**ACHIEVING UNIVERSAL HEALTH COVERAGE IN NIGERIA THROUGH HEALTH FINANCING**

**ANIEFIOK UDO**

**Department of Economics, University of Calabar,**

**phone:** +2348034042129 **email:** **aniefiok.benedict@gmail.com**

**Co-authors:**

**IBORO NELSON Department of Economics, University of Uyo**

**JEREMIAH OLU Department of Economics, Kogi State University**

**INTRODUCTION**

UHC entails that citizens have access to the health care services needed without undue financial hardship. This consist of three interrelated components: the population covered, the range of services made available; and the extent of financial protection from the costs of health services. Health is a priority for the state and a social obligation for all citizens but Nigerian health care funding is grossly inadequate with budgetary provision to health barely exceeding 3% of the country’s total budget. Also, there is lack of incentives for health providers to set up facilities in rural areas (inequity of access). Public health expenditures in Nigeria account for only 20-30% of total health expenditures, while private expenditures accounts for the remaining 70-80%. Again, there is lack of provision for the potential exclusion of those unable to pay from the national health insurance scheme (NHIS) or setting premiums for poorer people (inequity in finance). Nigeria is still ranks low among the World Health Organisation (WHO) member nations. The dominant private expenditure is through out-of-pocket, and this accounts for more than 90% of private health expenditures. This study seeks to examine the nexus between public health care financing and achieving UHC in Nigeria.

**METHOD**

The study utilizes multivariate logistic model as empirical technique in analyzing primary data collected through personal interview from randomly selected sample size of 720 households. 20 each from six villages of the two local government area chosen from the three senatorial districts in Akwa Ibom state.

**RESULT/CONCLUSION**

The result shows that 64.3 percent had only accessed the health facilities less than 4 times within the month for childhood related treatment, while 35.7 had accessed the health facility more than five times within the month. Also the findings reveals that the high levels of infant mortality rate was associated with the high incidence of out-of-pocket payment, and the wide disparity and inequality in income distribution. The study further observed an inequality in the distribution of health facilities, more in urban while less in rural areas. The study therefore recommended among other things that increase in public health spending is required to reduce the burden of cost of health services in the rural areas.