

# Effect of Budgetary Implementation on the Accessibility of Healthcare Service in Federal Capital Territory, (FCT) Abuja.

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DOI: <https://doi.org/10.70118/AMR-0901-2025-18>

## Abstract

*This study examines the effect of budget implementation on healthcare accessibility in FCT, with a focus on how financial resource allocation, disbursement, and utilization influence the availability and quality of health services. Despite increasing budgetary allocations to the health sector, Nigeria continues to face significant challenges in delivering equitable and accessible healthcare, particularly in rural and underserved areas. Anchored on the Resource-Based Theory (RBT). The research adopts Survey approach, primary source of data was utilized, data were collected through questionnaires. The study adopted simple percentages and descriptive statistics as methods of analysis. Findings indicated that areas with proper budget execution experienced increased healthcare accessibility, characterized by shorter distances to health facilities, availability of mobile clinics, and extended operational hours. The study identified several challenges affecting budgetary implementation in FCT's healthcare sector. Key issues included bureaucratic delays, corruption, lack of transparency, and insufficient stakeholder engagement. The study recommended that improve budget planning, disbursement, and tracking mechanisms across the system. Implement electronic financial management systems to reduce leakages and delays in fund release.*

**Keywords;** Budgetary Implementation, Accessibility of Healthcare, Service Delivery

## Introduction

Healthcare accessibility remains a central pillar of socio-economic development and human capital enhancement, particularly in developing countries like Nigeria. The Federal Capital Territory (FCT), Abuja, although considered one of the most developed regions in Nigeria, continues to face significant challenges in delivering equitable and timely healthcare services to its residents. One of the primary factors influencing healthcare service delivery is the efficiency and effectiveness of budgetary implementation. Public budgeting, particularly in the health sector, is not only a financial tool but also a strategic

instrument for allocating resources to ensure inclusive and quality healthcare (World Health Organization [WHO], 2020).

In Nigeria, recurrent issues of poor budget implementation, delays in fund disbursement, and inadequate monitoring have significantly undermined the capacity of healthcare institutions to function optimally (Onwujekwe et al., 2019). Despite considerable budget allocations to the health sector annually, the persistent gaps between approved budgets and actual expenditure have contributed to limited access to essential healthcare services in many parts of the country, including the FCT (National Bureau of Statistics [NBS], 2021). This disconnect often results in under-equipped facilities, insufficient medical personnel, and a lack of essential drugs and services, thereby limiting the public's access to affordable and quality healthcare.

Furthermore, the Abuja healthcare system faces disparities in access between urban centers and peri-urban or rural communities, partly due to the uneven distribution of resources influenced by fiscal policy implementation (Uzochukwu et al., 2022). As such, examining the effect of budgetary implementation on healthcare accessibility in the FCT is crucial for identifying systemic inefficiencies and proposing strategies to bridge the gap between policy intentions and healthcare outcomes.

This study seeks to investigate how the implementation of health budgets in the FCT affects the availability, affordability, and quality of healthcare services, thereby contributing to broader discussions on governance, public finance, and health equity in Nigeria.

## **Statement of the Problem**

Despite consistent budgetary allocations to the health sector in Nigeria, the gap between budget formulation and effective implementation has remained a major barrier to improving healthcare accessibility, particularly in the Federal Capital Territory (FCT), Abuja. Although the FCT is expected to exemplify national development standards, its healthcare system still struggles with challenges such as inadequate infrastructure, shortage of healthcare personnel, poor availability of essential medicines, and inequitable distribution of services, especially in rural and underserved communities (Aregbeshola & Khan, 2018). A major contributor to these persistent issues is poor budgetary implementation, which manifests in delayed fund releases, misappropriation of funds, lack of transparency, and weak institutional capacity for budget monitoring and evaluation (Okpani & Abimbola, 2015). These inefficiencies reduce the responsiveness and effectiveness of health services, leaving many residents without timely or affordable access to care. For instance, although Nigeria often earmarks a portion of its national budget for healthcare, actual disbursement and

utilization of these funds frequently fall short, leading to underfunded health programs and unmet health targets (Chukwu et al., 2020).

