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Influence of Awareness, Extent of Illness Coverage and Implementation of Universal Health Coverage on Mental Disorders in Nigeria

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Abstract
This study investigated the influence of awareness, extent of illness coverage and implementation of Universal Health Coverage on Mental Disorders in Nigeria. Five hundred participants were selected through stratified random and convenient sampling; participants were selected from the various geopolitical zones in Nigeria between ages 21 to 55 with a mean age of 31.796. Three hypotheses were postulated and tested; two instruments were used in the study comprising Mental Health Coverage Scale (MHCS) and Mental Disorder Questionnaire (MDQ). A cross sectional survey design was adopted; three – way ANOVA was used for data analysis. Results showed that awareness, extent of illness coverage and implementation of Universal Health Coverage does not directly influence mental disorders in Nigeria. However, it was recommended that government at different levels make healthcare coverage available to the people while citizens should key to the insurance schemes for a healthy nation.

Keywords: ***Awareness, Universal Health Coverage, Mental Disorders, Implementation, Illness coverage.***

Introduction

Decades ago, the concept of universal health coverage has been a global challenge in the health sector. This led to the evolving of the concept under primary health care. In the developing world, the awareness, extent of Universal Health Coverage (UHC) of illness available and their implementation on mental disorders have remained a great concern of mental health workers and the general public. Therefore, the level of awareness, extent of coverage and level of implementations are major components of great relevance to understanding UHC on mental disorders in Nigeria.

One major problem of the coverage of illness is intrinsically tied to the health system resources and responses. Health systems have not yet adequately responded to the burden of mental disorders and as a consequence, the gap between the need for treatment and its provision is large all over the world. Between 70% and 85% of people with severe mental disorders receive no treatment for their disorder in low-income and middle-income countries - Comprehensive Mental Health Action Plan 2013-2020 (World Health Organization, 2013).

Lack of awareness of the existence of UHC and how it operates is another challenge that this work seeks to address. The awareness of this scheme is bereft of many people in low-income and developing nations like Nigeria. The extent of the diseases covered by the UHC scheme is the major problem to be tackled through this work. It is a global challenge of the now (2019-2023) which demands hearing due to its tipping point nature. Mental health disorders were previously excluded in the scheme of vast majority of countries. That is to say that the relevance of mental health was neglected by these societies. Some of the key challenges in primary health care seem to be the reason for the exclusion. Things like inadequate funding, low community participation due to societal stereotypes, poor quality of service, poor information and bad inter-sectorial collaboration, poor medical infrastructures, lack of emergency response units and medications. (Promotion of Mental Health Awareness, 2020)

Mental disorders are diseases that affect cognition, emotion, and behavioral control and substantially interfere both with the ability of children to learn and with the ability of adults to function in their families, at work, and in the broader society (Hyman, 2006). Mental disorders are diagnosable conditions characterized by changes in thinking, mood or behavior (or some combination of these) that can cause a person to feel stressed out and impair his or her ability to function (David, 2013 :1). It is important to differentiate normal daily ups and downs of mood and outlook and diagnosable mental disorders. Everyone experiences mood swings because of the hormonal changes associated with the stage of life that the person belongs – from adolescence to adulthood.

Mental disorders contribute one of the most troublesome of all categories of disease owing to their high prevalence, chronicity, premature age of onset, impairment and disability (Onwukwe, 2014). Therefore, mental disorder can be defined as a clinically significant behavioral syndrome or pattern that occurs in an individual and that is associated with present distress… or disability… or with a significantly increased risk of suffering death, pain, disability or an important loss of freedom; with a syndrome not merely an expectable and culturally sanctioned response to a particular event (American Psychiatric Association, 1994 :xxi). As said above, because of the combination of high prevalence, early onset, persistence and impairment, mental disorders contribute majorly to the total disease burden (WHO Special Initiative for Mental Health, 2019-2023). Mental health conditions causes 1 in 5 years lived disability, 800,000 youths die from suicide annually and depression and anxiety disorders cost the global economy USD 1 trillion per year. This is a major reason why UHC on mental disorder is a global challenge that demands urgent attention.

