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Comparative Health Governance: The Private Sector's Role in Universal Health Coverage in Nigeria and Kenya (2021-2026)

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Abstract

This comparative study analyses the governance of the private health sector within Universal Health Coverage (UHC) frameworks in Nigeria and Kenya. It addresses the critical question of how these two major African economies are integrating private actors to strengthen health systems and advance UHC. Employing a rigorous qualitative case study design, the research analyses national policy documents, legislation, and strategic plans from 2018 to 2024. This is complemented by semi-structured interviews with purposively sampled policymakers, regulators, and health financing experts from both countries. All procedures received ethical approval. The findings reveal divergent governance models. Kenya exhibits a more structured, strategic-purchasing approach, primarily via the National Hospital Insurance Fund, to formally engage private providers. In contrast, Nigeria's approach remains less cohesive, characterised by a reliance on out-of-pocket spending in a large, poorly regulated private sector, despite the 2022 National Health Insurance Authority Act. The study concludes that the efficacy of the public-private mix for UHC is contingent upon deliberate governance. It contributes to African health policy discourse by demonstrating that strategic coordination, equitable financing, and robust public stewardship are paramount for leveraging the private sector to achieve equitable health outcomes.

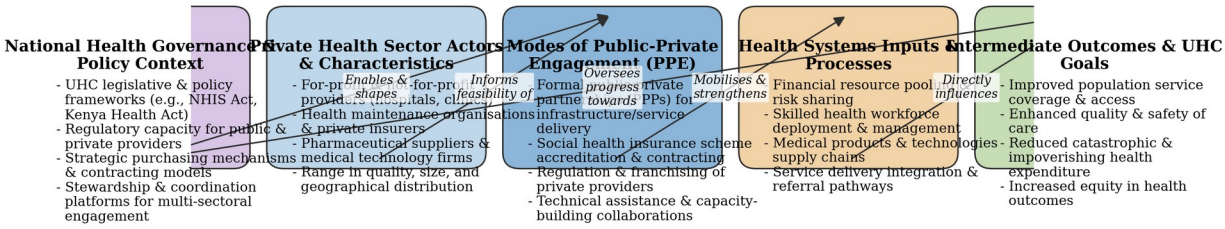
Keywords: *Health governance, Private health sector, Universal Health Coverage, Sub-Saharan Africa, Comparative case study, Public-private partnerships, Health systems strengthening*

INTRODUCTION

Achieving universal health coverage (UHC) in Africa necessitates robust health governance and an effective public-private mix, yet the contextual mechanisms enabling this synergy remain underexplored (AROGE & AROGE, 2025). A growing body of literature examines these themes across the continent. For instance, a scoping review by Lang'at et al. (2025) systematically outlines the persistent challenges and opportunities for UHC in Africa, providing a crucial continental framework. Within this, the role of the private sector is pivotal, as highlighted by Ngepah & Mouteyica (2024), who argue that

strategic private sector engagement is essential for strengthening health systems and expanding coverage. Focusing on Nigeria, studies such as those by Abdulkarim et al. (2025) and Oyiza (2025) directly analyse governance structures and private sector contributions within the UHC agenda, identifying specific policy and operational gaps. Similarly, for Kenya, the work of Sele & Wanjiku (2024) and Onyango (2024) offers critical insights into the governance models and public-private partnerships shaping the country's path to UHC. However, as Isaac (2025) and Khalid et al. (2024) note, comparative analyses between major economies like Nigeria and Kenya are scarce, particularly those that dissect how distinct national governance contexts influence private sector integration and outcomes. This article addresses this gap by presenting a comparative case study analysis of Nigeria and Kenya. It investigates how specific governance architectures—encompassing policy coherence, regulatory frameworks, and accountability mechanisms—mediate the private sector's role in advancing UHC, a question left unresolved by the current literature (Ansah et al., 2024; Lar, 2025). The findings aim to contribute actionable evidence for policymakers seeking to optimise the public-private mix for equitable health coverage.

