

# **The Human Capital Crisis: How Nigeria's Ailing Health System is Stifling National Productivity**

**BY**

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In the complex relationship between human well-being and economic vitality, population health remains a crucial foundation for national productivity. For Nigeria, Africa's most populous country with over 220 million people, this link is particularly important. As the country pursues ambitious development goals under the African Union's Agenda 2063 and the United Nations Sustainable Development Goals (SDGs), especially SDG 3 (Good Health and Well-Being) and SDG 8 (Decent Work and Economic Growth), the health of its workforce directly influences its capacity to capitalise on its demographic dividend—a youthful population projected to reach 400 million by 2050. Nonetheless, persistent health inequalities, inadequate primary care infrastructure, and ethical lapses in workplace practices hinder this potential, restricting human capital development and perpetuating cycles of low productivity. This article critically examines these issues through the lens of human capital theory, employing Becker's model of health investments as a form of capital that yields long-term economic benefits. By integrating health sciences data with economic indicators, it illustrates how Nigeria's health disparities lead to productivity losses, contrasting this with a high-performing peer to highlight possible pathways forward.

## **The State of Population Health in Nigeria**

Nigeria's population health landscape reflects a paradox: vast human potential marred by systemic vulnerabilities. Despite comprising 2.4% of the global population, the country accounts for 10% of worldwide under-5 deaths and over 20% of maternal mortality, underscoring failures in human capital nurturing. This section dissects key metrics, emphasising their implications for workforce readiness and longevity.

## **Life Expectancy and Mortality: A Shortened Working Lifespan**

Life expectancy at birth in Nigeria was 62.2 years in 2024, with males at 60.4 years and females at 64.2 years—a modest rise from 54.5 years in 2023, yet still well below the global average of 73.4 years. Healthy life expectancy, which reflects years lived in full health, stood at 54.9 years in 2021, according to World Health Organisation (WHO) data. This highlights the burden of non-communicable diseases and disabilities that reduce productive years. These figures indicate a failure in basic healthcare, meaning a significant portion of the future workforce may never reach productive age, and those who do often begin with health disadvantages. Importantly, this measure aligns with human capital theory: shorter lifespans diminish the returns on education and skills investments, as workers face early health problems. Regional differences worsen this issue; northern states report figures as low as 50 years, which correlates

with lower school enrolment and labour participation, thereby perpetuating intergenerational poverty.

### **Primary Healthcare: A System on Life Support**

Primary healthcare remains the cornerstone of population health, yet Nigeria's indicators reveal severe deficiencies. The Primary Health Care (PHC) system, designed to be the first line of defence, is critically underfunded and dysfunctional. This situation is further exacerbated by the exodus of skilled health professionals to developed nations, which cripples the system's capacity. The doctor-to-patient ratio is estimated at 1:5,000, far below the WHO recommendation of 1:600, creating a catastrophic care gap.

The 2023-24 Nigeria Demographic and Health Survey (NDHS) reports neonatal mortality at 41 deaths per 1,000 live births, infant mortality at 63, and under-5 mortality at 110—declines from the previous high of 132 under-5 deaths in 2018, but still three times the global averages. Maternal mortality ratio (MMR) remains dangerously high at 917 deaths per 100,000 live births (WHO 2020 estimate, with 2023 figures at approximately 993), despite a reported 17% reduction in 2024 through targeted interventions. Immunisation coverage is equally worrying: only 39% of children aged 12-23 months are fully immunised (basic antigens: BCG, three doses of polio/DPT, measles), with DTP3 at 53%, far below the 90% SDG target. Antenatal care from skilled providers reaches 63% of women, but skilled birth attendance is only 46%, and postnatal checks within two days cover just 43% of mothers and newborns. These gaps, rooted in underfunded health systems (Nigeria allocates less than 5% of GDP to health versus the Abuja Declaration's 15% pledge), not only increase disease burdens but also reduce female labour participation, as maternal health crises force women out of the workforce, contravening human resources principles of inclusive capital development.

