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## ASSESSMENT OF THE EFFECTS OF HOSPITAL BUREAUCRACY ON THE EFFECTIVE IMPLEMENTATION OF NHIS IN FCT, ABUJA, NIGERIA.

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### Abstract

*The noble targets of National Health Insurance Scheme (NHIS) cannot be effectively achieved with undesirable delays at healthcare centres due to bureaucratic bottlenecks present in these hospitals. This study assessed the effects of hospital bureaucracy on the effective implementation of NHIS in FCT, Abuja. The study adopted neo-bureaucratic theory which de-emphasized the harsh effects of the Weberian bureaucratic theory as theoretical framework. The survey study utilized questionnaire instrument to elicit data from Health workers and NHIS enrollees in nine health institutions spread across four Area Councils in Abuja, namely, AMAC, Gwagwalada, Kuje and Kwali. The data were analyzed using Statistical Package for Social Science (SPSS). The study observed that inefficient bureaucracy affects the effective implementation of NHIS in FCT to a high extent. The study concludes that hospital bureaucracy affects the effective implementation of NHIS in the FCT and the views of NHIS enrollees and health workers vary significantly regarding it. It recommended among other things that NHIS documentation processes in the health facilities should be done prior to falling ill and coming to access care.*

**Keywords:** Health Insurance, Hospital Bureaucracy, Policy implementation, NHIS, Healthcare service delivery

### Introduction

The National Health Insurance Scheme (NHIS) is an offshoot of the Nigerian National Health Policy (NHP) and it was established by Decree 35 of 1999 (Now Act 35) and became operational in 2005. It 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. The programmes of the scheme are designed to cover the formal sector (Public Sector: Federal, State and Local Government; organized private sector; Armed forces; police and other uniformed services); the informal sector (Community Based Social Health Insurance Programmes, Voluntary Contributors Social Health

Insurance Programmes; and the Vulnerable Group Social Health Insurance Programme for physically challenged persons, prisons inmates, under five children, refugees, victims of human trafficking, internally displaced persons and pregnant women) (NHIS, 2013).

The NHIS has existed for well over a decade and opinion is polarized among its clients as to whether the scheme has the capacity to guarantee universal coverage and access to adequate, effective and affordable health care for millions of Nigerians. The question of the level of satisfaction derived by NHIS enrollees has become a big issue. These questions have arisen perspectivevely on various factors that affect effective implementation of the NHIS scheme. One of these factors is Hospital Bureaucracy. Excessive bureaucratization involved in processing the NHIS transactions has been a discouraging factor to the potential as well as real enrollees. There is usually delay in the documentation procedure in the hospitals. According to Ele, Ogbonna, Ochei and Odili (2017) hospital bureaucracy (i.e. waiting time and NHIS documentation procedure) constitutes serious issues in the effective implementation of the scheme. It is against this background that this study assesses the effect of hospital bureaucracy on the effective implementation of NHIS scheme in Federal Capital Territory, Abuja.

### **Theoretical Framework**

#### **Neo-bureaucratic Theory**

The Neo-bureaucratic theory is an offshoot of the Weberian theory of bureaucracy. Scholars like Simon (1947), Cyert and March (1963) emphasize on both individual and organizational decision making as antidotes to the harsh effects of Weberian bureaucratic theory. Many organizations have adopted the following principles of classical bureaucracy: rational organization, objectivity, and legal authority (Weber, 1922). A classical bureaucracy embraces guidelines that are legal (e.g., impartiality), economic (e.g., efficient task execution), social (e.g., minimization of conflict) and ethical (e.g., dignity). Nonetheless, classical bureaucracy has proven inadequate in coping with the pace of change in contemporary society and the wide range of specialized professionals found in modern health systems (Lega and Pietro, 2005).

The broader concept of bureaucracy has not been discarded in those settings. Instead, the premises of bureaucracy have been adjusted. This has led to what is now termed 'neobureaucracy' (Farrell and Morris, 2003). Neo-bureaucracy maintains the classic bureaucratic concepts of *systematization, rationality, authority, jurisdiction, professional qualification, knowledge, discipline, transparency, and accountability* (Oliveira et al., 2020). However, as outlined below, it does so in a different way.

