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UNIVERSAL HEALTH COVERAGE IN NIGERIA AND ITS DETERMINANTS: THE CASE OF NATIONAL HEALTH INSURANCE SCHEME

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ABSTRACT

The research disaggregated some micro level factors against the National Health Insurance Scheme (NHIS) to determine the accessibility and utilization of Universal Health Coverage (UHC) in Nigeria. Data from 2018 Nigeria Health and Demographic Survey was used and analysed using logistic regression model for the study. The results revealed that only 2.5% Nigerians are covered by NHIS and micro-level factors such as age, region, level of education, wealth index, marital status and household size significantly determined both accessibility and utilization of the scheme. This result indicates that many Nigerians pay Out-of-Pockets (OOP) for healthcare service. Therefore, until due attention is given to these identified micro-level factors as determinants of health insurance, achieving Sustainable Development Goals (SDGs) on UHC by year 2030 becomes a mirage despite huge spending on NHIS by the government.

Keywords

Education,
Health Insurance,
Nigeria,
Out-of-Pocket Payment,
Wealth Index

NİJERYA'DA EVRENSEL SAĞLIK KAPSAMI VE BELİRLEYİCİLERİ: ULUSAL SAĞLIK SİGORTASI PROGRAMI ÖRNEĞİ

ABSTRACT

Araştırma, Nijerya'daki Evrensel Sağlık Kapsamının (UHC) erişilebilirliğini ve kullanımını belirlemek için bazı mikro düzey faktörlerini Ulusal Sağlık Sigortası Programına (NHIS) göre ayrıştırdı. 2018 Nijerya Sağlık ve Demografik Araştırmadan elde edilen veriler kullanılmış ve çalışma için lojistik regresyon modeli kullanılarak analiz edilmiştir. Sonuçlar, sadece% 2,5 Nijeryalıların NHIS kapsamında olduğunu ve yaş, bölge, eğitim düzeyi, refah endeksi, medeni durum ve hane halkı büyüklüğü gibi mikro düzey faktörlerin programın erişilebilirliğini ve kullanımını önemli ölçüde belirlediğini ortaya koymuştur. Bu sonuç birçok Nijeryalı'nın sağlık hizmetleri için Cepten (OOP) ödeme yaptığını göstermektedir. Bu nedenle, sağlık sigortasının belirleyicileri olarak tanımlanan bu mikro düzey faktörlere dikkat edilene kadar, 2030 yılına kadar UHC'de Sürdürülebilir Kalkınma Hedeflerine (SDG'ler) ulaşmak, hükümet tarafından NHIS'e yapılan büyük harcamalara rağmen bir serap haline gelir.

Keywords

Eğitim,
Sağlık Sigortası,
Nijerya,
Cepen Ödeme,
Servet İndeksi

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1. INTRODUCTION

Universal Health Coverage is one of the goals that world leaders seek to achieve by year 2030 (United Nation, 2015). It is very important because a lot of people are undergoing health challenges and complications beyond their income capacity and are forced to pay out of pockets (OOP) which mostly result in catastrophic health expenditures. According to World Health Organization (WHO, 2018), around the world, more than half of the population still lack access to essential health services and about 800 million people spend more than 10% of their household budget on healthcare. The report also added that close to 100 million people are forced into poverty yearly from out-of-pocket (OOP) health expenses while on the average, OOP payments represents about 32% of every country's expenditure. BudgIT (2018) reported that with the high poverty rate in Nigeria where about 70% Nigerians live in poverty, the use of OOP for health expenditures is still the most prevalent because it accounts for almost 71.7% of total health expenditure.

The Sustainable Development Goals (SDGs) has been set to achieve a better world by year 2030 and access to healthcare is one important area where nations are supposed to pay due attention. Goal 3 of the SDGs stated clearly that we should ensure healthy lives and promote well-being while target 3:8 specifically wish to achieve Universal Health Coverage (UHC), including financial risk protection, access to quality essential healthcare services and access to safe, effective, quality and affordable essential medicines and vaccines for all (United Nations, 2015). The World Health Organization reported in 2017 that for UHC to be achieved in any nation of the world, two important target of SDGs Goal 3 must be fulfilled and these include the coverage of essential health services and coverage of the proportion of a country's population with catastrophic spending (WHO, 2017). These indicators are to be disaggregated by micro level factors like income, sex, age, ethnicity, education, place of residence (rural/urban) etc. in order to determine the universal health coverage and the extent to which households use out-of-pockets payments for health expenditures in any nation.

