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REDRESSING NIGERIA'S HEALTHCARE AND PRODUCTIVITY DEFICITS: A CRITICAL LEGAL APPRAISAL OF THE NATIONAL HEALTH ACT, 2014 AND HUMAN CAPITAL GOVERNANCE FRAMEWORK

By

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Abstract

Nigeria's healthcare system remains overwhelmed by deep structural deficits that directly undermine national productivity and human capital development. With a population exceeding 200 million, the country contends with severe shortages in health infrastructure, a physician density of approximately 3.8 - 4 per 10,000 people, and persistent brain drain, as thousands of doctors and nurses emigrate annually in search of better opportunities, leaving fewer to serve the entire population. These challenges are compounded by chronic underfunding, with federal health budget allocations consistently flying around 4 - 6% of the national budget. Enacted in 2014, the National Health Act (NHA) represents a landmark attempt to redress these deficits by establishing a unified National Health System. It integrates public and private providers, delineates responsibilities across federal, state, and local tiers, and enshrines rights and obligations for users and providers, including emergency treatment without refusal. Key innovations include the Basic Health Care Provision Fund (BHCPF) for primary healthcare revitalization, provisions for human resources for health, addressing distribution, training, and retention, standards for health establishments, and mechanisms for research and information systems. This paper offers a critical legal appraisal of the NHA within broader human capital governance frameworks. While the Act provides a robust normative foundation through aligning with constitutional aspirations under Sections 17 and 33 of the 1999 Constitution (as amended). The analysis evaluates the NHA's strengths in rights-based approaches and institutional design against its operational shortcomings, drawing comparative insights from successful health human capital models. It argues that redressing Nigeria's deficits requires not legislative overhaul but strengthened enforcement, sustained financing, multi-tier coordination, and integration of health into national human capital strategies. Recommendations include mandatory implementation mechanisms, incentives for retention, digital governance tools, and judicial enforcement of health rights to harness healthcare as a driver of productivity.

Keywords: **National Health Act 2014, healthcare deficits, human capital governance, productivity, Basic Health Care Provision Fund.**

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1.0 INTRODUCTION

Health is not merely the absence of disease, it is the foundational infrastructure of human capital and, by extension, economic productivity.[1] The relationship is empirically settled that healthier populations work more, earn more, and contribute more to national output.[2] For Nigeria, Africa's most populous nation and largest economy, the stakes could not be higher.[3] Yet the country consistently ranks among the worst performers on global health indices, with maternal mortality ratios exceeding 500 per 100,000 live births, under five mortality rates above 100 per 1,000, and life expectancy languishing below 55 years.[4]

The paradox is that Nigeria possesses a comprehensive legal framework for health governance. The National Health Act, establishes a rights-based approach to healthcare, creating institutional structures, funding mechanisms, and regulatory standards designed to propel the nation towards universal health coverage.[5] Why, then, do Nigerians continue to die from preventable causes? Why does out of pocket expenditure remain the dominant mode of health financing? Why do health workers strike with impunity, and why do rural health centres remain unstaffed and unequipped?

This paper argues that the answer lies in a tripartite failure, constitutional, institutional, and accountability based. Firstly, the non-justiciability of Chapter II of the Constitution of the Federal Republic of Nigeria (as amended), renders the right to health unenforceable in courts, a structural defect that reduces the NHA 2014 to aspirational policy rather than enforceable right.[6] Secondly, Nigeria's federal governance structure fragments health authority across three tiers of government, creating coordination failures, duplication, and political

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[1] WHO, *Macroeconomics and Health: Investing in Health for Economic Development* (WHO 2001) 1
[2] D Bloom, D Canning & J Sevilla, 'The Effect of Health on Economic Growth: A Production Function Approach' *World Development* (2004) (32) (1) 3
[3] World Bank, 'Nigeria Overview' (World Bank, 2025) <https://www.worldbank.org/en/country/nigeria/overview> accessed 16 April 2026.
[4] WHO, 'Nigeria Country Profile' (WHO, 2025) <https://www.who.int/countries/nga/> accessed 16 April 2026
[5] National Health Act 2014, s 9
[6] Constitution of the Federal Republic of Nigeria 1999 (as amended), s 6(6)(c)

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interference that undermines implementation.[7] Thirdly, the absence of robust accountability mechanisms, legislative oversight, judicial enforcement, citizen participation, allows systemic failures to persist without consequence.[8]

This paper proceeds to traces the constitutional and statutory architecture of health governance in Nigeria and analyses the governance failures that subvert implementation, drawing on political economy analysis. The research paper establishes the causal link between health deficits and productivity losses through human capital theory and examines the accountability vacuum, identifying specific legal and institutional weaknesses. The paper concludes by proposing reform agendas.

