International Journal of Public Administration and Management Research (IJPAMR), Vol. 5, No 1, March, 2019. Available online at http://www.rcmss.com/index.php/ijpamr; www.academix.ng
ISSN: 2350-2231(E) ISSN: 2346-7215 (P)
Ogye Danlami Okolo, Attah, Amana Philip & Ali, Mohammed Attai , 2019, 5(1):120-133

FINANCING HEALTH CARE IN NASARAWA STATE, NIGERIA: ASSESSMENT OF THE UNIVERSAL HEALTH COVERAGE (UHC)

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Abstract
There are many challenges confronting health sector in Nasarawa State, but the issue of inadequate financing of healthcare is a worrisome. And the effects it has caused to the universal health coverage are great. The major factor hindering the path of sustainable health care delivery is poor funding. The health sector requires adequate funding in order to make health services available and affordable to the public. The State government introduced the UHC because it considered healthcare so demanding due to dwindling economy and poverty in the State. More importantly, the introduction of the policy was to guarantee good and qualitative access to efficient healthcare services for all citizens such that it could reduce catastrophic household out-of-pocket health expenditure. Since its introduction and resuscitation in the State, actual implementation of the policy by the State appeared not to have yielded desired result. In the face of achieving UHC, successful financing of health care system continues to be a challenge to the policy. This study therefore made an attempt to situate the impact of financing healthcare on the overall universal health coverage of Nasarawa State. Adopting a structural functionalist approach as a theoretical framework and relying on secondary sources of data, the study revealed the state's low level of coverage among the target population of the policy was recorded which also affects quality of health services provided. The study recommended among others that the state government in collaboration with relevant stakeholders should intensify optimal coverage on the UHC policy. It also suggested increased funding for health programs through increase budgetary allocation to the health sector in the State. The paper concludes that to achieve universal coverage using financing as the strategy, there is a dire need to review the system of financing health care and ensure that resources are used more efficiently while at the same time removing financial barriers to access by shifting focus from OOPs to other hidden resources.

Keywords: *Financing Health Care, Universal Health Coverage and Nasarawa State*

Introduction

Financing health care represents a flow of funds from various sources to healthcare providers in exchange for services. The way a health system is financed shows if the people get the needed health services and whether they suffer financially at the point of receiving services. A good financing of healthcare strategies is able to mobilize resources for healthcare; achieve equity and efficiency in use of healthcare spending; ensure that healthcare is affordable and of high quality; ensure that essential healthcare services are adequately provided for and ensure that the money is spent wisely so that healthcare services are accessible to all citizens. Financing mechanism provides sufficient financial protection so that no household is impoverished because of a need

to use health services. One-way of providing such protection is through government policy on how to finance health care, thereby the risk of incurring unexpected health care expenditure does not fall solely on an individual or household. One aim of universal health coverage (UHC) is how to ensure that all have adequate access to their health care needs without making significant out-of-pocket at the point of receiving care. One-way to achieve this is through government and international donors intervention financing of health care delivery (Aboh Akpata & Akintoye, 2016).

Globally, health as a critical component of development has continued to receive attention in recent times. This is due to the fact that investing in health could bring about growth and development. Health boosts society's effectiveness and the productivity of an individual via increase in physical and mental capacities, which are necessary for economic growth and development (Imoughele & Ismaila, 2013; Owumi & Sakiru, 2013; Yunusa, Irinoye, Suberu, Garba, Timothy, Dalhatu & Ahmed, 2014; Uzochukwu, Ughasoro, Etiaba, Okwuosa & Envulladu, 2015 and Eboh, Akpata, & Akintoye, 2016). As important as this health is, access to it as an integral part of the overall health system has been fraught with some difficulties in terms of financing for the services provided. Consequently, like many public utilities, it is not equally accessible to all people, and so, limited physical access to basic health care continues to be a major impediment to achieving the goal of health care for all (Ogye, 2018).

In view of this, governments all over the world consciously attempts policy formulation and implementation to bring healthcare services closer to people across economic divides and different social strata. This is basically to mitigate the constraint of finance in accessing healthcare services. While attempting to identify the major sources of health care financing in Nasarawa State, the core concern of this paper however, is to explore theoretically and empirically the nature of the Universal Health Coverage (UHC) in the State; its level of health coverage among the targeted populations, the policy impact on healthcare services utilization and the way forward.

