State Capacity and Health Justice: Evaluating the Edo State Health Insurance Scheme in Nigeria

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ABSTRACT

The relationship between state capacity and health justice remains insufficiently theorised despite its central importance to the realization of Universal Health Coverage (UHC) in developing democracies. Existing scholarship has largely examined health justice through normative theories of rights, equity, and distributive justice or evaluated health insurance reforms from administrative and health systems perspectives, with limited integration between these traditions. This article addresses this conceptual gap by developing the Capacity–Justice Nexus, an interdisciplinary analytical framework that integrates normative theories of health justice with contemporary state capacity theory to explain how institutional capability shapes the realization of equitable healthcare. Using the Edo State Health Insurance Scheme (EdoHIS) in Nigeria as a qualitative case study, the article draws on Michael Mann's concept of infrastructural power alongside the state-capacity perspectives of Peter Evans and Francis Fukuyama, while adopting Venkatapuram's capability approach as its normative benchmark. The analysis examines four interrelated dimensions of institutional capacity—infrastructural reach, administrative coordination, financial sustainability, and informal sector inclusion to evaluate the extent to which EdoHIS translates legal entitlements into substantive healthcare access. The findings demonstrate that although EdoHIS has achieved significant progress through provider expansion, equity-focused financing, increased enrolment, and administrative innovation, persistent weaknesses in territorial penetration, bureaucratic coordination, digital infrastructure, fiscal sustainability, and informal-sector integration continue to constrain the realization of health justice. The study argues that these limitations are better understood as manifestations of constrained state capacity rather than failures of policy design alone. The article advances the theoretical proposition that state capacity is not merely an implementation variable but a constitutive condition of health justice because legal rights become largely symbolic where governments lack the institutional capability to implement them effectively. The Capacity–Justice Nexus therefore contributes a novel framework for analysing health governance in federal developing democracies and provides policy guidance for strengthening subnational health insurance systems through sustained investment in administrative, fiscal, governance, and service-delivery capacities as prerequisites for achieving Universal Health Coverage.

Keywords: *State capacity; Health justice; Capacity–Justice Nexus; Universal Health Coverage; Edo State Health Insurance Scheme (EdoHIS); Infrastructural power; Capability approach; Nigerian federalism*

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INTRODUCTION

Whether states in the developing world possess the institutional capacity to translate their formally articulated obligations of health justice into substantive realities for the populations they govern remains one of the most pressing questions confronting contemporary political philosophy, public administration, and global health governance. Although many low- and middle-income countries have adopted ambitious Universal Health Coverage (UHC) policies, persistent institutional weaknesses, fragmented governance arrangements, inadequate public financing, and implementation deficits continue to undermine equitable access to essential healthcare services (Croke & Ogbuoji, 2024; Chukwuma, 2024; Adewoye et al., 2025; Christopher et al., 2024). In the Nigerian context, where out-of-pocket expenditure continues to account for approximately 70% of total health expenditure and progress towards Universal Health Coverage remains comparatively low despite the country's economic potential, healthcare financing continues to expose millions of households to catastrophic health expenditure and financial hardship (Ataguba et al., 2024). Recent evidence further demonstrates that weaknesses in governance, accountability, and institutional coordination within Nigeria's Basic Health Care Provision Fund have constrained effective implementation of health reforms intended to improve equitable healthcare delivery (Adeoye et al., 2024). Consequently, access to healthcare in Nigeria remains largely mediated by individuals' ability to pay rather than by citizenship rights or constitutional guarantees, thereby undermining distributive justice and the realization of health as a fundamental human right (Chukwuma, 2024; Croke & Ogbuoji, 2024).

The philosophical tradition offers rich accounts of health justice. Daniels (1985, 2008) grounds the justice of healthcare in its relationship to the fair distribution of opportunity, arguing that because disease systematically diminishes the range of life plans available to individuals, its equitable management is a demand of justice rather than benevolence. The capability approach, developed by Sen (1999) and Nussbaum (2006) and extended by Venkatapuram (2011) into the health domain, goes further, defining health as a meta-capability, a foundational capacity whose presence or absence conditions the exercise of every other human capability, and establishing a moral entitlement to a capability to be healthy.

While existing scholarship on health justice has made substantial contributions to understanding the ethical foundations of equitable healthcare access, the literature has remained predominantly normative, focusing on distributive justice, rights-based approaches, and moral obligations of the state (Daniels, 2008; Ruger, 2010; Venkatapuram, 2011). More recent studies on Universal Health Coverage in low- and middle-income countries have shifted attention towards health financing reforms, governance, and institutional implementation but have largely examined these issues from public administration or health systems perspectives without integrating them into a coherent theory of justice (Croke & Ogbuoji, 2024; Chukwuma, 2024; Adewoye et al., 2025). Consequently, a significant conceptual gap persists regarding how variations in state capacity shape the realization of health justice, particularly within decentralized health insurance systems in sub-national governments.

Furthermore, empirical research on Nigeria's State Social Health Insurance Schemes has concentrated primarily on enrolment, financial sustainability, service utilization, and operational performance, with limited attention to whether institutional capacity itself constitutes a normative determinant of justice in healthcare delivery. Existing evaluations rarely distinguish between policy design failures and failures arising from weak infrastructural state capacity, thereby overlooking the mechanisms through which governance capability influences equitable access to healthcare. This omission is particularly important because expanding insurance coverage alone does not necessarily translate into substantive health justice where administrative capacity, regulatory effectiveness, accountability, and implementation institutions remain weak.

To address this gap, the present study develops the Capacity–Justice Nexus Framework, which integrates the normative theories of health justice with state capacity theory as articulated by Michael Mann, Peter Evans, and Francis Fukuyama. Rather than treating institutional capacity merely as an administrative variable, the framework conceptualizes it as a constitutive condition for achieving health justice. The framework is applied to the Edo State Health Insurance Scheme (EdoHIS), established under the Edo State Health Insurance Commission Act of 2019 and operationalized in 2022. Although the scheme expanded from approximately 9,000 enrolled beneficiaries in 2022 to over 80,000 by 2024, this study argues that the remaining gap between observed institutional performance and the normative ideals of health justice is best explained by limitations in state capacity rather than deficiencies in policy design alone. By integrating political theory, public administration, and health systems governance, this study contributes a novel analytical framework for evaluating the institutional foundations of Universal Health Coverage in developing countries.

Theoretical Framework

Bridging State Capacity and Health Justice

The normative foundation of this article is drawn from the

health justice tradition. Daniels (1985, 2008) establishes that the equitable distribution of healthcare is demanded by justice because health preserves individuals' normal range of opportunities and enables meaningful participation in social, economic, and political life. The capability approach extends this argument. Sen (1999) and Nussbaum (2006) contend that justice should be evaluated according to people's substantive freedoms rather than merely the distribution of material resources. Venkatapuram (2011) advances this reasoning by arguing that every individual possesses a moral entitlement to the capability to be healthy, conceptualizing health as a meta-capability upon which the realization of other human capabilities depends. This article adopts Venkatapuram's formulation as its principal normative benchmark because it provides the most comprehensive ethical standard for evaluating health systems and places demanding obligations upon governments to ensure equitable access to healthcare. Recent scholarship on health justice further argues that achieving equitable health outcomes requires integrating normative commitments with institutional arrangements capable of translating rights into effective service delivery, thereby broadening the concept of health justice beyond distributive equity alone.

