



Achieving The Sustainable Health Development Goals In Nigeria: The Place Of Health Micro Insurance

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ABSTRACT: *The importance of good health to individuals and the society as a whole has been severally documented in literature. Good health promotes societal well-being through its ability to facilitate increased productivity. It is therefore not surprising that the third goal of the SDGs is good health and well-being being with the specific objective to ensure healthy lives and promote well-being for all at all ages. This goal must be achieved globally by 2030, in the next twelve years. Nigeria however, like many other low and middle income countries grapple with providing adequate health care for its people, and many of the poor and vulnerable in the countries are hardly able to fund their health needs without experiencing catastrophic health expenditure. Given the inability of the government to single-handedly fund the health needs of the teeming population of Nigerians, this study examined the import of a fast growing system of micro insurance - Micro Health Insurance – specifically designed to provide health insurance for low-income market, as a practicable means of raising funds to financing the health needs of the poor and vulnerable in Nigeria and to help achieve the third sustainable development goal by increasing access to health services in the country.*

KEY WORDS: SUSTAINABLE DEVELOPMENT GOALS; MICROINSURANCE; HEALTH MICRO INSURANCE; CATASTROPHIC HEALTH EXPENDITURE; NIGERIA,

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I. INTRODUCTION

The 2030 Agenda for Sustainable Development was adopted by the United Nations General Assembly on 25 September 2015. These new set of development goals are collectively called the Sustainable Development Goals (SDGs) and they became globally applicable in January 2016. The SDGs cover a wide range of issues bordering on development and general wellbeing. These issues include ending poverty and hunger, improving health and education, achieving gender equality, fostering innovation, promoting sustainable growth, combating climate change, and encouraging global partnership.

The third goal of the SDGs is good health and well-being being with the specific objective to ensure healthy lives and promote well-being for all at all ages. According to the United Nations Development Programme (UNDP), one of the leading organizations working to fulfil the SDGs by the year 2030, the main crux of the third goal is to make sure everyone has health coverage and access to safe and effective medicines and vaccines including financial risk protection by 2030 irrespective of their socio economic status.

The intents of the third goal of the SDGs may be attributed to the import of health to individuals and the society at large. Improved health status helps to accelerate the achievement of development objectives such as increased productivity and income growth and good health is a source of social, economic and personal development (WHO (1978); World Bank (2005); Jamison, Summers, Alleyne, Berkley, Binagwaho, ..., Yamey(2013); Nicholson, Yates, Warburton and Fontana (2015), Oyediran and Onikosi-Alliyu, 2015). Thus good health as proposed in goal three is closely linked with all the SDGs.

Despite the import of good health to societal well-being, available statistics reveal that health status in many African countries including Nigeria is deplorable. Many Africans die from treatable health conditions. Malaria, pneumonia, diarrhoea, measles, cholera, meningitis and HIV/AIDS are identified as the highest killers in Nigeria (Unicef (2015), Muanya (2016), Owoseye, (2018)). According to the National Strategic Health Development Plan (NSHDP) (2010) Nigeria shoulders 10% of the global disease burden with majority of the people dying from treatable diseases. Most of the deaths and misfortune associated with poor health statistics

occur among the poor and low income earners because of their inability to afford adequate basic health care services.

Scholars generally agree that access to insurance services is an important strategy for alleviating poverty and improving a people's standard of living Nwaebuni (2017). However, due to high and unaffordable premiums, the poor are often exempted or inadequately serviced by the private insurance market thus prompting the need for another system of insurance.

Micro-insurance is a specific type of insurance particularly developed to protect the poor. Three critical features which distinguishes micro-insurance schemes from other insurance schemes and makes it possible for the scheme to cater for the needs of the low income earners are, low transactions cost which also reflect members' willingness to pay; low-net-worth clients (but not necessarily poor clients); and the fact that these forms of insurance are set up to enhance risk management of the members of the entire pool of micro-insurance units over and above what each can do when operating as a stand-alone entity (fundsformgos, 2009).