Financing Health Care

Financing healthcare can be seen as the mobilization of funds for healthcare services (Eboh, Akpata & Akintoye, 2016). In other words, it is the provision of money, funds or resources to the activities designed by government to maintain people's health. These activities encompass the provision of medical and related services geared toward maintaining good health, especially in the aspect of disease prevention, diagnosis and curative treatment. The concept of financing health care succinctly deals with the quantity and quality of resources a society expends on health care based on its total income. The amount of resources earmarked for health care in a society is said to be a reflection of health value placement vis-à-vis other categories of goods and services. It has been argued that the nature of financing health care defines the structure and the behaviour of different stakeholders and quality of health outcomes (Kajang, 2004). The pattern of financing is therefore intricately connected and indivisibly linked to the provisioning of health services (Riman & Akpan, 2015). The duo, Riman & Akpan opined that financing health care cannot be narrowly conceived and confined to raising enough resources to fund health care needs of people alone, but also entails the questions of affordability and equitable access to health care services by them, including guaranteed financial risk protection.

Similarly, Cockerham (2012) contended that when it comes to area of financing health care, it is fraught with some nuances since some types of health care services are skewed towards benefitting groups and the community collectively. Worth mentioning here are vaccination against certain communicable diseases, surveillance, control of malaria and environmental sanitation. Other issues that make area of financing health care problematic are public expenditures on other services. The mutually reinforcing trajectory of relationships that exist between the aforementioned survival needs also makes health care financing analysis a difficult one. One of the intricate issues and nuances associated with the analysis of health care financing

is the identification of health care expenditure given the demarcation between preventive and curative health care services. The proposed integration of traditional medicine practitioners into the mainstream formal health sector will further pose a challenge to the analysis of health care financing as argued by Tile (2006).

There are various sources of financing health care in Nasarawa State. These sources include: government annual budget for health, household out-of-pocket health expenditure, Non-Government Organizations' support, among others. External financing of health care includes grants and loans from donor agencies like the World Bank, the World Health Organization (WHO), UNICEF, among others (Jegede, 2014; Riman et al, 2015 & Eboh et al, 2016).

Importantly, Government Annual Budget: this source of health care financing is derived from proceeds of tax-based revenue of government across all levels and sectors. At the State level, monthly allocation, pool of taxes (royalties and the component proceeds of domestic sales/other internal generated revenues of the State government), businesses/companies' income tax, among others (Abayomi, 2012 &Yunusa et al, 2014). Financing of the health care by the government is largely a function of its revenue base. In essence, there is a strong positive relationship between the proportions of tax-based health spending and the progressivity of total health expenditure. Eboh et al (2016) posited that one of the foremost advantages of tax revenue is the pooling of health risks across a large contributing population. Another implication of raising funds through taxes is that contributions are usually spread over a larger share of the population than might otherwise be the case. Although in many countries, some employers and employees are not captured in the tax net due to some informal work arrangements thereby concentrating health insurance on formal sector workers, through other revenues that affect almost everyone, such as VAT, and sales taxes, including the scope for mobilizing resources which may be larger for Tax-Based Systems (TBS). It is also noted that countries with more progressive tax systems such as USA, Switzerland, Netherlands and Germany rely less heavily on general tax revenues to finance health expenditure; though political trade-off may be involved. The way some countries use tax revenues is such that some rely heavily on general income tax to fund their healthcare system while others depend solely on regional or local taxes as a source of funding for health (Metiboba, 2012, Eboh et al, 2016).

Equally, Household Out-Of-Pocket (OOP) Health Expenditure:this is also referred to as user-charges. In Nasarawa State, the public health facilities impose some charges on individuals for healthcare services up-take. OOP health expenditure could be incurred directly by a patient to a health service provider without reimbursement. This covers on-the-spot payment for health care services received. The scope of individual health user-fees could be an admixture of drug costs, medical material costs, entrance fees, and consultation fees (Yunusa et al, 2014). Out-of-pocket payment, otherwise known as private health expenditures accounted for more than 80% cost in accessing health in Nasarawa State. Consequent upon this, it was noted that over-reliance on the ability to pay through OOP has the potency of reducing health care up-take. This can exacerbate the already inequitable access to quality care (Riman & Akpan, 2015; Adamu, 2016; Eboh et al, 2016 and Ogye, 2018). OOP expenses also comprise user-fees in public health facilities and any other private payments to healthcare providers for medicals and other treatment received.