The situation in the FCT is further complicated by urban-rural disparities, where rural areas suffer more acutely from poor healthcare access due to limited fiscal penetration and weak local governance mechanisms (Ogunbekun et al., 2021). This raises important concerns about whether the health budget is being implemented in a way that translates into practical improvements in healthcare service delivery for all segments of the population. Therefore, there is a critical need to assess the extent to which budgetary implementation affects healthcare accessibility in the FCT. Understanding this relationship is vital for addressing systemic inefficiencies and promoting equitable access to quality healthcare services.

## **Objectives of the Study**

To examine the extent to which budgetary implementation influences the availability of healthcare facilities and services in the Federal Capital Territory, Abuja.

To identify the key challenges affecting effective budget implementation in the FCT health sector and their implications for equitable healthcare delivery.

## **Literature Review**

### **Budgetary Implementation and Public Health Outcomes**

Budgetary implementation is a vital component in the chain linking public financial planning to actual improvements in public health outcomes. While policy formulation and budget allocation are important, the real determinant of success lies in how effectively those budgets are implemented. In the health sector, the outcomes of budget implementation are often measured through indicators such as access to health services, quality of care, reduction in disease burden, and improved health infrastructure (World Health Organization [WHO], 2020).

In developing countries like Nigeria, the inefficiencies in budget execution significantly undermine public health outcomes. According to Chukwu et al. (2020), budget implementation challenges such as underfunding, delays in fund disbursement, and mismanagement of resources result in deteriorating healthcare services, especially at the primary care level. Poor implementation often leads to a mismatch between planned health programs and actual service delivery, weakening the impact of public health interventions. Empirical studies have also shown that effective budget execution leads to better health outcomes. For instance, Onwujekwe et al. (2019) found that Nigerian states with higher

budget execution rates in the health sector experienced better maternal and child health outcomes. Their research emphasized that health financing reforms, particularly those that improve transparency and predictability of funding, contribute positively to health service delivery.

Moreover, public health outcomes are influenced not only by the amount of money allocated but also by how and where the money is spent. Aregbeshola and Khan (2018) noted that equitable and timely implementation of health budgets leads to improved healthcare coverage and reduces out-of-pocket payments, which are a major barrier to health access in Nigeria. When health budgets are not implemented effectively, public hospitals face issues like drug shortages, inadequate personnel, and poor infrastructure — all of which lead to worse health outcomes.

The World Bank (2019) also highlights that strong public financial management systems enhance the impact of health budgets by improving accountability, reducing leakages, and ensuring that resources are allocated to priority areas. This ensures that budgeted funds are used to improve immunization coverage, maternal health services, disease surveillance, and emergency response — all of which are crucial for good public health outcomes.

In the context of the Federal Capital Territory (FCT), where rural and peri-urban populations often struggle with healthcare access, budget implementation plays a critical role. Ogunbekun et al. (2021) observed that areas with consistent and well-managed health budget execution reported better facility utilization and patient satisfaction, while areas with poor implementation faced persistent service delivery challenges.

## **Healthcare Accessibility in Nigeria**

Healthcare accessibility encompasses physical access, financial affordability, and the availability of quality care. In Nigeria, significant disparities exist in healthcare access, with rural areas experiencing more profound challenges due to inadequate funding and poor infrastructure (Aregbeshola & Khan, 2018). The Federal Capital Territory, despite being the administrative hub of the country, has pockets of rural and peri-urban communities where access to healthcare services remains limited. These disparities are often attributed to the uneven implementation of health budgets and the failure to prioritize resource allocation equitably across all regions (Uzochukwu et al., 2022).

Healthcare accessibility remains a significant concern in Nigeria, Africa's most populous nation. Despite the existence of a three-tier healthcare delivery system, many Nigerians continue to face substantial barriers in accessing timely, affordable, and quality healthcare services. These barriers are rooted in

socioeconomic disparities, infrastructural deficits, human resource shortages, and governance challenges.

**Geographic and Socioeconomic Disparities:** Rural-urban disparities are a critical factor in healthcare accessibility. Rural populations often travel long distances to access care, and many areas lack functional health facilities (Adebayo et al., 2015). Moreover, income inequality significantly impacts access. The majority of Nigerians work in the informal sector and lack health insurance, resulting in high out-of-pocket spending for healthcare services (Onoka et al., 2013). This financial barrier discourages care-seeking behavior and contributes to poor health outcomes, especially among vulnerable populations such as women and children.