A fast growing system of micro insurance is the Micro Health Insurance - a financial arrangement that protects the poor and vulnerable against specific health shocks in exchange for regular considerable premium payments (Churchill, 2006). There is growing evidence of the impact of micro insurance worldwide. Health literature consistently stresses that fact that dependence on out-of-pocket payments for health care particularly in developing countries are among the main reasons people remain in poverty in these counties because the poor are often exposed to catastrophic health expenditure and their inability to work due to ill health results in loss of income and/or assets depletion (Klapper, El-Zoghbi and Hess, 2016).

The basic proposition of this study is that micro health insurance can provide a channel for alleviating the risks of health emergencies associated with health shocks and thus help to achieve the third sustainable development health goal. Therefore, the intent is to provide information on the concept of Micro health insurance as a means of financial protection for low-income households through an explorative study of the concept and its relative effectiveness by examining its advantages and benefits. Following the introductory section is the statement of problem which provides a brief overview of the health situation and health insurance atmosphere in Nigeria to justify the need for a mini-scheme such as the HMI that may be more user-friendly and accommodating of all irrespective of income level and source of employment. Thereafter, the paper presents a review of the concept of micro-insurance and health micro insurance (HMI) to provide a broad knowledge of the concept and its operations. The next section presents a discussion of the benefits and advantages of Micro insurance and HMI alongside literature review highlighting the success of micro health insurance in other countries to draw some salient lessons for Nigerian policy makers. The last section is the concluding remarks.

II. STATEMENT OF THE PROBLEM

The MDGs can be said to have achieved significant progress in a number of areas, howbeit this progress has been uneven particularly in low and middle income countries. Since the inception of the MDGs in 1990, UNICEF according to Childs (2015) has reported a 44 percent decrease in the global numbers of primary age children out of school; 41 percent reduction in stunting -a key marker of undernutrition and a 53% reduction in the global mortality rate for children younger than five years old. These positive indicators however represent international averages and pales as UNICEF (2015) again reports that the majority of the children in low and middle countries are still dying from preventable diseases. Based on their projection using current trends in child mortality, 68 million children under the age of five will die of mainly preventable causes by 2030 except the trend is altered. Efforts of the MDGs may have been focused on the easiest-to-reach children and communities, and not those in greatest need. Muanya (2016) and Owwoye (2018) also reports that many Nigerians are dying from treatable health conditions even after the MDGs in 2015.

The new Health Goal in the SDGs is fairer and more ambitious than the MDGs: the goal is to reach everyone irrespective of their health and socio economic status. This means efforts must be focused particularly on the poor and vulnerable who find it difficult to fund their health needs without experiencing catastrophic health expenditure, and those in the rural areas with poor and near-absent health facilities. These are usually the hardest to reach, and therefore the ones for whom more attention must be given.

Low income earners need a system of co-payment particularly to fund their health needs. Micro health insurance provides a very viable opportunity to make this possible particularly for the teeming population of Nigerians who live in abject poverty and are still faced with harsh economic conditions. However, the scheme must be accepted by the populace for it to find relevance. If embraced, it may just be the panacea for poor health among Nigerians and a leeway for achieving the third SDG without much ado in the country.

Health insurance in Nigeria is mostly handled by the National health Insurance Scheme (NHIS) an agency established for the purpose of facilitating easy access of health care services to all Nigerians. Even though the primary goal of the scheme is to improve the health status of Nigerian citizens as a significant co-factor in the national poverty eradication efforts, the program focuses mostly on employees in the public sector

and organised private sector, ignoring on a large scale the informal sector which is made up of the poor and vulnerable in Nigeria. The community based health insurance scheme under the NHIS targeted at rural dwellers has not recorded any significant success since its inception (Odeyemi, 2014).

