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The Adequacy and Perceived Impact of Nigeria's Health Policy

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Abstract

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MBChB, University of Nairobi, 1994

MPH, University of Dar es Salaam, 2000

Dissertation Submitted in Partial Fulfillment

of the Requirements for the Degree of

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Abstract

From 2004 to 2015, the health sector in Nigeria was substantially underfunded despite the existence of a federal health policy committing 15% of the national budget to health care financing. The purpose of this narrative and phenomenological study was to explore the nature and significance of economic claims made in this policy. The central research question examined the extent to which these economic claims were perceived to be realistic, attainable, and successful in meeting their intended policy objectives and impact. The study's conceptual framework combined Kingdon's ambiguity and multiple streams theory, Roe's narrative policy analysis, and Skocpol's policy feedback theory. Seventeen major health policy documents and transcripts from key informant interviews with a convenience sample of 15 representative health policy experts, were imported into a data software. Twenty-six nodes were identified and then manually organized into 3 themes to generate the findings. Policy experts perceived the 147 economic claims in the policy documents as marginally realistic, and a majority of these experts assessed the claims as unattainable and with limited chance of succeeding in addressing the underfunding of Nigeria's health sector. The study opened a new area of research inquiry in health policy and health care financing by linking the veracity of economic claims made in the national health policy with the actual financing of health care. Health policy experts can use study results to promote the formulation and use of evidence-based economic claims in future health policies. Increased use of specific, measurable, attainable, realistic, and time-bound economic claims will enhance future health policy contributions to human wellbeing and positive social change.

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Dedication

Dedicated to my dear wife Beatrice Monyenche Motari for encouraging me to register for the PhD; lovely children Moraa Nyatichi Ongwae, Nyamoita Kwamboka Ongwae, Okindo Aondo Ongwae; and caring mother Mary Gesare Ongwae. In memory of my father, the late Nelson Ongwae.

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Chapter 1: Introduction to the Study

Introduction

The topic for this study was the adequacy and the perceived impact of Nigeria's health policy with a focus on the period 2004 to 2015. The time period covered by the study was significant because the last health policy for Nigeria was developed and approved for implementation in 2004 through the end of 2015, which was also the end line for the Millennium Development Goals (MDGs; Federal Ministry of Health [FMoH], 2004). I formulated the research topic based on observations made on the perennial underfunding of the health sector in Nigeria despite the existence of a health policy that was expected to facilitate allocation of adequate resources to the sector (Mburu, Folayan, & Akanni, 2014). The potential social implications of the study were on the generation of new knowledge on the nature of economic claims made in the health policy and the potential use of the findings to develop effective health policies.

In Chapter 1, I outline the problem of underfunding of the health sector in Nigeria. The purpose of the study was to establish the adequacy and perceived impact of Nigeria's health policy during the period covered by the study. The research questions lead to a better understanding of economic claims made in the health policy and their perceived importance by the health policy experts working in Nigeria. A combination of three theories constituted the conceptual framework for the mixed narrative and phenomenological study. The conceptual framework included Kingdon's ambiguity and multiple streams theory that operates on the premise that the policy, politics, and problem streams come together when there is a policy window to initiate the making of a new policy (Buse, Mays, & Walt, 2005; Kusi-Ampofo, Church, Conteh, & Heinmiller, 2015;

Sabatier & Weible, 2014). The conceptual framework also included Skocpol's policy feedback theory that portends that existing policy influences the making of a future policy (Sabatier & Weible, 2014). Finally, the framework included Roe's narrative policy theory in which the case of policy-making process using narratives is made (Ball, 1995; Roe, 1989, 1994; Sabatier & Weible, 2014). The scope of the study was limited to the health policy context for Nigeria; given its qualitative nature, there were foreseen limitations in the generalization of the expected results. Despite the anticipated limitations, the study was significant for Nigeria's underfunded health sector as well as other developing countries with a similar challenge.

Background

In 2001, heads of African States meeting in Abuja, Nigeria, agreed to start allocating at least 15% of their subsequent annual national budgets to the health sector (Mburu et al., 2014). In 2011, Rwanda and South Africa were the only countries that allocated more than 15% of their general government expenditure to health, and only Swaziland complied with the call for the minimum allocation in 2013 and 2014 (Mburu et al., 2014; World Health Organization [WHO], 2013, 2014). In 2014, the total annual government budget allocated to the health sector in Nigeria was only 8%, which went against the 2001 Abuja agreement of an annual minimum of at least 15% (Mburu et al., 2014; WHO 2011, 2014). Therefore, as part of the literature review, I examined Nigeria’s health care financing trends from 2004 through 2015, as well as reviewing the underlying health policy architecture in the country (FMoH, 2004; Onwujekwe, Onoka, Uzochukwu, Obikeze, Ezumah, 2009; Uzochukwu et al., 2016). The literature review also covers the

processes involved in the making and implementation of health policies in general (Buse et al., 2005; Martiniuk, Abimbola, & Zwarenstein, 2015).

The literature containing information on various health policies was reviewed as a part of the process of understanding the nature of the economic claims made in the policies. The Affordable Care Act (ACA) of the United States is an example of a policy that claimed to make families richer, cut health care spending, stimulate economic growth, improve productivity of the workforce, improve job mobility, increase financial security, and improve vaccination coverage (Cohen, Neumann, & Weinstein, 2008; Geyman, 2015; Shen et al., 2014). However, these claims might not have been realized. As a case in point, an increase in immunization rates did happen as a part of the implementation of ACA; but, the increase did not happen for all of the immunization antigens as originally claimed (Shen et al., 2014).

Another example of a claim that was examined by Cohen et al. (2008) involved the 2008 U.S. presidential debates on preventive care. As a part of their campaign agenda on health care, most of the presidential candidates claimed that preventive care saves money, so they promised to invest in that area. In reality, the impact of preventive care on health care costs depends on the size of the target population reached and on the preventive intervention (Cohen et al., 2008). Different kinds of claims were, therefore, made in health policies; most of these claims touched on the financing of health care to achieve benefits, some of which are economic in nature. In the case of Nigeria, the nature and importance of economic claims in the country's health policy during the period covered by the study were unknown, which was why there was a gap in the literature.

The contribution of health policy to health care financing is a subject that continues to attract attention (Nguyena, Sniderb, Ravishankarc, & Magvanjavd, 2011; O'Donnella et al., 2016; Onoka, Hanson, & Mills, 2016). In a study on the policy on provision of reproductive health services by the public, private, and informal sectors in six sub-Sahara African countries, Nguyena et al. (2011) concluded that the policy was tied to the health care financing outcomes. According to Onoka et al. (2016) private health insurance and other private sector organizations have a role in the financing of universal health care in Nigeria, but regulatory mechanisms should be in place for them to play that role effectively. The migrant crisis in Europe has necessitated policy debate on financing a primary health care (PHC) system and improved entitlements against the financial burden of health care for the marginalized migrants (O'Donnella et al., 2016). In this study, therefore, I focused on the adequacy and perceived impact of the economic claims made in the health policy of Nigeria. The findings of this study may be used to influence future policy making as well as the allocation of adequate funds to the health sector.

Problem Statement

In 2014, Nigeria spent US$21 billion on health care and that included US$15.1 billion out-of-pocket spending by the households, US$5.3 billion spending by the government, and US$0.6 billion contribution from donors (WHO, 2014). The share of total government spending allocated to health care in 2014 was 8% against a recommended minimum of 15% (WHO, 2011). In this regard, the government allocation to the health sector was low. This was a result of the limited government fiscal space and inadequate capacity to mobilize domestic resources for investment in the health sector

(Ejughemre, 2014). The government might not have the flexibility to allocate more funds to the health sector without jeopardizing its overall financial position or economic stability.

Purpose of the Study

The purpose of this qualitative study was to understand the adequacy and perceived impact of economic claims made in the health policy of Nigeria from 2004 through 2015. The nature of the claims was determined using a narrative analysis of the policy documents approved for use during the period covered by the study, while the perceived impact of the claims was established through key informant interviews with selected health policy experts in Nigeria. I relied on the policy documents and the health policy experts as the sources of data for determining the perceived contribution of the health policy to the financing of the health sector, prudent use of resources in the sector, and the protection of beneficiaries of health care against the attendant financial costs. I focused on the study period because the last health policy for Nigeria was developed for implementation starting in 2004 and ending in 2015 (FMoH, 2004).

Research Questions

I used the following research questions to establish the nature of economic claims in the health policy in Nigeria, as well as the adequacy and perceived impact of the policy.

RQ1: What is the nature of economic claims made in the health policy in Nigeria over the period starting in 2004 and ending in 2015?

RQ2: What are the perceptions of health policy experts in Nigeria on the adequacy and impact of the economic claims made in the country's health policy over the period starting in 2004 and ending in 2015?

Conceptual Framework

The study was guided by a conceptual framework developed from Kingdon's ambiguity and multiple streams theory, Skocpol's policy feedback theory, and Roe's narrative policy analysis method (Ball, 1995; Buse et al., 2005; Kusi-Ampofo, et al., 2015; Roe, 1989, 1994; Sabatier & Weible, 2014). Organizational theory could also have been used to guide the study's conceptual framework but was not considered because of its general application in the presence of more specific theories on the policy-making process (Shafritz, Ott, & Jang, 2016). As further explained in Chapter 2, the three theories were used in an interrelated and complementary manner. I argued that a single theory might not satisfy all of the conceptual needs of the study. In this respect, Roe's narrative analysis theory was used to guide the collection, analysis, and the interpretation of data from both the content analysis of health policy documents as well as from the key informant interviews. The theory was, therefore, used to generate the storylines on the perceived impact of the economic claims made in the health policy.

Kingdon's theory is built on the premise that the problem, politics, and policy streams (policy entrepreneurs) converge when a policy window exists and policy-making is possible (Sebatier & Weible, 2014). The streams interact through a single theoretical lens that also makes it possible for other complementing theories to be used (Sebatier & Weible, 2014). Sebatier and Weible (2014) argued that the streams are related and the resulting policy-making process might have implications for the implementation of the

policy as well as on its long-term impact. The key informant interviews with health policy experts were used to gain further insights into the nature, adequacy, and impact of the economic claims made in the health policy for Nigeria during the period starting in 2004 and ending in 2015. Kingdon's theory was used to gain a better understanding of the process that was used in the creation of the health policy and its content. It was also used to gain a better understanding of the economic impact of the policy.

Sebatier and Weible (2014) argued that the ambiguity in the application of Kingdon's theory helps to connect the present with the future. The argument is in line with Skocpol's feedback theory that current policy influences future policy (Sabatier & Weible, 2014). The past health policy in Nigeria influenced the policy being studied and this will influence future health policy. In the key informant interviews, the health policy experts explored the perceived adequacy of the economic claims made in the health policy and their impact on health care financing, prudent use of resources, and the financial protection of beneficiaries of health services. The participants contributed to the potential impact of the policy on future policies by proposing some recommendations for the future health policy-making process. Therefore, Skocpol's theory was used as the basis for collating feedback on the implementation of the health policy and its perceived long term impact on future health policy and the society.

Nature of the Study

In this study, I adopted a qualitative methodology with mixed narrative and phenomenological approaches. A phenomenon is a pattern or trend that has been observed over time, and a phenomenological research approach, therefore, is used to better understand the observation (Creswell, 2009). The economic claims in the health

policy constituted the phenomenon. The qualitative approach included a review of the health policy, its sub policies, and related strategies for the economic claims made in them. The identified economic claims were organized into nodes and themes using Nvivo software. The study approach also included key informant interviews of 15 health policy experts to generate a narrative of the economic claims in the health policy and their perceived importance. The data from the key informant interviews were analyzed using narrative analysis methodology (Roe, 1989, 1994). A quantitative study approach was not feasible for the study because of the absence of relevant sources of quantitative data in Nigeria; but, the study findings helped to open new research frontiers that might be amenable to quantitative research.

Definitions

Given that the study was used to establish the economic claims made in the health policy of Nigeria, there was a need to develop a common definition of the terminologies that were commonly recurred to at various stages of the study and that had multiple meanings. The definitions of some of the key concepts are provided in the following paragraphs.

Adequacy: Appropriateness or sufficiency. In this study, adequacy was used in relation to the health policy under study to imply its appropriateness or sufficiency to influence the financing of the health sector (El Aty, Meky, Morsy, & El Sayed, 2014).

Catastrophic costs: Expenditures that negatively affect a family or household's ability to meet the needs of their daily livelihoods. The term is commonly used to refer to the large out-of-pocket spending on health care at the detriment of other activities (McIntyre, Ranson, Aulakh, & Honda, 2013; Onwujekwe et al., 2009).

Economic claim: A statement used to represent an economic or financial position or promise. These claims might be related to the financing of the health sector by the government and could be used to advocate for allocation of resources to the health sector. Economic claims could be made on many aspects of health care financing. In this study, economic or financial claims are interchangeably used to imply statements made to represent a monetary situation (Cao & Yan, 2016). Lundgrena, Courtney, Lopez, and Kamath (2016) used the terms concern and claim interchangeably.

Fiscal space: The flexibility of a government to allocate more funds for a purpose without jeopardizing its overall financial position or economic stability. Limited fiscal space, therefore, implies an inability to exercise flexible allocation of resources for a specific purpose (Ejughemre, 2014).

The period covered by the study: The period starting in 2004 and ending in 2015. The health policy for Nigeria that was the focus of the study was approved for implementation starting in 2004 until the end of 2015 (FMoH, 2004). This is the same time period covered by the study.

Assumptions

- The study is supported by a conceptual framework made up of Kingdon's ambiguity and multiple streams theory, narrative analysis theory, and policy feedback theory. I assumed that the framework was adequate to support the study design, data collection and analysis, discussion of the findings, and assessment of the study's contribution to social change. The assumption was necessary because there are other theories, such as the

organizational theory, that could be used as explained previously in the discussion of the conceptual framework.

- I used existing policy documents as one of the sources of data. The FMoH in Nigeria does not have a systematic archiving system for official documents. I, therefore, assumed that all of the official documents would be identified and made available using other means, such as online search and by requesting the documents directly from the relevant departments of the ministry. The assumption was necessary because I aimed at including all the official policy documents in the analysis.
- I further assumed that the official documents would contain a sufficient amount of information on economic claims to allow for meaningful data harvest for review and analysis.
- I used key informant interviews as the second source of data. The informants lived and worked in different locations in Nigeria. I assumed that the interviewees would be available for telephone interviews. The assumption was important in the event of substituting one key informant for another because of a failure to reach them using a telephone call.
- The focus of the study was on economic claims made in the health policy being studied. Economic claim, however, is not a commonly used term, hence the assumption that a brief introduction of the concept would have all the interviewees achieve a uniform understanding of what economic claims represent. This was important because economic claims constituted the phenomenon for the study.

- Some of the key informants were involved in the implementation of the health policy under study. It was, therefore, assumed that these informants would not view the study as an assessment of their performance as this could introduce bias in their responses. It was expected that their responses would be sincere and objective in order to give the study credibility.

Scope and Delimitations

The research problem is crucial in determining the potential role of the health policy in the inadequate public financing of health care in Nigeria as established in the literature review. The details on scope and delimitations are explained as follows.

- I examined the national health policy for Nigeria during the period starting in 2004 and ending in 2015 because the health policy was developed and officially approved for implementation in 2004 through to the end of 2015 in line with the MDG end line of 2015.
- I focused on the determination of economic claims made in the health policy, and the resulting findings were used to establish the adequacy and perceived impact of the health policy.
- I adopted a qualitative methodology with mixed narrative and phenomenological approaches involving a review of the official policy documents in use during the period covered by the study and key informant interviews with health policy experts. I examined the existence of the economic claim in the health policy (the phenomenon) to help establish the impact of the policy in the financing of health care in Nigeria.

The existence of economic claims in the health policy as a phenomenon is not commonly referred to as such in the sector, which means the findings might be understood by the high level researchers and decision makers involved in the development, financing, and implementation of the policy. Middle-level managers could have been included in the study but might not be conversant with the decision-making processes at the higher level. The beneficiary populations could also have been involved in the study, but participation might also have been challenging for most of them to identify with economic claims made in the policy and how that affects the health benefits they enjoy.

- The study's theoretical boundaries were defined by a conceptual framework made up of the ambiguity and multiple streams theory, policy feedback theory, and narrative policy analysis theory. I also reviewed the organizational theory but did not include it in the conceptual framework because I found the former three theories more applicable and relevant to the study. In addition, the organizational theory on politics and power was more on general applications.
- As demonstrated through the review of the literature, health policy-making processes take place under different contexts and in different countries. The process involves the making of economic claims but the phenomenon has little been studied as such. Furthermore, the impact of the economic claims on the financing of health care has also not been documented. In this study, I sought to establish the phenomenon and to further examine

the impact of the claims; therefore, it is potentially applicable in informing the development and drafting of economic claims for other country's health care systems. The study findings will be published and also shared with other researchers in conferences and other channels, and this will further enhance its transferability and use.

Limitations

As argued by Creswell (2009) and Tuli (2010), qualitative research should be understood as being complementary to quantitative research, and this helps to mitigate any limitations against the method. The use of the qualitative method allows research to be designed and conducted on little understood and often complex subjects, such as negative leadership and on the phenomenon of economic claims for this study (Schilling, 2009). The approach, therefore, allows research questions that are not amenable to quantitative research to be researched qualitatively, with explanations to be generated and exploration to be conducted. The greater flexibility in qualitative research, in turn, exposes it to critique, weaknesses, and limitations.

- I adopted a qualitative approach. The study findings and interpretation might be limited to the Nigeria health policy context, but given the nature of the study area, the application of the study findings to other contexts might be possible only with caution.
- I relied on official policy documents used during the period covered by the study as one of the main sources of data. These include the main health policy, the related sub policies, and strategic documents. The data for the

study were limited to the scope of the relevant content on economic claims contained in the policy documents.

- Given the qualitative nature of the study design, it was not possible to establish or prove cause and effect relationships between the existence of the economic claims in the health policy and the financing of health care in Nigeria. Furthermore, the qualitative research findings were not amenable to statistical computations, such as tests of significance, so their use in settings that might demand more rigorous statistical testing was limited.
- I relied on key informant interviews as the second source of data. Some of the key informants were involved in the high level implementation of the policy, so the study could be limited by potential bias and reliability of responses by the key informants.
- I established the adequacy and perceived impact of the Nigeria health policy during the period covered by the study by determining the nature of the claims in the approved health policy documents followed by key informant interviews with key health policy experts in Nigeria. It is possible that other noneconomic claims in the policy, notably programmatic claims, could have as well been used as the basis of the study. The failure to consider such claims is a potential limitation because their possible influence on the findings of the study is not known.
- The key informant interviewees revealed that they had varying levels of awareness on the existence of economic claims in the health policy

documents. The awareness was also different for the different economic claims in the policy documents. It is possible that these variations in awareness influenced the responses provided by the key informants adversely or otherwise.