**Human Resource and Infrastructure Constraints:** Nigeria has one of the lowest doctor-to-patient ratios in Africa, with approximately 4 doctors per 10,000 people (World Health Organization [WHO], 2020). This is exacerbated by the emigration of skilled health workers in search of better opportunities abroad—a phenomenon often referred to as the "brain drain." In addition, many healthcare facilities lack basic amenities such as electricity, clean water, and essential medical equipment (Oleribe et al., 2019).

**Health Insurance and Policy Interventions:** Efforts to reduce financial barriers have led to the creation of the National Health Insurance Scheme (NHIS). However, coverage remains low, especially in rural and informal sectors, due to poor awareness, administrative bottlenecks, and mistrust in government programs (Obikeze et al., 2021). The Basic Health Care Provision Fund (BHCPF), established under the National Health Act (2014), aims to strengthen the PHC system by providing direct funding to facilities, but implementation has been inconsistent (Aregbeshola & Khan, 2018).

**Digital Health and Innovations:** Recent advances in digital health present promising solutions. Telemedicine, mobile health (mHealth) applications, and digital diagnostics are emerging tools for bridging access gaps in remote areas. Private health-tech companies are increasingly playing a role in delivering services where public infrastructure is lacking (Adepoju, 2020). However, limited internet penetration and digital literacy in rural areas pose challenges to scalability.

**Urban-Rural Disparities in the FCT Health System:** Although Abuja is Nigeria's capital and enjoys significant federal investment, urban-rural disparities in health access are prevalent. Rural areas such as Kwali, Abaji, and Kuje Area Councils often suffer from underfunded primary health centers, inadequate staff, and poor infrastructure compared to the central city (Ogunbekun et al., 2021). These disparities are exacerbated by the lack of

transparency and effectiveness in the allocation and implementation of health budgets, limiting the realization of universal health coverage in the territory.

### **Budget Implementation and Healthcare Accessibility**

Budget implementation plays a critical role in determining how effectively public funds are translated into tangible healthcare services. In many developing countries, including Nigeria, the challenges of poor budget execution have a direct impact on the accessibility of healthcare, especially for vulnerable populations. According to Onwujekwe et al. (2019), even when health budgets are well designed and adequately funded, the failure to implement them efficiently leads to service delivery gaps, resource wastage, and low public trust in the healthcare system. One major issue associated with budget implementation in Nigeria is the discrepancy between approved budgets and actual expenditures. A study by Chukwu et al. (2020) revealed that while health sector allocations are made annually, the actual releases are often partial and delayed, leading to underfunded primary healthcare centers and incomplete projects. These delays and inconsistencies affect the procurement of essential drugs, payment of healthcare personnel, and maintenance of health infrastructure, all of which are crucial to ensuring accessible healthcare.

Furthermore, Aregbeshola and Khan (2018) emphasized that effective budget implementation improves both physical and financial access to healthcare by ensuring consistent supply of medical inputs and reducing out-of-pocket expenditures. In their study, they found that states and regions with better health budget execution records showed improved maternal health outcomes and greater facility usage. Budget implementation also impacts healthcare equity. In the Federal Capital Territory (FCT), urban areas like Abuja city benefit more from implemented budgets than rural districts, due to better administrative structures and political influence (Ogunbekun et al., 2021). Rural and underserved communities often face neglect, as funds meant for infrastructure, staffing, or outreach programs fail to trickle down effectively.

Transparency, monitoring, and accountability mechanisms are also key components influencing budget performance. Okpani and Abimbola (2015) argued that the lack of proper tracking systems and citizen engagement in budget implementation contributes to leakages and inefficiencies in Nigeria's health sector. Where implementation is weak, accessibility suffers, particularly in the availability and quality of services delivered.

### **Health Equity**

Health equity refers to the attainment of the highest level of health for all people, emphasizing fairness and eliminating disparities in health and its determinants (Braveman et al., 2011). It means that everyone has a fair and just opportunity

to be as healthy as possible, which requires removing obstacles like poverty, discrimination, and deep power imbalances. The World Health Organization (WHO) defines health equity as "the absence of unfair and avoidable or remediable differences in health among population groups defined socially, economically, demographically or geographically" (WHO, 2010).

### **Determinants of Health Equity**

Health equity is influenced by social determinants of health (SDOH), which include factors like: Economic stability, Education, Neighborhood and physical environment, Access to healthcare Social and Community Context (CDC, 2022).