2.0 THE LEGAL ARCHITECTURE OF HEALTH GOVERNANCE IN NIGERIA

2.1 Constitutional Foundations: The Right to Health as an Aspiration

The 1999 Constitution does not expressly recognise the right to health as a fundamental right enforceable in courts. Instead, health is relegated to the fundamental objectives and directive principles of state policy. Section 17(3)(d) provides that the state shall direct its policy towards ensuring that there are adequate medical and health facilities for all persons.[9] Section 17(3)(h) mandates government to direct its policy towards ensuring that the evolution and promotion of family life is encouraged.[10]

The effect of this placement is fatal to justiciability. Section 6(6)(c) of the Constitution expressly excludes Chapter II provisions from the judicial jurisdiction of courts. In *Attorney-General of Ondo State v Attorney-General of the Federation*,[11] the Supreme Court reaffirmed that Chapter II rights are non-justiciable, being merely declarations of aspiration.

[7] WHO Africa Health Observatory, 'Organization and Governance of the Health System-Nigeria Health System and Services Profile' (2025) <https://ahop.aho.afro.who.int/download/organization-and-governance-of-the-health-system-nigeria-health-system-and-services-profile/> accessed 16 April 2026.
[8] O Savage, 'Strengthening Accountability Mechanisms in the Oversight of the Right to Health in Nigeria' *International Journal of Contemporary Legal Issues and Public Policy* (2026) <https://nigerianjournalsonline.org/index.php/IJOCLLEP/article/view/3702> accessed 16 April 2026.
[9] Constitution of the Federal Republic of Nigeria (n 6), s 17(3)(d)
[10] ibid, s 17(3)(h)
[11] *Attorney-General of Ondo State v Attorney-General of the Federation* [2002] 6 NWLR (Pt 772) p 222, 250

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Consequently, no Nigerian citizen can approach a court to compel government to provide healthcare, no matter how outrageous the deprivation, no matter how preventable the death.

This constitutional architecture places Nigeria outside the mainstream of contemporary human rights jurisprudence. The African Charter on Human and Peoples' Rights (Ratification and Enforcement) Act incorporates the African Charter into Nigerian law,[12] and Article 16 of the Charter provides that, every individual shall have the right to enjoy the best attainable state of physical and mental health.[13] However, Nigerian courts have inconsistently applied the African Charter, with some decisions treating it as superior to the Constitution and others subordinating it.[14] In *Social and Economic Rights Action Center (SERAC) v Nigeria*,[15] the African Commission on Human and Peoples' Rights held that Nigeria violated the Charter by failing to protect the health rights of Ogoniland communities. Yet this decision remains unimplemented, illustrating the enforcement gap that plagues socio economic rights in Nigeria.

2.2 The National Health Act 2014: A Statutory Response

After over a decade of advocacy, the National Assembly passed the NHA 2014, which President Goodluck Jonathan assented to in December 2014.[16] The Act represents the most comprehensive legislative intervention in health governance since independence. Its key provisions include:

2.2.1 Establishment of Institutional Frameworks: Part I of the Act establishes the National Health System, comprising all healthcare providers, facilities, and institutions within Nigeria.[17] Section 4(1) creates the National Council on Health as the apex policy making

[12] African Charter on Human and Peoples' Rights (Ratification and Enforcement) Act, Cap A9, Laws of the Federation of Nigeria, 2004
[13] ibid, Article 16
[14] C Nwankwo, 'The Justiciability of Socio-Economic Rights in Nigeria: A Critique of Judicial Conservatism' *African Journal of Legal Studies* (2015) (7) (1) 45, 52
[15] *Social and Economic Rights Action Center (SERAC) v Nigeria* [2001] AHRLR 60 (ACHPR 2001) p 52
[16] National Health Act (n 5)
[17] ibid s 1(1)