- The different awareness levels among the key informants on the different economic claims in the policy documents introduced a subsequent and possible limitation. The key informant interviews adopted a collective approach and reference to the three different groups of claims in the health policy documents rather than making reference to specific economic claims from the respective groups. It is not known if the findings from the key informant interviews would be different if the latter option of using the economic claims to support the interviews had been adopted.

Significance

The high out-of-pocket health care spending in Nigeria amounts to catastrophic spending in a country where 64.4% of the population is poor (McIntyre et al., 2013; Onwujekwe et al., 2009). The impact of the catastrophic health care costs on poor households, particularly on households headed by women and in rural areas, is of significant importance to public policy given its potential contribution to poverty (Ewelukwa, Onoka, & Onwujekwe, 2013; McIntyre et al., 2013). On the other hand, researchers offer little information on the economic claims made in the health policy of Nigeria resulting in a gap in the literature (Onwujekwe et al., 2009; Uneke, Ezeoha, Ndukwe, Oyibo, & Onwe, 2012).

A well-articulated and supported health policy could be used to advocate for the allocation of adequate resources to the sector (Wiseman et al., 2016). The study might generate new knowledge on the use of economic claims in the health policy, and the insights could be used in the development of more effective health policies. The primary beneficiaries for the study are the professional staff in the FMOH in Nigeria and its departments and agencies, especially the ones that deal with health policy and health care financing. The secondary beneficiaries include health policy and financing experts and researchers in Nigeria as well as elsewhere in other countries with similar health financing challenges.

Summary

In this chapter, I discussed the key components of the study on the adequacy and perceived impact of Nigeria's health policy starting in 2004 and ending in 2015. The problem of underfunding of the health sector in Nigeria, despite the existence of a government health policy that was expected to facilitate the allocation of adequate funding to the sector, is presented and linked to the purpose of the study. I aimed to understand the nature and importance of economic claims made in the country's health policy during the period covered by the study. The ambiguity and multiple streams theory, Roe's narrative policy analysis method and the policy feedback theory were used in combination to develop the study's conceptual framework. The framework was used as the basis for the data analysis and interpretation needed to answer the research questions on the nature of economic claims made in the health policy, as well as on the perceptions that health policy experts hold over the claims. A qualitative methodology with a mixed

narrative and phenomenological study approach involving data collection from official policy documents and key informant interviews was adopted for the study.

In this chapter, I also presented a list of definitions and a summary of the assumptions made in the study including the availability of all relevant official documents, consent by the key informants, and nonbiased responses from the informants. The scope of the study was defined to highlight the focus on Nigeria's health policy during the period starting in 2004 and ending in 2015. The qualitative nature of the study and the limitations of applying the study findings were outlined without losing sight of the study's significance as it relates to catastrophic costs in health care and the potential to influence appropriate allocation of resources to the health sector, thereby filling a gap in the literature on economic claims in the health policy.

A more detailed description of the literature that was used to develop the study is provided in Chapter 2, beginning with the literature search strategy followed by the literature on the theories used to inform the conceptual framework for the study. A presentation of the departments and programs of the FMoH in Nigeria is followed by a description of the health policy actors in the country. The chapter concludes with a review of the health care financing trends and the economic claims made in health policies.

Chapter 2: Literature Review

Introduction

The study was designed to understand the adequacy and perceived impact of Nigeria's health policy during the period starting in 2004 and ending in 2015 by using a conceptual framework that combines ambiguity and multiple streams theory (Cairney & Jones, 2016; Kusi-Ampofo et al., 2015), policy feedback theory (Sabatier & Weible, 2014), and the narrative policy analysis (Ball, 1995; Roe, 1989, 1994). The conceptual framework was applied within the context of low government financing of health care. For example, in 2014 Nigeria spent US$21 billion on health care, which included US$15.1 billion out-of-pocket spending by the households, US$5.3 billion spending by the government, and US$0.6 billion in contributions from donors (WHO, 2014). The share of total government spending allocated to health care in 2014 was 8% against a recommended minimum of 15% (WHO, 2011). The financing of health care is a matter of public policy, hence the study's focus in the area.

In order to deliver a meaningful and value-added literature review, a systematic literature search strategy was adopted. This involved the identification of the health policy documents of the FMoH in Nigeria approved for use during the period covered by the study and the identification of the relevant search engines. Search engines were used to identify the databases containing the relevant literature. The identified literature was used to establish the theoretical foundation for the study, to identify the various policy actors in the health sector, and to identify and understand some of the economic claims made in the health policy of other countries. As a part of gaining an understanding of the impact of the health policy, I also considered the health care financing practices in

Nigeria during the period covered by the study. Finally, I tied together the insights gained from the analysis of the economic claims made in the policy and the health care financing trends during that time period. The linking of economic claims made in the policy and health care financing trends will lead to a new area of research inquiry in health policy and health care financing with the potential to contribute to the development of appropriate economic claims and an effective health policy for social change.

Literature Search Strategy

I used the official institutional structure of the FMoH, its 11 departments, and 22 programs to systematically search for all of the approved and official health policy documents. In the search, I targeted the policy documents that could be accessed from online sources as well as the physical copies from the relevant departments and programs. The search yielded a total of 17 policy documents that were developed and formally approved for use during the period starting in 2004 and ended in 2015.

The literature search strategy was further used to identify the databases and search engines, mostly in Walden University library resources, that would be used to identify relevant literature for the study. Google Scholar was also included as an additional search engine for the study. A total of seven relevant databases included the following:

- Political Science Complete
- Business Source Complete
- Sage Premier
- Academic Search Complete
- ProQuest Central
- ScienceDirect

- CINAHL and MEDLINES Simultaneous search

The multi database search engines that were identified included the following:

- Thoreau Multidisciplinary
- Google Scholar

While preparing to undertake the literature review, I participated in a webinar on making the most of Walden University library resources. I used the skills acquired from the webinar and from previous experience to search for relevant peer-reviewed journal articles starting in 2012 to 2016 using a combination of keywords. The combination of keywords were as follows:

- *adequacy* OR *capability* OR *suitability* OR *sufficiency* AND *impact* OR *influence* OR *effect* AND *health policy* OR *health strategy* OR *health plan* OR *health program* AND *Nigeria*
- *economic* OR *financial* OR *monetary* OR *fiscal* AND *claims* OR *statements* OR *assertions* AND *health policy* OR *health strategy* OR *health plan* OR *health program* AND *Nigeria*
- *Kingdon's theory* OR *multiple streams theory* AND *health policy*
- *Policy feedback* AND *theory* OR *framework* OR *method*
- *Roe's* AND *narrative policy analysis* AND *(method* OR *theory* OR *framework*)

In addition to the systematic search, other literature including textbooks on health policy and on theories was included among the identified material for the literature review. The search was also extended to specialized sites to obtain information on health

care financing trends in Nigeria. I used the search structure to identify materials on the economic claims and the adequacy and impact of various health policies but not specifically for Nigeria, which further points to the literature gap in the study area. I was successful in identifying literature covering the relevant health policy theories, and the material obtained was sufficient in the development of the study's conceptual framework. In particular, I identified four theories that could work together to provide a comprehensive conceptual framework for the study.

Conceptual Framework

The existence of economic claims in the health policy of Nigeria during the period covered by the study was the phenomenon that forms the basis for the study. An economic claim is a statement used to represent an economic or financial position or promise (University of Oxford, 2016). These claims could be made in relation to the financing of the health care system and could be used for advocacy purposes. Economic claims could be made in relation to any aspect of health care financing including the mobilization, leveraging, or increasing of health sector financing. The claims could also be made in relation to allocation, release, or use of funds. On the demand side, the claims could be formulated around accountability and on financial barriers to health care. In the review of the literature on the health policy-making process, I identified four theoretical frameworks that could work together to provide a comprehensive framework for the study of the nature, adequacy, and impact of the economic claims made in the health policy. The four theories that are explored in the following sections include organizational theory of power and politics, Kingdon's ambiguity and multiple streams theory, policy feedback theory, and Roe's narrative policy analysis theory.

Organizational Theory

Organizational theory is a complex theory that is composed of at least nine related theories (Shafritz et al., 2016). Shafritz et al. (2016) described the evolution of the organizational theory starting at its original classical theory through the neoclassical theory, human resources theory of organization and behavior, modern structural theory, organizational economics theory, and power and politics theory. From there it leans toward its more modern forms in the theories of organizational culture and change, organization and environment, and organization and society.

Because the policy-making process is a political process, the organizational theory on power and politics could be considered as a theoretical foundation for the study (Martiniuk et al., 2015). The theory includes descriptions of organizations as a complex web of individuals and coalitions each with its interests, views, and preferences (Shafritz et al., 2016). The position of the organizational theory on power and politics is, therefore, similar to that involved in the policy-making process, which often includes different interests and politics occurring in a complex environment. In addition, the policy-making process and the subsequent implementation of the policy take place within an organizational framework and a political context. A combination of theories could be considered in the event that one theory is not sufficient for the study purposes. The theory has applications that are relevant to health policy even though the theory itself is not specific to health policy. The review of the theory has been included in order to achieve a broader view and the involvement of power and politics in health policy-making process.

Kingdon's Ambiguity and Multiple Streams Theory

The ambiguity and multiple streams theory is used to explain the policy-making process by governments, often under uncertain circumstances (Sabatier & Weible, 2014). According to Sabatier and Weible (2014), Buse et al. (2005), and Kusi-Ampofo et al. (2015), the three policy streams of problems, politics, and policy are managed by political entrepreneurs taking advantage of emerging policy windows to advocate for the adoption of their preferred policy position. The policy becomes successful depending on the emergence of an appropriate policy window; a favorable political mood in the nation; and the nature of the claims that it proposes, some of which might be economical in nature.

Kingdon's ambiguity and multiple streams theory has been put to various uses by researchers, and some of the uses are similar to its use in this study. Cairney and Jones (2016) established the use of the theory in the development of other conceptual frameworks including the punctuated equilibrium theory. The theory has also been used as the theoretical foundation for studies on the generation of large literature and new knowledge. Kusi-Ampofo et al. (2015) used the theory to understand the health policy making process in Ghana occasioned by a policy window created by the 2000 generation election and democratic power transfer in the country. The policy-making process resulted in the adoption of a National Health Insurance Scheme in Ghana. Miles (2015) also used Kingdon's theory to study the implications of ACA on health care reforms in Cook County, Illinois.

Kingdon's theory has also been used to analyze the engagements in promoting universal health care (UHC) agenda by Brazil, Russia, India, China, and South Africa (BRICS) and their role in global health agendas (Tediosi, Finch, Procacci, Marten, &

Missoni, 2016). Most of the BRICS countries supported and engaged in the promotion of UHC, but only about three of the countries were active in pushing the agenda at the global level (Tediosi et al., 2016). As demonstrated by Balarajan and Reich (2016), the use of Kingdon's theory could be stretched beyond the policy-making process into the understanding of a failed agenda or policy. Following the attempted failure to implement India's Integrated Child Development Services (ICDS) scheme, Balarajan and Reich showed that the policy development process that brought together the problem, policy, and politics streams had been carried out, but the country lacked political economy, or political will to see through the implementation of the scheme, hence its failure. The application of the theory by Balarajan and Reich is, therefore, relevant for the study because of its focus on the adequacy and perceived impact of the health policy in Nigeria during the period starting in 2004 and ending in 2015.

Fischer and Strandberg-Larsen (2016) applied the theory to study stakeholders' perspectives of power and agenda setting in Tanzania's health policy using in-depth key informant interviews with 11 policy-makers. Fischer and Strandberg-Larsen contributed additional insights into a potential study methodology on sample size determination when using Kingdon's theory as the theoretical lens. Kingdon's theory might not be a perfect theory for the policy-making process and could be improved through the introduction of problem brokers to help integrate the various streams (Knaggard, 2015).

Policy Feedback Theory

According to the policy feedback theory, the policy-making process is influenced by already existing policy because the process starts with the analysis of existing policy (Sabatier & Weible, 2014). The policy feedback theory has found many applications

including its use as the theoretical lens for understanding the attitude towards smokers and second-hand smoke following the publishing of antismoking policies and a ban on smoking (Pacheco, 2013). According to Pacheco (2013), these antismoking actions influenced public opinion on smoking and had a follow-up impact on the making of future policies. Given that public opinion affects the mood of the nation, negative attitudes towards smoking could influence policy makers, which could lead to the development of similar policies in future.

The policy feedback theory manifests as positive attitudes by reinforcing or as negative attitudes by undermining, as shown by Fernandez and Jaime-Castillo (2013) in their study of the pension policy reforms in Europe. The positive attitudes are likely to favor continuity of the policy or development of similar policies while the negative attitudes could result in a decision to change the policy direction. Kent and Jacobs (2015) described the feedback associated with a negative attitude as self-undermining policies that become a source of policy change. Jordan (2013) showed that inclusive welfare institutions generate large bases of public support. The support translates into favorable attitudes toward the existing policies in capitalist democracies and their continued support.

Kwamie, van Dijk, Ansah, and Akua (2016) demonstrated the application of the policy feedback theory to explain the evolution of the district health system in Ghana from 1970 through 2007. Kwamie et al. used the theory to describe the four different phases of the evolution. Kwamie et al. gained insights into how the previous phases of the evolution influenced subsequent ones through a feedback mechanism. Kwamie et al. used a nonexhaustive literature review and key informant interview with high level public

officials to collect the data for the study. In addition to demonstrating the application of the feedback theory, Kwamie et al. also contributed insights into the methodology used, and this could be of use to the any future study that will use a similar methodology. The analysis of the adequacy and impact of the health policy in Nigeria based on the economic claims made in the policy and the results of the analysis could be used to influence public and policy experts' attitudes toward the policy and influence future policy-making with the broader perspective on social change.

Narrative Policy Framework

According to the narrative policy framework, stories and narratives developed during various stages of the policy-making and implementation process are important in the analysis of the policy and are a source of information for analysis (Lester, 1996; Roe, 1989, 1994; Sabatier & Weible, 2014; Veselkova, 2014). The narrative operates in three levels that include the microlevel representing individual, mesolevel representing group, and macrolevel representing institution or culture (Roe, 1989, 1994; Veselkova, 2014). As in most stories, policy narratives have a setting; characters; a beginning, middle, and end; and a moral or political solution. In a critique of Roe's narrative policy framework, Ball (1995) noted that Roe's framework brings out the force of language and storytelling into politics. Other researchers have also elaborated on Roe's framework as in the case of Jones and McBeth (2010) who proposed a new theory on narrative policy analysis.

The narrative policy framework has been applied in the analysis of the policy-making behaviors of two interest groups involved in shaping public policy and politics in the Greater Yellowstone Area (McBeth, Shanahan, Arnell, & Hathaway, 2007). McBeth et al. (2007) revealed various forms of narratives and their use to navigate through the

policy discussions in the area. The framework was also used to help resolve the 1980-1982 medfly controversy in California during which a policy decision needed to be made as to whether to use aerial spraying to control the medfly (Roe, 1989). The framework was useful for this case because only the stories and narratives of policy-makers were available as a source of information for resolving the uncertain and complex controversy (Roe, 1989). The analysis of the stories brought out a better understanding of the controversy in addition to reducing the uncertainties associated with the case.

The narrative policy framework was also applied in the review of health committees, councils, and boards in low-and middle-income countries (George et al., 2015). In the process, George et al. (2015) helped to identify new contextual factors that hinder or facilitate the functioning of the committees. Veselkova (2014) used the framework to gain a better understanding of the link between the introduction of a mandatory vaccination program, the antivaccination movement, and on the use of evidence to resolve the conflicts between the various interest groups. The framework was used to establish that positive press depiction of the beneficiaries of the ACA was good for the durability of the policy (Chattopadhyay, 2015). On the part of Jacobsen (2015), the framework was used to predict what will be and what ought to be with respect to the public elderly care policy in Norway. The potential use of the narrative policy framework points to the flexible nature of the framework that makes its application possible under a different context.

Further analysis of these theories suggested that Kington's theory, Skocpol's policy feedback theory, and narrative policy framework were particularly relevant to the study. The organizational theory on power and politics could not be considered further

because its application is broad and not specific to the policy-making process. The theoretical needs of the study go beyond the scope of any one of the preferred theories. The study is, therefore, guided by a combined conceptual framework developed from Kingdon's ambiguity and multiple streams theory, Skocpol's policy feedback theory, and Roe's narrative policy analysis method (Ball, 1995; Buse et al., 2005; Kusi-Ampofo et al., 2015; Roe, 1989, 1994; Sabatier & Weible, 2014). Figure 1 illustrates the interrelated and complementary application of the three-selected theories.

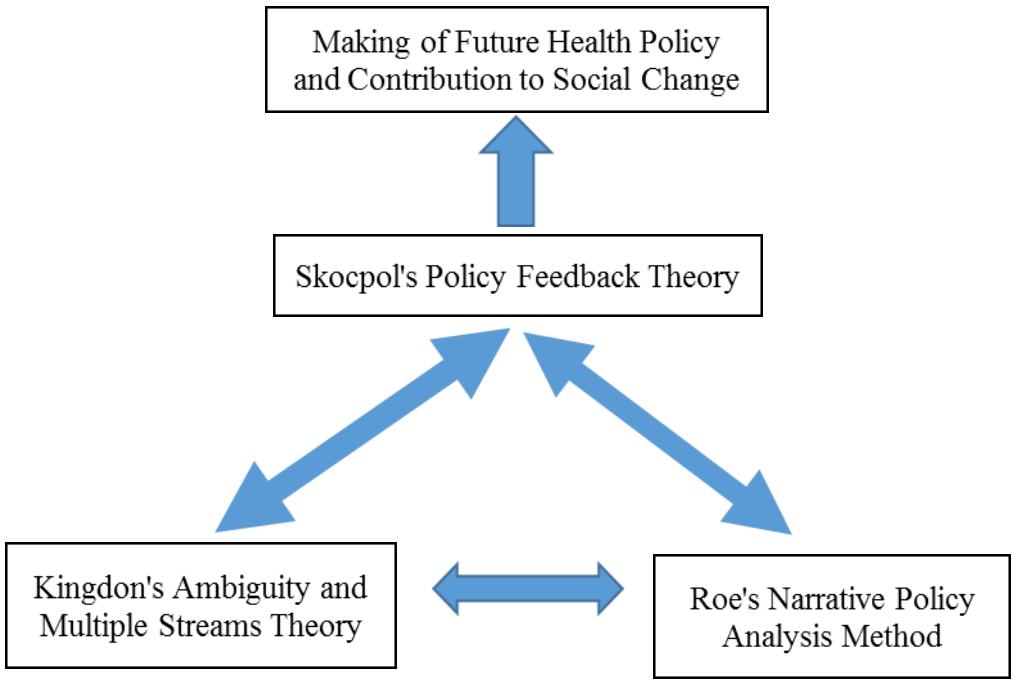

Figure 1. Schematic drawing of the conceptual framework for the study

Kingdon's theory is built on the premise that the problem, politics, and policy streams (policy entrepreneurs) converge when a policy window exists in order for the policy-making to be possible (Sebatier &Weible, 2014). The theory was used to understand the process used in making the health policy, to identify the actors, and to gain a better understanding of the impact of the policy on health care financing. For that reason, I used the key informant interviews with health policy experts to explore the perceived adequacy of the economic claims made in the health policy as well as their perceived impact on health care financing during the period covered by the study. I also used the interviews to understand the potential impact of the policy on future policies based on the recommendations for the making of future policies obtained from the health policy experts.