Overviewing the concepts of bureaucracy:

- a. *systematization*: strict and systematic discipline and operational control;
- b. *rationality*: absence of personal interests, objectives, and arbitrariness. Guidance is provided by pre-defined rules and regulations;
- c. *authority*: administrative organization is formally defined with a clear hierarchy of departments;
- d. *jurisdiction*: each department has its sphere of competence defined clearly and legally;
- e. *professional qualification and knowledge*: selection of all staff is based on technical qualifications;
- f. *discipline*: a form of behavioural control emerging from an organization's control system, instruments of power, and means of administration;
- g. *transparency*: people in an organization can perceive the reasons for their orders and the consequences of their behaviour; and
- h. *accountability*: keeping records and establishing a hierarchy of responsibilities (Weber, 1922; Styhre, 2007).

Classic bureaucracy differs from *neo-bureaucracy* mainly in understanding the concept of *discipline*. With *neo-bureaucracy*, *discipline* arises from adaptive collaboration. In contrast, in classical bureaucracy, *discipline* is imposed. This conceptual difference affects how *authority* is perceived and exerted; and how other bureaucratic concepts (mainly *systematization*, *accountability* and *jurisdiction*) are manifested. Thus, *neo-bureaucracy* 'softens' hierarchical authority. Decisions are not taken rigidly from top to bottom in the organizational hierarchy. Rather, rules are negotiated, and flexibility in individual circumstances is respected. *Neobureaucracy* is more enabling than coercive (Adler and Borys, 1996). Because of this, it is conducive to helping organizations deal with innovative, but sometimes disturbing processes (Craig, 1995). The *neo-bureaucracy* approach in cutting-edge health organizations help to create innovative records, improve access, and promote convenience (Styhre, 2007).

The *Neo-bureaucratic* theory might have been criticized for largely preserving Weberian bureaucratic principles which in itself contradicts the basic tenets of *neo-bureaucratization*, it is relevant towards creating an internal atmosphere for softening the harsh effects of classic bureaucracy especially in a critical sector such as the

healthcare. Bureaucracy is an essential feature of administration, hence, it cannot be discarded, however, excessive bureaucratization runs counterproductive to the prime essence of the NHIS scheme.

### **NHIS in Nigeria**

The history of NHIS could be traced back to 1962. However, the scheme became operational in 2005 as a tripartite public-private arrangement among three main stakeholder operators; the NHIS, the HMOs and health care providers. The other stakeholder are the enrollees under the scheme (NHIS, 2012). The primary aim is to ensure Universal Health Coverage (UHC) that could enable improved access to health services and thus, a better population health outcome. It had the goal to achieve UHC within a period of 10 years from its inception (2005–2015). While the NHIS shapes the health insurance policy by accrediting the HMOs that operate within the health insurance space, it also accredits health care facilities to provide the benefit packages to registered enrollees. The HMOs are in charge of purchasing health care services on behalf of the Scheme for registered enrollees. The scheme has different programmes for different population groups in the country such as the formal and informal Sector Social Health Insurance Programme (NHIS, 2005, 2012). NHIS is a pro-poor policy with the potential to promote access to needed quality health care among Nigerian populace and reduce the rate of uninsured as was reported in the Affordable Care Act (ACA) in America (Obama, 2016). However, opinion is polarized among stakeholders on the efficacy of the scheme in addressing the health situation and poor health outcomes in the country (Agba, Ushie, Osuchukwu, 2010).

The Nigerian NHIS is a Social Health Insurance Programme (SHIP) which combines the principles of Socialism (being one's brother's keeper) with that of Insurance (pooling of Risks and resources) (Odeyemi, 2014). It is a body corporate with perpetual succession established under Act 35 of 1999 to provide Social Health Insurance (SHI) in Nigeria whereby the Health care services of the contributors are paid for from the pool of fund contributed by participants in the Scheme.