Although these normative frameworks provide compelling ethical justifications for universal access to healthcare, they devote comparatively limited attention to the institutional mechanisms through which states transform moral obligations into effective public policy. Rights and constitutional guarantees do not implement themselves; they depend upon capable institutions possessing administrative competence, fiscal resources, regulatory effectiveness, and governance structures capable of sustaining equitable service delivery. Contemporary studies on Universal Health Coverage increasingly identify governance quality, institutional effectiveness, and implementation capacity as fundamental determinants of successful health system reforms, particularly in low- and middle-income countries where implementation failures often undermine ambitious policy commitments (Croke & Ogbuoji, 2024; Chukwuma, 2024; Adewoye et al., 2025; Odinenu & Anago, 2025). Recent evidence further demonstrates that weak state capacity remains a major obstacle to achieving financial risk protection and universal healthcare coverage despite expanding legislative commitments. It is at this point that the political sociology of the state becomes indispensable. Mann (1984) distinguishes despotic power, referring to the capacity of political elites to act unilaterally through coercive authority, from infrastructural power, defined as the state's ability to penetrate society, coordinate administrative institutions, and implement policy effectively throughout its territory. This distinction captures the governance challenges confronting many sub-Saharan African health systems, where constitutional guarantees and health sector reforms frequently coexist with weak implementation capacity, fragmented institutions, and inadequate public service delivery. Evans (1995) extends this perspective through the concept of embedded autonomy, arguing that effective developmental states combine internally coherent bureaucracies with collaborative relationships across civil society, thereby enabling both administrative effectiveness and public legitimacy. Fukuyama (2004) similarly distinguishes state scope from state strength, demonstrating that governments attempting to perform increasingly complex social functions without corresponding institutional capability often generate implementation failure rather than improved welfare. Recent comparative analyses reinforce these classical insights by demonstrating that state capacity including bureaucratic quality, government effectiveness, regulatory capability, and accountability is a critical determinant of health financing performance and progress toward Universal Health Coverage across developing countries. Building upon these complementary theoretical traditions, this article develops the Capacity–Justice Nexus as an integrated evaluative framework linking normative theories of justice with contemporary state capacity theory. Within this framework, health justice establishes the normative standard that defines what governments owe their citizens, while state capacity explains the institutional conditions under which those obligations can be realized. Rather than treating institutional capacity merely as an administrative or managerial variable, the Capacity–Justice Nexus conceptualizes it as a constitutive component of justice itself because legal rights become largely symbolic where governments lack the capability to implement them effectively. The framework therefore argues that progress towards Universal Health Coverage in developing federal democracies depends not only on the ambition of policy commitments but also on four mutually reinforcing dimensions of state capacity: administrative capacity, fiscal capacity, governance and accountability capacity, and service delivery capacity. These dimensions provide the analytical basis for evaluating the performance of the Edo State Health Insurance Scheme (EdoHIS) and assessing the extent to which institutional capability facilitates or constrains the realization of health justice. By integrating political philosophy, public administration, and contemporary health systems governance, the Capacity–Justice Nexus contributes a novel interdisciplinary framework for analyzing the institutional foundations of Universal Health Coverage in developing countries.

Contextual Background

Nigerian Federalism, Health Governance, and the Architecture of EdoHIS

Nigeria's tripartite federal structure formally distributes

health responsibilities across the federal government, thirty-six state governments, and seven hundred and seventy-four local government areas. In practice, this architecture produces jurisdictional fragmentation, administrative misalignment, and fiscal asymmetry (Sukare & Abdullahi, 2025; Njoku et al., 2026). States are not accountable to the federal government regarding healthcare spending, and the federal government raises more than ninety-two percent of government revenue while state and local governments account for thirty-six percent and eleven percent of spending respectively, producing a structural mismatch between where resources are pooled and where health delivery obligations reside (Bisiriyu et al., 2026; Sukare & Abdullahi, 2025).

According to the World Bank (2025) and the National Bureau of Statistics (2025), this fiscal imbalance continues to constrain subnational governments' ability to finance essential health services effectively. Per capita health allocations by the states have fallen from US$10.78 per person in 2020 to US$8.53 annually, against the World Health Organization's recommended benchmark of approximately US$86 per capita for delivering essential health services, while only 61.9% of approved health budgets were actually implemented in 2024 (World Health Organization [WHO], 2025; National Bureau of Statistics [NBS], 2025). These statistics illustrate that Nigeria's health sector challenges are increasingly associated with weak institutional implementation rather than the absence of policy commitments (Elgujja et al., 2025; Edokameh & Benin, 2026).

The National Health Insurance Authority (NHIA) Act of 2022 mandated universal health insurance coverage for all residents, yet the informal economy accounts for approximately 65% of Nigeria's total economic activity, rendering payroll-based contributory insurance fundamentally inadequate for achieving universal reach (Elgujja et al., 2025). According to the National Health Insurance Authority Annual Report (2024), by December 2024 approximately 19.2 million Nigerians had been enrolled in health insurance programmes from a national population exceeding 230 million, while only 2.4 million vulnerable Nigerians were sponsored through the Basic Health Care Provision Fund (NHIA, 2024). Similarly, the World Bank (2025) reports that Nigeria's Universal Health Coverage Service Coverage Index remains substantially below the global average and continues to lag behind countries such as Egypt, demonstrating persistent deficiencies in healthcare accessibility, financial protection, and institutional effectiveness.

Recent studies argue that these shortcomings arise less from deficiencies in legislative design than from weaknesses in governance, institutional coordination, implementation capacity, and administrative accountability (Sukare & Abdullahi, 2025; Elgujja et al., 2025; Adewoye et al., 2025). Consequently, Nigeria's healthcare paradox reflects the coexistence of relatively comprehensive policy frameworks with weak implementation institutions, reinforcing the argument that state capacity constitutes the principal determinant of effective health governance. It is within this institutional context that EdoHIS acquires its analytical significance. Edo State, located in Nigeria's South-South geopolitical zone, has a population of approximately four million across eighteen local government areas. Research conducted in Edo's primary healthcare facilities found that none surveyed possessed reliable internet connectivity or dedicated budgets for health information management systems, while only two of thirty-five facilities were capable of effectively operating health information management activities, highlighting the institutional constraints within which EdoHIS was introduced (Adewoye et al., 2025; Edokameh & Benin, 2026).