I used Roe's narrative policy analysis method to support the analysis of the narratives obtained from the interviews with the health policy experts and the data obtained from the review of the health policy documents (Ball, 1995; Roe, 1989, 1994). On the other hand, I used Skocpol's policy feedback theory as the basis for linking the findings from the study to the making of future health policy and to positive social change. In other words, the theory serves as the bridge between the study findings and the health policy entrepreneurs, with the making of future policies and the resultant impact on positive social change.

Departments and Programs of the Federal Ministry of Health Nigeria

The FMoH is responsible for the development and implementation of the health policy in the country. (FMoH, 2010). Table 1 contains the approved policies and

strategies developed by the respective departments and programs of the FMoH for the implementation of the policy.

Table 1

Policies and Strategies Approved by the Federal Ministry of Health in Nigeria

	Approved Policies 2004-2015	Approved Strategies 2004-2015
Departments		
Health Planning Research and Statistics	1. National Health Act 2014 2. Revised National Health Policy 2004 3. National Health Information System Policy 2014	1. National Strategic Health Development Plan II 2010-2015 2. National Health Information System Strategic Plan 2014-2016
Hospital Services	4. National Oral Health Policy 2012	-
Family Health	-	3. Integrated Maternal Child Health Strategy 2007
Programs		
National Malaria Elimination Program (NMEP)	-	4. National Malaria Strategic Plan 2009-2013 5. National Malaria Strategic Plan 2014-2020
National HIV/AIDS Control Program (NASCP)	5. National Policy on HIV/AIDS, 2009	6. National HIV/AIDS Strategic Plan 2010-2015
National Tuberculosis and Leprosy Control Program (NTLCP)	-	7. National Strategic Plan for Tuberculosis and Leprosy Control 2010-2015
Nutrition program	6. Health Sector Component of the National Food and Nutrition Policy and Strategic Plan of Action 2014-2019	-
Reproductive Health program	7. National Reproductive Health Policy 2008 8. National Policy on the Health and Development of Adolescents and Young	-

(table continues)

	Approved Policies 2004-2015	Approved Strategies 2004-2015
	People in Nigeria, 2007	
Health Promotion program	9. National Health Promotion Policy 2006	-
Expanded Program on Immunization	-	8. National Routine Immunization Strategic Plan 2013-2015
Total	9	8

Note. FMoH. (2010). *Championing Half a Century of Sustainable Health development*. Abuja, Nigeria: National Library of Nigeria.

As shown in Table 1, the eight policies, one combined policy and strategy, and eight strategies developed and approved for implementation during the period covered by the study are listed according to the responsible FMoH department or program. I identified these documents by consulting with the respective program officers from the various departments. Some of the existing departments and programs did not develop any policy or strategy during the period covered by the study, so they are not listed in Table 1. These included: Public Health, Human Resources Management, Procurement, Finance & Accounts, General Services, Reform Coordination and Service Improvement, Special Projects, National Blood Transfusion Services (NBTS), Avian Influenza Control Project (AICP), National Onchocerciasis, Guinea worm and Neglected Diseases Control Program (NOCP), Midwives Service Scheme (MSS), Saving One Million Lives, National Product Supply Chain Management Program, National Climate Change Program, Health Emergency Response, National Eye Health program, National Cancer Control Program, National Health Insurance Scheme, Food and Drugs Services, and Child Health program. I could not obtain a single document that describes the functions of the various

departments and programs. The description provided below is, therefore, based on the information provided by the various program officers with whom I consulted while identifying the official policy documents.

The department of Health Planning Research and Statistics is responsible for health sector-wide policy, strategic planning, and information. The department supports all the other departments and programs in these respects. The hospital services department is responsible for all secondary and tertiary care hospitals in the country including dental health. The food and drug services department help with the regulation of the pharmaceutical industry including food safety and standards. The department is responsible for the National Product Supply Chain Management Program.

The department of Family Health is responsible for the Nutrition, Child Health, Reproductive and Health Promotion programs. The Public Health Department is responsible for the Avian Influenza Control Project, the National Climate Change Program and the National Onchocerciasis, Guinea Worm and Neglected Diseases Control Programs. The department of Special Projects is responsible for emerging health and health related issues that are of national importance such as health emergency response and other forms of disasters. The other remaining departments are service and support departments and include Human Resources Management, Procurement, Finance and Accounts, and General Services Reform Coordination and Service Improvement. The following programs operate as semiautonomous entities with no direct or strong affiliation to any of the departments:

- National Malaria Elimination Program-responsible for malaria-related interventions in the country.

- National HIV/AIDS Control Program-responsible for HIV/AIDs prevention and care in the health sector.
- National Tuberculosis and Leprosy Control Program- manages all tuberculosis and leprosy interventions in the country.
- National Blood Transfusion Services-manages voluntary blood donation, screening, storage, and distribution in the country for emergency purposes.
- Midwives Service Scheme- responsible for out-posting of midwives in specific rural PHC centers.
- Saving One Million Lives- a special performance-based program that finances programs based on the performance of selected maternal and child health indicators.
- National Eye Health program-coordinates both preventive and curative eye care services.
- Non-Communicable Diseases Control Program- the program was started in response to the emergence of non-communicable diseases including hypertension and diabetes.
- Occupational Health and Safety program-responsible for setting safety standards and health-related regulation in various industries.
- National Cancer Control Program-specifically dealing with cancer registry and development of the capacity to manage cancers.
- National Health Insurance Scheme- managing the country's public health insurance scheme and the regulation of health management organizations.

Health Policy Actors

Health policy involves political negotiations that bring together politicians and other stakeholders to address a particular problem or issue within a given policy context (Martiniuk et al., 2015). There are many different stakeholders in the policy-making process who are variously referred to as policy advocates, researchers, policy-makers, policy entrepreneurs, and decision-makers (Shroff et al., 2015). According to Buse et al., these stakeholders and in particular the policy and decision-makers often determine the outcome of the policy-making processes. In the case of Nigeria, the list of the stakeholders in health policy include health professionals, health staff, managers and health consultants of the FMoH, and a similar cadre of staff from the police, military, paramilitary, and Civil Society Organizations (CSOs; FMoH, 2004). However, the list of stakeholders excludes the primary beneficiaries of health care services.

Awareness on the Health Policy

According to Martiniuk et al. (2015), health policy-making involves the political establishment, other stakeholders, and technocrats. These actors set the policy guidelines and subsequently elaborate these into various sub policies and strategies, thereby establishing the health policy architecture. For purposes of situating this study within its proper context, the understanding of Nigeria's health policy architecture was, therefore, important. Low public awareness on new policy guidelines in relation to the introduction of a new electronic patient record in the United States was found by Bratan, Stramer, and Greenhalgh (2010). The low level of awareness was particularly significant because the new electronic patient record allowed the sharing of confidential patient information among service providers in a country where patient confidentiality is a sensitive issue that

is protected by the law (Bratan et al., 2010). Patient confidentiality is also protected by the law in Nigeria (Federal Republic of Nigeria [FRN], 2014). The low public awareness on sensitive policy issues as established by Bratan et al. (2010) might as well be the case for many of the economic claims made in the health policies. The level of public awareness on the claims and benefits that are made in health policy is important because it might influence the success of the implementation process.

As revealed by Onwujekwe et al. (2009), policy-makers and researchers in South East Nigeria assumed that households have the capacity to cope with health care payments even when there was no functional system of fee exemptions in place. Other studies conducted in Nigeria have also established the existence of low awareness on research evidence among policy-makers and researchers, and unwillingness by some researchers to search for the evidence (Uzochukwu et al., 2016). These actors are expected to generate evidence for policy-making while at the same time promoting the use of the evidence to make policies. The reliance on assumptions in policy-making decisions could be minimized through increased interactions between the policy researchers, policy advocates, policy-makers, and decision-makers (Shroff et al., 2015).

Health Care Financing in Nigeria

The strengthening of the health sector in developing countries has been attracting global, regional, and in-country interests. In 2000, 189 heads of States adopted the global MDGs. (Mburu et al., 2014). About one year later, in April 2001, heads of States and Governments of the Organization of African Unity met in Abuja, Nigeria, and agreed to each devote at least 15% of their annual budgets to the health sector (Mburu et al., 2014). This commitment was subsequently reaffirmed by the same governments in 2006 and in

2013 (Mburu et al., 2014). In addition, the affirmations were tied to the agenda of ensuring ownership, accountability, and sustainability towards UHC in the countries. Nigeria hosted the 2001 meeting in Abuja and was a signatory to the initial commitment and all the reaffirmations thereafter.

Despite these commitments, the health sector in Nigeria has been perennially underfunded (Ejughemre, 2014). The total health care expenditure was US$19 billion in 2013 increasing to US$21 billion in 2014, and the per capita expenditure increased from US$109 in 2013 to US$118 in 2014 (WHO, 2013, 2014). Table 2 shows that the government allocation to health care is low while households predominantly incur out-of-pocket expenditures to pay for the health care. The high out-of-pocket expenditure predisposes households to catastrophic health expenditure. According to Onoka, Onwujekwe, Hanson and Uzochukwu (2011) about 40% of households in South Eastern Nigeria incurred health costs greater than 10% of their consumption expenditure, and this amounted to catastrophic expenditure.

Table 2

The Health Care Financing Status for Nigeria in 2013 and 2014

Description	2013	2014
% Expenditure s Out-of-pocket by Households	73	72
% Expenditure by government	24	25
% Expenditure from Other Sources	6	8

Note. US$=United States Dollar. Source: WHO. (2013). Health system financing country profile: Nigeria, 2013. Retrieved from http://www.who.int/gho/health_financing/en/; WHO. (2014). Health system financing country profile: Nigeria, 2014. Retrieved from http://apps.who.int/nha/database/Country_profile/Index/en

The perennial underfunding of the health sector in Nigeria continued despite the emergence of evidence in support of the assertion that investment in health is growth-enhancing (Dada, 2013; Ejughemre, 2014). The underfunding also occurred despite the International Monetary Fund's structural adjustment programs that predicted the short-/long-term gain progression for the implementing countries (Hoddie & Hartzell, 2014). The observation that Nigeria failed to honor the commitments it made in Abuja might have contributed to catastrophic health expenditure by households and to the country's inability to provide universal health care for its citizens (Adisa, 2015; Onwujekwe, Hanson, & Uzochukwu, 2012; WHO, 2011). The underfunding of health care in Nigeria is socially significant given that health expenditure is income inelastic, hence the poor will be compelled to spend any available resources on health care (Omotor, 2009). Furthermore, rural areas and women-headed households were particularly affected by the catastrophic health expenditure (Ewelukwa et al., 2013; Onah & Govender, 2014; Onwujekwe et al., 2012).

Claims Made in Health Policies

As demonstrated through a review of various policies, the making of economic claims in health policies is a common occurrence including in the ACA of the United States (Cohen et al., 2008; Geyman, 2015; Shen et al., 2014). The ACA that was enacted into law in 2010 made many economic claims including its ability to make families richer, cut health care spending, stimulate economic growth, increase the productivity of the workforce, improve job mobility, and increase financial stability (Geyman, 2015). Five years after the law was enacted, about 37 million Americans were still uninsured,

and the cut in health care spending might not have been realized to the extent claimed in the policy (Geyman, 2015).

The claims that the drinking of water is healthy and that increasing the tax on the commodities used in sugar manufacturing will reduce consumption of sugared drinks are some of the famous health-related claims made in the literature (Klaus, 2012; Tepper & Wojciechowski, 2013). It has long been claimed that the consumption of water is good for the human body's normal physical and cognitive performance and that it helps with temperature regulation (Klaus, 2012). Water bottling companies were, however, not allowed to use the claims to market their water products until they went to court and asked for a review of the law to clarify the ban on advertising water products based on these claims. As an outcome of the law review, the ban was declared illegal which gave way for the use of the claims to advertise specific water products (Klaus, 2012). The idea of increasing tax on sugared drinks seemed to be a logical way of reducing consumption of the sugared drinks. Even then, the consumption of sugared drinks increased instead of the anticipated decline after the introduction of the tax (Tepper & Wojciechowski, 2013).

Most of the 2008 presidential debates in the United States seemed in favor of the claim that preventive care is more cost effective than curative care (Cohen et al., 2008). Most of the presidential candidates used this line of argument in their debates while overlooking the fact that the impact of preventive care on health care costs depended on the size of the target population and the specific intervention involved. As argued by Cohen et al. (2008) the screening of the entire population of middle-aged and elderly men against cancer of the prostate attracts huge costs because the actual numbers that will eventually benefit from the intervention are small compared to the overall cost. Along

with a similar line, Shen et al. (2014) analyzed the effect of the ACA on vaccination coverage in the United States and came out with a revelation that although the act was expected to increase the coverages, some of the coverages did increase, but not for all of the vaccines. Cohen et al. made the argument on preventive care before ACA came into being in 2010 (Shen et al., 2014). As elaborated by Miles (2015), the shift to preventive care involved a radical change in the health care delivery system as well as the adoption of desirable behavior changes in diet, exercise at the individual level, and community building.

Summary and Conclusions

I used seven databases, two multi database search engines, and a combination of five keywords for the literature search. The literature obtained adequately supported the study design, theoretical justification, and the methodology. The literature supported the construction of the study's conceptual framework based on the three interrelated and complementary theories. The literature also helped to clarify who the health policy actors are in general and specifically for Nigeria. The literature revealed that awareness on health policy and the health policy-making process in Nigeria might not be optimal. The available data showed a large out-of-pocket expenditure on health care and underfunding by the government. The analysis of the health financing related claims revealed that such claims exist in various health policies, but what they claim might not always be realized. In Chapter 3, I will demonstrate how I used the evidence from the literature to develop the study design including an elaboration on data collection, coding, analysis, and strengthening the research trustworthiness.

Chapter 3: Research Methods

Introduction

The purpose of this qualitative study was to determine the adequacy and perceived impact of the health policy of Nigeria during the period starting in 2004 and ending in 2015. The adequacy and impact of the policy were studied through an examination of the nature of economic claims made in the policy. The nature of the claims made was determined using a narrative analysis of the policy documents approved for use during the period covered by the study while the perceived impact of the claims was established through key informant interviews with selected health policy experts in Nigeria. The FMoH is responsible for the development of all the health sector policy documents with the participation of all the key stakeholders working in the sector. In this study, I focused on the period covered by the study because the last health policy for Nigeria was developed in 2004 and remained in effect until the end of 2015 (FMoH, 2004).

The details of the research design for the study will be elaborated upon in this chapter. The design was based on a qualitative study methodology with the rationale of responding to the gaps in the literature of an underfunded health care system in Nigeria and the perceived impact of the policy on health care. My role will be discussed based on the various stages of the design and execution of the research study. I will next provide details on the tools used in content analysis and for the conduct of the key informant interviews including the selection of the key informants. The process of managing the data using Nvivo in preparation for manual analysis will be discussed followed by the issues of trustworthiness and other related ethical considerations.

Research Design and Rationale

The qualitative methodology with mixed narrative and phenomenological research design was the basis for developing the research questions. The questions were used to establish the nature of economic claims made in Nigeria's health policy over the period covered by the study. The questions were also used to establish the perceptions of health policy experts in Nigeria on the economic claims made in the health policy. The experts were asked about their perceptions on the adequacy of the economic claims and whether they were realistic, attainable, and adequate for the intended policy objectives.

The research questions used in the study were as follows:

RQ1: What is the nature of economic claims made in the health policy in Nigeria during the period starting in 2004 and ending in 2015?

RQ2: What are the perceptions of health policy experts in Nigeria on the adequacy and impact of the economic claims made in the country's health policy during the period starting in 2004 and ending in 2015?

The study was aimed at establishing the adequacy and perceived impact of the health policy in force in Nigeria over the period covered by the study using the understanding of the nature of the financial or economic claims made in the health policy. The focus of the study was mainly on economic claims despite the fact that many other types of claims could also be made in health policy. The existence of the economic claims in health and health-related policies was the central concept and basis of the study. Economic claims could influence the eventual implementation of the health policy because they might be related to the financing of health care and could be used for advocacy. Economic claims could be made on any aspects of the health care financing

and on the use of the allocated funding. The claims could also be made on the accountability of the health care funding and on financial protection and mitigation against financial barriers to accessing health care.

The data were collected by conducting content analysis for the economic claims on all of the 17 policy documents approved during the period covered by the study to determine the type of economic claims made in them. The study involved 15 key informant interviews with health policy experts and decision makers working in the health sector. The content analysis was used to determine the existence and nature of economic claims in the policy documents while the key informant interviews were used to establish the perceptions of the health policy experts on the importance of the economic claims made in the policy.

The study is primarily qualitative; hence, its findings might only be generalized to the health policy context in Nigeria. However, I generated new knowledge on economic claims in health policy, an area where little research has been identified and could be ideal for exploring and coming up with new knowledge. A similar research approach was used by Kwamie et al. (2016), who used a nonexhaustive literature review and key informant interview with high-level public officials to collect the data on the use of policy feedback theory to explain the evolution of the district health system in Ghana from 1970 through 2007. Miles (2015), also used document review and key informant interviews to study the implications of the preventive care agenda in ACA on the health care reform in Cook County, Illinois.

Role of Researcher

I identified the study area based on professional interest and determined that the study area was valid for research through an initial literature search. I further narrowed down the study area into the study topic; this was accomplished with the support of my research committee, class tutors, and colleagues with whom I interacted in various courses. I further elaborated on the research premise and prospectus, both of which were approved by the program director. As a part of the prospectus development, I conducted a preliminary literature search to further elaborate on the research problem, the conceptual framework, possible research questions, and the methodology. Finally, I expanded the prospectus into a proposal with a more detailed introductory chapter, a chapter on detailed literature review, and a chapter on research methods.

As a researcher, I sought to ensure confidentiality in the entire research process by avoiding unwanted solicitation, intrusion, observation, or unwanted intrusion of the privacy of others not involved in the study. For all the key informant interviews, I first requested their informed consent before proceeding with the interviews. All the information collected and the respective sources will be kept confidential, and this intention was made known to the potential interviewees before the interview and reiterated again after the interview was completed. This action was important for this study because some of the experts and decision makers who served as senior FMoH officials, health policy experts, and consultants in Nigeria might be active in the sector and performing similar or related responsibilities. I asked some of these officials to serve as key informants for this study. This and the fact that I no longer worked in Nigeria, in addition to the safeguards on confidentiality, helped to mitigate against any power

imbalances with the key informants and to avoid possible bias in the responses provided during the interviews.

