THE EFFECT OF HEALTH CAPITAL ON LABOUR PRODUCTIVITY IN NIGERIA FROM1970 TO 2013: A STANDARD NEO-CLASSICAL GROWTH FRAMEWORK APPROACH

BY

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Abstract

This study evaluates the effect of health capital on labour productivity in Nigeria from 1970 to 2013, using the standard neo-classical growth framework approach. The study adopts Ordinary Least Square (OLS) technique, Cointegration and Granger Causality test procedures, for estimation. The Unit root test result conducted shows that the variables under consideration, PERCAPITA, D(HEALTH), EDUCATIO, AGRICULT,EXCHR and INF are stationary and integrated of order one I(1) at 5% level of significance in the ADF statistics. The cointegration test result indicates at most five cointegrating equations. The Granger causality test result conducted indicates a bilateral causality existing between D(HEALTH) and PERCAPITA income. A unilateral causality exits from EDUCATIO to PERCAPITA. There is unilateral causality existing between PERCAPITA and AGRICULT variable. There is no direction of causality existing between D (LABFORCE) and PERCAPITA. The OLS result shows that an educated, healthy-labour force are among the key determinants of labour productivity in Nigeria.

JEL CLASSIFICATION: C12, C51, J24.I12, N3, N37

KEYWORDS: Health, Labour Productivity, Granger Causality, Cointegration, OLS, Nigeria

Introduction

The importance of health as a form of human capital cannot be overemphasised. A healthy workforce is one of the most importance asset a nation could possess. Lilliard and Weiss(1997) were of the view that health is one of the most importance asset a person has as it permits to fully develop our capacities. Ajani and Ugwu(2008)assert that good health and productive workforce are important in any economy especially in the fight against poverty. Health is importance for economic agents as it directly contributes to the wellbeing of individuals, besides constituting part of the human capital stock which determines the productivity and income levels reached (Alves and Andrade, 2002). A country's capability to improve its national output growth over time depends almost entirely on the size of its labour force. This in turn propels the country's productive capacity and hence raises productivity (Qaiser and Foreman-Peck, 2007).

The link between health and both income and labour productivity has been long studied by economists and development experts. The significance and positive correlation that observers clearly see between measures of health status and of income and work performance has motivated much of the research (McNamara, Ulinwengu and Leonard, 2010). The authors were of the view that the strong association between good health and economic prosperity is easily appreciated and appears in the context of agricultural productivity as well as in context such as income, wages and other wealth measures. Strauss and Thomas (1998) stated that there is a positive relationship between health and productivity of skilled and unskilled labour. Good health according to the authors, as related to labour output or better production organisation can enhance farmers/household income and economic g` rowth. Healthier worker are physically and mentally more energetic and robust, so they are less likely to miss work due to illness, either of themselves or their families (The World Health Organisation, 2002).

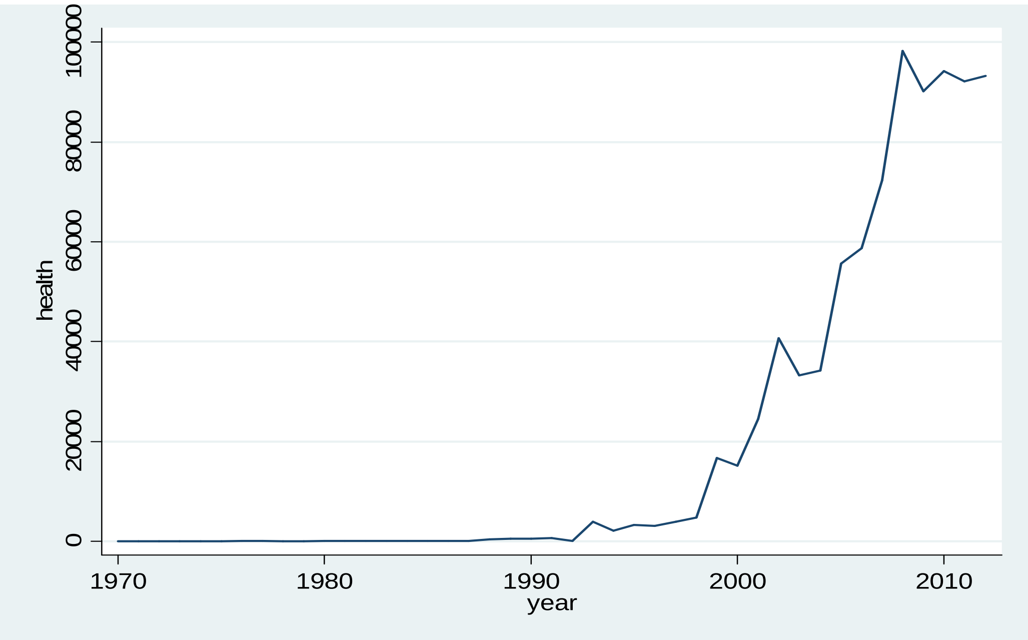
The economic effect of health related problems like malaria, musculoskeletal disorders, HIV/AIDS , farm injuries, yellow fever, typhoid fever, schistosomiasis, onchocerciasis, diarrhoea will be felt first by individuals and their families, then ripple outwards to firms and business and the macroeconomy (Nwaorgu,Bollinger and Stover,1999). According to the authors, the household impacts begin as soon as a member of the household starts to suffer from these related illness which include,