Examining the prospects and challenges of micro insurance in Nigeria, Mohammed and Muktar (2012) noted that income level, educational attainment and property ownership, availability of infrastructural facilities in the rural areas were basic determinants. The implications of these findings will be that most rural dwellers may not demand HMI because of low income level, low level of educational attainment and poor health infrastructures. Adeyemo, Odetola and Yusuf (2017) noted that rural dwellers demanded for micro insurance based on the value they placed on their businesses. By implication, if they place high value on their health, then they will see the need to demand for micro health insurance.

III. CONCEPTUAL REVIEW

The International Labour Organisation (ILO) coined the term 'micro-insurance' in 1999. The term has been defined in different ways though the crux of its meaning remains the same. Dror and Jacquier (1999) saw micro-insurance as the use of insurance as an economic instrument at the "micro" (i.e. smaller than national) level of society while Preker, Carrin, Dror, Jakab, Hsiao and Arhin-Tenkorang (2002) regarded the term as being synonymous to community-based financing arrangements. Generally the term is used to refer to protection of assets and lives against insurable risks of target populations (IRDA Concept paper, 2004) or a financial arrangement to protect low-income people against specific perils in exchange for regular premium payments proportionate to the likelihood and cost of the risk involved (Churchill 2006). In 2012, Tan, Allen and Overy (2012) extended the definition by defining the range of income involved. They defined micro-insurance as the protection of low-income people (those living on between approximately \$1 and \$4 per day) against specific perils in exchange for regular premium payment proportionate to the likelihood and cost of the risks involved. Generally, insurance operates on risk pooling, and so does micro-insurance.

Micro-insurance is not so described because of the size of the institution but rather because of the small transactions on which these organisations are founded (Develtere, Doyen and Fonteneau, 2004) and the tendency to include a target population typically consisting of persons ignored by mainstream commercial and social insurance schemes, as well as persons who have not previously had access to appropriate insurance products (Tan, Allen and Overy, 2012). Develtere, Doyen and Fonteneau (2004) further noted that these micro institutions are unique because its members make only relatively small financial contributions. Secondly, the 'micro' is also to be understood in relation to the proximity, or short distance, between the members and the institution. Thus micro-insurance does not describe the size of the risk-carrier, but the scope of the risk the delivery channel since it can be delivered through a variety of different channels, including small community-based schemes or enormous multinational insurance companies (Churchill, 2006). Also as observed by Llyods - the world's leading specialist insurance market - micro insurance is not charity, it is business even though there is no easy money to be made from it.

Because of the element of social exclusion identified with the target population for micro insurance, Dror and Jacquier (2001) further identified three characteristics that makes micro insurance adequate for vulnerable groups on the informal sector – simplicity, affordability and proximity. Simplicity is important since the target population are often not adequately educated to cope with excessive procedural complexities. This characteristic also makes micro insurance approachable to the poor and uneducated. While affordability is defined by the flexibility of micro insurance which enables its affiliates to pay when they can due to the erratic nature of their income flow, proximity ensures that the micro-insurance units are close to the target population, simply because the poor or members of the rural population may not be able to afford the luxury of travelling to service.

Because of its distinguishing features, micro-insurance is often recognized as a useful tool in economic development since it has the ability to sustain the livelihood of the vulnerable and poor in the society by making it possible for them to take more risks. Dercon (2005) cited the example of farmers who when insured against a bad harvest (resulting from drought), are better able to grow crops which give high yields in good years, and bad yields in year of drought. The reverse may be the case if farmers have to safeguard a minimal level of income for themselves and their families. Without insurance, crops will be grown which are more drought resistant, but which have a much lower yield even when the weather is good. There is growing evidence of the impact of micro insurance worldwide, even in Africa. It is estimated to cover about 500 million risks worldwide, up from 135 million in 2009. In Africa, micro insurance grew by 200 per cent between 2008 and 2012, with more than 44.4 million low-income lives and properties covered in 39 countries (McCord et al, 2012). Nigeria is however not identified with this growth process.