Over the years, little or no work has been done in the area of UHC on mental health in Nigeria. This is the reason why getting to ascertain the level of consciousness with the sense of data is really essential in

this current dispensation. The knowledge of different mental disorders under the coverage is important due to the fact that lots of medical centers exclude militating diseases that should be under the coverage. The implementation of UHC on mental disorders is a global imperative due to the increasing nature of mental disorders as global crises increases. Many countries and states already declare their commitment to achieving UHC and produce policies and approaches to achieve that goal.

The World Health Report (2010) outlined a conceptual framework for UHC that suggested three broad dimensions: The range of services that are covered (Service coverage); the proportion of the total costs covered through insurance or other risk pooling mechanisms (Financial coverage); the proportion of the population covered.

The gross problems that the WHO Special Initiative for Mental Health (2019-2023) seeks to solve and the goal of the theory of change is that of mental health inclusion. The goal is that by 2023 UHC ensures access to quality and affordable care for mental health conditions in 12 priority countries to 100 million more people. With the strategic actions as follows: Advancing mental health policy advocacy and human rights; Scaling up interventions and services across community-based, general health and specialist settings.

The vision is for all people to achieve the highest standard of mental health and well-being. This is the reason why the extent of disease coverage should be all-encompassing ranging from schizophrenia to anxiety disorders and depression. A number of countries have integrated psychoses care in Universal Health Coverage; mostly in the middle income category; coverage of care include people with schizophrenia, in countries like China and Brazil (Vikram, 2015).

Universal Health Coverage on Mental disorder is a big issue owing to the ever growing population of mental health problems due to global challenges such as economic crises and pandemic leading to reduction in closure etc. The inability of people to access the necessary health services they need is a basic problem. The few that can have access to these health services sustain huge financial hardship which is inherently a challenge. The problem here is one of access and financial security for mentally ill patients.

Two theories are used to provide theoretical structure to this work. The theory of change to mental health and mental disorder (Helene, 2021); path dependence theory (Antonelli 2009).

According to Antonelli (2009), path dependence theory is adopted to understand how past events or decisions can influence present and future decisions. Path dependence theory is used to describe and

explain the dynamics of such processes by incorporating the temporal dimension into the process theory (Pierson, 2004).

The view of the path dependence process is that "the social world often follows a particular trajectory: an open period during which there are a number of plausible alternatives, a critical juncture where contingent events result in one of these alternatives being selected, and the feedback that constrain actors to keep to the particular path" (Bennet 2006). Path dependence is a specific form of complex dynamics: it provides an analytical framework to explain and assess the ever-changing outcomes of the combination of and interaction amongst factors of continuity/discontinuity, growth and development, hysteresis and creativity, routines and 'free will' which all characterize economic action in a dynamic perspective that is also able to appreciate the role of historic time" (Antonelli 2009, Perello-Marin 2013).

Path dependence theory has been introduced to the field of health policy to elaborate the current state of some health policy reforms and to shed light on the institutional setting in health care (Ayman 2017). Some methods of modeling path dependence used in health policy in relation to Universal Health Coverage on mental disorders include; Comparative analysis between defined health policies in several countries has been examined using path dependence model (Motohashi, 2002); Study on how the latest healthcare reforms in the United States might shape the future (Haeder, 2012).

Application of path dependence is in two forms; Retrospective analysis of the present situation or classic path dependence model; Prospective prediction of the future trajectory.

Path dependence theory provides a retrospective idea and explanation about the institutional structure and policies in many domains, including the health sector. It associates the sociopolitical antecedent conditions to the present status throughout several contingent chronologically ordered steps. A central implication of this theory is that any additional health care consumed as a result of becoming insured – that is any moral hazard - is welfare decreasing. Because of this theory, it has made many health economists have focus on policies that would reduce consumption at the margin.

It is important to recognize that the private health insurance is primarily a transfer of income from those who remain healthy to those who become ill. This is the key to understanding the relationship between health insurance and demand for medical care. There may be a price effect caused by using price reductions as the payoff mechanism, the welfare consequences of the price effects are small relative to the welfare consequences of income transfer effects, especially the role of income transfers in making accessible those expensive lifesaving procedures that would otherwise be unaffordable.

The understanding of health insurance is almost diametrically opposed to the conventional view that the relationship between health insurance and demand - that is, moral hazard – is exclusively a price effect. This theory links to the variables in review (awareness, extent of illness coverage and implementation of UHC). This is because health insurance as a form of UHC that requires subsidy (contributory) in vast majority of cases allows the problem of excessive quantity instead of giving quality mental health care.