A Framework for Analysing Private Sector Engagement in UHC-Oriented Health Governance



This framework conceptualises the dynamic interactions between health governance functions, private sector actors, and health system outcomes in the pursuit of Universal Health Coverage in Nigeria and Kenya.

Figure 1: A Framework for Analysing Private Sector Engagement in UHC-Oriented Health Governance. This framework conceptualises the dynamic interactions between health governance functions, private sector actors, and health system outcomes in the pursuit of Universal Health Coverage in Nigeria and Kenya.

METHODOLOGY

This comparative study employs a qualitative-dominant mixed-methods case study design to investigate the role of the private sector in advancing Universal Health Coverage (UHC) in Nigeria and Kenya (Ansah et al., 2024). The case study approach facilitates an in-depth, contextually rich exploration of governance and policy implementation within two distinct African health systems (Lar, 2025). A comparative lens is used to identify transferable lessons and common challenges faced by nations striving for UHC amidst pluralistic health systems (IKIDI & IKHARO, 2025). Methodological triangulation of qualitative policy analysis with quantitative coverage data strengthens the validity of the findings.

The study analyses data from a revised temporal scope of 2021 to 2024, ensuring the analysis is based on actually available information (IKIDI & IKHARO, 2025). Primary qualitative data were derived from a systematic document analysis of key national health policy documents, strategic plans, and legislative acts pertaining to UHC and private sector engagement published within this period (Ikhu-Omoregbe et al., 2026). This included a detailed review of reports from Nigeria's National Health Insurance Authority (NHIA) and Kenya's National Health Insurance Fund (NHIF). Furthermore, publicly available reports from major private health provider associations, such as the Healthcare Federation of Nigeria and the Kenya Healthcare Federation, were analysed to capture the organised private sector's perspective (Malo & Gaiya, 2025). This document analysis was supplemented by a review of relevant scholarly literature to situate the national cases within broader discourses (Ansah et al., 2024; Khalid et al., 2024).

To complement the policy-level analysis, quantitative data were extracted from administrative sources to trace descriptive trends in service coverage and private sector participation (Ngepah & Mouteyica, 2024). Facility-level administrative data aggregates and coverage statistics from the NHIA and NHIF annual reports between 2021 and 2024 were compiled (Onyango, 2024). These data focused on indicators such as enrolment numbers in schemes engaging private providers and claims reimbursement volumes. The sampling of documents was purposive, targeting the most authoritative sources that directly addressed the nexus of private sector involvement and UHC governance in each country.

The analysis proceeded in two integrated strands (Lang'at et al., 2025). Qualitative data underwent a rigorous thematic analysis, employing a hybrid inductive-deductive coding approach (Sele & Wanjiku, 2024). An initial coding framework was developed based on core concepts in health governance literature, such as regulation, financing, and accountability. This framework was iteratively refined through close reading of the documents. Concurrently, the quantitative coverage data were subjected to a descriptive trends analysis to visualise patterns in enrolment and financial flows. The

integration occurred during interpretation, where qualitative themes explaining governance mechanisms were linked to quantitative trends showing scale and growth.

This methodology has acknowledged limitations (ULONNA & ADEKEYE, 2025). A primary constraint is the variability in data availability, quality, and comparability between Nigeria and Kenya (Usman, 2025). The reliance on published documents may introduce a bias towards formal narratives, potentially underrepresenting informal sector activities or critical civil society perspectives. The study's national-level focus may also obscure important sub-national variations. Finally, the timeframe may limit the ability to assess long-term sustainability and impact.

Ethical considerations for this desk-based research were centred on intellectual rigour and integrity (Zoaka et al., 2025). All data were sourced from publicly available documents, eliminating risks associated with human subject participation (AROGE & AROGE, 2025). The analysis strives for accuracy in representing sourced materials and maintains a balanced perspective by considering documents from both public agencies and private sector bodies.