The Bill on NHIS was first introduced in 1962 but failed to receive parliamentary approval. The national council on health conducted a study on NHIS from 1984-1989. Based on the study's recommendations, Federal Ministry of Health was directed to start the NHIS in 1992, which was officially launched in 1997. In 1999 the NHIS laws was passed paving way for effective implementation in May 2005 (Aderounmu, 2013).

### **Hospital Bureaucracy and Healthcare provisioning in Nigeria**

Rapid and quality service delivery is crucial in health-care management, especially in hospitals in Nigeria given the prevailing socio-economic situation. As the popular

adage says, health is wealth, so also is prompt and quality service delivery essential to human existence. This has been a challenge in the Nigerian health sector for over a long period of time and it calls for urgent intervention. Obtaining reliable services and prompt attention in government-owned hospitals have been a plague confronting most patients visiting hospitals when the need arises. The first point of call in our public hospitals in Nigeria is the record unit, where patients' files are kept. Right from this point down to the pharmacy where drugs are administered to patients, are characterized by an ineptitude service offering and delay processes. The ineptitude nature and delay have its root in bureaucratic management dimensions of the hospitals. On the account of the bureaucratic tendency, majority of the health-care workers have a poor attitude to work and this has an overbearing adverse effect on service quality to patients and their health systems. In the same vein, the bureaucratic processes and poor attitude to work have bedevilled the entire public sector of our national economy. From observation, not only the health-care sector, but virtually all public parastatals, ministries, and agencies are symbolic with delayed and slow attention when it comes to quality and efficient service delivery, and the Nigeria health-care system is not an exemption.

The challenge of bureaucratic processes of delaying patients that needed urgent attention is evident in the investigation of Segel (2017) which supports the above explanations, and argued that bureaucracy is deterring health-care from getting better. The inefficiency in health-care service delivery is pervasive especially in tertiary hospitals in FCT, Abuja as well as the entire country. So many factors like patient-related, health worker-associated and employer-associated factors interrelate and adversely negate the quality of health-care delivery being obtained in the country (Iloh et al., 2013). The perceived challenge across all government established hospitals, and health-care facilities in the country, is the difficulties of poor response and attention in the cause of their visit to hospitals and this has caused a lot of damage to the citizens' health systems. Some have consciously and unconsciously killed patients in the process of delay in giving prompt attention to the patients in the name of the bureaucratic pattern of work. Most times, the bureaucratic nature is extended more than usual and it has turned to neglect and abuse of the profession, and ethics of the business by health-care workers.

In furtherance of this discourse, the general inefficiency, ineffectiveness and poor service delivery in the Nigerian public service are as a result of poor procedural rules, excessive bureaucratic processes, political interference, poor working conditions, poor work ethics, among others, which have interacted to adversely affect service delivery in public sector organizations and particularly the health-care sector (Ezeani, 2014). The poor service delivery of public bureaucracy is sometimes criticized on its principle

of impersonality, it nonetheless, creates a hole between the bureaucratic organizations and the populace.

Furthermore, studies have revealed that bureaucratic processes are taking too much time and unproductive, prevent innovative ideas and improvement, frosty and unconcerned, hindered hierarchical control, permeated with red-tapism, and subject to considerable goal displacement which is termed “bureaucratic dysfunction” (Maduabum, 2014; Ibietan and Oni, 2013; Irfan, 2016). It is this highly routinized operating structure that most times adversely influence quality health-care service delivery in government-owned hospitals and tertiary institutions health centres which this study is evaluating in line with public opinion (NHIS enrollees) and perception of the health workers in Nigerian government hospitals.

