the SNHAs into the NHA. The implementation guidelines provided a unified framework to ensure standardization of processes and comparability of the output across the 36 states and the FCT.

Lagos State has successfully conducted health account studies for the period 2015-2019. The estimates have guided the development of investment cases for health, formulation of health financing policies and strategies, and informed other health financing-related activities in the State.

Organization of the Report

This report is organized into 6 Chapters, followed by appendices. This Chapter (Chapter 1) provides background on the concept of national health accounts and history of NHA and SNHA production in Nigeria. Chapter 2 highlights Lagos state context and several demographic and health indices necessary for computing health accounts indicators. Chapter 3 describes the approach and methodology used in the study and concludes with limitations of the study. Chapter 4 presents the general Lagos SNHA findings. Chapter 5 provides an overview of expenditure on priority disease areas while policy discussions appear in Chapter 6.

2. Lagos State Context

Political Context

Lagos State was created on May 27, 1967, through the States Creation and Transitional Provisions Decree No. 14 of 1967 which restructured Nigeria's Federation into 12 States in Nigeria. The state is bounded on the North and East by Ogun State, to the West by Republic of Benin and to the South by the Atlantic Ocean. Approximately 22% of its area of 3,577km² are lagoons and creeks.

As a federating state of Nigeria, Lagos State runs a democratic system of Government with the three (3) arms of Government. These include the executive arm currently led by His Excellency Governor Babajide Olusola Sanwo-Olu, the legislative arm comprising forty (40) members with two (2) members representing each of the twenty (20) LGAs, and the Judicial arm. The State is administratively divided into three (3) Senatorial Districts, twenty (20) Local Government Areas (LGAs), thirty-seven (37) Local Council Development Areas (LCDAs), and three hundred & seventy-four (374) political wards.

Figure 2. Map of Lagos State showing LGAs

Macro-Fiscal Context

Lagos state is the economic, financial, and commercial nerve centre of the West-African sub-region and the fifth largest economy in Africa. It ranks as the most industrialized economy in Africa. The city of Lagos is projected to be the second largest urban agglomeration in sub-

Saharan Africa region and 11th largest in the world by 2030, up from 18th in 2018[2]. The rapid population growth is influenced in large part by continuous inflow of migrants seeking economic opportunities from other Nigerian states and the rest of West Africa.

The State exhibits a high concentration of residential, industrial, commercial, educational, and military facilities; accounts for over 60% of Nigeria's industrial and commercial activities, and about 30% of national branch network of banks. The economy benefits substantially from high revenues accruing from the entertainment industry, the booming information, communication, and technology (ICT) sector, and its extensive seaport which is the largest in continental Africa.

Table 1. Lagos State Economic and Population Indices (2016-2021)

	2016	2017	2018	2019	2020	2021
Agriculture -N' Trillions	0.4	0.3	0.3	0.3	0.3	0.3
Mining and Quarrying -N' Trillions	0.0	0.0	0.0	0.0	0.0	0.0
Manufacturing -N' Trillions	2.8	3.1	2.9	2.9	2.8	3.0
Construction -N' Trillions	0.6	0.6	0.6	0.7	0.7	0.7
Human Health and Social Services -N' Trillions	0.9	0.9	1.0	1.0	1.0	1.0
Trade -N' Trillions	12.1	13.9	15.0	15.7	14.0	14.8
Other Services -N' Trillions	10.3	9.5	9.7	10.3	11.0	10.8
Total GDP -N' Trillions	27.1	28.3	29.6	30.9	29.7	30.6
GDP Growth Rate (%)		4.43	4.59	4.39	(3.88)	3.03
Population (Millions)	24.1	24.8	25.6	26.4	27.3	28.2

Source: Lagos State Ministry of Economic Planning and Budget (GDP figures), Lagos Bureau of Statistics (Population figures)

Internally generated revenue (IGR), with taxation as the major source, remains the dominant component of the state's revenue over the years, and accounts for 64.1% of total revenues in 2020. The state records the highest of IGR among all federating states.

Table 2. Revenue Generation in Lagos State (2016-2020) (N' Billions)

	2016	2017	2018	2019	2020
IGR	302.4	333.9	501.2	398.7	418.9
Non-IGR	133.9	259.8	58.1	182.3	234.8
Total Revenue	436.3	593.7	559.3	581.0	653.7
IGR/ Total Revenue (%)	69.3	56.2	89.6	68.6	64.1

Source: Lagos State Treasury Office, Medium Term Budget Framework 1996-2020

[2] United Nations, Department of Economic and Social Affairs, Population Division (2019). World Urbanization Prospects: The 2018 Revision (ST/ESA/SER.A/420). New York: United Nations.

Demography & Epidemiology

Lagos was originally inhabited by the Awori group of the Yoruba people. Today, it has a very diverse population due to incessant migration from other parts of the country and surrounding countries. While Yoruba is the dominant ethnic group, there are more than 250 ethnic groups in Lagos, including the Hausa, Igbo, and Fulani. Small minorities of American, British, East Indian, Chinese, white Zimbabwean, Greek, Syrian, Lebanese, and Japanese are also present in the State. In the mid-19th century, many ex-slaves of Afro-Brazilian and Afro-Cuban descent and immigrants from Sierra Leone created communities in Lagos, along with ex-slaves from the Americas, and became missionaries and merchants in the city.

With land area of 3,577 square kilometers and a projected population of 28.2 million in 2021, Lagos is one of the densely populated states of Nigeria. Lagos State is dominated by a working-age population with persons aged 15-64 accounting for 62.2% of total population. Children of age 5 and below represent 12.4%, those aged 6-14 represent 20.4% while the elderly aged 65 and above account for 4.9%[3].

Lagos state is increasingly facing the problem of a double disease burden. Although the epidemiological profile is dominated by infectious diseases, deaths from non-communicable diseases are on the rise.

As a mega city, Lagos state faces environmental pollution and pockets of urban slums resulting from rapid population growth. These negatively impact the health status of the population, disease patterns and adaptability of the health system.

The Healthcare System

Lagos State has a broad and decentralized health care delivery system consisting of a wide range of service providers including public, private-for-profit and private-non-profits (faith-based and other non-governmental organizations).

Key institutional managers of the healthcare system include the Lagos State Ministry of Health (SMoH); Lagos State Primary Healthcare Board (LSPHCB); Lagos State Health Management Agency (LASHMA); Board of Traditional Medicine; Lagos State AIDS Control Agency (LSACA); College of Health Technology, Health Facility Monitoring and Accreditation Agency (HEFAMAA); Lagos State Blood Transfusion service (LSBTS); Health Service Commission (HSC), Lagos State University Teaching Hospital (LASUTH); the Lagos State University College of Medicine and Hospital Governing Boards of the public secondary health facilities.

[3] National Bureau of Statistics (NBS). Nigeria Living Standards Survey-2018/2019.

Private and public health facilities are registered and monitored by the Healthcare Facilities Monitoring and Accreditation Agency (HEFAMAA) established by the Health Sector Reform Law of 2006 and functioning as an agency of the State Ministry of Health (SMoH).

The Primary Healthcare Board coordinates the public primary health care facilities while the Health Service Commission coordinates the public secondary health care facilities.

The State Ministry of Health has an oversight role over all the health facilities in the State, both public and private excluding the federal facilities which fall under the purview of the Federal Ministry of Health.

Healthcare is dominantly privately provided including investor-owned hospitals, group practice hospitals and sole proprietorships with rosters of consultants. There are also nurse-led maternity clinics, with links to doctors that are available for call-ups.

Revenue sources for health financing include government, individuals/households, private institutions, and development partners. Public health resources are derived from taxes, loans, grants, and in-kind donations. Development partners provide financial assistance through the government and direct health program implementation. Households contribute directly to health financing through insurance premiums and out-of-pocket payments, and indirectly through taxes. Firms contribute to health financing through social and private health insurance contributions and premiums, own health facility, workplace program, contract with providers, staff reimbursement, corporate social responsibility on health and indirectly through taxes. Government's expenditure on health ranges from healthcare services, infrastructure, health workforce remuneration to different priority disease areas. However, increased prominence of the share of public, compulsory, and prepaid funding in the health financing mix is essential to achieving progress toward UHC.

Public Private Partnerships (PPP)

Lagos State Public Private Partnership Law, 2011 has been crucial to filling the resource gaps in the health system[4]. Below are some of the successful public-private partnerships in the sector.

1. Mortuary Services: The State Government partnered with TOS Funerals, Caring Global Resources Ltd and Farewell Funeral Homes Ltd for the operationalization and management of mortuary services in some public health facilities such as LASUTH,

[4] The statutory regime for PPP has evolved from the Lagos State Roads, Bridges and Highway Infrastructure Development Board Law enacted in 2004, to the more streamlined Lagos State Roads (Private Sector Participation) Authority Law passed in 2007 and finally to the PPP law of 2011.

General Hospital Isolo, Mainland hospital Yaba, General Hospital Lagos and Gbagada General Hospital

2. Diagnostic/Laboratory services: in order to ensure the availability of Diagnostic and Laboratory services, the State Government outsourced some high-end laboratory and diagnostic services including pathology, histology, and radiology services in some of its public owned hospitals. Some of the organizations include Alpha Mead Diagnostics at General Hospital Gbagada, Arrive alive diagnostics and imaging services at General Hospital Isolo, The specialist laboratories Nigeria Limited, Echolab radiology and laboratory services and Ikons Systems Limited at General Hospital Randle
3. Revenue collection: in order to ensure accountability and transparency, the State Government outsourced the e-collection of payments at State secondary health facilities to Megalek Nigeria Limited. This PPP arrangement is operational in General Hospitals Gbagada, Isolo, Randle, Ibeju-Lekki, Orile-Agege, Ifako-Ijaiye, Shomolu, Mushin and Harvey Road Health Centre.
4. Pharmaceutical Services: to operate a fee-paying pharmacy that would ensure availability of adequate, safe, effective, and affordable drugs to patients who patronize the pharmacy, the State is in PPP arrangement with LOBA Pharmacy Ltd for General Hospital Lagos, L'Pacemaker Pharmacy for LASUTH and Delmar Medipros for Joint Venture Pharmacy.

Other PPPs include blood screening services outsourced to Banner Diagnostics International Centre, Facility management outsourced to Elvinas Investment and Logistics LTD, E-Health program outsourced to Software Business Solutions Consulting at General Hospital Isolo, Ophthalmology services outsourced to Rachel Ventures at LASUTH, Radiology services in General Hospital Ikorodu outsourced to Hospital Assist Nigeria Ltd and many others.

Healthcare Delivery and Outcomes

The coverage of essential health services in Lagos State compares favorably with national averages, owing majorly to active participation of private sector in healthcare delivery (see Table 3).

Table 3. Selected health service delivery indicators: Lagos State vs. National Average

Service	State Coverage (%)	National Coverage (%)	Data Source
Attendance of at least 4 ANC visits (any provider)	94.2	60.4	NMICS 2021
Attendance of at least 1 ANC visit (skilled provider)	90.8	69.6	NMICS 2021
Delivery by SBAs	91.1	50.7	NMICS 2021
Institutional delivery	86.7	49.0	NMICS 2021
Children 12-23 months fully vaccinated	66.0	36.0	NMICS 2021
Contraception among married/ in union women (any method)	45.3	21.7	NMICS 2021
Birth registration coverage	93.7	57.3	NMICS 2021

Source: National Bureau of Statistics (NBS) and United Nations Children's Fund (UNICEF). August 2022. Multiple Indicator Cluster Survey 2021, Statistical Snapshot Report. Abuja, Nigeria: National Bureau of Statistics and United Nations Children's Fund.

Lagos state has made remarkable progress with curtailing neonatal mortality rate to 11 per 1,000 live births and under-5 mortality rate to 15 per 1,000 live births, both below the 2030 SDG targets of 12 per 1,000 live births and 25 per 1,000 live births respectively (see Table 4).

Table 4. Selected health outcomes in Lagos State

Service	Value	Data Source	SDG Target
Neonatal mortality rate	11/1,000 live births	NMICS 2021	12/1,000 live births
Under-5 mortality rate	15/1,000 live births	NMICS 2021	25/1,000 live births

Source: National Bureau of Statistics (NBS) and United Nations Children's Fund (UNICEF). August 2022. Multiple Indicator Cluster Survey 2021, Statistical Snapshot Report. Abuja, Nigeria: National Bureau of Statistics and United Nations Children's Fund.

3. Methodology

System of Health Accounts (SHA)

The Lagos SNHA estimation for 2020-2021 was carried out in accordance with the accounting framework of 'System of Health Accounts (SHA) 2011' used by OECD countries. This accounting framework was adopted in Nigeria by Federal Ministry of Health in conjunction with 36 States and the Federal Capital Territory (FCT) Ministries/Departments of Health. The SHA framework is an internationally comparable standard for reporting expenditure on health. It classifies health expenditures according to the three axes of consumption, service provision and financing (Figure 3) based on the principle that "whatever is consumed has been provided and paid for". The purpose is to provide policymakers with timely and accurate information they require for identification of health system challenges and improvement of health system performance.

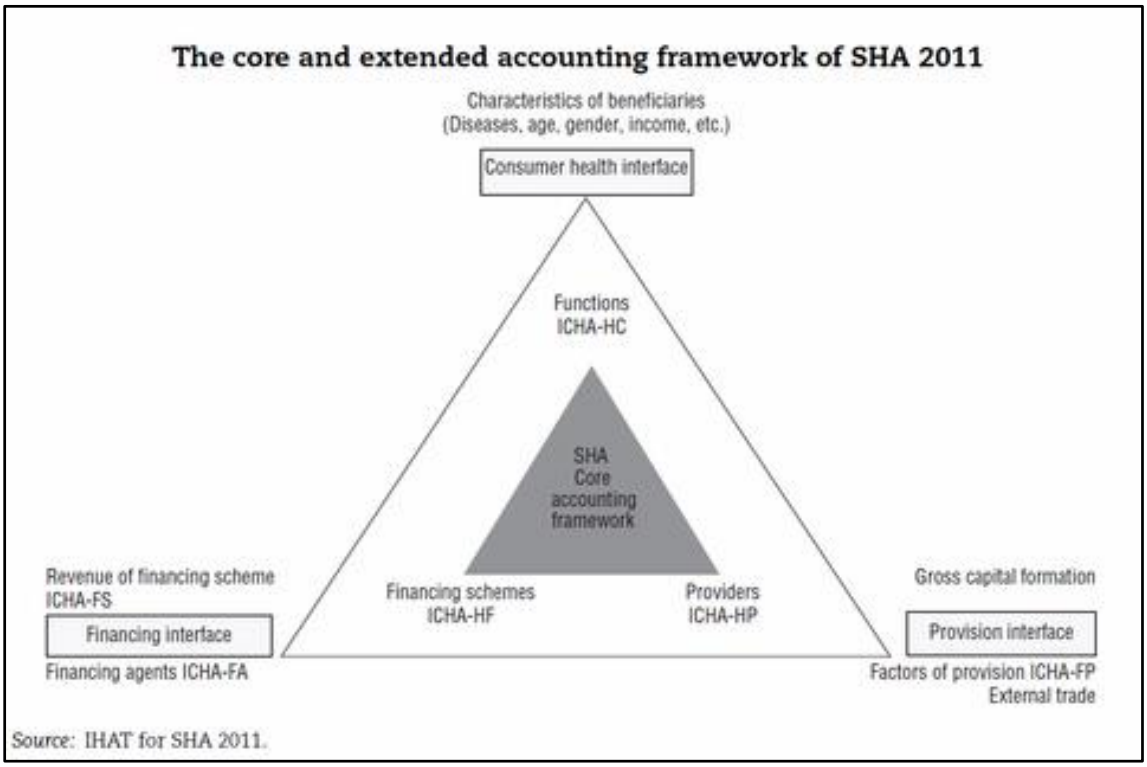

Figure 3. SHA Framework

In specific terms, the SHA model provides the structure for estimating health expenditures that are amenable to international, sub-national and sub-accounts comparisons. The framework defines the boundaries of health care activities to include "*all spending activities whose primary purpose is to improve, maintain and prevent the deterioration of the health status of individuals, groups of a population or the entire population of the nation* or *state".*

This is the guiding principle underlying the health accounts production tool (HAPT), a software application developed jointly by USAID's Health Finance Governance (HFG) project, World Health Organization (WHO) and the World Bank with contribution and backing from countries. Its development was informed by the need to reduce complexity in the documentation and methodology of measuring financial resource flows in the health sector and to enhance the comparability of outcomes across countries.

The key functions of the HAPT include:

- Provision of step-by-step guidance to country teams on health accounts estimation procedure.
- Creation of conducive platform to deal with complex databases and thereby reduce the problems associated with data management.
- Generation of survey questionnaires and import functions that allow for easy storage and retrieval of data within the tool as well as the alignment of data collection with data analysis method.
- Facilitation of review and adjustment for double counting of expenditures with its in-built auditing function.
- Automation of data mapping.
- Provision of interactive diagram that enables data entry personnel and analysts to visualize the flow of funding among entities in the health sector.
- Production of automatically generated health accounts tables.

Although HAPT provides standard core classifications as provided by the System of Health Accounts (SHA), it can be customized by country NHA teams to allow for country-specific codes and peculiarities. The HAPT in-built survey questionnaire was generated to produce four questionnaires for donors and bilateral agencies, NGOs, insurance companies and employers.

Data Collection

HOUSEHOLD ESTIMATES

Household health expenditures were estimated based on data from the cross-sectional household survey conducted in the state in 2020. The survey instruments included modules on household demographics, asset wealth, household expenditures (non-health), health care utilization, health care expenditures and willingness to pay for healthcare financial protection. The sampling strategy was based on the sampling frame used for the Nigeria Demographic and Health Survey (NDHS) 2018 and the Harmonised Nigeria Living Standard Surveys (HNLSS) 2018/19. The sampling strategies of both surveys were designed to produce reliable estimates for key indicators at the national level, for urban and rural areas in the six geographical zones. Based on their sample design, the survey applied state-level sampling strategy and stratified by senatorial districts, urban and rural areas. The final sample comprised 3400 households from 340 enumeration areas (EAs). Household health

expenditure for 2021 was estimated from the data with adjustments for inflation and population growth.