Oyefabi, Aliyu & Idris (2014) further noted that significant number of people footed their health bills based on user-charges. Similarly, healthcare financing across the less developed and developing countries is still characterized by OOP health expenditure. Given the resonating poverty situation in Nasarawa State, health care spending on some debilitating illnesses can be catastrophic. It is catastrophic if OOP exceeds the household income or its capacity to pay for healthcare services received. In other words, if the large proportion of the household budget goes into health expenditure thereby leaving little to meet other basic health components like food, shelter, education, hygiene, etc. In terms of measurement criteria, catastrophic health expenditure can be determined when OOP healthcare expenditures exceed a pre-specified fraction of the

household total expenditure. That is, OOP healthcare expenditures exceeding 40% of non-subsistence expenditure. Catastrophic health expenditure for any household may further push it into poverty (Eboh et al, (2016).

In extreme situation, the implication of a very high level of OOP health spending is that a significant proportion of the poor may be driven into squalor after paying for health care. A chronic ill-health situation that afflicts the breadwinner of the family may completely impoverish it especially those who sell their labour on daily basis to fend for their families. Even the non-poor may be impoverished by large random out-of-pocket payments arising from unpredictable ill health (Nwani, 2015). In like manner, Adinma (2010) argued that OOP health expenditure is a major barrier to seeking orthodox healthcare services. Out-Of-Pocket health spending can negatively affect people's health seeking behaviour. Its negative consequences can be analyzed in two ways: (a) how many people are impoverished by out-of-pocket spending. (b) What is the percentage earmarked by households for health expenses? Medical impoverishment and catastrophic health expenditures are the likely outcome of over-reliance on OOP health spending. Incidence of catastrophic health expenditure is said to be generally greater in the rural areas compared to the urban areas.

Similarly, the socioeconomic status of a household is coterminous with its monthly catastrophic total household health spending with the poorest having the highest incidence of catastrophic expenditures (Ejughemre, 2014). Other issues associated with OOP health expenditure include gender, age, income level, family size, nature of illness, healthcare services utilization among others (Apere & Karimo, 2014). Also, in view of the enormous demand for the funding of healthcare, government alone cannot shoulder the responsibility of good and quality health care provisioning given the dwindling economy culminating in an abysmally poor budgetary allocation to health sector. Therefore, it has become imperative to engage the private sector in financing of healthcare in Nasarawa State (Akpo, 2018). Private sector health financing include donor funding as well as Public-Private Partnership (PPP). Some of the health donors are UNICEF, the World Bank, WHO, UNDP UNAIDS, etc. The international community's contributions to global health come in various forms, namely: financial assistance (loans and grants), commodities (drugs, medical equipment), technical expertise, training, study tours and fellowship, research funding among others. It is on record that government donation and concession loans that include at least a 25% non-reimbursement component are referred to as official development assistance, and they serve as the major source of external financing for the health sector in the developing world (Lawanson & Olaniyan, 2014). Examples of some health-oriented donor agencies to Nsarawa State are United States (USAID), United Kingdom (DFID), etc. Besides these major funds from the aforementioned agencies and countries, global public-private partnerships that tend to focus on specific diseases or health conditions have proliferated. Some of these foundations include GAVI Alliance, the Global Fund, the Medicines for Malaria Venture, and the Partnership for Maternal Newborn and Child Health, etc (Abimiku, 2015).

It has also been noted that the benefits of engaging the private sector to expand the financing of health systems cannot be underrated. This is in tandem with the growing recognition of the importance of strong health systems, which provide a promising prospect that systematically include the private sector as a vibrant component of Nasarawa State's health system strengthening strategy. Although**,** there have been efforts tailored towards increasing public funding to health sector in Nasarawa State as statutory allocation to health will not address the burgeoning health needs for about two million people (Abimiku, 2015). However, private sector health financing is not without its challenges. One of the persistent challenges is duplication of financing efforts by the donor agencies and foundations coupled with lack of global coordination among donor agencies in sending health care aids to the State.