Micro-insurance schemes have been found to be very useful where there is need to enhance social protection. Although the scheme is relatively new, it is gaining ground particularly in the health sector where it is increasingly being found to be capable of protecting low income families from catastrophic health expenditures and providing financial protection for those covered under the scheme.

HEALTH MICRO INSURANCE (HMI)

Many of the world's poor have limited access to adequate health care. This group of people often cite financial barriers as reasons for delaying or deferring or completely avoiding seeking health care (Kimani, 2014; Chandani and Garand, 2013). When care is sought, the resulting effect can be catastrophic and impoverishing (Adisa, 2015). Thus the poor often remain sick, with deteriorating health and lowered well-being. HMI holds great promise in expanding access to health protection for the poor particularly in the rural areas of low income countries where the majority of the poor live.

HMI is broadly defined as the provision of health insurance for the low-income market. Several terms have been used to describe HMI. While some refer to it as mutual health insurance or health service funds, others prefer to describe the scheme as community-based health insurance (or financing) or micro-health insurance. Irrespective of the identity adopted, HMI is a form of micro-insurance in which resources are pooled to mitigate health risks and cover health care services in full or in part. The scheme can be provided by government, a private insurance company, or an NGO (findsforngos, 2009).

Develtere *et al* (2004) identifies some basic features of HMI which distinguishes it from other forms of insurance and also makes it a veritable tool in the field of health care. HMI is specifically focused on offering protection against the financial difficulties imposed by health problems. It does this by pooling the financial contributions of enrolees and spreading the health risks between them. Since it is members' financial contributions that keep the scheme afloat, HMIs seek to develop a premium collection system that is suitable for the local population and which coincides with periods when members collect or earn incomes. Unlike regular insurance companies, HMI's premium does not reflect the risk, but the service provision. It is more interested in offering financial protection from catastrophic illness.

Membership in HMI is voluntary except done on a group basis where members of the group necessarily become members of the system. The schemes are not set up for profit maximization. Nevertheless financial health is encouraged since excess cash increases reserve will help expand service delivery while encouraging reduced premium payment. Usually, clients are extremely sensitive to benefits, costs, and how health services are rendered—so generating demand is not easy; a situation compounded by poor “insurance literacy” and mistrust (Chandani and Garand 2013). Consequently, No micro-insurance institution can function properly unless the activities or services it offers satisfy the needs of its members who must also have confidence in the care providers and the people who run the institution. Thus member-involvement in running HMIs is necessary for it to succeed.

Chandani and Garand, (2013) noted that the presence of HMIs can induce moral hazard by inducing greater utilisation of health care but can also change morbidity patterns by preventing deaths since it increases access to health care. It has been demonstrated that insured persons visited health facilities more often than uninsured persons (Kihale, 2015, Wagstaff, 2007, Devadasan, Crie, Van-Damme, Ranson, and Vander-Stuyft (2007). Out-of-pocket expenses for health care has also been found to reduce drastically with HMI. More so, ILO (2014) noted that access to health services and insurance is associated with a reduction in maternal and child mortality and that extending accident and health insurance to all members of a household lowered the incidence of child labour.

In many developing countries, the formal sector has to some extent been able to provide some form of social protection for its employees though evidence suggests that coverage is rather limited and often times inadequate. These countries often lack the resources and administrative capacity to administer social protection (in any form) to the relatively large informal sector. Generally, insurance companies which are profit driven will naturally charge premiums which are proportionate with the level of risks involved. If this system is applied in the provision of health insurance, then the elderly and the chronically sick will be forced to pay much higher premiums than the young and the healthy. Where these group of persons cannot afford the required premium, they become solely responsible for their health needs and the resulting effect can be catastrophic. HMIs which are specifically designed to provide protection for low income people can help fill in this gap in the society.

MODELS OF HMI

India has the highest concentration of HMI programs in the world (Koven, 2013). Ten years ago in Dalal (2008) observed that 35 million households in India fall below the poverty line every year because of a health shock and HMI was considered the most important protection mechanism for low income households that are particularly susceptible to health shocks because of their low saving buffer and poor living conditions.