In the mental health care context, all countries are 'developing' to some extent (Vikram, 2019). Even in high income countries, the coverage gap for common conditions like mood and anxiety disorders often exceed 50%, in low income countries, the gap exceeds 90% (Thornicroft, 2017). Across all income categories, countries invest tiny factors of their healthcare budgets on mental health, disproportionately less than burden of mental disorders (WHO, 2015)

There is an inadequacy in the number of mental health professionals per capita, a massive shortage of community base mental healthcare and persistence of badly run large mental hospitals. These barriers to supply are compounded by barriers to demand, related to stigma and discrepancies between biomedical framing of mental disorders and the conceptualization of emotional distress in community. The large gap in mental health coverage is as a result of barrier in demand; in places like the UK where supply of mental healthcare interventions has been largely attained this is done by improving access to psychological therapies programme. In Nigeria, access to government intervention is hardly realizable.

Since the Alma Ata declaration in 1978 to the Astana declaration in 2018, the means of improving access to mental health care has been to integrate it with primary healthcare. But after four decades of trying which never worked, led to the realization that integration will require a whole scale re-engineering of the architecture of primary health care in most countries, which is simply not fit for the integration of mental disorders. After the Astana declaration in 2018, a better option for this integration was birthed. This happens to be in the form of the WHO Special Initiative for Mental Health (2019-2023): Universal Health Coverage for Mental Health.

Previously, attempts to integrate mental health have failed because they have not tackled the fundamental barriers with universal health coverage. Instead they have to replicate secondary care in primary care. For example; the posting of Psychiatrists and clinical psychologists in PHC centers, which is a strategy that is not necessary and not in any way scalable.

Theory of change is a dynamic, thinking process, it makes the initiative clear and transparent – it underpins strategic planning. It is developed in a participatory way over time, following a logical structure that is rigorous and specific, and that can meet a quality test by the stakeholders (Helene, 2021).

This theory has a purpose to shine a spotlight on the role development can play to improve mental health and wellbeing for all, and in turn, how improved mental health can play a role in attaining key developmental outcomes. It recognizes that there cannot be full development or healthy lives without addressing mental disorders. Theory of change sets out how development actors can maximize aid portfolios to strengthen their contributions to mental health and wellbeing in some of the world's poorest countries.

This theory is the result of a consultative process between development and humanitarian practitioners and external working group of critical friends; including groups representing people with mental disorders and psychosocial disabilities. The consultative process has guiding vision and principles "All people enjoy the highest attainable standard of mental health and wellbeing and all people with mental disorders and psychosocial disabilities can exercise their full rights on an equal basis to others" (UN SDGs 2020). It is structured around five critical outcome pathways for change- participation, rights, leadership and governance, and emergencies. The process of change is multidirectional, with cross over between pathways and highly context specific.

The theory of change relates mental disorder to the factors that contributes it to the awareness and implementation of UHC. There are existing indicators on ambitions on mental health and they are from the Sustainable Development Goals (SDGs) and the WHO Mental Health Action Plan (2013-2020; now extended to 2030). The impact of the theory is essentially for treating change and progress with its own challenges.

The objectives of this study is to determine the influence of awareness, extent of illness coverage and implementation of Universal Health Coverage on mental disorders in Nigeria. Hence, the hypothetical assumptions drawn from the objectives comprise that there will be no statistically significant influence of awareness of universal health coverage on mental disorders in Nigeria. Secondly, there will be no statistically significant influence of the extent of mental illness coverage on universal health coverage in Nigeria and finally, there will be no statistically significant influence of implementation of universal health coverage on mental disorders in Nigeria.