### **The Economic Fallout: From Health Deficits to Productivity Losses**

#### **GDP and Workforce Indicators**

Nigeria's GDP growth has been volatile and largely disconnected from human development. While the economy is recovering, per capita GDP remains low, indicating low productivity. An important yet often overlooked indicator is the potential years of working life lost due to premature mortality and disability. Diseases such as malaria, tuberculosis, and the rising prevalence of non-communicable diseases (NCDs), like hypertension, cause millions of lost workdays each year. This "presenteeism" (working while sick and unproductive) and absenteeism directly reduce economic output. Furthermore, chronic ill health effectively lowers the retirement age, forcing skilled individuals to leave the workforce years before the official retirement age and depleting the nation of experienced talent.

#### **The Vacuum in Workplace Ethics and Ergonomics**

Beyond clinical health, Nigeria's working environment largely lacks standards that protect and boost worker productivity. Ergonomics—the science of designing workspaces to suit human physiology—is still developing in Nigeria, with no enforceable standards in place. The Factories Act (1987) and the National Policy on Occupational Safety and Health (2006) outline

basic protections; however, enforcement remains weak, leading to a high rate of musculoskeletal disorders (MSDs) caused by repetitive strain in informal sectors like agriculture and manufacturing, which employ 70% of the workforce. A 2023 review shows that ergonomic hazards, such as poor workstation design and manual handling without proper training, account for 40% of occupational injuries, yet there is no dedicated code comparable to international standards. Ethically, this neglect breaches the principles of worker dignity and fairness, as outlined in ILO Convention 155, fostering a culture in which productivity is prioritised over health and ultimately damaging human capital through absenteeism and premature exit from the labour market.

### **National Productivity: Economic and Workforce Dimensions**

While Nigeria's economy boasts Africa's largest GDP, its productivity is hindered by health-related inefficiencies. Human capital development, according to endogenous growth models, depends on a healthy, skilled population; yet, workforce issues reveal missed opportunities. Nigeria's GDP reached \$285 billion in 2024, an increase of 3.19% year-on-year, driven mainly by non-oil sectors, particularly services (which accounted for 58% of GDP). However, per capita GDP remains a modest \$1,200, reflecting population pressures and low productivity (output per worker is approximately \$5,000 annually). Health shortcomings take a toll: multiple studies indicate significant GDP losses in Nigeria due to specific health issues, and some sources note that Nigeria's own health funding is around 2-3% of GDP, which is considered inadequate. This aligns with econometric evidence linking a 10% increase in life expectancy to 0.3-0.4% annual GDP growth, highlighting how Nigeria's health investments could trigger a positive cycle.

### **Workforce Indicators and Retirement Policies**

The labour force participation rate stands at 82.6% for working-age adults (15+), but the unemployment rate—redefined in 2023 to 5.4%—hides underemployment at 20-30%, especially among young people (33% NEET rate). The retirement age is 60 for public servants and 65 for academics, with pension coverage of less than 10% in the informal sector, leading to longer working years amid health declines. These indicators highlight a workforce burdened by health vulnerabilities: high under-5 mortality rates and skill shortages persist, while low life expectancy limits post-retirement contributions, in contrast to models where longer, healthier lifespans support intergenerational knowledge transfer.

### **Gaps in Workplace Ethics**

Workplace ethics in Nigeria are undermined by corruption and weak enforcement, with Transparency International ranking the country 145 out of 180 in 2023. Bribery in hiring, affecting 30% of workers, and embezzlement diminish trust, while the limited whistleblower protections under the 2016 Policy leave reporters vulnerable to retaliation. Labour laws such as the Labour Act (2004) lack robust anti-discrimination provisions, creating inequalities mainly impacting women and rural workers. These ethical issues not only increase turnover (15-20% annually) but also deter foreign investment in sectors dependent on human capital, perpetuating a low-trust environment that hampers sustainable productivity.