Methodology

Participant Selection Logic

In this qualitative, mixed narrative, and phenomenological study, the economic claims in the 2004–2015 health policy was the phenomenon of interest. Key informant interviews with the health policy experts were preferred because of the absence of sources of systematic quantitative data that could be used for a quantitative inquiry. Furthermore, Nigeria does not have systematic data sets that could provide the relevant quantitative information needed to determine the impact of the health policy. A similar study approach was used to resolve the medfly controversy in California because only the stories and narratives of policy-makers were available as sources of information for resolving the uncertain and complex controversy (Roe, 1989).

Policy documents and the health policy experts were the two sources of information for the study. Narrative researchers document a story as told by an individual, and in this study, the individuals were the health policy experts (Creswell, 2009). On the other hand, phenomenology is used to research an evolving situation or observation made over time by interviewing individuals with information on the event or observation. For the purposes of this study, the making of economic claims in the health policy was the phenomenon (Creswell, 2009; Reynolds, 2007).

I adopted a purposeful sampling approach using a mixed strategy sampling (Patton, 2001). I established that there were 17 eligible policy documents that were used during the period covered by the study. All 17 documents were included in the study

because of the small number involved. I conducted content analysis for economic claims made in the health policy documents for Nigeria over the period starting in 2004 and ending in 2015. The analysis generated themes for the economic claims. I randomly initiated the key informant interviews with the selected key informants who served the sector during the period covered by the study. The experts were the best available source of information for the study because their identifications followed the critical case sampling approach (Griffith, 2013; Hart, 2007; Patton, 2001).

Griffith (2013), Hart (2007), and Patton (2001) promoted the use of saturation, redundancy, and representation rules in sample size determination for qualitative studies. I considered the saturation/redundancy rule that requires that an adequate number of research subjects are involved, and representation to ensure the variations within the policy experts and researchers were taken into account during final selection of the interviewees. The health policy researchers were drawn from the universities and other research institutions, while the health policy experts and decision makers were drawn from the FMoH and from development organizations such as the World Bank, the United Nations, and donor agencies. Based on the rule of the thumb guidance from Patton (2001) and Fischer and Strandberg-Larsen (2016), I targeted 15 policy experts and researchers for the key informant interviews. My target number was higher than that used by Fischer and Strandberg-Larsen (2016), who conducted a study on stakeholders' perspectives of power and agenda setting in Tanzania's health policy based on Kingdon's theory and data collection using key informant interviews with 11 health policy-makers.

Instrumentation

I could not identify any existing tools that could be used for the study. Because of that, I developed a data collection template for capturing data on the economic claims made in the health policy documents and open-ended questions for interviews with health policy experts (Appendices A&B). I formatted the data collection template in Nvivo software for use in organizing the data obtained from the policy documents. The key informant interviews involved open-ended questions focused on aspects of economic claims in the health policy in relation to health care financing, the use of the financial resources, and the protection of the health care users. I minimized the reliability issues by subjecting the tools to peer review and testing. This ensured that if used repeatedly on the same sample population, they will generate similar information; they will also measure what they are supposed to measure and, in the process, ensure internal validity (Creswell, 2009). I requested two health policy experts working in the health sector in Nigeria to undertake a testing of the open-ended questions. I subsequently conducted telephonic interviews with the actual key informants who were working in the health sector in Nigeria.

The data for responding to RQ1 on the nature of economic claims made in the health policy were collected using the content analysis data collection template, and the sources of data were the 17 policy documents from FMoH. This process took about 15 days. The data were collected using the data collection template as formatted in Nvivo to facilitate the organization of the data. The study was not about the number of claims made but their nature.

The data for responding to RQ2 on perceived impact of the health policy and the importance of the economic claims contained in the policy were collected through key informant interviews with health policy experts over a period of approximately 10 days. I conducted all the telephone interviews. The interviews were digitally recorded and thereafter translated verbatim into text. The written interview scripts were shared with the respective key informant interviewees for validation. The text was then uploaded into Nvivo software for further organization and manual analysis. I interviewed the 15 key informants as scheduled, and the participants exited the study after providing feedback on the transcripts prepared from their respective interviews and shared with them for verification.

Data Analysis Plan

The health policy documents uploaded into Nvivo software were reviewed and the data on the nature of economic claims in the documents were moved into nodes generated from the data collection template (Appendix A). The verified key informant transcripts were also imported into the Nvivo and the information in the transcripts was then moved into the respective nodes (also referred to as codes in Nvivo) in order to help organize the data for manual analysis (Flexara Software LLC., 2014). The data obtained from the analysis of the policy documents were organized into 11 nodes. I generated the responses to RQ1 by manually analyzing the information contained in the following 11 nodes:

- Act of Parliament
- Policy
- Strategy

- Combined policy and strategy
- Claims on impact on the economy
- Claims on financing of health care
- Claims on use of health care resources
- Claims on protection of health care users
- Claims that are specific
- Claims that are time-bound
- Claims that are measurable

The nature of the claims obtained from the analysis of the policy documents and their natural groupings were used to structure the interviews with the health policy experts. Subsequently, the data obtained from the interviews with the health policy experts was organized into 15 nodes. The information in the following 15 nodes was analyzed to respond to RQ2:

- Financing realistic
- Financing attainable
- Financing adequate
- Financing impact
- Financing recommendations
- Prudent realistic
- Prudent attainable
- Prudent adequate
- Prudent impact

- Prudent recommendations
- Protection realistic
- Protection attainable
- Protection adequate
- Protection impact
- Protection recommendations

Issues of Trustworthiness

I developed this study in order to understand the nature and impact of economic claims made in Nigeria's health policy given the problem of public underfunding of health care in the country (FMoH, 2004; WHO, 2011, 2013). The underfunding of the health sector by the government happened despite the existence of a national health policy that was expected to be used to advocate for adequate financing of health care in the country. In this study, therefore, I aimed to examine the economic claims made in the health policy by asking how realistic, attainable, and adequate for the intended policy objectives they were. Secondarily, I aimed to examine the perceived impact of the economic claims in the health policy on the health sector.

The points at which I faced tests of bias and trustworthiness included the stage of developing the data collection tools, selection of the study participants, and during the actual preparation and analysis of the data. The credibility of the research process was ensured by conducting a member check of all the data received from the key informant interviews for concurrence as well as for any divergence. The member check involved sharing the written interview scripts with the key informant interviewees for validation before moving to the next stage of analysis. I targeted all 15 policy experts for the key

informant interviews while taking note of the point of saturation as reported in this chapter. The interviewing of all 15 scheduled key informant interviewees rather than stopping at the point of saturation helped strengthen the credibility of the study.

Given the qualitative nature of the study, the findings are applied to the health policy context in Nigeria but with the possibility of transferability to other countries and policy environments. For this particular study, the findings have a higher potential for transferability because of the involvement of high-level policy experts; some of them sharing rich international experience and perspectives. The study was underpinned by three different theories, and one of them, Skocpol's policy feedback theory, supports the argument that past policies influence future policies. In effect, this strengthens the transferability of the study findings and their implications for future health policies in Nigeria and elsewhere. This is particularly the case given that the basis of the research problem was the underfunding of health care in Nigeria, and as demonstrated through the review of the literature, underfunding of health care might be existing in other developing countries. I ensured that the research process was dependable by developing both a high-quality data collection template for the content analysis of the policy documents and pretested questions for the key informant interviews. I could not identify the use of similar tools in previous research; however, the tools as developed allowed me to achieve a high level of clarity and accuracy (National Academy of Sciences, 2009).

To undertake data analysis, the 17 health policy documents were uploaded into Nvivo software and subsequently analyzed for economic claims. The data obtained were organized into nodes and thereafter manually analyzed. The voice-recordings from the key informant interviews were translated into text verbatim. I shared the transcripts with

the respective interviewee for verification before importing the transcripts into Nvivo software for organization and subsequently, manual analysis. At this stage, I exercised a high level of responsibility in the treatment of data to avoid manipulation, mistakes, and negligence. I ensured a high level of intra and internode reliability by aligning the nodes to the open-ended questions and developing themes based on careful manual analysis of the data in the nodes.

Ethical Procedures

The ethical procedures for the study were handled per the requirements of the Institutional Review Board (IRB) in line with IRB approval reference number 01-13-17-0510084. I was guided by the IRB requirements to ensure that the study is valid, and the findings will be useful for social change (Rudestam & Newton, 2015). To fulfill the requirements, I observed regulations, codes, and informed consent procedures while taking actions to minimize bias (National Academy of Sciences, 2009). The adherence to standard ethical procedures was important for the study which involved high-profile research experts and policymakers as key informant interviewees. The protection of these high-profile personalities required a high sense of responsibility and honor to the trust that the research community has placed on researchers, and the demonstration of a high sense of obligation and confidentiality, and to act in ways that serve the public (National Academy of Sciences, 2009).

As part of the informed consent, I clarified to all interviewees that the study would be conducted in a neutral manner and was not an evaluation of the policy-making and implementation process. Further to that, I included a clause in the informed consent form to the effect that the decision of the experts on participation in the study would be

accepted and treated in confidence. The data are kept secure by use of password protection for all equipment used for the study and use of codes in place of the names of the participants. The data will be kept for a period of at least five years, as required by the university. I also clarified that the study was investigating the claims as made and not their correctness or effectiveness. The study design did not include any experimental or quasi-experimental aspects and therefore carried no direct health risks to the participants.

Summary

In Chapter 3, I provided the rationale behind selecting the research methodology and design based on the study's aim of understanding the adequacy and perceived impact of Nigeria's health policy. The country did not have systematic data sets that could be used to support a quantitative assessment of the adequacy and impact of the health policy, hence the choice of the qualitative approach. I defined my role in selecting the topic, designing, and executing the study. Particular emphasis was placed on ensuring trustworthiness and ethical conduct. As part of the study methodology, the purposeful recruitment of health policy experts as key informants was described as well as the process used to collect and analyze data from the health policy documents. The two tools used for data collection included the data collection template developed and formatted in Nvivo software for the collection and organization of data from the health policy documents and the open-ended interview questions. The data from the two sources were organized into nodes using Nvivo and analyzed manually to generate themes and subsequently, the study findings. In Chapter 4, I present the study findings.

Chapter 4: Results

Introduction

In this qualitative study, I sought to establish the adequacy and perceived impact of the health policy of Nigeria during the period that began in January of 2004 and ending in December of 2015. The nature of economic claims made in the health policy was determined by conducting a content analysis of the 17 policy documents that were developed for the implementation of the health policy during the period covered by the study. Following the content analysis, the adequacy and perceived impact of the claims were established through key informant interviews with the health policy experts who worked in the health sector in Nigeria during the period covered by the study. The data obtained from the two sources were used to answer the two main research questions for the study:

RQ1: What is the nature of economic claims made in the health policy in Nigeria during the period starting in 2004 and ending in 2015?

RQ2: What are the perceptions of health policy experts in Nigeria on the adequacy and impact of the economic claims made in the country's health policy during the period starting in 2004 and ending in 2015?

The subsequent sections of this chapter will include a description of the setting in Nigeria at the time of conducting the study, a brief on participants' demographics, data collection, and analysis, evidence of trustworthiness, the results, and a summary of the chapter at the end.

The Setting

This study was conducted at a time when Nigeria was undergoing economic recession following the low oil prices in the international markets. Oil is the main foreign exchange earner for Nigeria. The government cut down budget allocations to the sectors including health, and the effect was felt by all the actors in the sector including most of the policy experts interviewed. The appreciation of the economic situation was captured by one of the key informants who remarked,

> There was limited fiscal space in Nigeria because the underpinning of the budget was oil, based on volume and price which for the past three to four years was based on 2.2 million barrels a year, but not anymore given the dip in the oil market and low price. The country was, therefore, borrowing more and further constricting the fiscal space going forward so we end up with programs that are non-implementable. (M1-PHS)

The federal minister of health in Nigeria at the time of conducting the study started focusing on PHC immediately after his appointment. This was one of his key strategies for the delivery of UHC in the country. Administratively, the minister reorganized various departments in the Ministry of Health including the appointment of a new head of the Department of Health Planning, Research, and Statistics. The various technical working groups to which some of the key informants were affiliated were also reorganized or dissolved. These changes could have affected the policy-making environment in the sector including the relationships and links to some of the study's key informants. These shifts, which were happening at the time of data collection, could then have influenced the participants and their responses during the interviews.

The health sector in Nigeria had audit issues on the management of global funds as well as funding from Global Alliance for Vaccines and Immunization (GAVI). The use of the funds from these two sources of funding for the country were subjected to audits, and the findings were in the public domain. Most of the key informants were conversant with the audit processes, the findings, and the outcomes. One of the main goals of the study was to establish the adequacy and perceived impact of Nigeria health policy with respect to the prudent use of resources. It is, therefore, possible that these headlines on governance and accountability of donor funds could have affected the nature of responses received from the key informants on prudent use of resources in the sector.

Demographics

A total of 15 key informants were interviewed. They included 12 males and three females. 6 of the key informants were from representative donor and development agencies; two were consultants in the health sector, one was from a university in Nigeria, and six were from the public health sector. The mix of the key informants was critical to minimizing bias while injecting diversity into the study's findings and their eventual translation for positive social change.

Data Collection

The data were collected from two different data sources based on the research questions. The first source was a content analysis for economic claims conducted on 17 health policy documents that were developed and approved for use in Nigeria during the period covered by the study. The data from the analysis of the documents were used to answer the first research question: RQ1: What is the nature of economic claims made in the health policy in Nigeria during the period starting in 2004 and ending in 2015? I

analyzed the 17 documents for economic claims using Nvivo. I further reviewed the claims and identified the emergence of three broad groups. The first group was for claims on increasing financing of health care, the second group was for claims on the prudent use of resources, and the last group was for claims on the protection of the beneficiaries of the health services from the attendant financial costs. Within each of the three groups, the claims were further categorized into subgroups including those that were specific in their formulation, time-bound, and measurable. These subgroups were converted into the respective nodes that were used to organize the claims in Nvivo for manual analysis.

The second source of data were from key informant interviews with health policy experts who worked in Nigeria during the period covered by the study. The key informant interviews were conducted through the normal telephone calls, Skype, and WhatsApp calls. The initial plan was to have all the calls through normal telephone lines. The plan changed because, for some of the call destinations, WhatsApp and/or Skype calls were clearer and had better connectivity. All the calls were made from Islamabad, Pakistan, with 13 of them going to Nigeria, one to the United States, and one to Kabul, Afghanistan. The calls lasted between 25-45 minutes, and all were tape recorded and then translated verbatim into text. I initially anticipated having the interviews last for about 45 minutes each. The variation arose because some of the key informants provided detailed responses to the questions while others preferred giving succinct responses even after I probed for additional information. I used the data from the key informant interviews to answer the second research question: RQ2: What are the perceptions of health policy experts in Nigeria on the adequacy and impact of the economic claims made in the country's health policy over the period covered by the study?

Data Analysis

In a review of the 17 policy documents, I found three broad categories of economic claims. The categories included the claims on the financing of the health sector, prudent use of resources available to the sector, and claims on the protection of beneficiaries of health services from the attendant financial costs. In order to represent information on these claims, four nodes were created to capture the specifics of the policy document where the claims were made. Another set of four nodes was created to capture the category of the claim in relation to its stated impact on the economy, financing of health care, use of resources, and protection of health services beneficiaries from financial costs. An additional three nodes were created to capture the nature of the claims with respect to specificity, time binding, and measurability.

Three main themes emerged from the coding of data on claims obtained from the content analysis of the documents. These included a theme on increasing the financing of health care, prudent use of resources, and protecting beneficiaries against financial costs of seeking health care. The three themes formed the basis for the follow-up key informant interviews with the selected health policy experts. The key informant interviews were captured in 15 nodes organized according to the three main themes that emerged from the content review of the documents. The nodes on the financing of health care were financing realistic, financing attainable, financing adequate, financing impact, and financing recommendations. Following a similar formulation, the nodes on prudent use of resources were prudent realistic, prudent attainable, prudent adequate, prudent impact, and prudent recommendations. Lastly, the nodes on protecting beneficiaries of health

care services against financial costs were protection realistic, protection attainable, protection adequate, protection impact, and protection recommendations.

The discrepant views on the economic claims mainly originated from two areas; some of the key informants based a part of their discussions on the subnational level, which in the case of Nigeria are the states. Their perception of the performance of some of the states in relation to the claims on increasing the financing of health care was different from the overall national perception. Similarly, the performance of some government projects that were initiated during the period covered by the study, with respect to the use of resources, was judged differently from the overall national performance. Some of these responses will be cited and discussed as evidence supporting the observation that the perceptions with respect to the economic claims at the national and subnational level, at program and project level, could be different.

Evidence of Trustworthiness

The credibility of the research process was ensured by sharing the verbatim narration of the interviews with the respective key informant interviewees for their review and validation before moving the verbatim narrative to the next stages of organization and analysis in Nvivo. All of the e-mail trails with the interviewees will be retained for 5 years. All 15 interview scripts were shared accordingly, and the validated scripts were imported into Nvivo for further organization. In the course of conducting the interview, saturation of ideas started to appear after the ninth interview. By the 12^{th} interview, there were no more new ideas emerging. However, I decided to complete all 15 interviews as scheduled to minimize the possibility of locking out any new insights, further contributing to the credibility of the study. The credibility of the study was also

enhanced by including at least one quote from as many of the key informants as possible depending on the relevance of the comment to the respective theme.

The study involved a diverse group of health policy experts in Nigeria, with some having international exposure. Some of the experts were based at the state level, and most were based at the federal level. They originated from academia, the public sector, and from among the donor and development partners' community. The findings, therefore, are potentially transferable because of the diverse nature of the experts involved. In addition, the experts shared some recommendations on future policy-making in line with Skocpol's policy feedback theory (Sabatier & Weible, 2014). The theory's main premise is that past policies influence the making of future policies, and this argument strengthens the transferability of the study findings and their implications for future policy making in Nigeria and elsewhere where underfunding of health care is an issue of concern.

I did a test run on the suitability and comprehensiveness of the nodes created to capture data obtained from content analysis using some of the policy documents. That helped me to finalize the creation of the 11 nodes that were then applied to collect the data using Nvivo. I also pretested the key informant questions with two health policy experts because no similar questions were available from the available previous research. The pretesting confirmed the overall suitability of the questions as formulated. A suggestion to give some examples of the different claims before fielding the actual interview questions was adopted, and it helped to improve health policy experts' clarity and focus on the interview questions.