Borrowing from the works of Dalal (2008), Chandani, (2009), Chandani and Garand, (2013), and Dror and Piesse (n.d.) the following models have been used successfully to market HMI and Nigeria can adopt any of the models.

- i. **Partner-Agent Model:** This is the dominant HMI delivery model in India. In this model the insurance company, i.e., the partner, takes responsibility for designing, pricing, and underwriting of products as well as for the scheme's solvency in the long-term (Dror and Piesse, 2014) in partnership with delivery channels or intermediaries, i.e., the agent, (e.g., microfinance institutions (MFIs) or cooperatives) whose tasks include distribution and marketing, premium collection, and product servicing. They may also involve third-party administrators (TPAs) as noted by Chandani and Garand, (2013). Basically, the idea is for mainstream insurance companies to partner with microfinance institutions and NGOs. The insurance companies design the products and bear the actuarial risks while the NGOs and MFIs act as the delivery channel and earn a commission for their effort (Dalal, 2008).
- ii. **Community-based health insurance (CBHIs):** also known as mutual health organisations, which are not-for-profit associations based on member solidarity and participation that typically are governed by non-insurance regulations (Chandani and Garand, (2013)). With this model, communities are allowed to be actively involved in designing their own insurance package by involving them actively at the designing stage. In India for instance, a tool called CHAT (Choosing our HealthPlan Together) was used to help community members understand the trade-offs between covering illnesses within the plan and the associated costs (Dalal, 2008). A key characteristic of community-based schemes is that they are formed at the community level by people who are uninsured, who come together for the purpose of pooling their risks. They promote participatory decision-making and group solidarity with the group defining the products offered (Chandani, 2009). Summarily, the insured are at the same time the insurer and the needs of the members can better be mirrored in the benefit package.
- iii. **Health-provider managed insurance schemes:** The unique feature of this model is the involvement of the healthcare provider in the design and management of the HMI. Healthcare providers may launch an insurance scheme to facilitate access to health services for specific segments of population, and/or generate larger volumes of activity in a network of facilities (Deglise, 2016). For instance, a health center in this model may offer users a reduction in health expenses, typically for a defined package of services, in exchange for the payment of a premium (Chandani and Garand, 2013) from policyholders. They are, in turn, allowed to use the services of this provider according to the conditions that have been agreed upon in the insurance policy for free or with a co-payment. The model is also known as the provider-driven model (Dror and Piesse, 2014)
- iv. **Social health insurance programs:** These are conceived and funded by governments (through general or payroll taxes), sometimes in partnership with private insurers, administrators and non-state delivery channels (such as community groups or co-operatives) (Chandani and Garand, 2013).
- v. **Charitable insurance model:** According to Dror and Piesse (2014), in this model, an external charitable organisation supplements the HMI scheme financially. The organization basically takes over all responsibilities of the "insurer" and ensures its long-term sustainability through subsidization.

IV. EMPIRICAL LITERATURE ON HMIS AND LESSONS FOR NIGERIA

Poverty is still a harsh reality for most of humanity even in the 21st century. About 80% of the world's population live on less than \$10 a day and nearly 50% live on less than \$2 a day while 100 million households are pushed into poverty each year as a result of paying for health care (World Bank Development Indicators, 2008, WHO, 2010, 2018). Health literature consistently stresses the fact that dependence on out-of-pocket payments for health care particularly in developing countries are among the main reasons people remain in poverty in these counties (Adisa (2015), Sahoo and Madheswaran (2014), Mwandira (2011)). Unregulated direct charges often constitute a major access barrier to needed health care and pushes the burden of medical costs on the poor and sick people especially in the absence of an efficient public health system (Pannarunothai and Mills 1997; Frenk and Knaul 2002). Because of their inability to work, the sick are often exposed to income loss and/or assets depletion to confront health costs (Klapper, El-Zoghbi and Hess, 2016). Some countries have been able to use MHI to mitigate this trend because of the following benefits associated with HMI.