ENTERPRISE SURVEY

Private employer component includes spending on workers' health through social and private health insurance premiums, own health facility, workplace program, contract with providers, staff reimbursement as well as corporate social responsibility on health. A multi-stage sampling method was used in the selection of enterprises from all sectors in Lagos state. Within each sector, employers were stratified by numbers of employees and from each stratum, a systematic random sampling technique was used to select 500 enterprises. 356 survey tools were successfully completed, yielding a response rate of 71.2 percent.

HEALTH FACILITY SURVEY

Health facility component includes both recurrent and capital expenditures of public and private health facilities (primary, secondary, tertiary) and disease-specific cost of healthcare services. The survey was conducted to provide guidance on the distribution of expenditure by disease categories. A total of 34 out of 72 sampled facilities responded, yielding a response rate of 47.2 percent.

GOVERNMENT MINISTRIES/DEPARTMENT/AGENCIES PARASTATALS

Sources include Ministry of Health, Ministry of Economic Planning and Budgeting, Office of the State Auditor General and LGA Auditor General, Ministry of Local Government and Chieftaincy Affairs, Local Government health departments and Federal Ministry of Health. Documents collected include the state auditor general's report, state budget, local government auditor general's report and local government health department expenditure.

HEALTH INSURANCE SURVEY

The health insurance survey covers the number of enrollees, total health insurance premium received, funds received for health-related insurance, and funds disbursed to benefiting entities. Information was also collected on the nature of health services rendered (e.g inpatient, outpatient, pharmaceuticals). Lagos State Health Management Agency (LASHMA) and 15 of 49 health maintenance organizations (HMOs) completed the survey, yielding a response rate of 32 percent. The team observed that most insurance companies claimed their clients registered online and enjoyed direct communication with the head office. Direct communication between the client, the insurance company's head office and the service providers denied the branch offices direct access to their clients' data, hence enumerators were referred to their head offices for the required information.

DONOR SURVEY

The donor component captures the total financial assistance to Lagos state for health care interventions and services channeled through budgetary support and direct program interventions. It captures expenditure on program management and coordination, technical assistance and actual amount development partners spent on health goods and services. A

total of 12 donor agencies in the state were contacted but only 5 completed the survey, yielding a response rate of 41.7 percent.

NON-GOVERNMENTAL ORGANIZATION SURVEY

NGOs receive support from donors (both international and local). From the catalogue of all NGOs operating in Lagos State, a list of those working in the health sector was drawn. The NGO module captures the actual health revenue received from different sources and the total expenditure on health programs/activities in the state. Also, the actual amount spent on health care facilities, ambulatory health care centres, providers of medical goods and general health administration was included. The team contacted a total of 45 NGOs/CSOs but only 9 responded yielding a response rate of 20 percent.

Table 5. Survey Response Rates of Contacted Data Sources

Entities	Number Contacted	Number Responded	Response rate (%)
Households	3,400	3400	100
Enterprises	500	356	71.2
Health Insurance Institutions	50	16	32.0
Donor Agencies	12	5	41.7
NGOs/CSOs	45	9	20.0
Health Facilities	72	34	47.2
Government	State Auditor-General Report		100
	State Budget		100
	Local Government Auditor-General Report		100
	Local Government Health Department Approved Budget/Expenditure		94.7

Data Audit

During data collection exercise, data audit for quality checks was conducted on retrieved questionnaires. The audit involved careful and thorough examination of each instrument for completeness and consistency. In a situation where data collected were seen to be incomplete, ambiguous or were perceived to be untrue, such data were returned to the team supervisor for clarification or completion by the institution(s) involved. If there were reasons to doubt truthfulness of collected data, the enumerator was contacted for clarification. Calls were also put across to some entities for clarification of the information provided. Audited questionnaires were collated and arranged for data entry and mapping.

Data Cleaning and Entry

The dataset obtained from the Ministries, Departments and Agencies (MDAs) at all tiers of government was entered into Microsoft Excel templates. Since the survey questionnaires for donor agencies, NGOs, enterprises, and health insurance institutions were generated from

the HAPT, the completed survey instruments were entered into the respective HAPT templates. Entry was made by data entry participants in groups consisting of two personnel, with quality assurance carried out by the data entry personnel, and groups exchanging their excel files for peer review and correction of errors where necessary. Completed entry files were collated by a supervisor who arranged the data sources in the HAPT. The data captured in the HAPT were cleaned and validated for quality and completion checks.

Data Mapping

The data mapping exercise was conducted using Health Accounts Production Tool (HAPT) version 4.0.0.6 under the supervision of CHECOD Africa personnel to promote agreement on classification of uncertain line items, engender knowledge sharing among participants and ensure effective mapping of dataset to agreed classifications.

All line items were mapped along the tri-axial relationship expressed by the extended SHA framework: Revenues of financing schemes, Financing agents, Health financing schemes, Health care providers, Factors of provision, Health care functions and Beneficiary characteristics. Distribution rules were employed for expenditure line items that were non-disease specific and unspecified by health care functions.

Data Analysis and Report Writing

All data mapped in HAPT were reviewed using the cross tabs to have a single cleaned study file. The study file was linked to Health Accounts Analysis Tool (HAAT) for analysis and tabulations. Standard SHA tables and Time Series were generated and exported to Microsoft Excel for tabulation, visualization, and further analysis. Following the technical validation of the analysis and tabulations, the technical report was produced. Among other things, the study provided answers to the following questions:

- How are resources mobilized and managed in the health system?
- Who pays and how much is paid for health care?
- Who provides goods and services and what resources do they use?
- How are health care funds distributed across the different services and activities that the health system produces?
- Who benefits from health care expenditure?
- What is the level of resources mobilized for health within the state by development partners?
- What is the Total health expenditure (THE) for the state?
- What is the level of expenditure for preventive and curative health care?
- What is the share of social and private insurance to general health expenditure?

Quality Assurance

The health accounts estimation process is subjected to quality assurance at different stages- team composition, study tools development, analysis, and reporting. The study team was carefully selected to ensure compliance with standard procedures. Participants were drawn from the Lagos State Bureau of Statistics, Lagos State Ministry of Health, the NHA core team (Federal Ministry of Health, National Bureau of Statistics, WHO and CHECOD Africa) and other relevant institutions[5]. Skills and experiences of personnel from these institutions guided the methodology and processes in alignment with the established national implementation guidelines on health accounts. During the data collection process, at least one member of the NHA core team was part of the technical supervisors in each of the 3 senatorial districts of Lagos state. Effective data management procedure was employed to ensure quality output. An audit by CHECOD Africa and SMoH personnel was conducted on the data collected and further clarifications with the respondent or enumerator were sought where necessary. Entry was made by data entry participants in groups, each of which consisted of two personnel, with groups exchanging their excel files for peer review and correction of errors where necessary. The financing sources of NGOs/CSOs were triangulated with the donors/development partners at all levels to avoid double counting. At the data mapping and analysis stages, CHECOD Africa personnel reviewed all mapping decisions in the study file and the cross tabulations output.

A series of technical validation meetings were held. First was with the LSMoH health financing team, second meeting was held with the study team including Lagos State Ministry of Health, Lagos State Bureau of Statistics, Federal Ministry of Health, the National Bureau of Statistics, and CHECOD Africa. Finally, the findings from the study were presented to the Honorable Commissioner for Health, the Permanent Secretary, the Director of Planning Research and Statistics and other staff of the ministry. The report was shared with relevant stakeholders for final validation.

Limitations

The following challenges are notable:

- Slow and difficult process of retrieving data from some enterprises and private health insurance companies due to bureaucratic bottlenecks and inflexible data sharing protocols.
- Outright refusal of some institutions to release data.
- Challenges associated with logistics around Lagos metropolis.
- 2020 State Auditor- General Report not disaggregated by line items. This affected the reporting of capital items for 2020.

[5] See Appendix D for list of all participants and their institutions.

- The low response rates especially from insurance companies, development partners and non-governmental organizations (NGOs) mean that expenditures from these sources may be under-reported.

4. General Findings

Aggregate Health Expenditure

Estimated health expenditures by all agents – households, government, employers, insurers, donors, and NGOs – in Lagos State totaled N870.2 billion (2020) and N990.0 billion (2021) of which N851.2 billion and N963.0 billion were current health expenditures respectively. Based on state population projections, Total health expenditure (THE) per capita was N31,897.7 (2020) and N35,162.7 (2021).

Table 6. Aggregate Health Expenditure Indices 2020 - 2021

	2020	2021
Current Health Expenditure (CHE) – N' Million	851,202.3	963,041.3
Capital Heath Expenditure –N' Million	19,010.8	26,941.2
Total Health Expenditure (THE) – N' Million	870,213.1	989,982.4
Population Est. (Million)	27.3	28.2
Gross Domestic Product (GDP Est) – N' Million	29,717,096.2	30,608,609.0
THE per capita (Naira)	31,897.7	35,162.7
THE/GDP (%)	2.9%	3.2%

Current Health Expenditure

Current health expenditure was N851.2 billion (2020) and N963.0 billion (2021) in nominal terms representing 97.8% and 97.3% of total health expenditure for 2020 and 2021 respectively.

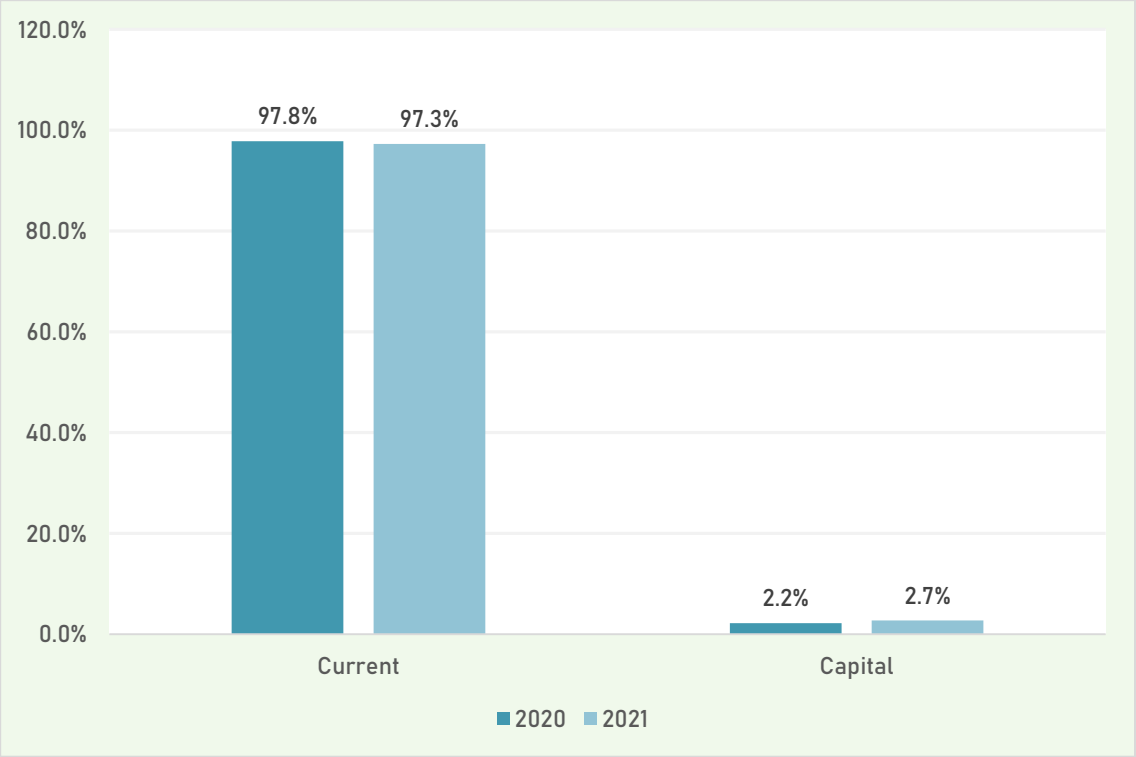

Figure 4. Current Health Expenditure as % of THE

WHO PAID FOR HEALTHCARE (FSRI)?

The burden of healthcare financing was borne dominantly by households. Estimated household health expenditure was N746.0 billion in 2020 and N839.4 billion in 2021 accounting for 87.6% and 87.2% of CHE respectively.

Table 7. Institutional Sources of Health Financing

Institutional Sources of Health Financing	2020 (Millions)	Percentage (%)	2021 (Millions)	Percentage (%)
Households	746,012.3	87.6	839,376.0	87.2
Corporations	21,589.5	2.5	21,482.1	2.2
Non-profit Institutions	418.3	0.0	481.7	0.1
Donors	10,965.6	1.3	9,186.9	1.0
Federal Government	15,735.7	1.8	18,687.8	1.9
State Government	52,178.3	6.1	69,164.6	7.2
Local Government	4,302.6	0.5	4,662.2	0.5
Total	851,202.3	100.0	963,041.3	100.0

Government financing of healthcare (federal, state, and local governments combined) rose from N72.2 billion (2020) to N92.5 billion (2021) in nominal terms and also increased from 8.5% in 2020 to 9.6% in 2021 as a share of CHE. Contributions by corporations, Nonprofit

Institutions and Donors to CHE reduced from 3.9% (2020) to 3.2% (2021) occasioned primarily by nominal decrease in donor financing.

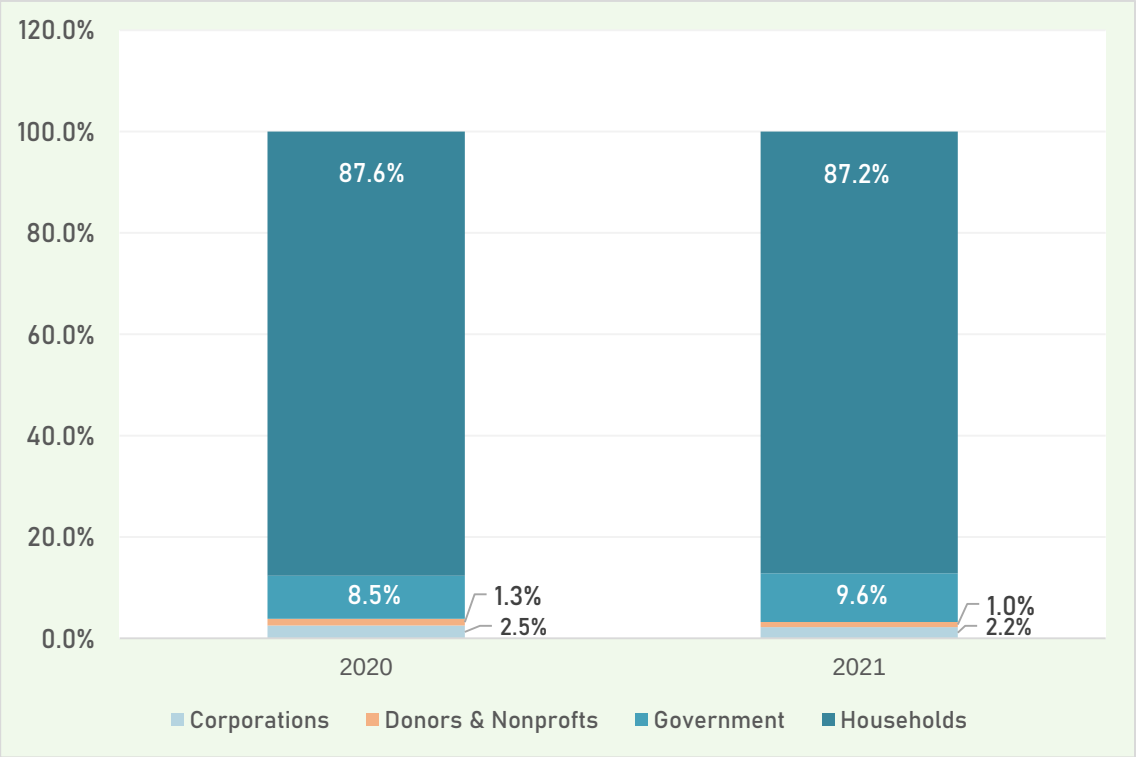

Figure 5. Institutional Sources of Health Financing (%)

HOW WERE SERVICES PAID FOR (HF)?

Out-of-Pocket (OOP) payments were the dominant means of paying for healthcare services during the period. In nominal terms, estimated OOP expenditure was N743.2 billion in 2020 and N836.0 billion in 2021. The next important means were government schemes which predominantly were input financing of healthcare provision by government. Payments through these schemes summed up to N72.4 billion in 2020 and N88.1 billion in 2021. Health spending through social insurance schemes increased from N3.4 billion to N5.9 billion over the period, driven mainly by enrolment into the Lagos State Health Scheme (LSHS) which commenced in 2019.

Table 8. Financing Schemes

Financing Schemes	2020 (Millions)	Percentage (%)	2021 (Millions)	Percentage (%)
Household out-of-pocket payment	743,154.9	87.3	835,960.0	86.8
Enterprise financing schemes	14,599.0	1.7	12,275.8	1.3
Government schemes	72,376.0	8.5	88,122.2	9.2
Social health insurance schemes	3,352.8	0.4	5,933.5	0.6
Voluntary health insurance schemes	9,912.4	1.2	12,476.9	1.3

Non-profit financing schemes	7,807.2	0.9	8,272.9	0.9
Total	851,202.3	100.0	963,041.3	100.0

As a share of CHE, household OOP payments were 87.3% (2020) and 86.8% (2021). Total payments made through private schemes (enterprise healthcare financing schemes, voluntary insurance schemes, Nonprofit Institutions financing schemes and household OOP payments) were 91.1% and 90.2% of CHE in 2020 and 2021 respectively. Health spendings through social insurance schemes increased from 0.4% to 0.6% of CHE and expenditure through government schemes increased from 8.5% to 9.2% over the period.