The Edo State Health Insurance Commission was established under the Edo State Health Insurance Commission Act (2019) and became operational in 2022 with responsibility for policy formulation, provider accreditation, premium administration, strategic purchasing, and beneficiary enrolment. Through its Equity Plan, the Commission finances healthcare for children under five years, pregnant women, elderly persons, persons living with disabilities, and vulnerable households. The scheme operates through more than 380 accredited healthcare facilities across all eighteen local government areas and expanded from only three primary healthcare centres at inception in 2022 to approximately 134 facilities by 2024, although this remains below the nationally recommended benchmark of 192 functional primary healthcare centres (NHIA, 2024; Alawode et al., 2026).

Recent evidence further demonstrates that strengthening local government autonomy, improving intergovernmental coordination, and enhancing institutional governance are indispensable for sustaining Universal Health Coverage reforms in Nigeria (Alawode et al., 2026; Bisiriyu et al., 2026). Rather than interpreting the remaining implementation gaps as evidence of policy failure, this article argues that they are more appropriately understood as manifestations of constrained state capacity operating within Nigeria's federal governance architecture. This distinction between policy ambition and institutional capability forms the central analytical proposition of the Capacity–Justice Nexus developed in this study.

Linking Paragraph

Against this institutional backdrop, **EdoHIS** provides an appropriate empirical case for examining how state capacity mediates the relationship between public policy and health justice. While previous studies have primarily evaluated health insurance schemes in terms of enrolment, financing, and service utilization (Adewoye et

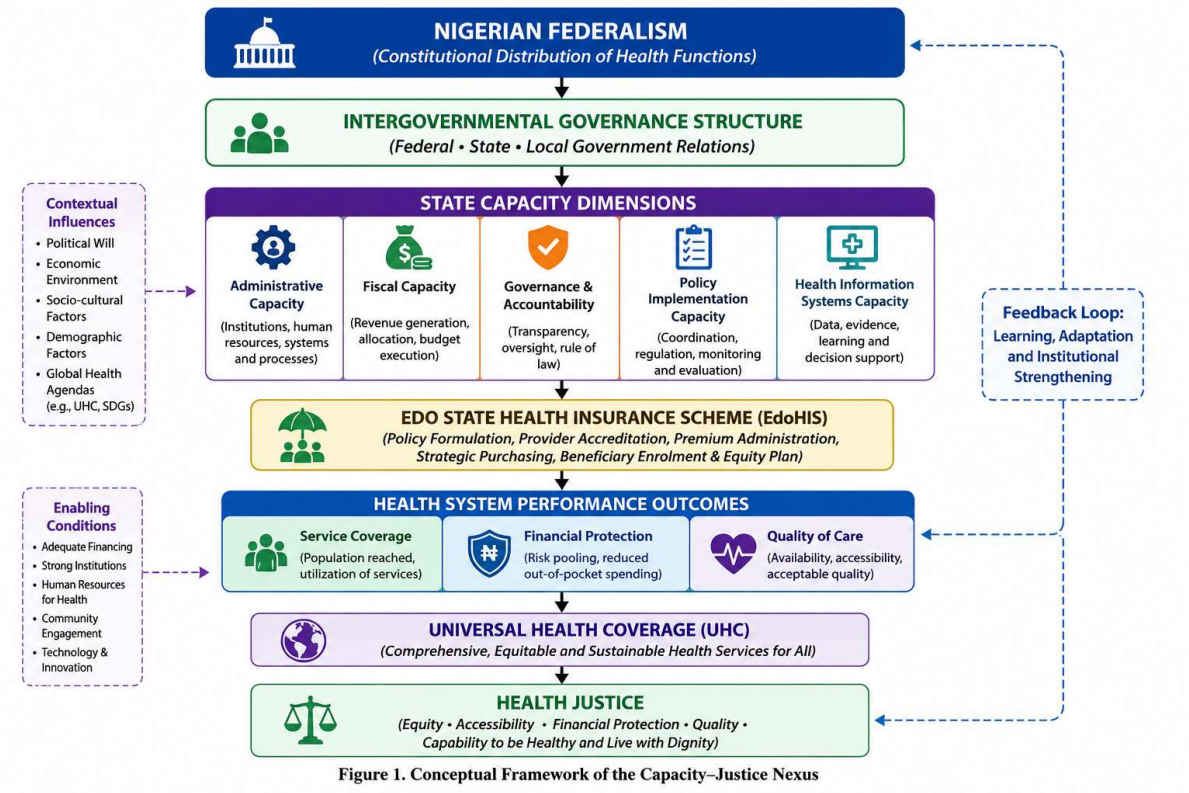

Figure 1. Conceptual Framework of the Capacity–Justice Nexus

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al., 2025; Elgujja et al., 2025), this article investigates whether the institutional capacities required to realize health justice are themselves sufficiently developed. By integrating normative theories of justice with contemporary state capacity theory, the Capacity–Justice Nexus demonstrates that progress towards Universal Health Coverage depends not merely on legislative commitment but fundamentally on the administrative, fiscal, governance, and service-delivery capacities of state institutions. Consequently, EdoHIS serves as an appropriate analytical lens through which the institutional foundations of health justice can be evaluated within Nigeria's federal system (Figure 1).

RESULTS

The Capacity-Justice Nexus Applied to EdoHIS

The Capacity-Justice Nexus holds that health justice can only be progressively realized where the state possesses sufficient infrastructural power to penetrate its territory, coordinate its administrative functions, sustain its financial obligations, and maintain the trust of the populations it serves. The following analysis applies each dimension to EdoHIS, reading the scheme's achievements and limitations as evidence of the unresolved tension between what justice demands and what current state capacity in Edo can consistently deliver (Table 1 and Figure 2).

Infrastructural Reach and the Limits of Territorial Penetration

Mann's (1984) concept of infrastructural power foregrounds the state's capacity to implement policy decisions effectively across the full extent of its territory, ensuring that public authority penetrates everyday social life rather than remaining confined to formal administrative centres. Recent scholarship has significantly expanded this perspective by conceptualising infrastructure as both a material and institutional mechanism through which states construct legitimacy, coordinate governance, and shape socio-political relations (Albert et al., 2026; Bieling & Mattioli, 2026; Téllez Contreras, 2025). Rather than viewing infrastructure merely as physical assets, contemporary social science understands it as the connective architecture that enables governments to transform policy commitments into lived social outcomes (Ruonavaara, 2026; Coombs, 2025). Consequently, universal health coverage depends not only on statutory authority but also

Table 1. Application of the Capacity–Justice Nexus to the Edo State Health Insurance Scheme (EdoHIS).

