



The Universal Health Coverage in Nigeria: The Perception of Public Health Professionals Towards the United Nations Sustainable Development Goal 3

Andre Ben Moses Akuche (Madonna University, Nigeria), Kennedy Nsan (Obafemi Awolowo University), and Precious Tariela Ebikabowei Victor (Madonna University, Nigeria)

Abstract

The Ministry of Health have vast potential to facilitate the realization of universal health coverage (UHC) and health system development in Nigeria. Until now, significant gaps exist and threaten its sustainability in many low-income and middle-income countries. Therefore, this study examined nurses' knowledge of UHC for inclusive and sustainable development in healthcare professional practice. This study was a cross-sectional survey. A convenience sample of 125 currently practicing auxiliary, pediatric and critical-care nurses was recruited. Respondents completed a questionnaire which was based on the perception, evaluation, implementation strategies advocated by the WHO Global Forum for nursing officers. Questions covered the government initiative, healthcare financing policy, human resources policy, and the respondents' perception of importance and contribution of nurses in achieving UHC. The results of the study revealed that the effect of nurses' knowledge on UHC on perception of development of healthcare services was significant ($\beta = .38$; $F = 23.29$; $p < .00$). Also, the contribution of the role of nurses in Nigeria was significant to the improvement in the perception of the universal health services for health workers [$\beta = .39$; $F = 32.77$; $p < .00$] and the challenges faced by nurses was statistically significant to the decline in achievement recorded in the universal health coverage [$\beta = .42$; $F = 27.19$; $p < .00$]. In addition, nurses in both clinical practice and management perceived themselves as having more contribution and importance than those in education. They were relatively indifferent to healthcare policy and politics. The study concluded that the survey uncovered a considerable knowledge gap in nurses' knowledge of UHC in healthcare professional practice and shed light on the need for nurses to be more attuned to healthcare policy towards achieving the UN SDGs Goal 3. The educational curriculum for nurses should be strengthened to include studies in public policy and advocacy. Nurses can make a difference through their participation in the development and implementation of UHC in healthcare services.

Keywords: Nurses Knowledge, Universal Health Coverage, Nigerian Healthcare Policy

Introduction

The international community has vast potential to facilitate the realization of universal health coverage (UHC) and health system development. Until now, significant gaps exist and threaten its sustainability in many low-income and middle-income countries (Sachs, 2013). People worldwide still lack access to basic healthcare. In response to this challenge, the United Nations General Assembly passed a resolution unanimously in December 2012. It called on all countries

to plan or pursue the transition of their health systems toward universal coverage (United Nations General Assembly Resolution on Global Health and Foreign Policy, 2013).

The World Health Organization, (2012), sets its objective to ensure that all people obtain the health services they need without suffering financial hardship when paying for them. According to the WHO Director-General, Universal Health Coverage is the single most powerful concept that public health has to offer (Chan, 2013). This consensus has arisen as a mounting body of evidence shows that Universal Health Coverage can deliver significant benefits: for individuals, in terms of access to health services and protection from financial ruin caused by ill health; for countries, in terms of population health and contribution to economic growth (Global Health Strategies, 2013).

However, Nigeria faces challenges that delay the progress toward the attainment of the national government declared goal of universal health coverage. One such challenge is system-wide inequalities resulting from lack of financial protection for the healthcare needs of most Nigerians (Okolo, Nwankwo, Okoli and Obikeze, 2019). This paper aims to synthesize the research evidence on Universal Health Coverage and challenges as it affects health workers perception as well as present policy recommendations in an accessible way to stakeholders and policymakers who might not have a technical background in the plight of health workers.

Universal health coverage (UHC) is defined as the entire spectrum of health services, ranging from health promotion, disease prevention, acute care and treatment, rehabilitation, to palliative care, and it should be financially affordable and geographically accessible to everyone in need (Awojumobi, Remilekun and Okpara, 2017). The definition embraces two key concepts, inclusiveness of the coverage and the sustainable development of the services provided. The former being, how the coverage is representative of the people and how far-reaching are its policies as well as sustaining consistency in effectiveness in accomplishing aims, while the latter portends the how plans, policies are integrated into local and international programmes and what strategies to adopt in other accomplish long and short-term objectives (Awojumobi *et al.*, 2017). The multifaceted quest for sustainable health and development, communities represent a unique and potent resource. Communities that are healthy, empowered, and prosperous are the grassroots drivers of national and regional development (Woodward, Smart, Benavides-Vaello, 2015). Without communities as partners and leaders, all our aspirations for health and development will amount to little more than rhetoric (Iwu, Ekeh and Austin-Evelyn, 2017).

Community health workers who come from the communities they serve, are answerable to these communities, and receive training that is shorter than that required for doctors, nurses or other health professionals represent the essential missing gap, between broad societal yearnings and the communities who both need assistance the most and serve as essential vehicles for progress (Woodward *et al.*, 2015). Few, if any, of our health and development tools match the potential of community health workers to drive gains on multiple fronts. A substantial body of evidence demonstrates that community health workers increase uptake of health services, reduce health inequalities, provide a high quality of services, and improve overall health outcomes (Iwu *et al.*, 2017).

Statement of the Problem

The World Health Organization has been advocating UHC over the past few decades to ensure all human beings are able to seek health services and are not deprived of services because of financial hardship (Willmann, 2012). The elderly population is one of the most vulnerable groups that require extra effort to achieve UHC. This is partly because of the loss of gainful employment and partly because of the increased incidence of co-morbidity in this group of people (Willmann, 2012). As expected, demands for health and social care will increase by many folds due to the trending rise in the aging population. Thus, the rights of elderly in accessing healthcare may face unprecedented levels of threat; Nigeria is no exception (Department of Health, 2015).

In Nigeria, the healthcare system, including elderly services, relies on both public sector and private sector. While 88% of the secondary and tertiary healthcare services were provided by the public sector, nearly 70% of the primary healthcare services were provided by the private sector (Chimezie and Faloye, 2014). All Nigeria citizens are eligible to seek medical services from the public sector at an extremely low fee. This fee may also be waived if the person covered by the comprehensive social security scheme (Chimezie and Faloye, 2014).

The development of the nursing profession in Nigeria is considered relatively more mature than in many African countries, yet the level of nurses' participation in politics was reported to be low (Tajudeen, Ifeanyi and Owoeye, 2015). Often, nurses were perceived to be apathetic to political decisions, even if they were healthcare related (Nwanfor, Ogoribuno and Nza, 2018). Heavy workloads, a sense of powerlessness, gender bias, lack of understanding of the political and policy making process, and ethical conflicts between professional and political values may account for this. Nurses, as one of the major healthcare providers, are the key members in the provision of quality healthcare services, and advocate for health choices and health policies (Tajudeen *et al*, 2015). It is important for them to be knowledgeable of the implementation strategies for UHC, even if they do not fully understand.

Healthcare services for impoverished in Nigeria are far from adequate, despite many new initiatives have been implemented (Nwanfor *et al.*, 2018). Many institutions, such as day centers, skilled nursing facilities and infirmaries want to support the initiatives; however, they cannot find enough nurses to do so. The goal of achieving UHC for public healthcare services is moving farther away. The situation does not appear to have any impact on nurses. This is rather unusual, as nurses have been very devoted to vulnerable people in Nigeria (Kayode and Ossai, 2018). Hence, this paper focuses on fundamental challenges of health workers in the purview of the UHC.

Now, a vast proportion of health policy debate is focused on realizing the 2030 Sustainable Development Agenda, a milestone which places specific importance on universal health coverage (UHC) a concept which supports a collective credence that all people should have access to the health services they need without risk of financial ruin or impoverishment (World Health Organization, 2012). However, considering the present inequalities within countries, achieving

UHC in Africa and particularly Nigeria, will require inclusive participation between health systems and the citizens across primary, secondary, and tertiary levels (Smith, 2004; Adongo, Phillips and Aikins, 2014). As a result, community health system performance has become increasingly relevant to both high-income countries and low-income and middle-income countries (London, 2008).

One of the fundamental problems associated with UHC is healthcare consolidation, funding, and investment (Adongo *et al.*, 2014). While the case for investment in health is clear, it is less straightforward to determine whether investments in health are more beneficial than those in areas such as education or infrastructure. Also, the strength of the case for investing in health varies among countries. The return on investment is likely to be highest for emerging economies; they can obtain significant improvements in health outcomes (e.g., life expectancy) through modest increases in health expenditure. However, higher income countries might already be at a level of expenditure where the marginal return, in economic and health terms, for increased investment would be relatively small (Adongo *et al.*, 2014).