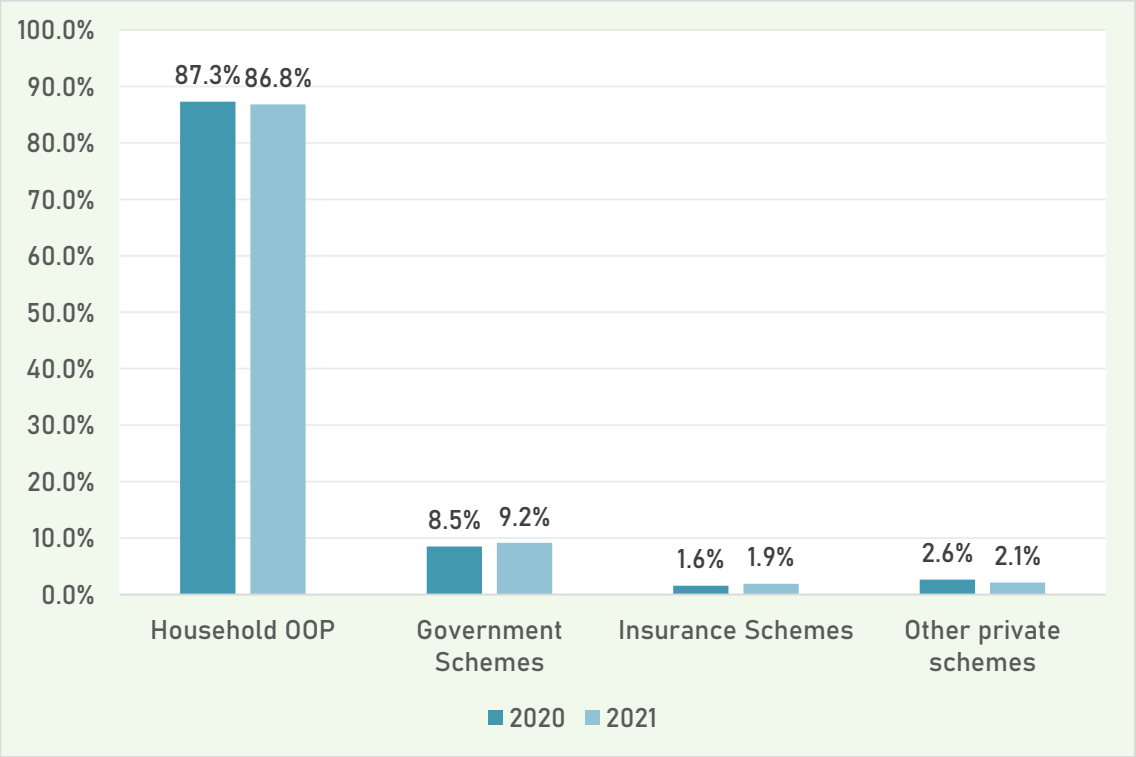

Figure 6. Distribution of Healthcare Payments by Financing Schemes (%)

HOW DID THE PAYMENT SCHEMES RAISE FUNDS (FS)?

Total public health financing, comprising revenues from government finances, donor funds distributed by government, social insurance revenues (inclusive of premiums paid by households and enterprises) increased nominally from N75.7 billion in 2020 to N94.1 billion in 2021. Private health financing (comprising revenues from households, voluntary prepayments, revenue from enterprises and other revenues from private sources) increased from N775.5 billion in 2020 to N869.0 billion in 2021.

Table 9. Revenues of Financing Schemes

Revenues of Financing Schemes	2020 (millions)	Percentage (%)	2021 (millions)	Percentage (%)
Revenues From Government Finances	68,799.4	8.1	87,348.4	9.1
Donor Funds Distributed by Government	3,576.6	0.4	1,457.1	0.2
Social Insurance Revenues	3,352.8	0.4	5,250.1	0.5
Voluntary Insurance Revenues	9,912.4	1.2	12,476.9	1.3
Donor Funds Managed by their Agencies	7,375.0	0.9	7,569.6	0.8
Revenues From Households	743,154.9	87.3	835,960.0	86.8
Revenues from NGOs	432.2	0.1	703.4	0.1
Revenues From Enterprises	14,599.0	1.7	12,275.8	1.3
Total	851,202.3	100.0	963,041.3	100.0

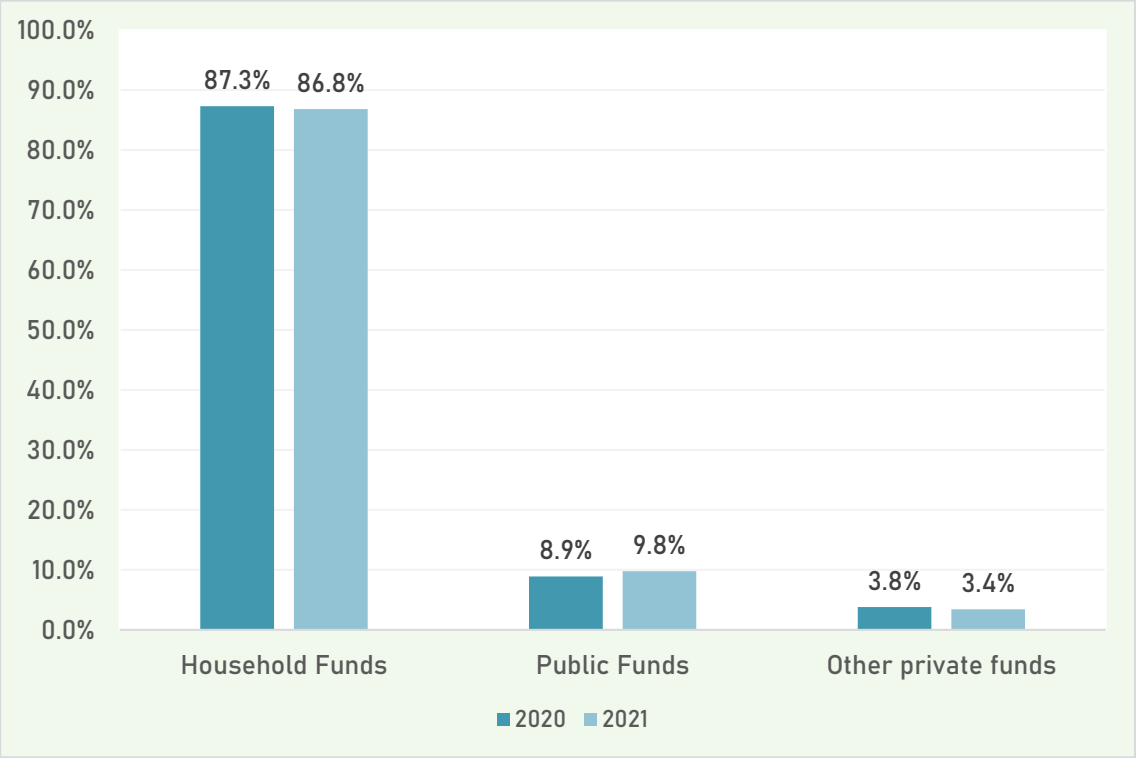

Figure 7. Revenues of Financing Schemes (%)

WHO MANAGES THE HEALTHCARE FUNDS (FA)?

Health financing through government schemes is managed by government institutions/agencies. Corporations' and households' expenditures are managed mainly by the corporations and households respectively, but a small share is managed by insurance

agencies. Whereas some donor funds are provided as direct support to government and are therefore managed by government, others are managed by non-profit institutions serving households.

Table 10. Institutional Financing Agents

Institutional Financing Agents	2020 (Millions)	Percentage (%)	2021 (Millions)	Percentage (%)
Households (OOP)	743,154.9	87.3	835,960.0	86.8
Corporations	14,599.0	1.7	12,275.8	1.3
Insurance corporations	9,912.4	1.2	12,476.9	1.3
Non-profit Institutions	7,807.2	0.9	8,272.9	0.9
Government	75,728.9	8.9	94,055.6	9.8
Total	851,202.3	100.0	963,041.3	100.0

Households as financing agents managed nearly all their funds – 87.3% OOP out of 87.6% contribution to CHE in 2020 and 86.8% out of 87.2% contribution to CHE in 2021, leaving only about 0.4% of their contributions managed through prepayment schemes. Similarly, Corporations managed nearly all their funds – 1.7% out of 2.5% contribution to CHE in 2020 and 1.3% out of 2.2% contribution to CHE in 2021, leaving about 1.0% of their contributions managed through prepayment schemes. Correspondingly, governments at all levels contributed 8.5% but managed 8.9% of CHE in 2020 and contributed 9.6% but managed 9.8% of CHE in 2021. The additional 0.4% and 0.2% funds managed by government are from households' contribution to social insurance and donor funds distributed by government in 2020 and 2021 respectively.

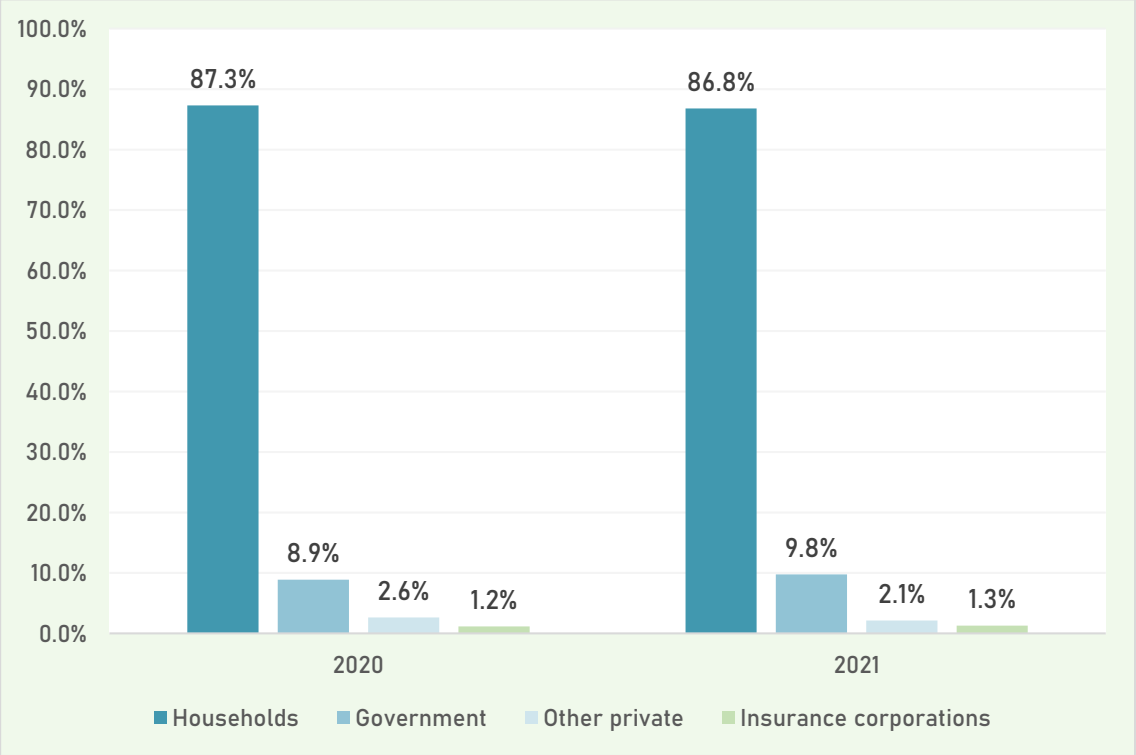

Figure 8. Institutional Financing Agents (%)

WHO ARE THE PROVIDERS (HP)?

Secondary hospitals provided most of the services with current expenditure of N472.2 billion (2020) and N534.8 billion (2021) received by them. Next were retailers and other providers of medical goods (including pharmacies and chemists) where the sums of N107.2 billion (2020) and N120.7 billion (2021) were spent. Primary health care centres followed closely at N83.0 billion in 2020 and N94.1 billion in 2021. Tertiary hospitals received N51.7 billion in 2020 and N61.3 billion in 2021 while providers of healthcare administration and financing received N46.0 billion in 2020 and N55.1 billion in 2021.

Table 11. Expenditure Received by Healthcare Providers

Healthcare Providers	2020 (Millions)	Percentage (%)	2021 (Millions)	Percentage (%)
Secondary Hospitals	472,220.9	55.5	534,809.6	55.5
Pharmacies & other providers of Medical Goods	107,164.3	12.6	120,745.9	12.5
Primary Healthcare Centres (PHC)	82,967.6	9.7	94,085.9	9.8
Tertiary Hospitals	51,724.5	6.1	61,254.0	6.4
Healthcare System Admin & Financing	46,011.3	5.4	55,058.4	5.7
Rest of the Economy	34,504.7	4.1	34,183.9	3.5
Rest of the World	25,981.6	3.1	29,145.8	3.0
Traditional Providers	14,882.0	1.7	16,711.3	1.7

Unspecified Providers	8,632.0	1.0	9,704.7	1.0
Specialized Hospitals (Other than Mental Health)	3,889.7	0.5	3,887.9	0.4
Mental health Hospitals	3,092.7	0.4	3,218.5	0.3
Providers of preventive care	122.7	0.0	235.5	0.0
Providers of ancillary services	8.4	0.0	-	0.0
Total	851,202.3	100.0	963,041.3	100.0

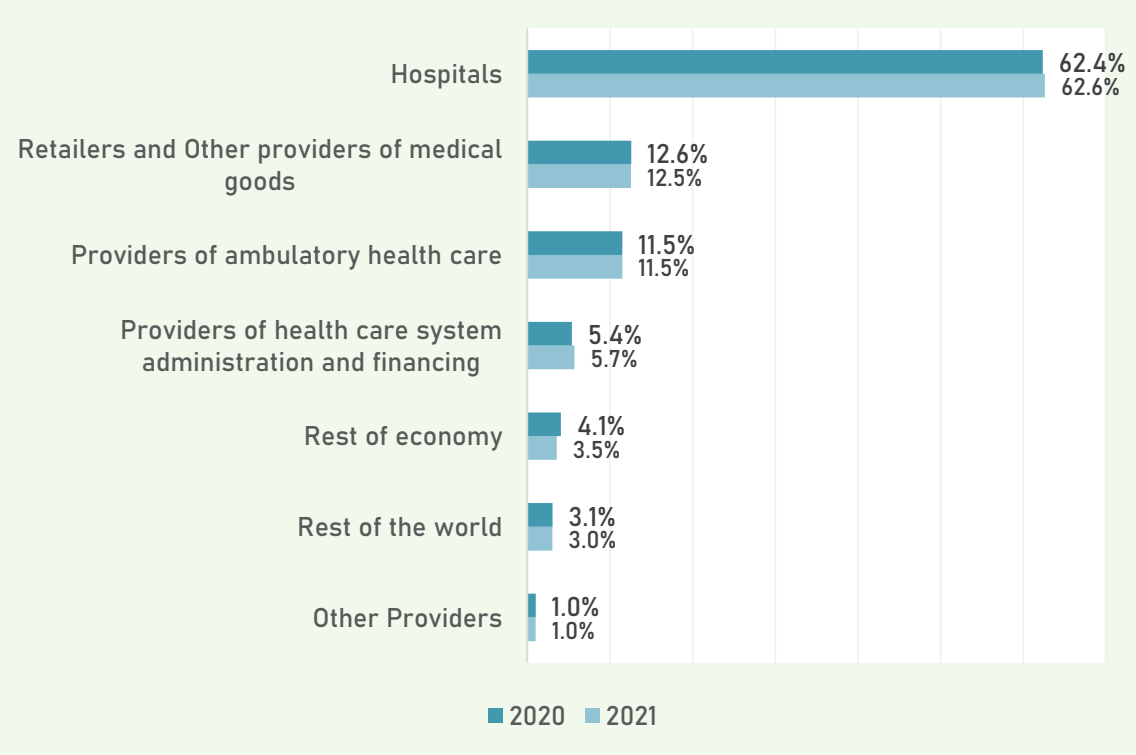

Figure 9. Expenditure Distribution by Healthcare Providers (%)

As a share of CHE, Hospitals and PHCs received 72.1% (2020) and 72.4% (2021); retailers of medical goods (including pharmacies and chemists) received 12.6% (2020) and 12.5% (2021). Traditional providers received 1.7% each year; rest of the economy and world received 7.1% (2020) and 6.6% (2021); health system administration and financing provided services valued at 5.4% (2020) and 5.7% (2021); and unspecified providers received 1.0% each year.

In 2021, about 66.3% of household OOP expenditure was spent in hospitals, followed by pharmacies including other providers of medical goods – 14.3% and Providers of ambulatory health care – 13.1%. The remainder was shared among Rest of the world – 3.5%, Rest of the economy – 1.7% and other providers of healthcare – 1.2%. (See Appendix C: SHA Matrices).

HOW MUCH WAS SPENT ON DIFFERENT TYPES OF SERVICES (HC)?

In 2020 and 2021, curative care received the highest spendings at N668.5 billion and N752.2 billion equivalent to 78.5% and 78.1% of CHE. In 2021, 92.1% of the health services (excluding

health system administration) were financed through out-of-pocket expenditures while 4.6% was through government and social contributory schemes and 3.3% was through voluntary health care payment schemes (including private health insurance, enterprise financing schemes and nonprofit Institutions financing schemes) (See Appendix C: SHA Matrices). Next was preventive care at N102.3 billion in 2020 and N115.6 billion in 2021, equivalent to 12% of CHE each year. Health financing/administration expenditure was N46.0 billion in 2020 and N55.0 billion in 2021. Expenditure on medical goods (unspecified by function) followed at N7.8 billion in 2020 and N11.7 billion in 2021.

Notably, expenditure on curative care was six-fold the corresponding expenditure on preventive services in both years.