The World Health Organization (WHO, 2019) defined Universal Health Coverage (UHC) as a health programme in which all people receive the quality health services they need, including public health services designed to promote better health (such as anti-

tobacco infection campaigns and taxes), prevent illness (such as vaccinations), and to provide treatment, rehabilitation and palliative care (such as end-of life care) of sufficient quality to be effective, while at the same time ensuring that the use of these services does not expose the user to financial hardship. Universal Health Coverage as simply captured by Wang et al., (2016) refers to the unhindered opportunity to make use of essential quality health services in most affordable and stress free manner which will assist to easily achieve human welfare, economic and social development. This is usually achieved through prepayment for health services and utilization. Attempts to use Health Insurance in Low and Middle Income Countries (LMICs) are recognised as a powerful tool in achieving UHC (Badu et al., 2018).

Health Insurance is a form of prepayment for health which is defined by the WHO (2005) as a situation where funds for health are collected through taxes and/or insurance contributions. Nigeria as a nation in a bid to provide better healthcare access and improve the health status of her citizens, established the National Health Insurance Scheme (NHIS) in 1995 which became fully operational in the year 2005 (Adewole and Osungbade, 2016). Apeloko (2017) reported that NHIS was built on the framework that it will cover both the formal and informal sector of the economy. As defined by National Health Insurance Scheme (2012), National Insurance refers to a system of advanced financing of health expenditure through contributions, premiums or taxes paid into a common pool to pay for all or part of health services specified by a policy or plan. The scheme was established primarily as spelt out in the NHIS Operational Guidelines (2012) to fulfil some specific objectives that will ensure accessibility to good healthcare and protection from financial burden accruing from medical treatment. It will also bring about equity and fairness in the distribution of healthcare cost especially among people of different income level and improve the efficiency of the healthcare services for all participants. Equitable distribution of health facilities and patronage at all levels of healthcare and availability of funds to the health sector for improved services were hallmarks of the scheme as well.

Wang, Temsah and Carter (2016) studied OOP health expenditures in the Democratic Republic of the Congo, Liberia, Namibia and Rwanda, and reported that health insurance coverage stands out as an important factor affecting the magnitude of OOP expenditures in all countries studied. Gustafsson-Wright and Schellekens (2013) opined that in practice, health insurance is expected to contribute to achievement of UHC because

it increases access and utilization by lowering the price of healthcare. Some empirical works by earlier researchers such as Adewole and Osungbade (2016); Adewole et al., (2016); Azuogu et al., (2016); Wielen et al., (2017); and Badu et al., (2018) revealed that the scheme has not been achieving its set objectives because not more than 5% of the whole population is covered by the scheme. The main challenge accruing from the ineffectiveness of the scheme is the perpetual financial health burden placed on people who mostly pay by OOP for health expenditures. This research work therefore employed the WHO (2017) indicators using the most recent Nigeria Demographic and Health Survey (NDHS, 2018) and disaggregated some micro level factors against access to National Health Insurance Scheme to ascertain the extent to which micro level factors determines access and the prevalence of OOP in Nigeria as a direct effect of lack of UHC. It also appraises the extent to which these range of factors affect accessibility of NHIS in order to determine the level of OOP in Nigeria which usually lead to catastrophic health expenditure for citizens.

2. METHOD

2.1. Data and Sample

Data from 2018 Nigeria Demographic and Health Survey (NDHS) conducted by the National Population Commission (NPC) [Nigeria] and ICF (USA) was used for this research. The 2018 NDHS sample was collected using a stratified two-stage cluster design with Enumeration Area (EA) as the sampling unit for the first stage. The second stage was a complete listing of households carried out in the 1,400 selected EAs. The sample included 47,235 men and women of reproductive age who were successfully interviewed from randomly selected households of approximately 42,000 across the 36 states of Nigeria and the Federal Capital Territory (FCT). The survey was designed to produce reliable estimates for key indicators at the national level as well as urban and rural areas.