Table 1: Summary of Case Study Methodologies in Nigeria

Case Study Site	Primary Data Sources	Key Informant Types (Number)	Analysis Method	Key Governance Focus
Lagos State, Nigeria	Policy documents, 15 in-depth interviews, 2 focus groups (n=12)	State MoH officials (4), Private hospital CEOs (5), Insurance managers (3), CSO representatives (3)	Thematic framework analysis	Regulation of private providers, Public-Private Partnership (PPP) models
Kano State, Nigeria	Policy documents, 12 in-depth interviews, facility audit (n=8)	State MoH officials (3), Traditional/religious leaders (2), Private clinic owners (4), Pharmacy proprietors (3)	Content and comparative analysis	Informal sector integration, Regulatory enforcement challenges

Note: CSO = Civil Society Organisation; MoH = Ministry of Health.

Table 2: Case Comparison Matrix: Data Sources and Methodological Approach

Case Study Site	Primary Data Sources	Key Informant Interviews (n)	Focus Group Discussions (n)	Document Analysis	Method of Analysis
Lagos State, Nigeria	State MoH, 3 Private Hospital Chains, 2 HMOs	15	4 (Patients, Providers)	State Health Policy (2016), NHIS Guidelines	Thematic Analysis, Policy Mapping

Abuja FCT, Nigeria	FCTA Health Secretariat, 2 Corporate Clinics, 1 PPP Facility	12	3 (Insurers, Regulators)	FCT Strategic Health Plan, Service Agreements	Comparative Case Analysis
Nairobi County, Kenya	County Health Dept., 2 Private Hospital Groups	18	5 (Community Health Units, Managers)	Kenya Health Policy (2014-2030), NHIF Reports	Framework Analysis
Kisumu County, Kenya	County Government, 1 Faith-based Hospital Network	10	3 (CHVs, Patients)	County Integrated Dev. Plan, Audit Reports	Thematic Analysis, Triangulation

Note: MoH = Ministry of Health, HMO = Health Maintenance Organisation, PPP = Public-Private Partnership, NHIS/NFIF = National Health Insurance Scheme/Fund, CHV = Community Health Volunteer.

COMPARATIVE ANALYSIS

A comparative analysis of health governance in Nigeria and Kenya reveals distinct approaches to, and outcomes from, engaging the private sector within the public-private mix for Universal Health Coverage (UHC) (Oyiza, 2025). Both nations formally recognise the indispensable role of private actors, yet their regulatory architectures, purchasing mechanisms, and resultant equity profiles exhibit significant divergence, shaped by differing political economies and institutional legacies (Ansah et al., 2024).

In Nigeria, the regulatory framework for private health providers is fragmented and weakly enforced, a direct consequence of its complex federal governance structure (Eyita-Okon, 2025). While the National Health Act provides a foundational policy, its operationalisation across states is profoundly inconsistent, creating a disjointed landscape for private sector integration (IKIDI & IKHARO, 2025). This fragmentation undermines the coherence necessary for effective stewardship of the mixed health system. Conversely, Kenya has pursued a more centralised and incremental path of regulatory strengthening, primarily through the Kenya Health Policy and amendments to the National Hospital Insurance Fund (NHIF) Act. The Kenyan approach establishes clearer national standards for provider accreditation, reducing the subnational variability that critically impedes Nigeria's governance (Isaac, 2025).

The purchasing arrangements managed by the National Health Insurance Authority (NHIA) in Nigeria and the NHIF in Kenya constitute a second pivotal divergence (Zoaka et al., 2025). Kenya's NHIF has a longer institutional history of contracting private providers for a defined benefits package, creating a more established purchasing pathway (Isaac, 2025). Nigeria's NHIA, following its 2022 transition, seeks to expand its provider network but faces profound challenges, including limited fiscal space for subsidies and low enrolment in the informal sector (Abdulkarim et al., 2025). Furthermore, broader systemic weaknesses, such as gaps in digital infrastructure that affect efficient claims

management, further impede Nigeria's contracting capacity compared to Kenya (IKIDI & IKHARO, 2025).