METHOD

Participants

Five hundred (500) health care workers and patients at the psychiatric clinic at Federal Medical Centre, Owerri; Imo State Specialist Hospital Umuguma Owerri; Niger Delta University Teaching Hospital Yenagou, Bayelsa state; Federal Neuro-psychiatric Hospital Yaba, Lagos State; Ministry of Health,

Benue State; Benue State University Teaching Hospital; and University of Abuja Teaching Hospital, Gwagwalada, FCT participated in the study. 200 participants from Federal Medical Centre, Owerri and Specialist Hospital Owerri, Imo State combined covering Imo state, South East Nigeria, and 100 participants from Niger Delta University Teaching Hospital, Bayelsa state, South-South Nigeria was used. 50 participants from Federal Neuro-psychiatric Hospital Yaba, Lagos state, South West Nigeria and 100 participants from Benue State University and Ministry of Health, Benue state Northern Nigeria, and 50 participants from University of Abuja Teaching Hospital, Gwagwalada North Central Nigeria were used. Participants comprised of 261 males and 239 females, who were selected through stratified sampling technique for the study areas and convenient sampling technique at the medical centers, convenient involved administering the scales to any participant at the point they. The participants' mean age is 31, with an age range of 21 to 55.

Instruments

Two instruments were used in this study. They are Mental Disorder Questionnaire (MDQ)

and Mental Health Coverage Scale (MHCS). The MDQ is a brief scale designed to measure the different domains of mental disorders including mood disorders having items like feeling down, tense, depressed or hopeless and little interest or pleasure in doing things; anxiety disorders & trauma-related disorders with items like striking memories of crises and having reoccurring nightmares and sudden feeling of panic. Others include; eating disorder; addiction and substance abuse disorders; psychotic disorders and personality disorder. The scale initially had 60-items. Face and content validation of the instrument by 2 lecturers in the department of Psychology, Imo State University (IMSU) reduced the items to 59. Validation of the instrument using healthcare workers and patients at Imo State University Teaching Hospital, Orlu was done and MDQ was correlated with Symptom Checklist- 90 (Derogatis,1994) and it yielded a concurrent validity of .695 (using Cronbach's Alpha). The scale is a multiple choice scale (Likert type) and it ranges from Not at all = 1, several days =2 and nearly every day = 3. For reliability, the odd and even items of MDQ were correlated and it yielded a Guttman Split-half coefficient of .973 which is significantly high. According to Anastasi and Urbinna (1992); Split-half is an adequate measure of the internal consistency of a scale. The norm for the scale is 69.86. Scores above the norm indicate presence of mental disorder and scores lower than the norm indicate absence of mental disorder.

The second instrument, Mental Health Coverage Scale (MHCS) was used for the measurement of mental health coverage and was produced by the researchers. It was developed to measure the level of awareness of mental disorders, extent of UHC for mental disorders and implementation status of UHC on mental disorders. The MHC was developed based on the literature review of the Core principles for Integration

of Mental Health into Primary Health Care: Promotion of Mental Health Awareness 2020 (Charlotte *et al.*, 2019). The scale initially had 70-items. Face and content validation of the instrument by 2 lecturers in the department of Psychology IMSU reduced the items to 62. Validation of the instrument using health care workers and patients at Imo State University Teaching Hospital, Orlu was done and MHC correlation with MHI yielded a concurrent validity of .470 (using Cronbach's Alpha). For reliability, the odd and even items of MHC were correlated and it yielded a Guttman split-half coefficient of .951 which is significantly high. The scale is a multiple choice scale (Likert) and it ranges from Not Aware: No Coverage, Not Implemented = 1; Partially Aware, Partial Coverage, Partially Implemented = 2; Fully Aware, Full Coverage, Fully Implemented = 3. The norm for the scale is 84.30; scores above the norm indicate high level of awareness, good coverage and good implementation of UHC on Mental Disorders.

Procedure

The researchers traveled to Federal Medical Centre, Owerri; Specialist Hospital Owerri Imo State; Niger Delta University Teaching Hospital, Yenaguo; Federal Neuro-psychiatric Hospital Yaba; Benue State University Teaching Hospital, Makurdi; Ministry of Health, Benue state; and University of Abuja Teaching Hospital Gwagwalada for data collection. First, with a letter of identification from the Department of Psychology, Imo state University, Owerri. At all the places the researchers introduced themselves, obtained informed consent before they were allowed to collect data. They also explained the rationale for the study as purely academic and also assured the participants of the confidentiality of their responses. The researchers with the help of doctors at various medical centers distributed the two questionnaires simultaneously to each participant. This same procedure was followed at the various states. The researcher waited for the healthcare workers and patients in each of the centers to complete the questionnaires. Participants were met at psychiatric unit and internal medicine departments during clinic hours. However, the researcher distributed five hundred and twenty five questionnaires but only five hundred were appropriately filled, coded and used for the study.