Where policymakers have decided to make transformative investments in health, there are further choices to be made, such as how to allocate resources between improving health services and addressing the social determinants of health. Improving water quality and sanitation, or funding girls' education, may be as effective at improving health outcomes as spending on health services. However, given that strengthening health systems is vital to improving health outcomes, Universal Health Coverage is a highly effective way for countries to deliver significant health, economic and political benefits.

Review of Related Literature

The empirical evidence from various regions mostly supports the theoretical expectations described above. Several evaluations of a national health insurance program in Nigeria, for example, find positive impacts on health care utilization. Nwanfor, Ogoribuno and Nza, (2018) for example measure the subsidized regime component of the program finding the intervention to greatly increase utilization of medical care among poor and previously uninsured individuals Giedion *et al.* (2017).

In a recent study, King *et al.* (2019) examine the impact of the randomly assigned Mexican universal health insurance program Seguro Popular. The phased rollout of the program provides an experimental design for a study of a program aimed at reaching 50 million uninsured Mexicans. This study, however, shows Seguro Popular to have no significant impact on the use of medical services but it is important to note that the study is based on a time span of only 10 months. Galarraga *et al.* (2010) found that in Seguro Popular there was a reduction of catastrophic health expenditures of 49 percent for the experimental evaluation database (the same used by King *et al.* but using a different method) and 54 percent for the whole country based on a DHS-like survey. In addition, the authors found a reduction of out-of-pocket health expenditures for most types of services.

Findings in Asia are mostly positive. Chen *et al.* (2007) find that one year after the establishment of Taiwan's National Health Insurance scheme, previously uninsured elderly people increased their use of outpatient care by nearly 28 percent. Previously insured elderly people increased their use by over 13 percent leaving a chance of nearly 15 percent which can be solely attributed to the National Health Insurance scheme. In a study of a national rural health insurance scheme in China, Wagstaff *et al.* (2017) find that the scheme increased utilization of both inpatient and outpatient care by 20-30 percent but that the scheme had no impact on utilization among the poor. Yip *et al.* (2008) find that the China health insurance program increased utilization by 70 percent. Wagstaff and Moreno-Serra (2017) investigate the impact of the introduction of social health insurance in 14 countries in Central and Eastern Europe and Central Asia and find an increase in acute in-patient admissions.

There are few impact evaluations of health insurance in African countries and those that do exist demonstrate a weaker methodology than the articles reviewed above. One example is Smith and Sulzbach (2018) which examines the impact of health insurance in three African countries. The authors find a correlation between health insurance and use of maternal health services but highlight that the inclusion of maternal health care in the benefits package of the insurance is key. In Jutting (2003), the author finds in a study of community-based health insurance in Senegal an increase in utilization of hospitalization services but a failure of the program to address the needs of the poorest of the poor. In addition to impacts on health care utilization, health insurance is expected to provide financial protection because it reduces the financial risk associated with falling ill. Financial risk in the absence of health insurance is equal to the out-of-pocket expenditures because of illness.

Additional financial risk includes lost income due to the inability to work. There is little rigorous empirical evidence measuring the impact of health insurance in its ability to provide financial protection. The existing literature examines the impact of health insurance on out-of-pocket expenditures for health care measured in either absolute or in terms relative to income (expenditures are labeled catastrophic if they exceed a certain threshold). King *et al.* (2009) in their study of the Mexican universal health insurance program Seguro Popular find reductions in the proportion of households that suffer from catastrophic expenditures and a reduction in out-of-pocket expenditures for in- and out-patient medical care (though no effect on spending for medication and medical devices).

Wagstaff *et al.* (2007) find no impact on out-of-pocket health expenditures in rural China which contrasts with Wagstaff and Yu (2007) who find reduced out-of-pocket. Achieving universal health coverage in Nigeria one state at a time may involve payments, lower incidence of catastrophic spending and less impoverishment due to health expenditures. By contrast, in a later study, Wagstaff and Lindelow (2018) find health insurance in rural China to increase the risk of high and catastrophic spending. The authors define high spending as spending that exceeds a threshold of local average income and catastrophic spending is defined as exceeding a certain percentage of the household's own per capita income. This finding contradicts the hypothesis that health insurance always will reduce financial risk.

The above mentioned Wagstaff and Moreno-Serra (2017) study of Central and Eastern Europe and Central Asia finds an increase in government spending per capita on health but not in private health spending, while a switch to fee-for-service does increase private health spending. They find negative effects of social health insurance on overall employment levels but positive effects on average gross wages in the informal sector. Since it is difficult to measure the impact of improvements in quality per se, and because few insurance interventions explicitly address the supply-side, the literature is unclear about the separate impact of quality improvements of the supply of care versus making health insurance available and affordable.

Theoretical Explanation

Public-Private Partnership Community-Based Model

The necessary elements to ensure a functioning health system are: financing (risk pools and prepayment); administrative systems; health care providers such as clinics and hospitals, medication and laboratories; and the client/patient relationship. The demand (financing) side and the supply (delivery) side should be aligned and managed to deliver care to the patient, who will therefore be willing to prepay to ensure the availability of quality services when needed. An alternative model is a public-private partnership community-based health insurance model (PPP-CBHI). This model has the potential to contribute to the achievement of UHC by addressing many of the constraints described in the previous section. The PPP-CBHI model is based on three main pillars:

1. Building on existing local public and private institutions and informal networks;
2. Leveraging existing capital; and
3. Empowering local clients and communities.

Achieving universal health coverage in Nigeria one state at a time. In this model, donor funds can be used to catalyze the development of a more sustainable health system by stimulating investment and risk pooling mechanisms. In this way both the demand and supply-side are addressed. In developed countries, public institutions facilitate economic exchange in society by reducing risk and moral hazard. Public and social goods like health care, water, sanitation and education are effectively organized by the state through public or semi-public institutions. However, in low and middle-income countries like Nigeria the limited functioning of the state and its institutions hampers economic development and the rendering of public goods and services. Informal institutions often take the place of public institutions and transactions within those institutions are commonly enforced by social pressure and other social norms. Interventions therefore, that build on existing local and often informal institutions for which there may be greater trust, are more likely to succeed.

This can be achieved by, for example, leveraging social capital of communities and their local leaders, and their existing ties with private providers. In this model, groups such as microcredit

members, farmers, or market women are targeted to build on the existing social capital present in the group. Also, contributing to the strengthening of formal institutions (e.g. quality standards/accreditation, investment funds for social infrastructure), through involvement of the private sector in the delivery of essential public, semi-public and social goods, is a logical step.

Leveraging Existing Capital

In many developing countries, the private sector is an important provider of health care, including for its poor who pay for these private services largely out-of-pocket. Increasingly, many of the facilitating functions for healthcare information, quality certification, technology support, human resources are also provided by the private sector. This makes the private sector an important partner to reach the primary beneficiaries, namely, low-income groups, and facilitate systemic change in a bottom-up approach.

Harnessing the out-of-pocket expenditures into prepaid systems rather than crowding them out with public health funding is another important element of this model. Another important element is the leveraging of donor funding to mobilize private capital.

Empowering Clients and Local Communities

Ownership by and empowerment of clients and the communities they belong to is of crucial importance for the approach to succeed. A client-oriented approach requires knowledge about what clients want and need and what they can afford and are willing to (pre) pay. It implies the importance of delivering good quality care to the clients/patients, which requires building a strong health care supply chain: without good quality supply the willingness to prepay is likely to be low (Ogungbe and Eche-Gilbert, 2019).

How the Model Works

Based on these three main pillars, a multi-pronged approach for an alternative insurance model was developed by the Health Insurance Fund (HIF), a Dutch foundation set up in 2005 to increase access to quality basic health care and to provide financial protection through the provision of private community-based health insurance to low-income Africans. On the demand side, existing private resources for health care are used more efficiently to realize solidarity (based on health risk) and protect scheme members from unexpected financial shocks due to ill health. At the same time, the health insurance schemes generate financial resources to build up an efficient supply chain and empower members to insist on high-quality care, creating a snowball effect. People who can pay are induced to pay into risk pools, thereby creating stable health care demand. Improved efficiency in the supply chain lowers costs and raises quality, increasing peoples' willingness to pay. As more people buy health insurance, schemes grow, resulting in larger cross-subsidization, which enhances equity.

Through volume effects, the costs and premiums can be further reduced. These schemes do not compete with government programs but complement them. Beneficiaries are involved in

determining who has access to the schemes, the design of the benefits package, the level of premiums, and the costs to be covered.

The supply side is strengthened through facilitating private investments, both debt and equity capital. Supply-chain upgrading is undertaken through quality-improvement programs with rigorous monitoring and control, preferably in cooperation with international accreditation organizations. Where regulatory capacity of the government is weak, enforcement of quality standards to ensure adequate delivery of care can be a task for the private sector. Output-based contractual agreements provide a good opportunity to do this while achieving universal health coverage in Nigeria is possible in one state at a time (Ogungbe and Eche-Gilbert, 2019).