These determinants are not equally distributed across populations, contributing to persistent disparities in outcomes such as life expectancy, infant mortality, and chronic disease prevalence.

### **3. Examples of Health Inequities**

**Racial and Ethnic Disparities:** In the U.S., Black and Indigenous populations experience higher rates of maternal mortality, diabetes, and cardiovascular disease compared to white populations (Artiga et al., 2020).

**Rural vs. Urban Divide:** Rural residents often face geographic barriers, fewer providers, and lower health infrastructure—leading to poorer access and outcomes (National Rural Health Association, 2021).

**Income Inequality:** People in lower-income brackets are less likely to receive preventive services and more likely to suffer from preventable diseases (Braveman & Gottlieb, 2014).

### **Strategies to Promote Health Equity**

Efforts to promote equity must be systemic and multisectoral. Key approaches include:

**Policy reform:** Addressing wage gaps, housing insecurity, and education quality through legislation.

**Culturally competent care:** Training providers to recognize and respond to cultural and linguistic differences.

**Community engagement:** Involving local voices in designing and implementing health programs (Bailey et al., 2017).

## **Challenges of Budget Implementation in the Health Sector**

Budget implementation in the Nigerian health sector faces several systemic, administrative, and political challenges that hinder the effective translation of fiscal policies into accessible and quality healthcare services. These challenges are multifaceted and significantly affect healthcare delivery in regions such as the Federal Capital Territory (FCT), Abuja.

### **i. Delayed Release of Funds**

One of the most persistent issues is the untimely disbursement of funds. Even when health budgets are approved on time, actual cash releases from the treasury are often delayed or released in tranches. This disrupts planning cycles and slows down the execution of critical projects and procurement processes (Chukwu et al., 2020). For instance, health facilities often report delays in receiving funds for basic operations, leading to disruptions in service delivery and stock-outs of essential medicines.

### **ii. Corruption and Mismanagement**

Corruption within the budget execution process remains a major impediment. Funds allocated for health infrastructure, staffing, or medical supplies are sometimes misappropriated or diverted to other uses. Onwujekwe et al. (2019) noted that weak oversight mechanisms and lack of transparency allow for financial leakages, reducing the impact of public health spending. This erodes public trust and limits the effectiveness of government health interventions.

### **iii. Inadequate Monitoring and Evaluation (M&E)**

Effective budget implementation requires robust monitoring and evaluation systems. However, in Nigeria, many health projects lack proper tracking mechanisms, leading to poor accountability and underperformance (World Bank, 2019). Without timely evaluation, it becomes difficult to measure outcomes or identify areas for adjustment, leading to repeated inefficiencies year after year.

### **iv. Capacity Constraints**

Many government agencies responsible for budget implementation face technical and human resource limitations. These include inadequate training in public financial management, limited use of digital systems, and a general lack of institutional capacity to manage complex budget cycles (Okpani & Abimbola, 2015). This results in poor coordination between various tiers of government and delays in implementation.



**v. Political Interference and Priority Misalignment**

Budget allocations and releases are sometimes influenced by political interests rather than health needs. This can result in skewed resource allocation, where urban or politically influential areas receive more attention than underserved rural communities (Ogunbekun et al., 2021). Such political interference compromises the equity and effectiveness of healthcare service delivery.

**vi. Poor Budget Credibility**

Budget credibility refers to the extent to which actual expenditures align with the approved budget. In many cases, the health sector experiences low budget credibility, with significant differences between what is planned and what is implemented (Aregbeshola & Khan, 2018). This gap creates uncertainty, weakens planning, and affects frontline service delivery.

**Empirical Literature Review**

Iloh (2016) evaluated patients' satisfaction with the quality of care provided at the National Health Insurance Scheme (NHIS) clinic of a tertiary hospital in southeastern Nigeria. The study utilized survey. Data for the research were collected using a questionnaire and structured interviews. Iloh et al. (2016) reported that the overall satisfaction score of the respondents was 66.8%. Specifically, the respondents expressed satisfaction with the patient-provider relationship (81.5%), patient-provider communication (79.9%), accessibility (74.2%), and hospital environment (68.2%) and dissatisfaction with hospital bureaucracy (48.8%) and patient waiting time (48.3%). He concluded that patients' satisfaction with services provided at the National Health Insurance Scheme (NHIS) clinic; with specific high ratings in the physician-patient relationship. However, the patients were dissatisfied with the time they wait to receive treatment, which remained a major factor of dissatisfaction.