Universal Health Coverage (UHC)

Universal Health Coverage (UHC) is defined by the World Health Organisation (WHO) as a state where 'all people and communities can use the promotive, preventive, curative, rehabilitative and palliative services they need, of sufficient quality to be effective, while also ensuring that the use of these services does not expose the user to financial hardship.' It is described as a situation where citizens can access health services without incurring financial hardship (WHO, 2013).It has been suggested that key to achieving this goal is the provision of coverage on the basis of need, generating the greatest total improvement in health, and financial contributions based on the ability to pay and not need (Ogidi, 2013). UHC is at the frontline of the global health agenda, featuring in the United Nation's Sustainable Development Goals 2030, and also as a priority of the WHO. The WHO has led the global advocacy effort for instance on Universal Health Coverage Day is commemorated every 12th December. Support has grown for UHC due to suggestions that it has the potential to improve global health security, for instance during an epidemic such as that experienced with the Cholera and Lassa fever. UHC increases the ability of a country to prevent, detect or respond to an infectious disease outbreak. The economic benefits of UHC include a healthier, more productive population, resulting in increased economic productivity and reduced poverty ultimately fostering economic development. Citizens with access to healthcare when needed are more likely to seek treatment earlier and get the treatment they require to continue to lead a healthy and productive life (Ejima, 2012 & Jain and Alam, 2017).

Brandy (2017) describes universal health coverage as the "single most powerful concept that public health has to offer" since it unifies "services and delivers them in a comprehensive and integrated way". One of the goals with universal healthcare is to create a system of protection which provides equality of opportunity for people to enjoy the highest possible level of health. UHC is firmly based on the WHO constitution of 1978 declaring health a fundamental human right and on the Health for All agenda set by the Alma Ata declaration in 1978. UHC cuts across all of the health-related Sustainable Development Goals (SDGs) and brings hope of better health and protection for the world's poorest.As part of SDGs, United Nations member states have agreed to work toward worldwide universal health coverage by 2030. UHC is about ensuring that people have access to the health care they need without suffering financial hardship (WHO, 2016). Health is a foundational investment in human capital and in economic growth; becausewithout good health, thesociety will not function. UHC is also key to achieving the World Bank Group's (WBG) twin goals of ending extreme poverty and increasing equity and shared prosperity, and as such it is the driving force behind all of the WBG's health and nutrition investments. It is also an essential part of the Sustainable Development Goals (SDGs): SDG goal includes a target to achieve universal health coverage for all citizens; including financial risk protection, access to quality essential health care services, and access to safe, effective, quality, and affordable essential medicines and vaccines for all.Also, with the goal to end poverty in all its forms everywhere, is also in peril without UHC, as hundreds of millions of people are impoverished by health expenses every year (Obiajulu, 2009 and Chukwumah & Enabulele, 2015).

In recent years, the UHC movement has gained global momentum, with the World Health Assembly and the United Nations General Assembly calling on countries to "urgently and significantly scale up efforts to accelerate the transition towards universal access to affordable and quality healthcare services." At the same time, challenges remain. Recent World Bank/WHO research from 2017 shows that half the world's population cannot access needed health services, while 100 million people are pushed into extreme poverty each year because of health expenses. In addition, 800 million people spend at least 10 percent or more of their household budget on healthcare expenses (WHO, 2017).

Similarly, political benefits of UHC should not be ignored. It is recognised that social harmony and solidarity develop alongside UHC creation within populations and countries,

building resilient nations. There is no one-size-fits-all solution for nations to achieve UHC. What is recognised is that crucial to achieving this goal is the use of appropriate health financing models and health system strengthening. Innovation, and smart, successful policy decisions are paramount. Multiple methods of health financing exist, namely public payments e.g. taxation, private payments, social insurance and community health services. These methods can be used alone or in combination. The literature conveys consensus that public financing of a health system is the most reliable way of making progress towards UHC. An example is Georgia, which recently successfully switched to a publicly financed health system.

In 2013, the Governments of Nigeriare-launched the Universal Health Care Programme to improve access to health care and strengthen financial protection. Over 50% of the population now benefits from publically financed health coverage. This significant progress towards UHC was attributed to public spending on health. Government recognises the need to spend a greater percentage of her GDP on healthcare, and proceed to act on it. They also take responsibility for revenue rising, pooling funds and the distribution of such through careful public expenditure management. The World Health Report 2016 has estimated that 20-40% of what is currently spent on healthcare could be recovered and redirected due to waste and corruption (World Bank, 2016). Inefficiencies are rife, in combination with underuse of more economical options such as generic drugs. Efficiency is required for sustainability of UHC and is a key policy intermediate. Even at low levels of health spending, health systems can improve the way that funds are pooled and spent, in order to get the most out of limited resources and ensure UHC. Risk needs to be shared amongst populations, ensuring that individuals are not forced below the poverty line by out-of-pocket payments. The 2016 'Public Financing for Health in Nigeria' report showed that increased GDP in Nigeria over the past 15 years has rarely led to increased government spending on health. It states that 'For every US$100 that goes into state coffers in Nigeria, on average US$16 is allocated to health, only US$10 is in effect spent, and less than US$4 goes to the right health services'(UNDP, 2017:34).