(a) Loss of income of the patients (who as bread winner)
(b) Household expenditures for medical expenses may increase substantially
(c) Other members of the household usually daughters and wives may miss school or work less in order to care for the sick person
(d) Death results in: a permanent loss of income from the less labour on the farm or from lower remittances; funeral and mourning cost and the removal of children from school in order save on educational and increase household labour resulting in a severe loss of future earning potentials.

Health expenditure outcomes in Nigeria

In Nigeria, the Federal Government's percentage growth in health expenditure lagged behind their normal counterpart all through from 1978 till 2003. For example while the sum of N452.6 million in nominal terms was spent in 1989; this amount was only worth N62.69 million in real terms during the same year. In 2003, approximately N396.86 million was the nominal amount spent by the Federal Government in Nigeria, this amount in 2000 real terms is worth N272.96 million. This is not significantly different from the N257. 01 million spent in 1977 in real terms. However, in recent times, the Federal Government expenditure has been on the increase. The figure 1 below shows the total of Federal Government expenditures on health in Nigeria from 1970 -2013:

Figure 1: The health expenditures of Nigeria from 1970 -2013.



Source: author's computation

From the graph, it could be seen that the health expenditure of the Nigeria government took a positive dive. For example, in the year 1991 a total amount of N755million was spent; this rose nominally to N63171.2 million in 2002. Considering changes in price level, this amount spent in 2002 reduced to a mere N495.42 million in 2009 (CBN,2009). In 2013, the Federal Government allocated a total of N279.23 billion to health care and N81.41 billion to agricultural sector. The top three expenditures for the country in 2013 were education, defence and police formations and commands. The increase in the education allocation of N493.5 billion is commendable when compared to the 2012 but still it is considered insufficient considering the level of deterioration in public education at all levels in the country**.**

The labour force population based on the 2011 estimate indicates that the country has a total of 51.53 active labour force (CIA World fackbook, 2014). Based on the 2011 report, the population of the country's labour force by occupation show that agriculture dominates the population of labour force participation with 70 %, industry 10 % and services 20%. The CIA World fact book report (2014) noted that 23.9 % of the country's active population are unemployed. The figure indicates an astronomical increase in unemployment rate from 4.9% estimate in 2007. Among the sub-Saharan African countries, Nigeria ranked first with the highest number of labour with a total of 52.64 million based on the 2011 estimate (CIA World fackbook, 2014).

Statement of the problem

In recognising health as a fundamental basic need for development purpose, Yesufu(2000) affirms that development comes through the abilities and work of those members of the population who are fit, healthy and capable of productivity.

Dauda(2007)stated that attaining high level of economic development by a nation with a population crippled by pervasive illness of its workforce, high infant and maternal mortality and low life expectancy will be an illusion. Alaba and Alaba (2002) in a study of health situation in the Nigerian economy noted that sickness at the household level affects productivity and income level. Equally, the prevention and treatment of illness consume scarce household resources including productive time. Karen, Sara, Michelle, Alice and Alyssa (2005) stated that when people are unable to work or drop out of workforce because of serious health problems or disability, they do not generate economic output, pay taxes on earning or help raise the nation's standard of living. The United Nation's (2008) report on AIDS epidemic in Nigeria noted that around 3.1% of adults between ages of 15-49 are living with HIV and AIDS. According to the report, although the HIV prevalence is much lower in Nigeria than in other African countries, the size of the population (around 148 million) meant that by the end of 2007, there were an estimated 2,600,000 people infected with HIV. Despite various declarations by African governments in the 1990s and complementary effort promised in the main content of the Roll back malaria declaration in Abuja in 2000, malaria remains a major health challenge facing Nigeria and entire continent. About 107 countries and territories involving about 3.2 billion people are still at risk of malaria attack as at 2004(The World Health Organisation (WHO), 2005).

These has presented a serious implication for labour productivity and household welfare. Prevalence of redundant labour, low income growth, lack of training, low level of technology, low capacity utilisation, low investment expenditures and poor performing infrastructure are critical factors, amongst others that are responsible for low productivity of labour in Africa (Mordi and Mmieh, 2008). A dramatic reduction in life expectancy has equally affected the Nigerian labour force and hence productivity in addition to allied potential lasting adverse effect on growth within the economy (Umoru and Yaqub,2013). This study therefore seeks to answer the following questions: Does health capital affect labour productivity in Nigeria? What is the direction of causality between health capital and labour productivity in Nigeria?

