African Journal of Social Sciences and Humanities Research
ISSN: 2689-5129
Volume 6, Issue 4, 2023 (pp. 85-100)
www.abjournals.org

ASSESSMENT OF FUNDING IN THE IMPLEMENTATION OF NATIONAL HEALTH INSURANCE SCHEME IN THE FEDERAL CAPITAL TERRITORY (FCT), ABUJA, NIGERIA

Okafor Ikechukwu Joseph (Ph.D)[1], Nweke Obinna Innocent[2] and Yusuf Lawal (Ph.D)[3]

[1]Department of Public Administration, University of Abuja, Nigeria.
Email: ikennaiyk@yahoo.com (+2348036785625)

[2]Department of Public Administration, University of Abuja, Nigeria.
Email: innocentobi36@yahoo.com (+2347065803470)

[3]Department of Public Administration, University of Abuja, Nigeria.
Email: yusflawal@gmail.com (+2348033377744)

Cite this article:

Okafor I.J., Nweke O.I., Yusuf L. (2023), Assessment Of Funding in the Implementation of National Health Insurance Scheme in the Federal Capital Territory (FCT), Abuja, Nigeria. African Journal of Social Sciences and Humanities Research 6(4), 85-100. DOI: 10.52589/AJSSHR-1YCHIAKJ

Manuscript History

Received: 6 May 2023

Accepted: 25 July 2023

Published: 14 Aug 2023

ABSTRACT: *The National Health Insurance Scheme (NHIS) is an initiative of the federal government of Nigeria targeted at easing the financial burden of healthcare on the general public while enabling access to quality healthcare services. However, progress checks in implementation suggest that there is a considerable gap between policy objectives and outcomes. In light of this observation, the paper examines the extent to which funding affects the implementation of NHIS in the Federal Capital Territory (FCT), Abuja. The study, which is survey research, was anchored on Grossman's health production function theory and employed the instrument of questionnaire to elicit data from Health workers in nine health institutions spread across four Area Councils in Abuja, namely, AMAC, Gwagwalada, Kuje and Kwali and NHIS staff. The data were analysed using Statistical Package for Social Science (SPSS). The study observed that the paucity of funds affects the effective implementation of NHIS in FCT to a high extent. It concludes that the problem of paucity of funds is a hindrance to the effective implementation of NHIS in the FCT. The paper recommends that the community and voluntary sectors of NHIS should be aggressively implemented; that government budgetary allocation to the health sector should be upwardly reviewed and sustained; and finally, that the HMOs should be closely monitored to ensure that capitations to accredited NHIS health facilities are remitted as at when due.*

KEYWORDS: Health Insurance, Healthcare Financing, Policy implementation, NHIS, Healthcare service delivery

Article DOI: 10.52589/AJSSHR-1YCHIAKJ
DOI URL: https://doi.org/10.52589/AJSSHR-1YCHIAKJ

African Journal of Social Sciences and Humanities Research
ISSN: 2689-5129
Volume 6, Issue 4, 2023 (pp. 85-100)

www.abjournals.org

INTRODUCTION

Over the past decades, many Low and Middle-Income Countries (LMCs) have found it increasingly difficult to sustain sufficient financing for healthcare, particularly for the poor. As a result, international policymakers and other stakeholders have been recommending a range of suitable measures, including conditional cash transfers, cost-sharing arrangements and various health insurance schemes, including Social Health Insurance (SHI). Moving away from out-of-pockets for health care at the time of use to prepayment (health insurance) is an important step towards averting the financial hardship associated with paying for health services, particularly for the poor. In 2005, the World Health Organisation (WHO) passed a resolution that social health insurance should be supported as one of the strategies used to mobilise more resources for health, for risk pooling, increasing access to health care for the poor and for delivering quality health care in all its member states and especially in low-income countries, a strategy also supported by the World Bank (Hsiao, 2007). This is one of the ideals upon which the National Health Insurance Scheme (NHIS) was conceived and established in Nigeria.

The National Health Insurance Scheme (NHIS) is a social health insurance programme designed by the Federal Government of Nigeria to complement sources of financing the health sector and to improve access to health care for the majority of Nigerians (Mbaya, 2009). It guarantees the provision of needed health services to persons without them having to pay fully at the time of need because payment has previously been made by regular contribution by the insured or his employer or both. The scheme is statutorily mandated to ensure that Nigerians can access affordable health care regardless of their social status.

The Federal Government of Nigeria (FGN_ (2015) had actually corroborated the findings from other studies when it reported, among others, that one of the major challenges facing the NHIS is the paucity of funds. However, the critical question worth asking now is: why are these challenges still confronting the NHIS after over a decade of its existence? But more importantly, these challenges raise other pertinent questions worth asking. For instance, could these challenges be a result of more fundamental and general problems facing the Nigerian health sector and not particularly rooted in the NHIS alone? Some scholars, however, have tended to generalise these challenges to the entire health sector regardless of which sub-sector is being investigated. For example, again, some scholars have identified, among others, paucity of funds as one of the major challenges confronting the entire health sector, regardless of the uniqueness of some sub-sectors such as the NHIS.