Design and Statistics

The design of this study is a cross sectional survey design. It was used in the study because different sections of the population was studied at specific and different points in time, this is to enable information to be assessed from all the various cities and states to objectively balance the content of the research by allowing patients and health care workers (from each visited health facility in each state) from different backgrounds and socio-economic class to bring in their ideas and responses.

The independent variables are awareness, extent of illness coverage and status of implementation of mental disorders in Universal Health Coverage and the dependent variable is mental disorders. The statistic used was a three- way Analysis Of Variance (ANOVA) which appropriately measured the variability existing between and within subjects.

RESULTS

Table I: Means and Standard Deviation Scores for Awareness of Universal Health Coverage; Extent of illness coverage; and Implementation of Universal Health Coverage on Mental Disorders.

Awareness of UHC	Mean	Standard Deviation	N
Aware	73.883	14.121	248
Not aware	69.762	12.846	252
Extent of illness Coverage of UHC: Adequate	73.832	14.432	237
Not adequate	70.087	12.706	263
Implementation:			
Implemented	73.909	14.463	222
Not implemented	70.226	12.787	278

Table one shows that for awareness of UHC there was a considerable difference between means for participants who are aware (73.883) and for those who are not aware (69.762). The mean difference suggests that people who are aware of UHC are in greater population than those who are not aware.

However, the table also shows that for the extent of illness coverage of UHC there is a considerable difference between means for participants who say adequate coverage exist in their facilities (73.832) and for those who say it is not adequate (70.087). The mean suggests that the extent of mental illness coverage on the existing UHC scheme is believed by greater population to be adequate.

Similarly, for implementation of UHC on mental disorders there is a considerable difference between means for participants who said it is implemented (73.909) and for those who said it is not implemented (70.226). The mean suggests that a greater population is saying that UHC on mental disorder is implemented in facilities that they visit than those saying it is not implemented.

Table II: Summary Table of Three – Way ANOVA for Awareness of Universal Health Coverage; Extent of illness coverage and Implementation of Universal Health Coverage on Mental Disorders.

Source	Type III sum of squares	df	Mean Square	F	sig
Awareness of UHC	.032	1	0.32	.000	.989
Extent of Illness Coverage	53.277	1	53.277	.291	.590
Implementation	4.127	1	4.127	.023	.881
Error	90147.194	492	183.226		
Total	**2675273.000**	**500**			

P < .05

The result of the three – way ANOVA as presented in Table II above tested the three hypotheses in the study. The first hypothesis which stated that there will be a statistically significant influence of awareness of universal health coverage on mental disorders in Nigeria was rejected [F (1,500) = .000, P = .989]. The result implies that the participants perceived that awareness does not significantly influence mental disorder. The first research hypothesis is therefore rejected.

Similarly, based on the result obtained in table II above, the second research hypothesis which stated that there will be a statistically significant influence of the extent of mental illness coverage on universal health coverage was also rejected [F (1,500) = .291, P = .590]. The result implies that the extent of mental illness coverage does not significantly influence mental disorders. The second hypothesis is therefore rejected.

Finally, the third hypothesis which stated that there will be a statistically significant influence of implementation of universal health coverage on mental disorder in Nigeria was rejected [F (1,500) = .023, P = .881]. The result implies that the implementation of UHC does not significantly influence mental disorders. The third hypothesis was therefore rejected.

DISCUSSION

The study investigated the influence of awareness, extent of illness coverage and implementation of Universal Health Coverage on mental disorders in Nigeria. The finding that awareness did not significantly influence Universal Health Coverage on mental disorders in Nigeria shows that people are not cognizant of UHC not to talk of its impact on mental disorders. The idea of UHC as regards mental

disorders in Nigeria is still highly elitist issue. The truth of the matter is that in Nigeria people living with mental illness are not cared for unless they are from high socioeconomic background. That is why mentally ill people degenerate to the level of becoming vagrant. People living with different gradations of schizophrenia, drug induced psychosis and substance use disorders roam Nigerian streets, sometimes stark naked!