MHI has the ability to reduce inequity in access to health services. Yang (2013) assessed the effectiveness of China's New Cooperative Medical Scheme (NCMS) established to tackle the deterioration in access to health services and inequity problems in rural areas of China. Results from the study showed that the NCMS was able to reduce income-related health inequity in doctor and preventive care, though the contribution was small. The study recommended a more comprehensive health insurance package for the poor in order to

achieve the desired goal of equity in access to health care. Liang and Lu (2014) also reported that participation in NCMS improved the general health of the elderly in China.

MHI can facilitate the achievement of universal health coverage (UHC) in developing countries. Lu, Chin, Lewandowski, Basinga, Hirschhorn, Hill, Murray and Binagwaho (2012) reported the relative effectiveness of Mutuelles - a HMI - to reduce out-of-pocket payments and incidence of CHE among households in Rwanda which are necessary conditions for achieving UCH. The study by Dror, Majumbara, Pandaa, John and Koren (2014) corroborates this view and provided empirical evidence of the development of health insurance driven by the beneficiary communities in rural Nepal. Their study noted that the MHI schemes examined were successful in retaining many/most enrollees beyond the original one-year contract and in attracting many new enrollees. The experience provides evidence that MHI can successfully help in overcoming one of the most challenging obstacle to UHC in the informal sector in low-income countries, namely, generating contributions from rural poor populations. According to Dror et al (2014), where the CHBI scheme is adopted, partial coverage is financially and administratively possible and the rural poor can be convinced to contribute for health insurance at the micro level.

MHI can help reduce poverty. In a study by Hamid, Roberts and Mosley (2011), using household level primary data collected from the operating areas of the Grameen Bank during 2006, results showed that MHI had a positive association with household income which was statistically significant. This significant impact was said to be generated via improvements in health which increased household's productive capability and their income generating power. The study concluded adding MHI to microcredit schemes can contribute to improving the poverty status of household. This conclusion corroborates the findings of Liu, Rao and Hsiao (2003) who noted that increasing access to health care might decrease the poverty impact of medical expenses by improving the population's health and enabling the poorest households to lift themselves out of poverty. The World Bank Group also supports the notion that micro insurance can be an effective complement to helping households avoid poverty traps Maleika and Kuriakose (2008).

HMI can increase households' consumption by reducing precautionary saving. In 2003, the Chinese government launched the New Cooperative Medical Scheme (NCMS) specifically intended to cover the rural residents in China. The scheme was aimed at increasing rural access to health care, reduce the burden of rural health expenditures and reduce precautionary saving or self-insurance which rises due to lack of completeness of insurance markets. Cheung and Padiou (2013) investigated whether participating in NCMS decreased household precautionary saving rate and encouraged consumption in rural China. Their study revealed NCMS reduced the income risk or precautionary saving of participants of low and middle income households and enabled them to access more consumer goods.

HMI can help low-income people manage risk and reduce their vulnerability to shocks. Particularly for poor women in the rural areas of Guinea, India and Kenya, HMI and other forms of microinsurance have been reported as life savers to rural women. For instance, according to the ILO (2010) a French NGO called *Centre International de Développement et de Recherche* (CIDR) has developed a health insurance product with maternity cover and sold at the village level in Guinea. In India, SEWA Bank offered all self-employed poor women a choice of three microinsurance schemes covering death, health and assets. Maleika and Kuriakose (2008) describes microinsurance schemes as flexible and powerful instruments, which reduces vulnerability and mitigates the negative effects of external shocks on poor households. In Burkina Faso, Parmar, Reinhold, Soares, Savadogo and Sauerborn (2012) reports how HMI protects and increases households' assets. Very often in the face of health shocks, poor households have been noted to sell off assets in order to fund their medical expenses. HMI protects such households.