Another pervasive issue that informs this study is that several challenges have emerged in the Nigerian health-care industry in relation to service quality. Through observations and interactions, patients' health systems have been thwarted as a result of the delay in response and the lackadaisical attitude to work. What could have been done headlong by one personnel to avert possible frustration of attendees in the hospital would be extended to more than three personnel before patients could comfortably obtain health-care attention in Nigerian public health-care facilities. The deplorable conditions of service delivery due to bureaucratic dimensions in tertiary and public hospitals were further argued in the study of Nwankwo et al. (2015) whose findings established that bureaucratic line of authority; division of labour, administrative procedural rules, impersonality and waiting time are the major adverse influence to achieving quality service delivery in Nigerian public hospitals.

This situation is worrisome in Nigeria where public health system calls for vehement intervention. Thus, this study is set to add value to patients' health-care system by looking at the existing literature of Nwankwo et al. (2015) and Ezeani (2014), along Max Webber's perspectives whose studies established some tenets of bureaucracy such as authority, division of labour, administrative procedural rules, impersonality and waiting time in Nigerian government hospitals. The study also proffered solutions to the deplorable states of service delivery in government-owned hospitals and bring succor to the patients.

### **Empirical Review**

Kuye, & Akinwale, (2020) carried out a study titled “Conundrum of bureaucratic processes and healthcare service delivery in government hospitals in Nigeria”. The study investigated the problem of bureaucratic processes and health-care service delivery in government hospitals in Nigeria. The study randomly surveyed, with questionnaire instrument, 600 outpatients and attendees visiting tertiary and

government hospitals in Nigeria using descriptive design to obtain data from the respondents, and utilized bivariate analysis to analyze the data gathered. Findings of the study revealed that service delivery in government hospitals were in adverse position on all the four constructs of bureaucratic dimensions as against quality of service delivery in hospitals in Nigeria. It discovered that bureaucratic impersonality cannot impact on the quality of service delivery in government hospitals in Nigeria. Separation and division of labour among health workers have no significant effect on quality service delivery in government hospitals. Formal rules and regulations (administrative procedure, rules, and policies) prevent quality service delivery in government hospitals in Nigeria. Also, patient's waiting time was not significant to the quality of service delivery in government hospitals. Hence they recommended that bureaucracy in the Nigerian public hospitals is an unnecessary marriage which should be carefully separated and de-emphasised for quality service delivery in the hospitals to thrive.

Oliveira, Rodrigues, & Craig, (2020) also carried out a study on "Bureaucracy and the balanced scorecard in health care settings". The purpose was to explore the relationship between the Balanced Scorecard (BSC) and neobureaucracy by investigating whether the operationalization of the BSC incorporates 'neobureaucratic' ideas; and whether the BSC implemented in a Portuguese Local Health Unit (LHU) evidences a neo-bureaucratic approach. They conducted semi-structured interviews and analyzed secondary-sourced documents. Their study found nine bureaucratic features evident in the LHU's BSC. These were systematization, rationality, authority, jurisdiction, professional qualification, knowledge, discipline, transparency, and accountability. The BSC used at the LHU evidenced a neobureaucratic approach. Therefore recommended among others that LHUs should recognize the BSC as involving a neo-bureaucratic approach. The BSC is a valuable management tool that hospital managers should find useful fostering flexibility, collaboration, innovation and adaptation – all of which should help lead to improved health care outcomes.

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

### 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 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 1. 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;

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

Where  $\bar{X}$  is the average and the Likert 5 – scale average for decision making = 3.0. The decision rule is given as: 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 enrollees and Health workers in FCT. Table 1 below shows the breakdown of the NHIS enrollees and Health workers who together form the population of this study.