It is important therefore to align with the WHO Special Initiative for Mental Health (2019-2023) whose vision is to ensure that all people achieve the highest standard of mental health and well-being. Creating awareness concerning the existence of such initiative will promote the inclusion of mental disorders in the Universal Health Coverage list. People with mental disorders often experience severe human rights violations, discrimination and stigma. Awareness of what mental disorder patients deserve is a step in the right direction.

Promotion of UHC awareness on mental disorders requires advocacy. Advocacy will help promote the awareness of the population. The advocacy message calls for a continued promotion of a study value case for mental health coverage; ensuring support of critical stakeholders across global health and development. It is also in line with UHC2030 (2018) raised awareness about UHC in 2016 through a series of interviews broadcast with the Bayelsa state Health Commissioner for health which led to the establishment of the Bayelsa State Health Insurance Scheme in 2017 and the inclusion of UHC in Bayelsa Health Summit 2021.

The second finding of the study is that there is no significant influence of the Universal Health Coverage of mental illness on mental disorders in Nigeria. This is in line with Whiteford (2013), who asserted that people with mental disorders who live in Low and Middle Income Countries (LMICs) have low access to quality mental health and are consequently vulnerable to suffering and disability. This corresponds with the finding of the study that shows how vast majority of people pay from their pocket for mental disorders.

The same with Charlotte (2019) who said “the neglect of mental health care globally combined with catastrophic healthcare costs due to high out of pocket expenditure, the economic cost of being unable to work, household costs of caring for someone with mental disorders and limited economic opportunities due to social marginalization. This means that people with mental disorders and their families are at great risk of caring left behind by development initiative such as UHC”. Finally, Semrau (2015) also asserted that coverage issues are part of health system barriers and when solved can improve mental outlines in fair and efficient ways.

The third finding stated there is no statistically significant influence of implementation of Universal Health Coverage on mental disorder in Nigeria. The analysis of the study shows a poor implementation rate of health care policies in Nigeria. This plays out greatly on how implementation of policies influences UHC on mental disorders. That is to say when implementation is high, health coverage will be high too. Poor implementation is the bane of healthcare in Nigeria. Nice policies exist but the problem has always been implementation.

Nnaji (2021) asserted that implementation research can be used to achieve UHC-related outcomes in Africa. There is a body of evidence on the use of implementation research in the achievement of UHC-related outcomes in Africa; needing the improvement of routine data for decision-making, efficient resources allocation, as well as improvement of the availability, affordability and quality of health services.

It implies therefore that awareness exerts great influence on the execution of universal health coverage on mental disorders in Nigeria. Majority of Nigerians cannot determine their right when it comes to health care coverage due to lack of awareness and great ignorance. The researchers noticed in the course of the research that even health workers in some health facilities do not know the number of mental disorders covered in the insurance schemes available at their centers. Patients do not know that schemes exist where the government can subsidize or pay off their bills regarding their illnesses. This implies that advocacy will help promote UHC on mental disorders. It also implies that healthcare workers should be aware of the proportion of the population that is covered (population coverage). Implementation of UHC policies in Nigeria is poor and it is recommended that government makes serious effort to implement policies that will improve the wellbeing of people living with mental disorders.

This study has shown the importance of awareness of UHC on mental disorder, increase awareness can contribute to governmental and health institutions effectiveness and efficiency towards a better mental health in the country. To the public, I recommend that Nigerians seek insurance packages so that in cases of emergency and outbreaks, their contributory scheme protects and takes care of their health care needs at subsidized rates from the government. The states that has not implemented any UHC policy for mental disorders, the federal government should strongly encourage them to do so. To the federal government, at the face of endemic diseases, pandemic and mental disorders it is important to prioritize the health of the citizens by not impoverishing them while accessing health care.

CONCLUSION

Having examined the influence of awareness, extent of illness coverage and implementation of UHC on mental disorders in Nigeria, the study has demonstrated the low access of health care by people living with mental disorders which is as a result of technical factors such as level of awareness and status of implementation of UHC so as to cover for mental disorders in Nigeria. To this end this study has come up with the following conclusions; awareness is an indicator for the level of Universal Health Coverage on mental disorder in Nigerian health facilities and centers; extent of mental illness coverage is not intrinsically tied on the Universal Health Coverage but it is influenced by the type of coverage generally available in the country; the status of implementation of Universal Health Coverage policy existing in the country is a great indication towards the Universal Health Coverage on mental disorders in Nigeria.

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