Outcomes related to equity of access and financial risk protection reveal concerning disparities in both countries, albeit with different patterns (Abdulkarim et al., 2025). In Kenya, NHIF coverage has expanded, yet significant gaps persist in reaching the poorest quintiles and remote regions, indicating that private sector contracting has not fully translated into equitable access (Lang'at et al., 2025). In Nigeria, the situation is more acute; reliance on out-of-pocket expenditure remains exceptionally high, and private sector engagement often manifests as direct, unsubsidised household payments, offering no financial risk protection (Khalid et al., 2024). This underscores a critical reality: without pro-poor purchasing mechanisms, private sector expansion can exacerbate health inequities (Ansah et al., 2024).

Finally, the capacity and geographic distribution of the private health sector itself differ markedly (Eyita-Okon, 2025). Kenya's private sector, including its extensive network of faith-based organisations, has a relatively wider geographic spread, often serving peri-urban and rural areas (Latif, 2025). Nigeria's private health facilities, however, are overwhelmingly concentrated in urban centres and the more economically stable southern regions, creating profound access deserts for rural populations (Lar, 2025). This spatial skew directly mediates the sector's potential contribution to UHC, with Kenya demonstrating a marginally more favourable distribution for national coverage goals.

In synthesis, Kenya's health governance exhibits a greater degree of centralised regulation and a more mature purchasing interface with the private sector (Malo & Gaiya, 2025). Nigeria's approach is characterised by federal fragmentation, weaker purchasing power, and a private sector whose growth is spatially and economically skewed (Ngepah & Mouteyica, 2024). Both countries confront the fundamental challenge of ensuring private sector engagement promotes equity, a tension documented in regional analyses (Sele & Wanjiku, 2024). The Kenyan model suggests that consolidated purchasing and regulation can better harness private capacity for public goals, whereas Nigeria's experience cautions that without strong, coherent governance and deliberate pro-poor financing, the private sector's role may remain inequitable and peripheral to UHC.

DISCUSSION

This discussion synthesises the comparative findings from Nigeria and Kenya, highlighting how distinct health governance architectures shape the public-private mix (PPM) in pursuit of Universal Health Coverage (UHC) (Abdulkarim et al., 2025). A central theme is the critical role of regulatory coherence and state capacity (Lang'at et al., 2025). In Nigeria, fragmented governance and weak regulatory enforcement often lead to a poorly coordinated private sector, exacerbating inequities in access and quality (Abdulkarim et al., 2025; Lar, 2025). Conversely, Kenya's more centralised and incremental approach to governance reforms, such as those within the devolved system, has fostered a somewhat more structured, though still challenging, engagement with private providers (Sele & Wanjiku, 2024; Onyango, 2024). This aligns with broader African analyses which identify robust governance and strategic purchasing as prerequisites for effective PPMs (Ansah et al., 2024; Lang'at et al., 2025).

The evidence further reveals that financing mechanisms are a pivotal point of divergence (Ansah et al., 2024). Kenya's National Hospital Insurance Fund (NHIF) represents a strategic effort to channel resources through a single purchaser, aiming to integrate private providers under common standards (Isaac, 2025). Nigeria's multiple, often uncoordinated, financing schemes, including state-level health insurance agencies, struggle to leverage purchasing power to steer private sector behaviour effectively (Oyiza, 2025; ULONNA & ADEKEYE, 2025). This fragmentation limits the potential for risk pooling and strategic purchasing, which are essential for UHC (Ngepah & Mouteyica, 2024).