Some scholars argue that the paucity of funds is a constraint to the effective operations of the Nigerian healthcare system. Funding of healthcare in Nigeria has not only affected the quality of services but has also led to impoverished healthcare standards of the populace. Over the years, the budgetary allocation to health over the years has been between 2 to 4 per cent of the total annual budget. For instance, in the 2021 national budget, only a meagre 4.5 per cent was allocated to the health sector and was even dropped to 4.3 per cent in 2022 (Nigerian National Budget, 2021 and 2022). The Healthcare sector is arguably one of the most critical sectors that drive other sectors of a country and coupled with the complex health situation occasioned by the Covid-19 pandemic. The Nigerian budgetary allocation to the health sector over the years is far below the WHO 13 per cent recommendation for developing countries of the world. In support of this, WHO (2007 & 2010; World Bank, 2009) revealed that poor funding is a serious factor affecting the healthy development of Nigeria. Gana (2015) identified these funding

Article DOI: 10.52589/AJSSHR-1YCHIAKJ
DOI URL: https://doi.org/10.52589/AJSSHR-1YCHIAKJ

challenges as a low level of public (government) spending high burden of health care costs on individuals and households (70 per cent of all expenditure), thereby ranking Nigeria as the country with the second highest level of out-of-pocket spending on health financing in the world. The task before this study, therefore, is to determine the extent to which a paucity of funds affects the effective implementation of NHIS in FCT, Abuja, Nigeria.

Theoretical Milieu

In order to establish the linkage between resources invested in the health sector and health outcomes in Nigeria, this research uses a framework that captures health financing as health input that generates health outcomes, such as the provision of modern health facilities and access to the health system. This framework draws heavily on the production function of health developed by Grossman (1972). The central proposition of the Grossman model (Grossman 1972) is that health can be viewed as a durable capital stock that produces an output of good health over time. It is assumed that individuals inherit an initial stock of health that depreciates with age and can be increased by investment. The model is similar to human capital models that have been used to measure wage rates. In the Grossman model, individual activity affects one's stock of health and, thus, duration of life.

People can improve their health through diet, exercise and preventive visits to see the doctor. However, all these items take time and money. Thus, it is not optimal to spend 100% of your time improving your health since (i) you would not be able to work to generate income to consume goods and services during your life, and (ii) you would not have leisure time to enjoy your life. Thus, individuals will inevitably trade off time cost and monetary spending (e.g., on medicines, doctors visits) against leisure and consuming other goods. Additionally, there is likely some finite upper limit in terms of how much health investment can actually affect your long-term help.

However, another interesting aspect of the Grossman model is that it concludes that health does not affect productivity. He assumes that human capital affects productivity and wage rate; health only affects the number of days a person can work (because they are not sick). Thus, in the Grossman model, health affects one's annual salary but not one's hourly wage.

The model makes a number of predictions.

First, people will invest more in medical goods and services as they age. He assumes that health stock may depreciate faster as people age, and in response, people will invest more in health activities and medicine as they age. "…given a relatively inelastic demand curve for health, individuals would desire to offset part of the reduction in health capital caused by an increase in the rate of depreciation by increasing their gross investments."

Second, the model predicts high-wage individuals will invest more in health through spending on medical goods and services compared to their own time investments since the cost of time is higher.

Third, "if education increases the efficiency with which gross investments in health are produced, then the more educated would demand a larger optimal stock of health."

This model views health resources as an input or investment in the health system that yields improvement in the health sector. Developing countries tended to emphasise the need for

Article DOI: 10.52589/AJSSHR-1YCHIAKJ
DOI URL: https://doi.org/10.52589/AJSSHR-1YCHIAKJ

adequate health funding, given that good health is a catalyst for economic development. Health financing comprises public and private financing; however, the prevailing healthcare system in a country always informs the health financing models that need to be adopted. The predominant source of financing healthcare in less developed economies is direct government funding. This can be attributed to the role of government in the creation and execution of health plans. A major issue of healthcare financing in developing countries is the inadequate budgetary allocation or poor implementation, hence the poor state of health.

Healthcare Financing

Healthcare financing can be defined as the mobilisation of funds for healthcare services (Oyefabi, Aliyu & Idris, 2014). In other words, it is the provision of money, funds or resources to the activities designed by the government to maintain people's health. These activities encompass the provision of medical and related services geared toward maintaining good health, especially in the aspect of disease prevention and curative treatment. The concept of health care financing succinctly deals with the quantity and quality of resources a country spends on health care. This is proportionate to the country's total national income. The amount of resources earmarked for healthcare in a country is said to be a reflection of health value placement vis-à-vis other categories of goods and services. It has been opined that the nature of healthcare financing defines the structure and the behaviour of different stakeholders and the quality of health outcomes (Metiboba, 2012).