Additionally, studies have shown that countries with most success in striving towards UHC tend to adopt a simple approach, limiting complexity and fragmentation. The Philippines introduced a 'sin tax', taxing alcohol and tobacco, which raised revenues that were earmarked for the provision of UHC and public health initiatives in primary care to prevent Non-communicable diseases. Within the first year, more than USD$1.2 billion was raised, which provided health care to an additional 45million Filipinos. In December 2016, 91% of Filipinos were covered by Phil-Health and the national health insurance programme (Onotai & Awankwo, 2012). Regarding health system strengthening, a holistic approach is required to tackle the interacting relationships of the building blocks of a health system. The WHO Health Systems Framework advises that these building blocks are: governance, information, financing, service delivery, human resources and medicines and technology. A system thinking approach is key. When analysing health systems, the debate between public and private healthcare provision continues, often with a negative opinion of private providers due to the associated increased out-of-pocket payments that make necessary healthcare unaffordable for many, resulting in poverty and poorer health outcomes. However, the literature has shifted its focus to potential benefits of healthcare financing. The key is for governments to work towards widespread availability of financially accessible and competent providers, regardless of whether they are public or private. It has been suggested that policy makers need to take a systems perspective, managing the private sector to contribute to the performance of the system as a whole. Universal Health Coverage shows great promise. With prominence on the global health agenda and greater buy-in from governments worldwide, the potential for improved public health outcomes and economic development is an exciting prospect (Michael, 2010; Mill, 2014 and Brandy, 2017).

In December 2017, a high-level forum on UHC was jointly organized by the Nigeria Government, the World Bank, the World Health Organization, the United Nations Children's Fund (UNICEF) and Nigerian Health Sector (NSHS). The UHC Forum aimed to galvanize the

health sector, states, development partners, civil society and the private sector toward the common goal of UHC, including pandemic preparedness, and highlight state success and breakthrough experiences to accelerate the progress of UHC. Currently, WHO called on Nigeria Government to live up to their pledges they made when the world leaders agreed on the Sustainable Development Goals in 2015, and commit to concrete steps to advance Health for All. This means ensuring that everyone, everywhere can access essential quality health services without facing financial hardship.

The concept of UHC embodies several related objectives; these include:

i. Ensure equity in access to health services - everyone who needs services should get them, not only those who can pay for it;
ii. The quality of health services should be good enough to improve the health of users or those receiving services;
iii. People should be protected against financial-risk, ensuring that the cost of using services does not put people at risk of financial harm. That is citizens should be protected from financial catastrophe and impoverishment as a result of using health services;
iv. Develop and implement health financing strategies at state and local levels consistent with the National Health Financing Policy;
v. Secure a level of funding needed to achieve desired health development goals and objectives at all levels in a sustainable manner; and
vi. Ensure efficiency and equity in the allocation and use of health sector resources at all levels.

Nasarawa State has shown commitment to achieving UHC, but progress has been slow. The state government led by Governor Tanko Almakura re-energises the drive towards achieving UHC in Nasarawa State. The 2017 Lafia Summit Declaration affirms that UHC is key to ensuring equitable access to high-quality, affordable health care for all citizens in the State. Although the summit was built on a highly participatory stakeholder engagement process, its concomitant momentum has waned. A recent review of health-system financing for UHC in Nasarawa state shows high out-of-pocket expenses for health care, a very low budget for health at state level of government, and lackof health insurance implementation. According to WHO, general government expenditure on health as a percentage of total government expenditure was very low at 3·3% in 2012, increasing consistently per year to 9·4% in 2014, and dropped to 6·7% in 2016. Private expenditure on health as a percentage of total health expenditure remains high, dropping slightly from 74·4% in 2002 to 68·9% in 2016. Out-of-pocket expenditure as a percentage of private expenditure on health has consistently remained higher than 90% since 2007, and was 95·7% in 2017 (WHO, 2017). Currently, less than 2% of Nasarawa state citizenry have health insurance coverage; most enrolees are in the federal institutions with no coverage in the state formal and informal sectors and inherent implementation challenges (Abimiku, 2015 and Adamu, 2016).