Table 12. Expenditure by Healthcare Functions

Healthcare Functions	2020 (Millions)	Percentage (%)	2021 (Millions)	Percentage (%)
Curative care	668,467.9	78.5	752,157.2	78.1
Rehabilitative care	5,484.5	0.6	5,306.9	0.6
Ancillary services	5,760.2	0.7	8,807.5	0.9
Medical goods	7,772.0	0.9	11,700.0	1.2
Preventive care	102,292.0	12.0	115,634.8	12.0
Health financing/admin	46,009.9	5.4	55,040.7	5.7
Other services	15,415.9	1.8	14,394.2	1.5
Total	851,202.3	100.0	963,041.3	100.0

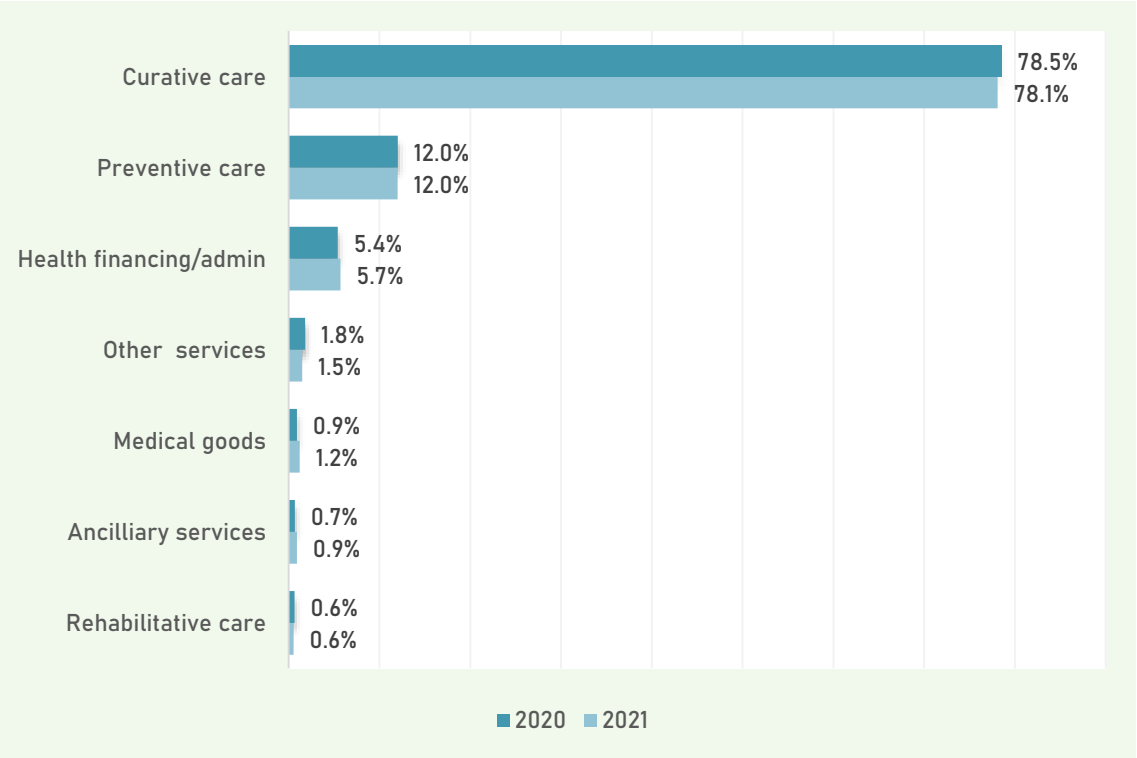

Figure 10. Distribution of CHE by Healthcare Functions (%)

HOW MUCH OF INPUTS CATEGORIES WERE USED (FP)?

Current health expenditure was evaluated in terms of healthcare delivery inputs. The inputs were classified into employee compensation, healthcare and non-healthcare goods, healthcare and non-healthcare services, and other materials and services used. In 2020 and 2021, 62.7% and 61.2% of CHE was spent on healthcare goods and services. The remainder was distributed among non-specified factors – 29.0% in 2020 and 30.0% in 2021; employee compensation – 6.8% (2020) and 7.7% (2021); non-healthcare goods at 1.1% (2020) and 0.2% (2021); and non-healthcare services at 0.4% (2020) and 0.7% (2021).

The allocation of CHE to factors underlying this distribution is provided in the table below:

Table 13. Classification of Expenditure by Input Factors

Input Factors	2020 (Millions)	Percentage (%)	2021 (Millions)	Percentage (%)
Employee Compensation	58,201.3	6.8	73,884.3	7.7
Healthcare Goods	355,681.1	41.8	399,422.9	41.5
Healthcare Services	178,004.2	20.9	189,546.6	19.7
Taxes	137.5	0.0	1,895.7	0.2
Non-healthcare Goods	9,362.2	1.1	2,001.0	0.2
Non-healthcare Services	3,148.6	0.4	7,209.2	0.7
Other & unspecified factors	246,667.4	29.0	289,081.6	30.0
Total	851,202.3	100.0	963,041.3	100.0

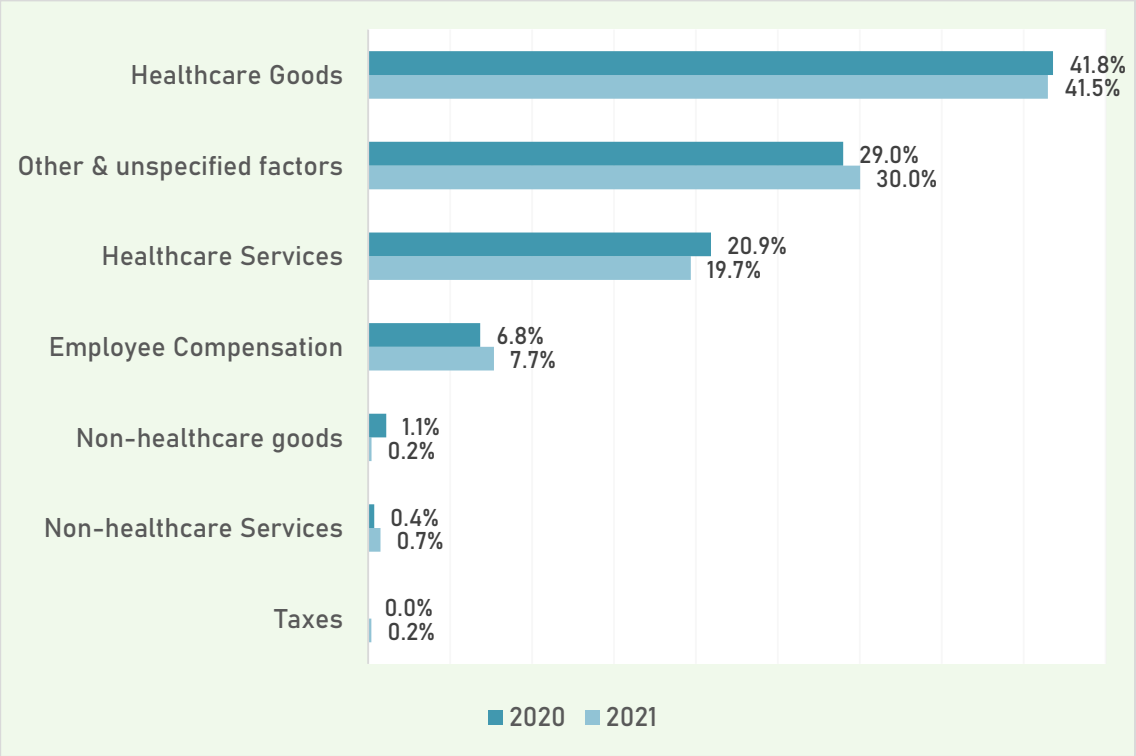

Figure 11. Distribution of CHE by Input Factors (%)

WHAT TYPES OF DISEASES OR CONDITIONS WERE TREATED (DIS)?

Infectious diseases consumed about 63% of current healthcare resources, totaling 607.1 billion in 2021. This disease category is further disaggregated into Malaria which consumed the largest resources at approximately N235.9 billion in 2021, equivalent to 24.5% of CHE. HIV/AIDS & Other STDs consumed N35.4 billion representing 3.7% of CHE respectively, while N222.6 billion was spent on vaccine preventable diseases[6], representing 23.1% of CHE. Others are Tuberculosis – N78.8 billion (8.2%); Other Respiratory Infections – N4.9 billion (0.5%); Diarrheal Diseases –N18.7 billion (1.9%) Other Infectious Diseases –N172.1 million (0.02%) of CHE in 2021.

Reproductive health consumed – N137.4 billion representing 14.3% of CHE in 2021. Others are Non-Communicable Diseases (NCDs) – N83.0 billion (8.6%); Injuries – N21.2 billion (2.2%); Neglected Tropical Diseases – N23.8 billion (2.5%); Other and unspecified diseases N90.5 billion (9.4%); and N66.3 million was spent on Nutritional Deficiencies.

[6] This includes spending on vaccination (preventive) and treatment (curative).

Table 14. Expenditure classification by Diseases/Conditions

Diseases/ Conditions (DIS)	2021 (Millions)	Percentage (%)
Malaria	235,946.3	24.5
Vaccine preventable diseases	222,648.6	23.1
Reproductive health	137,356.6	14.3
Noncommunicable diseases	83,044.6	8.6
Tuberculosis	78,817.1	8.2
HIV/AIDS & Other STDs	35,351.0	3.7
Neglected tropical diseases	23,813.9	2.5
Diarrheal diseases	18,695.1	1.9
Hepatitis	9,847.3	1.0
Covid-19	684.7	0.1
Other Respiratory infections	4,898.7	0.5
Other Infectious/Parasitic Diseases	172.1	0.0
Injuries	21,186.6	2.2
Nutritional deficiencies	66.3	0.0
Other Diseases	90,512.4	9.4
Total	963,041.3	100.0

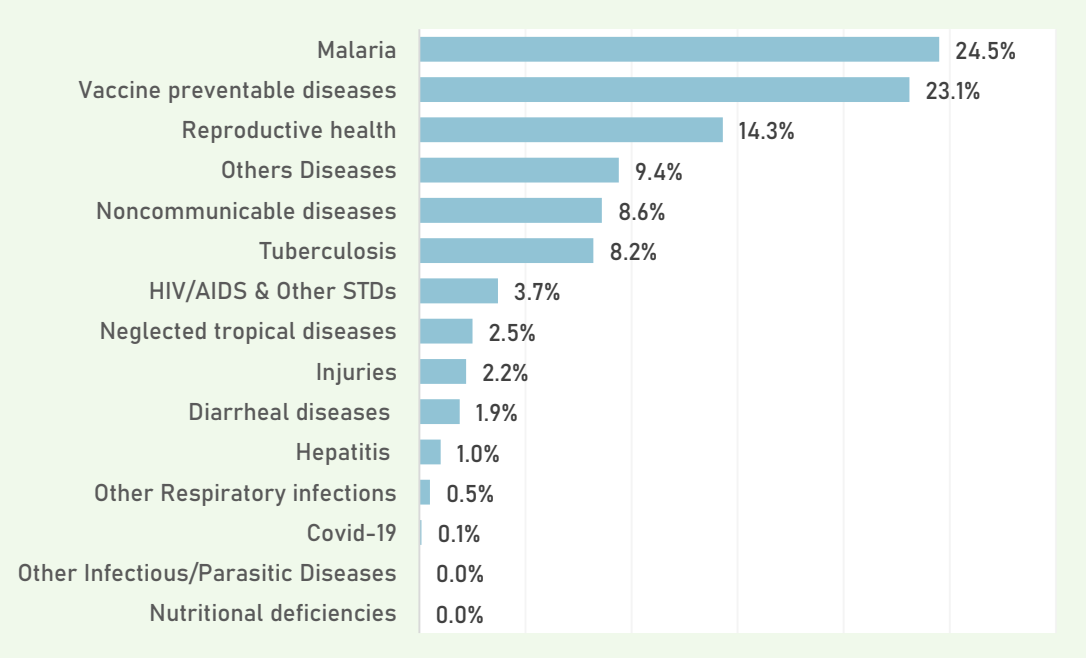

Figure 12. Expenditure Classification by Diseases/Conditions (%)

Capital Health Expenditure

WHAT CAPITAL ITEMS WERE ACQUIRED (HK)?

Capital health expenditure was N19.0 billion in 2020 and N26.9 billion in 2021. As a share of capital expenditure in 2020 and 2021, 7.1% and 54.9% were spent on infrastructure; 4.5% and

12.5% on machinery and equipment; 18.7% and 20.6% on education, training, and research; 3.3% on changes in inventories only in 2021; 69.7% and 8.1% on unspecified gross fixed capital formation and less than 1% on non-produced non-financial asset and Intellectual property products in 2021.

Table 15. Distribution of Health Expenditure by Capital Items Acquired

Gross Capital Formation	2020 (Millions)	Percentage (%)	2021 (Millions)	Percentage (%)
Buildings & Structures	1,355.3	7.1	14,778.6	54.9
Machinery & Equipment	849.5	4.5	3,362.7	12.5
Education, Training and Research	3,548.2	18.7	5,543.9	20.6
Intellectual property products	1.6	0.0	172.6	0.6
Other and Unspecified GFCF	13,256.3	69.7	2,186.0	8.1
Changes in Inventories	-	0.0	879.9	3.3
Non-produced non-financial assets	-	0.0	17.4	0.1
Total	19,010.8	100.0	26,941.2	100.0

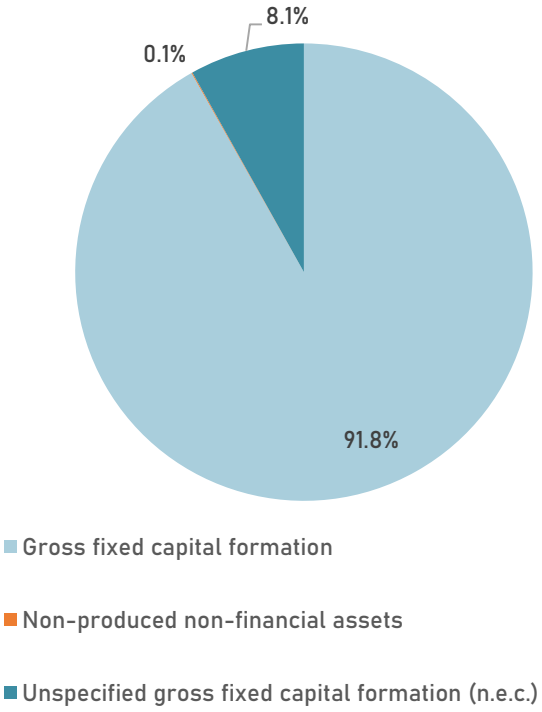

Figure 13. 2021 Distribution of Capital Health Expenditure (%)

WHO FUNDED INVESTMENTS IN HEALTHCARE (FSRI)?

Government was the largest financier of capital expenditures at N17.8 billion (93.8%) in 2020 and N25.8 billion (95.6%) in 2021. Capital expenditure by private bodies (Corporations, Donors, and Non-profit institutions) combined was 6.2% and 4.4% in 2020 and 2021.

Table 16. Distribution of Capital Health Expenditure by Source of Funding

Institutional Sources of Health Financing	2020 (Millions)	Percentage (%)	2021 (Millions)	Percentage (%)
Government	17,839.8	93.8	25,766.1	95.6
Corporations	9.8	0.1	83.1	0.3
Non-profit Institutions	1.6	0.0	3.8	0.0
Donors (External)	1,159.5	6.1	1,088.1	4.0
Total	19,010.8	100.0	26,941.2	100.0

WHICH PROVIDERS ARE INVESTING (HP)?

Majority of the investments were made by providers of health care system administration and financing at 71.7% in 2020 and 59.3% in 2021[7], followed by investments by rest of the economy accounting for 26.0% in 2020 and 29.1% in 2021. Hospitals followed at 1.5% (2020) and 10.9% (2021). Capital health expenditure by providers of preventive care stood at 0.8% each year. The table below gives insight into providers who are investing to expand physical capacity to provide health care.

Table 17. Distribution of Capital Health Expenditure by Provider (Investor)

Healthcare Providers	2020 (Millions)	Percentage (%)	2021 (Millions)	Percentage (%)
Hospitals	291.7	1.5	2,937.1	10.9
Providers of preventive care	150.2	0.8	204.0	0.8
Providers of health system admin/financing	13,632.8	71.7	15,964.0	59.3
Rest of economy	4,936.1	26.0	7,836.1	29.1
Total	19,010.8	100.0	26,941.2	100.0

[7] This includes investments made by government agencies such as Lagos State Primary Healthcare Board (LSPHCB) towards the establishment and equipping of PHCs.

5. Expenditure by Selected Disease Areas

This section highlights the current health expenditure shares of the following selected disease areas: HIV/AIDS, Tuberculosis, Malaria, Reproductive Health, Non-Communicable Diseases (NCDs), Nutritional Deficiencies and Neglected Tropical Diseases (NTDs) for 2021.

HIV/AIDS

The current expenditure incurred on HIV/AIDS in 2021 was N35.4 billion, equivalent to 3.7% of CHE. Federal Government provided N3.8 billion (10.8%), State Government provided N1.2 billion (3.4%), and Local Government provided N9.3 million (0.03%), totaling N5.0 billion (14.2%) expenditures by government at all levels. Households contributed approximately N24.2 billion (68.4%), Corporations provided N90.9 million (0.3%), and Donors provided N6.0 billion (17.0%).

Table 18. HIV/AIDS Financing Sources

HIV/AIDS Financing Sources	Amount (Million Naira)	Percentage (%)
Households	24,179.5	68.4
Donors (Rest of the world)	5,996.8	17.0
Federal Government	3,832.2	10.8
State Government	1,191.2	3.4
Corporations	90.9	0.3
Non-profit Institutions	51.1	0.1
Local Government	9.3	0.03
Total	35,351.0	100.0
Share of CHE	3.7%	

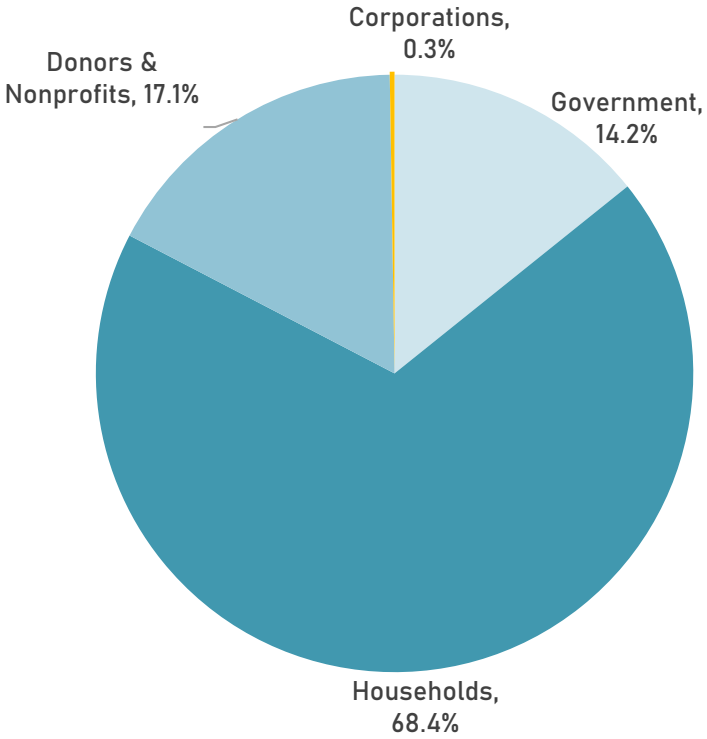

Figure 14. Share of HIV/AIDS Financing Sources

Tuberculosis

The current expenditure incurred on tuberculosis (TB) was N78.8 billion, equivalent to 8.2% of CHE. Households contributed the highest at N70.0 billion (88.9%), Federal Government provided N1.1 billion (1.4%), State Government - N5.5 billion (6.9%), and Local Government - N191.1 million (0.2%), totaling N6.8 billion (8.6%) by government at all levels. Donors provided N1.5 billion (1.9%) and Corporations provided N498.1 million (0.6%).