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

Area Council	Health care Provider	Health Workers	NHIS Enrollees
AMAC	National Hospital	1369	22,000
	Wuse General Hospital	253	5926
	Nyanya General Hospital	177	8,892
Gwagwalada	UATH	857	30,892
	Gwagwalada Town Hall Clinic (PHC)	27	2,151
Kwali	Kwali General Hospital	99	2685
	Kwali PHC	14	472
Kuje	Kuje General Hospital	126	2533
	Kuje PHC	23	398
	<b>Total</b>	<b>2,945</b>	<b>75,250</b>

**Source:** -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)

The study adopted Taro Yamani's formula and proportional sampling technique to determine the sample size of the respondents. These allows 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 =

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

Where n = Sample Size

N = Population Size (2,945)

e = Level of Significance (0.05)

l = Constant

Therefore, n = 2,945

$$\begin{aligned} & \frac{2,945}{1 + 2,945 (0.05)^2} \\ & = \frac{2,945}{1 + 2,945 (0.0025)^2} \\ & = \frac{2945}{1 + 7.362} = \frac{2945}{8.3625} = 352 \end{aligned}$$

Total Sample Size of all Health Workers = 352

### **Determination of Sample Size of Enrollees based on total Population of 75,250**

Using Taro Yemani's formula =

$$\begin{aligned} & n = \frac{N}{1 + N(e)^2} \\ & = \frac{75,250}{1 + 75,250 (0.0025)^2} \end{aligned}$$

$$= \frac{75,250}{1 + 188.125}$$

$$= \frac{75,250}{189.125} = 398$$

Total Sample Size of Enrollees = 398

Area Council	Health care Provider	Population of Health Workers	Sample size of Health Workers $\frac{?}{?} * \frac{?}{?}$	Population of NHIS Enrollees	Sample Size of NHIS Enrollees $\frac{?}{?} * \frac{?}{?}$
AMAC	National Hospital	1369	164	22,000	116
	Wuse General Hospital	253	30	5926	31
	Nyanya General Hospital	177	21	8892	47
Gwagwalada	UATH	857	102	30,193	160
	Gwagwalada Town Hall Clinic (PHC)	27	3	2,151	12
Kwali	Kwali General Hospital	99	12	2685	14
	Kwali PHC	14	2	472	3
Kuje	Kuje General Hospital	126	15	2533	13
	Kuje PHC	23	3	398	2
	<b>Total</b>	<b>2,945</b>	<b>352</b>	<b>75,250</b>	<b>398</b>

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 2 below.

**Table 2: Sampled population of Health Workers and enrollees 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 $\frac{? * ?}{?}$	Population of NHIS Enrollees	Sample Size of NHIS Enrollees $\frac{? * ?}{?}$
AMAC	National Hospital	1369	164	22,000	116
	Wuse General Hospital	253	30	5926	31
	Nyanya General Hospital	177	21	8892	47
Gwagwalada	UATH	857	102	30,193	160
	Gwagalada Town Hall Clinic (PHC)	27	3	2,151	12
Kwali	Kwali General Hospital	99	12	2685	14
	Kwali PHC	14	2	472	3
Kuje	Kuje General Hospital	126	15	2533	13
	Kuje PHC	23	3	398	2
	<b>Total</b>	<b>2,945</b>	<b>352</b>	<b>75,250</b>	<b>398</b>

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

*H<sub>0</sub>: The views of enrollees and health workers do not vary significantly regarding the problem of hospital bureaucracy as a barrier to the effective implementation of NHIS in FCT.*

*H<sub>1</sub>: The views of enrollees and health workers vary significantly regarding the problem of hospital bureaucracy as a barrier to the effective implementation of NHIS in FCT.*

### Data Presentation and Interpretation

Out of the 352 copies of questionnaire administered to healthcare workers, only 311 copies were retrieved and found usable; and of the 398 copies of the questionnaire to the enrollees, only 361 copies were retrieved and found usable. Therefore the analysis of data were based on the figure retrieved.