Donor funds are used to subsidize the community-based health insurance schemes' premiums. Disease-specific donor programs such as for HIV/AIDS, malaria, tuberculosis support the insurance schemes through a risk-equalization arrangement built into the programs. These long-term donor commitments are made with the solvency of the insurance funds serving as collateral, which lowers the investment risk and makes investments in the health care supply chain feasible. Limited donor funding is also used to upgrade the supply chain. Finally, donor funding is used as a lever to mobilize additional private capital to scale up the interventions.

The Health Insurance Fund and PPP-CBHI Model in Nigeria

In 2006, Health Insurance Fund (HIF) received a £100 million grant from the Dutch Ministry of Foreign Affairs to launch, together with its implementing partner, community-based insurance programs in four African countries, including Nigeria. In this public-private partnership model of community-based health insurance, donor funds are linked to African health maintenance organizations (HMOs), insurance companies, or third party administrators. These organizations are responsible for the execution of HIF's insurance programs and for contracting a network of public and private providers where scheme members can get their health services. Payment of insurers and providers is performance-based, measured as the medical care delivered and the number of enrollees. Insurers' prices and profit margins are contractually fixed.

The insurance package consists of primary and limited secondary care, including treatment for malaria, testing for HIV/Aids and TB. The programs are always complementary to regular public sector health programs. The programs create stable healthcare demand by subsidizing insurance premiums for target groups of African workers that enroll with the HMOs.

The program covers groups with at least some income, who must pay part of the (reduced) premium themselves. HIF's resources are also used to upgrade medical and administrative capacity of the insurers and health providers contracted under the program. Quality and efficiency are further pursued by strictly enforcing medical and administrative standards through independent audits. This reinforces the output-based approach: payment only takes place if the patient has received treatment that meets the agreed quality requirements. The quality improvement activities of health care providers under the HIF program are formalized and put under the aegis of an independent quality improvement and evaluation body called SafeCare.

This organization acts as the custodian of internationally recognized standards covering the spectrum of basic health care for providers in resource-restricted countries.

To date, HIF programs have been established for market women and farmers in Lagos, Nigeria, coffee growers in Tanzania and for groups of dairy and tea farmers in Kenya. Currently, a total of 121,000 people are enrolled. The expansion of the program to other African countries is currently under discussion.

Conceptual Review

This study reviewed several literature concerning to the following areas such as; identifying and categorizing prospects and challenges for health workers especially nurse's perception towards Universal Health Coverage within the Nigerian polity as well as theoretical framework that explains specific areas of this study. The health and well-being of Africans are fundamental to Africa's future. To ensure a healthier, more secure future, Africa has embarked on a historic effort to lay the foundation for sustainable health and development for all.

Agenda envisages a 50-year effort to galvanize a socioeconomic transformation across the continent. A key element of this transformation involves harnessing the "demographic dividend" to drive progress towards increased economic growth, social development and shared prosperity. The African Union's 'Africa Health Strategy' and the 'Catalytic Framework to End AIDS, TB and Eliminate Malaria by 2030' provide key goals, strategies and milestones for the journey towards a healthy and prosperous Africa. Making optimal use of technology, including digital communications platforms where feasible, will play a pivotal role in achieving these aims.

In this multifaceted quest for sustainable health and development, communities represent a unique and potent resource. Communities that are healthy, empowered and prosperous are the grassroots drivers of national and regional development. Without communities as partners and leaders, all of our aspirations for health and development will amount to little more than rhetoric. Community health workers who come from the communities they serve, are answerable to these communities, and receive training that is shorter than that required for doctors, nurses or other health professionals represent the essential "missing link" between broad societal yearnings and the communities who both need assistance the most and serve as essential vehicles for progress. Few, if any, of our health and development tools match the potential of community health workers to drive gains on multiple fronts (Chizaram and Uchenna, 2017).

A substantial body of evidence demonstrates that community health workers increase uptake of health services, reduce health inequalities, provide a high quality of services and improve overall health outcomes (Chizaram and Uchenna, 2017). Community health worker programmes also represent good jobs, bolster national and local economies and increase productivity by improving health and well-being. Investments in community health workers will also enable Africa to turn the projected near-doubling in the youth population through 2050 from a potentially perilous "youth bulge" into a dynamic "demographic dividend" that drives economic growth and improves living standards. Indeed, investments in community health workers represent an ideal opportunity to

tackle one of the most vexing problems in Africa, the perilously high levels of unemployment among young people.

Impacts of Health Insurance in Low and Middle-Income Countries

A broad range of risk-pooling mechanisms or insurance schemes are increasingly being utilized across the developing world to increase access and reduce the financial burden of health. The number of evaluations of such efforts is growing and while findings are mixed, the overall findings on impacts are encouraging. In theory, we expect health insurance to contribute to achievement of UHC because it increases access and utilization by lowering the price of health care. Individuals will have better health if they utilize preventive and curative health care when needed and in a timely manner (UNDP, 2011).

Several studies that evaluate the impacts of programs ranging from NHI and SHI to CBHI on health care utilization and financial protection (Usoroh, 2012; Sachs, 2013). Broader definition of UHC given the lack of agreement on the specific systems that might be utilized to achieve it and because we argue that a national system may not be the only answer to achieving universal coverage. A systematic review of the impacts of health insurance on health status in low and middle-income countries can be found in Giedion *et al.* (2013).

Nigeria Strives to Achieve Universal Health Coverage

Nigeria, with its population of around 162.5 million and a population growth rate of 2.5 percent, is the most populous country in Africa and the 8th most populous country in world (Iwu, *et al.*, 2017). The country's tumultuous history is reflected in its abundance of states beginning with only three states at the time of Nigeria's independence from the United Kingdom in 1960 and now with 36 states and the Federal Capital Territory (FCT), where the capital Abuja is located. This highlights the potential challenges of managing such a heterogeneous country.

Nigeria is ranked as one of the fastest growing economies in the world with a growth rate of 6.4 percent in 2007 and 7.4 percent in 2011 (Dutta and Hongoro, 2013). Nigeria's GDP per capita in PPP adjusted dollars is \$1,500 according to World Bank estimates from 2011. One of the main issues facing the country is balancing oil sector revenues and government spending. Over the last few years, the accrued oil revenues have not led to improvements in the welfare of most of the population (Dutta and Hongoro, 2013).

Poverty incidence has varied but remained high over the past decade. In 2004, the poverty rate was 54.4 percent., it rose to 62.6 percent in 2010 and dropped back down to 54.4 percent in 2011 (Kayode and Ossai, 2018). There are great regional disparities, reflected in a contrast between rural areas with a poverty rate of 69.0 percent and 51.2 percent in the urban sector. The poorest zones of the country are those in the North while the South East zone has the lowest incidence of poverty. Inequality, as measured by the Gini coefficient, rose steadily since 1985, save for a slight decline in 1992 (Kramer, Osagbemi, Tanović and Gustafsson-Wright, 2013).

As of 2011, the total population inequality is back at the only slightly better 1992-levels with a Gini coefficient of 0.397. Human development indicators are staggeringly low considering the country's GDP per capita. Nigeria ranks 156th out of 173 countries with data on the Human Development Index (HDI) (Okolo *et al.*, 2019).

The State of Health in Nigeria

Nigeria's health indicators have either stagnated or worsened during the past decade despite the federal government's efforts to improve healthcare delivery. Life expectancy at 52 years is below the African average, while the numbers on child mortality are astounding partly because of the country's size. Annually, one million Nigerian children die before the age of five due mostly to neonatal causes followed by malaria and pneumonia (Smith and Sulzbach, 2018).

Maternal mortality is 630 per 100,000 live births which is comparable to low-income countries such as Lesotho and Cameroon. An estimated 3.3 million Nigerians are infected with HIV and access to prevention, care and treatment is minimal. Nigeria also continues to combat the double burden of both communicable and non-communicable diseases (Smith and Sulzbach, 2018).

Policymakers and political leaders face tough choices and trade-offs when considering where to allocate the limited resources at their disposal. Competing priorities make such decisions very hard, and political dynamics often have a bigger role in determining the answers than evidence-based evaluations of value for money. In this opening chapter we seek to briefly make the case for investment in UHC (Giedion and Díaz, 2010).