Table 19. Tuberculosis Financing Sources

Tuberculosis Financing Sources	Amount (Million Naira)	Percentage (%)
Households	70,039.4	88.9
State Government	5,459.1	6.9
Donors (Rest of the world)	1,506.5	1.9
Federal Government	1,122.8	1.4
Corporations	498.1	0.6
Local Government	191.1	0.2
Non-profit Institutions	0.04	0.0
Total	78,817.1	100.0
Share of CHE	8.2%	

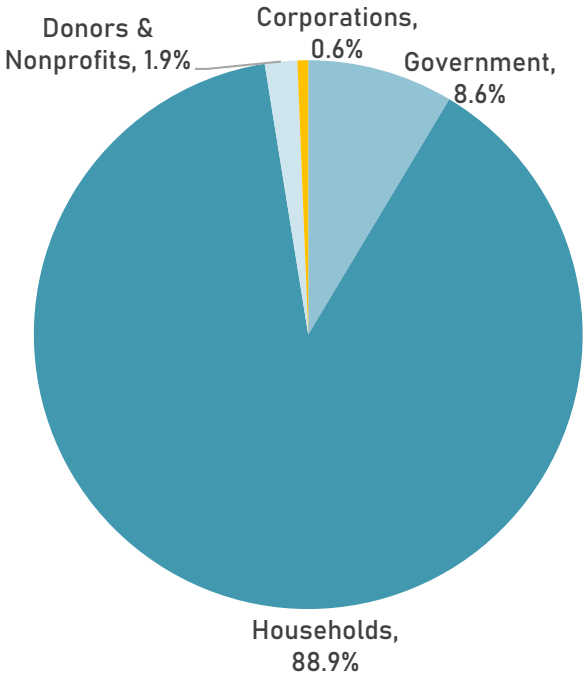

Figure 15. Share of Tuberculosis Financing Sources

Malaria

The current expenditure on malaria was approximately N235.9 billion, equivalent to 24.5% of CHE. Households contributed the highest at approximately N216.1 billion (91.6%), Federal Government provided N623.1 million (0.3%), State Government - N17.3 billion (7.3%), and Local Government - N331.0 million (0.1%), totaling N18.2 billion (7.7%) by government at all levels. Corporations provided N1.6 billion (0.7%), and Nonprofit Institutions provided N1 million (less than 0.1%).

Table 20. Malaria Financing Sources

Malaria Financing Sources	Amount (Million Naira)	Percentage (%)
Households	216,104.9	91.6
State Government	17,274.0	7.3
Corporations	1,612.2	0.7
Federal Government	623.1	0.3
Local Government	331.0	0.1
Non-profit Institutions	1.0	0.0
Total	235,946.3	100.0
Share of CHE	24.5%	

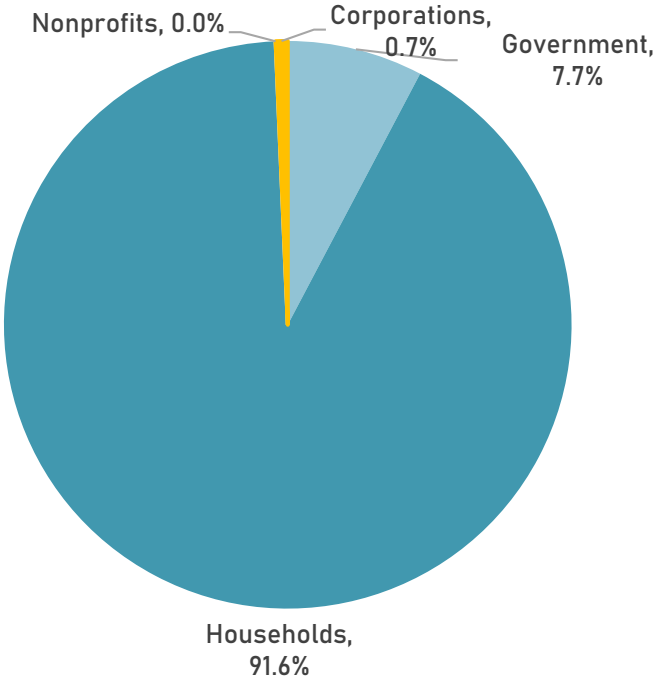

Figure 16. Share of Malaria Financing Sources

Reproductive Health

The current expenditure incurred on reproductive health was N137.4 billion, equivalent to 14.3% of CHE. Households contributed N120.9 billion (88.0%), Federal Government provided N1.4 billion (1.0%), State Government at N12.4 billion (9.0%), and Local Government - N447.6 million (0.3%), totaling N14.2 billion (10.3%) by government at all levels. Corporations provided N1.1 billion (0.8%), Donors provided N1.0 billion (0.8%), and Non-Profit Institutions provided N105.2 million (0.1%).

Table 21. Reproductive Health Financing Sources

Reproductive Health Financing Sources	Amount (Million Naira)	Percentage (%)
Households	120,888.6	88.0
State Government	12,367.6	9.0
Federal Government	1,399.5	1.0
Corporations	1,111.7	0.8
Donors (Rest of the world)	1,036.5	0.8
Local Government	447.6	0.3
Non-profit Institutions	105.2	0.1
Total	137,356.6	100.0
Share of CHE	14.3%	

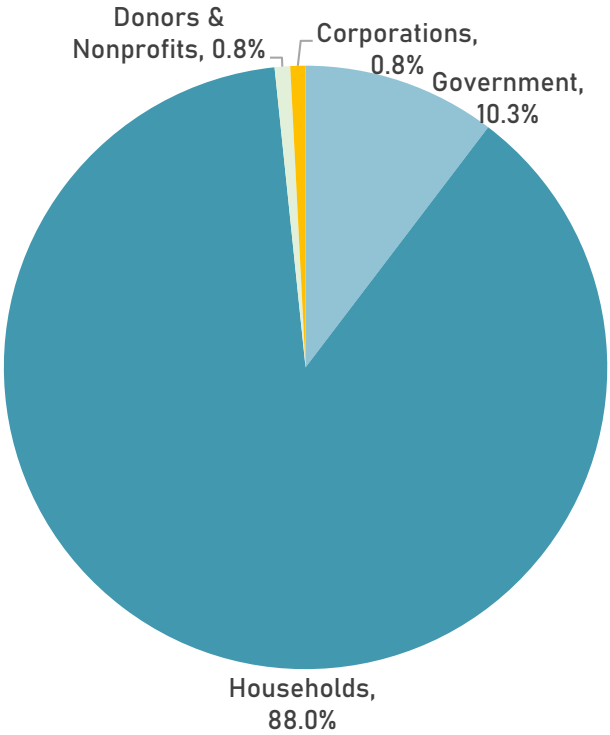

Figure 17. Share of Reproductive Health Financing Sources

Non-Communicable Diseases (NCDs)

The current expenditure incurred on NCDs was N83.0 billion, equivalent to 8.6% of CHE. Federal Government provided N5.8 billion (6.9%), State Government provided N5.7 billion (6.9%), and Local Government provided N42 million (0.1%), summing up to N11.5 billion (13.9%) by government at all levels. Households contributed the highest share of N71.0 billion (85.5%) and Corporations provided N540.6 million (0.7%).

Table 22. Non-Communicable Diseases Financing Sources

NCDs Financing Sources	Amount (Million Naira)	Percentage (%)
Households	70,986.9	85.5
Federal Government	5,766.5	6.9
State Government	5,708.6	6.9
Corporations	540.6	0.7
Local Government	42.0	0.1
Total	83,044.6	100.0
Share of CHE	8.6%	

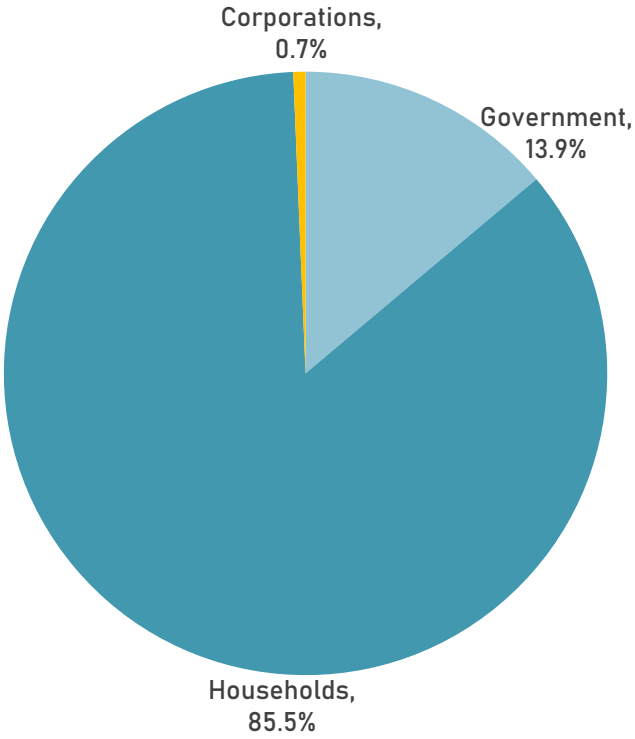

Figure 18. Share of Non-Communicable Diseases Financing Sources

Nutritional Deficiencies

The current expenditure incurred on nutritional deficiencies was N66.3 million, equivalent to 0.01% of CHE. Government spending of N10.8 million (16.3%) was provided by Federal Government only. Households contributed the highest share of N55.4 million (83.5%), and Corporations provided N0.1 million (0.1%).

Table 23. Nutritional Deficiencies Financing Sources

Nutritional Deficiencies Financing Sources	Amount (Million Naira)	Percentage (%)
Households	55.4	83.5
Federal Government	10.8	16.3
Corporations	0.1	0.1
Total	66.3	100.0
Share of CHE	0.01%	

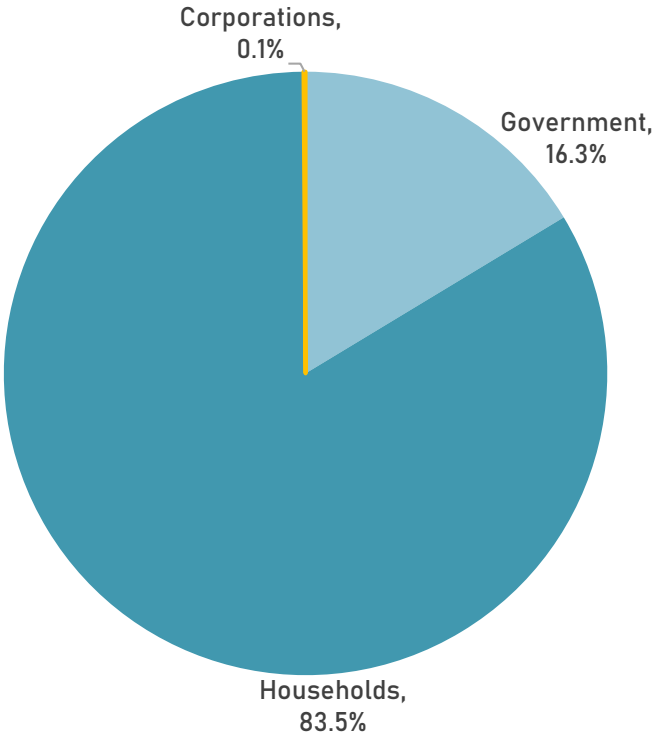

Figure 19. Share of Nutritional Deficiencies Financing Sources

Neglected Tropical Diseases (NTDs)

The current expenditure incurred on NTDs was N23.8 billion, equivalent to 2.5% of CHE. Households contributed the highest share of N20.8 billion (87.2%). Federal Government provided N9.6 million (0.04%), State Government provided N2.1 billion (8.8%), and Local Government contributed 867.2 million (3.6%). Hence, total government contribution was N3.0 billion (12.4%). Corporations provided N90.3 million (0.4%).

Table 24. Neglected Tropical Diseases Financing Sources

NTDs Financing Sources	Amount (Million Naira)	Percentage (%)
Households	20,759.7	87.2
State Government	2,087.1	8.8
Local Government	867.2	3.6
Corporations	90.3	0.4
Federal Government	9.6	0.0
Total	23,813.9	100.0
Share of CHE	2.5%	

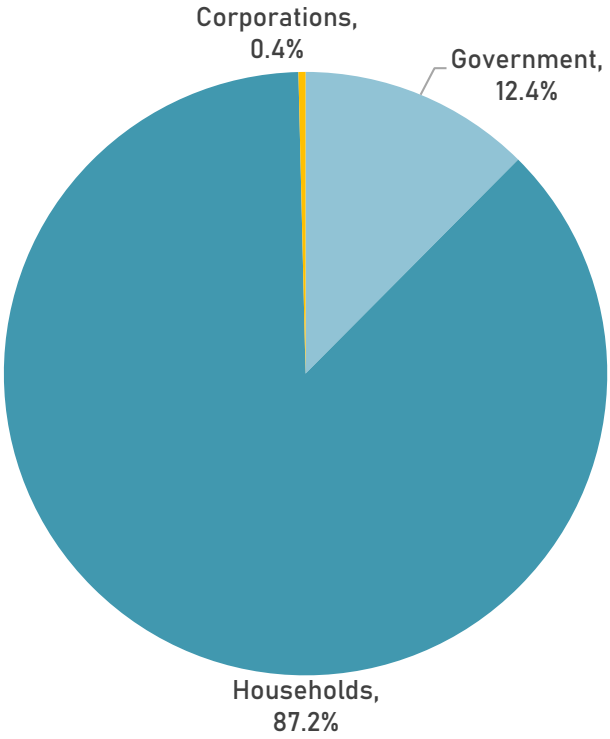

Figure 20. Share of NTDs Financing Sources

6. Discussions

Key Performance Indicators

This section discusses the key performance indicators grouped into the three main functions of health financing – resource mobilization, risk-pooling, and purchasing of health services.

Table 25. Health Financing Key Performance Indicators

Health Financing Key Performance Indicators	2017	2018	2019	2020	2021
State Context					
Nominal gross domestic product (GDP, Trillions)	28.3	29.6	30.9	29.7	30.6
Population (Millions)	24.8	25.6	26.4	27.3	28.2
State Government Expenditure (Billions)	746.4	650.1	795.3	844.5	1052.2
Local Government Expenditure (Billions)	80.0	109.7	107.8	112.6	122.7
Exchange Rate - Period Average (Naira/US$)	306.0	306.0	306.0	356.9	399.1
General					
Current Health Expenditure (Billions)	590.1	701.0	797.9	851.2	963.0
Total Health Expenditure (Billions)	608.4	713.2	809.2	870.2	990.0
Total Government Health Expenditure (Billions)	55.6	81.7	73.6	90.1	118.3
Federal Government (Billions)	13.1	12.1	18.5	16.8	24.1
State Government (Billions)	41.3	68.2	53.7	67.3	88.0
Local Government (Billions)	1.1	1.3	1.3	6.0	6.1
Donor Health Expenditure (Billions)	13.4	11.2	10.1	12.1	10.3
Private and Social Insurance (Billions)	7.0	7.8	8.4	13.3	17.7
Social/Compulsory Insurance (Billions)	3.7	3.7	3.7	3.4	5.3
Voluntary Insurance (Billions)	3.2	4.1	4.7	9.9	12.5
Household health expenditure (Billions)	525.9	607.2	699.2	746.0	839.4
Out-of-pocket (OOP) household health expenditure (Billions)	525.8	607.2	699.1	743.2	836.0
Resource Mobilization					
THE as a share of GDP (%)	2.1	2.4	2.6	2.9	3.2
Government general health expenditure (GGHE)[8] as a share of CHE (%)	6.8	10.3	8.2	8.9	9.8
Government general health expenditure (GGHE)[9] as a share of THE (%)	9.1	11.5	9.1	10.3	11.9
GGHE[9] as a share of GGE (State Govt. %)	5.5	10.5	6.8	8.0	8.4
GGHE[9] as a share of GGE (Local Govt. %)	1.4	1.2	1.2	5.3	5.0
External/THE (%)	2.2	1.6	1.2	1.4	1.0

[8] This refers to all revenues of government financing schemes including 1. transfers from government domestic revenue (allocated to health purposes), 2. transfers distributed by government from foreign origin and 3. social insurance contributions.

[9] This includes capital expenditure.