The pattern of healthcare financing is, therefore, intricately connected and indivisibly linked to the provisioning of health services (Rao, Salvaraju, Nagpal & Sakthivel, 2009 & Riman & Akpan, 2012). The duo, Riman & Akpan, argued that the definition of healthcare financing cannot be narrowly conceived and confined to raising enough resources to fund the healthcare needs of people alone, but also entails the questions of affordability and equitable access to healthcare services by them, including guaranteed financial risk protection. In consonance, Metiboba (2012) contended that when it comes to analysing healthcare financing, several nuances have been advanced because some types of healthcare services are skewed towards benefitting groups and the community collectively. Worth mentioning here are vaccination against certain communicable diseases, control of malaria and environmental sanitation. Other issues that make the analysis of healthcare financing problematic are individuals' out-of-pocket expenditures on food, clothing, shelter and education. The mutually reinforcing trajectory of relationships that exist between the aforementioned survival needs also makes healthcare financing analysis a difficult one.

One of the intricate issues and nuances associated with the analysis of healthcare financing is the identification of healthcare expenditure, given the demarcation between preventive and curative healthcare services. The proposed integration of traditional medicine practitioners into the mainstream formal health sector will further challenge healthcare financing analysis, as Metiboba (2012) argues.

Article DOI: 10.52589/AJSSHR-1YCHIAKJ
DOI URL: https://doi.org/10.52589/AJSSHR-1YCHIAKJ

African Journal of Social Sciences and Humanities Research
ISSN: 2689-5129
Volume 6, Issue 4, 2023 (pp. 85-100)

www.abjournals.org

Health Insurance

Health insurance is a healthcare financing system which entails mobilising funds for healthcare services (Oyetabi, Aliyu and Idris, as cited in Eboh, Akpata and Akintoye, 2016). It means the process of pooling funds together in advance to take care of the health challenges of the participants (those covered by the insurance). Health insurance, in the opinion of Chikeleze (2004), is the ability to get health services when required without having to pay fully at a time of need because payment has been made by a fixed, regular contribution by the insured or his/her employers or both (prepayment plan). This definition shows that health insurance may or may not completely cover the cost of healthcare services provided by the healthcare provider to the insured.

The insured may have to pay part of the cost (co-payment arrangement). Similarly, Ogechukwu (2004) views health insurance as the pooling of resources by a group of individuals to care for health needs. The NHIS Operational Guidelines (2012) conceived health insurance as a system of advance financing of health expenditure through contributions, premiums or taxes paid into a common pool to pay for all or part of health services specified by a policy or plan. Also, Toyin (2014) opined that health insurance is a social security mechanism that guarantees the provision of needed health services to persons on the payment of some amount at regular intervals.

It is designed to protect people against the high costs of health care by making payments in advance of falling ill. The scheme, therefore, protects people from huge out-of-pocket expenditures and financial hardship occasioned by large or unexpected medical bills. It saves money in the short run and protects the poor from medical conditions that can lead to greater loss of money in the long run. Many advantages accrue from participation in health insurance. These advantages include:

i) Broadening the sources of healthcare financing

ii) Reducing the dependence and pressure on government budgets.

iii) Increasing the financial resources and ensuring a stable source of revenue.

iv) Ensuring a visible flow of funds to the sector

v) Assisting in establishing patients' rights as customers.

vi) Combines risk pooling with actual support by allocating services according to need and distributing financial burden according to the ability to pay.

vii) Solves equity and affordability problems in providing and financing the health sector.

viii) Improves and harnesses private sector participation in the provision of health services (Toyin, 2014).

In general terms, health insurance is the ability of an individual or family member to access health needs freely or by paying a token amount because payment has been made in advance through a contribution by the individual alone or both the individual and his employer.

Article DOI: 10.52589/AJSSHR-1YCHIAKJ
DOI URL: https://doi.org/10.52589/AJSSHR-1YCHIAKJ

African Journal of Social Sciences and Humanities Research
ISSN: 2689-5129
Volume 6, Issue 4, 2023 (pp. 85-100)

www.abjournals.org

EMPIRICAL REVIEW

Eboh, Akpata and Akintoye (2016) carried out a study titled *Healthcare Financing in Nigeria: An Assessment of the National Health Insurance Scheme (NHIS)* and concluded that several sources of healthcare financing abound to be leveraged, such as tax-based public sector health financing, household out-of-pocket health expenditure, the private sector (donor funding) and social health insurance. According to the researchers, the all-inclusive one is social health insurance which has the capacity and potency to reduce catastrophic health expenditure. The study recommended among others, that the government, in collaboration with relevant partners, should intensify optimal awareness and education on the scheme to all Nigerians to trigger an increase in enrollees.

Iloka, Edeme and Ede (2018) carried out a study on *Equity in Financing Health Care Services in Nigeria*. The study was designed to investigate the extent to which payments towards healthcare are related to the ability to pay and if poor households make proportionally more out-of-pocket payments on health. The study utilised secondary sources of data through the data generated by the General household survey of the National Bureau of Statistics in 2014. Their study employed the Kakwani progressivity index to analyse the data generated. Findings from their study show a regressive out-of-pocket payment which suggests that payments towards healthcare are not related to the ability to pay. The result also shows that poor households make proportionally more out-of-pocket payments. Therefore, they recommended that the government provide an insurance policy specifically designed for the poor populace.