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body, responsible for coordinating health policies across federal, state, and local governments.[18]

2.2.2 Rights and Obligations of Users: Section 1(1)(e) enshrines the rights of healthcare users, including the right to access healthcare services, emergency medical treatment, participation in decision making, and confidentiality.[19] Section 20 prohibits healthcare providers from refusing emergency treatment, imposing criminal liability on any person who denies such treatment.[20]

2.2.3 National Health Fund: Section 11 establishes the National Health Fund, financed through the Basic Health Care Provision Fund (BHCPF), federal government allocations, donor funding, and other sources.[21] The BHCPF is funded by not less than one per cent of the Consolidated Revenue Fund and other sources specified in the Act.[22]

2.2.4 Regulatory Bodies: The Act creates multiple regulatory institutions, including the National Tertiary Health Institutions Standards Committee (NTHISC) and the National Health Research Committee.[23]

2.3 The National Health Insurance Authority Act 2022

The National Health Insurance Authority Act 2022 (NHIA Act) repealed the National Health Insurance Scheme Act 2004 and established a new framework for health insurance.[24] Its most significant innovation is the mandatory health insurance provision, section 14 requires all citizens and legal residents to enroll in a health insurance scheme.[25] The Act also establishes the Vulnerable Group Fund, financed by the BHCPF, donor contributions, and other sources, to provide coverage for poor and vulnerable populations.[26]

[18] ibid s 4(1)
[19] ibid s 1
[20] ibid s 20
[21] ibid s 11
[22] ibid s 11(2)a
[23] ibid ss 9 & 31
[24] National Health Insurance Authority Act 2022, No 17 of 2022
[25] ibid, s 14
[26] ibid, s 25

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However, the NHIA Act suffers from implementation deficits mirroring those of the NHA 2014. As of 2025, coverage remains below 10 per cent of the population, with the informal sector, comprising over 80 per cent of Nigeria's workforce, largely uninsured.[27] The mandatory provisions remain unenforced, and the Vulnerable Group Fund is chronically underfunded.

2.4 The Primary Health Care Under One Roof Policy

At the state level, the Primary Health Care Under One Roof (PHCUOR) policy, adopted in 2013, seeks to unify primary health care governance by establishing State Primary Health Care Development Boards (SPHCDBs) responsible for all primary health care functions.[28] While 35 states have enacted laws implementing PHCUOR, implementation varies widely, with many states failing to adequately fund or staff their SPHCDBs.[29]

3.0 GOVERNANCE FAILURES: FROM LEGISLATIVE INTENT TO IMPLEMENTATION REALITY

3.1 The Political Economy of Health Reform

The gap between statutory provisions and health outcomes is not accidental, it is produced by identifiable political and institutional dynamics. Kevin Croke's analysis of Nigeria's health reforms deploys political settlement analysis to explain why evidence-based policies fail to achieve implementation.[30]

Croke identifies Nigeria as a competitive clientelist political settlement, a system where political power is distributed among competing elites who maintain loyalty through patronage rather than programmatic policies.[31] In such settings, health reforms that threaten established patronage networks generate powerful opposition. The NHA 2014's governance reforms, which sought to centralise certain functions and reduce political interference, created conflicts

[27] National Health Insurance Authority, *Annual Report 2024* (NHIA, 2025) 15
[28] National Primary Health Care Development Agency, *PHCUOR Implementation Guidelines* (NPHCDA, 2013) 5
[29] WHO Africa Health Observatory, (n 7)
[30] K Croke, 'Health Reform in Nigeria: The Politics of Primary Health Care and Universal Health Coverage' *Health Policy and Planning* (2024) (39) (1) 22, 24
[31] ibid, 25

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between health sector agencies about both reform content and process.[32] Nine years after the Act's passage, Croke notes, disbursements have been sporadic, and implementation remains incomplete.[33]

The implications are profound, where politicians derive power from controlling access to resources, including health budgets, reforms that seek to insulate health governance from political manipulation are inherently threatening. The result is what scholars call implementation attrition, policies are adopted at the federal level, but their provisions are progressively diluted, delayed, or defunded as they encounter resistance at state and local levels.[34]

3.2 Federal Fragmentation and Coordination Failures

Nigeria's three-tier government structure, federal, state, and local governments, creates inherent coordination challenges. The NHA 2014 assigns responsibility for tertiary health services to the federal government, secondary services to states, and primary services to local governments.[35] In practice, this division produces three pathologies.