Capacity Dimension	Empirical Evidence from EdoHIS	Capacity Challenge	Health Justice Implication	Policy Direction
Infrastructural Reach	Accredited health facilities increased from 3 facilities at inception to 134 facilities (2022–2024), although below the estimated requirement of 192 functional PHCs.	Unequal territorial penetration; inadequate rural coverage; uneven digital and referral infrastructure.	Geographical inequalities limit the effective exercise of healthcare rights despite formal insurance enrolment.	Expand accredited PHCs, strengthen referral systems, improve digital health infrastructure, and prioritise underserved rural communities.
Administrative Coordination	Creation of the Edo State Health Insurance Commission and introduction of the Canvasser Model (2024) to improve grassroots enrolment.	Weak coordination among ministries, local governments, PHC authorities and insurance administrators; fragmented information systems.	Institutional fragmentation reduces equitable implementation and weakens public confidence in government health programmes.	Integrate health information systems, strengthen inter-agency coordination, institutionalise community engagement, and improve bureaucratic capacity.
Financial Sustainability	Equity Plan subsidises approximately 80,000 vulnerable beneficiaries. Edo State consistently provides the required 25% BHCPF counterpart funding.	Heavy dependence on political commitment; limited fiscal protection for long-term sustainability.	Financial insecurity threatens continuity of healthcare access for vulnerable populations and undermines distributive justice.	Establish legally protected financing mechanisms, strengthen public financial management, improve accountability, and diversify funding sources.
Informal Sector Inclusion	Majority of Edo's workforce remains in informal employment with low insurance enrolment despite canvasser outreach.	Irregular incomes, administrative barriers, low awareness, distrust of government programmes, and affordability constraints.	Informal workers remain the largest excluded population despite having the greatest health needs, reinforcing structural inequalities.	Introduce flexible premium payment systems, expand subsidies, simplify registration, strengthen community-based enrolment, and improve public awareness.

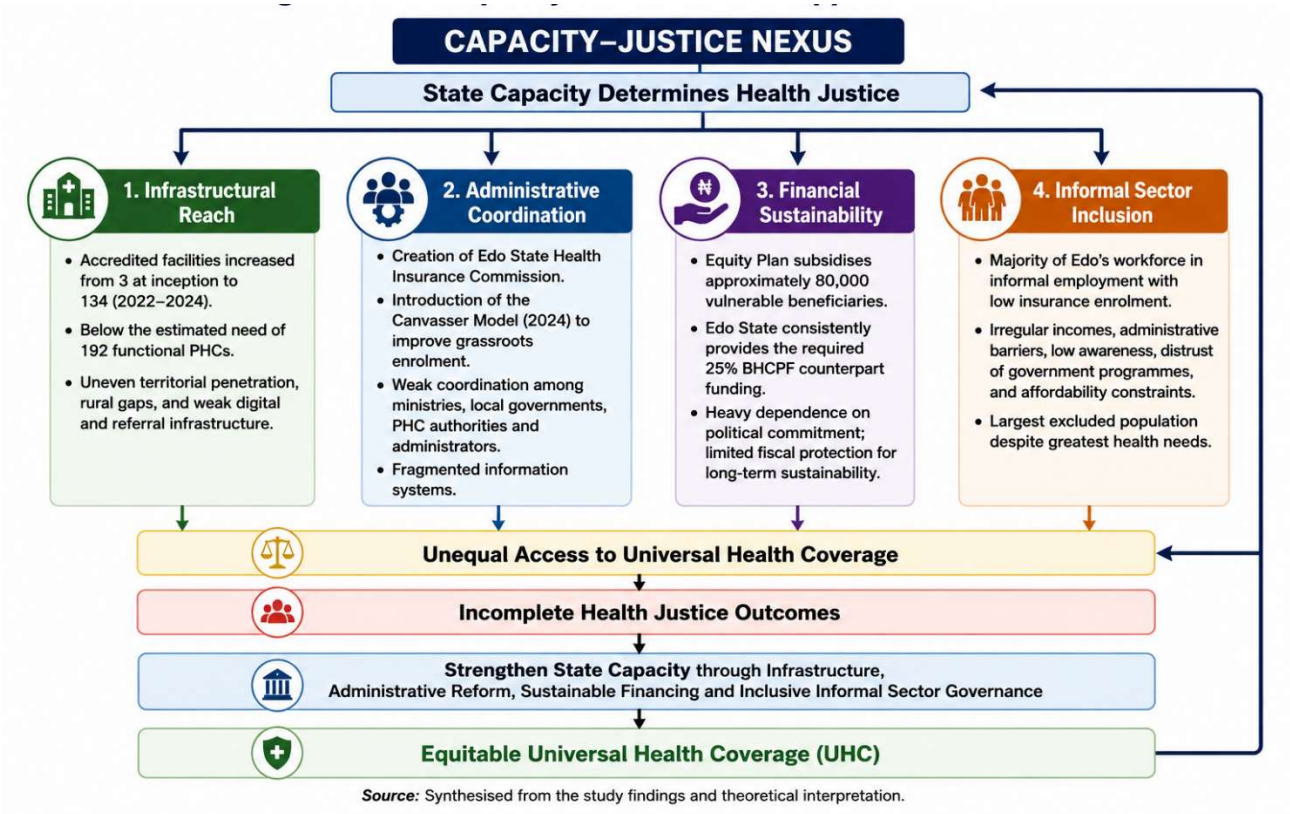

Figure 2: The Capacity–Justice Nexus Applied to EdoHIS

on the state's ability to ensure that health facilities, personnel, technologies, and administrative systems penetrate all territorial and social spaces.

Within this theoretical context, Edo State Health Insurance Scheme (EdoHIS) demonstrates measurable progress in extending institutional infrastructure. The expansion from only three accredited primary healthcare facilities at inception to 134 accredited centres between 2022 and 2024 represents a significant improvement in the state's organisational capacity to decentralise healthcare delivery. However, this expansion must be interpreted against the nationally recommended benchmark of approximately 192 functional primary healthcare centres. The remaining deficit represents more than a numerical shortfall; it reflects unequal territorial penetration that determines which communities can realistically benefit from publicly financed healthcare and which remain effectively excluded despite formal enrolment. Kunwar (2026) argues that contemporary state-capacity research increasingly recognises territorial reach as a defining indicator of governance effectiveness because institutions derive legitimacy from their ability to deliver services consistently across geographically diverse populations rather than merely establishing administrative structures.

Venkatapuram's capability approach reinforces this concern by insisting that health entitlements possess value only when individuals can realistically exercise them. Legal enrolment into EdoHIS therefore constitutes only the first stage of health justice. Where residents in rural wards of Edo North or Edo Central lack accredited facilities within reasonable travelling distance, insurance membership becomes largely symbolic because the institutional infrastructure required to transform entitlement into actual healthcare remains absent. Similar arguments have emerged in infrastructural politics scholarship, which demonstrates that infrastructure determines who becomes visible to the state and who remains marginal to public service delivery (Téllez Contreras, 2025). In this sense, spatial inequality becomes a form of institutional inequality because physical distance translates directly into unequal access to constitutionally guaranteed social rights.

The challenge extends beyond the physical distribution of health facilities to include the administrative, technological, and digital infrastructures that sustain contemporary healthcare governance. Research on digital policy implementation in Nigeria indicates that institutional effectiveness increasingly depends upon the successful integration of information systems, digital competencies, and administrative coordination throughout service delivery networks (Eddy et al., 2026). Likewise, studies of digital transformation across Africa demonstrate that technological infrastructures simultaneously create opportunities for inclusion while reproducing new forms of exclusion where connectivity, digital literacy, or institutional capacity remain uneven (Joanita, 2025). Consequently, EdoHIS's infrastructural reach should be assessed not solely by the number of accredited facilities but also by the extent to which referral systems, claims management, digital enrolment platforms, provider monitoring, and health information systems function seamlessly across urban and rural communities.