The robustness of 'health for all' notwithstandinghas limitations according to Eboh et al (2016) who notedthat quality health services are not visible to rural dwellers. However, urban areas are partially covered according to them. Some of the target population that UHC policy is made for are the children, women and thepoor.On a critical note, it is argued that the UHC negated its own philosophy of universal coverage and accessibilityby excluding such target population like the rural dwellers (Uzochukwu et al, 2015). Given the shallow and the segregatory coverage of the policy to theexclusions of major setof people mentioned above, catastrophic OOP healthexpenditure may continue to confront people in Nasarawa state.

Theoretical Framework

Explanations of the UHC can be viewed within the framework of Structural-functionalist approach. Structural functionalism as loosely explained refers to the large-scale social structures

and institutionsof society, their interrelationships, and their constraining influence on actors (Ritzer, 2008). Historically, somefounding fathers of sociology like Auguste Comte, Herbert Spencer and Emile Durkheim, laid the classicalfoundation of structural-functionalism. Talcott Parsons later refined it to reflect his work titled “the socialsystem” in 1951 (Scott & Marshall, 2005). As a theoretical perspective in sociology, functionalism holds a viewof society as a social system that is made up of different parts, which are interdependent and interrelated (Igbo,2003). These component parts of society, which include the family, school, government, law; economy, etc.perform various functions positively toward the maintenance, stability and survival of the social system.

From the organismic analogy, the functionalists equate the human society with the human or biologicalorganism that has a structure comprising organs, systems and capillaries, which must function for themaintenance and survival of the whole organism. To understand the structure of the organism (man), therespective component parts and their interconnected functions must be examined. The foregoing forms the basisof Parsons’ concept of Adaptation, Goal maintenance, Integration and Latency function (AGIL). AGIL is anelaborate model of systems and sub-systems. It implies that for any society to survive, each system must meetthe aforementioned four functional prerequisites namely: Adaptation (adjustment to the physicalenvironment); Goal attainment (a means of organizing resources to achieve societal goal and obtaingratification), Integration (forms of internal coordination and ways of dealing with differences), and Latency orpattern maintenance (means of achieving comparative stability). The point of emphasis here is how socialequilibrium can be achieved and maintained between and among the various elements or institutions of a socialsystem and sub-systems.Parsons further opined that among these different structures and institutions such as economic, social,educational, political, religious, health, etc. institutions, any dysfunctionality in a structure could equally affectothers that are intricately connected to it because of its mutually re-enforcing interdependence on others. Forexample, bad governance and political leadership can mar effective health care delivery system throughcorruption and misappropriation of funds (Haralambos and Holbons, 2008 &Giddens, 2010).

Practically, thehealth sector has some components and institutional stakeholders that must workharmoniously to achieve efficient and effective health care delivery to the target public.Some of thesestakeholders repeatedly mentioned include the government, health managers, health workers or personnel, donor agencies, healthusers or the public, etc. Among its statutory functions, the government through the UHCpolicy setsstandards and guidelines for all the stakeholders to observe. The public health sector must rendersome services as expected to the public whovoted governmentinto power. This chain of activities between and among these stakeholders must be kept intactand unbroken if the entire policy is to achieve sustainable result. The interdependence of these variousinstitutions and agencies in the health policy underscores the practical engagement of structural-functionalism. Though,individual alone cannot adequately, effective and efficient cater for his or her health care, hence the introduction of the UHC,all the concerned stakeholders are expected to work cooperatively as it is in tandem with the principle offunctionalism.

Impact of UHC in Nasarawa State

Since the renascence of the UHC in the State, several empirical studies have been conducted onthe impactof the policy. From this motley of studies, records have shown that many citizens have so far enjoyed the health care delivery (Akpo, 2018&Ogye, 2018). On these accounts, majority of the populace inthe Stateare currently enjoying health services with most of them reside in the rural areas (Adamu, 2016).Also, diverse aspects of the UHC have equally been studied, ranging from people’s level of awareness of modern healthcare, actual coverage rate, satisfaction with the public healthcare, to its effect on healthcare services utilizationand public health status in the State (Nwani, 2015&Abimiku, 2015).