The benefits of investing in health are significant and not limited to improving the health of the population: there can be significant economic returns and social benefits. A recent report by the Lancet Commission on Investing in Health lays out the channels by which health improvements have a direct impact on GDP: productivity (healthy people are more productive and less likely to take sick days); education (healthier children are more likely to go to school); investment (people are more likely to save when life expectancy is longer); access to natural resources (can be affected positively by a reduced risk from endemic diseases); temporary impact on ratio of working-age to dependent people (Tajudeen, Ifeanyi and Owoeye, 2015). It showed that reductions in mortality accounted for about 11 percent of recent economic growth in low- and middle-income countries, or even 24 percent of growth if the value of added life years is used to calculate a country's 'full income' (Smith and Sulzbach, 2018).

While the case for investment in health is clear, it is less straightforward to determine whether investments in health are more beneficial than those in areas such as education or infrastructure. Also, the strength of the case for investing in health varies among countries (Gertler and Gruber, 2002). The return on investment is likely to be highest for emerging economies: they can obtain significant improvements in health outcomes (e.g., life expectancy) through modest increases in health expenditure (Takian and Akbari-Sari, 2016). However, higher income countries might already be at a level of expenditure where the marginal return, in economic and health terms, for

increased investment would be relatively small (Preker, Lindner, Chernichovsky and Schellekens, 2013).

Where policymakers have decided to make transformative investments in health, there are further choices to be made, such as how to allocate resources between improving health services and addressing the social determinants of health (Davig, Eric and Leeper, 2018). Improving water quality and sanitation, or funding girls' education, may be as effective at improving health outcomes as spending on health services (Gerdtham and Magnus, 2020). However, given that strengthening health systems is vital to improving health outcomes, UHC is a highly effective way for countries to deliver significant health, economic and political benefits:

- a. Health: There is now significant evidence that UHC brings health improvements to the population of countries that implement it. Researchers using data from 153 countries concluded in *The Lancet* that “broader health coverage generally leads to better access to necessary care and improved population health, with the largest gains accruing to poorer people”.⁸ A recent review study⁹ found that UHC reforms have been a powerful driver for improving women's health in a number of low- and middle-income countries including Afghanistan, Mexico, Rwanda and Thailand.
- b. Economic: Apart from delivering the aforementioned economic benefits deriving from improved health, UHC can be an effective policy to reduce inequalities and poverty levels. The financial protection it provides can have further beneficial effects, for example helping reduce excessively high savings rates in families concerned about unpredictable healthcare costs as has been the case in China. UHC systems can help generate and support significant employment in the health and life sciences sectors.
- c. Political: The debate around the Affordable Care Act in the United States shows that the politics of UHC can be highly controversial. However, introducing UHC in a country with limited healthcare coverage for the majority of the population can provide significant benefits for politicians. The most recent example of this has been President Joko Widodo (Jokowi) of Indonesia, whose focus on improving healthcare coverage has been an important driver in his political rise from city mayor, to Governor of Jakarta, to head of state. Politicians have also recognized the power of UHC to maintain social order and reduce the scope for conflict. Reporting on the decision of the Chinese Government to launch massive public health reforms in 2009, the then Minister of Health Chen Zhu said that the government's primary motivation was to ensure a harmonious society (Gerdtham & Magnus, 2020).

Nigeria's Health System

Nigeria has a federally funded National Health Insurance Scheme (NHIS), designed to facilitate fair financing of health care costs through risk pooling and cost-sharing arrangements for individuals. Since its launch in 2005 the scheme claims to have issued 5 million identity cards, covering about 3 percent of the population (Nyandekwe, Nzeribe and Kakoma, 2018). Under the

National Health Insurance Act 2008, the national health insurance started a Rural Community-Based Social Health Insurance Program (RCSHIP) in 2012. The majority of the enrollees, however, are individuals working in the formal sector and the community scheme still leaves large gaps among the poor and informally employed (Nyandekwe *et al.*, 2018).

Several proposals are currently in the works to expand the reach of NHIS. One such proposal is to make registration mandatory for federal government employees. The creation of a “health fund” collecting an earmarked “health tax” of 2 percent on the value of luxury goods was proposed (Opatunde & Zachariah, 2019). This fund would be used for the health insurance of specified groups of Nigerian citizens, including: children under five, physically challenged or disabled individuals, senior citizens above 65, prison inmates, pregnant women requiring maternity care, and indigent persons. At a broader level, the National Health Bill which was first proposed in 2006 to improve its poor health sector by allocating at least 2 percent of the federal government’s revenue to the health sector is still not signed into law (Opatunde & Zachariah, 2019).

Constraints to Achieving UHC in Nigeria

According to Omehi and Azubuike, (2018) the constraints to achieving UHC in Nigeria are numerous and complex. Factors limiting Nigeria’s health outcomes are both demand and supply-side including inadequate financing, weak governance and enforcement, inadequate infrastructure and poor service quality, weak governance and enforcement, household poverty and insufficient risk pooling.

1. Inadequate Government Financing for Health

Dehinde & Osagie (2019) postulated that there are four main sources of public funding for the public (non-federal) health sector: state governments, local governments, direct allocations from the federal government, and private individuals and organizations, including non-governmental organizations and international donors in some states. The federal government and some state governments have increased funding to public health care (PHC) over the past decade, with a dramatic increase between 2005 and 2007 (Dehinde & Osagie, 2019).

Achieving universal health coverage in Nigeria one state at a time 7 increase in health sector allocations jumped from 31.4 percent to 86.2 percent. Nonetheless, Nigeria spends a mere 5.3 percent of its GDP,) or \$139 (PPP) per capita on health care. This is extremely low, in particular when compared to other African countries such as Burkina Faso (6.7 percent) and the Democratic Republic of Congo (7.9 percent), which have considerably lower GDP per capita (Dehinde & Osagie, 2019).

The government contributes only 36.7 percent of the country’s total spending on health. In order to achieve effective access and financial protection, the government must begin by making a more serious commitment to spend on health. The absence of institutionalized National Health Accounts (NHA), however, contributes to the challenge of reassessing health spending in the country. Finally, low levels of external health financing reflect an unwillingness to invest in the

country. Just 9.2 percent of spending is donor funded, which is very low compared to, for example, Ghana with 16.9 percent, which has a comparable GDP per capita (Alhassan & Okonji, 2019).

Weak Governance and Enforcement.

The existing legislative structure for budget allocations to social sectors as well as weak governance and institutions leads to inefficient spending and lack of trust in the system. State governments in Nigeria have substantial autonomy and exercise considerable authority over the allocation and utilization of their resources. This arrangement constrains the leverage that the federal government has over state and local governments in terms of getting them to invest in the health sector (Alli and Uwaji, 2018).

Therefore, top-down approaches continue to fail to produce improvements in access, financial protection, and health indicators. In addition, the public system lacks transparency and enforcement, making it subject to corruption and lending inadequate medical and administrative capacity to produce services efficiently and of adequate quality. A weak institutional framework leads to high uncertainty and risk and thereby low levels of trust which reduces the willingness of individuals to invest. Therefore, the willingness to prepay for health care remains low (Alli & Uwaji, 2018).

Inadequate Health Infrastructure and Poor Service Quality

Low government spending combined with weak institutions and lack of enforcement lead to inadequate health infrastructure and poor service quality. Due to the unwillingness to invest in health or prepay for health care, predictable revenue flow is unavailable for health providers to improve the supply chain leaving much of the country's health infrastructure in a dismal state (Tangcharoensathien, Oyeneeye & Jafarudeen, 2019). Many health facilities lack access to clean water and a reliable supply of electricity, face shortages of medical equipment, and are missing necessary medications or blood to treat their patients.

In addition, there is a deficiency in qualified health professionals in particular in poor communities (Ogungbe & Eche-Gilbert, 2019). Large disparities exist between urban and rural areas and between states due to the variation in remuneration packages for health professionals across states and between federal and state level, health professionals gravitate to better paying federal facilities and states (Ogungbe & Eche-Gilbert, 2019). Private providers mainly operate in urban settings where income levels are the highest. This situation results in a lack of qualified and competent health professionals for individuals who live in poor rural areas that tend to bear a greater disease burden (Tangcharoensathien *et al.*, 2019).

Gap in Literature

The essence of this study is to fill the existing gap in knowledge where focus on the Nigeria's quest towards achieving the Universal Health Coverage in line with Goal 3 of the United Nations

Development Goals is being challenged by pragmatic policy focus because of lack of knowledge of the UHC for inclusive and sustainable development in healthcare professional practice.

Methodology

A cross-sectional survey was conducted in June and July of 2021. The study made use of primary source of data collection. Through the administration of pencil-paper questionnaire to elicit responses from nurses. A list of potential respondents was generated from a pool of nurses who had experience interacting with the researcher and her research team. The respondents were informed about the purpose of the study and how the details of the study would help improve nursing practice.