Onwujekwe, Ezumah, Mbachu, Obi, Ichoku, Uzochukwu and Wang (2019) conducted a study titled "*Exploring effectiveness of different health financing mechanisms in Nigeria; what needs to change and how can it happen*?" The study set out to find an in-depth assessment of different health financing mechanisms in Nigeria. They conducted the study on Niger State, Kaduna State and Federal Capital Territory, Abuja. They combined the primary and secondary sources of data by first reviewing government publications and conducting an in-depth interview of purposively selected respondents. The authors applied the content analysis method to analyse the data gathered. They found in the study that Health financing mechanisms in Nigeria do not operate optimally. Allocation and use of resources are neither evidence-based nor results-driven. Resources are not allocated equitably or in a manner that minimises wastage and improves efficiency. The study also found that Issues with social health insurance cut across legal frameworks and the use of Health Maintenance Organisations (HMOs) as purchasers. The concomitant effect is that the attainment of Universal Health Coverage is greatly compromised. It recommended, In order to improve the efficiency of health financing mechanisms, the government needs to allocate more funds for purchasing health services; this spending must be based on evidence (strategic) and appropriately tracked. The legislation that established the National Health Insurance Scheme should be amended so that social health insurance becomes mandatory for all citizens.

Article DOI: 10.52589/AJSSHR-1YCHIAKJ
DOI URL: https://doi.org/10.52589/AJSSHR-1YCHIAKJ

African Journal of Social Sciences and Humanities Research
ISSN: 2689-5129
Volume 6, Issue 4, 2023 (pp. 85-100)

www.abjournals.org

Unlike the studies presented above, the significant contribution of this present study to knowledge is that it interrogates the implementation of NHIS in FCT by probing the role of funding in the implementation of the scheme. In order to achieve these, the study identified critical stakeholders in the implementation process, such as the health workers and NHIS staff and sampled their opinion on issues relating to funding in implementing the scheme in the FCT.

METHODOLOGY OF STUDY

This study made use of both secondary and primary data. Secondary data were obtained through a review of existing literature relevant to the implementation of NHIS in Nigeria. Primary data were generated through a questionnaire distributed to stakeholders in implementing NHIS in FCT, as shown in Tables 1 and 2 below. The questionnaire was modelled on the Rensis Likert Scale of a five-point rating and adapted to suit the objective of the study. The scale provides five options: Very High Extent (VHE), High Extent (HE), Undecided (U), Low Extent (LE) and Very Low Extent (VLE). The numerical values assigned to the rating are as follows: Very High Extent (VHE)5, High Extent (HE)4, Undecided (U)3, Low Extent (LE)2, and Very Low Extent (VLE)1. The decision rule guiding this Likert scale is given as;

$$\bar{X} = \frac{5+4+3+2+1}{5} = \frac{15}{5} = 3.0$$

Where $\bar{X}$ is the average and the Likert 5 – scale average for decision making = 3.0. The decision rule is given as follows: On the one hand, if a mean score of a statement is 3.0 and above, the decision is positive. This means that the mean score lies on the high to very high extent side of the continuum. On the other hand, if a mean score of a statement is below 3.0, the decision is negative. This means that the mean score lies on the low to very low extent side of the continuum.

The study strictly focused on NHIS staff and Health workers in FCT, which together form the institutional stakeholders. These stakeholders are directly responsible for receiving and administering hospital funds. Table 1 and 2 below shows the breakdown of the stakeholders who together form the population of this study. According to the NHIS staff nominal roll as of September 2020, there are 135 staff at the headquarters in Abuja. This number includes junior staff (40), senior staff (71) and Directorate staff (24).

Article DOI: 10.52589/AJSSHR-1YCHIAKJ
DOI URL: https://doi.org/10.52589/AJSSHR-1YCHIAKJ

African Journal of Social Sciences and Humanities Research
ISSN: 2689-5129
Volume 6, Issue 4, 2023 (pp. 85-100)

Table 1: Population of Health Workers across the selected Area Councils and Health care providers in FCT

Area Council	Health care Provider	Health Workers
AMAC	National Hospital	1369
	Wuse General Hospital	253
	Nyanya General Hospital	177
Gwagwalada	UATH	857
	Gwagwalada Town Hall Clinic (PHC)	27
Kwali	Kwali General Hospital	99
	Kwali PHC	14
Kuje	Kuje General Hospital	126
	Kuje PHC	23
	Total	**2,945**

Sources: -*National Hospital (2023)*
-*Wuse General Hospital (2023)*
-*Nyanya General Hospital (2023)*
UATH, (2023)
Gwagwalada Town Hall Clinic (2023)
-*Kwali General Hospital (2023)*
-*Kwali PHC (2023)*
-*Kuje General Hospital (2023)*
-*Kuje PHC (2023)*