Per-capita THE (Naira)	24,532.3	27,859.4	30,651.5	31,897.7	35,162.7
Per-capita OOP (Naira)	21,201.9	23,717.1	26,482.4	27,240.4	29,692.0
Per-capita Government expenditure (Naira)	2,240.9	3,190.1	2,787.2	3,301.0	4,201.2
Per-capita Donor expenditure (Naira)	542.3	437.5	381.4	444.4	365.0
Per-capita THE (US Dollar)	80.2	91.0	100.2	89.4	88.1
Per-capita OOP (US Dollar)	69.3	77.5	86.5	76.3	74.4
Per-capita Government expenditure (US Dollar)	7.3	10.4	9.1	9.2	10.5
Per-capita Donor expenditure (US Dollar)	1.8	1.4	1.2	1.2	0.9
Government general health expenditure[8] as a share of GDP (%)	0.1	0.2	0.2	0.3	0.3
Government general health expenditure[8] per capita (Naira)	1,609.1	2,820.0	2,470.9	2,775.8	3,340.7
Government general health expenditure[8] per capita (US Dollar)	5.3	9.2	8.1	7.8	8.4
Risk pooling and financial equity					
OOP as a share of CHE (%)	89.1	86.6	87.6	87.3	86.8
Social & voluntary Insurance as a share of CHE (%)	1.2	1.1	1.1	1.6	1.8
Social insurance as a share of CHE (%)	0.6	0.5	0.5	0.4	0.5
Voluntary insurance as a share of CHE (%)	0.6	0.6	0.6	1.2	1.3
OOP as a share of THE (%)	86.4	85.1	86.4	85.4	84.4
Social & voluntary Insurance as a share of THE (%)	1.1	1.1	1.0	1.5	1.8
Social Insurance as a share of THE (%)	0.6	0.5	0.5	0.4	0.5
Voluntary Insurance as a share of THE (%)	0.5	0.6	0.6	1.1	1.3
Service structure efficiency					
Preventive health spending as a share of CHE (%)	15.2	12.4	15.7	12.0	12.0
Curative health spending as a share of CHE (%)	47.9	47.5	47.5	78.5	78.1
Medical goods (including drugs) spending as a share of CHE (%)	15.2	14.8	13.5	0.9	1.2
Hospital/THE (%)	59.7	61.6	60.4	61.0	61.2
Targeting Service Focus Efficiency					
Malaria spending as a share of CHE (%)	39.0	37.9	38.3	24.4	24.5
HIV/AIDS & Opportunistic Infections spending as a share of CHE (%)	7.0	6.3	6.2	3.8	3.7
Tuberculosis spending as a share of CHE (%)	4.9	4.8	4.8	8.3	8.2
Other respiratory infections spending as a share of CHE (%)	2.8	2.7	2.7	0.5	0.5
Diarrheal diseases spending as a share of CHE (%)	0.7	0.7	0.7	2.0	1.9
Vaccine preventable diseases spending as a share of CHE (%)	1.1	1.3	1.2	23.3	23.1
Reproductive health spending as a share of CHE (%)	8.9	8.6	8.8	14.2	14.3
NCDs spending as a share of CHE (%)	12.0	11.7	11.9	8.6	8.6
Injuries spending as a share of CHE (%)	10.1	9.9	10.0	1.7	2.2
Nutritional deficiencies spending as a share of CHE (%)	0.2	0.2	0.2	0.01	0.01
NTDs spending as a share of CHE (%)	0.1	0.1	0.1	2.5	2.5

Government general health expenditure per capita of less than $10 each year is far below the benchmark of $86[10]- approximately the minimum amount needed to ensure universal health coverage (UHC) for priority services for everyone. At 0.3% each year, Government general health expenditure to GDP ratio falls below the recommended range of 4-5%[11] for UHC. Per capita THE increased from N31,897.7 in 2020 to N35,162.7 in 2021, at a growth rate of 10.2%. In US dollar terms, per-capita THE decreased from $89.4 in 2020 to $88.1 in 2021.

Health spending by all institutional sources increased or remained relatively the same from 2020 to 2021 whereas expenditure by donors declined significantly during this period. This reflects dwindling donor support, a need for efficiency in utilization of donor funds and innovative domestic health financing.

Out-of-Pocket (or point-of-service) household spending as a proportion of CHE declined slightly from 87.3% (2020) to 86.8% (2021) but is still very high compared to the benchmark of 30-40%[12]. This implies that the health system is over-reliant on households and exposes them to catastrophic health spending. Improvements in coverage of prepayment and financial risk protection mechanisms are needed to reduce the burden of healthcare financing on households, increase utilization of preventive services and raise household welfare.

Although paltry at 0.6% of current health expenditure in 2021, health expenditure channeled through social insurance schemes increased significantly from N3.4 billion to N5.9 billion[13] in one year. This reflects efforts at expanding social insurance coverage.

Contract with healthcare providers without third-party administrators ranked next to private health insurance among the health benefits provided to employees by enterprises (as depicted in Table 26). Lagos State Health Management Agency should consider strategies to redirect these funds to the State's social health insurance scheme for more efficient management of resources and expansion of the scheme.

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[10] Chatham House Report, "Shared responsibilities for health, A coherent global framework for health financing. Final report of the on Global Health Security Working Group on Health Financing", May 2014 (http://www.chathamhouse.org/sites/files/chathamhouse/field/field_document/20140521HealthFinancing.pdf)

[11] World Health Organization 2018. The World Health Report. Health Systems Financing: The Path to Universal Coverage. Geneva: WHO; 2010. Contract No.: WHO Report ISBN, 978, 4. (https://apps.who.int/iris/handle/10665/44371)

[12] World Health Organization benchmark for OOP/CHE is 30-40%

[13] This includes the Basic Health Care Provision Fund (BHCPF).

Table 26: Health Benefits offered by Enterprises.

Benefit Type	Percentage (%)
Private Health Insurance Scheme	47.3
Contract with Provider	36.6
National Health Insurance Scheme	8.6
Reimbursement	3.0
Own Health Facility	3.0
Workplace Program	0.8
First Aid	0.5
Corporate Social Responsibility	0.1
Medical Support	0.1
State Health Insurance Scheme	0.0
Total	100.0

Policy Discussions

The performance of the health financing function is crucial to the performance of any health system; thus, reforms addressing resource mobilization, pooling, and purchasing of healthcare services are core strategies for moving the health system toward universal healthcare coverage (UHC). Changes in financing system are naturally expected to spur changes in the organization of service delivery, production, and engagement of human resources for health, coverage of health information systems, supply of medicines and commodities, and the functioning of institutions responsible for health system governance.

The enactment of the National Health Insurance Act (2022) and the Lagos State Health Scheme (LSHS) Law (2015), mandate all residents to obtain health insurance. Although the state developed a health financing policy in 2015 with an objective to reduce OOP "to the barest minimum", the policy lacked specific targets and therefore could not spur sufficiently strong strategic actions. In the absence of strategic focus, a 3% reduction in OOP payment share of current health expenditure from 89.1% in 2017 to 86.8% in 2021 (0.6% decrease per year) would leave OOP spending above 80% of current spending by 2030, which will be too high compared to the target of 30-40%.

Public financing of current expenditures increased from 6.8% in 2017 to 9.8% in 2021, reflecting progress in state health insurance scheme coverage, government budgetary spending and Basic Healthcare Provision Fund (BHCPF). However, progress toward universal health coverage (UHC) by 2030 requires that this share grows very rapidly. Although there is no specific benchmark for public financing, it is expected to reach a minimum of 50% of current expenditures for the purpose of UHC.

Given the position of Lagos state as the largest industrial economy in Nigeria and the outstanding leader in internal revenue generation, employment-based healthcare benefits

by private employers, government budgetary financing and earmarks are key potential sources of predictable and sustainable financing of healthcare in the state.

Although limited, data on employment-based healthcare benefits indicate potential for sustainable healthcare resource mobilization in the state. In the sample of enterprises used for health account estimation, 60% of sampled employers that provide healthcare benefits are small enterprises (10-49 employees). However, only 20% of small enterprises offering healthcare benefits do so through health insurance, indicating a large room for expanding health insurance pools. Thus, the state government needs to engage the private sector on provision of employment-based healthcare benefits, while the state health management agency also needs to engage them on embracing health insurance mechanisms. The plans offered by the state insurance scheme are currently limited to government employees, individuals, and families with a view to expanding coverage of households. The focus needs to scale up coverage of private sector employees and the informal sector.

On the part of government, health budget performance has not been optimal at an average of 76% between 2017 and 2021. Budget allocation to the health sector averaged 8% of total budget, leaving a gap of 7% relative to the Abuja declaration target of at least 15%. These are indicative of room for increases in government spending.

The three leading consumers of current spending – VPDs, malaria and reproductive health – accounting for 64% of current spending are dominantly primary care level issues. However, secondary hospitals provide the leading share of services suggestive of expensive primary care services which contribute to the high level of OOP spending. Given the strength of health insurance institutions and employers in negotiating service tariffs to the effect of bringing down the cost of care, this phenomenon necessitates rapid expansion of health insurance coverage at the level of individuals, households, and employers.

Donors' current expenditure dwindled from N11.8bn in 2017 to N9.2bn in 2021. Of these, the amount provided as budget support, which is more likely to align with the state government's priorities, increased from N900m in 2017 to N1.5bn in 2021. In percentage terms, donor budgetary support as a share of total support increased from 8% in 2017 to 16% in 2021. Further progress in alignment of donor support with the priorities of the state government should translate to increases in this measure.

Providers of health financing include 49 HMOs and the state social health insurance agency (LASHMA). There are indications that private health insurance companies are more successful with enterprises than households and may explain the predominant focus of the social health insurance agency on households and individuals. Notwithstanding, there is ample opportunity for LASHMA to upscale coverage of enterprises across all sectors, especially microenterprises. Through partnership with insurance companies, banks and other financial institutions are making inroads into health insurance under the bancassurance guidelines provided by the National Insurance Commission (NAICOM).

In conclusion, efforts are needed from a broad spectrum of stakeholders to address the weaknesses in the health financing landscape in the state and make progress toward UHC. The roles of relevant stakeholders are enumerated in the table below.

Actor	Role
Lagos State Government (LASG)	• Improve health budget and spending to achieve Abuja declaration target of at least 15% • Engage the private sector on institutionalization and expansion of employment-based healthcare benefits • Engage donors to align their spending with state government priorities and transit from direct implementation to budget support • Establish healthcare development fund to reduce the cost of investments in healthcare sector
Lagos State Ministry of Health (LSMoH)	• Actively engage stakeholders and sources of data for health accounts production • Update the health financing policy and strategy, enumerate clear milestones and targets to drive the transition of government spending from input financing toward output-based financing and toward pro-poor spending • Progressively separate healthcare delivery and financing, shift role of government from delivery toward policy, regulation, and quality assurance • Engage the state government on the UHC health financing reforms
Lagos State Health Management Agency (LASHMA)	• Aggressively expand social health insurance coverage • Extend focus of social health insurance to enterprises across all sectors
Lagos State House of Assembly	• Review the LASHMA law to increase the earmark to 2% of CRF to expand coverage of vulnerable population groups
Organized Private Sector Employer Associations	• Sensitize member organizations to the need for employment-based healthcare benefits
Development Partners	• Increase budgetary support for programs
Civil Society Organizations (CSOs)	• Support dissemination of the health accounts and use of the findings as advocacy tool for domestic resource mobilization

Appendix A: Current Health Expenditure Classifications

A.1 REVENUES OF HEALTHCARE FINANCING SCHEMES

Classification Name	Code	Amount	
		2020	2021
Revenues of health care financing schemes	FS	851,202,311,502	963,041,272,191
Transfers from government domestic revenue (allocated to health purposes)	FS.1	68,799,395,990	87,348,423,320
Internal transfers and grants	FS.1.1	68,799,395,990	87,348,423,320
Earmarked funds	FS.1.1.1		683,364,000
Non-earmarked funds	FS.1.1.2	68,799,395,990	86,665,059,320
Internal Transfer and grants from Federal Government	FS.1.1.2.1	15,734,601,853	17,944,907,071
Internal Transfer and grants from State Government	FS.1.1.2.2.1	48,762,190,162	64,057,980,623
Internal Transfer and grants from Local Government	FS.1.1.2.2.2	4,302,603,974	4,662,171,626
Transfers distributed by government from foreign origin	FS.2	3,576,638,356	1,457,122,383
Transfers distributed by government from Global Fund	FS.2.2	3,524,627,563	1,440,854,811
Other Transfers distributed by government from foreign origin	FS.2.nec	52,010,793	16,267,572
Social insurance contributions	FS.3	3,352,841,146	5,250,095,314
Social insurance contributions from employees	FS.3.1	739,840,844	31,677,985
Social insurance contributions from employers	FS.3.2	67,087,012	2,153,213,115
Other social insurance contributions	FS.3.4	2,545,913,290	3,065,204,214
Voluntary prepayment	FS.5	9,912,351,439	12,476,899,953
Voluntary prepayment from individuals/households	FS.5.1	287,317,586	319,154,350
Voluntary prepayment from employers	FS.5.2	7,522,481,722	8,846,268,549
Other voluntary prepaid revenues	FS.5.3	2,102,552,131	3,311,477,054
Other domestic revenues n.e.c.	FS.6	758,186,056,822	848,939,175,434
Other revenues from households n.e.c.	FS.6.1	743,154,859,709	835,960,043,103
Other revenues from corporations n.e.c.	FS.6.2	14,599,022,830	12,275,772,582
Other revenues from NPISH n.e.c.	FS.6.3	432,174,283	703,359,749
Direct foreign transfers	FS.7	7,375,027,749	7,569,555,787
Direct foreign financial transfers	FS.7.1	7,375,027,749	7,569,555,787

Direct bilateral financial transfers	FS.7.1.1	7,168,179,701	7,569,104,187
Direct multilateral financial transfers	FS.7.1.2	206,848,048	
Other direct foreign financial transfers	FS.7.1.3		451,600

A.2 INSTITUTIONAL UNITS PROVIDING REVENUES TO FINANCING SCHEMES

Classification Name	Code	Amount	
		2020	2021
Institutional units providing revenues to financing schemes	FS.RI	851,202,311,502	963,041,272,191
Government	FS.RI.1.1	72,216,598,945	92,514,594,827
Federal Government	FS.RI.1.1.1	15,735,723,167	18,687,803,907
State Government	FS.RI.1.1.2.1	52,178,271,804	69,164,619,295
Local Government	FS.RI.1.1.2.2	4,302,603,974	4,662,171,626
Corporations	FS.RI.1.2	21,589,539,362	21,482,097,260
Households	FS.RI.1.3	746,012,332,807	839,375,972,552
NPISH	FS.RI.1.4	418,254,663	481,706,561
Rest of the world	FS.RI.1.5	10,965,585,725	9,186,900,990
Bilateral donors	FS.RI.1.5.1	7,182,099,321	7,649,474,494
United Kingdom	FS.RI.1.5.1.24	13,919,620	80,370,308
DFID	FS.RI.1.5.1.24.1		61,430,368
Other United Kingdom	FS.RI.1.5.1.24.nec	13,919,620	18,939,940
United States	FS.RI.1.5.1.25	7,168,179,701	7,569,104,187
USAID	FS.RI.1.5.1.25.1	790,041,916	1,572,543,366
PEPFAR	FS.RI.1.5.1.25.2	6,378,137,785	5,996,560,821
Multilateral donors	FS.RI.1.5.2	3,783,486,404	1,536,974,896
EU Institutions	FS.RI.1.5.2.6	754,975	2,668,930
Global Fund	FS.RI.1.5.2.8	3,524,627,563	1,440,854,811
UNAIDS	FS.RI.1.5.2.12	28,540,931	12,911,019
UNFPA	FS.RI.1.5.2.15	229,562,935	80,540,136
Private donors	FS.RI.1.5.3		451,600
Bill & Melinda Gates Foundation (BMGF)	FS.RI.1.5.3.1		451,600

A.3 FINANCING AGENTS

Classification Name	Code	Amount	
		2020	2021
Financing agents	FA	851,202,311,502	963,041,272,191
General government	FA.1	75,728,875,491	94,055,641,017
Central government	FA.1.1	18,390,040,592	21,082,205,907
Other ministries and public units (belonging to central government)	FA.1.1.2	27,373,820	523,304,484
National Health Service Agency	FA.1.1.3	15,725,424,248	17,419,705,055
National Health Insurance Agency	FA.1.1.4	2,637,242,524	3,139,196,367
State/Regional/Local government	FA.1.2	57,338,834,899	72,973,435,111
State Ministry of Health	FA.1.2.1	6,382,386,511	18,964,916,247
Other state ministries and public units (belonging to state government)	FA.1.2.2	2,489,700	
State Health Service Agency	FA.1.2.3	45,383,858,937	45,995,413,953
State Health Insurance Agency	FA.1.2.4	1,267,495,777	3,350,933,285
LGA Health Department	FA.1.2.5	4,302,603,974	4,662,171,626
Insurance corporations	FA.2	9,912,351,439	12,476,899,953
Commercial insurance companies	FA.2.1	9,912,351,439	12,476,899,953
Corporations (Other than insurance corporations)	FA.3	14,599,022,830	12,275,772,582
Health management and provider corporations	FA.3.1	8,963,000	8,621,000
Corporations (Other than providers of health services)	FA.3.2	14,590,059,830	12,267,151,582
Non-profit institutions serving households (NPISH)	FA.4	7,807,202,033	8,272,915,536
Households	FA.5	743,154,859,709	835,960,043,103

A.4 FINANCING SCHEMES

Classification Name	Code	Amount	
		2020	2021
Financing schemes	HF	851,202,311,502	963,041,272,191
Government schemes and compulsory contributory health care financing schemes	HF.1	75,728,875,491	94,055,641,017
Government schemes	HF.1.1	72,376,034,346	88,122,181,703
Central government schemes	HF.1.1.1	15,734,601,853	17,943,009,539
State/regional/local government schemes	HF.1.1.2	56,641,432,492	70,179,172,164
State government schemes	HF.1.1.2.1	52,338,828,518	65,517,000,538
Local government schemes	HF.1.1.2.2	4,302,603,974	4,662,171,626
Compulsory contributory health insurance schemes	HF.1.2	3,352,841,146	5,933,459,314
Social health insurance schemes	HF.1.2.1	3,352,841,146	5,933,459,314
National health insurance scheme	HF.1.2.1.1	2,637,242,524	3,139,196,367
State health insurance scheme	HF.1.2.1.2	715,598,622	2,794,262,947
Voluntary health care payment schemes	HF.2	32,318,576,301	33,025,588,071
Voluntary health insurance schemes	HF.2.1	9,912,351,439	12,476,899,953
Primary/substitutory health insurance schemes	HF.2.1.1	937,862,954	1,471,472,537
Employer-based insurance (Other than enterprises schemes)	HF.2.1.1.1	937,862,954	1,471,472,537
Unspecified voluntary health insurance schemes (n.e.c.)	HF.2.1.nec	8,974,488,485	11,005,427,416
NPISH financing schemes (including development agencies)	HF.2.2	7,807,202,033	8,272,915,536
NPISH financing schemes (excluding HF.2.2.2)	HF.2.2.1	432,174,283	703,359,749
Resident foreign agencies schemes	HF.2.2.2	7,375,027,749	7,569,555,787
Enterprise financing schemes	HF.2.3	14,599,022,830	12,275,772,582
Enterprises (except health care providers) financing schemes	HF.2.3.1	14,590,741,330	12,267,151,582
Health care providers financing schemes	HF.2.3.2	8,281,500	8,621,000
Household out-of-pocket payment	HF.3	743,154,859,709	835,960,043,103