This research considered the eligibility of the nurses who volunteered to participate in the study. Having obtained their consent to participate, the research team continued the exercise by giving out questionnaires to the (nurses) respondents electronically. Phone calls were sent to them two and four weeks after the initial distribution of the questionnaire. Names were not collected, to ensure anonymity of the respondents.

Data analysis was conducted using the version 20 of the Statistical Package for Social Sciences, version 20 and to ensure ecological validity, the research team developed a demographic profile section and 4 questions initially based on the implementation biographical information as recommended by the WHO Global Forum for the Governmental Chief Nursing Officers and Midwives (GCNOMs).

Apart from the demographic profile, there were two parts in the final version of the questionnaire, namely, knowledge of inclusiveness of UHC and the perceived contribution to sustainable development of UHC. Inclusiveness of UHC was composed of the government initiative (Q3), healthcare insurance and financing policy (Q1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11 and 12), and human resources policy (Q13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26 and 27). Respondents were asked to indicate how they evaluate the importance of contribution of Nurses in Nigeria to their level of knowledge of UHC. For sustainable development of UHC, respondents were asked to rate their perceived contribution (Q28, 29, 30, 31, 32, 33, 34, 35, and 36) and perceived importance of nurses (Q37, 38 and 39, 40, 41, 42, 43 and 44).

Split half reliability was performed using Spearman's coefficient which was satisfactory at 0.881. With the unique function of the Likert-type questionnaire system, the respondents' answers were automatically compiled in a table format. Descriptive and inferential statistics were then computed and a comparison was performed by years of experience, job title, nature of one's role, and their qualifications.

Data Interpretation

The study considered the analysis of data generated from the research study in relation to the responses obtained through questionnaire administration. A total of one hundred and thirty-one

(131) questionnaires were initially distributed, however, only one hundred and twenty-five (125) were retrieved. Three (3) healthcare facilities were engaged for this study namely; Federal Medical Centre, Airport Road, Jabi Federal Capital Territory, Abuja and Save-A-Life Mission Hospital Stadium Road, Port-Harcourt, Rivers State, Nigeria, as well as, New General Central Hospital GRA, Asaba, Delta State, Nigeria. Respondents (Nurses) at the Federal Medical Centre, Airport Road, Jabi FCT, Abuja were sixty-nine, 69 making a total of 55%, of the entire population of the study. Nurses from the Save-A-Life Mission Hospital Stadium Road, Port-Harcourt, Rivers State Nigeria were forty-one 41 making a total of 33% respondents and the nurses who participated in this study, from New General Central Hospital GRA, Asaba, Delta State, Nigeria were fifteen 15 making a total of just 12%. The responses or data retrieved from the questionnaire administration formed the basis of the following results.

Table 3.1: Showing the Categories of Nurses (Respondents) from the 3 Hospitals that Participated in the Study

s/n	Categories of Nurses	Frequency	Percent	Valid Percent	Cumulative Percent
1.	Auxiliary Nurses	56	44.8	45.0	45.0
2.	Pediatric Nurses	41	32.8	33.0	33.0
3.	Critical Care Nursing	28	22.4	22.0	22.0
	Total	125	100	100	100

Source: Field Analysis, (2021).

From the result 3.1., categories of Nurses that participated in the study from the three hospitals used in the study suggest that auxiliary nurses had the highest population with 56(44%), closely followed by Pediatric Nurses who were 41(32.8%) of the entire population and the least category were critical care nurses who were 28(22.4%) of the entire population.

Table 3.2: Showing the Age Distribution Information of Nurses from the 3 Hospitals that Participated in the Hospital

Age Range	Mean	Standard Deviation	Frequency	Percent	Valid Percent	Cumulative Percent
17-30	34.56	6.37	66	52.8	53.0	53.0
31-50			36	28.8	29.0	29.0
50above			23	18.4	18.0	18.0

Source: Field Analysis, (2021).

From the result Table 3.2., revealed that age distribution of nurses with an average age of 34.56 and the majority of respondents were within the age bracket of 17-30 (53%), closely followed

respondents within the age bracket of 31-50 (29%), and age bracket of 51 and above was 18.2% of the entire population of the study. Thus it can be inferred that the respondents of the study were knowledgeable enough to provide informed consent pertaining to the questions asked in the questionnaire regarding customer satisfaction.

Table 3.3: Table Showing the Gender Distribution of Respondents from the 3 Hospitals that Participated in the Study

Genders	Frequency	Percent	Valid Percent	Cumulative Percent
Male	77	61.6	62.0	62.0
Female	48	38.4	38.0	38.0
Total	125	100	100	

Source: Field Analysis, (2021).

The descriptive analysis in Table 3.3 indicated the gender distribution of respondents in this study. The analysis demonstrated that gender of respondents was representative the differences in the number of male and female respondents. Result showed that female respondents were the majority with 77 (61.6%) and male respondents were the least with 48 (38.4%), indicating that majority of the respondents were female. This implies that there are more females than males in the study.

Table 3.4: Showing Educational Qualification Obtained by Each of the Respondents from the 3 Hospitals

Educational Qualification	Frequency	Percent	Valid Percent	Cumulative Percent
SSCE	31	24.8	19.0	19.0
B.Sc.	66	58.2	58.0	58.0
M.Sc.	23	18.4	24.0	24.0
PhD.	05	04.0	04.0	04.0
Total	125	100	100	100

Source: Field Analysis, (2020).

From the Table 3.4 majority of respondents had reportedly obtained bachelor's degree, 66 (58.2%), followed by respondents who had obtained Senior Secondary School Certification 31(24.8%), this is followed by respondents with a Master's degree 23 (18.4%), however, only 3 respondents indicated that the highest qualification was Doctorate Degree making up 5(4%) of the total population. Thus, it can be inferred that the majority of the respondents of the study had university education, this indicates that the respondents who were educated were more likely to report perceptions of universal health coverage is required to form opinion and responses on the items of the questionnaires.

Table 3.5: Showing Religious Belief as Indicated by Each of the Respondents from the 3 Hospitals

Religious Beliefs	Frequency	Percent	Valid Percent	Cumulative Percent
Christian	75	60.0	60.0	60.0
Muslim	41	32.8	33.0	24.0
Others	09	7.2	7.0	7.0
Total	125	100	100	100

Source: Field Analysis, (2021).

From the Table 3.5 majority of respondents indicated that they were Christians, 75 (58.2%), followed by respondents who reported that they were Muslims 41(18.4%), and the least category of respondents with other beliefs 9(18.4%). Thus, it can be inferred that the majority of the respondents of the study had been Christians.

Data Presentation, Analysis and Discussion

This section presents the results obtained from the study analysis in tabular formats where inferences were drawn. The study considered the analysis of data generated from the research study in relation to the responses obtained from the questionnaire administration. A total of one hundred and twenty-five (125) were retrieved. Respondents (Nurses) at the Federal Medical Centre, Airport Road, Jabi FCT, Abuja were sixty-nine, 69 making a total of 55%, of the entire population of the study. Nurses from the Save-A-Life Mission Hospital Stadium Road, Port-Harcourt, Rivers State Nigeria were forty-one 41 making a total of 33% respondents and the nurses who participated in this study, from New General Central Hospital GRA, Asaba, Delta State, Nigeria were fifteen 15 making a total of just 12%. The responses or data retrieved from the questionnaire administration formed the basis of the following results. The responses or data retrieved from the questionnaire administration formed the basis of the following results.

Testing of Results

Nurses' knowledge of Universal Health Coverage (UHC) for inclusive and sustainable development would not significantly influence the perception of development of healthcare services in Nigeria. Below is the regression analysis for the test of hypotheses.

Table 4.1: Regression Analysis on Nurses' Knowledge of Universal Health Coverage (UHC) on Perception of Development of Healthcare Services in Nigeria

Model	Unstandardized Coefficient		Standardized Coefficients β	T	Sign.	Collinearity Statistics.	
	B	Std. Error				Tolerance	df
Constant	3.651	2.674	.233	2.87	.000		
Nurses' Knowledge	3.771	.092	.384	3.67	.000	.078	1 (400)

Model Statistics

R	.455
R ²	.717
Adjusted R ²	.219
Standard Error Estimate	3.331
F Statistic	23.291
Level of Significance	.000
DW statistics	1.390

*NOTE: Field Analysis, (2021).

The regression analysis above showed that the nurses' knowledge on UHC was statistically significant on perception of development of healthcare services in Nigeria. The overall effect of nurses' knowledge on UHC on perception of development of healthcare services was significant ($\beta = .38$; $F = 23.29$; $p < .00$). Therefore, the null hypothesis 1 was rejected. This result implies that nurses' knowledge on UHC is a significant contributor to the perception of development of healthcare services, such that, when increased level of nurses' knowledge on universal health coverage, this increases the tendency for nurses to perceive development of healthcare services. The result further revealed R² of .71, implying that the contribution of facets of customer service contributed 71% to the overall variance on customer satisfaction. This suggests that other variables not considered in this study may account for more than 29% of the total variance observed in the study.