Recent developments in governance theory further suggest that infrastructural power has become increasingly intertwined with institutional legitimacy and resilience. Bieling and Mattioli (2026) argue that states exercise durable authority through infrastructures that embed governance within everyday social and economic life, while Coombs (2025) similarly demonstrates that infrastructural arrangements determine whether public institutions can sustain trust, accountability, and policy effectiveness over time. Evidence from fragile governance settings also illustrates that reliable service delivery itself generates political legitimacy by demonstrating the state's capacity to fulfil fundamental social obligations (Koehnlein, 2025). Within the healthcare sector, this implies that the expansion of accredited facilities, digital systems, and administrative networks contributes not only to improved service access but also to strengthening citizens' confidence in government institutions.

Furthermore, African governance scholarship highlights that effective infrastructural development should remain sensitive to local social contexts rather than relying exclusively on technocratic expansion. Lunga et al. (2025) argue that governance systems grounded in Ubuntu principles strengthen institutional responsiveness by embedding service delivery within relationships of solidarity, reciprocity, and community participation. Such perspectives are particularly relevant for rural health governance, where community engagement often determines whether healthcare infrastructure becomes socially accessible rather than merely physically available. Similarly, Omoigberale (2025) demonstrates that fiscal and administrative arrangements substantially influence subnational governments' capacity to sustain equitable public service provision, suggesting that infrastructural expansion requires corresponding improvements in fiscal coordination and institutional financing.

Therefore, the establishment of enabling legislation and the creation of the Edo State Health Insurance Commission represent only the despotic dimension of state authority—that is, the formal institutional capacity to legislate and regulate healthcare provision. The more fundamental question concerns infrastructural power: whether the state possesses sufficient territorial, administrative, technological, and fiscal capacity to guarantee healthcare delivery whenever and wherever enrolled beneficiaries require it. Although EdoHIS has made substantial progress in expanding institutional reach, persistent geographic disparities indicate that

infrastructural capacity remains uneven. Until healthcare infrastructure penetrates underserved communities with sufficient density and operational effectiveness, universal health coverage will continue to represent an aspirational policy commitment rather than a fully realised instrument of health justice.

Administrative Coordination and the Problem of Institutional Coherence

Evans's concept of embedded autonomy posits that developmental states derive effectiveness from the simultaneous existence of internally coherent bureaucratic institutions and durable, trust-based relationships with societal actors. Institutional coherence enables administrative agencies to coordinate policies, share information, minimize duplication of responsibilities, and implement reforms consistently across multiple levels of government. Recent scholarship on Nigerian public administration demonstrates that these conditions remain only partially developed, as governance reforms continue to be constrained by fragmented institutional mandates, bureaucratic rivalry, policy inconsistency, and weak administrative coordination (Gado, 2025; Ochiga & Gogo, 2025; Eleyi & Ogidi, 2026). Consequently, public institutions frequently possess formal legal mandates without the organizational capacity necessary to translate policy objectives into equitable public service delivery.

Both dimensions of embedded autonomy reveal significant weaknesses in the current configuration of the Edo State Health Insurance Scheme (EdoHIS). Internal bureaucratic coherence remains constrained by inadequate coordination between state ministries, local government structures, primary healthcare authorities, and health insurance administrators. Studies on Nigerian administrative governance consistently identify poor institutional coordination, weak accountability systems, fragmented information management, and overlapping administrative responsibilities as persistent impediments to effective policy implementation (Sukare & Abdullahi, 2025; Gado, 2025; Nwambuko, Chigozie, & George, 2026). Similar governance deficiencies have been observed across multiple sectors including national security administration, education, taxation, and renewable energy regulation where fragmented authority and bureaucratic competition undermine implementation effectiveness despite well-designed policy frameworks (Malabu, 2025; Alabi, 2025; Bello, Musa, & Sagir, 2026).

Capacity deficiencies at subnational levels further reinforce these coordination challenges. Research examining Nigeria's administrative architecture for Sustainable Development Goal implementation demonstrates that local governments frequently experience shortages of skilled personnel, inadequate administrative planning, poor data management systems, weak monitoring mechanisms, and limited institutional collaboration, thereby reducing implementation effective-ness (Nwambuko, Eromosele, & Ike, 2026). Similarly, studies of public sector digital governance argue that fragmented information systems and weak digital integration significantly reduce administrative efficiency, policy monitoring, and inter-organizational learning (Alikornwo, Sam-Kalagbor, & Nyeche, 2026). These findings closely correspond with the health information deficits, fragmented administrative processes, and coordination limitations documented within EdoHIS.

The commissioning of the canvasser model in late 2024, which deployed trained volunteers to promote grassroots enrolment across Edo State's three senatorial districts, illustrates an adaptive administrative response to these institutional weaknesses. While the initiative reflects managerial innovation and responsiveness, it simultaneously acknowledges that conventional bureaucratic structures have been unable to achieve sufficient community penetration through existing administrative channels. Rather than representing institutional failure alone, such adaptive mechanisms demonstrate attempts to compensate for weaknesses in bureaucratic outreach capacity. However, development administration literature cautions that sustainable governance reforms require strengthening permanent institutional capabilities rather than relying primarily on temporary administrative innovations (Ochiga & Gogo, 2025; Gado, 2025).

The second dimension of embedded autonomy societal embeddedness is equally challenged by historically weak state society relations. Administrative effectiveness depends not only on bureaucratic competence but also on citizens' confidence that public institutions will consistently deliver promised services. Contemporary analyses of Nigerian governance reforms emphasize that policy implementation frequently suffers from a persistent gap between policy design and actual developmental outcomes because institutional credibility remains weak (Eleyi & Ogidi, 2026). Likewise, research on policy coherence argues that successful implementation of complex public programmes requires sustained coordination among institutions while simultaneously fostering trust, participation, and legitimacy among affected communities (Dzebo, Shawoo, & Browne, 2025). Within the health sector, distrust of government programmes, negative experiences with healthcare facilities, and inconsistent service quality continue to discourage voluntary participation in health insurance schemes.

These public attitudes are not irrational responses but historically grounded assessments formed through prolonged experiences of inconsistent public service delivery. Studies of Nigerian governance increasingly demonstrate that institutional legitimacy is cumulative, emerging through repeated demonstrations of competence, accountability, transparency, and administrative consistency rather than through policy announcements alone (Sukare & Abdullahi, 2025; Gado,

2025). Similar findings are evident in analyses of flood governance, policing reforms, and regulatory administration, where fragmented institutional authority and weak enforcement mechanisms have diminished public confidence in state institutions (Igba, 2026; Omoyeni, 2026; Malabu, 2025). Consequently, trust should be understood as a strategic institutional resource rather than merely a behavioural outcome.