Table 2: Population of NHIS Staff at the Headquarters

Staff Category	Population
Junior Staff	40
Senior Staff	71
Directorate Staff	24
Total	135

NHIS (2023)

The study adopted Taro Yamani's formula and proportional sampling technique to determine the sample size of the respondents. This allowed for fair representation of the population. The details are presented below:

Article DOI: 10.52589/AJSSHR-1YCHIAKJ
DOI URL: https://doi.org/10.52589/AJSSHR-1YCHIAKJ

African Journal of Social Sciences and Humanities Research
ISSN: 2689-5129
Volume 6, Issue 4, 2023 (pp. 85-100)

www.abjournals.org

Determination of Sample Size of Health Workers Based on the Total Population of 2,945

Using Taro Yamani's formula =

$$n = \frac{N}{1+N(e)^2}$$

Where n = Sample Size

N = Population Size (2,945)

e = Level of Significance (0.05)

I = Constant

Therefore, $n = \frac{2,945}{1+ 2,945\ (0.05)^2}$

$$= \frac{2,945}{1+ 2,945\ (0.0025)^2}$$

$$= \frac{2945}{1+7.362} = \frac{2945}{8.3625} = 352$$

Total Sample Size of all Health Workers = 352

Determination of Sample Size of NHIS Staff based on the total population of 135

Using Taro Yemani's formula =

$$n = \frac{N}{1+N(e)^2}$$

$$= \frac{135}{1+ 135\ (0.0025)}$$

$$= \frac{135}{1+ 0.34} = \frac{135}{1.34} = \mathbf{101}$$

Total Sample Size of NHIS Staff = **101**

Article DOI: 10.52589/AJSSHR-1YCHIAKJ
DOI URL: https://doi.org/10.52589/AJSSHR-1YCHIAKJ

African Journal of Social Sciences and Humanities Research
ISSN: 2689-5129
Volume 6, Issue 4, 2023 (pp. 85-100)

www.abjournals.org

The Study employed purposive sampling technique to choose 4 out of the 6 Area Councils in FCT namely; Abuja Municipal Area Council (AMAC), Gwagwalada, Kwali, and Kuje. In each of these Area Councils, various health institutions were chosen for the study to generate the views of stakeholders. In AMAC, the study chose National Hospital, Wuse General Hospital and Nyanya General Hospital; in Gwagwalada, the University of Abuja Teaching Hospital and Gwagwalada Town Hall Clinic were sampled, while in Kwali, Kwali General Hospitals and Kwali Primary Health Centre (PHC) were chosen; and in Kuje, Kuje General Hospital and Kuje PHC were sampled. A breakdown of the sample size as drawn from the population of various units of the study is presented in Table 3 below.

Table 3: Sampled population of Health Workers across the Selected Area Councils and Health care Providers in FCT

Area Council	**Health care Provider**	**Population of Health Workers**	**Sample size of Health Workers** $\frac{SP * SS}{GP}$
AMAC	National Hospital	1369	164
	Wuse General Hospital	253	30
	Nyanya General Hospital	177	21
Gwagwalada	UATH	857	102
	Gwagalada Town Hall Clinic (PHC)	27	3
Kwali	Kwali General Hospital	99	12
	Kwali PHC	14	2
Kuje	Kuje General Hospital	126	15
	Kuje PHC	23	3
	Total	**2,945**	**352**

Table 4: Sample of NHIS Staff at the Headquarters

Staff Category	**Population**	**Sample Size** $\frac{SP*SS}{GP}$
Junior Staff	40	30
Senior Staff	71	53
Directorate Staff	24	18
Total	135	101

The study also utilised proportional sampling technique to prorate the sample size for each study unit according to the strength of its contribution to the general population of the respondents' category. The formula for this proportional allocation is given as follows:

Article DOI: 10.52589/AJSSHR-1YCHIAKJ
DOI URL: https://doi.org/10.52589/AJSSHR-1YCHIAKJ

$$\frac{SP * SS}{GP}$$

Where SP= Specific Population of a Study Unit

SS= Sample Size of Respondents' Category

GP= General Population of Respondents' Category

Data generated from the questionnaire instrument were analysed using Version 25 of Statistical Package for Social Science (SPSS) and independent two-sample t-test was used to test the hypotheses.

Hypothesis

The study tested the following hypothesis:

H_0: The opinion of NHIS staff and that of health workers do not vary significantly concerning the problem of paucity of funds as a hindrance to the effective implementation of NHIS in FCT.

H_I: The opinion of NHIS staff and that of health workers vary significantly concerning the problem of paucity of funds as a hindrance to the effective implementation of NHIS in FCT.

Data Presentation and Interpretation

Out of the 352 copies of the questionnaire distributed to Healthcare workers, only 311 copies were retrieved and found usable; and of the 101 copies of the questionnaire distributed to NHIS staff, only 93 copies were returned and found usable. Therefore analysis of data is based on the questionnaire retrieved.