The contribution of the role of nurses in Nigeria would not lead to significant improvement in the perception of the universal health coverage for health workers.

Table 4.2: Regression Analysis Showing the Contribution of the Role of Nurses in Nigeria to Perception of the Universal Health Coverage for Health Workers

Model	Unstandardized Coefficient		Standardized Coefficients β	T	Sign	Collinearity Statistics.	
	B	Std. Error				Tolerance	Df
Constant	2.93	2.342	.277	2.13	.000		
Contribution of the Role of Nurses to Perception of UHC	3.89	6.441	.398	3.11	.000	.091	1(400)
Model Statistics							
R				.356			
R ²				.632			
Adjusted R ²				.341			
Standard Error Estimate				1663			
F Statistic				31.08			
Level of Significance				.000			
DW statistics				3.111			

Source: Field Analysis, (2021).

From the results above, the regression analysis above showed that there is a contribution of the role of nurses in Nigeria was significant to the improvement in the perception of the universal health services for health workers [$\beta = .39$; $F = 32.77$; $p < .00$]. The overall contribution of the role of nurses in Nigeria was significant to the improvement in the perception of the universal health coverage. Therefore, the null hypothesis two was rejected. This result implies that technological innovation is a significant contributor to customer satisfaction, such that, technological innovation increases, the higher the perception of customer satisfaction.

The challenges faced by nurses in Nigeria will not lead to a decline in achievement recorded in the universal health coverage. The result is presented in Table 4.3.

Table 4.2.: Regression Analysis Showing the Relationship Between Challenges Faced by Nurses Would Decline in Achievement Recorded in the Universal Health Coverage

Model	Unstandardized Coefficient	Standardized	T	Sign	Collinearity Statistics.
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	<i>B</i>	<i>Std. Error</i>	Coefficients β			Tolerance	Df
Constant	1.771	2.332	.389	3.33	.000		
Quality of Service Delivery	4.16	.311	.422	3.92	.000	.092	1, (400)
Model Statistics							
R				.344			
R ²				.502			
Adjusted R ²				.513			
Standard Error Estimate				2.44			
F Statistic				27.19			
Level of Significance				.000			
DW statistics				1.299			

Source: Field Analysis, (2021).

The regression analysis above showed that the challenges faced by nurses was statistically significant to the decline in achievement recorded in the universal health coverage [$\beta=.42$; $F = 27.19$; $p < .00$], therefore, null hypothesis 3 was rejected. The overall challenges faced by nurses to the decline in achievement recorded in the universal health coverage was significant. This result implied that the overall challenges faced by nurses in assessing universal health coverage is significant contributor to perception of the decline of universal health coverage, such that decrease in the overall challenges faced by nurses leads to high perception of the decline in achievement recorded in the universal health coverage. The result signifies that the nurses' knowledge of universal health coverage, the contribution of the role of nurses, as well as, when pulled together yield a multiple R of .34 and R² of .50 [$F = (2, 125) = 27.19, p < 0.01$].

Summary

This study revealed that nurses showed low political involvement and powerlessness in the process of policy making, which was consistent with the findings from previous studies (Boswell, Cannon & Miller, 2019). Focusing on the difference between Auxiliary Nurses (AN's) and Pediatric Nurses (PN's), majority of the former believed that it was important for nurses to develop evidence-based policy for managing the nursing workforce, and to ensure the continuity of the health care system, pressure groups should be lobbied, while of the latter agreed that it was the nurse's role and they should help support educational institutions in developing/implementing training programmes to meet the changing quantitative demand of healthcare delivery.

This may reflect the importance of training and education in fostering nurses' political sense, particularly their understanding of the policy making process. From the core competencies

stipulated by The Nursing Council of Nigeria, AN's are only required to practice in accordance with policies while PNs and Critical-Care Nurses (CCNs) are expected to understand the process of developing health care policies. However, attention was suggested for teaching health care policies in the curriculum for nursing education. The inadequacy of policy studies in nursing education can be reflected in the answers of the respondents to the questions about the perceived contribution to evidence-based policy making. Only ANs and PNs, respectively, claimed that they had more contribution in the development of evidence-based policy. This finding suggests that the majority of nurses feel powerless and remote from policy-making related to healthcare services.

As a result, they are indifferent to the political process leading to UHC for healthcare workers to access healthcare services in Nigeria. This phenomenon warrants the immediate attention of the nursing profession. It may be timely and appropriate to reconsider the long standing suggestion to incorporate political education in the education of nurses.

From the findings of this study, nurses with higher academic qualifications, such as the master's degree and higher, perceived a significantly higher level of importance in helping to develop/strengthen policies to improve the quality of nursing education. In recent years, the Government has proposed several major changes in elderly care policy in response to the challenges evolving from our rapidly aging society, such as strengthening primary care, emphasizing aging in place, and a voluntary health insurance scheme. Understandably, these changes mean increasing demand for both ANs and PNs at the community level.

The question is, will nurses be able to meet the demand, or an even better question may be, have nurses been prepared for it? Unfortunately, with the present ANs, PNs and CCNs mix, the answer is negative. The findings of this study reaffirmed this. It is crucial, therefore, to involve nurses in policy-making, particularly when a major change is expected to occur. To ensure nurses are competent in the political process, the professional body such as The Nursing Council of Nigeria should consider revising nursing curriculum to increase nurses' knowledge on the universal health coverage.

Conclusion

Universal health care evolves from the 'Health for All' movement advocated by the WHO in the 1970s. Since then, the Nigerian government has launched many initiatives in order to achieve UHC, particularly for inclusive and sustainable healthcare services for healthcare workers such as nurses. Although the outcomes of these initiatives are yet to be seen, the researcher and her supervisor considered it to be appropriate to conduct the reported survey to identify nurses' knowledge of and involvement in the process, including policy-making and implementation. It was hoped that the findings would inform major stakeholders of some issues which may possibly affect the success of these initiatives.

The survey has revealed some knowledge gaps among nurses. Their knowledge of healthcare financing, including health insurance, drug-dispensing, and human resource policy needs to be

enhanced. The low perceived importance and contribution to the sustainable development of elderly healthcare services are deterrents to their possible involvement in the initiatives. After all, nurses constitute a major work force in healthcare. They should be better prepared to participate with policy-making knowledge for the benefit of the population that they serve.

Recommendations

Since the demand for healthcare services will increase in the future. To meet the escalating demand, the government needs to allocate additional resources, be they human or financial, to prepare the society. The nurses constitute the major healthcare workforce in Nigeria. There is no reason for nurses to have such low level knowledge of the universal health coverage and to be unprepared for this forthcoming challenge. Based on the findings, the following recommendations were made for this study.

1. It is crucial, therefore, to involve nurses in policy-making, particularly when a major change is expected to occur. To ensure nurses are competent in the political process, the professional body such as Nursing Council of Nigeria should consider revising the indicated nursing curriculum and core-competency of nurses to strengthen the nurses' knowledge and ability to participate in policy development. Thus, the gap between policy and practice could be bridged.
2. Since nurse educators are responsible for nurturing the future generation of nurses, they should be role models for their students, and should equip themselves well in this area. There is an urgent need to involve more nurse educators in the political process leading to decision-making.
3. The survey uncovered a considerable knowledge gap in nurses' knowledge of UHC, but care must be taken in interpreting the findings from such a non-random sample. Having collected the data on nurses' perceived contribution and importance to policy-making across clinical, management and education sectors, the research team believes that, with the increase of the aged population, regulatory bodies such as the Nursing Council of Nigeria could do more to enhance their capacity at various fronts to support the government's initiatives to provide UHC for nurses and other healthcare workers.
4. To ensure that more knowledge with regards to universal health coverage for nurses in Nigeria, the National Health Insurance Scheme (NHIS), National Primary Healthcare Development Agency (NPHCDA) as well as, the Hospital/Healthcare Management Boards (HMO's) under the auspices of Ministry of Health are encouraged to reform the healthcare policy mandate nurses and other allied healthcare workers are to attend and actively participate in seminars, conferences and workshops on universal health coverage so as to assuage and increase knowledge regarding universal health coverage as it concerns health workers especially nurses in Nigeria.

References

Books

Giedion, U., Alfonso, E. A. & Díaz, Y. (2013). *The impact of universal coverage schemes in the developing world: A review of the existing evidence*. Washington, D.C., The World Bank. pp. 122-125.