First, duplication and overlap. The federal government maintains primary health care facilities (through teaching hospitals' community health programme) even as local governments claim primary health care as their domain.[36] This duplication wastes scarce resources and creates confusion about accountability.

Second, fiscal mismatches. The federal government controls the majority of nationally generated revenue, but states and local governments bear primary responsibility for frontline health services.[37] When federal transfers to states are delayed or reduced, as frequently happens, health services suffer disproportionately.

[32] ibid, 28
[33] ibid, 29
[34] M Grindle, 'Good Enough Governance: Poverty Reduction and Reform in Developing Countries' *Governance* (2004) (17) (4) 525, 530
[35] National Health Act (n 5), s 5
[36] WHO Africa Health Observatory, (n 7)
[37] National Bureau of Statistics, 'Health Sector Expenditure Report 2024' (NBS, 2025) 12

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Third, political interference at all levels. State governors, who control secondary health facilities, often appoint unqualified political loyalists to head health institutions.[38] Local government chairpersons, who are politically vulnerable, similarly prioritise patronage over professional management. The WHO's Africa Health Observatory notes that overlaps between tiers and party or political influences weaken coordination in the system.[39]

3.3 The Funding Gap: Legal Mandates Versus Fiscal Reality

The NHA 2014's funding provisions are legally mandatory, yet consistently violated. Section 11(2)(a) requires that not less than one per cent of the Consolidated Revenue Fund be allocated to the BHCPF.[40] Even this modest requirement has been routinely ignored. Nigeria's health budget has consistently fallen short of the 15 per cent of annual budget recommended by the 2001 Abuja Declaration, a commitment Nigeria has never met.[41]

The work of Marius, Agu, and Okwor examines the relationship between health expenditure, governance, and economic growth using Nigerian data.[42] Applying the augmented Solow-Mankiw-Romer-Weil structural model, they find that governance quality adversely affects growth and this reduces the capacity of health spending to stimulate growth by an almost equal margin.[43] In other words, poor governance does not merely reduce health spending, it actively undermines the productivity of whatever spending occurs. The authors recommend legislative backing to the African Union health funding commitment, a recommendation that has gone unheeded.[44]

The Association of Community Pharmacists of Nigeria (ACPN) recently highlighted the consequences of underfunding, the Nigeria Institute of Pharmaceutical Research and

[38] C Onwuatuegwu, 'Healthcare Inequality in Nigeria: Structural Barriers and Policy Solutions' *African Journal of Law and Public Policy* (2025) (8) available at <https://nigerianjournalsonline.org/index.php/ALJPPL/article/view/3768> accessed 16 April 2026
[39] WHO Africa Health Observatory (n 7)
[40] National Health Act, (n 5) s 11(2)(a)
[41] African Union, 'Abuja Declaration on HIV/AIDS, Tuberculosis and Other Related Infectious Diseases' (OAU Doc AHG/Decl (XXVII) 2001) para 26
[42] K Marius, SU. Agu & SA. Okwor, 'Reassessing the Empirical Relationship between Health Expenditure, Governance and Economic Growth in Africa: Analysis of Nigerian Data' (2023) Available at <https://doi.org/10.60692/WCRJH-DYA18> accessed 16 April 2026
[43] ibid, 15
[44] ibid, 18

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Development (NIPRD) does not enjoy a recurrent or capital expenditure budget of up to ₦20 million monthly, an absurdly inadequate sum for a national research institute.[45] Rather than strengthen existing institutions, the National Assembly has contemplated creating new commissions, prompting ACPN to warn against unnecessary bureaucracies and economically unrealistic proposals.[46]