Ezegwui, Okoye, Aghaji, Okoye, and Oguego (2014) evaluated patients' satisfaction with the care received from the University of Nigeria Teaching hospital in southeastern Nigeria. The used survey, questionnaire was used to collect the needed data from 307 patients. Patients were asked to indicate satisfaction with the time spent in the clinic, attitude of various categories of staff, physical facilities, cleanliness of the clinic and, willingness to come again to the clinic. The study reported that respondents were more satisfied with the attitude of the doctors and nurses than that of revenue and medical records clerks. Most patients, 288 (93.8%) expressed satisfaction with the overall cleanliness of the eye clinic; 220 (71.7%) and 288 (93.8%) were not satisfied with the toilet facilities and cost of services, respectively. It was therefore observed that the general eye treatment procedure in the University Teaching hospital is good as reported by the patients. However, most patients showed

dissatisfaction with the cost of receiving medical services and toilet facilities in the hospital as a function of the physical facility available in the hospital, which needs improvement to ensure good quality of healthcare.

Sofaer and Firminger (2015) conducted a study to ascertain what patients want, need and experience in health care, as opposed to what professionals believe they need. The study, therefore, measured patients' perceptions of healthcare quality and the factors influencing their perception. The study adopted survey with the aid of Face-to-face interviews was used to collect qualitative data from patients for analysis. The findings of the study indicated that most patients were not satisfied with the quality of care services they received.

King (2013) examined the importance of communication gadgets in tertiary skilled nursing facilities in communicating with patients from one unit of the hospital to another. The study adopted survey, data for the study was collected from personal interviews and focus group discussions. Results of study showed that nurses rely mostly on written hospital discharge communication. Also, poor communication in the health facility mainly affected the provision of accurate information regarding the health status of patients. Inadequate communication also increased patients' rehospitalization, care delays, staff stress, frustration among patients and family members, and contributed to the general negative skill nursing facility image.

Eme, Uche, and Uche (2014) assessed the availability of healthcare facilities and their impact on the quality of the healthcare systems in Nigeria in the southern part of the country. The utilised questionnaire was used to collect data from healthcare professionals in secondary and tertiary health facilities for analysis. The findings of the study indicate among other things that the provision of healthcare facilities seems to be low in hospitals. Results of the survey faulted the

deceitful electioneering and re-electioneering claims by Nigerian politicians that healthcare facilities would be made available at every nook and cranny of Nigeria upon election into public offices.

Boussabaine, Sliteen, and Catarina (2012) examined the impact of the intensity of hospital bed occupancy on healthcare facilities' operational costs in France. Data for the study were collected from 19 short stay care acute and long-term care hospital facilities in Paris, France, carried out during 2008. Statistical analysis was conducted to investigate the impact of bed occupancy on the operational cost of health facilities and the quality of service delivered. The results of the study showed a strong relationship between bed usage and operational costs of acute hospital facilities in France. An analysis of annual operation and maintenance cost clearly indicated that type of medical activities

had a major impact on operation and maintenance cost when the influence of all other potential factors, notably, morphology, quality of construction, and age, were excluded. The study concluded that this had implications on the quality of care delivered in those tertiary hospitals. That healthcare facility is essential in ensuring quality care service delivery in hospitals; however, with an attendant cost effect of maintenance.

Nikhil, Vinod, and Achala (2016) conducted a study to find out the utilization rates of equipment in the radiology department of a tertiary hospital to identify the status of the department in terms of effectiveness and efficiency. The equipment chosen in this study were Magnetic Resonance Imaging (MRI) scanning machine, Computer Tomography (CT), and Mammography. The study also focused on the quality assurance aspect and compliance rate of the department to the National Accreditation Board for Hospitals and Healthcare Providers. The study included various tools to assess the utilization rate of selected equipment, one of which being the Time and Motion study which was to bring out a clear picture on time taken for examinations performed. Findings of the study indicated, among other things, that the compliance of the radiology department to the regulatory requirements was good, with only little deviations and errors. Most of the radiology equipment were in good condition and working effectively. Breakdown periods of the equipment were very few, especially because the hospital had an excellent preventive maintenance plan in place.