Preker, A. S., Lindner, M. E., Chernichovsky, D. & Schellekens, O. (2013). *Scaling up affordable health insurance staying the course*. Washington D.C.: The World Bank.

Usoroh, E. E. (2012). Achieving universal health coverage in Nigeria: *The national health insurance scheme as a tool*. Amsterdam: Vrije Universiteit Amsterdam. pp. 16-17.

Book Chapters

Giedion, U., & Díaz, B. Y. (2010). *Chapter 2: A review of the evidence*. In Griffin, C., Escobar, M., and Shaw, R. (Eds.). *Impact of health insurance in low- and middle-income countries* (pp. 13-32). Washington, D.C. Brookings Institution Press.

Schellekens, O. P., van der Gaag, J., Lindner, M. E., & de Groot, J. (2013). *Chapter 20: New development paradigm*. In Preker, A. S., Lindner, M. L., Chernichovsky, D., and Schellekens, O. P. (Eds.), *Scaling up affordable health insurance: Staying the course* (pp. 539-557). Washington, D.C.: The World Bank.

Journal Articles

Adongo, P. B., Phillips, J. F. & Aikins M, (2014). Does the design and implementation of proven innovations for delivering basic primary health care services in rural communities fit the urban setting: The case of Ghana's Community-based Health Planning and Services (CHPS). *Health Resource Policy & System*, 12(1), 23-29.

Alli, S. L. & Uwaji, O. P. (2018). The terrain of health policy analysis in low and middle income countries: a review of published literature 1994-2007. *Nigerian Health Policy Plan*, 23(2), 294–307.

Austin-Evelyn, K. (2019). Community health worker perspectives on a new primary health care initiative in South-Eastern Nigeria. *PLoS One*, 82(2), 112-119.

Awojumobi, A. J., Remilekun, E. I. & Okpara, N. W. (2017). Transforming the delivery of care in the post-health reform era: What role will community health workers play? *African Journal of Public Health*, 5(2), 101-115.

- Beegle, K., de Weerd, J., & Dercon, S. (2008). Adult mortality and consumption growth in the age of HIV/AIDS. *Economic Development and Cultural Change*, 56(2), 299-326.
- Boswell, C., Cannon, S. & Miller, J. (2014). Nurses' political involvement: Responsibility versus privilege. *Journal of Professional Nursing*, 21(1), 5-8. doi:10.1016/j. profnurs.2014.11.005.
- Boswell, C., Cannon, S. & Miller, J. (2019). Nurses' political involvement: Responsibility versus privilege. *Journal of Professional Nursing*, 121(3):55-58.
- Chan, S. W. C., & Cheng, B. S. (1999). Political participation in Nigeria: A study. *Journal of Nursing Management*, 18(7), 167-175.
- Chen, L., Yip, W., Chang, M., Lin, H., Lee, S., Chiu, Y., & Lin, Y. (2007). The effects of Taiwan's national health insurance on access and health status of the elderly. *Health Economics*, 16, 223-42.
- Chimezie, R. S. & Faloye, E. J. (2014). Nigeria's evolving community health worker system: qualitative assessment of client and provider perspectives. *Human Resources for Health*, 12(2), 71-76.
- Chizaram S. W. & Uchenna, B. S. (2017). Political participation in Hong Kong: A study. *Journal Nursing Management*, 18(7), 167-75.
- Davig, T., Eric, M. & Leeper, O. (2018). Monetary–fiscal policy interactions and fiscal stimulus. *European Economic Review*, 155 (2): 211–27.
- Dehinde, E. R. & Osagie, W. M. (2019). From research to national expansion: 20 years' experience of community-based case management of childhood pneumonia in Nigeria. *Bulletin World Health Organ*, 86 (3), 339-343.
- Fox, M. P., Rosen S., Macleod W. B., Wasunna, M., Bii, M., Foglia, G., and Simon, J. L. (2004). The impact of HIV/AIDS on labour productivity in Kenya. *Tropical Medicine & International Health*, 9(3), 318-324.
- Galarraga, O., Sosa-Rubi, S. G., Salinas-Rodriguez, A., & Sesma-Vazquez, S. (2010). Health insurance for the poor: Impact on catastrophic and out-of-pocket health expenditures in Mexico. *European Journal of Health Economics*, 11 (5), 437-447.
- Gerdtham, U. G., & Magnus, J. (2020). New estimates of the demand for health: Results based on a categorical health measure and Indonesian micro data. *Social Science & Medicine* 149 (10): 1325–1332.
- Gertler, P. & Gruber, J. (2002). Insuring consumption against illness. *American Economic Review*, 92, (3), 51-70.

- Gustafsson-Wright, E., Janssens, W., & van der Gaag, J. (2010). The inequitable impacts of health shocks on the uninsured in Namibia: The potential for low-cost health insurance schemes to protect the poor. *Health Policy & Planning*, 26 (2), 142-156.
- Iwu, A. B., Ekeh, R. T., & Austin-Evelyn, K. (2017). Community health worker perspectives on a new primary health care initiative in the South-Eastern Nigeria. *PLoS One*, 12, 173-178.
- Jutting, J. (2003). Do community-based health insurance schemes improve poor people's access to health care? Evidence from rural Senegal. *World Development*, 32 (2), 273-288.
- Kayode, E. E., & Ossai, M. (2018). Teaching mothers to provide home treatment of malaria in Tigray, Ethiopia: a randomised trial. *Lancet*, 356 (5), 550-555.
- King, G., Gakidou, E., Imai, K., Lakin, J., Moore, R. T., Nall, C. & Llamas, H. H. (2009). Public policy for the poor? A randomized assessment of the Mexican universal health insurance programme. *The Lancet*, 103(2), 236-241.
- Legislative Council, (2014). Residential care homes for the elderly. *International Studies*, 21(3), 24-29.
- Leung, J. L., Sezto, N. W., Chan, W. C., Cheng, S. P., Tang, S. H., & Lam, L. C. (2013). Attitudes and perceived competence of residential care homes staff about dementia care. *Asian Journal Gerontology & Geriatric Studies*, 8(1):13-19.
- Litvack, J., & Bodart, C. (1993). User fees plus quality equals improved access to health care: Results of a field experiment in Cameroon. *Social Science & Medicine*, 37 (3), 369-83.
- London, L. (2008). What is a human-rights based approach to health and does it matter? *Health Hum Rights*, 10, (65), 23-29.
- Nwanfor, M. K., Ogoribuno, S. K. & Nza, W. K. (2018). Improving health system quality in low- and middle-income countries that are expanding health coverage: A framework for insurance. *International Journal of Quality Health Care*, 25:497–504.
- Nyandekwe, M. M., Nzeribe, A. R. & Kakoma, J. (2018). Universal health coverage in Nigeria and Rwanda: Dream or reality. *Pan African Medical Journal*, 17(2), 228-231.
- Ogungbe, M. J., & Eche-Gilbert, N. W, (2019). Transforming the delivery of care in the post-health reform era: What role will community health workers play in Nigeria? *American Journal of Public Health*, 20(2), 104-110.

- Okolo, C., Nwankwo, A. C., Okoli, C., Obikeze, E. (2019). The challenges of establishing universal health coverage in Enugu State, South-East, Nigeria. *Developing Country Studies*, 9(4), 12-19.
- Omehi, E. E. & Azubuikwe, J. (2018). Nigeria's evolving community health worker system: Qualitative assessment of client and provider perspectives. *Human Resources for Health*, 92 (3), 71-81.
- Perker, A. S., Harding, A., and Travis, P. (2000). Make or Buy. Decisions in the production of health care goods and services: New services from Institutional economics and organizational theory. *Bulletin of Psychology*, 102(2), 89-92.
- Sachs, J. D. (2013). High stakes at the UN on the Sustainable Development Goals. *Lancet*, 21: 382, (9897):1001-2.
- Smith J. (2004). Transnational processes and movements: The Blackwell companion to social movements, *African Journal of Social Science*, 23(2), 311–335.
- Smith, K., & Sulzbach, S. (2008). Community-based health insurance and access to maternal health services: Evidence from three West African countries. *Social Science & Medicine*, 66, 2460-2473.
- Tajudeen, E. R., Ifeanyi, P. A., & Owoeye, M. A. (2015). Accelerating health equity: the key role of universal health coverage in the Sustainable Development Goals. *BMC Medicine*, 13(2), 101-109.
- Takian, A. & Akbari-Sari, A. (2016). Sustainable health development becoming agenda for public health academia. *Iran Journal of Public Health*, 45(2), 1502-1522.
- Tangcharoensathien, V., Oyeneye, W. M., A., & Jafarudeen, K. P. (2019). Accelerating health equity: The key role of universal health coverage in the Sustainable Development Goals (SDG's). *BMC Medicine*, 23(2), 106-111.
- Trujillo, A., Portillo, J. & Vernon, J. (2015). The impact of subsidized health insurance for the poor: Evaluating the Colombian experience using propensity score matching. *International Journal of Health Care Finance and Economics*, 5, 211–239.
- Wagstaff, A. & Lindelow, M. (2008). Can insurance increase financial risk? The curious case of health insurance in China. *Journal of Health Economics*, 27 (4), 990-1005.
- Wagstaff, A. (2007). The economic consequences of health shocks: Evidence from Vietnam. *Journal of Health Economics*, 26, 82-100.