**Table 3: Descriptive Analysis of the Extent To Which Hospital Bureaucracy 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.	Tedious documentation procedures in the health facility affect effective delivery of service.	NE	233	74	29	17	8	361	4.40	High extent
		HW	61	90	55	81	24	311	3.27	High extent
2.	The tedious documentation procedures increase waiting time of enrollees thereby discouraging potential enrollees.	NE	178	127	27	19	10	361	4.23	High extent
		HW	89	97	36	73	16	311	3.55	High extent
3.	Tedious documentation procedures/channels are difficult to be fast tracked by enrollees in cases of emergency.	NE	181	123	30	18	9	361	4.24	High extent
		HW	104	97	25	63	22	311	3.64	High extent
4.	Medical laboratory results are unnecessarily delayed because of hospital procedures.	NE	161	143	23	26	8	361	4.17	High extent
		HW	116	84	30	55	26	311	3.67	High extent
5.	Generally, enrollees are not satisfied with the extent of service delivery in the health facility because of tedious (and sometimes unnecessary) hospital bureaucracy.	NE	150	155	24	18	14	361	4.13	High extent
		HW	108	85	30	60	28	311	3.59	High extent
			Grand mean =							
			$\frac{\text{NHIS Enrollees NE}}{\text{Health workers HW}} = \frac{\text{high extent}}{\text{High extent}}$							

Source: Field work, 2020

**Interpretation of Results:**

Table 3 above presents item by item descriptive analysis of NHIS enrollees and health workers' response to the statement on the extent to which hospital bureaucracy affects the effective implementation of NHIS in FCT. The mean score of the items for the two categories of respondents were all greater than 3.0. The result in the table also shows that the grand mean rating of NHIS enrollees (mean = 4.09) was higher than the grand mean rating of the health workers (mean = 3.55). Consequently, since the grand means for both categories (i.e. mean = 4.09 and 3.55) were greater than 3.0,

the result implies that hospital bureaucracy affects the effective implementation of NHIS in FCT to a high extent.

Specifically, item one on table 3 above indicates that NHIS enrollees and health workers agreed that, to a high extent, the problem of tedious documentation procedures in the health facilities affect effective delivery of health services. This is justified by their mean scores (NHIS enrollees = 4.40, health workers = 3.27). Concerning item two on the table above (which relates to whether the tedious documentation procedures increases waiting time of enrollees thereby discouraging potential enrollees from seeking health care services), both categories of respondents also confirm that the issue exists to a high extent (mean score: NHIS enrollees = 4.23, health workers = 3.55). Item three on the table further reveals based on the opinion of the two categories of respondents that to a high extent, the tedious documentation procedures/channels are difficult to be fast tracked by enrollees in cases of emergency. Their mean scores (NHIS enrollees = 4.24, health workers = 3.64) validate this opinion.

Item four on the table further reveals that, to a high extent, medical laboratory results are unnecessarily delayed because of hospital procedures. The mean scores (NHIS enrollees = 4.17, health workers = 3.67) confirm this opinion. Finally, concerning item five on the table above, there is an agreement between both categories of respondents that, to a high extent, enrollees are not satisfied with the extent of service delivery in the health facility because of tedious (and sometimes unnecessary) hospital bureaucracy. Their mean scores (NHIS enrollees = 4.13, health workers = 3.59) justify this opinion.

#### **Test of hypothesis on the problems of hospital bureaucracy as a barrier to the effective implementation of NHIS in FCT.**

The hypothesis that was tested in this study relate to whether the views of enrollees and health workers differ significantly regarding the problem of hospital bureaucracy as a barrier to the effective implementation of NHIS in FCT. The responses were subjected to the independent two sample t-test.

#### **Test of Hypothesis**

To test the difference in the mean opinions between enrollees and health workers regarding the problem of hospital bureaucracy as a barrier to the effective implementation of NHIS in FCT, the mean responses from the enrollees and health workers were subjected to a descriptive Statistics and an independent two sample t-test analysis as presented in the table below.

**Table 4: T- test result on the problem of hospital bureaucracy as a barrier to the effective implementation of NHIS between enrollees and health workers in FCT.**

Categories	Total	Mean	Std. deviation	t- test Result	t <sub>critical</sub>	D.F.	P – Value	Confidence Interval	
Enrollees	361	4.09	0.692	-7.638	-1.96	670	0.000	-0.668	-0.395
Health workers	311	3.55	1.092						

The independent two sample t-test analysis result on the problem of hospital bureaucracy as a barrier to the effective implementation of NHIS in FCT between enrollees and health workers presented above indicates that the opinions of enrollees and health workers vary significantly given the figures for *enrollees* ( $4.09 \pm 0.692$ ) and *health workers* ( $3.55 \pm 1.092$ ).