The verbatim narrative of the voice-recorded interviews was shared with the respective interviewees for their review and feedback before importation into Nvivo

software for further organization into nodes and subsequently, manual analysis. This was the starting point for ensuring confirmability. In addition, the three main themes emerging from the initial content analysis of the health policy documents were used to finalize the formulation of the three categories of the key informant questions. The existence and nature of the economic claim in the health policy documents were established through the content analysis of the documents. The health policy experts were given examples of the claim from the three main categories as established through the content analysis of the health policy documents; they, too, confirmed that these claims are a part of the health policy documents. The interviews with the experts were then used to establish the perceived impact of health policy using questions per the three categories of the established economic claims. The alignment of the nodes between the two sources of data and the contribution to confirmability was, therefore, demonstrated and is further elaborated in the results section.

Coding of the Key Informants

The responses from interviewees were obtained between January 17, 2017, and February 11, 2017, and they were conducted as specified in the signed IRB consent form. The subsequent reference to the results obtained from the informant is coded according to the gender of the informant, an assigned serial number, and their affiliation in the health sector in Nigeria. The male respondents were, therefore, coded M1 to M12, while the female respondents were coded F1 to F3. The respondents working for the public health sector were further assigned a PHS code, those from the donor and development agencies were coded DA. The informants from the university were coded U, while the freelance consultants supporting the health sector at policy level were coded CHS. The coding

added to the trustworthiness of the study. To set the stage for the presentation of the results, a short description of the health policy documents and their development process is described. This is followed by the presentation of the findings from the content analysis of the health policy documents and from the key informant interviews.

The Health Policy Documents

A total of 17 health policy documents that were developed and endorsed for the implementation of the health policy during the period covered by the study were analyzed for economic claims made in them. One of the documents, the National Health Act of 2014, is an act of Parliament, and by that nature, is a law in Nigeria. Seven other policy documents are policies including the Revised National Health Policy of 2004. The other eight policy documents are strategies including the Federal Ministry of Health, National Strategic Health Development Plan (NSHDP) 2009-2015. The last policy document is a combined policy and strategy, and this is the Health Sector Component of National Food and Nutrition Policy and National Strategic Plan of Action for Nutrition 2014-2019.

The policy, sub policies, and strategy development activity started in 2004 with the number of policy documents developed in 2007, 2009, and 2010 increasing to two in each of these years and then to five documents in 2014. The first increase in the 2007-2010 period appeared at the midpoint of the policy implementation period while the last documents developed in 2014 happened towards the end of the policy implementation period as shown in Figure 2. In the figure, the numbers 0-5 from the center to the perimeter represent the number of policies that could be developed during the period covered by the study. The graphics at the center represent the actual number of policies developed by year starting with the development of one policy each in 2004, 2006, 2008,

2011, 2012, and 2013; no policy was developed in 2005 nor in 2015, while two were developed in 2007, 2009, and 2010, and five in 2014. This comes to a total of 17 policy documents. The total number of years of implementation of the 17 policy documents based on their respective year of development was 96 years (47.1%) out of a possible total years of implementation of 204 given the 12 year implementation period starting in 2004 and ending in 2015.

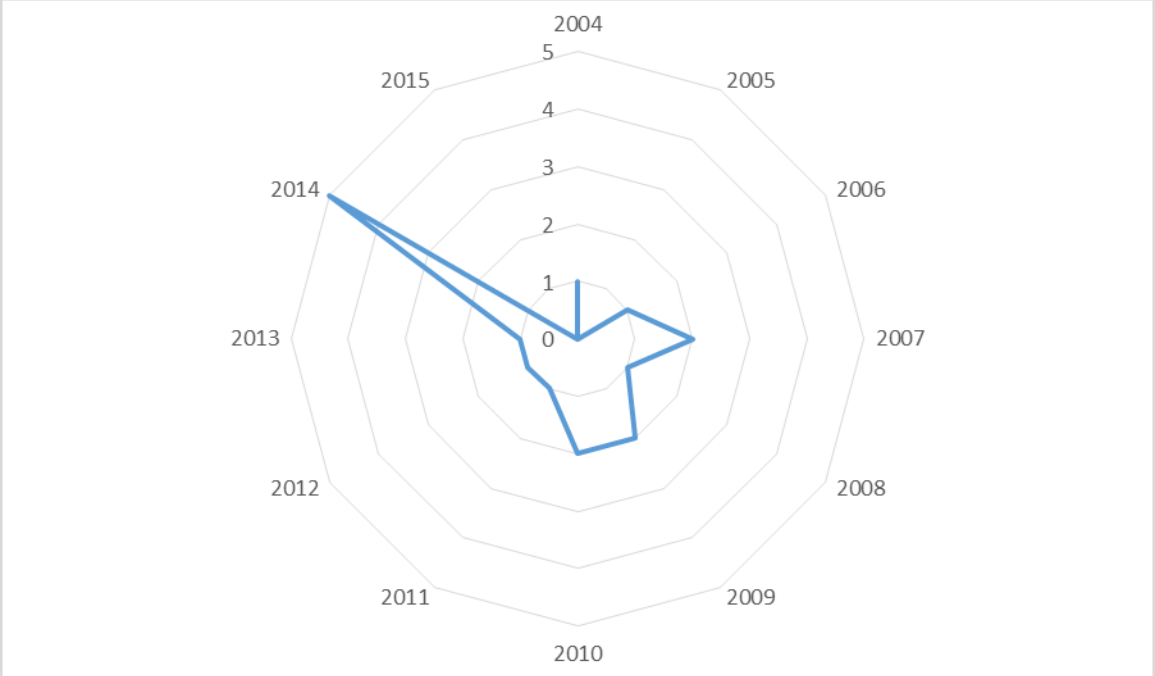

Figure 2. The health policy documents development activities in Nigeria

Economic Claims on Increasing the Financing of Health Care in Nigeria

Content Analysis of the Health Policy Documents

Through the content analysis of the 17 health policy documents, I identified 103 economic claims on increasing health care financing in Nigeria. Through a further review of the claims, I established that 43 of the claims were specific in their formulation, while

the remaining 60 claims were not; only 12 of the specific claims were time-bound and, therefore, measurable. The following are examples of the specific claims that I identified during the analysis of the policy documents:

- "Increasing budget allocations to health at the Federal, State and LGAs from the present level by at least 25% each year towards achieving the Abuja Declaration target of 15%" (FMOH, 2010b, p. 11).
- "Committing to at least 90% budget release and 100% utilization by the end of the year" (FMOH, 2010b, p. 11).
- "At least 2% of health budget will be allocated for health research at all levels" (FMOH, 2010b, p. 56).
- "Advocate for the progressive increase in government's funding of HIV/AIDS response at all levels to at least 30% by 2015" (FGN, 2010, p. 48).
- "At least 2% of annual health and health-related institutions' budget at all levels shall be allocated for HIS" (FMOH, 2014, p. 9).
- "At least 1% of annual health and health-related institutions' budget at all levels shall be allocated for data management governance" (FMOH, 2014, p. 9).

The following include examples of the nonspecific claims on the financing of health care that I also identified from the analysis of the policy documents:

- "To ensure that adequate and sustainable funds are available and allocated for accessible, affordable, efficient and equitable health care provision and consumption at Local, State and Federal levels" (FMOH, 2010b, p. 49).
- "To develop and implement evidence-based, costed health financing strategic

plans at LGA, State and Federal levels in line with the National Health Financing Policy" (FMOH, 2010b, p. 49).

- "Setting up of technical working groups for health financing at each tier of government and capacity building for the development and implementation of the Strategic Plans at all levels" (FMOH, 2010b, p. 49).
- "Eliminate funding delays and increase funding for Routine Immunization" (FMOH, 2013, p. 13).

Through the content analysis of the documents, I also established that some of the claims were appearing in more than one policy document; in some of the instances, similar claims were formulated differently. An example of such a claim is the Abuja declaration of increasing the budget allocation to the health sector by at least 15% of total annual government budget (Mburu et al., 2014). The following are some of the different formulations of the Abuja declaration that I identified in the various health policy documents:

- "Increasing budget allocations to health at the Federal, State and LGAs from the present level by at least 25% each year towards achieving the Abuja Declaration target of 15%" (FMOH, 2010b, p. 11).
- "Mechanisms will be put in place to get governments at all levels to increase the allocation of public resources to the health sector (apportion 15% of total budget on health in line with Abuja Declaration) and to assist them in the effective and efficient use of these resources" (FMOH, 2010b, p. 50).
- "Advocate for an increase in the allocation of not less than 15% of total national budget for health in accordance with Abuja declaration" (FMOH, 2007b, p.71).

Perceptions of the Key Informants on the Economic Claims

To answer the second research question in relation to the perceptions of health policy experts on increasing financing of health care over the study period, I used three key interview questions. The findings on these perceptions are presented according to each of the sub questions.

Q1. What is your view on claims made in the various policy documents about increasing the financing of health care in Nigeria? (*Follow-up questions*) Were they realistic, attainable, and adequate for the intended policy objectives?

The responses I, obtained suggest that the economic claims made in the policy documents about increasing the financing of health care in Nigeria tended to being marginally realistic; 8 of the 15 key informants affirmed that the claims were realistic as shown in Table 3.

Table 3

Perceptions That Claims on Increasing Health Care Financing Were Realistic

Interviewee	Perceptions of Health Policy Experts
M2-U	"The claim never happened, it didn't happen eventually, but I think the people who wrote it were right in putting it as a policy direction, it is only that it never worked. It never worked at federal level, but I think for some states, we heard about two states that have achieved it in Nigeria."
M3-DA	"The claim should be realistic depending on the resources available in Nigeria. Generally, it is realistic."
F1-DA	"I think, earlier, maybe it was attainable, but naturally the trend is that they will have to then prioritize health which did not happen over time and has gotten worse in the last two years or so."
M4-PHS	"The claim is actually realistic because the gaps for health care funding is large in Nigeria and in the last decade the proportion of budget that is being financed in health is low…."
M7-DA	"The claim might be realistic…but whether it has happened or not, I think it has not happened. I give you an example. Following the Abuja declaration that most African Governments should provide 15% of their budgets to health care only Jigawa and I think one other state have been able to attain that mark of 15% so in terms of increase in funding for the health sector…At the national level over the past 10 years…the funding for health in terms of proportion of money budgeted for health is actually falling."
M8-CHS	"I think the claim is realistic because there was actually a two to three year period when President Yaradua was there when there was an actual increase of the national budgetary allocation to health care of up to 6% of national budget.
M9-CHS:	"I think 15% for a budget for a country that is not at war is something attainable if there was political will because, what else does the Government do, it is social development, it is not into economic development much, more than facilitating the policy environment for economic development."
F2-PHS	"To that extent, 15% of the national budget is realistic. Now the only problem has been- have there been enough of the will around the financing sector to appropriately finance the health sector itself…."

The seven respondents who thought the claims were not realistic supported their perceived positions with the views shown in Table 4.

Table 4

Perceptions That Claims on Increasing Health Care Financing Were Not Realistic

Interviewee	Perceptions of Health Policy Experts
M10-PHS	"I don't recall any time … when the allocation exceeded 8%. It has been between 5-6%, although overall share of the health budget was increased but never reached the Abuja declaration of 15%. As to whether the claims were realistic…., my answer is a re-sounding no."
M11-PHS	"My view is that they were not realistic in the sense that instead of moving forward towards 15%, we are unfortunately declining. The 2017 budget if you look at, was within the context of 7 billion Naira, less than for last year."
F3-DA	"I think in the first instance there has been some move to increase the financing for health with a lot of advocacy and a lot of statements made and there was a marginal increase in the financing to about 5% and the highest coming to about 7% but it was not sustained and that was more at the federal level than at state level."
M12-DA:	"I think if you look at the targets, the targets was never met in terms of the federal budgetary allocation to health… last year alone, one of the states allocated 11% of its budget to health, which is quite substantial and close to the target of 15% for health…If you aggregate everything together, state and federal, there is an increase, but not meeting the target of Abuja declaration."
M5-DA	"The government signed up to the Abuja Declaration of commitment to allocate 15% of government budget for health. That commitment was also eventually taken up by the states. However, very few of the states are coming close to the 15% commitment. The federal government allocation for health was 4% in 2016."
M1-PHS	"There is a role that CSOs and development partners play in pushing what is ideally right but may not be fiscally realistic and because the Federal Ministry of Health does not have this capability or thought leadership to think through on the short term and on the long term what this really means, we are always disconnected and want to do everything at ones."
M6-PHS:	"Now that they may not have been realistic because when you are working with fiscal space, Pareto principle says that you cannot make one person better without making the other worse."

I obtained mixed responses when I asked the respondents whether the claims made in the various policy documents about increasing the financing of health care in Nigeria were attainable. As shown in Table 5, three of the respondents felt that the claims

were attainable. They supported their arguments based on the performance of two of the state governments that were substantially financing health care.

Table 5

Perceptions That Claims on Increasing Health Care Financing Were Attainable

Interviewee	Perceptions of Health Policy Experts
F2-PHS	"To that extent, I will say it is a realistic amount, it not impossible to get that amount of money. Is it appropriate, is it the right amount?"
M7-DA	"… whether the claim of increasing the financing is attainable, I think it is also attainable, but whether it has happened or not, I think it has not happened."
M9-CHS	"I think 15% for a budget for a country that is not at war is something attainable if there was political will because, what else does the Government do, it is social development, it is not into economic development much, more than facilitating the policy environment for economic development."

As shown in Table 6, I established that most of respondents felt that the economic claims on increasing the financing of health care were not attainable.

Table 6

Perceptions That Claims on Increasing Health Care Financing Were Not Attainable

Interviewee	Perceptions of Health Policy Experts
M1-PHS	"At federal level, concentration is on tertiary care and states get allocation from federal and should focus on primary care. But the federal is taking up both primary and tertiary care with little thinking on what this means for fiscal space at federal level."
F1-DA	"So the straight answer of attainability, I think for Nigeria like for most countries considering the resources it had in the recent past, maybe it was attainable but the lack of prioritization made it un-attainable."
M4-PHS	"Because of changes in the political will and changes in the perception of people in power, I don't think that claim was attainable, looking at the budgets by year, looking at 2016 budget that had very low performance, the 2017 budget was just a replica of the 2016 one."
M5-DA	"So the claim of allocating more resources to health has not been achieved…private spending accounted for up to about 70% of the total health expenditures in Nigeria, followed by government (24%), and the rest by donors and other sources, confirming that the claim of allocating more funding for health has not been realized in Nigeria.
M6-PHS	"… doesn't look realistic at the time these policy documents were developed, hence, they are not attainable and that is why you can see- if not realistic, it will not be attainable."
M8-CHS	"… there was some oscillation of the budget to the health sector up and down hence the increase was not sustained but that is not enough to say that it was not realistic, even at sub-national level some states had gone beyond what the federal comes up with. A summary of my answer is that it's realistic but not completely feasible."
M10-PHS:	"As to whether the claims were …attainable…, my answer is a re-sounding no."
F3-DA	"I think in the first instance there has been some move to increase the financing for health with a lot of advocacy and a lot of statements made and there was a marginal increase in the financing to about 5% and the highest coming to about 7% but it was not sustained and that was more at the federal level than at state level."
M12-DA:	"If you aggregate everything together, state and federal, there is an increase in budget, but not meeting the target of Abuja declaration."
M11-PHS:	"… so I don't know whether the policy statement had contributed to improving the health care financing in states. I have not, I don't know what is happening."

Going by the findings shown in Table 7, I established that most of the respondents were of the view that the economic claims made in the policy documents about increasing

the financing of health care were not adequate for the intended policy objectives. The respondents pointed out that over the period covered by the study, the government had not provided adequate finances to the health sector.

Table 7

Perceptions That Claims on Increasing Health Care Financing Were Not Adequate for the Intended Policy Objectives

Interviewee	Perceptions of Health Policy Experts
M1-PHS	"The engagement between health, the ministries of planning, budgeting, and finance is patchy…there was a bit of commitment from that level but broadly speaking and over a period of time there is a disconnect between the song that health is singing and the music that finance wants to listen to, where finance wants to see maximum impact for resources provided…."
F1-DA:	"…this has been a challenge for most countries. Interestingly enough the countries that have increased the financing close to approaching or even exceeded the Abuja declaration are not necessarily the countries that have financial might. Specifically for Nigeria, I think, earlier, maybe it was attainable, but naturally the trend is that they will have to then prioritize health which did not happen over time and has gotten worse in the last two years or so."
M5-DA	"Ok: The impact of not realizing the claims is evident in the inability of the public health system to provide adequate health care. This situation is reflected in the payment of user fees for health services in the public sector - because government funding is not sufficient."
M6-PHS:	"Adequacy here is a bit tricky, yes adequacy means for the intended policy objective, proposing 15% in line with Abuja declaration mean if a budget is increased three times of what it is now, the budget should be more than adequate. But what we see is that the budget is actually decreasing."
M7-DA	"Overall, the absolute amount of money allocated to health in dollar terms may have increased but in terms of the proportion to the total budget, was reducing."
M10-PHS	"First, the intention of the government in setting aside 15% of total budget for health was noble, but I don't recall any time …when the allocation exceeded 8%. As to whether the claims were … and adequate for the intended policy objective, my answer is a re-sounding no."
F2-PHS:	"No, I mean, we have not met that 15%, we have not met 10%, the highest that I think we have gone is like 7% or so in that period... Over that period, we haven't met or reached those claims of wanting to reach 15% and we haven't provided the finances required to ensure that the citizenry have the required outcome."

(table continues)

Interviewee	Perceptions of Health Policy Experts
F3-DA:	"So I think there was some marginal increase initially, but subsequently… there have been in fact a decline. Although there is also some extra funding through the MDG and they get relief funds earmarked for health but there is no place where you can actual check to see that it is spent on health."
M12-DA:	"I think if you look at the targets, the targets were never met in terms of the federal budgetary allocation to health…The other thing which I think I need to bring out is that budgetary allocation does not necessarily lead to results, what we should be looking at is the expenditure. The government allocation to meet the Abuja declaration has been on the upward trend, maybe except 2016, when we have inflation."

Q2. What is your view of the impact of these claims?

As demonstrated by the findings in Table 8, most of the respondents could not appreciate the impact of the economic claims on increasing health care financing in Nigeria. They based their views on the poor health outcomes in the country, the fact that the country missed its MDG related targets in 2015, and the weak state of the health system.