Table 3: Descriptive Analysis of the Extent to Which Paucity Of Fund Affects The Effective Implementation Of NHIS In FCT

S/N	Statement	Category		Response Categories				Total	Mean score	Decision
			VHE (5)	HE (4)	U (3)	LE (2)	VLE (1)			
1.	Management of funds is a big and controversial issue in the implementation of NHIS.	**NS** **HW**	50 81	24 124	11 45	3 40	5 21	93 311	4.19 3.66	High extent High extent
2.	Poor funding resulting from a lack of prudent management of available resources plays a role in hampering the effective implementation of NHIS.	**NS** **HW**	14 124	52 102	11 35	12 37	4 13	93 311	3.65 3.92	High extent High extent

Article DOI: 10.52589/AJSSHR-1YCHIAKJ
DOI URL: https://doi.org/10.52589/AJSSHR-1YCHIAKJ

3.	Capitation due to health facilities are delayed or not paid by HMOs.	**NS** **HW**	20 113	31 113	17 32	19 42	6 11	93 311	3.43 3.88	High extent High extent
4.	The failure or delay by some HMOs in providing the required capitation to health facilities is a result of corruption.	**NS** **HW**	20 112	36 105	22 45	14 27	1 22	93 311	3.65 3.83	High extent High extent
5.	Unavailability of some drugs contained in NHIS approved list of drugs is because of the delay or lack of payment of capitation by HMOs to health facilities.	**NS** **HW**	12 121	46 92	11 50	15 36	9 12	93 311	3.39 3.88	High extent High extent
	Grand mean = $\frac{NHIS\ Staff}{Health\ workers}\ \frac{(NS)}{(HW)} = \frac{3.66}{3.83} = \frac{High\ extent}{High\ extent}$									

Source: *Field work, 2020*

The result above presents the item-by-item descriptive analysis of NHIS staff and health workers' response to the statements on the extent to which paucity of fund affects the effective implementation of NHIS in FCT. The mean score of the items for the two categories of respondents is all greater than 3.0.

The result in the table also shows that the grand mean rating of health workers *(mean = 3.83)* was slightly higher than the grand mean rating of the NHIS staff *(mean = 3.66)*. Since the grand mean for both categories *(i.e. mean = 3.83 and 3.66)* was greater than 3.0, the result implies that the paucity of funds affects the effective implementation of NHIS in FCT to a great extent.

In specific terms, item one reveals that both the NHIS staff and health workers agreed that, to a great extent, the management of funds is a big and controversial issue in the implementation of NHIS in FCT. Their mean score (NHIS staff = 4.19, health workers = 3.66) justifies this evidence. Agreement also exists between the two categories of respondents on item two, which dwells on whether poor funding resulting from a lack of prudent management of available resources plays a role in hampering the effective implementation of NHIS in FCT. They are both of the opinion that the problem exists to a high extent. Their mean score (NHIS staff = 3.65, health workers = 3.92) confirms this evidence. In a similar vein, concerning item three, which relates to whether capitation due to health facilities being delayed or not paid by HMOs, they both agreed that the issue exists to a great extent. Their mean score (NHIS staff = 3.43, health workers = 3.88) validates this conclusion.

Regarding item four in Table 3 above, evidence exists that the failure or delay by some HMOs in providing the required capitation to health facilities is a result of corruption. This is because the two categories of respondents confirm that the problem exists to a great extent by their mean scores (NHIS staff = 3.65, health workers = 3.83). Concerning item five in the table above, both categories of respondents confirm that, to a great extent, the unavailability of some

Article DOI: 10.52589/AJSSHR-1YCHIAKJ
DOI URL: https://doi.org/10.52589/AJSSHR-1YCHIAKJ

drugs contained in NHIS approved list of drugs is because of the delay or lack of payment of capitation by HMOs to health facilities. Their mean scores (NHIS staff = 3.39, health workers = 3.88) justify this evidence.

Test of Hypothesis

To test the difference in views between NHIS staff and health workers regarding the problem of paucity of funds as a hindrance to the effective implementation of NHIS in FCT, the mean response from the NHIS staff and health workers were subjected to a descriptive Statistics and an independent two-sample t-test analysis and presented in the table below;

Table 4: T-test result on the problem of paucity of funds as hindrances to the effective implementation of NHIS between NHIS staff and health workers in FCT

Categories	Total	Mean	Std. deviation	t-test Result	$t_{critical}$	D.F.	P – Value	Confidence Interval	
NHIS staff	93	3.66	0.733	1.85	1.96	402	0.102	-0.035	0.387
Health workers	311	3.83	0.949						

The independent two-sample t-test analysis result on the problem of paucity of funds as a hindrance to the effective implementation of NHIS in FCT between NHIS staff and health workers presented above indicates that the opinions of NHIS staff and health workers do not vary significantly concerning the problem of paucity of funds as a hindrance to effective implementation of NHIS in FCT given the figures for health workers (3.83 ± 0.949) and NHIS staff (3.66± 0.733). This means that there was no significant difference between the mean response of NHIS staff and health workers as determined by the independent two-sample t-test because $t_{(402)} = 1.85$ *is less than t-critical = 1.96 and p = 0.102 is greater than the level of significance = 0.05.* Consequently, the null hypothesis cannot be rejected. The conclusion reached, therefore, is that the opinions of NHIS staff and health workers do not vary significantly concerning the problem of paucity of funds as a hindrance to the effective implementation of NHIS in FCT.