From a justice-centred perspective, the implications extend beyond administrative efficiency. Administrative coordination constitutes an essential component of state capacity because fragmented governance disproportionately disadvantages vulnerable populations that depend most heavily on publicly financed health services. Evans's embedded autonomy therefore suggests that equitable health insurance expansion requires more than increased financial investment; it demands coherent bureaucratic coordination, integrated information systems, stable institutional relationships, and sustained engagement with communities. Without these complementary institutional capacities, EdoHIS is likely to experience continued implementation gaps in which formal policy commitments remain only partially translated into substantive health justice outcomes. Strengthening institutional coherence therefore becomes not simply an administrative objective but a fundamental prerequisite for achieving equitable, legitimate, and sustainable universal health coverage in Edo State.

Financial Sustainability and the Equity Imperative

The Equity Plan reflects an implicit acceptance of Daniels's argument that justice requires health systems to compensate for the morally arbitrary disadvantages that constrain the life chances of the most marginalised members of society. In the Nigerian context, where poverty remains a major determinant of health exclusion, equity-oriented financing has become central to achieving universal health coverage (UHC). Official demographic and poverty statistics indicate that approximately 30–40% of Edo State's estimated population of 4.7 million experience multidimensional or extreme poverty, making voluntary contributory health insurance unattainable for a substantial proportion of households. Consequently, the Equity Plan's coverage of approximately 80,000 beneficiaries represents only a limited proportion of the population requiring financial protection against catastrophic health expenditure. This gap demonstrates that while targeted subsidies improve access for vulnerable groups, they remain insufficient unless supported by broader fiscal expansion and institutionalised financing mechanisms (Josiah et al., 2025; Odinenu & Anago, 2025).

Recent scholarship increasingly argues that sustainable universal health coverage depends less on isolated insurance programmes than on predictable public financial management systems capable of guaranteeing long-term health financing. Comparative evidence from Kenya's Universal Health Care pilot demonstrates that effective public financial management including transparent budgeting, timely fund releases, expenditure tracking, and accountability mechanisms is indispensable for sustaining equity-oriented health reforms (Adjagba et al., 2025). Similar conclusions emerge from analyses of Nigeria's Basic Health Care Provision Fund (BHCPF), which identify delayed counterpart funding, fragmented governance arrangements, weak accountability structures, and inconsistent fiscal commitment across states as the principal obstacles to equitable healthcare financing (Odinenu & Anago, 2025; Uzochukwu, 2025).

Within this broader national context, Edo State occupies an exceptional position. It remains among the relatively few Nigerian states that consistently provided the mandatory 25% counterpart funding required to access BHCPF resources, thereby demonstrating stronger political commitment to primary healthcare financing than many subnational governments. However, this achievement simultaneously exposes a structural weakness in Nigeria's decentralised health financing architecture. Because continued programme implementation depends largely on the fiscal priorities and political commitment of successive administrations rather than legally guaranteed financing arrangements, the sustainability of equity interventions remains uncertain. Recent studies of local government financing similarly demonstrate that effective primary healthcare delivery depends on institutionalised revenue administration and predictable fiscal transfers rather than discretionary political allocations (Mgbonyebi & Edegware, 2025).

This dependence on political commitment raises important concerns regarding distributive justice. Daniels's theory of justice requires that access to healthcare should not depend upon changing political preferences but should instead constitute an enforceable institutional guarantee protecting citizens against arbitrary disadvantage. Likewise, contemporary analyses of healthcare inequality in Nigeria argue that equity cannot be realised solely through policy declarations; it requires durable governance institutions capable of protecting vulnerable populations irrespective of electoral cycles or administrative transitions (Ezeaka et al., 2025). Evidence from national assessments of healthcare financing further indicates that persistent underfunding, high out-of-pocket expenditure, and unequal distribution of health resources continue to undermine the quality and accessibility of healthcare services despite successive reform initiatives (Josiah et al., 2025).

Financial sustainability therefore extends beyond securing additional resources to encompass the quality of fiscal governance itself. Emerging research on African health economics emphasises that sustainable healthcare financing requires prudent resource allocation,

fiscal sustainability, debt management, and efficient public expenditure to maintain essential health services over time (Otorkpa et al., 2026; Yahaya, 2026). Parallel evidence from infrastructure financing studies also demonstrates that long-term public investment outcomes depend upon stable institutional budgeting frameworks rather than episodic political expenditure, reinforcing the broader governance principle that equitable service delivery requires predictable fiscal systems (Visigah & Nkiruka, 2026). These findings are consistent with broader public administration scholarship, which argues that institutional capacity and governance quality determine whether social programmes evolve into enduring public institutions or remain vulnerable to political discontinuity (Egberi et al., 2026).

The governance dimension is equally significant. Accountability mechanisms surrounding the BHCPF remain uneven across Nigerian states, limiting transparency in fund utilisation and weakening public confidence in equity programmes. Uzochukwu (2025) argues that stronger monitoring systems, independent oversight, citizen participation, and performance-based accountability are essential for transforming the BHCPF into a genuinely equitable financing mechanism. Similar governance principles have been emphasised across other sectors of Nigerian public health administration, where institutional accountability, regulatory effectiveness, and coordinated governance are increasingly recognised as prerequisites for sustainable service delivery (Anekwe et al., 2026; Egberi et al., 2026).

From a state-capacity perspective, therefore, Edo's Equity Plan illustrates both the possibilities and limitations of subnational health financing reforms. The programme demonstrates that targeted subsidies can substantially improve access for vulnerable populations when supported by committed political leadership and effective administrative coordination. Nevertheless, its continued success remains contingent upon institutional arrangements that have not yet been fully insulated from political change. As Fukuyama argues, states that assume expansive welfare responsibilities before establishing durable fiscal and administrative institutions risk producing programmes that depend on political discretion rather than embedded governance capacity. Consequently, achieving health justice requires moving beyond programme-based interventions towards legally protected, fiscally sustainable, and institutionally accountable financing systems capable of guaranteeing equitable healthcare access irrespective of changes in political leadership. This financial sustainability challenge therefore represents a critical dimension of the broader capacity–justice nexus examined in this study.

The Informal Sector as the Frontier of Justice

The most searching test of any subnational scheme's claim to embody health justice is its performance in relation to the informal economy, where populations most structurally excluded from formal social protection reside. Across much of sub-Saharan Africa, and particularly in Nigeria, the informal economy constitutes the dominant source of employment and livelihood, yet remains largely excluded from contributory social insurance systems because of irregular incomes, weak institutional registration, and limited state oversight (Ezekiel Adetola, 2025; Dzreke & Dzreke, 2025). Contemporary scholarship increasingly argues that the informal sector should no longer be viewed merely as an administrative challenge but as a central arena for advancing distributive, procedural, and epistemic justice within public policy (Ayodele, 2025; Nwosu, 2025).