The outcome variable considered for this study is "*Health Insurance Coverage*" measured by question "*Are you covered by health insurance*?" with responses; "1 = Yes" and "0 = No". The effects of explanatory variables such as; age, gender, religion, place of residence, region, level of education, employment status, wealth index, marital status and household size on usage of health insurance by the respondents were also examined.

2.2. Data Analysis

The statistical analysis was carried out at three levels; the first level used descriptive analysis to depict the accessibility and utilization of NHIS in Nigeria. Results were presented pictorially using the pie chart and table. At the second level, bivariate analysis using Pearson Chi-square test is used to measure the association between micro-level factors and health insurance usage with criterion for significance as p-value < 0.05. Furthermore, the final level involved the use of multivariate analysis to determine the effect of micro-level factors on usage of NHIS in Nigeria using binary logistic regression model as a measure to validate the extent of UHC and its role in the cause and effect of OOP health expenses on the Nigerian citizens. The Odds Ratio (OR) is used in interpreting the results obtained, a variable is considered significant determinant of health insurance usage if the p-value associated with the Odd is < 0.05. All analyses were carried out using SPSS version 25.

3. RESULTS

3.1. Characteristics of the Population

Figure 1 reveals that one-in-forty (2.5%) persons are covered by health insurance in Nigeria. Table 1 further presents the distribution of the sampled respondents. The age distribution shows that almost a quarter (23.5%) of the respondents is between ages 25-29 years, representing the group with the highest representation. This is followed by age group 30-34 years which is one-fifth (19.9%) of the respondents while the least (3.1%) is recorded for age group 50years and above. The sample show a significant gender differential as can be seen that more than seven-in-ten (71.8%) are females while only 28.2% are males. The data also reveal that more than half (57.3%) are Muslims, slightly more than two-fifths (41.9%) are Christians while only 0.8% practice other religions. As evidenced from the data, there are more rural dwellers than urban, as rural dwellers make up almost two-thirds (63.6%) of the sample while urban dwellers are only 36.4%. More (38.8%) of the respondents have no form of education, 35.6% attended up till secondary school while only about one in every ten (10.3%) respondents have higher education. More than seven-tenths (72.8%) are employed while a small percent (27.2%) are unemployed. About six-sevenths (85.2%) of the respondents are currently in union, less than two-in-fifteen are never in union while only 2.5% were formerly in union. Almost

two-fifths (38.9%) live in households of 3-5 members, one-fifth (19.6%) live in ten or more person's households while one-in-twenty live in households of 1-2 members.

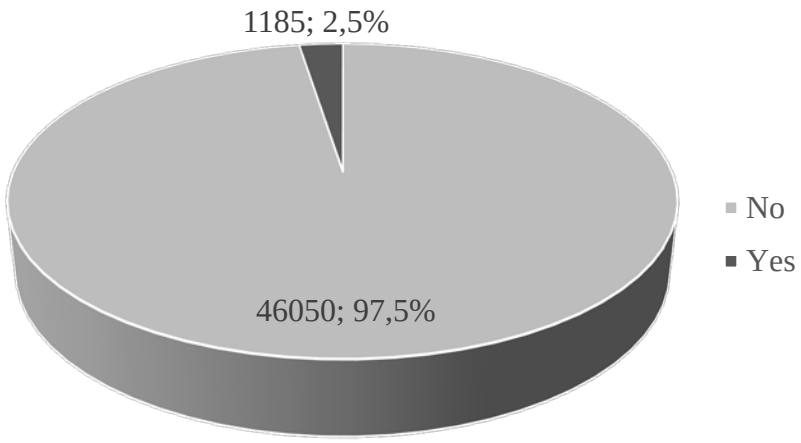

Figure1: Percentage Covered by Health Insurance

3.2. Bivariate Analysis

The association between health insurance usage and micro-level factors are presented in Table 2. The results reveal that all the factors considered have significant association with NHIS. Also, NHIS has more patronage from older people compared to the young because the age cohort 50 and above (5.9%) is highest while age cohort 15-19 is the lowest with 0.6%. More male (3.4%) utilizes the scheme than their female (2.2%) counterparts.