DISCUSSION OF FINDINGS

The conclusion reached in the test of the hypothesis is that the opinion of NHIS staff and that of health workers do not vary significantly concerning the problem of paucity of funds as a hindrance to the effective implementation of NHIS in FCT. Both categories of respondents (i.e. NHIS staff and health workers) are in agreement that the paucity of funds affects the effective implementation of NHIS in FCT to a high extent. This is evident by their grand mean scores (NHIS staff = 3.66, health workers = 3.83).

It was discovered, specifically, that the management of funds is a big and controversial issue, and poor funding resulting from a lack of prudent management of available funds plays a role in hampering the effective implementation of NHIS in FCT. The study also reveals that

Article DOI: 10.52589/AJSSHR-1YCHIAKJ
DOI URL: https://doi.org/10.52589/AJSSHR-1YCHIAKJ

capitation due to health facilities are delayed or not paid by Health Maintenance Organisations (HMOs) and that the unavailability of some drugs contained in NHIS approved list of drugs is because of such delay or lack of payment of capitation by HMOs to health facilities. The study further established that the failure or delay by some HMOs in providing the required capitation to health facilities is as a result of corruption on the part of some HMOs. This may not be far from the truth, considering the fact that some HMOs were recently de-registered because of a breach of one ethical principle or the other and were asked to put in for fresh registration and accreditation. In support of this, (WHO 2007 and 2010; World Bank, 2009) revealed that poor funding is a serious factor affecting the health development of Nigeria. Ghana (2015) identified these funding challenges to include a low level of public (government) spending high burden of health care costs on individuals and households (70 per cent of all expenditure), thereby ranking Nigeria as one of the countries with the highest level of out-of-pocket spending on health financing in the world.

CONCLUSION

Healthcare financing is an integral feature of health insurance policy in Nigeria. The dilemma of public policy implementation and its effectiveness in Nigeria is that there is often a gap between policy expectations and policy outcomes. In Nigeria, experience has shown that part of the explanation for leadership failures is that, what the government chooses to do, has often fallen short of meeting the requirements of public interest. Based on the hypotheses tested using T-test statistical tool, the study concludes that the problem of paucity of funds is a hindrance to the effective implementation of NHIS in the FCT. Also, the opinion of NHIS staff and health workers does not vary significantly concerning its existence.

RECOMMENDATIONS

Based on the findings of this study, the following recommendations were made;

1. The informal sector programmes of NHIS, such as the Community Based Social Health Insurance Programme (CBSHIP) and Voluntary (Vital) Contributors Social Health Insurance Programme (VCSHIP), should be aggressively implemented in order to carry along those who are not employed under the formal sector and increase the pool of funds towards achieving Universal Health Coverage (UHC).

2. Government's Health Expenditure (GHE) has to be reworked to meet the 13 per cent WHO recommendation for developing countries of the world. Over the years, evidence abounds to show that the Nigerian National budget on health has never been close to the WHO's 13 per cent budgetary prescription for the health sector for developing countries, and this has had a negative implication on the healthcare facilities in Nigeria (from primary to secondary facilities). On this note, the paper recommends significant and consistent improvement in the budgetary allocation to the health sector towards meeting WHO's advice.

3. The paper further recommends that NHIS should closely regulate the activities of the HMOs, which are saddled with the statutory responsibility of paying capitations to

Article DOI: 10.52589/AJSSHR-1YCHIAKJ
DOI URL: https://doi.org/10.52589/AJSSHR-1YCHIAKJ

healthcare providers. This is very necessary because research evidence exists to show that some of the HMOs delay the payment of capitations to the healthcare providers and consequently, this affects the provision of quality drugs to NHIS enrollees.

REFERENCES

Agbatogun, K. K., & Taiwo, A. S. (2010). Determinants of health expenditure in Nigeria. *Journal of Research in National Development*, *8*(2).

Alabi, R. A. (2011). *Marginal benefit incidence analysis of public spending on health services in Nigeria* (No. 121). IWIM Discussion Paper Series.

Babatude, M. A. (2012). An Analysis of the Growth-Health Relationship in Nigeria-A Paper Presented at the Center for the Study of Africa Economic Development, Dakar, Senegal. *Journal of Economic Thought*, *3*(1), 65-83.

Bakare, A. S., & Sanmi, E. D. (2011). The effect of health on economic growth: Theory and Evidence. *NBER Working Paper Series*, (8587).

Bokhari, F. A., Gai, Y., & Gottret, P. (2007). Government health expenditures and health outcomes. *Health economics*, *16*(3), 257-273.

