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Assessment Of Funding In The Implementation Of National Health Insurance Scheme In The Federal Capital Territory (Fct), Abuja

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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 considerable gap between policy objectives and outcomes. In the light of this observation, the paper examines the extent to which funding affect the implementation of NHIS in the Federal Capital Territory (FCT), Abuja. The study which is a 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 Kwaliand NHIS staff. The data were analyzed using Statistical Package for Social Science (SPSS). The study observed thatpaucity of funds affect 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; and that government budgetary allocation to health should be upwardly reviewed and sustained; and finally that the HMOs should be closely monitored to ensure that capitations are remitted as at when due.

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

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I. Introduction

Over the past decades, many Low and Middle-Income Countries (LMCs) have found it increasingly difficult to sustain sufficient financing for health care, particularly for the poor. As a result, international policy makers and other stakeholders have been recommending a range of suitable measures, including conditional cash transfers, cost sharing arrangements and a variety of 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 Organization (WHO) passed a resolution that social health insurance should be supported as one of the strategies used to mobilize more resources for health, for risk pooling, for 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 have access to affordable health care regardless of their social status.

Federal Government of Nigeria (FGN_ (2015) has actually corroborated the findings from other studies, when it reported among others that one of the major challenges facing the NHIS is paucity of fund. 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 some other pertinent questions worth asking also. For instance, could these challenges be as 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 generalize 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.

Paucity of funds is a constraint to the effective operations of the Nigerian healthcare system some scholars argue. Funding of health care in Nigeria has not only affected the quality of services but has also led to impoverished health care standard of the populace. The budgetary allocation to health over the years have been between 2 to 4 percent of the total annual budget. For instance in the 2021 national budget, only a meager 4.5 percent was allocated to the health sector and was even dropped to 4.3 percent 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 as occasioned by Covid-19 pandemic. The Nigerian budgetary allocation to the health sector over the years is far below WHO 13 percent 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 health development of Nigeria. Gana (2015) identified these funding challenges as low level of public (government) spending, high burden of health care costs on individuals and households (70 percent of all expenditure); thereby ranking Nigeria as a country with 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 paucity of funds affect the effective implementation of NHIS in FCT, Abuja, Nigeria.

II. Theoretical Milieu

In order to establish the linkage between resources invested in 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 provision of modern health facilities and access to 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 by diet, exercise and preventive visits to see the doctor. However, all these items take time or 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.

Another interesting aspect of the Grossman model, however, 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 emphasize on the need for 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 the 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 inadequate budgetary allocation or poor implementation, hence the poor state of health.

III. Healthcare Financing

Healthcare financing can be defined as the mobilization 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 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 expends on health care. This is proportionate to the country's total national income. The amount of resources earmarked for health care 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 health care financing defines the structure and the behaviour of different stakeholders and 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 health care financing cannot be narrowly conceived and confined to raising enough resources to fund health care needs of people alone, but also entails the questions of affordability and equitable access to health care services by them, including guaranteed financial risk protection. In consonance, Metiboba (2012) contended that when it comes to analyzing health care financing, several nuances have been advanced because some types of health care 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 analysis of health care 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 health care financing analysis a difficult one.

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

IV. Health Insurance

Health insurance is a system of health care financing, which entails the mobilization of funds for health care 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 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 cover completely the cost of health care services provided by the health care provider to the insured.

The insured may have to pay part of the cost (co-payment arrangement). In the same vein, Ogechukwu (2004), views health insurance as the pooling of resources by a group of individuals to take care of 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 payment 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 health care 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 ability to pay.
vii) Solves equity and affordability problem in providing and financing health sector.
viii) Improves and harness private sector participation in the provision of health services (Toyin, 2014).

In a general term, health insurance is the ability of an individual or a member of his family 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.