HMI can protect households from catastrophic health expenditure (CHE). Studies by Chankova, Sulzbach and Diop (2008) in Ghana, Dekker and Wilms (2010) in Uganda, Kihale (2015) in Tanzania, all reveal that insured households were protected from CHE in the event of a health shock when compared to uninsured households. For uninsured households, direct out-of-pocket payment for health services were significantly higher which increased their risk of being exposed to CHE.

HMI increases access to health services by the poor and vulnerable. HMI has been very effective in increasing access to health care for the teeming Indian poor population and India has the highest concentration of HMI programs in the world (Koven, 2013). This is understandable given its population and the fact that healthcare financing largely relies on direct out-of-pocket spending. Reliance on OOP spending for health increases health-related financial burdens for the poor in India and according to Balarajan, Selvaraj and Subramanian (2011), nearly 39 million people in India are pushed into poverty because of ill health every year. According to Yee (2015) India accounts for 65% of Asia's micro-insurance market with some 37 million poor families signed up to *Rashtriya Swasthya Bima Yojana*, or national health insurance programme. Increasing access to health services in India has helped to prevent already vulnerable people being propelled into further privation.

CONCLUDING REMARKS

The United Nation in 1948 proclaimed that every member of society has the right to social security, including access to health care. 63 years after this proclamation, Bachelet (2011) reported that 75 per cent of the world's population lacks adequate protection from financial hardship associated with health expenditure and approximately 40 per cent lacks even basic protection.

Despite the import of good health to societal well-being, available statistics reveal that health status in many African countries including Nigeria is deplorable. The WHO Country Cooperation Strategy, 2008-2013 for Nigeria reported very dismal statistics for Nigeria. For instance, less than 20% of health facilities provide emergency obstetric care (EOC) services, and only 36% of deliveries are attended by skilled personnel. The report also has that most of the deaths among children are due to treatable diseases such as malaria (24%), pneumonia (20%), diarrhoea (16%), measles (6%) and HIV/AIDS (5%), with malnutrition contributing to about 60% of the deaths.

The pursuit of the Millennium Development Goals (MDGs) in Nigeria did not significantly alter the statistics described above. The Nigeria's End-Point-Report on the health related MDGs (2015) for goals four and six which has to do with reducing child mortality and combating HIV and AIDS, malaria and other diseases reports that the goals were not met. UNICEF (2015) reported that every single day, Nigeria lost about 2,300 under-five year olds and 145 women of childbearing age making the country the second largest contributor to the under-five and maternal mortality rate in the world. Preventable or treatable infectious diseases such as malaria, pneumonia, diarrhoea, measles and HIV/AIDS account for more than 70 per cent of the estimated one million under-five deaths in Nigeria.

Most of the deaths and misfortune associated with poor health statistics occur among the poor and low income earners because of their inability to afford adequate basic health care services. Thus when planning for health, low-income populations often need additional attention specifically because persons living in poverty are considerably more likely to be in poor health and to have disabling conditions. Low-income earners have a myriad of accessibility limitations. They also have less access to healthcare services, eat less nutritious food. Many poor people do not have health-insurance coverage consistently throughout the year which compounds their other disadvantages (Johnson and Miller, n.d.).

MHI has been identified as possessing characteristic that can help mitigate the health problems in Nigeria and thus sustain the country on the path of achieving the SDGs come 2030. To reiterate, such benefits include low premiums, protecting the poor and their assets from negative external shock and compensating the effects of covariate shocks, addressing gender-specific vulnerabilities, freeing up household capital for investment and increasing present consumption through a reduction in precautionary savings, helping households avoid poverty traps, expanding informal insurance schemes, increasing rural access to health services and most importantly, fast tracking the achievement of UHC in low income countries. To achieve the third SDG and prevent Nigerians – particularly the poor and vulnerable – from becoming poor or further impoverishment due to illness, natural disaster, lack of savings, or loss of assets or livestock, Nigeria must intentionally the growth HMI.

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