Urban dwellers (4.6%) use NHIS more than rural dwellers (1.3%). The result also reveals the significance of education in accessing and utilizing NHIS. Respondents with highest education (14.4%) utilize NHIS much more than those with no education/primary education which is 0.7% each while those with secondary education stood at 1.9%. The employed respondents also showed higher utilization (2.7%) as compared to the unemployed (1.7%). Access to and level of wealth also determined the utilization of NHIS with more than 10% of the richest and only 0.4% of the poorest utilizing the scheme. The result also indicates that those currently in unions (2.7%) utilizes the scheme, 1.6% of those never in union and 1.3% of those formerly in union utilise the scheme. Household size also determines NHIS access and utilization with the smallest household of 1-2 people

(3.9%) having higher access and utilization than those with the highest household size (1.1%).

3.3. Multivariate results

Table 3 presents the results of the binary logistic regression analyses identifying micro-level factors; age, region, level of education, wealth index, marital status and household size significantly predicts NHIS accessibility and Utilization. More specifically; increased age, education and wealth, northern region and being currently in union are protective factors for NHIS usage while increased household size is a risk factor for NHIS usage.

The older persons are significantly more likely to use health insurance than younger people. Northerners are significantly more likely to use NHIS than Southerners. Those with secondary education (OR = 1.73; CI = 1.32 – 2.26)) are significantly more likely to use NHIS, likewise, those with higher education (OR = 7.40; CI = 5.64 – 9.71) are seven time significantly more likely to use health insurance than those who do not have education. Respondents who belongs to middle households (OR = 2.29; CI = 1.55 – 3.37) are significantly more than two times likely, those belonging to richer households (OR = 4.16; CI = 2.82 – 6.13) are significantly more than four times likely while those belonging to richest households (OR = 13.47; CI = 9.10 – 19.94) are significantly more than thirteen times more likely to use NHIS than those belonging to poorest households. Those who are currently in marital union (OR = 1.48; CI = 1.11 – 1.98) are significantly more likely to use NHIS than those who are never in union. However, those living in households which members are ten and above (OR = 0.44; CI = 0.32 – 0.62) are significantly less likely to use NHIS.

Table 1: Sociodemographic characteristics of the study population (n =47235)

Age	Frequency	Percent
15-19	3908	8.3
20-24	8171	17.3
25-29	11088	23.5
30-34	9398	19.9
35-39	7221	15.3
40-44	3921	8.3
45-49	2062	4.4
50+	1466	3.1
Gender		
Male	13311	28.2
Female	33924	71.8
Religion		
Christianity	19774	41.9
Islam	27076	57.3
Others	385	0.8
Place of residence		
Urban	17205	36.4
Rural	30030	63.6
Region		
North Central	8290	17.6
North East	9658	20.4
North West	13265	28.1
South East	5553	11.8
South South	4899	10.4
South West	5570	11.8
Level of Education		
No education	18337	38.8
Primary	7188	15.2
Secondary	16823	35.6
Higher	4887	10.3
Employment Status		
Unemployed	12829	27.2
Employed	34406	72.8
Wealth Index		
Poorest	10497	22.2
Poorer	10186	21.6
Middle	10029	21.2
Richer	9051	19.2
Richest	7472	15.8
Marital Status		
Never in union	5794	12.3
Currently in union	40244	85.2
Formerly in union	1197	2.5
Household Size		
1-2 persons	2155	4.6
3-5 persons	18382	38.9
6-9 persons	17461	37.0
10+ persons	9237	19.6
Total	**47235**	**100.0**