A.5 HEALTHCARE PROVIDERS

Classification Name	Code	Amount	
		2020	2021
Health care providers	HP	851,202,311,502	963,041,272,191
Hospitals	HP.1	530,927,784,820	603,169,955,294
General hospitals	HP.1.1	523,945,464,044	596,063,552,802
Tertiary Hospital	HP.1.1.1	51,724,515,521	61,253,971,342
Secondary Hospital	HP.1.1.2	472,220,948,523	534,809,581,460
Mental health hospitals	HP.1.2	3,092,658,368	3,218,521,561
Specialised hospitals (Other than mental health hospitals)	HP.1.3	3,889,662,408	3,887,880,932
Providers of ambulatory health care	HP.3	97,849,612,010	110,797,173,020
Traditional healthcare providers	HP.3.6	14,881,966,955	16,711,311,768
Ambulatory health care centres	HP.3.4	82,967,645,055	94,085,861,253
All Other ambulatory centres	HP.3.4.9	82,967,645,055	94,085,861,253
Providers of ancillary services	HP.4	8,443,704	
Other providers of ancillary services	HP.4.9	8,443,704	
Retailers and Other providers of medical goods	HP.5	107,164,274,272	120,745,859,771
Pharmacies	HP.5.1	107,164,274,272	120,745,859,771
Providers of preventive care	HP.6	122,698,649	235,462,471
Providers of health care system administration and financing	HP.7	46,011,290,872	55,058,422,292
Government health administration agencies	HP.7.1	43,165,226,484	50,391,339,223
Federal Government health administration agencies	HP.7.1.1	530,782,890	522,651,225
State Government health administration agencies	HP.7.1.2	38,331,839,621	45,206,516,372
Local Government health administration agencies	HP.7.1.3	4,302,603,974	4,662,171,626
Social health insurance agencies	HP.7.2	562,070,047	1,031,251,412
Private health insurance administration agencies	HP.7.3	2,283,994,340	3,635,831,657
Rest of economy	HP.8	34,504,684,769	34,183,915,935
Households as providers of home health care	HP.8.1	6,111,851,845	6,861,204,738

All Other industries as secondary providers of health care	HP.8.2	21,943,402,522	20,067,098,908
Community health workers (or village health worker, community health aide, etc.)	HP.8.3	6,449,430,402	7,255,612,289
Rest of the world	HP.9	25,981,564,378	29,145,791,680
Unspecified health care providers (n.e.c.)	HP.nec	8,631,958,029	9,704,691,728

A.6 HEALTHCARE FUNCTIONS

Classification Name	Code	Amount	
		2020	2021
Health care functions	HC	851,202,311,502	963,041,272,191
Curative care	HC.1	668,467,880,374	752,157,195,821
Inpatient curative care	HC.1.1	77,065,814,586	86,327,511,934
General inpatient curative care	HC.1.1.1	75,490,751,117	82,052,761,943
Specialised inpatient curative care	HC.1.1.2	1,455,859,007	1,138,496,454
Unspecified inpatient curative care (n.e.c.)	HC.1.1.nec	119,204,462	3,136,253,538
Day curative care	HC.1.2	19,783,403	14,056,645
General day curative care	HC.1.2.1	19,783,403	14,056,645
Outpatient curative care	HC.1.3	591,382,282,385	665,815,627,242
General outpatient curative care	HC.1.3.1	589,766,433,785	662,257,257,539
Dental outpatient curative care	HC.1.3.2	160,340,356	112,453,161
Specialised outpatient curative care	HC.1.3.3	1,305,704,611	927,738,579
Unspecified outpatient curative care (n.e.c.)	HC.1.3.nec	149,803,633	2,518,177,962
Rehabilitative care	HC.2	5,484,486,831	5,306,877,055
Inpatient rehabilitative care	HC.2.1	1,088,087,176	773,115,483
Outpatient rehabilitative care	HC.2.3	1,147,437,386	815,285,418
Unspecified rehabilitative care (n.e.c.)	HC.2.nec	3,248,962,269	3,718,476,154
Ancillary services (non-specified by function)	HC.4	5,760,154,264	8,807,533,358
Laboratory services	HC.4.1	5,150,713,085	7,488,999,274
Imaging services	HC.4.2	457,747,139	1,053,893,990
Patient transportation	HC.4.3	113,240,085	235,894,832
Unspecified ancillary services (n.e.c.)	HC.4.nec	38,453,956	28,745,261
Medical goods (non-specified by function)	HC.5	7,772,032,247	11,699,950,391
Pharmaceuticals and Other medical non-durable goods	HC.5.1	4,562,104,167	6,559,082,170
Prescribed medicines	HC.5.1.1	2,575,271,668	2,445,443,888

Other medical non-durable goods	HC.5.1.3	1,986,832,499	4,113,638,282
Therapeutic appliances and Other medical goods	HC.5.2	1,244,226,742	2,768,109,458
All Other medical durables, including medical technical devices	HC.5.2.9	1,244,226,742	2,768,109,458
Unspecified medical goods (n.e.c.)	HC.5.nec	1,965,701,338	2,372,758,763
Preventive care	HC.6	102,291,982,290	115,634,814,611
Information, education, and counseling (IEC) programmes	HC.6.1	225,740,835	475,824,754
Safe sex IEC programmes	HC.6.1.3	407,500	300,000
Other and unspecified IEC programmes (n.e.c.)	HC.6.1.nec	225,333,335	475,524,754
Immunisation programmes	HC.6.2	3,497,922,889	3,188,195,836
Other Immunisation programmes	HC.6.2.nec	3,497,922,889	3,188,195,836
Early disease detection programmes	HC.6.3	1,042,363,246	1,100,191,987
Healthy condition monitoring programmes	HC.6.4	613,285,499	435,755,999
Epidemiological surveillance and risk and disease control programmes	HC.6.5	1,521,399,021	2,789,120,279
Planning & Management	HC.6.5.1	69,753,213	1,671,045,762
Monitoring & Evaluation (M&E)	HC.6.5.2	104,352,260	194,627,629
Procurement & supply management	HC.6.5.3	159,625,061	295,070,269
Unspecified epidemiological surveillance and risk and disease control programmes (n.e.c.)	HC.6.5.nec	1,187,668,486	628,376,619
Unspecified preventive care (n.e.c.)	HC.6.nec	95,391,270,800	107,645,725,755
Governance, and health system and financing administration	HC.7	46,009,905,872	55,040,695,031
Governance and Health system administration	HC.7.1	43,163,841,484	50,838,020,143
Planning & Management	HC.7.1.1	13,072,146,445	15,390,161,023
Monitoring & Evaluation (M&E)	HC.7.1.2	8,597,627,154	10,127,959,749
Procurement & supply management	HC.7.1.3	17,195,254,308	20,255,919,497
Other governance and Health system administration (n.e.c.)	HC.7.1.nec	4,298,813,577	5,063,979,874
Administration of health financing	HC.7.2	2,846,064,387	4,202,674,887
Other health care services not elsewhere classified (n.e.c.)	HC.9	15,415,869,623	14,394,205,925

A.7 FACTORS OF HEALTHCARE PROVISION

Classification Name	Code	Amount	
		2020	2021
Factors of health care provision	FP	851,202,311,502	963,041,272,191
Compensation of employees	FP.1	58,201,342,715	73,884,322,241
Wages and salaries	FP.1.1	58,200,987,115	58,861,489,416
Social contributions	FP.1.2		1,962,563,450
All Other costs related to employees	FP.1.3	355,600	13,060,269,375
Materials and services used	FP.3	550,990,928,795	625,100,135,973
Health care services	FP.3.1	178,004,220,870	189,546,590,351
Laboratory & Imaging services	FP.3.1.1	84,309,320,437	94,719,640,507
Other health care services (n.e.c.)	FP.3.1.nec	93,694,900,433	94,826,949,844
Health care goods	FP.3.2	355,681,116,791	399,422,901,015
Pharmaceuticals	FP.3.2.1	296,716,477,908	332,816,310,504
ARV	FP.3.2.1.1	2,562,532,101	2,409,226,661
TB drugs	FP.3.2.1.2		5,095,157
Antimalarial medicines	FP.3.2.1.3	443,700	1,194,200
ACT	FP.3.2.1.3.1	287,200	905,100
Other antimalarial medicines	FP.3.2.1.3.2	156,500	289,100
Vaccines	FP.3.2.1.4	1,689,633,603	1,947,256,821
Contraceptives	FP.3.2.1.5	772,421,714	900,191,009
Other pharmaceuticals (n.e.c.)	FP.3.2.1.nec	291,691,446,789	327,553,346,655
Other health care goods	FP.3.2.2	58,964,638,883	66,606,590,511
ITNs	FP.3.2.2.1		361,607
Insecticides & spraying materials	FP.3.2.2.2	30,000	92,000
Injection supplies	FP.3.2.2.3	80,000	760,350
Diagnostic equipment	FP.3.2.2.4	95,323,050	27,736,761

Other and unspecified health care goods (n.e.c.)	FP.3.2.2.nec	58,869,205,833	66,577,639,793
Non-health care services	FP.3.3	3,148,583,009	7,209,151,876
Transport	FP.3.3.4	3,601,841	59,214,011
Training	FP.3.3.1	21,803,337	749,481,536
Technical Assistance	FP.3.3.2	1,810,176,592	1,781,908,464
Operational research	FP.3.3.3	255,847,512	265,915,280
Other non-health care services (n.e.c.)	FP.3.3.nec	1,057,153,727	4,352,632,585
Non-health care goods	FP.3.4	9,362,152,287	2,000,964,714
Other materials and services used (n.e.c.)	FP.3.nec	4,794,855,837	26,920,528,018
Consumption of fixed capital	FP.4	207,599,446	195,824,651
Other items of spending on inputs	FP.5	137,539,539	1,895,731,159
Taxes	FP.5.1	30,039,368	1,174,962,082
Other items of spending	FP.5.2	107,500,171	720,769,077
Unspecified factors of health care provision (n.e.c.)	FP.nec	241,664,901,006	261,965,258,167

A.8 CLASSIFICATION OF DISEASES/CONDITIONS

Classification Name	Code	Amount	
		2020	2021
Classification of diseases / conditions	DIS	851,202,311,502	963,041,272,191
Infectious and parasitic diseases	DIS.1	560,383,955,056	630,874,742,672
HIV/AIDS and Other Sexually Transmitted Diseases (STDs)	DIS.1.1	32,487,879,277	35,351,022,817
HIV/AIDS and Opportunistic Infections (OIs)	DIS.1.1.1	31,855,442,102	34,640,305,913
HIV/AIDS	DIS.1.1.1.1	31,855,442,102	34,640,305,913
STDs Other than HIV/AIDS	DIS.1.1.2	632,437,175	710,716,904
Tuberculosis (TB)	DIS.1.2	70,363,573,978	78,817,120,210
Unspecified tuberculosis (n.e.c.)	DIS.1.2.nec	70,363,573,978	78,817,120,210
Malaria	DIS.1.3	207,838,275,283	235,946,294,875
Other respiratory infections	DIS.1.4	4,234,140,572	4,898,672,631
Diarrheal diseases	DIS.1.5	16,612,500,110	18,695,058,932
Neglected tropical diseases	DIS.1.6	21,236,027,999	23,813,904,794
Vaccine preventable diseases	DIS.1.7	198,653,095,717	222,648,602,999
Hepatitis	DIS.1.8	8,792,141,087	9,847,346,517
Public Health Emergencies of International Concern (PHEICs)	DIS.1.9	37,174,515	684,665,734
Disease from coronavirus 2019-nCov (COVID-19)	DIS.1.9.2	37,174,515	684,665,734
Other and unspecified infectious and parasitic diseases (n.e.c.)	DIS.1.nec	129,146,518	172,053,164
Reproductive health	DIS.2	121,006,856,926	137,356,564,932
Maternal conditions	DIS.2.1	73,385,497,346	83,456,838,116
Perinatal conditions	DIS.2.2	6,588,559,373	7,492,607,865
Contraceptive management (family planning)	DIS.2.3	40,827,369,626	46,378,553,957
Unspecified reproductive health conditions (n.e.c.)	DIS.2.nec	205,430,581	28,564,994
Nutritional deficiencies	DIS.3	43,048,839	66,265,910
Noncommunicable diseases	DIS.4	72,944,333,103	83,044,646,434

Neoplasms	DIS.4.1	559,634,913	697,884,735
Endocrine and metabolic disorders	DIS.4.2	20,473,232,258	23,379,171,999
Other and unspecified endocrine and metabolic disorders (n.e.c.)	DIS.4.2.nec	20,473,232,258	23,379,171,999
Cardiovascular diseases	DIS.4.3	36,064,539,502	41,143,766,877
Other and unspecified cardiovascular diseases (n.e.c.)	DIS.4.3.nec	36,064,539,502	41,143,766,877
Mental & behavioural disorders, and Neurological conditions	DIS.4.4	6,015,506,922	6,786,054,564
Mental (psychiatric) disorders	DIS.4.4.1	3,652,293,281	697,884,735
Unspecified mental & behavioural disorders and neurological conditions (n.e.c.)	DIS.4.4.nec	2,363,213,641	6,088,169,829
Respiratory diseases	DIS.4.5	6,275,303,133	7,043,651,500
Diseases of the digestive	DIS.4.6	1,054,061,958	1,184,528,173
Sense organ disorders	DIS.4.8	195,000	
Oral diseases	DIS.4.9	874,407,929	986,685,842
Other and unspecified noncommunicable diseases (n.e.c.)	DIS.4.nec	1,627,451,487	1,822,902,743
Injuries	DIS.5	14,886,474,746	21,186,606,917
Road traffic accidents	DIS.5.1	1,093,224,012	1,147,669,111
Other Injuries	DIS.5.nec	13,793,250,734	20,038,937,806
Other and unspecified diseases/conditions (n.e.c.)	DIS.nec	81,937,642,830	90,512,445,325

Appendix B: Capital Health Expenditure Classifications

B.1 CAPITAL FORMATION

Classification Name	Code	Amount	
		2020	2021
Gross fixed capital formation	HK	19,010,782,231	26,941,162,473
Gross capital formation	HK.1	5,756,277,247	24,737,716,504
Gross fixed capital formation	HK.1.1	5,754,517,431	23,857,840,511
Education, Training and Research	HK.1.1.4	3,548,154,650	5,543,868,972
Infrastructure	HK.1.1.1	1,355,305,554	14,778,635,765
Residential and non-residential buildings	HK.1.1.1.1	1,354,305,554	14,778,635,765
Other structures	HK.1.1.1.2	1,000,000	
Machinery and equipment	HK.1.1.2	849,466,930	3,362,696,784
Medical equipment	HK.1.1.2.1	790,966,385	2,921,899,825
Transport equipment	HK.1.1.2.2	48,564,397	90,825,183
ICT equipment	HK.1.1.2.3	6,296,403	40,578,010
Machinery and equipment n.e.c.	HK.1.1.2.4	3,639,745	309,393,767
Intellectual property products	HK.1.1.3	1,590,297	172,638,990
Computer software and databases	HK.1.1.3.1	1,590,297	172,638,990
Changes in inventories	HK.1.2		879,875,993
Unspecified gross capital formation (n.e.c.)	HK.1.nec	1,759,816	
Non-produced non-financial assets	HK.2		17,409,281
Land	HK.2.1		17,409,281
Unspecified gross fixed capital formation (n.e.c.)	HK.nec	13,254,504,984	2,186,036,688

B.2 INSTITUTIONAL UNITS PROVIDING REVENUES TO FINANCING SCHEMES

Classification Name	Code	Amount	
		2020	2021
Institutional units providing revenues to financing schemes	FS.RI	19,010,782,231	26,941,162,473
Government	FS.RI.1.1	17,839,838,464	25,766,148,052
Federal Government	FS.RI.1.1.1	1,048,389,014	5,445,975,475
Sub-national Government	FS.RI.1.1.2	16,791,449,450	20,320,172,577
State Government	FS.RI.1.1.2.1	15,115,985,603	18,862,469,746
Local Government	FS.RI.1.1.2.2	1,675,463,847	1,457,702,831
Corporations	FS.RI.1.2	9,831,340	83,117,933
NPISH	FS.RI.1.4	1,590,297	3,769,810
Rest of the world	FS.RI.1.5	1,159,522,130	1,088,126,679
Bilateral donors	FS.RI.1.5.1	1,153,892,339	1,086,493,019
United Kingdom	FS.RI.1.5.1.24		1,633,170
United States (USAID)	FS.RI.1.5.1.25	1,153,892,339	1,084,859,849
Multilateral donors	FS.RI.1.5.2	5,629,791	1,633,660
EU Institutions	FS.RI.1.5.2.6	510,858	
UNFPA	FS.RI.1.5.2.15	5,118,932	1,633,660

B.3 FINANCING AGENTS

Classification Name	Code	Amount	
		2020	2021
Financing agents	FA	19,010,782,231	26,941,162,473
General government	FA.1	17,847,058,552	25,771,384,692
Central government	FA.1.1	1,170,219,394	5,444,342,305
Other ministries and public units (belonging to central government)	FA.1.1.2	905,947,894	2,942,751,816
National Health Service Agency	FA.1.1.3	264,271,500	2,501,590,489
State/Regional/Local government	FA.1.2	16,676,839,158	20,327,042,387
State Ministry of Health	FA.1.2.1	11,504,687,924	13,755,076,146
Other state ministries and public units (belonging to state government)	FA.1.2.2	1,590,297	1,969,810
State Health Service Agency	FA.1.2.3	3,482,857,318	5,112,293,600
State Health Insurance Agency	FA.1.2.4	12,239,772	
LGA Health Department	FA.1.2.5	1,675,463,847	1,457,702,831
Insurance corporations	FA.2	5,805,000	79,100,000
Commercial insurance companies	FA.2.1	5,805,000	79,100,000
Corporations (Other than insurance corporations)	FA.3	4,026,340	4,017,933
Health management and provider corporations	FA.3.1	860,000	1,250,000
Corporations (Other than providers of health services)	FA.3.2	3,166,340	2,767,933
Non-profit institutions serving households (NPISH)	FA.4	1,153,892,339	1,086,659,849