3.4 Workforce Crisis: Strikes, Emigration, and Demoralisation

No analysis of Nigeria's health governance can ignore the human factor, health workers are demoralised, underpaid, and emigrating in unprecedented numbers. The brain drains known euphemistically as medical tourism in reverse, has reached crisis proportions.[47] The United Kingdom's National Health Service actively recruits Nigerian trained doctors and nurses, offering salaries and working conditions Nigeria cannot match.[48]

Industrial action is endemic, the Joint Health Sector Unions (JOHESU) began a strike on November 15, 2025, citing 12 years of unpaid entitlements and worsening industrial relations.[49] The frequency of strikes reflects systemic governance failure, government repeatedly enters into agreements with health unions, then fails to implement them. The legal framework provides mechanisms for dispute resolution, but these are rarely utilised or enforced.

4.0 HEALTH AS HUMAN CAPITAL: THE PRODUCTIVITY COST OF POOR HEALTH

4.1 The Economic Argument for Health Investment

[45] 'ACPN Opposes Creation of New Health Commissions' *The Guardian (Nigeria)* (4 December 2025) Available at <https://guardian.ng/news/acpn-opposes-creation-of-new-health-commissions/> accessed 16 April 2026
[46] 'ACPN to Lawmakers: Halt New Health Commissions, Fix Failing Oversight First' *Independent Newspaper Nigeria* (1 December 2025) Available at <https://independent.ng/acpn-to-lawmakers-halt-new-health-commissions-fix-failing-oversight-first/> accessed 16 April 2026
[47] T Ogunlesi, 'Nigeria's Health Crisis: Why Doctors Are Leaving in Droves' *Financial Times* (London, 15 March 2025) 8
[48] General Medical Council (UK), 'International Medical Graduates Statistics 2025' (GMC, 2026) 10
[49] 'JOHESU Begins Indefinite Strike Over Unpaid Entitlements' *Premium Times* (Abuja, 15 November 2025) available at <https://www.premiumtimesng.com/news/headlines/745212-just-in-johesu-begins-indefinite-strike-over-unpaid-entitlements.html> accessed 16 April 2026

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The economic case for health investment is well established. Health is not merely a consumption good but an investment in human capital, the stock of knowledge, skills, and health that individuals accumulate over their lifetimes.[50] Healthy individuals are more productive, earn higher wages, and contribute more to economic growth.[51] The WHO's Commission on Macroeconomics and Health estimated that a 10 per cent improvement in life expectancy is associated with a 0.3 - 0.4 per cent increase in economic growth.[52]

For Nigeria, the arithmetic is sobering with life expectancy below 55 years, a maternal mortality ratio of over 500 per 100,000, and an under five mortality rates exceeding 100 per 1,000, Nigeria forfeits billions of dollars annually in lost productivity.[53] Sick adults cannot work, parents caring for sick children cannot work, premature death eliminates years of potential contribution. The World Bank estimates that Nigeria loses approximately $15 billion annually to malaria alone, a preventable and treatable disease.[54]

4.2 Empirical Evidence from Nigerian Data

Marius, Agu, and Okwor provides rigorous econometric evidence specific to Nigeria, using Autoregressive Distributed Lag (ARDL) modelling, they demonstrate a positive association between health expenditure and economic growth but only where governance quality is adequate.[55] Where governance is poor, health spending's growth enhancing effects are substantially diminished. Their finding that governance quality adversely affects growth and this reduces the capacity of health spending to stimulate growth by an almost equal margin is a damning indictment of Nigeria's governance deficits.[56]

The policy implication is clear: increasing health spending without improving governance is unlikely to yield desired outcomes. Conversely, governance reforms that reduce corruption,

[50] G Becker, *Human Capital: A Theoretical and Empirical Analysis, with Special Reference to Education* (3rd edn, University of Chicago Press 1993) 15
[51] T Schultz, 'Investment in Human Capital' *American Economic Review* (1961) (51) (1) 1, 3
[52] WHO (n 1) 25
[53] World Bank, 'Human Capital Index 2024: Nigeria Country Report' (World Bank, 2025) 5
[54] World Bank, 'Malaria Control and Economic Development in Nigeria' (World Bank, 2023) 12
[55] K Marius, SU. Agu & SA. Okwor, (n 42) 14
[56] ibid, 15

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enhance accountability, and improve policy implementation would amplify the productivity gains from any given level of health spending.