Table 8

Perceptions That Claims on Increasing Health Care Financing Did Not Have Impact

Interviewee	Perceptions of Health Policy Experts
M1-PHS:	"When we agree to commitments at the global level the finance ministry is typically not involved…There is limited fiscal space because the underpinning of the budget was on the volume and price of oil, and for the past 3-4 years was based on 2.2 million barrels, but not anymore given the dip in oil market and the low price. The country is therefore borrowing more and further constricting the fiscal space going forward so we end up with programs that are non-implementable. So we have lofty programs but that are un-implementable."
M2-U:	"I don't think we have seen much impact even the one that were presented because the country indices still remain low- only 4% -5% of total budget for health. The health system is still quite weak, so I think even the ones that were implemented weren't implemented very well. I don't think they have achieved the objectives for which they were implemented."
M3-DA:	"I don't think they have any impact to be honest. I don't think they were able to achieve those claims consistently even on the financing. Secondly, I

(table continues)

Interviewee	Perceptions of Health Policy Experts
	don't think there was much impact towards attaining those goals and claims. I think there were a lot of opportunities for leakages that were not plugged. Perhaps as I said the will was not there so the resources were not put to good use. I think the impact intended for wasn't achieved."
F1-DA:	"I will start with a no in the sense that Nigeria like most countries in the region will simply make these statements because they are being made across the region and to some extent globally. Within the region, the Abuja declaration was a regional forum and all countries used it as a benchmark."
M5-DA:	"The impact of not realizing the claim is made worse by the fact that health insurance coverage is very low as such patients rely on out of pocket spending to meet their health care costs, a situation that is negatively affecting attainment of UHC, and further exposing the population to poverty."
M6-PHS:	"Yes, my answer on impact is no at federal level."
M7-DA	"The impact of the claims is that it tends to portray that the government is spending so much in the health sector and therefore should expect to see results in terms of improving health indices but in reality, the impact is negative in terms of outcomes, in terms of the release of the funding, and actual expenditure is reducing so the impact is negative."
M8-CHS:	"I think that the impact of the claim has not had the desired effect. It has had sub-optimal effect because it was not followed with vigorous advocacy at sub-national level, hence less than desirable effect. I personally think that the claim was not followed by appropriate consultation."
M9-CHS:	"On impact, the first question to ask is that- did we actually have that much money in the health sector? Very doubtful, we didn't, and I tell you we didn't because, look at all major cost studies in Nigeria like the National Health Accounts, the private sector is the biggest funder of health services in Nigeria especially the out of pocket expenditure is coming at an average of 75%, then you ask yourself, where is the government contribution?"
M10-PHS:	"The impact of the claims was expected to be an increase in quantity and quality of services in terms of number of people reached and from the equity angle by reaching the poor. It varies from program to program, Expanded Program on Immunization reached its objectives through increased coverages, but the Reproductive Health was much tricky."
F3-DA:	"There hasn't been much impact. If you look at the indices around that time, there was a very marginal lowering of the indices… Given the investments, the impact was not well achieved."

On the other hand, a few respondents felt that even though the claims might not have had the desired impact nationally, maybe the situation at the sub-national level and for particular programs was different as shown in Table 9.

Table 9

Perceptions That Claims on Increasing Health Care Financing Had Some Impact

Interviewee	Perceptions of Health Policy Experts
M6-PHS	"…But at state level, the answer is yes for some states like Jigawa, Bauchi and one other state… one other thing I don't know whether appropriate for this study is that the claims have raised a lot of awareness among policy makers as to the need to increase health budget and that this is the right thing to do."
M10-PHS	"The impact ….It varies from program to program, Expanded Program on Immunization reached its objectives through increased coverages, but the Reproductive Health was much tricky."
M11-PHS	"The only good news I heard in 2017 is from my state, Bauchi government allocated a little bit above 15% which make the state, the only state that has done that."
M12-DA	"It is a mixed bag, you know it yourself, and it is mixed. For example infant and under five mortality is reducing. Maternal mortality is reducing but not substantial, Nigeria missed its MDG targets…The impact is mixed, it is marginal, and the improvements of outcomes do not match the resources going to the health sector."

Q3. What do you recommend in relation to the making of such economic claims in future policies?

At the end of the sub-set of questions on the economic claims on increasing of the financing of health care, the key informants were asked to give their recommendations in relation to the making of similar economic claims in future policies. Most of the respondents gave general recommendations relevant to program implementation and delivery and only a few were able to focus on recommendations for making of future health policies. The following are some of the relevant recommendations concerning increasing the financing of health care that key informants proposed for consideration in future health policies:

- Include the cost of delivering a package of services and the availability of the funds to buy the services.

- Include relevant international and regional benchmarks and commitments such as the Abuja declaration of 2001, in the future policy.
- Use evidence including the analysis of fiscal space to guide the drafting of these claims in future health policy.
- Formulate the sector policies, strategies, and their claims in a language that is understandable to a minister of finance, to a minister of planning and budgeting, to the technocrats, as well as the cabinet.
- Include an accountability framework in future policy-making.
- The claims should build the case for providing more financing to PHC.

Economic Claims on Prudent Use of Resources for Health Care

Content Analysis of the Health Policy Documents

Through the analysis of the 17 health policy documents, I identified a total of 15 economic claims concerning prudent use of resources set aside for the health sector in Nigeria. While seven of those claims were formulated in a specific manner, the other eight were not specific. The following list shows some example of the specific economic claims made in relation to the use of resources in the health sector:

- "The FMoH will provide technical assistance to aid States and LGAs in developing costed, annual operational plans" (FMOH, 2010b, p. 50).
- "Credible mechanisms will be put in place to increase financial transparency through the development of National and State Health Accounts (NHA and SHAs) and Public Expenditure Reviews (PERs) and tracking of health budgets" (FMOH, 2010b, p. 50).

- “Develop a performance plan for monitoring the budget allocated and released by the FMoH for HIS activities” (FMOH, 2014a, p. 18).

The following three claims are examples of the nonspecific claims made in the health policy documents in relation to the use of resources for the health sector:

- "Establish and maintain transparent and accountable financial and program management systems that are able to effectively track resource allocation and utilization within their area of jurisdiction" (Federal Government of Nigeria [FGN], 2009, p. 35).
- "To improve health budget execution, monitoring, and reporting" (FMOH, 2007b, p. 84).
- “To strengthen financial management skills.” (FMOH, 2007b, p. 84).

Out of the seven specific claims, the following two claims were also time-bound, hence, measurable:

- “Money from the fund shall be used to finance the following: (a) 50% of the Fund shall be used for the provision of basic minimum package of health services to citizens, in eligible primary or secondary health care facilities through the National Health Insurance Scheme (NHIS); (b) 20 percent of the fund shall be used to provide essential drugs, vaccines, and consumables for eligible PHC facilities; (c) 15 percent of the fund shall be used for the provision and maintenance of facilities, equipment, and transport for eligible primary health care facilities; (d) 10 percent of the fund shall be used for the development of human resources for PHC; and (e) 5 percent of the fund shall be used for emergency medical treatment to be administered by a committee appointed by the National

Council on Health" (FRN, 2014, p. 14).

- "The National Primary Health Care Development Agency shall not disburse money to any: (a) Local government health authority if it is not satisfied that the money earlier disbursed was applied in accordance with the provisions of this Act; (b) State or local government that fails to contribute its counterpart funding; and (c) State and local governments that fail to implement the national health policy's norms, standards and guidelines prescribed by the National Council on Health" (FRN, 2014, p. 14-15).

Perceptions of Key Informants on the Economic Claims

To answer the second research question in relation to the perceptions of health policy experts on prudent use of financial resources for the health sector, I used three sub questions. The findings on the perceptions in relation to prudent use of resources are presented according to sub questions.

Q1. What is your view on claims made in the various policy documents about prudent use of financial resources for the health sector in Nigeria? (*Follow-up questions*) Were they realistic, attainable, and adequate for the intended policy objectives?

The responses from six of the key informants suggested that the economic claims made in the policy documents about prudent use of resources were realistic as represented in Table 10. The majority of these respondents justified their views on the need for the claims in the country's health policy given that transparency, accountability, and proper governance in the use of resources in the health sector in the country is a

major issue of concern. Many of the respondents who thought that the claims were realistic also linked them to the absence of structures for their enforcement.

Table 10

Perceptions That Claims on Prudent Use of Resources Were Realistic

Interviewee	Perceptions of Health Policy Experts
F2-PHS	"...I don't see any reason why these statements should not be there. The only thing is that we should make consented efforts to be able to enforce those statements and that is where some of the lessons we are learning on results based financing are coming in."
M1-PHS:	"I think like in many policies, what they tried to do is build monitoring and evaluation framework or provide skeletal framework to ensure money is used and in that way it's a step in the right direction."
M2-U:	"They are all realistic and attainable, as we said, the only problem is actual implementation."
F1-DA:	"So the straight answer is yes, that those statements are made without a big reflection because they are statements made across many countries. When countries are making strategies and policies, naturally they look at what other countries are doing. This is a practice that is desirable, so normally, any technocrat involved in the process of this nature will naturally want to document the right principles, the right practice. But I think that is where it ends as a commitment."
M7-DA:	"I think, those claims in theory are realistic but are not attainable, and were not adequate for the intended policy objectives…."
M11-PHS:	"…for me, the claim of prudent use of resources tying release of funds commensurate with results is realistic but depends on many factors."

On the other hand, eight of the respondents who thought the claims were not realistic gave very emphatic responses as shown in Table 11. As also shown in the table, one of the respondents did not have enough information to make a judgement on the realistic nature of the claims.

Table 11

Perceptions That Claims About Prudent Use of Resources Were Not Realistic

Interviewee	Perceptions of Health Policy Experts
M3-DA	"I think on prudent use of resources if I was to rate Nigeria, I score the country very low. I think that is the other issue, corruption and lack of prudent use of resources. So we waste a lot of resources on projects that do not necessarily impact on more numbers, more lives."
M4-PHS	"The framework of governance has not changed much despite the introduction of due process, the public procurement act. But the inputs are being managed the same way. Nigeria planning is not evidence based planning."
M5-DA	"I think the key emphasis there, was for the policy documents to promote preventive health, basically PHC to address the disease burden and the common disease conditions that are affecting the people. From what we see apart from the resources that are inadequate, is that the allocation has not matched that policy intention of giving more to PHC particularly for preventive and promotion services. So they are falling short in that."
M8-CHS	"Again I think that claim, I don't have any problems with anybody making claims but I think that claim is not realistic in the context of what is happening in the health sector and a lot more need to be desired in terms of prudence, I don't think there is prudency in the health sector, it's totally not a reflection of what is on the ground which is also a mirror of what is happening in society."
M9-CHS	"We haven't developed a mechanism to ensure that the resources will be put into the activities. If I was the Governor, I will give you this money, and get an independent person to measure this results at the end of the year. Nobody asks about the results, even at federal level, we give money to the referral hospitals but nobody follows on what they have done with the money."
M10-PHS	"…the resources have not been prudently used, lots of leakages, and if these are all sealed, there will be a lot of money plugged back into the sector. So, the claim was not realistic and not achieved because of the environment and lack of structure for output financing and structures to ensure prudent use."
F3-DA	"I don't think there was prudent use of resources, what you commonly see are national level people coming to the states… they operate parallel to the local and state government even they don't inform these levels of their presence in the state."
M12-DA	"No. No, I don't think we have used resources well…I don't think we are using resources prudently. Over the years resources available have gone to paying salaries and there is no rational use and end up with facilities with staff who are doing nothing. You know the GAVI problem, you

(table continues)

Interviewee	Perceptions of Health Policy Experts
	know the Global Fund problem and what corruption does, the money coming to the health sector is not spent on health alone, I will say no."
M6-PHS	"In other words, I do not have facts, information, and data to measure prudent use of resources or an appropriate measure to be able to respond"

According to the views of six of the respondents shown in Table 12, the claims on prudent use of resources in the health sector were not attainable.

Table 12

Perceptions That Claims About Prudent Use of Resources Were Not Attainable

Interviewee	Perceptions of Health Policy Experts
M1-PHS	"The question is when we put too much in an individual instead of building the system- for example, the Minister will/ shall."
M7-DA	"There are no adequate measures for managing corruption in the health sector. So tracking of resources up to the lowest level has been a challenge so it is not an attainable claim per se in terms of saying that there is prudent use of resources in the health sector."
M8-CHS	"I don't think the claim is correct, realistic, I don't know, but how far they have adhered to it? Not gone far."
M10-PHS	"So, the claim was not realistic but not achieved because of the environment and lack of structure for output financing and structures to ensure prudent use."
M11-PHS	"… there has to be some very, clear conversation between NPHCDA and the states and ensure that transparency and accountability is very much enshrined and by that we can improve our prudence. We can't get 100% and nowhere in the world have you got that, at least by and large for the intended purpose. We can be able to achieve that reality if we are able to put this measures in place."
F2-PHS	"… I don't think government sets itself up to failure or not to deliver on its mandate… nobody will assume that the funds will be used prudently but when you put it in the policy, that enhance the chances that it will be used judiciously and can be called to order within the ambit of that policy. You know policies are one thing, it's another thing in terms of implementation."

Nine of the respondents were of the view that the economic claims made in the policy documents about prudent use of resources in the health sector during the period covered by the study were not adequate for the intended policy objectives. As presented

in Table 13, many of the respondents linked the issue on prudent use of resources with governance, transparency, and accountability in the health sector.

Table 13

Perceptions That Claims About Prudent Use of Resources Were Not Adequate for the Intended Policy Objectives

Interviewee	Perceptions of Health Policy Experts
M2-U	"They are all realistic and attainable, as we said, the only problem is actual implementation."
F1-DA	"The problem is that in any document contents are desirables, that is the right thing to do, that is what the population requires and the system requires. Where the disconnect occurs is that there is no follow-up thereafter… Most mechanisms especially in Nigeria do not have solid accountability processes, let me call it broadly-mechanism."
M4-PHS	"The current system is data driven and the system is not strong to safe guard this funding and it cannot attain its purposes and has not changed during the last 2 decades. Nobody is looking at what strategic investments should be safe guarded to be able to change the health indicators that are being observed over the years."
M5-DA	"I think the key emphasis there, was for the policy documents to promote preventive health, basically PHC to address the disease burden and the common disease conditions that are affecting the people. From what we see apart from the resources that are inadequate, is that the allocation has not matched that policy intention of giving more to PHC particularly for preventive and promotion services."
M7-DA	"I think those claims were not adequate for the intended policy objectives because we need to do a little more in terms of accountability and ensuring that the little resources are used judiciously."
M8-CHS	"I don't know, but how far they have adhered to it? Not gone far."
M9-CHS	"… unfortunately, they are just statements and nobody has developed the instruments to make them work at the level of implementation and we have to ask ourselves questions on how did we get to where we said we want to go."
M10-PHS	"So, the claim was not realistic but not achieved because of the environment and lack of structure for output financing and structures to ensure prudent use."
M11-PHS	"…We can't get 100% and nowhere in the world you get that, at least by and large for the intended purpose, we can be able to achieve that reality if we are able to put this measures in place."

Q2. What is your view of the impact of these claims?

8 of the respondents could not appreciate the impact of the economic claims on prudent use of financial resources in Nigeria as shown in Table 14.

Table 14

Perceptions That Claims About Prudent Use of Resources Did Not Have Impact

Interviewee	Perceptions of Health Policy Experts
M2-U	"The health system is still very poor, lot of waste in the system, lots of corruption in the system, lack of accountability, so it's something that has not been used well. The citizens have not benefitted from all the funds that have gone into the system."
M3-DA	"In terms of impact, it is very limited at all levels. Even at tertiary level, it's limited because you cannot guarantee quality health care. Equally you can't guarantee quality secondary health care in Nigeria and all the resources that have been used, PHC is a huge challenge and not prudently used. We are not there yet."
F1-DA	"So far no impact because there hasn't been a framewo implement, so that is why they remain an intention and good statements."
M4-PHS	"The current system is data driven and the system is not strong to safe guard this funding and it cannot attain its purposes and has not changed during the last 2 decades."
M5-DA	"From what we see apart from the resources that are inadequate, is that the allocation has not matched that policy intention of giving more to PHC particularly for preventive and promotion services. So they are falling short in that… It is always underspent and the reasons for underspending including a variety of factors such as being over optimistic about what the government is putting in the budget (revenue size and sources) and therefore the actual revenue that is realized is much less than what the projected."
M11-PHS	"… they do have impact because it has been mentioned so from my own view point people will also need to think twice before making claims and potentially linking this allocation to utilization and ensuring that they do the right thing. It is better it is stated, but it can be better in terms of its implementation."
F3-DA	"I think the impact is overstated a little bit. There is no doubt that there have been some progress, but the progress could have been much more if it was well streamlined and well followed. It could have seen much more of an impact while building the system. So the conceptualization is OK, but when it comes to implementations to have a real impact, there is a problem."
M12-DA	"No, the claims have had no impact."

The following discrepant and only such view on prudent use of resources and impact came from one of the study respondents:

> There is no doubt that there have been some progress, but the progress could have been much more if it was well streamlined and well followed so the conceptualization is ok, but when it comes to implementation to have a real impact, there is a problem. I think we could have done a lot better.

Q3. What do you recommend in relation to the making of such economic claims in future policies?

At the end of the subset of questions on the economic claims on prudent use of resources in the health sector, the key informants were asked to give their recommendations in relation to the making of these economic claims in future policies. The following recommendations were given by some of the respondents:

- Include specific whole sector governance and accountability measure for the prudent use of resources in future health policy. According to one of the respondents, “I will say, tie budget to plans which currently is not the case and have deliverables to be verified periodically by independent group and I will put that in the policy or in the strategies for implementing the policy” Use evidence in developing the economic claims on prudent use of resources to be included in future policy.
- Specify the use of evidence-based budgeting and planning process in the future policy.

Economic Claims on Protecting Beneficiaries against Financial Costs

Content Analysis of the Health Policy Documents

I identified a total of 29 economic claims concerning the protection of beneficiaries of health care services against financial costs through the content analysis of the 17 health policy documents. While 15 of those claims were specific in their respective formulations, only one was time-bound and therefore measurable.

The following is a sample of some of the nonspecific economic claims that I identified in the health policy documents:

- To strengthen systems for financial risk health protection (FMOH, 2007b, p. 81).
- Establish financial mechanisms that protect the poor and vulnerable groups' especially pregnant women, newborns and under-fives, and orphans, to include exemptions, subsidies, insurance, vouchers and other methods in the utilization of IMNCH services (FMOH, 2007b, p. 81).
- Subsidy Reinvestment and Empowerment Programme (SURE-P)-The Federal Government of Nigeria, in its bid to plow back the gains from the oil subsidy removal, developed a relief package for the masses, especially the poor (FMOH, 2007b, p. 42).
- Ensuring better value for expenditures being incurred by households by promoting effective social health insurance and risk pooling mechanisms (FMOH, 2010, p. 70).
- To ensure that people are protected from financial catastrophe and impoverishment because of using health services (FMOH, 2010, p. 49).

The only claim that was both specific and measurable was "to reduce by 50%

malaria-related morbidity and mortality in Nigeria by 2013 and minimize the socio-economic impact of the disease" (FMOH, 2009, p. 17).