Wagstaff, A., & Yu, S. (2007). Do health sector reforms have their intended impacts? The World Bank's Health VIII project in Gansu province, China. *Journal of Health Economics*, 26, 505–535.

Willmann, J. H. (2012). Advocating for nursing through public policy. *Perioperative Nursing & Clinical Practice*, 13;7(4):367-74.

Woodward, B., Smart, D., & Benavides-Vaello, S. (2015). Modifiable factors that support political participation by nurses. *Journal of Professional Nursing*, 16, (2), 23-29.

Official Documents

Cotlear, D., Somil, N., Ajay, T. & Rafael, C. (2019). Going universal: How 24 developing countries are implementing universal health coverage from the bottom up. World Bank Publications.

FMoH, (2009a). Nigeria demographic health survey of 2008. Federal Ministry of Health and ORC Macro., XVI, 178-181.

Gustafsson-Wright, E., Tanović, Z., & van der Gaag, J. (2013). The impact of private subsidized health insurance and clinic upgrades on health care utilization and financial protection in rural Nigeria Amsterdam: Amsterdam Institute for International Development.

Kramer, B., Osagbemi, G. K., Tanović, Z., & Gustafsson-Wright, B. S. (2013). The impact of subsidized health insurance on hypertension in rural Nigeria: A population-based study. Amsterdam: Amsterdam Institute for Global Health and Development.

Perry, H. & Zulliger, R. (2012). How effective are community health workers? Johns Hopkins Bloomberg School of Public Health: Baltimore (USA).

The World Health Organization. (2009). WHO country cooperation strategy 2008-2013: Nigeria. Republic of Congo: World Health Organization, 2009. p. 8.

UNDP (2011). Human development report 2011: Sustainability and equity: A better future for all. New York: United Nations Development Programme.

United Nations Children's Fund, (2014). Access to healthcare through community health workers in East and Southern Africa. Bulletin of the United Nations Children's Fund: New York.

Conference/Seminar/Position Papers

- Alhassan, R. & Okonji, T. A. (2019). Africa's got work to do: Employment prospects in the new century. Excerpt from the Proceedings of the 239th Summit on employment index in Sub-Saharan Africa. International Monetary Fund: Washington DC, XVI, 1073-1086.
- Carrin, G. (2003). Community-based health insurance schemes in developing countries: Facts, problems and perspectives. Discussion Paper No. 1. Geneva: World Health Organization
- Dutta, A., & Hongoro, C. (2013). Scaling up national health insurance in Nigeria: Learning from case studies of India, Colombia, and Thailand. Washington, DC: Futures Group, Health Policy Project. pp. 3-4.
- Dutta, A., & Hongoro, C. (2013). Scaling up national health insurance in Nigeria: Learning from case studies of India, Colombia, and Thailand. Washington, DC: Futures Group, Health Policy Project. p. 1.
- Opatunde, H. & Zachariah, A. B. (2019). How effective are community health workers? Johns Hopkins Bloomberg School of Public Health: Baltimore (USA), Research Paper XIX, 1020- 1034.
- Wagstaff, A., & Moreno-Serra, R. (2007). Europe and central Asia's great post-communist social health insurance experiment: Impacts on health sector and labor market outcomes. World Bank Policy Research Working Paper, 4371. Washington, D.C
- Wagstaff, A., Lindelow, M., Junc, G., Ling, X., & Juncheng, Q. (2007). Extending health insurance to the rural population: An impact evaluation of China's new cooperative medical scheme. World Bank Impact Evaluation Series No. 12.
- WHO. (2008a). World health statistics, 2008. Geneva: World Health Organization.
- WHO. (2008b). World health statistics, 2008. Geneva: World Health Organization.
- WHO. (2010). Health systems financing: The path to universal coverage. Geneva: World Health Organization.
- Yip, W. & Hsiao, W. (2008). The impact of rural mutual health care on access to care: Evaluation of a social experiment in rural China. Harvard School of Public Health.

Internets

Chan, M. (2013). Opening remarks at a WHO/World Bank ministerial-level meeting on universal health coverage. Geneva: WHO. Available at:
www.who.int/dg/speeches/2013/universal_health_coverage/en/

Department of Health, (2015). Major Health Indicators: Managed-care analysis. Accessed on the 9th of May, 2021]. Retrieved from:
http://www.healthcareindicators_djhospital.disponível em:
http://www.healthyhk.gov.hk/phিসweb/en/healthy_facts/health_indicators/

Food and Health Bureau (2014). Consultation document on voluntary health insurance scheme. Hong Kong: Food and Health Bureau; Dec. 193 p.
http://www.vhis.gov.hk/doc/en/full_consultation_document/consultation_full_eng.pdf

Global Health Strategies, (2013). Health for all, universal health coverage day. Available at:
www.universalhealthcoverageday.org/en/

Kim, J. K. (2013). Poverty, health and the human future. Geneva: World Health Assembly, 2013. Available at: www.worldbank.org/en/news/speech/2013/05/21/world-bank-group-president-jim-yong-kim-speech-atworld-health-assembly.

National Health Insurance Scheme (NHIS). Retrieved on 14 June 2013 from
http://nhis.gov.ng/index.php?option=com_content&view=article&id=47:welcome-note-from-executive-secretary&catid=34:home.
Nigeria: Country profile. Retrieved on 17 June 2013 from
<http://data.un.org/CountryProfile.aspx?crName=Nigeria>.

The World Bank. (2011). Nigeria summary report. Retrieved on 17 June 2013 from
<http://iresearch.worldbank.org/PovcalNet/index.htm?2>.

The World Databank. (2010). Maternal mortality ratio (modeled estimate, per 100,000 live births). Retrieved on 17 June 2013 from
<http://data.worldbank.org/indicator/SH.STA.MMRT>.

The World Databank: Health Nutrition and Population Statistics, (2010). Adults (age 15+) and children (0-14 years) with HIV. Retrieved on 17 June 2013 from <http://databank.worldbank.org/data/views/reports/tableview.aspx>.

The World Databank: Poverty and Inequality Database (2011). Retrieved on 17 June 2013 from
<http://databank.worldbank.org/data/views/reports/tableview.aspx>.

The World Databank: Poverty and Inequality Database, (2010). Retrieved on 17 June 2013 from
<http://databank.worldbank.org/data/views/reports/tableview.aspx>.

The World Databank: World Development Indicators. (2011). Retrieved on 17 June 2013 from <http://databank.worldbank.org/data/views/reports/tableview.aspx?isshared=true&ispopular=series&pid=1>.

The World Bank. (2011). Nigeria population total. Retrieved on 17 June 2013 from <http://data.worldbank.org/country/nigeria>; United Nations Statistics Division.

United Nations General Assembly Resolution on Global Health and Foreign Policy (2013). A/67/L.3 approved 2012 December 10. Available at: www.un.org/press/en/2012/ga11326.doc.htm

Wagstaff, A. (2013). Universal health coverage: Old wine in a new bottle? If so, is that so bad? Retrieved on 19 June 2013 from <http://blogs.worldbank.org/developmenttalk/universal-health-coverage-old-wine-in-a-new-bottle-if-so-is-that-so-bad>.

WHO, (2014). Universal health coverage. Accessed May, 2021; from: <http://www.who.int/mediacentre/factsheets/fs395/en/>

WHO. (2011). Global health observatory data repository. Retrieved on 19 June 2013 from <http://apps.who.int/gho/data/node.main.75?lang=en>.

World Health Organization, (2012). What is universal health coverage? Available at: www.who.int/features/qa/universal_health_coverage/en/

World Health Organization, (2014). WHO global forum for government chief nursing and midwifery officers, 14-15 May 2014, Geneva, Switzerland: Nursing and Midwifery Workforce and Universal Health Coverage. Forum Statement [Internet]. 2014 May [updated 2019 May]; Retrieved from: http://www.who.int/hrh/events/global_forum_chiefnursing/en/

World Health Organization, (2015). Universal health coverage (UHC). [Internet]. Sep [updated 2014 Sep]; ; [Acesso 1 jul 2021]; Disponível em: <http://www.who.int/mediacentre/factsheets/fs395/en/>