In Edo State, the labour market is dominated by petty trading, artisanal production, subsistence agriculture, transport services, home-based enterprises, and numerous forms of unregistered self-employment. These are precisely the populations that Venkatapuram's health justice framework identifies as having the greatest moral claim to public protection because they experience multiple and intersecting forms of socioeconomic disadvantage. Ironically, they are also the populations that conventional contributory insurance architecture is least capable of reaching. The absence of stable salaries, formal employment contracts, and payroll deduction mechanisms significantly limits their integration into mandatory health insurance arrangements, thereby reproducing longstanding patterns of health inequity (Briggs-Megafu, 2025; Dzreke & Dzreke, 2025).

Recent evidence demonstrates that poor enrolment among informal sector workers remains one of the most persistent barriers to achieving universal health coverage in Nigeria. Financial insecurity, irregular cash flows, limited awareness of insurance benefits, low financial literacy, administrative complexity, distrust of government institutions, and perceptions of poor service quality collectively discourage voluntary participation (Briggs-Megafu, 2025; Ezekiel Adetola, 2025). These structural barriers reinforce cycles of out-of-pocket expenditure, catastrophic health spending, delayed care-seeking, and preventable morbidity and mortality, particularly among women, children, and other socioeconomically vulnerable populations. Briggs-Megafu (2025) further demonstrates that dependence on out-of-pocket healthcare financing among households operating within the informal economy is closely associated with adverse maternal and infant health outcomes, underscoring the profound distributive justice implications of exclusion from health insurance.

The challenge extends beyond economic informality to questions of recognition and institutional legitimacy. Ayodele (2025) argues that state policies frequently frame informal economic actors through narratives of illegality or non-compliance rather than recognising their essential contribution to national productivity and

community resilience. Such epistemic exclusion influences policy design by treating informal workers as administratively difficult populations instead of legitimate citizens entitled to equal social protection. Similarly, Nwosu (2025) advocates design frameworks that intentionally integrate informal economic systems into formal governance structures rather than expecting informal workers to adapt to institutional arrangements originally designed for salaried employment. These perspectives align closely with health justice scholarship, which emphasises that equitable policy requires institutional adaptation to citizens' lived realities rather than expecting disadvantaged populations to overcome structural barriers independently.

The mandatory compliance framework covering formal sector employers leaves the informal majority dependent upon voluntary enrolment, whose limitations are well documented across African health financing systems. International comparative evidence similarly demonstrates that voluntary insurance mechanisms consistently struggle to achieve broad coverage among informal workers because adverse selection, affordability constraints, administrative transaction costs, and unstable incomes reduce sustained participation (Nuryanto & Ogli, 2025). Experiences from Indonesia illustrate that successful expansion of national health insurance among informal populations requires substantial government subsidies, simplified registration procedures, community-based mobilisation, and continuous public investment rather than reliance upon individual purchasing decisions alone (Nuryanto & Ogli, 2025). Comparable lessons emerge from Kenya and Ghana, where digital identity systems have improved administrative inclusion but require complementary livelihood-sensitive policies to avoid deepening exclusion among the poorest households (Dzreke & Dzreke, 2025). Within EdoHIS, the canvasser model represents an important institutional innovation intended to bridge this structural divide by extending enrolment beyond conventional employer-based channels. Nevertheless, its long-term sustainability depends upon administrative capacity, adequate financing, community trust, effective incentive structures, reliable digital infrastructure, and continuous monitoring. Without these institutional supports, canvasser-driven recruitment risks producing episodic enrolment gains without generating sustained insurance participation among highly mobile and economically vulnerable populations. Evidence from social protection programmes operating in fragile contexts similarly suggests that outreach mechanisms alone cannot compensate for weak administrative systems unless embedded within broader state capacity-building reforms (Merttens, 2025).

The informal sector also illustrates the broader intersection between health justice and multidimensional poverty. Extreme poverty reduces individuals' capability to pay insurance premiums, while exclusion from healthcare further entrenches economic vulnerability through lost productivity, catastrophic expenditure, and intergenerational deprivation (Okonta, 2025). Recent analyses further demonstrate that labour precarity among educated youth increasingly channels graduates into informal employment characterised by unstable earnings, limited social protection, and restricted access to employer-sponsored health insurance (Olaniyan, 2026). Consequently, health insurance exclusion should be understood not merely as a consequence of poverty but also as a mechanism through which poverty is reproduced across generations.

Urbanisation and demographic change further complicate this landscape. Rapid urban growth throughout the Global South has expanded informal settlements and precarious employment, placing increasing pressure on governments to develop inclusive welfare systems capable of reaching populations outside traditional formal labour markets (Kundu et al., 2026). At the same time, the interdependence of health, economic security, climate vulnerability, and sustainable development reinforces the need for integrated policy responses rather than sector-specific interventions (Mensah et al., 2026).

Health insurance therefore functions not only as a healthcare financing mechanism but also as a foundational component of broader social resilience and sustainable development strategies.

From the perspective of health justice, therefore, the central challenge confronting EdoHIS is not simply expanding enrolment but transforming the institutional relationship between the state and citizens working outside formal employment. Justice requires designing financing arrangements that recognize income irregularity, reducing administrative burdens associated with registration and premium collection, expanding targeted premium subsidies for economically vulnerable households, strengthening community-based enrolment mechanisms, and ensuring that informal workers participate meaningfully in policy design and implementation. Such reforms would move health insurance beyond a narrowly contributory model toward a genuinely inclusive system capable of addressing structural inequalities.

Ultimately, the gap between what justice demands and what EdoHIS can currently deliver is not primarily a policy design failure but a state capacity challenge. Achieving health justice within the informal economy depends upon strengthening administrative capability, institutional trust, fiscal commitment, and inclusive governance so that the populations most vulnerable to ill health become the primary beneficiaries rather than the persistent exceptions to universal health coverage.

This capacity–justice nexus provides the critical analytical bridge to the subsequent discussion of institutional capability and governance as foundational determinants of equitable health system performance.

DISCUSSION

Toward a Capacity-Conscious Theory of Health Justice in Federal Developing Democracies

The analysis of EdoHIS generates theoretical and practical insights that extend beyond the specific context of one Nigerian state's health financing experiment and contribute to the broader discourse on health justice, state capacity, and institutional governance in developing federal democracies. Contemporary scholarship increasingly argues that health equity cannot be understood solely through distributive justice or rights-based frameworks but must also account for the institutional capabilities that determine whether governments can translate normative commitments into measurable health outcomes (Fox, 2025; Havercamp et al., 2025; Raphael et al., 2025; Salmond, 2025). The international human rights framework, codified in the International Covenant on Economic, Social and Cultural Rights, particularly Article 12, and elaborated through General Comment No. 14, establishes that states bear a continuing obligation to take deliberate, concrete, and targeted steps toward the progressive realization of the right to health. While the doctrine of progressive realization explicitly recognises resource limitations, it remains comparatively underdeveloped in explaining situations where the principal constraint is neither inadequate political commitment nor financial scarcity, but rather limited institutional capacity. The EdoHIS experience demonstrates that a subnational government may possess constitutional authority, legislative backing, political commitment, and moderate fiscal resources while still lacking the administrative, informational, regulatory, and implementation capacities necessary to achieve equitable healthcare delivery. This finding supports recent calls for a more institutional conception of health equity in which governance capacity becomes an integral component of justice rather than merely an implementation concern (Waite & Iheduru-Anderson, 2026; Willison, 2026).