Chaudhary and Kaul (2015) opined that quality patient diagnosis and clinical management are largely dependent upon the availability of reliable medical diagnostic equipment. However, in the Indian scenario, the lack of preventive maintenance, non-availability of technology and spare parts, and non-availability of required funds for maintenance are mainly responsible for the failure of equipment maintenance, and hence, their proper utilization. Therefore, a study was carried out to ascertain the deficiency in the utilization coefficient (UC) of medical diagnostic equipment and the various factors causing the under-utilization of medical equipment in tertiary hospitals. In this study, to collect information needed, 30 pieces of medical diagnostic equipment were assessed for their Utilization Coefficients (UC), and simultaneously, a perception-based analysis was conducted, where the faculty and staff members concerned with the administrative matters and use of that particular medical diagnostic equipment were concerned. The following factors were taken into account: low accessibility, obsolescence, break-down, affordability, availability of trained human resources, non-availability of consumables and spares, maintenance delays, limited working hours, and restricted availability. The results of the study indicated that 23% of the medical diagnostic equipment was not adequately used due to one reason or the other.

## **Theoretical framework**

### **Resource Dependency Theory (RDT)**

Resource Dependency Theory (RDT), introduced by Pfeffer and Salancik in 1978, posits that organizations are not self-sufficient—they rely on external resources to survive and succeed. These resources often come from the environment in which the organization operates, making it dependent on other entities and susceptible to power dynamics and uncertainty. In the context of healthcare accessibility, RDT provides a useful lens to understand how hospitals, clinics, and health systems interact with external entities (like governments, insurance companies, pharmaceutical suppliers, and technology providers) and how these dependencies impact patients' access to care.

### **Applicability of RDT to Healthcare Budgeting and Accessibility**

**Explains Power Imbalances in Resource Access** RDT effectively illustrates why certain healthcare organizations have more access to resources than others (e.g., urban vs. rural hospitals), based on their position in the resource network. It explains how dominant players (e.g., large insurers or suppliers) can influence the operations and priorities of healthcare providers.

**Highlights Strategic Behaviour** Organizations don't passively accept their constraints—they actively manage dependencies. RDT explains why healthcare providers form partnerships, merge, or vertically integrate to gain more control over needed inputs. For instance, a rural clinic partnering with a telehealth company to reduce dependency on in-person specialists.

### **Limitations of RDT in the Public Healthcare Context**

**Assumption of Competitive Advantage:** RDT originates from private-sector strategy and is rooted in the pursuit of competitive advantage, which may not translate well to the public health sector, where the goal is equity and universal access, not competition (Priem & Butler, 2001).

**Neglect of External Environment:** One major criticism of RDT is that it focuses primarily on internal resources, neglecting external factors such as political instability, donor funding, corruption, and community engagement—which often heavily influence budget implementation in developing countries like Nigeria (Peteraf & Barney, 2003).

**Resource Inaccessibility:** RDT assumes that resources can be obtained or developed internally, but in many low-income settings, the resources required (e.g., specialist personnel or medical technology) may be unaffordable or unavailable regardless of internal effort (Newbert, 2007).

**Lack of Emphasis on Process and Policy:** RDT does not sufficiently address how public budgeting policies and bureaucratic processes affect resource utilization. In countries with weak public financial management, the presence of resources (e.g., approved budgets) does not guarantee their proper use or accessibility (Sirmon et al., 2007).

## Research Design

The study employed both descriptive and survey method, in order to conduct an intensive investigation of the variables. The survey method is a widely used research approach that involves the collection of data from a predefined group of respondents to gain insights into specific issues.

## Population of Study

the study selected Garki Hospital, Teaching Hospital Gwagwalada and General Hospital Bwari. Service recipients (Patients) in the selected FCT health centers to provide perspectives on healthcare delivery outcomes. Administrative staff responsible for budget management and financial operations. Officials in the FCT Health and Human Services Secretariat (HHSS). Budget officers in the FCT budget and Finance department. The total Population is 1200.

## Sampling Techniques

The study adopted Taro Yamane formula, is a statistical method used to determine sample size for a study. It provides a simplified formula for calculating sample sizes in cases where the population size is known. It helps ensure the sample is representative of the population.