Budget Office of the Federation (2021), 2021 Budget, *Federal Government of Nigeria*, https://www.budgetoffice.gov.ng/index.php/resources/internal-resources/budget-documents/2021-budget

Budget Office of the Federation (2022), 2022 Budget, *Federal Government of Nigeria*, https://www.budgetoffice.gov.ng/index.php/resources/internal-resources/budget-documents/2022-budget

Chikeleze, C. (2004). *Principles of Insurance.* Enugu, Nigeria: Precision Printers.

Eboh, A.; Akpata, G.O. and Akintoye, A.E. (2016). "Health care Financing in Nigeria: An Assessment of the National Health Insurance Scheme (NHIS)." *European Journal of Business and Management. 8, 27.*

Gana, D. (2015). Roles of the Healthcare Provider in Health Insurance. An Article Presented at Nigerian Medical Association Annual Conference. 2015.

Grossman, H. I. (1972). A choice-theoretic model of an income-investment accelerator. *The American Economic Review*, *62*(4), 630-641.

Gwagwalada Town Hall Clinic (2020). PHCs and Health Staff in Kuje Area Council.

Hsiao, W.C. (2007). *Social Health Insurance for Developing Nations*. Washington, D.C: The World Bank and Harvard University.

Idowu, D. O., Benjamin, S. S., & Mercy, O. A. (2018). Healthcare Financing and Health Status Analysis in Nigeria. Amity Journal of Healthcare Management, 3(2), 31–42.

Iloka, C. E., Edeme, R. K., Edeh, R. A., & Ikeagu, U. F. (2018). Equity in Financing Health Care Services in Nigeria. *Journal of Economics and Sustainable Development*, *9*(3), Accessed on 19 Jun. 2021 from: www.iiste.org ISSN 2222-1700 (Paper) ISSN 2222-2855 (Online)

Imoughele, I.L. & Mohammed, I. (2013).Determinants of Public health care expenditure in Nigeria: An Error correction mechanism approach. *International Journal of Business and Social Sciences*, 4(13):220-233

Kuje Area Council (2023). PHCs and Health Staff in Kuje Area Council

Kuje General Hospital (2023). Staff Profile.

Kwali Area Council (2023).List of Health Staff and their Disposition in Kwali Area Council.

Kwali General Hospital (2023).Statistics of Kwali General Hospital Staff Strength.

Article DOI: 10.52589/AJSSHR-1YCHIAKJ
DOI URL: https://doi.org/10.52589/AJSSHR-1YCHIAKJ

Mbaya, P.Y. (2009). *National Health Policy Administration in Nigeria.* Maiduguri, Nigeria: Mike B. Print and Publication.
Metiboba, S. (2012). Contemporary Issues in Health Sociology (A revised and enlarged edition): Owerri. *Banter Multimedia Network*.
NHIS (2015): National Health Insurance Scheme Programmes.
NHIS (2023), Staff Nominal Roll of NHIS
Nyanya General Hospital (2023).Staff Strength.
Ogechukwu, P. (2004). "Health care Services Financing in Nigeria." *Medical Journal. 16, 3.*
Onwujekwe, O., Ezumah, N., Mbachu, C., Obi, F., Ichoku, H., Uzochukwu, B., & Wang, H. (2019). Exploring effectiveness of different health financing mechanisms in Nigeria; what needs to change and how can it happen? *BMC health services research*, *19*(1), 1-13.
Oyefabi, A. O., Aliyu, A. A., & Idris, A. (2014). Sources of health care financing among patients at the Ahmadu Bello University Teaching Hospital, Zaria, Nigeria. *Journal of Medicine in the Tropics*, *16*(1), 27.
Rao, S.K., Salvaraju, S., Nagpal, S. & Sakthivel, S. (2005). Health Financing in India. Available online: www.whoindia.org/:/. Commission on Macroeconomic and Health Finance
Riman, H.B. & Akpan, E.S. (2015). Healthcare Financing and Health Outcomes in Nigeria: A State Level Study Using Multivariate Analysis. *International Journal of Humanities and Social Science*, 2(15): 296-309.
Saad, W., & Kalakech, K. (2009). The nature of government expenditure and its impact on sustainable economic growth. *Middle Eastern Finance and Economics*, *1*(4), 39-47.
Toyin, A. (2014). "Repositioning Health Insurance in Nigeria: Prospects and Challenges." *International Journal of Health Sciences. 2,2.*
UATH (2023), Staff Profile of University of Abuja Teaching Hospital
WHO (2007).World Health Statistics 2007. Geneva: WHO.
WHO. (2010): Health systems financing: the path to universal coverage. Geneva, Switzerland.
World Health Organization. (2011). Introduction to medical equipment inventory management.
Wuse District Hospital (2023).Staff Strength.

Article DOI: 10.52589/AJSSHR-1YCHIAKJ
DOI URL: https://doi.org/10.52589/AJSSHR-1YCHIAKJ