V. Empirical Review

Eboh, Akpata and Akintoye (2016), carried out a study titled *Health care Financing in Nigeria: An Assessment of the National Health Insurance Scheme (NHIS)* and concluded that several sources of health care financing abound to be leveraged on, 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 the social health insurance which has the capacity and potency of reducing 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 increase in the number of 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 health care are related to ability to pay and if poor households make proportionally more out-of-pocket payment on health. The study utilized secondary sources of data through the data generated by the General household survey of the National Bureau of statistics of 2014. Their study employed the Kakwani progressivity index as a method of analyzing the data generated. Findings from their study show a regressive out-of-pocket payment which suggests that payments towards healthcare are not related to ability to pay. The result also shows that the poor households make proportionally more out-of-pocket payment. They recommended therefore that the government should provide an insurance policy that is 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 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 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 minimizes wastage and improves efficiency. The study also found that Issues with social health insurance cut across legal frameworks and use of Health Maintenance Organisations (HMOs) as purchasers. The concomitant effect is that attainment of Universal Health Coverage is greatly compromised. It recommended, In order to improve efficiency of health financing mechanisms, 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 National Health Insurance Scheme should be amended such that social health insurance becomes mandatory for all citizens.

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 the implementation of the scheme in the FCT.

VI. Methodology of Study

This study made used of both secondary and primary data. Secondary data were obtained through a review of existing literature relevant to implementation of NHIS in Nigeria. Primary data were generated through questionnaire which was distributed to stakeholders in the implementation of NHIS in FCT as shown in Table 1and 2 below. The questionnaire was modeled on Rensis Likert Scale of a five-point rating and adopted 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;

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

Where $\overline{X}$ is the average and the Likert 5 – scale average for decision making = 3.0. The decision rule is given as: 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 the funds in the hospitals. Table 1and 2 below shows the breakdown of the stakeholders who together form the population of this study. According to the NHIS staff nominal roll as at September, 2020, there are 135 staff at the headquarters in Abuja. This number includes junior staff (40), senior staff (71) and Directorate staff (24)

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 Wuse General Hospital Nyanya General Hospital	1369 253 177
Gwagwalada	UATH Gwagwalada Town Hall Clinic (PHC)	857 27
Kwali	Kwali General Hospital Kwali PHC	99 14
Kuje	Kuje General Hospital Kuje PHC	126 23
	Total	**2,945**

Sources: *-National Hospital (2020)*
-Wuse General Hospital (2020)
-Nyanya General Hospital (2020)
UATH, (2020)
Gwagwalada Town Hall Clinic (2020)
-Kwali General Hospital (2020)
-Kwali PHC (2020)
-Kuje General Hospital (2020)
-Kuje PHC (2020)

Table 2: Population of NHIS Staff at the Headquarters

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

NHIS (2020)

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:

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

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

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

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 =

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

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

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

Total Sample Size of NHIS Staff = 101

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, 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. Breakdown of the sample size as drawn from population of various units of the study are 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 Wuse General Hospital Nyanya General Hospital	1369 253 177	164 30 21
Gwagwalada	UATH Gwagalada Town Hall Clinic (PHC)	857 27	102 3
Kwali	Kwali General Hospital Kwali PHC	99 14	12 2
Kuje	Kuje General Hospital Kuje PHC	126 23	15 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 utilized 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:

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

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 analyzed 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_1: 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 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 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
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 as 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 = $\frac{NHIS\ Staff\ (NS)}{Health\ worker\ s\ (HW)} = \frac{3.66}{3.83} = \frac{High extent}{High extent}$									

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 are 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)* were greater than 3.0, the result implies that paucity of funds affects the effective implementation of NHIS in FCT to a high extent.

In specific terms, item one reveals that both the NHIS staff and health workers agreed that to a high extent, 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 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) confirm this evidence. In a similar vein, concerning item three which relates to whether capitation due to health facilities are delayed or not paid by HMOs, they both agreed that the issue exists to a high extent. Their mean score (NHIS staff = 3.43, health workers = 3.88) validates this conclusion.

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

VII. 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 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 management of funds is a big and controversial issue and poor funding resulting from lack of prudent management of available funds play a role in hampering the effective implementation of NHIS in FCT. The study also reveals that capitation due to health facilities are delayed or not paid by Health Maintenance Organisation (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. It was further established by the study 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 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 low level of public (government) spending, high burden of health care costs on individuals and households (70 percent 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.

VIII. 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 do not vary significantly concerning its existence.

IX. 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 Programmme (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 re-worked to meet the 13 percent WHO recommendation for developing countries of the world. Over the years, evidence abound to show that the Nigerian National budget on health has never been closed to the WHO's 13 percent budgetary prescription to 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 on 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 who are saddled with the statutory responsibility of paying capitations to the healthcare providers. This is very necessary because research evidence exist 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.

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