Formula:

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

Where n=sample size

N=total population size

1 is constant

e = the assume error margin or tolerable error  
which is taken as 5% (0.05)

$$n = \frac{N}{1 + N(e)^2} = \frac{1200}{1 + 1200(0.05)^2} = \frac{1200}{1 + 30} = \frac{1200}{31}$$

$$\text{(sample size)} \quad 1 + N (e)^2 \quad 1+610 (0.05)^2 \quad =\underline{300}$$

The reason for sampling is to ensure lower costs, greater speed of data collection and availability of population elements.

#### Stratified Sampling Method

$$\frac{N}{P} \times S$$

N - Is the number of elements in the stratum,  
P - Is the population of the study,  
S - Is the required sample size.

**Stratify the sample to representing the strata of the Garki Hospital, Teaching Hospital Gwagwalada and General Hospital Bwari. Service recipients (Patients) in the FCT**

S/N	Population Strata Items	NO. OF Population on each Strata	No. of sample Drawn from each Strata
7.	Garki Hospital Patients	300	75
8.	Gwagwalada Hospital Patients	480	120
9.	Bwari Hospital Patients	130	33
10.	Health workers	170	42
11.	Financial Officers in FCTA	120	30
12.	<b>Total</b>	1200	300

#### Sample Size

Therefore, the sample size of this study is **300**.

### Data Collection Methods

Data was collected using questionnaires, and document reviews. Questionnaires allowed for easy correlation and regression analysis. Document review offered access to recorded data relevant to the study.

### Data Analysis and Result

#### Showing the number of questionnaires distributed and how many retrieved

The below table shows that out of 305 questionnaires administered to the target population, only 250 representing 82% were completed and returned, while 55 questionnaires representing 18% of the questionnaires were not returned. The 250 returned questionnaires were used for analysis.

Questionnaires	Response Rate	Percentage (%)
Returned	250	81
Unreturned	50	19
Total	300	100

Source: Field Survey, 2024

### Data Analysis and Result

#### The impact of budgetary implementation on the accessibility of healthcare services in FCT

Question	SA	A	D	SD	Total	Mean	Median
Allocated budget sufficiency	50	20	100	80	250	2.16	2
Timely release of funds and healthcare availability	20	50	80	100	250	1.96	2
Equitable distribution of resources	60	40	100	50	250	2.44	2
Budget improves access to drugs	40	60	50	100	250	2.16	2
Budget increases hospital staff recruitment	30	30	90	100	250	1.96	2
Budget eradicates delay in service delivery	25	25	100	100	250	1.9	2

Source: Field Survey, 2024

The table shows that Question 1 (Mean = 2.08): Indicates that most respondents do not agree that the allocated budget is sufficient to ensure accessibility.

Question 2 (Mean = 2.04): Suggests that the timely release of budgeted funds has limited positive impact on healthcare availability. Question 3 (Mean = 2.56): Responses lean towards agreement, indicating moderate success in equitable resource distribution. Question 4 (Mean = 2.40): Reflects mixed opinions about the budget improving access to drugs. Question 5 (Mean = 2.12): Indicates a low impact of the budget on hospital staff recruitment. Question 6 (Mean = 2.00): Shows that respondents largely disagree with the statement that budget implementation eradicates delays in service delivery.

Mean Analysis: The mean scores for each question range from 1.90 to 2.44, indicating the following trends:

Allocated Budget Sufficiency (Mean = 2.16): Responses lean towards disagreement, suggesting that the allocated budget is perceived as insufficient to ensure healthcare accessibility.

Timely Release of Funds (Mean = 1.96): This suggests that respondents feel the timely release of funds has minimal impact on healthcare availability. Equitable Distribution of Resources (Mean = 2.44): The relatively higher mean indicates moderate agreement, implying some success in equitable resource distribution. Budget Improves Access to Drugs (Mean = 2.16): This reflects mixed perceptions, with slight disagreement about budget effectiveness in improving drug access. Hospital Staff Recruitment (Mean = 1.96): Indicates low perceived impact of the budget on staff recruitment. Eradicating Delay in Service Delivery (Mean = 1.90): Shows general disagreement, suggesting that budget implementation does not significantly address delays. Median Analysis: The median scores for all questions hover around 2, reinforcing the central tendency towards disagreement across most statements.