Table 2: Observed Differences of Micro-Level Factors as Determinants of NHIS

Explanatory Variable	Covered by Health Insurance		P-value
	No	Yes	
Age			<.001
15-19	3886 (99.4)	22 (0.6)	
20-24	8080 (98.9)	91 (1.1)	
25-29	10892 (98.2)	196 (1.8)	
30-34	9104 (96.9)	294 (3.1)	
35-39	6957 (96.3)	264 (3.7)	
40-44	3761 (95.9)	160 (4.1)	
45-49	1990 (96.5)	72 (3.5)	
50+	1380 (94.1)	86 (5.9)	
Gender			<.001
Male	12861 (96.6)	450 (3.4)	
Female	33189 (97.8)	735 (2.2)	
Religion			<.001
Christianity	19130 (96.7)	644 (3.3)	
Islam	26544 (98.0)	532 (2.0)	
Others	376 (97.7)	9 (2.3)	
Place of residence			<.001
Urban	16417 (95.4)	788 (4.6)	
Rural	29633 (98.7)	397 (1.3)	
Region			<.001
North Central	7982 (96.3)	308 (3.7)	
North East	9577 (99.2)	81 (0.8)	
North West	12926 (97.4)	339 (2.6)	
South East	5420 (97.6)	133 (2.4)	
South South	4779 (97.6)	120 (2.4)	
South West	5366 (96.3)	204 (3.7)	
Level of Education			<.001
No education	18213 (99.3)	124 (0.7)	
Primary	7141 (99.3)	47 (0.7)	
Secondary	16511 (98.1)	312 (1.9)	
Higher	4185 (85.6)	702 (14.4)	
Employment Status			<.001
Unemployed	12585 (98.1)	244 (1.9)	
Employed	33465 (97.3)	941 (2.7)	
Wealth Index			<.001
Poorest	10455 (99.6)	42 (0.4)	
Poorer	10123 (99.4)	63 (0.6)	
Middle	9922 (98.9)	107 (1.1)	
Richer	8850 (97.8)	201 (2.2)	
Richest	6700 (89.7)	772 (10.3)	
Marital Status			<.001
Never in union	5700 (98.4)	94 (1.6)	
Currently in union	39169 (97.3)	1075 (2.7)	
Formerly in union	1181 (98.7)	16 (1.3)	
Household Size			<.001
1-2 persons	2072 (96.1)	83 (3.9)	
3-5 persons	17846 (97.1)	536 (2.9)	
6-9 persons	16998 (97.3)	463 (2.7)	
10+ persons	9134 (98.9)	103 (1.1)	
Total	**46050 (97.5)**	**1185 (2.5)**	

Table 3: Micro Level Determinants of NHIS Access and Utilization in Nigeria

Explanatory variables	Odd Ratio	Confidence Interval	
		Lower Bound	Upper Bound
Age			
15-19	1.00		
20-24	1.38	0.84	2.25
25-29	1.59	0.98	2.56
30-34	2.21**	1.36	3.58
35-39	2.77***	1.70	4.52
40-44	3.63***	2.19	6.04
45-49	3.02***	1.75	5.23
50+	4.32***	2.48	7.52
Gender			
Male	0.98	0.82	1.17
Female	1.00		
Religion			
Christianity	1.00		
Islam	0.86	0.72	1.02
Others	1.87	0.92	3.80
Place of residence			
Urban	1.01	0.87	1.17
Rural	1.00		
Region			
North Central	2.55***	2.09	3.11
North East	1.60**	1.19	2.14
North West	5.06***	4.03	6.37
South East	1.02	0.80	1.30
South South	0.93	0.72	1.19
South West	1.00		
Level of Education			
No education	1.00		
Primary	0.75	0.53	1.07
Secondary	1.73***	1.32	2.26
Higher	7.40***	5.64	9.71
Employment Status			
Unemployed	1.00		
Employed	0.89	0.76	1.06
Wealth Index			
Poorest	1.00		
Poorer	1.42	0.95	2.11
Middle	2.29***	1.55	3.37
Richer	4.16***	2.82	6.13
Richest	13.47***	9.10	19.94
Marital Status			
Never in union	1.00		
Currently in union	1.48**	1.11	1.98
Formerly in union	0.88	0.49	1.59
Household Size			
1-2 persons	1.00		
3-5 persons	0.80	0.61	1.05
6-9 persons	0.93	0.71	1.23
10+ persons	0.44***	0.32	0.62