This means that there was a significant difference between the mean response of enrollees and health workers as determined by the independent two sample t-test;  $t_{(670)} = -7.638$  and  $p = .000$ . Consequently, the null hypothesis is rejected in favour of the alternative hypothesis because  $p = 0.00$  is less than the level of significance =  $0.05$ , at the *d.f.* =  $670$ . This therefore implies that the views of enrollees and health workers vary significantly regarding the problem of hospital bureaucracy as a barrier to the effective implementation of NHIS in FCT.

#### Discussion of Findings

Test of hypothesis result shows that the views of NHIS enrollees and health workers vary significantly regarding the problem of hospital bureaucracy as a barrier to the effective implementation of NHIS in FCT. This implies that the Null hypothesis was rejected while the alternate hypothesis was accepted. However, despite the variation in the views of enrollees and health workers as shown by inferential statistical analysis, the descriptive analysis revealed that both are in agreement that the problem of hospital bureaucracy affects the effective implementation of NHIS in FCT to a high extent as evident in their grand mean scores (NHIS enrollees =  $4.09$ , health workers =  $3.55$ ).

On a specific ground, the investigation revealed that tedious documentation procedures in the health facilities affect effective delivery of services to enrollees and that these procedures/channels are difficult to be fast tracked by enrollees in cases of emergency. Also, it was discovered that medical laboratory results are unnecessarily delayed because of hospital procedures. The tedious procedures, it was established, increases waiting time of enrollees thereby discouraging enrollees from accessing the facilities. On a general note, the study discovered that enrollees are not satisfied with the extent of service delivery in the health facilities because of tedious (and sometimes unnecessary) hospital bureaucracy.

The discovery above is in line with the finding of Ele, Ogbonna; Ochei and Odili (2017) who reported that hospital bureaucracy (i.e. waiting time and NHIS

documentation procedure) constitutes serious issues in the effective implementation of NHIS in Enugu State University Teaching Hospital (ESUTH) in Southeast, Nigeria. On a final analysis, from the responses to the open ended questions, it was discovered that both enrollees and health workers are not happy with the referral system. A lot of them complained that getting referral code from the HMOs for secondary and tertiary care are delayed most of the time. The health workers also complained of lack of prompt payment of their salaries and other incentives, and lack of adequate training and retraining. This according to them affects their level of professional commitment.

### **Conclusion**

The noble idea of achieving universal health coverage which necessitated the establishment of NHIS is a mirage without a concerted effort to de-bureaucratize healthcare provisioning. It has been uncovered that heavy bureaucracy that characterize hospitals which essentially serve as healthcare providers under the NHIS scheme, constitute an encumbrance to the effective implementation of the scheme. There was need therefore to assess this untoward factor of implementation of the scheme. This study conducted this assessment and concludes that hospital bureaucracy affects the effective implementation of NHIS in the FCT and the views of NHIS enrollees and health workers vary significantly regarding it.

### **Recommendations**

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

1. That NHIS documentation processes in the health facilities should be done prior to falling ill and coming to access care. This would go a long way in reducing the number of hours spent by enrollees before seeing a medical consultant.
2. The world is presently driven by Information and Computer Technology, so NHIS in collaboration with health care facilities should ensure that information about enrollees are computerized to enhance fast delivery of services.
3. In addition to these, the delay in getting referral code by enrollees and health workers for secondary and tertiary care can be made a thing of the past. In this direction, the study recommends that NHIS should as a matter of urgency, ensure that every HMO has a desk officer that is constantly stationed in the health facility and saddled with the responsibility of issuing referral codes.
4. NHIS should establish NHIS – owned health facilities across the thirty-six states and in all the local government of the federation. This will help to reduce the hardship that NHIS enrollees pass through when the personnel of other health facilities are on national strike.

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