Perceptions of Key Informants on the Economic Claims

In order to answer the second research question in relation to the perceptions of health policy experts about protecting beneficiaries against financial costs of health care, I used three interview sub questions. The findings from the interviews are presented according to the sub questions.

Q1. What is your view on economic claims made in the various policy documents about protecting beneficiaries against financial costs of health care in Nigeria? (*Follow-up questions*) Were they realistic, attainable, and adequate for the intended policy objectives?

The respondents gave mixed views when asked if they thought the economic claims made in the policy documents about protecting users of health care services were realistic. As shown in Table 15, only three respondents thought the claims were realistic; despite being positive on their realistic nature, the respondents felt that the problem with the claim was implementation.

Table 15

Perceptions That Claims About Protecting Beneficiaries Against Financial Costs of Health Care Were Realistic

Interviewee	Perceptions of Health Policy Experts
F1-DA	"First and foremost, as a policy the intention was noble, the problem is implementation and that led one to reflect on the issue of impact. I will say almost no impact. The reason why I am saying so is that even though the country unfortunately had not developed the National Health Accounts to help them have evidence over time, the little data that is there is that the out of pocket expenditure in Nigeria is a minimum of 70% which is extremely high. What it means is that there is a huge population that is not protected."
M8-CHS	"Remember a claim is a statement of intent and the policy wanted to protect clients and customers from probable catastrophic expenditure which stems from the fact that out of pocket expenditure is about….. It is a major claim and realistic because they have admitted the situation is bad and want to make it better."
M12-DA	"This is a very desirable objective. It is desirable from many points of view. Even where there have been declarations of free health care, at the end nothing is free. Are they attainable? We need more resources, more efficient use of resources. We know that about 64% of Nigeria's are poor, who is this poor person, where are the poor… It is desirable, not been achieved and require government to come in."

On the other hand, seven of the respondents thought that the claims were not realistic. As shown in Table 16, most of the respondents who share this view seemed to link their views with the failure by the government to provide adequate funding for social protection schemes.

Table 16

Perceptions That Claims About Protecting Beneficiaries Against Financial Costs of Health Care Were Not Realistic

Interviewee	Perceptions of Health Policy Experts
M3-DA:	"That is the biggest of the country's failure, I think. If you look at the NHAs, out of pocket contributes to 65-70-80% of the funding of health care in Nigeria, you can work out and imagine the impact of that on the poor who cannot afford it. Secondly, most of these is spent on very poor quality of health care, with 70-80% use of user fees, they still don't get quality health care and they don't go to appropriate facilities for health care; many seek care from private medical vendors, traditional healers, etc. …The policy is not realistic but it is attainable if the will is there and I think the resources put there is not adequate and the impact is devastating."
M5-DA:	"Because health insurance coverage is very low, out of pocket spending on health care make individuals vulnerable to financial risks, and inability to access quality health services. Patients have to pay user fees through direct payment and not through insurance so imposing a financial burden to households as a result of the medical situation."
M7-DA:	"Again, one of the major trust of the health policy in Nigeria is to be able to provide PHC to all Nigerians at an affordable cost and trying to prevent Nigerians who are suffering hardship because of the financial cost of health care. However, the mechanisms for attaining this goal is not clearly defined, it is not realistic, and we all know it is not attainable within a short period of time and the reasons is that we all know that 70% of the health care expenditure is out of pocket and because of this, it means that families, individuals, and communities are prone to catastrophic consequences of ill health if they have to face emergencies or even chronic health conditions…Nigerians do not have a social protection mechanism. So that policy statement or claims is not realistic and we know it is not attainable."
M10-PHS:	"Approved policies, to what extent these policies have been pro-poor. We need to do cost benefit analysis of the policies. But none has been done to see how the policies are translating into benefits. Using secondary sources, the total money is supposed to translate into services to the populace in terms of services provided, number of people reached. Look at antenatal care, immunization, skilled birth attendance across the health quintiles- it is the middle income people who are patronizing the services and not the lower income group, who do not use the services, are not completely reached, they are disenfranchised and the indices for the lower quintile are becoming lower. Services in the facilities are charged, no risk protection for the intended beneficiaries so not able to access the services

(table continues)

Interviewee	Perceptions of Health Policy Experts
	hence we are seeing the situation the way it is."
M11-PHS:	"They were not realistic, they were not attainable because we did not put the required infrastructure that will ensure the delivery of those services that would protect individuals from especially financial costs… So in terms of equity to get services, they are not still there. Community based insurance, where is it, where are we as big as Nigeria, there is still at infancy level when other African countries have gone far. So financial protection, we are not yet there."
F2-PHS:	"They haven't been realistic and it doesn't mean having a document around social protection. You cannot have financial protection from water, financial protection happens with money. You can't do financial protection without money and there is no other way of doing it to prevent that catastrophic spend."
F3-DA:	"I think for that one we didn't really do well. We haven't made any progress, in fact we seem to have regressed a little bit for example in the recent times when we have so many recession coming in and the funds not coming into the public sector. And the people have generally to bear the burden of whatever it is for education, health or whatever. I think that the last set of claims, we haven't really done much. There has been some attempts, but they have been too few and for example there has been attempts to introduce community based health insurance. Maybe you can point to one or two initiatives that have worked but even then, they are heavily donor driven and donor dependent so now that donors are pulling out we need to see whether this will actually be sustained. I think the last set of claims about reducing the burden of health care, I am afraid we have seen much impact on that."

According to the views of a majority of the respondents shown in Table 17, the claims on protecting beneficiaries of health care were not attainable. The key informants linked their position on the claims to the lack of political goodwill and its negative influence on health care financing.

Table 17

Perceptions That Claims About Protecting Beneficiaries Against Financial Costs of Health Care Were Not Attainable

Interviewee	Perceptions of Health Policy Experts
M2-U	"That policy declaration is a failure because coverage of people against financial risk is about 5% in the country. It is a failure of the policy direction."
F1-DA	"To me…the system is nonresponsive to the general population in relation to that particular policy."
M4-PHS	"For the purpose of risk protection, I think the available resources cannot cater for it and a lot more things need to be done in order to get financial inclusion for the poorest of the poor and those who are marginally at risk."
M5-DA	"The cost of health care is increasing and so is the size of the population, so if you had to cover cost of care largely through government funding, it would be unattainable for example to cover or buy medicine for health care."
M7-DA	"The intention might be good, but we know that there is a lot that needs to be done in order to cover the poorest of the poor who as result of ill health suffers catastrophic consequences."
M8-CHS	"The policy want to do that but the "how" is not there only the "what" is there, it is a statement of intent and it is realistic."
M11-PHS	"… they were not attainable because we did not put the required infrastructure that will ensure the delivery of those services that would protect individuals from especially financial costs."
F2-PHS	"It is difficult to say that because, if you haven't invested the right amount of money, there is no way you can be making those claims. Like I said, for me that bit is what I feel has not happened."
F3-DA	"I think for that one we didn't really do well. We haven't made any progress, in fact we seem to have regressed a little Bit for example in the recent times when we have so many recession coming in and the funds not coming into the public sector."
M12-DA	"It is desirable, not been achieve and require government to come in."
M10-PHS	"Approved policies, to what extent these policies have been pro-poor. We need to do cost benefit analysis of the policies. But none has been done to see how the policies are translating into benefits."

As shown in Table 18, most of the respondents were of the view that the economic claims made in the policy documents about protecting beneficiaries of health care in the health sector during the period covered by the study were not adequate for the

intended policy objectives. The inadequacy of the claims was linked to the performance of the National Health Insurance Scheme (NHIS).

Table 18

Perceptions That Claims About Protecting Beneficiaries Against Financial Costs of Health Care Were Adequate for the Intended Policy Objectives

Interviewee	Perceptions of Health Policy Experts
M2-U	"…2005 was the starting of the informal sector NHIS. It is only about 5% of the people that are covered by the NHIS- does not work very well, the government hasn't done well with the NHIS."
M3-DA	"That is the biggest of the country's failure, I think. If you look at the NHAs, out of pocket contributes to 65-70-80% of the funding of health care in Nigeria…."
F1-DA	"First and foremost, as a policy the intention was noble, the problem is implementation."
M4-PHS	"The pooling of the risk of the poor is difficult because they constitute the majority, so what they have is not adequate – the government contribution alone is not adequate to guard against the financial risk of the poor."
M5-DA	"Because health insurance coverage is very low, out of pocket spending on health care make individuals vulnerable to financial risks, and inability to access quality health services."
M7-DA	"The intention might be good, but we know that there is a lot that needs to be done in order to cover the poorest of the poor who as result of ill health suffers catastrophic consequences."
M10-PHS	"Services in the facilities are charged, no risk protection for the intended beneficiaries so not able to access the services hence we are seeing the situation the way it is."
M11-PHS	"So in terms of equity to get services, they are not still there. Community based insurance, where is it, where are we as big as Nigeria, is still at infancy level when other African countries have gone far. So financial protection, we are not yet there."
F3-DA	"There has been some attempts, but they have been too few and for example there has been attempts to introduce community based health insurance. Maybe you can point to one or two initiatives that have worked but even then, they are heavily donor driven and donor dependent …we need to see whether this will actually be sustained."
M12-DA	"Even where there has been declarations of free health care, at the end nothing is free."

Q2. What is your view of the impact of these claims?

Two of the respondents felt that the claims had some impact and more so on raising awareness about the need to protect the poor:

> These claims have had an impact because we have a 5% population coverage by National Health Insurance Scheme (NHIS). The question is whether the result is appropriate or whether we needed to do more. The claim created a lot of awareness and consciousness among policy makers on the importance of health insurance.

> The impact of these claim is that it has brought to the fore the obvious disparity between what is on ground and where we need to go to because there is a huge gap between level of out of pocket expenditure and the NHIS cover which is only 4% and can imagine the disastrous situation people go through when using money to pay for medical bills. The claim has heightened awareness on what is on the ground in terms of protecting users of health care.

However, most of the respondent could not appreciate the impact of the economic claims on protecting beneficiaries of health care services in Nigeria. For most of the respondents as shown in Table 19, the claims could hardly be associated with any impact.

Table 19

Perceptions That Claims About Protecting Beneficiaries Against Financial Costs of Health Care Did Not Have Impact

Interviewee	Perceptions of Health Policy Experts
M2-U:	"That policy declaration is a failure because coverage of people against financial risk is about 5% in the country. It is a failure of the policy direction."
F1-DA:	"I will say almost no impact. The reason why I am saying so is that even though the country unfortunately had not developed the National Health Accounts to help them have evidence over time, the little data that is there is that the out of pocket expenditure in Nigeria is a minimum of 70% which is extremely high. What it means is that there is a huge population that is not protected. Another point on the magnitude of the problem is that the government itself admits that PHC is almost nonfunctional in Nigeria because this is one of the tools of ensuring not only access to services to the largest population but sustainable access, if I may put it that way. To me, just looking at these two broad areas, already says that the system is nonresponsive to the general population in relation to that particular policy."
M4-PHS:	"The pooling of the risk of the poor is difficult because they constitute the majority, so what they have is not adequate – the government contribution alone is not adequate to guard against the financial risk of the poor…For the purpose of risk protection, I think the available resources cannot cater for it and a lot more things need to be done in order to get financial inclusion for the poorest of the poor and those who are marginally at risk."
M9-CHS:	"It has had very little impact, and I will tell you how that has happened. During this period the NHIS has taken off and that scheme has only covered a federal government sub-system, at most 5 million people at the federal level only. So for that minute population, it has impact but for the remaining out of 180 million Nigerian, that is not enough."
M10-PHS:	"…look at antenatal care, immunization, skilled birth attendance across the health quintiles- it is the middle income people who are patronizing the services and not the lower income group, who do not use the services, are not completely reached, they are disenfranchised and the indices for the lower quintile are becoming lower. Services in the facilities are charged, no risk protection for the intended beneficiaries so not able to access the services hence we are seeing the situation the way it is."
M11-PHS:	"The claim did not have any impact."
F2-PHS:	"The National Health Insurance Scheme had been set up, but, in terms of whether it has created the financial protection that is required for an appropriate number, that hasn't been met. First of all, we don't even have

(table continues)

Interviewee	Perceptions of Health Policy Experts
	the absolute number of people covered by insurance, we have very low percentage coverages. We haven't met that. The Agency has been set up but for a long time, there wasn't anything happening on health insurance. Now we do have a bit of activity around health insurance."
M12-DA:	"The impact is minimum because the NHIS is limited to the formal sector and living out the informal sector which include the artisan and such like groups."

Q3. What do you recommend in relation to the making of such economic claims in future policies?

At the end of this subset of questions on protecting the beneficiaries of health care services, the key informants were asked to give their recommendations in relation to the making of these economic claims in future policies. The following were some of the recommendations by some of the respondents:

- Include the running of a proof of concept on financial protection of beneficiaries of health services in future policies.
- Use evidence to develop the claims and specify the accountability structures in policy.
- Set up of a mechanism in future policy to identify the poorest of the poor and properly have a register for them.
- Make claims that are smarter.

Summary

I came up with the findings of this study by conducting a content analysis of the 17 health policy documents developed for implementation during the period starting in 2004 and ending in 2015 followed by key informant interviews with health policy experts who worked in Nigeria during the period covered by the study. Because the health policy

documents were developed at different times, their implementation periods varied. The documents were implemented for a cumulative of 97 years out of a possible total of 204 years for all 17 documents over the 12-year period.

I identified 103 economic claims in the policy documents on increasing the financing of health care in Nigeria. Out of this total, 43 were specific, but only 12 of these were time-bound and measurable. I further revealed a second set of 15 economic claims on the prudent use of resources in the health sector. Only seven of these were specific, and two were time-bound and measurable. The last set of 29 economic claims that I revealed were on protecting beneficiaries of health care services; of this set, 15 were specific, but only one was time-bound, hence, measurable. In total, I established the making of 147 economic claims in health policy documents.

A marginal number of the key informants felt that the economic claims on increasing the financing of health care were realistic. However, they were divided almost equally when asked to give their views on the attainability of the claims. Most of the key informants shared the view that these claims were not adequate for the intended policy objectives and did not have much impact. However, the key informants shared some information from some states in Nigeria that had witnessed increased health care financing. These states were just a few, hence the overall observation on the limited impact stands.

In response to the second group of claims on the prudent use of resources in the health sector, most of the key informants felt that the claims might be realistic but were not attainable nor adequate for their intended policy objectives. These observations were matched by the perception that they did not have much impact, given the low levels of

transparency and accountability in the health sector as reported by the respondents. The views of the key respondents on the last group of claims on protecting beneficiaries of health care services against the financial cost of health care were more adverse. They shared mixed views when asked if they thought the claims were realistic. Most of the key informants found the claims on protecting beneficiaries of health care services against financial costs unattainable and inadequate for the intended policy objectives. They also did not judge them has having had any significant impact given that the National Health Insurance Scheme, was only covering a small section of the population in the country. Based on these findings, the health policy that was implemented by Nigeria during the period covered by the study was inadequate for most of its intended policy objectives and was perceived to have had limited impact.

I built the discussion in Chapter 5 on the interpretation of the findings given some collaborating insights from the literature on the formulation and implementation of the health policy. The discussion also elaborates on the perceptions on increasing health care financing, on prudent use of financial resources, and on protecting beneficiaries of health care services against financial costs by making reference to relevant literature. The findings are further interpreted within the context of the study's conceptual framework. The chapter ends with a discussion of the limitations of the study, recommendations, and the implications of the study on positive social change.

Chapter 5: Discussion and Recommendations

Introduction

The purpose of the study was to establish the adequacy and perceived impact of the health policy of Nigeria during the period starting in 2004 and ending in 2015. I employed the qualitative methodology to determine the nature of the economic claims made in the health policy documents that were developed and approved for use during the period covered by the study, as well as the perceived impact of the economic claims. The study was conducted to establish the perceived contribution of the health policy to the financing of health care, prudent use of resources, and protection of beneficiaries of health care against financial costs in Nigeria. The study findings mirrored the observations made in previous literature that the public health care financing in Nigeria was suboptimal (Ejughemre, 2014; Mburu et al., 2014; WHO, 2011, 2014). The situation exposed a majority of the poor population to catastrophic health expenditure (Adisha, 2015; Onwujekwe, Hanson & Uzochukwu, 2011).

The 2001 health policy for Nigeria, its subsequent sub policies, and implementation strategies all contained economic claims purporting to increase health care financing, encourage prudent use of resources, and protect beneficiaries of health care services, especially the poor from the attendant financial costs (FMOH, 2001). It is possible that the health policy experts and the policymakers at the time included these claims in the policy documents to address the respective problems facing each of these areas of health policy. However, according to the findings from the study, the convergence of the problem, the politics, and the policy streams might not have been realized. The health policy experts were of the view that the key political ministries of

finance, budget, and planning might not have been involved in the health care financing policy dialogue, and the political will to act in that direction was as a result weak.

I established the existence of 147 economic claims in the health policy documents. The claims were made in relation to increasing financing of health care, prudent use of resources, and on the protection of the beneficiaries of health care services against financial costs. A number of the policy documents were developed late into the implementation period; hence, they had shorter implementation timeframes. Whereas a marginal number of the health policy experts perceived the claims in the policy document as realistic, they judged the claims as unattainable and failed in meeting the intended policy objectives and impact. The health policy experts, as a part of the group of policy entrepreneurs, were involved in making the health policy under study. As a target for the study findings, the experts provide a window of opportunity for the formulation of context-specific and evidence-based economic claims that will make future health policies instrumental in creating positive social change.

Interpretation of the Findings

Formulation and Implementation of Health Policy

Through the content analysis of the 17 health policy documents, I identified a total of 147 economic claims. I found that 103 were on increasing health care financing, 15 were on prudent use of resources set aside for the health sector, and 29 were on the protection of beneficiaries of health care services against the financial costs of health care. However, only 65 of the 147 claims were specific in their formulation (44%); only 15 of the claims were specific and time-bound, hence, measurable (10%). Most of the economic stipulations made in the health policy were not specific, and even when they

were specific, most were not time-bound and, therefore, not amenable to measurement. This is an important finding because many economic claims made in the health policy might have been included without undergoing a review of the evidence or taking their future measurement, review, and assessment into consideration.

The observation on the making of economic claims in the health policy of Nigeria was consistent with findings from the examination of other health-related policies. As a case in point, the ACA contains economic claims, some of which were not realized after implementation of the laws for some years (Cohen et al., 2008; Geyman, 2015; Shen et al., 2014). The policies on the health benefits of drinking water, the taxation of sugar-based commodities as a strategy of reducing their respective consumption, and political campaigns of 2008 in the United States that fronted preventive care as a cost-effective option have also been associated with the making of economic claims (Cohen et al., 2008; Klaus, 2012; Tepper & Wojciechowski, 2013). The making of economic claims in health policies is consistent, and the case of the Nigeria health policy is no exception.