B.4 HEALTHCARE PROVIDERS

Classification Name	Code	Amount	
		2020	2021
Health care providers	HP	19,010,782,231	26,941,162,473
Hospitals	HP.1	291,687,987	2,937,134,001
Providers of preventive care	HP.6	150,210,941	203,978,525
Providers of health care system administration and financing	HP.7	13,632,820,751	15,963,981,546
Rest of economy	HP.8	4,936,062,551	7,836,068,401

B.5 CLASSIFICATION OF DISEASES/CONDITIONS

Classification Name	Code	Amount	
		2020	2021
Classification of diseases / conditions	DIS	19,010,782,231	26,941,162,473
Infectious and parasitic diseases	DIS.1	12,008,057,939	16,054,845,786
Hepatitis	DIS.1.8	214,525,180	277,112,913
Public Health Emergencies of International Concern (PHEICs)	DIS.1.9	5,846,000	
HIV/AIDS and Other Sexually Transmitted Diseases (STDs)	DIS.1.1	1,539,333,017	2,475,611,852
HIV/AIDS and Opportunistic Infections (OIs)	DIS.1.1.1		253,993,946
HIV/AIDS	DIS.1.1.1.1		253,993,946
Tuberculosis (TB)	DIS.1.2	1,178,563,902	1,734,784,139
Unspecified tuberculosis (n.e.c.)	DIS.1.2.nec		1,425,005,380
Malaria	DIS.1.3	3,693,624,954	5,405,530,288
Other respiratory infections	DIS.1.4	90,672,144	157,865,091
Diarrheal diseases	DIS.1.5	154,128,246	203,969,159
Neglected tropical diseases	DIS.1.6	475,147,185	400,225,701
Vaccine preventable diseases	DIS.1.7	4,655,951,503	5,391,339,920
Other and unspecified infectious and parasitic diseases (n.e.c.)	DIS.1.nec	265,808	8,406,724
Reproductive health	DIS.2	2,867,156,476	3,626,167,100
Maternal conditions	DIS.2.1	1,525,829,616	2,255,804,875
Perinatal conditions	DIS.2.2	160,090,342	204,547,776
Contraceptive management (family planning)	DIS.2.3	945,713,772	1,163,146,459
Unspecified reproductive health conditions (n.e.c.)	DIS.2.nec	235,522,746	2,667,989
Nutritional deficiencies	DIS.3	88,603	3,733,147
Noncommunicable diseases	DIS.4	1,227,070,767	2,179,529,309
Neoplasms	DIS.4.1	1,151,835	33,869,146
Endocrine and metabolic disorders	DIS.4.2	334,805,637	599,728,122

Other and unspecified endocrine and metabolic disorders (n.e.c.)	DIS.4.2.nec		408,002,628
Cardiovascular diseases	DIS.4.3	793,108,937	1,269,099,925
Other and unspecified cardiovascular diseases (n.e.c.)	DIS.4.3.nec		972,929,344
Mental & behavioural disorders, and Neurological conditions	DIS.4.4	6,467,150	160,516,145
Unspecified mental & behavioural disorders and neurological conditions (n.e.c.)	DIS.4.4.nec		15,692,409
Respiratory diseases	DIS.4.5	52,018,848	66,004,190
Other and unspecified noncommunicable diseases (n.e.c.)	DIS.4.nec	39,518,361	50,311,781
Injuries	DIS.5	71,182,955	498,404,777
Road traffic accidents	DIS.5.1		32,273,244
Other Injuries	DIS.5.nec	71,182,955	466,131,534
Other and unspecified diseases/conditions (n.e.c.)	DIS.nec	2,837,225,491	4,578,482,353

Appendix C: 2021 Standard SHA Matrices

C.1 WHO FUNDS WHAT? (HC X HF)

	Central government schemes	State government schemes	Local government schemes	National health insurance scheme	State health insurance scheme	Voluntary health insurance schemes	NPISH financing schemes (including development agencies)	Enterprise financing schemes	Household out-of-pocket payment	All HF
Curative care	8,504,270,311	4,851,097,094		760,352,705	439,704,850	6,617,046,053		399,904,227	730,584,820,582	752,157,195,821
Rehabilitative care	4,947,010,815	269,534,960		43,806,329	25,332,790	20,743,397		448,765		5,306,877,055
Ancillary services (non-specified by function)	1,883,590,449	5,172,451,080		835,449,268	483,132,490	395,606,223	27,650,761	9,653,087		8,807,533,358
Medical goods (non-specified by function)	1,092,000	5,044,762,026		810,417,080	468,656,610	2,006,519,748	3,338,362,495	30,140,433		11,699,950,391
Preventive care	2,084,833,481	2,576,312,557		369,224,770	213,519,228	174,837,207	4,830,533,450	10,331,397	105,375,222,521	115,634,814,611
Governance, and health system and financing administration	518,201,225	45,692,630,559	4,662,171,626	10,172,892	984,777,967	3,115,461,872	57,278,889			55,040,695,031
Other health care services not elsewhere classified (n.e.c.)	4,011,259	1,910,212,262		309,773,324	179,139,013	146,685,453	19,089,940	11,825,294,674		14,394,205,925
All HC	17,943,009,539	65,517,000,538	4,662,171,626	3,139,196,367	2,794,262,947	12,476,899,953	8,272,915,536	12,275,772,582	835,960,043,103	963,041,272,191

C.2 WHO PROVIDES WHAT? (HC X HP)

	Hospitals	Providers of ambulatory health care	Retailers and Other providers of medical goods	Providers of preventive care	Providers of health care system administration and financing	Rest of economy	Rest of the world	Unspecified health care providers (n.e.c.)	All HP
Curative care	510,957,249,149	95,235,270,392	107,176,404,795			9,398,763,562	20,276,301,047	9,113,206,875	752,157,195,821
Rehabilitative care	5,290,928,681	15,902,177	32,657			13,540			5,306,877,055
Ancillary services (non-specified by function)	8,443,665,478	335,311,577	622,808			27,933,496			8,807,533,358
Medical goods (non-specified by function)	6,397,145,906	352,189,299	1,607,408,098		366,242	3,342,840,846			11,699,950,391
Preventive care	69,647,171,952	14,741,833,422	11,961,160,484	235,462,471	17,361,019	9,570,849,777	8,869,490,633	591,484,852	115,634,814,611
Governance, and health system and financing administration					55,040,695,031				55,040,695,031
Other health care services not elsewhere classified (n.e.c.)	2,433,794,129	116,666,154	230,929			11,843,514,714			14,394,205,925
All HC	603,169,955,294	110,797,173,020	120,745,859,771	235,462,471	55,058,422,292	34,183,915,935	29,145,791,680	9,704,691,728	963,041,272,191

C.3 WHO FUNDS WHO? (HP X HF)

	Central government schemes	State government schemes	Local government schemes	National health insurance scheme	State health insurance scheme	Voluntary health insurance schemes	NPISH financing schemes (including development agencies)	Enterprise financing schemes	Household out-of-pocket payment	All HF
Hospitals	17,415,905,055	18,968,155,462		3,129,023,476	1,126,120,980	7,460,019,363		428,763,579	554,641,967,380	603,169,955,294
Providers of ambulatory health care		607,474,785			683,364,000	281,656,277			109,224,677,958	110,797,173,020
Retailers and Other providers of medical goods						1,619,762,441			119,126,097,330	120,745,859,771
Providers of preventive care		235,462,471								235,462,471
Providers of health care system administration and financing	522,651,225	45,705,907,820	4,662,171,626	10,172,892	984,777,967	3,115,461,872	57,278,889			55,058,422,292
Rest of economy	4,453,259						8,215,636,646	11,847,009,003	14,116,817,027	34,183,915,935
Rest of the world									29,145,791,680	29,145,791,680
Unspecified health care providers (n.e.c.)									9,704,691,728	9,704,691,728
All HP	17,943,009,539	65,517,000,538	4,662,171,626	3,139,196,367	2,794,262,947	12,476,899,953	8,272,915,536	12,275,772,582	835,960,043,103	963,041,272,191

C.4 WHO DOES THE MONEY COME FROM? (HF X FS)

	Earmarked funds	Internal Transfer and grants from Federal Government	Internal Transfer and grants from State Government	Internal Transfer and grants from Local Government	Transfers distributed by government from foreign origin	Social insurance contributions	Voluntary prepayment	Other domestic revenues n.e.c.	Direct foreign transfers	All FS
Central government schemes		17,943,009,539								17,943,009,539
State government schemes		1,897,532	64,057,980,623		1,457,122,383					65,517,000,538
Local government schemes				4,662,171,626						4,662,171,626
National health insurance scheme						3,139,196,367				3,139,196,367
State health insurance scheme	683,364,000					2,110,898,947				2,794,262,947
Voluntary health insurance schemes							12,476,899,953			12,476,899,953
NPISH financing schemes (including development agencies)								703,359,749	7,569,555,787	8,272,915,536
Enterprise financing schemes								12,275,772,582		12,275,772,582
Household out-of-pocket payment								835,960,043,103		835,960,043,103
All HF	683,364,000	17,944,907,071	64,057,980,623	4,662,171,626	1,457,122,383	5,250,095,314	12,476,899,953	848,939,175,434	7,569,555,787	963,041,272,191

C.5 WHO MANAGES THE PAYMENT SCHEMES? (HF X FA)

	Other ministries and public units (belonging to central government)	National Health Service Agency	National Health Insurance Agency	State Ministry of Health	State Health Service Agency	State Health Insurance Agency	LGA Health Department	Insurance corporations	Corporations (Other than insurance corporations) (part of HF.RI.1.2)	Non-profit institutions serving households (NPISH)	Households	All FA
Central government schemes	523,304,484	17,419,705,055										17,943,009,539
State government schemes				18,964,916,247	45,995,413,953	556,670,338						65,517,000,538
Local government schemes							4,662,171,626					4,662,171,626
National health insurance scheme			3,139,196,367									3,139,196,367
State health insurance scheme						2,794,262,947						2,794,262,947
Voluntary health insurance schemes								12,476,899,953				12,476,899,953
NPISH financing schemes (including development agencies)										8,272,915,536		8,272,915,536
Enterprise financing schemes									12,275,772,582			12,275,772,582

Household out-of-pocket payment											835,960,043,103	835,960,043,103
All HF	523,304,484	17,419,705,055	3,139,196,367	18,964,916,247	45,995,413,953	3,350,933,285	4,662,171,626	12,476,899,953	12,275,772,582	8,272,915,536	835,960,043,103	963,041,272,191

C.6 WHAT INPUTS WERE USED IN PROVISION BY PROVIDERS? (HP X FP)

	Compensation of employees	Health care services	Health care goods	Non-health care services	Non-health care goods	Other materials and services used (n.e.c.)	Consumption of fixed capital	Other items of spending on inputs	Unspecified factors of health care provision (n.e.c.)	All FP
Hospitals	29,411,216,894	131,314,333,830	207,642,541,375	1,969,214,927	746,226,741	19,145,432,400	645,000	1,794,008,245	211,146,335,882	603,169,955,294
Providers of ambulatory health care	539,062,115	23,954,898,316	68,098,220,126	30,894,729	32,415,647	1,684,646,791			16,457,035,297	110,797,173,020
Retailers and Other providers of medical goods		16,405,646,289	89,715,066,434			4,383			14,625,142,664	120,745,859,771
Providers of preventive care	146,384,519	2,783,849		80,030,441	6,263,661					235,462,471
Providers of health care system administration and financing	43,261,974,105	1,940,925,659	199,207,822	3,194,885,567	1,214,084,606	3,798,563,241		539,568	1,448,241,724	55,058,422,291
Rest of economy	525,684,608	3,619,219,328	10,465,699,087	1,934,126,212	1,974,059	1,785,530,106	195,179,651	101,183,346	15,555,319,539	34,183,915,935
Rest of the world		9,375,841,730	19,263,598,854			506,351,096				29,145,791,680
Unspecified health care providers (n.e.c.)		2,932,941,351	4,038,567,316						2,733,183,061	9,704,691,728
All HP	73,884,322,241	189,546,590,351	399,422,901,015	7,209,151,876	2,000,964,714	26,920,528,018	195,824,651	1,895,731,159	261,965,258,167	963,041,272,191

C.7 WHO IS PAYING FOR EACH DISEASE? (DIS X FS.RI)

	Federal Government	State Government	Local Government	Corporations	Households	NPISH	Rest of the world	All FS.RI
HIV/AIDS and Other Sexually Transmitted Diseases (STDs)	3,832,165,415	1,191,249,951	9,324,343	90,850,695	24,179,540,165	51,078,654	5,996,813,594	35,351,022,817
Tuberculosis (TB)	1,122,785,901	5,459,134,603	191,149,037	498,086,224	70,039,446,769	36,200	1,506,481,476	78,817,120,210
Malaria	623,138,208	17,274,022,005	331,014,185	1,612,217,165	216,104,903,311	1,000,000		235,946,294,875
Other respiratory infections	149,237,577	419,244,326	4,662,172	39,506,248	4,286,022,309			4,898,672,631
Diarrheal diseases	25,255,106	721,189,824	9,324,343	67,794,796	17,871,494,861			18,695,058,932
Neglected tropical diseases	9,612,522	2,087,103,152	867,163,922	90,310,602	20,759,714,595			23,813,904,794
Vaccine preventable diseases	495,324,012	21,386,659,321	2,755,343,431	1,698,032,680	196,313,243,555			222,648,602,999
Hepatitis	20,426,609	1,005,738,464	4,662,172	95,594,745	8,720,924,527			9,847,346,517
Disease from coronavirus 2019-nCov (COVID-19)	490,426			3,375,500		86,572,965	594,226,843	684,665,734
Other and unspecified infectious and parasitic diseases (n.e.c.)	36,947,207				135,105,958			172,053,164
Reproductive health	1,399,494,191	12,367,566,785	447,568,476	1,111,662,143	120,888,557,387	105,235,597	1,036,480,352	137,356,564,932
Nutritional deficiencies	10,833,383			72,500	55,360,028			66,265,910
Noncommunicable diseases	5,766,525,824	5,708,629,591	41,959,545	540,648,271	70,986,883,203			83,044,646,434

Injuries	5,191,681,169	117,298,828		12,892,699	15,864,734,221			21,186,606,917
Other and unspecified diseases/conditions (n.e.c.)	3,886,357	1,426,782,444		15,621,052,991	73,170,041,662	237,783,145	52,898,726	90,512,445,325
All DIS	18,687,803,907	69,164,619,295	4,662,171,626	21,482,097,260	839,375,972,552	481,706,561	9,186,900,990	963,041,272,191

Appendix D: Study team participants list and institutions

NAME	INSTITUTION
PROF. AKIN ABAYOMI	HONOURABLE COMMISSIONER, HEALTH
DR. OLUSEGUN OGBOYE	PERMANENT SECRETARY, HEALTH
DR. OLUDAYO LAJIDE	LSMOH
DR. OLUWATOSIN IJIMAKINWA	LSMOH
DR. CHINYERE GIFT-OKORIE	LSMOH
DR. OLUTOMIKE AJOSE	LSMOH
BASIT BARUWA	LBS
PETER OLOWU	LBS
DR. OLAJUMOKE OYENUGA	LSMOH
DR. FAITH ONIYIRE	LSMOH
DR. ADEBANKE ODUNSI	LSMOH
JOAN OLUYEMI	LSMOH
EMMANUEL OJERINDE	LSMOH
HAZEEZAT OLAJUMOKE BUSARI	LSMOH
OLUWAKEMI SHITTU	LSMOH
ADEKUNLE JOSEPH SURU	LSMOH
ADIJAT OPEYEMI SHITTU	LSMOH
DR. UZOMA NWANKWO	FMOH
DR. AYOMOH JUSTINE CHUKWUNONSO	FMOH
SANDRA IKE	FMOH
ADIJAT CYNTHIA ELIJAH	FMOH
BENAZIR BISONG	FMOH
CHARLES UCHECHUKWU	NBS (ABUJA)

CHICHI MARGARET NKIRE	CSO (LACSOP)
OLUWATOSIN LASISI	LSMOH
MARK OKONJI	LSMOH
ADESHOLA MORENIKEJI BARUWA	LSMOH
FOLARIN ROLLINS AMOSU	LSMOH
FORTUNE OGUIKE-OLERU	LSMOH
ONOME EUNICE OFORHO	LSMOH
OLATUNDUN RUFAI	LSMOH
OLUWATIMILEHIN AKINTAYO	LSMOH
KELECHI EGEKENZE	LSMOH
OLUWASEUN ONIYIROKUN	LSMOH
OLUWADAMILOLA MOSOPE	LSMOH
ADEOLA OLUWATOSIN FARAMADE	LSMOH
ARIT EDEM	LSMOH
OLUWABUKOLA AYODEJI OJO	LSMOH
DR. OLORUNFEMI OLONIRE	HEFAMAA
DR. MORENIKE ABIDAKUN	HSC
DAMOLA JOHN DAWODU	LASUTH
OLUNIKE ABODUNRIN	LASHMA
ABDULLAHI SANNI	MEPB
GEBNGA FALOLA	NBS (LAGOS)
ARINOLA WASILAT ADETUNJI	NBS (LAGOS)
CYNTHIA IKHARO	LBS
WASIU LAWAL	LBS
OLUWATOSIN DARAMOLA	LBS
DANIEL OKAFOR	LBS

OLAYINKA OLADUNJOYE	LBS
ADELEKE AJAYI	LBS
SEGUN AUGUSTINE DARE	LBS
OLAJIDE OLABIYI	LBS
FUNMILOLA OLANIPEKUN	LBS
OLUWASEUN OGUNMOLU	LBS
KEHINDE OGUNBIYI	LBS
QUADRI OLAOYE	LBS
ADEBAYO TAJUDEEN KAZEEM	LBS
OLANIRAN BANWO	PFMU
DR. SIJUWADE OJUKO-ALADEJANA	CHECOD Africa
MICHAEL ABEREJESU	CHECOD Africa
UBONG EKERETE	CHECOD Africa
PAUL AKENI	CHECOD Africa
OLUWOLE SMILE	CHECOD Africa
DR. OLUMIDE TAIWO	CHECOD Africa
DR. FRANCIS UKWUIJE	WHO