4.3 The Intergenerational Trap

Poor health perpetuates poverty across generations. Malnourished children suffer cognitive impairments that reduce educational attainment and future earnings.[57] Sick children miss school, falling behind peers. Families impoverished by healthcare expenses withdraw children from school to save money.[58] The cycle is self-reinforcing, poor health reduces income, low income prevents health investment, poor health persists across generations.

Nigeria's demographic profile, a young population with high dependency ratios, makes this intergenerational trap particularly dangerous.[59] Without substantial health investment, today's children will become tomorrow's unproductive adults, perpetuating poverty into the next generation. Breaking this cycle requires not merely healthcare spending but legally enforceable entitlements that ensure resources reach those who need them most.

5.0 THE ACCOUNTABILITY VACUUM: WHY LEGAL RIGHTS REMAIN UNENFORCEABLE

5.1 The Non-Justiciability Problem

The most fundamental accountability deficit is constitutional. As noted, the right to health is non-justiciable under the 1999 Constitution (as amended). No Nigerian can sue government for failing to provide healthcare, regardless of how outrageous conduct the violation. This absence of judicial enforcement removes the most powerful accountability mechanism available in democratic societies.[60]

Comparative experience demonstrates the difference justiciability makes. In India, the Supreme Court has interpreted Article 21 of the Constitution, the right to life, to include the

[57] S Grantham-McGregor *et al*, 'Developmental Potential in the First 5 Years for Children in Developing Countries' *The Lancet* (2007) (369) (9555) 60, 62
[58] World Bank (n 53) 8
[59] UN Population Division, 'World Population Prospects 2024: Nigeria Profile' (UN, 2025) 10
[60] O Savage (n 8) 5

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right to health. In *Paschim Banga Khet Mazdoor Samity v State of West Bengal*,[61] the Court held that government's failure to provide emergency medical treatment violated the right to life. In South Africa, Section 27 of the Constitution enshrines the right to access healthcare, and the Constitutional Court has enforced this right in cases like *Treatment Action Campaign v Minister of Health*,[62] compelling government to provide antiretroviral drugs to prevent mother to child HIV transmission.

Nigerian courts have shown willingness to develop socio-economic rights jurisprudence through the backdoor, via the right to life,[63] the right to dignity,[64] and the African Charter, but these efforts remain inconsistent and undertheorised.[65] What is needed is constitutional amendment, the movement of health from Chapter II to Chapter IV, or at minimum a provision rendering Chapter II objectives justiciable.

5.2 Weak Legislative Oversight

The National Assembly's oversight function, constitutionally mandated under Section 88, is minimally effective in the health sector.[66] The ACPN's recent intervention is instructive, what is missing has been adequate oversight responsibilities by the National Assembly, which ought to insist on providing a robust budget that positions the NTHISC to carry out its statutory responsibilities.[67] Rather than strengthen existing oversight, the National Assembly has contemplated creating new commissions, a classic bureaucratic solution that adds complexity without addressing root causes.[68]

Legislative oversight failures include, infrequent committee hearings, inadequate budgetary scrutiny, failure to compel agency heads to account for performance, and absence of sanctions for non-compliance.[69] The boards of 73 (seventy-three) Federal Health Institutions remain

[61] *Paschim Banga Khet Mazdoor Samity v State of West Bengal* [1996] AIR 2426 (Supreme Court of India) para 9
[62] *Treatment Action Campaign v Minister of Health* [2002] 5 SA 721 (CC) para 135
[63] Constitution of the Federal Republic of Nigeria (n 6), s 33
[64] ibid, s 34
[65] C Nwankwo (n 14) 58
[66] Constitution of the Federal Republic of Nigeria (n 6), s 88
[67] 'ACPN Opposes Creation of New Health Commissions' (n 45)
[68] 'ACPN to Lawmakers' (n 46)
[69] O Savage (n 8) 12

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unreconstituted, 13 professional regulatory councils lack inaugurated boards, leadership vacancies persist for over a year.[70] These are failures of oversight, not of law.