In the review of the development process and timing of the 17 health policy documents that were developed and approved for implementation, I found that they were implemented for only 47.1% of the expected implementation time. Most of the policy documents that were expected to facilitate the realization of the health policy were only allowed limited time for implementation. This general finding has implications on the interpretation given to the realistic nature of the health policy including its attainability, adequacy, and perceived impact. This finding aligns with several observations made by the key informants for the study on the limitations associated with the implementation of the health policy. The limitations in the implementation time could be an obstacle for the

health policy in Nigeria, rendering it unrealistic and unattainable. The health policy experts who made this observation are stakeholders in the health policy-making and implementation in Nigeria (FMoH, 2004).

Perceptions on Increasing Health Care Financing

Slightly more than half of the key informants suggested that the economic claims made in the policy documents about increasing the financing of health care in Nigeria were realistic. One of the informants thought that the claims were realistic "depending on the resources available in Nigeria". This view was collaborated by Uzochukwu et al. (2015) who argued that despite having different sources of health care financing in Nigeria, out-of-pocket payments were the most dominant. Uzochukwu et al., therefore, supported an increase in public financing of health care as part of the strategy of reducing reliance on out-of-pocket payments to finance health care in Nigeria. However, a few of the respondents thought the claims were not realistic because of a failure to use evidence in their formulation. The failure to develop evidence-based economic claims in health policy could be linked to a general lack of awareness on policy stipulations among policy experts (Martiniuk et al., 2015). In the case of Nigeria, a low awareness of research evidence for policy-making among policy-makers and researchers had been documented by Onwujekwe et al. (2009, 2012).

According to WHO (2014), the public expenditure on health as a share of overall public expenditure in Nigeria ranged from just above 6% in 2004 to a maximum of about 8% in 2014. The marginal increase in financing of health care in Nigeria, as demonstrated by the WHO report, confirmed the divided responses that were obtained from respondents when asked to give their view as to whether the claims were attainable. The

maximum of about 8% of public expenditure on health was below the Abuja declaration target of 15% of the annual public health expenditure for health and supported the status of underfunding of health care in Nigeria (Ejughemre, 2014; Mburu et al., 2014). The economic claims on increasing health care financing were not realistic or attainable. A policy that is not attainable might not be realistic at the same time; the views that the claims on increasing the financing of health care were only marginally so. As noted by some of the key informants, the origin of the 15% benchmark could not be traced to any existing evidence in the literature. The question as to whether 15% of public expenditure on health care is evidence-based and an ideal investment level for health for countries in the sub-Saharan region of Africa remains open to debate while calling for increased use of evidence in the making of health policy.

The most compelling evidence that the economic claims made in the health policy on increasing health care financing failed to achieve their intended policy objectives, and consequently a positive impact, was based on the reported catastrophic expenditure affecting poor households in Nigeria, particularly female-headed households (Adisha, 2015; Omotor, 2009; Onwujekwe et al., 2009, 2012; WHO, 2011). Most of the respondents based their views on the poor health outcomes and the fact that the country missed its health-related MDG targets in 2015. Increased public spending that is also linked to good public governance is statistically significant in improving health outcomes (Makuta & O'Hare, 2015). Makuta and O'Hare (2015) suggested that the policy might have been realized among the better performing states in Nigeria that had significantly increased and sustained their health care expenditure. However, the number of states that might have made such progress was small and of little impact to the national picture.

Furthermore, an increase in health care expenditure might not be equitable. The health care delivery systems tended to be pro-rich, and it needed a strong PHC approach to convert the systems towards being pro-poor (Asante, Price, Hayen, Jan, & Wiseman, 2016).

Perceptions on Prudent Use of Financial Resources in the Health Sector

According to the WHO (2014) report on public financing for health in Africa, most of the public resources devoted to health care are fragmented, poorly distributed, and inefficiently used. The report was based on the situation in many African countries including Nigeria. The economic claims made in the policy documents regarding the prudent use of resources in the health sector in Nigeria are necessary. The need to have the claims in place was further supported by Mostert (2015), who highlighted the existence of widespread corruption in the health care systems in Africa. According to Mostert, corruption is a problem because of a large number of actors involved in health care in Africa, a large number of suppliers, and the complex nature of the health care delivery systems. In addition, there is asymmetry among the players and health industry, an imperfect health market, and poor information and record keeping (Mostert, 2015). In the case of Nigeria, the majority of respondents linked the need for the claims to the observation that transparency, accountability and proper governance in the use of resources in the health sector in the country is a major issue of concern.

The findings by WHO (2014) that less than 10% of public resources are allocated for health care and less than 50% of the allocated resources are devoted to maternal and child health priorities points to a problem of prioritization of resource use. The finding supports the views of the respondents on the unattainable nature of claims made in the

health policy on prudent use of resources in the health sector. Chima and Homedes (2017) asserted that prudent use of resources is often distorted by global health initiatives that prioritizes improved service delivery and supply chains while neglecting the rest of the health system, coordination, and proper policy formulation.

Mostert (2015) argued that there are no easy solutions for strengthening the prudent use of resources in the health sector; the misuse of resources is spreading, is deeply rooted, multifaceted, and complex, and it often requires political solutions. The existing economic claims in the Nigerian health policy on prudent use of resources might not be adequate for the intended policy objectives. There is a need to address the wide spread problem of resource use in the health sector. Both the literature and the study participants suggested that both policy and political solutions are needed to address the misuse of resources in the health sector (Mostert, 2015). In the absence of political will and governance systems and accountability, the claims on the prudent use of resources in the health policy will not be realistic and attainable. The claims will also not meet the intended policy objectives and desired impact.

Perceptions on Protecting Beneficiaries Against Financial Costs

I found evidence in the literature justifying the protection of beneficiaries of health care services from financial costs. Hosseinpoor (2011) concluded that wealth-related inequities accounted for more than one-quarter of health interventions coverage gaps in 28 Sub-Saharan African countries which included Nigeria. Despite the existence of several social and financial protection initiatives in Nigeria, out of pocket payments for health care remained the most predominant health care financing modality in the country (Okoli et al., 2014; Okpani & Abimbola, 2015; Umukoro, 2013a; WHO, 2015). As a

consequence, catastrophic health expenditure was a reality among 9.6% of elderly households in urban Nigeria, generally the case for the poor, and among female-headed households (Adisa, 2015; Onah & Govender, 2014). The literature, therefore, qualifies the views from among the study respondents when asked about the realistic nature of the economic claims made in the health policy.

Despite being marginally positive on its realistic nature, a number of the respondents felt that the problem with the economic claims on protecting the users of health care against financial costs was implementation. On this account and in agreement, the available literature indicate that only about four to five percent of Nigerians are covered by the National Health Insurance Scheme and that private health insurance covers less than one percent of the Nigerian population (Garba & Ejembi, 2015; Onoka, Onwujekwe, Uzochukwu & Ezumah, 2013; Uzochukwu et al., 2015). Umukoro (2013b) further reported that community-based health insurance system and conditional cash transfers had limited coverage that extended to only 0.001-002% of the poor people in the country. The limited implementation of the economic claims on protecting users of the health care services implied that they were largely unattainable and inadequate for the policy objectives. As a consequence, the impact was also only limited to raising awareness among policy-maker about the need to protect the poor.

Through the study, I established that more claims were made concerning the financing of health care than for the other two groups of claims. There was less focus given to the prudent use of resources, and financial protection of the users of health care going by the far lower number of economic claims made in relation to these two areas in the policy. The performance of the health policy in these two areas was also more poorly

perceived than in the case of increasing financing of health care. Sustainable financing of health care relies on the prudent use of the available resources to generate the desired results; the sustainability of the health care financing also relies on the measures being taken to financially protect users of health care services. Consistent with the study's findings, poor performance in any of the three areas of health policy undermines progress in the other two areas.

Interpretation of the Findings in the Context of the Conceptual Framework

Through the study, I established the existence of a total of 147 economic claims in the health policy with 65 of these being specific in their formulation. Out of the specific claims, only 15 were time-bound and therefore measurable. The claims were made in relation to increasing financing of health care, prudent use of resources, and on the protection of the beneficiaries of health care services against financial costs. A substantial number of the policy documents were developed late into the implementation period. Whereas some of the health policy experts perceived the claims in the policy document as realistic, they judged the claims as unattainable and a failure in meeting the intended policy objectives and impact. These findings were interpreted within the context of the conceptual framework for the study as informed by a combination of Kingdon's ambiguity and multiple streams theory, Skocpol's policy feedback theory, and Roe's narrative policy theory (Ball, 1995; Buse et al., 2005; Kusi-Ampofo et al., 2015; Roe, 1989, 1994; Sabatier & Weible, 2014).

The content analysis of the 17 health policy documents for economic claims and the collection of the views of the study respondents were underpinned by Roe's narrative policy theory (Roe, 1989, 1994). The theory promotes the use of narratives in policy

analysis. Narrative analysis methodology as developed in the theory was used to conduct an analysis of the documents for economic claims resulting in the discovery of 147 of them. The narrative analysis methodology was also used in the analysis of the data obtained from the interviews with the health policy experts. On its part, the Kingdon's ambiguity and multiple streams theory brought together the policy, politics, and the problem streams to offer solutions to the problems of the underfunding of health care, the misuse of resources, and the protection of the beneficiaries of health care against financial costs of health care in Nigeria.

The 2001 health policy for Nigeria, its subsequent sub policies, and implementation strategies all contained economic claims purporting to increase health care financing, encourage prudent use of resources, and protect beneficiaries of health care services, in particular, the poor. It is possible that the health policy-makers and experts at the time included these claims in the policy documents to address the respective problems facing each of these areas of health policy. In line with Kingdon's ambiguity and multiple streams theory, these problem streams were then expected to converge within the context of an enabling political environment and supportive health policy entrepreneurs resulting in an effective policy (Ball, 1995; Buse et al., 2005; Kusi-Ampofo et al., 2015; Roe, 1989, 1994; Sabatier & Weible, 2014). Going by the findings from the study, the convergence of the three streams might not have happened as anticipated. The health policy experts were of the view that the key political ministries of finance, budget, and planning were not effectively involved in the health care financing policy dialogue leading to a lack of the political will and support to achieve effective policy implementation

The observation by Mostert (2015) that the solutions for strengthening prudent use of resources in the health sector often require political solutions; links well with the study's finding that the existing economic claims in the Nigerian health policy on prudent use of resources were perceived as inadequate and had limited impact. Both the literature and the study participants suggested that prudent use of resources is a problem in Nigeria that require both policy and political solutions (Mostert, 2015). This is an interesting observation that links the policy to politics and the problem of prudent use of resources in the health sector in Nigeria which is in line with Kingdon's ambiguity and multiple streams theory (Buse et al., 2005; Kusi-Ampofo et al., 2015; Sabatier & Weible, 2014).

The recommendations from the respondents on the making of future policy were interpreted within the context of Skocpol's policy feedback theory (Sabatier & Weible, 2014). The theory argues that the feedback generated from an existing policy influences the making of a future policy (Sabatier & Weible, 2014). The study used the policy experts as the key informants on the adequacy and perceived impact of the health policy over the period covered by the study. The health policy experts as part of the group of policy entrepreneurs were involved in the making of the health policy under study and will be involved in the making of future health policies including sharing of lessons learned with other stakeholders. Through the policy feedback theory, I find the evidence that justifies the dissemination of the findings of the study to health policy experts and other audiences in Nigeria and elsewhere. The findings generated by the study might help in strengthening the evidence based needed by the health policy experts to effectively support the formulation of context specific and evidence-based economic claims that will make future health policies effective in their contribution to positive social change.

Limitations of the Study

As noted in Chapter 1, the study's qualitative approach limits the findings and their interpretation to the Nigerian health policy context; the methodology does not allow for the generalization of the findings. The analysis and interpretation of the data is also limited to the actual economic claims contained in the policy documents. Given the qualitative nature of the study, its findings might not be used to prove cause and effect relationships between the existence of the economic claims in the health policy on one hand, and the financing of health care, prudent use of resources, and the protection of the beneficiaries of health care from financial costs on the other hand. The study findings might be exposed to potential bias given that some of the key informant interviewees were responsible for the implementation of the policy during the period covered by the study. The following additional limitations were identified during the course of collecting data, its analysis, and interpretation:

- Through the study, I established the adequacy and perceived impact of the Nigerian health policy by determining the nature of economic claims in the approved health policy documents followed by key informant interviews with selected health policy experts in Nigeria. It is possible that other noneconomic claims in the policy, notably programmatic claims, could have as well been used as the basis of the study. The failure to consider such claims potentially limits the study because the influence of the other claims on the study findings is not known.
- The interactions with the key informant interviewees revealed that they had varying levels of awareness on the existence of specific economic claims in the

health policy. It is, therefore, possible that this variation in awareness influenced the responses provided by the key informants in various and unknown ways.

- The different awareness levels among the informants on the different economic claims in the policy documents introduced a subsequent and possible limitation. The key informant interviews adopted a collective approach and reference to the three different groups of claims in the health policy documents rather than making reference to specific economic claims from the respective groups. Therefore, it is not known if the findings from the key informant interviews were going to be different if the latter option of referencing the specific economic claims during the interviews was adopted.
- The key informant interviewees were drawn from a pool of health policy experts who often interacted in the same health policy technical working groups and networks. It is, therefore, possible that through the various professional interactions, the experts' views might have shifted and became similar, and this could have introduced bias into the study findings.

Recommendations

A further reflection on the study limitations within the context of the expected impact of the health policy on health care delivery reveals the following areas for further research:

1. Given that the study findings may not be used to make conclusions about the relationship between the existence of the economic claims in the health policy and health care financing, an appropriate quantitative research method or a mixed research methodology is proposed to further explore the relationship. This

proposed approach could add new knowledge on the impact of the health policy on health care as well as on health outcomes.

2. What will be the difference in the findings and conclusions between using economic claims and using non-economic claims to establish the adequacy and perceived impact of a health policy? The answer to this research question could help to contribute to a new approach to the analysis of health policy based on the claims made in it and the link to its impact.
3. Does the level of awareness among the health policy experts on the existence of economic claims in the health policy affect the implementation and the impact of the health policy? I think that the level of awareness on the content of the health policy among the policy experts might affect both the implementation of the policy and its eventual impact. Nonetheless, there is little evidence to support the assumption hence the proposal to consider this particular area for further research.
4. What will be the difference in the findings and conclusions between using specific economic claims and using groups of economic claims to establish the adequacy and perceived impact of a health policy? I think that there will be no difference in adopting any of the different approaches, but the lack of evidence from the literature to clarify the position implies that this is another good area for further research.

Implications

The findings from the study suggest increased potential impact for positive social change through the development of specific and measurable economic claims and their use in policy implementation. The inclusion and use of these claims could facilitate

positive social change at different levels. The level of awareness of the health policy among the individual policy experts could influence its translation and implementation towards achieving the intended policy objectives. The call by the study for greater awareness on the economic claims made in health policies among the policy experts may then improve the implementation of the policy leading to better health outcomes and positive social change.

The study used one strand of claims-the economic claims-to establish the adequacy and perceived impact of the health policy in Nigeria during the period covered by the study. The approach proved useful in focusing the study on the financing of health care, the prudent use of resources, and financial protection of the beneficiaries of services. I did not identify any other study from the literature that has used a similar methodology. Therefore, by conducting the study, I may have contributed a new methodology for the study of health policy.

In relation to the policy-making process and practice, the findings from the study justify the added value of developing evidence-informed and specific economic claims that are measurable for inclusion in health policy. Through the study findings, I identified the need to start the policy-making and implementation process early in the implementation period. The early lead time will allow for the policy implementation to take place over a longer period which might, in turn, improve on its implementation and effectiveness while creating better opportunities for positive social change to happen. This is unlike the case with the health policy of Nigeria understudy where the elaboration of the policy for implementation was taking place at the tail end of the implementation period.

Conclusion

Through the study, I revealed new knowledge with respect to the nature of economic claims made in Nigeria's health policy 2004-2015. Most of the claims were not specific nor time-bound which made them unmeasurable. The implementation of the health policy took place for less than half of the entire implementation period. The claims on the financing of health care, prudent use of resources, and financial protection of beneficiaries of health care were all perceived as marginally realistic. However, given their nature and short implementation duration, the claims were strongly perceived as not attainable, and this status negated their realistic nature. The claims failed to achieve most of their policy objectives and consequently had little impact on the health sector.

Through the study findings, I demonstrate the potential to influence positive social change by identifying the need for the health policy-makers to start the policy-making process early in the implementation period and to develop specific, measurable, and evidence-based economic claims for new policies. These actions will improve the health policy's chances to positively influence decision making with respect to the financing of health care, prudent use of resources for the health sector, and the protection of the beneficiaries of health care services against the attendant financial costs. On account of progress along these three fronts, the study's contribution to positive social change will likely be strong.

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Appendix A: A Data Collection Template for the Economic Claims Made in the Health Policy Documents

Instruction: Complete this form for each of the identified claim

1. Name of Policy document:

   _____

   _____

2. Type of document (pick one):
   a. Policy
   b. Strategy
3. Year developed
4. Claim as stated in the policy document:

_____

_____

_____

_____

5. What is the main characteristic feature (s) of the claim (select the most applicable)
   a. Financing of health care
   b. Use of the health care resources
   c. Financial protection of health care users
6. Is the claim specific? Yes/ No
7. Is the claim time-bound? Yes / No
8. Is the claim measurable? Yes / No

Appendix B: Open-Ended Question Guide for Interviews with Health Policy Experts

The main health policy for Nigeria was developed and officially approved in 2004. The policy was implemented between 2004 and 2015. During the same period, the main policy was further elaborated into other sub-policies and strategies. I have identified a total of 17 such policy documents developed and approved for use during the period covered by the study and further reviewed them for economic claims. By economic claim, I am referring to statements made in the policy document stating a financial position or promise or benefit. The economic claims have further been grouped, and the groupings form the subject of this interview.

a) The first group of claims made in the various policy documents is about increasing the financing of health care in Nigeria.

Q1. What is your view on these set of claims? (*Follow-up questions*) Were they realistic, attainable, and adequate for the intended policy objectives?

Q2. What is your view of the impact of these claims?

Q3. What do you recommend in relation to the making of such economic claims in future policies?

b) The second group of claims made in the various policy documents is about prudent use of resources in the health sector in Nigeria.

Q4. What is your view on these set of claims? (*Follow-up questions*) Were they realistic, attainable, and adequate for the intended policy objectives?

Q5. What is your view of the impact of these claims?

Q6. What do you recommend in relation to the making of such economic claims in future policies?

c) The last group of claims made in the various policy documents is about protecting beneficiaries against financial costs of health care in Nigeria.

Q7. What is your view on these set of claims? (*Follow-up questions*) Were they realistic, attainable, and adequate for the intended policy objectives?

Q8. What is your view of the impact of these claims?

Q9. What do you recommend in relation to the making of such economic claims in future policies?

Thank you for your time.