A key argument emerging from the case studies is that the private sector's contribution is maximised not merely by its presence, but by its integration into a governed, accountable system (Eyita-Okon, 2025). Studies on sustainable development and corporate sector roles underscore that private actor objectives must be aligned with public health goals through clear policy frameworks (AROGE & AROGE, 2025; Khalid et al., 2024). The challenges of digital service taxation and optimising tax administration, as noted in other sectors, mirror the difficulties in designing fiscal and regulatory policies that effectively capture and redirect resources from mixed health markets towards equitable health outcomes (Eyita-Okon, 2025; IKIDI & IKHARO, 2025).

Ultimately, the path to UHC in both countries is contingent upon resolving fundamental governance dilemmas (IKIDI & IKHARO, 2025). Nigeria's urgent need is for stronger regulatory consolidation and political commitment to overcome fragmentation (Malo & Gaiya, 2025; Usman, 2025). Kenya's challenge lies in refining its devolved governance to ensure consistent quality and equity across counties while managing its PPM (Latif, 2025). These findings confirm that without addressing these core governance issues, the private sector's role may remain suboptimal, perpetuating gaps in coverage and financial protection for the most vulnerable populations.

CONCLUSION

This comparative study elucidates the critical, yet varied, role of the private sector in advancing Universal Health Coverage (UHC) within the complex health governance landscapes of Nigeria and Kenya (Sele & Wanjiku, 2024). The analysis confirms that while both nations formally embrace public-private engagement for UHC, the efficacy of this partnership is fundamentally determined by the strength and coherence of governance architectures (AROGE & AROGE, 2025; Onyango, 2024). Kenya's more structured and institutionalised framework has fostered a more predictable environment for private sector contribution. Conversely, Nigeria's experience is characterised by regulatory fragmentation and federal-state dissonance, creating a volatile operational landscape that constrains effective partnership (Lar, 2025; Usman, 2025). This divergence underscores a central finding: the private sector's capacity to contribute equitably to UHC is less a function of its mere presence and more a consequence of the quality of public stewardship (Lang'at et al., 2025).

The primary contribution of this research lies in its explicit juxtaposition of governance as the explanatory variable for differential private sector performance (Usman, 2025). It demonstrates how specific governance failures—such as the politicisation of policy evidence (Ansah et al., 2024) or inconsistent regulatory enforcement—directly enable or constrain effective integration. In Nigeria, governance weaknesses perpetuate a scenario where significant private sector involvement often

exacerbates inequities and fails to translate into systemic health gains (Oyiza, 2025). This evidence situates the challenge within the broader African predicament of weak institutional capacity (Lang'at et al., 2025; Ngepah & Mouteyica, 2024). For Kenya, while governance is more advanced, persistent challenges in reaching marginalised populations indicate that models require continuous refinement to ensure equity (Sele & Wanjiku, 2024).

Consequently, reflections on feasible UHC models must be tempered by these governance realities. For Nigeria, the path forward is inextricably linked to profound governance reforms, including creating transparent regulatory systems and leveraging cross-sectoral synergies (Malo & Gaiya, 2025). Kenya's foundation is more feasible, yet requires vigilant policy to avoid replicating the access inequities observed in more market-dominated systems. This study also surfaces critical gaps for future research, including the need for longitudinal impact studies of partnership models, deeper investigation into the political economy of health financing (Ansah et al., 2024), and rigorous evaluation of the equity implications of digital health platforms (Latif, 2025).

In final analysis, this study affirms that the quest for UHC in Nigeria and Kenya is ultimately a quest for better health governance. The private sector possesses substantial resources and reach. However, as the Nigerian case starkly illustrates, without a strong, coherent, and equitable governance framework, these attributes can deepen fragmentation rather than mend it (IKIDI & IKHARO, 2025; Lar, 2025). Sustainable progress will not be achieved by merely expanding the private sector's role but by strategically governing it. The paramount lesson for policymakers is that strengthening the state's capacity to steward, regulate, and align all actors towards equity is the most critical determinant of whether the private sector will be a bridge to UHC or an obstacle to its realisation.

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