While some Local Government Areas experienced high level of health coverage where health services is currently available (Nwani, 2015; Ogye, 2018&Akpo, 2018), some of them recorded lowlevel coverage of public healthcare (Apere & Karimo, 2014). There is no doubt however, that the public healthcare has had some multi-faceted effects on the entire healthcare system and the people'shealth-seeking behaviour in the state. Significantly, the introduction of the UHC has prompted an unprecedented increase in the utilizationof health facilities in the State (Ndie, 2013 & Imoughele *et al*, 2013). Not only has the policycaused the increase in utilization of health services, it has also led to the reduction of OOP health expenditure culminating in availability of services offered (Ozuchukwu *et al*, 2012). Economically, the introduction of UHC has led to the "mushrooming" of several health personnel, which in turn generates employmentand investment opportunities for the State. Despite the fact that Nasarawa state government have keyed into the policy in the country, access to quality health care delivery still remains a high profile challenge. It has been noted that there isa discrepancy among geographicalareas in access to quality health services. This was noted with urbanareas havingmore access to health services than their counterparts do in the rural areas (Adamu,2016). Consequent upon this, the implementation of the UHC is not without its challenges as they areexamined.

The Implementation of the UHC and its Challenges in Nasarawa State

Fundamentally, the UHC is a policy component programme of the entire health care delivery system in Nasarawa State. Therefore, the resonating problems confronting the state's healthcare system over the years are likely to affect the policy's implementation and sustainability. These problems among others include poor governmental allocation of funds to the health sector (Anyika, 2014, Ejughemre, 2014, Riman & Akpan, 2012, Yunusa *et al*, 2014 & Abimiku, 2015), inadequate supply of physicians accentuated by brain-drain syndrome in the health sector (Abimiku, 2015 & Eboh et al, 20016), poor distribution of health facilities or urban-biased establishment of health facilities (Jegede, 2012),shortage of drugs, management lapses, corruption, attitude of the health workers, obsolete and dilapidated health infrastructure (Anyika, 2014).

Generally, the interplay of the above mentioned problems plaguing the state's health sector havesome constraining effects on the implementation and sustainability of the policy. Though not insurmountable, noticeable specific areas of challenge facing the holistic implementation of the policy according to Joseph (2002) are:

i. Delay in the reimbursement of funds to the health facility coupled with corruption and fund diversion (Abimiku, 2015).

ii. Obsolete and inadequate health facilities availableto provide quality healthcare service (Ogye, 2018).

iii. The challenge of poor managementstrategy in partneringstakeholders like private health organization and international donors coupled with the problem ofdetermining equitable distribution, public needs assessmentin the health programs, modalities of implementing health packages without constraining access to health services. Some health personnel may be reluctant to work in the rural areas where basic/social amenities may be difficult, but may prefer the city centres inorder to leverage on both the ease of servicedelivery and large-scale users into the policy (Ogye, 2018).

iv. Sustainability of UHC policy may become problematic if resources' accruing for health is not adequate to cater for the running of health programs.

v. Dearth of medical personnel to implement the policy. It was documented that at a time, the state had 15 physicians per 100,000 people between 1999 and 2007. While in 2010, there were 53 physicians in Nasarawa State; giving a doctor-patient ratio of 0.28 per 1000 patients as compared to what is obtainable in advanced societies (Abimiku, 2015).

vi. Inequality in the distribution of health facilities between urban and rural areas coupled with policy inconsistency (Eboh et al, 2016).
vii. Poverty and inability to pay for healthcare services up-take through the policy.
viii. Lack of health programme synergy between the state and local governments in implementing the UHC.
ix. Lack of centralized patient information system for the healthcare centres in Nasarawa state to facilitate efficienthealthcare delivery. In other words, patients' data kept by the health systems are scattered among various health systems. Coverage level of health programs in the state is still relatively low (Abimiku, 2015 and Adamu, 2016).

Other barriers to the attainment of UHC include:

- Inadequate political commitment to health, leading to poor funding of health in general, and PHC in particular;
- Gaps in the area of stewardship and governance as evidenced by lack of clarity of the role of government, at all levels in financing health care;
- Absence of a health policy that clearly spells out how funds are to be allocated and spent in the health sector and Non-exploitation of other sources of health financing;
- Dominance of OOPs presents possibilities of under/oversupply of services depending on financial abilities;
- Several stakeholders, including development partners finance health independently and not in accordance with governments' policy thrust. This has led to inefficient use of scarce resources and duplication of efforts.