The proposed Capacity–Justice Nexus therefore advances an important philosophical distinction between different forms of state failure in the realization of health rights. Classical theories of justice often evaluate governments primarily according to distributive outcomes or normative intentions. However, emerging health equity scholarship increasingly recognizes that institutional power, governance quality, and administrative competence shape the extent to which justice can actually be realized (McMurtry et al., 2025; Ortega & Abarca-Brown, 2026). A government possessing sufficient institutional capacity but deliberately refusing to provide equitable healthcare bears a qualitatively different moral responsibility from a government that demonstrates genuine political commitment yet lacks the organizational infrastructure required for effective implementation. This distinction does not diminish governmental obligations under international human rights law. Minimum core obligations remain binding, and states cannot invoke institutional weakness as a permanent justification for failing to secure essential health services. Nevertheless, recognizing capacity constraints substantially changes the nature of policy prescriptions. Where political unwillingness constitutes the principal obstacle, stronger accountability mechanisms, democratic oversight, and legal enforcement become appropriate responses. Conversely, where institutional capacity represents the dominant limitation, sustainable investments in administrative systems, workforce development, governance reforms, information infrastructure, and organizational learning become indispensable. This perspective resonates with recent scholarship advocating stronger collaboration between public administration, political philosophy, and health systems governance in advancing health justice (Fox, 2025; Gomes, 2026; Waite & Iheduru-Anderson, 2026; McKinney, 2026).

Comparative evidence from African health insurance systems further reinforces this argument. Countries such as Gabon, Ghana, and Rwanda have achieved substantially higher levels of population health insurance coverage than many comparable jurisdictions, not merely because of superior policy design, but because institutional infrastructure, administrative coordination, financing mechanisms, digital health information systems, and community-level implementation capacities were progressively strengthened alongside policy expansion. The sequencing of institutional development relative to programme expansion therefore emerges as a critical determinant of whether health insurance schemes produce substantive health justice or merely symbolic policy achievements. This observation aligns with contemporary health equity literature, which increasingly emphasizes that structural determinants, governance quality, and institutional resilience are foundational drivers of equitable health outcomes (Mathews et al., 2025; Raphael et al., 2025; Suthakaran & Raphael, 2025). Rather than treating implementation as a secondary administrative concern, the Capacity–Justice Nexus conceptualizes implementation capability as a normative prerequisite for justice itself.

The EdoHIS experience consequently generates four interrelated theoretical and policy implications. First, investment in integrated health information systems should become an immediate strategic priority because reliable epidemiological, demographic, actuarial, and utilisation data constitute the epistemic foundation upon which equitable premium determination, risk pooling, provider reimbursement, and evidence-based policymaking depend. Without credible data infrastructures, governments cannot accurately evaluate programme performance or sustain public confidence in health insurance systems. Second, financial sustainability should be institutionally insulated from annual political

bargaining by establishing statutory funding guarantees, independent actuarial oversight, transparent claims management systems, and accountability mechanisms capable of protecting equity-oriented expenditure from fiscal volatility. Third, enrolment strategies targeting informal sector populations should move beyond passive voluntary participation towards community-based administrative integration, local governance partnerships, trusted intermediaries, behavioural incentives, and sustained civic engagement capable of transforming community presence into durable insurance participation. These recommendations reflect broader international evidence demonstrating that community participation and institutional trust are indispensable components of successful health system implementation (Cruz et al., 2026; Chung & Liu, 2026).

Finally, the EdoHIS case advances a broader theoretical proposition for contemporary political philosophy and health policy scholarship. Existing theories of health justice have made substantial progress in defining the moral entitlements individuals possess and the distributive obligations governments owe their populations. The capability approach, for example, specifies the freedoms and functionings that public institutions ought to secure.

However, considerably less theoretical attention has been devoted to the institutional conditions under which these normative aspirations become administratively achievable. The state-capacity tradition addresses precisely this gap by explaining how bureaucratic competence, administrative coordination, organizational resilience, policy learning, and governance effectiveness determine whether rights can be transformed into lived realities.

A comprehensive theory of health justice in federal developing democracies therefore requires the integration of normative theories of justice with empirically grounded theories of institutional capacity. The Capacity–Justice Nexus proposed in this study contributes to this emerging interdisciplinary agenda by arguing that health justice is ultimately realized not only through legal recognition or distributive commitments but also through the construction of capable, accountable, and resilient public institutions able to sustain equitable healthcare delivery over time. Such an integrated framework provides a more robust conceptual foundation for understanding the persistent implementation gap between health policy aspirations and health outcomes across many low- and middle-income federal democracies.

This theoretical synthesis is increasingly consistent with emerging international scholarship that views governance capacity, institutional resilience, community participation, and structural equity as inseparable dimensions of sustainable health justice (Havercamp et al., 2025; McMurtry et al., 2025; Waite & Iheduru-Anderson, 2026; Ortega & Abarca-Brown, 2026).

Conclusion

EdoHIS represents one of the most analytically instructive experiments in subnational health governance in contemporary Nigeria, not because it has resolved the tension between state capacity and health justice, but because it has rendered that tension visible with particular clarity. Its enrolment growth, Equity Plan provisions, provider network expansion, and administrative innovations are genuine achievements deserving scholarly recognition. Yet the Capacity-Justice Nexus reveals that these achievements remain substantially below the threshold at which they constitute the delivery of health justice as Venkatapuram demands or satisfy the state's obligation of progressive realisation under Article 12 of the ICESCR and Article 16 of the African Charter on Human and Peoples' Rights. The gap between what has been achieved and what justice demands is a function of infrastructural deficit, administrative fragmentation, fiscal vulnerability, and the relational mistrust that histories of poor state performance have sedimented in the relationship between Nigerian citizens and their public health institutions. The central theoretical contribution of this article is the argument that health justice is not merely a normative standard against which health systems are evaluated. It is a practical achievement whose possibility is constituted by state capacity. Where that capacity is weak, the right to health remains despotically proclaimed but infrastructurally undeliverable. The task of building health justice in subnational Nigeria is therefore inseparable from the task of building the state itself. Future scholarship should build on the Capacity-Justice Nexus by developing empirically grounded measures of infrastructural health capacity at the subnational level, examining comparative capacity-building trajectories across Nigerian states, and interrogating the mechanisms through which the right to health can be constitutionalized in ways that impose discipline on the pace of progressive realization without disregarding the genuine constraints of subnational institutional development. EdoHIS, imperfect and evolving as it remains, provides an indispensable starting point for all of these inquiries.

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