5.3 Judicial Avoidance and Doctrinal Conservatism

Even where legal avenues exist, Nigerian courts have often avoided enforcing health rights. The doctrine of political question that certain matters are committed to the political branches, has been invoked to dismiss health related claims.[71] Judicial conservatism, rooted in the pre-1999 era when courts were systematically subordinated to the executive, persists.[72]

There are, however, doctrinal pathways available. The African Commission's SERAC decision articulated the minimum core obligations doctrine, even where resources are constrained, states must immediately ensure minimum essential levels of each right.[73] The Commission held that Nigeria violated this obligation by failing to protect Ogoniland communities from environmental degradation causing health harms.[74] Nigerian courts could adopt this doctrine, holding government accountable for minimum core health obligations even while resource constraints might excuse broader failures.

5.4 Citizen Participation Deficit

The NHA 2014 envisions citizen participation in health governance, community health committees, representation in health facility management, and complaints mechanisms.[75] In practice, participation is minimal where citizens lack awareness of their legal rights, lack avenues to voice complaints, and lack power to compel accountability when complaints are ignored.[76]

This participation deficit is particularly acute for vulnerable populations, rural communities, women, children, persons with disabilities, and internally displaced persons.[77] Those who

[70] 'ACPN Opposes Creation of New Health Commissions' (n 45)
[71] C Nwankwo (n 14) 60
[72] ibid 62
[73] *SERAC v Nigeria* (n 15) para 60
[74] ibid para 65
[75] National Health Act (n 5) s 5
[76] C Onwuatuegwu (n 38) 15
[77] ibid 16

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need accountability most are least able to demand it. Legal empowerment approaches, community paralegals, legal aid, rights awareness programme, remain underfunded and underutilised.

6.0 RECOMMENDATION AGENDA

6.1 Constitutional Amendment

The most urgent reform is constitutional to render health rights justiciable. First, amendment of Section 6(6)(c) to render Chapter II objectives justiciable, either generally or specifically for health, education, and other social rights.[78] Second, amendment of Chapter IV to include an express right to health, drawing on the South African model which provides that everyone has the right to have access to healthcare services while recognising progressive realisation within available resources.[79]

Constitutional amendment is politically difficult, requiring two-thirds majorities in both Houses and approval by two-thirds of state Houses of Assembly.[80] However, the alternative, perpetual non-justiciability, consigns health rights to permanent aspiration. Civil society organisations should prioritise constitutional amendment as a long-term advocacy goal.

6.2 Legislative Strengthening of Oversight

Pending constitutional amendment, legislative reforms can strengthen accountability. The National Assembly should firstly, amend the NHA 2014 to establish an independent Health Ombudsman with power to investigate complaints, compel production of documents, and recommend sanctions while the Ombudsman's decisions should be enforceable in court.[81] Secondly, strengthen the National Council on Health's oversight powers, including power to withhold funding from states that fail to meet minimum health standards.[82] Thirdly, mandate annual health sector performance audits by the Office of the Auditor-General, with specific

[78] Constitution of the Federal Republic of Nigeria (n 6), s 6(6)(c)
[79] Constitution of the Republic of South Africa 1996, s 27
[80] Constitution of the Federal Republic of Nigeria (n 6), s 9
[81] O Savage (n 8) 18
[82] ibid 19

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focus on BHCPF utilisation.[83] Fourthly, enact the Public Health Accountability Bill, which would establish citizen report cards, community scorecards, and other social accountability mechanisms.[84]

The ACPN's recommendation that lawmakers should shun unnecessary bureaucracies and instead strengthen the National Tertiary Health Institutions Standards Committee (NTHISC) to carry out its statutory responsibilities.[85]

6.3 Judicial Activation of Minimum Core Obligations

Drawing on the African Commission's SERAC decision and comparative jurisprudence, Nigerian courts can adopt the minimum core obligations doctrine.[86] Under this approach, courts would hold that regardless of resource constraints, government must ensure the essential primary health care services, emergency medical treatment, maternal and child health services, and control of epidemic diseases.[87]

These minimum obligations are not aspirational, they are immediately binding. Courts could grant declaratory relief, mandatory orders compelling specific actions, and structural injunctions requiring systemic reforms.[88] The Supreme Court's decision in *Attorney-General of Lagos State v Attorney-General of the Federation*,[89] held that the National Assembly cannot compel states to fund primary education which creates challenges for federal enforcement of health obligations. However, the Court distinguished between compulsion and coordination. Federal health agencies can coordinate, set standards, and condition funding on compliance without unconstitutionally compelling states.