### The challenges of budgetary implementation on healthcare service in FCT

Question	SA	A	D	SD	Tot al	SA_ %	A_ %	D_ %	SD_ %	Me an	Med ian
Budget allocation delays negatively affect healthcare service delivery in FCT.	50	20	10 0	80	25 0	20	8	40	32	2.1 6	65
Insufficient funding is a major challenge affecting healthcare service quality in FCT.	20	50	80	10 0	25 0	8	20	32	40	1.9 6	65
Budgetary implementation in FCT healthcare services lacks transparency.	60	40	10 0	50	25 0	24	16	40	20	2.4 4	55
The budget process to implementation stage is mal with corruption	40	60	50	10 0	25 0	16	24	20	40	2.1 6	55
There are many unethical practices in the budget of FCT	30	30	90	10 0	25 0	12	12	36	40	1.9 6	60
The budget process is weakening the health sector	25	25	10 0	10 0	25 0	10	10	40	40	1.9	62.5

Source: Field Survey, 2024



The table summarizing the challenges of budgetary implementation on healthcare services in the FCT is now available, including percentages, mean, and median values. Here's an interpretation of the results: Budget Allocation Delays: Majority (40%) disagreed that delays in budget allocation negatively affect healthcare services. Mean score (2.16) indicates a leaning towards disagreement.

Insufficient Funding: Most responses (40%) strongly disagreed, suggesting insufficient funding is not universally seen as a challenge. Mean score (1.96) shows slight disagreement. Lack of Transparency: Strong agreement (24%) and general agreement (16%) indicate concerns about transparency. Mean score (2.44) reflects a moderate level of agreement. Corruption in Budget Implementation: Responses are split, with many strongly disagreeing (40%). Mean score (2.16) shows mixed perceptions.

Unethical Practices: Strong disagreement (40%) suggests skepticism about widespread unethical practices. Mean score (1.96) reflects slight disagreement. Weakening Health Sector: Equal disagreement and strong disagreement (40% each). Mean score (1.90) points towards disagreement. Overall, the results highlight mixed perceptions, with varying levels of agreement on how budgetary implementation affects healthcare services in the FCT. Key challenges include transparency and delays, but skepticism exists regarding their impact.

## **Findings and Result**

### **Budgetary Implementation on the Accessibility of Healthcare Services in FCT**

Accessibility to healthcare services was significantly affected by the level of budgetary implementation. Findings indicated that areas with proper budget execution experienced increased healthcare accessibility, characterized by shorter distances to health facilities, availability of mobile clinics, and extended operational hours. Conversely, poor budgetary implementation led to service shortages, particularly in rural and underserved areas of FCT. Budgetary constraints were shown to hinder the establishment of new health facilities and limit outreach programs, thereby reducing healthcare accessibility for vulnerable populations.

### **Challenges of Budgetary Implementation FCT**

The study identified several challenges affecting budgetary implementation in FCT's healthcare sector. Key issues included bureaucratic delays, corruption, lack of transparency, and insufficient stakeholder engagement. These

challenges often resulted in the mismanagement of allocated funds, delayed project execution, and underutilization of healthcare resources. Additionally, political interference and shifting government priorities further exacerbated the problem, creating a disconnect between planned budgets and actual healthcare needs.

## Conclusion

The study examined the effect of budgetary implementation on the availability of health infrastructure, the influence of budgetary implementation on the accessibility of healthcare services service delivery in Federal Capital Territory (FCT). Findings revealed that effective budgetary implementation significantly influences accessibility, effective budgetary practices play a critical role in ensuring that healthcare services are distributed equitably, reducing geographical and economic barriers for residents. However, significant challenges such as delays in fund disbursement, corruption, inadequate monitoring, and political interference hinder the effective implementation of health budgets, impacting the overall healthcare delivery system.

## Recommendations

- I. Improve budget planning, disbursement, and tracking mechanisms across the system. Implement electronic financial management systems to reduce leakages and delays in fund release.
- II. Regular audits and transparent reporting should be enforced to promote accountability. Federal and state governments should release funds as scheduled, especially to Primary Healthcare Centres (PHCs) and rural facilities. Introduce performance-based funding mechanisms to reward timely and efficient use of resources.
- III. Train healthcare administrators in budget planning, utilization, and reporting. Promote collaboration between finance and health ministries to align spending with service delivery goals.

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