* Significant at 0.05 level, ** Significant at 0.01 level, *** Significant at 0.001 level and 1.00 is reference category

4. DISCUSSION

It is pertinent to note that even though concerted efforts have been made to see that the NHIS succeeds as a health programme for all, it has continuously performed below expectation (between 3-5%) since inception (NHIS, 2012; Adewole et al., 2016; Apeloko, 2017). In Nigeria, private expenditure accounts for almost 70% of total expenditure on health of which 90% is OOP (Onoka et al., 2010). This high level of OOP expenditure implies that health care places significant financial burden on households. Aregbeshola and Khan (2018) also opined that in spite of a general consensus to move closer to Universal Health Coverage (UHC) over the years in Nigeria, there remains high reliance on OOP health payments as a means of financing health system in Nigeria. Awosusi, and Folaranmi (2015) stated that healthcare continued to suffer in Nigeria because there is high level of OOP expenses, very low budget for health care at all levels of governments and poor health insurance penetration. Less than 5% of Nigerians have health insurance coverage (HIC) and most enrolees are in the formal sector with very poor coverage in the informal sector. This is consistent with the result of this study which postulates the fact that NHIS usage is one in forty persons in Nigeria.

The results as presented above show that the continuous negligence of the impact of micro-level determinants of NHIS accessibility and utilization is a major setback that must be addressed in the right context if Nigeria truly as a nation desire a better universal healthcare coverage. Households' profile such as age, region, increased education and wealth, and staying in union have been shown to be key predictors for NHIS active membership in-line with earlier research of Badu et al., (2018).

Additionally, results also corroborate the work of Fan et al., (2012) which opined that individuals who are educated are more likely to understand the benefits of preventative care or capable of identifying symptoms and seeking health care compared to individuals who are illiterates or less educated, and they are also more likely to be able to afford healthcare. In a related study, Kurfi and Aliero (2017) unveiled from their study that educational level, knowledge of financial contribution and marital status and occupational level have positive and significant influence on clients' access and better utilization for satisfaction. Similarly, the result revealed that riches is a positive contribution to NHIS usage in the country, this positive relationship is supported by

previous works of other researchers (Latunji and Akinyemi, 2018; Vander Wielen et al., 2017).

5. CONCLUSION AND POLICY IMPLICATION

Findings from this research have shown that the level of access and utilization of NHIS in Nigeria has regrettably dropped from 3% to 2.5% over the last five years. This implies that over the last fifteen years of her services, NHIS in Nigeria has not been effective in addressing UHC. The obvious therefore, is that in Nigeria, OOP continue to thrive especially among the poorest leading to catastrophic health expenditures among the people. Since healthcare is paid for and also very expensive, only those who can afford it, utilize it. An imperative but deserted fact is the negligence of micro-level factors in the accessibility and utilization of NHIS. Until due attention is given to issues of education, employment, rural development, wealth creation, etc. the healthcare services no matter how much is spent will not address UCH.

Following the findings of this research work, the following are identified as its policy implication if Nigeria really seek to achieve UHC as part of SDGs by year 2030:

- There should be a total overhauling of NHIS programme, objectives and coverage
- There is need to use all avenue possible to register all citizens whether in the formal or informal sector.
- Close monitoring of activities carried out by NHIS is very paramount
- Some level of force should be used to get more people to register for NHIS
- More proactive steps should be adopted in the publicity and advocacies' measures employed
- The rural poor should be given due attention as they are often forgotten by reason of their residence
- People's sociocultural practices like religion and other traditions should be addressed publicly
- The economic life of the people should be enhanced to reduce poverty which remains a serious underlying factor

- Education remains a weapon in social movements and stratification, as such should be improved among the people by all standards.
- Gender equity in access and utilization should also be handled as a matter of urgency.

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