6.4 Institutional Redesign of Governance Structures

[83] K Marius, SU Agu & SA Okwor, (n 42) 18
[84] O Savage (n 8) 20
[85] 'ACPN to Lawmakers' (n 46)
[86] *SERAC v Nigeria* (n 15) para 60
[87] UN Committee on Economic, Social and Cultural Rights, 'General Comment No 14: The Right to the Highest Attainable Standard of Health' (2000) UN Doc E/C.12/2000/4, para 43
[88] O Savage (n 8) 22
[89] *Attorney-General of Lagos State v Attorney-General of the Federation* [2014] 16 NWLR (Pt 1434) 431, 460

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The fragmentation of health authority across three tiers of government is a structural barrier to accountability. The governance structures could be redesigned to include:

Establishment of a National Health Commission: An independent body, insulated from political interference, responsible for strategic purchasing, resource allocation, and performance monitoring. The Commission's board should be appointed through a transparent process with fixed terms and removal only for cause.[90]

State Health Accounts: Mandatory publication of state health budgets, expenditures, and outcomes, with civil society verification.[91]

Performance Based Funding: Link federal transfers to states to achievement of verifiable health outcomes like immunisation coverage, skilled birth attendance, etc.[92]

Professionalisation of Health Management: Require that heads of health facilities and agencies meet professional qualifications, with transparent appointment and performance review processes.[93]

The Primary Health Care Under One Roof (PHCUOR) policy provides a framework, but its implementation remains uneven. States that have not enacted PHCUOR legislation should be incentivised through enhanced federal funding.

6.5 Legal Empowerment and Citizen Participation

Rights are only as effective as the mechanisms for their enforcement. The community members should be trained to provide basic legal advice, assist with complaints, and advocate for health rights. Some jurisdictions demonstrate community paralegals which has significantly improve health service delivery and accountability. The government can establish a fund to support strategic litigation on health rights, enabling civil society organisations to bring test cases establishing legal precedents.

[90] K Croke (n 30) 30
[91] O Savage (n 8) 21
[92] K Marius, SU Agu & SA Okwor, (n 42) 19
[93] C Onwuatuegwu (n 38) 22

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7.0 CONCLUSION

Nigeria's National Health Act 2014 represents a remarkable legislative achievement, a comprehensive framework for health governance that, if fully implemented, would dramatically improve health outcomes and, through improved human capital, economic productivity. Yet the gap between statutory promise and delivery reality remains vast. The article has argued that the failure is not one of legal design but of governance, specifically, the absence of accountability mechanisms that translate legal entitlements into enforceable claims.

The constitutional non-justiciability of health rights is the foundational defect. Without judicial enforcement, health rights remain aspirational rather than actionable. Legislative oversight is weak, fragmented, and unproductive. Citizen participation is minimal, and legal empowerment is underfunded. The result is a health system that produces some of the world's worst outcomes despite substantial legal and policy frameworks.

The reform agenda is clear through constitutional amendment to render health rights justiciable, legislative strengthening of oversight and accountability mechanisms, judicial activation of minimum core obligations doctrine, institutional redesign to reduce fragmentation and political interference, and legal empowerment to enable citizen enforcement.

These reforms are politically difficult but not impossible. The passage of the NHA 2014 itself demonstrates that sustained advocacy can overcome political resistance. What is required now is a second generation of advocacy focused not on policy adoption but on implementation and accountability. The cost of inaction is measured in preventable deaths, lost productivity, and intergenerational poverty. The benefit of action is not merely healthier citizens but a more productive, prosperous, and equitable Nigeria.

The law can redress Nigeria's healthcare and productivity deficits but only if it is rendered enforceable, accountable, and politically irresistible. The task for legal scholars, advocates, and policymakers is to build the legal architecture that makes health rights real, not merely rhetorical.