Conclusion and Recommendations

Several sources of financing healthcare abound to be leveraged on, such as public revenue or tax-based public sector health financing, household out-of-pocket health expenditure, and the donor funding. It has the capacity and potency of reducingcatastrophic health expenditure and exists either as community-based health or as universal health targets. The focus of this paper is on the assessment of the UHC and its multi-dimensional impact across the State. On this premise, the study concludes that the introduction of the policy is a positive welcome development that has the capacity and potency to boost preventive, promotive and curative components of healthcare delivery. It can facilitate rapid access to quality healthcare services by the citizens, the poor, the marginalized and the socially excluded if the policy is holistically implemented thereby achieving the Sustainable Development Goals respectively. In terms of investment opportunities, the policy has the generating capacity to absorb the army of unemployed graduates in the State's health sector. This can be made possible through the programs and activities of the health sector and increased patronage to health facilities as the case may be. Therefore, the State government should be encouraged and persuaded actively to continue with the policy of UHC with a view to bringing quality health care closer to people.

Similarly, lack of success in achieving financing health care has continued to be a challenge in achieving UHC in Nasarawa State. The review has identified barriers to efficient health care financing and the following strategies are recommended if the State is to achieve UHC:

The recent Health Insurance Scheme bill passed by the Nasarawa State House Assembly should be signed and ensure full implementation. In doing so, the state government should create its health insurance agency with guidance from the National Health Insurance Scheme and implement innovative ways to capture the formal and informal sectors. These steps will greatly increase healthcare penetration across the state. This is because investments on health contribute to economic growth and social development. Adequate public investments in health reduce financial impoverishment as a result of catastrophic cost of health care by shifting cost away from out-of-pocket expenditures and facilitating prepayment risk pooling mechanisms. Healthy citizens are productive. They work, earn, and save, and contribute to economic growth. UHC will

catalyse a robust healthcare that will create a level of equality/equity for the people within the state. Also, governments that facilitate substantial progress towards or achieve UHC are perceived favourably by their citizens and are more likely to be re-elected.

Political leaders in Nasarawa state should therefore, muster enough political will to ensure that quality and affordable healthcare services in Nasarawa state are provided. They should stop paying lip service to healthcare issues. The need to achieve UHC in Nasarawa state has become necessary now, more than ever before, considering that the famous Alma Ata Declaration of 1978 anchored on the slogan, "health for all by the year 2000 and beyond." It is good news that Nasarawa state government have demonstrated that removing user fees increases systematically the utilisation rates of healthcare services. Recently, the United State' millionaire and financier of some health programmes in Nigeria, Bill Gates, enjoined the government at all levels to develop its human capital with emphasis on health and education. Like Gates, it is believe that without healthy citizens, we cannot sustain our development plans.

The government should prioritise the provision of affordable healthcare to all citizens. For government to do this effectively there is the need to reinvigorate the Primary Health Care (PHC) system, which was effectively managed when the Dr Janet Angbazo was the Commissioner of Health. The state government should bring back the basic healthcare services and make them available to all citizens. The state can hardly afford quality healthcare with the annual meagre allocation to the health sector that hovers between six and seven per cent. The state government should increase its annual budget for healthcare services in keeping with the 2001 Abuja Declaration where African Union (AU) member states agreed to invest 15 per cent of their annual budgets to finance healthcare development. Besides, there will be no meaningful socio-economic development in any society that plays with its healthcare delivery system.

It is good that the State Ministry of Health has identified the PHC centres across the state as the vehicle to provide universal health coverage to all citizens. Government should go ahead to adequately equip PHCs to ensure the success of the universal health coverage. For this programme to be effective, government should consider offering free medical services at these centres to the aged, women and children.

Other recommendations offered include:

i. The government in collaboration with relevant stakeholders and partners should intensify optimal coverageon the freehealth care delivery for all citizens to trigger increase in the number of modern health care users.
ii. The government should scale up funding for the UHC in particular and the health sector in general to meetthe national and internationalrequired allocation being suggested globally. Governments should give higher priority to health in their budget allocations.
iii. The UHC should further be repositioned to focus on quality improvement of health services to meetthe satisfaction level of the populace.
iv. The current UHC policy should be restructured to gain a wider coverage and ensures equity in accessinghealth services especially among the poor, rural dwellers and marginalized populace.
v. There should be establishment of functional structures of arbitration to engage the policy managementconstantly, health care personnel and users in order to minimize mistrust and improve healthcare and servicedelivery.

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