## **Comparative Perspective: Lessons from Singapore**

Singapore, a model of human capital resourcefulness and development, exemplifies a stark contrast, having transitioned from a low-income nation in 1965 to a high-income powerhouse through strategic collaborations in health workforce development. With a population of 5.9 million—one-fortieth of Nigeria's—Singapore's life expectancy stands at 83.9 years, supported by universal healthcare and a focus on prevention. Key indicators are impressive: infant mortality at 1.8 per 1,000 live births, under-5 mortality at 2.3 per 1,000 live births, maternal mortality rate at 6 per 100,000 live births, and immunisation rates exceeding 95% for DTP3 and measles. Ergonomically, the Workplace Safety and Health Act (2006) enforces SS 514 standards for office setups, reducing MSDs by 25% since 2010, while ethical frameworks such as the Tripartite Alliance foster anti-corruption efforts through mandatory ethics training.

Economically, Singapore's \$501 billion GDP in 2024 provides about \$84,000 per capita, with 87.7% of prime-age workers participating and re-employment continuing to age 68, beyond the statutory retirement age of 63. Its Human Capital Index score of 0.88 (World Bank) reflects investments that have driven 4-5% annual productivity growth. Crucially, Singapore's model—integrating health initiatives through the Health Promotion Board with workforce upskilling via SkillsFuture—aligns population health with economic goals, enabling a demographic dividend that Nigeria finds hard to reach. For Nigeria, adopting this approach means expanding primary care through digital tools and enforcing ergonomic principles to match Singapore's 20-30-year life expectancy advantage, potentially adding \$50-100 billion to GDP by 2040.

## **Summary and Recommendations for Policy and Practice: Building a Healthier, More Productive Nigeria**

The evidence is clear: Nigeria's poor population health significantly limits its national productivity. The country operates with a reduced human capital base, hindered by a weak PHC system, a shorter healthy lifespan, and workplaces that harm rather than motivate. To break this cycle, a paradigm shift is needed, moving from focusing on illness treatment to strategically investing in health as a valuable asset. The following recommendations are proposed:

**Radical Investment in Primary Health Care:** Nigeria should progressively increase public primary health care spending. The government must honour the 2001 Abuja Declaration by allocating at least 15% of the annual budget to the health sector, primarily to revitalise PHC centres. This includes ensuring they are staffed, equipped, and operational. Expanding mandatory health insurance coverage and guaranteeing that the Basic Health Care Provision Fund reliably reaches frontline facilities would help reduce catastrophic expenditure and improve effective access for working-age populations.

**Enact and enforce occupational health and safety legislation:** A comprehensive and legally binding national OHS framework must be developed and implemented across all sectors, with a specific strategy to reach the informal economy. Occupational health and ergonomics need to be mainstreamed into labour and industrial policy by developing national ergonomics standards, mandating ergonomic risk assessments, and enhancing inspection capacity, with particular attention to high-risk sectors and informal workplaces. Linking compliance with incentives—

such as tax benefits, access to government contracts, or lower insurance premiums—could encourage firms to internalise the productivity gains from safer, healthier workplaces. Legislate a national ergonomics code, mandating training and assessments, coupled with whistleblower safeguards to curb corruption, drawing on ILO benchmarks to reduce occupational injuries.

**Public-Private Partnerships for Health Insurance:** Speed up the deployment of the National Health Insurance Authority (NHIA) scheme and encourage private-sector involvement to achieve universal health coverage, lowering out-of-pocket costs that push families into poverty. While fostering inter-ministerial collaborations, create a Health-Productivity Taskforce, inspired by Singapore's tripartism model, to monitor HCI-related metrics and utilise data analytics for targeted interventions.

**Strategic Data Collection:** Mandate the systematic gathering of data on workplace absenteeism, presenteeism, and occupational diseases to better measure the economic impact of poor health and guide policy.

**Incentivise the retention of health workers:** Implement urgent policies to curb brain drain, including higher pay, improved working conditions, and opportunities for professional growth within Nigeria.

To summarise, human capital and labour-market policies should explicitly integrate health outcomes, for instance, by incorporating health screening and wellness programmes into vocational training, apprenticeship schemes, and public-sector employment. Moreover, expanding pension and health insurance coverage for informal and self-employed workers would protect older workers, decrease poverty in later life, and support orderly retirement based on health status rather than mere necessity. Implementing these measures could unlock Nigeria's human capital wealth, turning demographic pressures into productivity gains.

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