Objectives of the study

The broad objective of this study is to evaluate the effect of health capital on labour productivity in Nigeria. The specific objectives are:

(1) To ascertain the direction of causality between health capital and labour productivity in Nigeria.
(2) To proffer policy measures that would enhance labour productivity in Nigeria

Research hypothesis

The research hypotheses employed in this study are stated as follows:
$H_{0:}$ Health capital have no effect on labour productivity in Nigeria
$H_{0:}$ There is no direction of causality between health capital and Labour productivity in Nigeria

Scope of the study

The study covers the period from 1970-2013. The period was chosen as it gives a chance for a comprehensive and accurate data estimate.

Significance of the study

An examination of the impact of health capital on labour productivity in Nigeria would reveal that among the traditional factor inputs, land, labour and capital (human and materials), labour are to a large extent most affected by health. This study would therefore bring to knowledge of governments at all levels , the economic need to invest in the health of workers by providing them with adequate health facilities at reduced or subsidised cost; since adverse health reduces productivity of the nation's workforce. Given that poverty, food security and economic growth continues to maintain priorities in government policies in most African countries, the efficiency of health capital as indispensable production input cannot be over emphasized.

Literature review

The literature relating health to labour market outcomes according to Campolieti and Krashinsky(2006), originates with Becker's (1964) discussion of human capital and health capital , in which he argues that motivation for investment in general human capital, such as education is similar to the rational for investing in health capital. According to the authors, Grossman (1972) formalised this idea with a model in which health directly affects consumption and labour market outcome. Mankiw, Romer and Weil(1992) extended the Solow growth model by adding human capital, specifying that this variable has significant impact on economic growth. According to Galleg(2000), following a Ramsey scheme, Baro (1996) develops a growth model including physical capital and quantity of hours worked. The author noted that by obtaining first order conditions, Baro finds that increase in health indicators raises the incentives to invest in education and a raise health capital lowers the rate of depreciation of health; adding that there are diminishing marginal return to investment in health.

Aguayo-Rico,Guera,Iris and Ricardo(2005) in their study noted that Grossman (1972) developed a model that allow health capital formation seen as capital good, to be able to work ,to earn money and to produce domestic goods. He showed that an increase in the quantity of health capital reduces the time loss of being sick. The model assumes people are born with initial endowment of health which depreciate with age and grow with investment in health (Aguayo-Rico et.al, 2005). In their study, Bloom and Canning (2000) described how healthy population tends to have higher productivity due to their greatest physical energy and mental clearness. Also Strauss and Thomas (1998) reviewed the empirical evidence of the relationship between health and productivity, establishing correlations between physical productivity and some health indicators especially those related to nutrition or specific disease.

In health economics, the endogenous causality between health and income has been the topic of several studies whose purpose is to establish the direction of the causality. Luft(1978) gives an informal explanation of this causality, according to the author, a lot of people who otherwise wouldn't be poor are, simply because they are sick; few people who otherwise would be healthy are sick because they are poor. In explanation of the direction of causality of the impact of health over income, Smith (1999) uses life cycle models which links health condition with future income, consumption and welfare. Bloom and Canning (2000) noted that healthy people live more and higher incentives to invest in their abilities since the present value of the human capital formation is higher.

Empirical literature

Umoru and Yaqub(2013) analyse the labour productivity effects of health capital in Nigeria using Generalised Method of Moment (GMM) methodology. The result indicate that health capital investment enhances productivity of the labour force.

Chansarn (2010) calculates the growth rates of labour productivity of 30 countries categorised into four groups ,including G7 countries, Western developed countries; Eastern developed countries and eastern developing countries during 1981-2005. The result reveals that growth rates of labour productivity of every country, except the Philippines were greater than four percent per annum during 1981-2005. He notes that eastern developed countries had the highest average annual growth rate of labour productivity.

Ugwu(2009) examines the impact of HIV/AIDS on farm women in Nigeria with particular reference to Enugu State using Multi-Stage and purposeful sampling methodologies in the selection of farm families /households including (women) persons living with HIV/AIDS for the study. The result shows that the impact of HIV/AIDS on the farm women and their households were significance

Ajani and Ugwu(2008) examine the impact of adverse health on productivity of famers in Kainji Labke Basinin the North central Nigeria. The study use Stochastic Frontier Production model. The result indicate that technical efficiency of farmers fall in the range of 0.28-0.99 with mean of 0.85.

Research Methodology

Under the Standard Neo-Classical growth framework, conditional convergence studies assumes that a country with higher initial human capital among others, performs better. The growth implication of health which is another component of capital to education have not been investigated thoroughly within the optimum growth framework (Muysken, Yetkiner and Ziesmer, 1999). The aim of this study is to show rigorously the positive association between labour productivity proxies with percapita income and health status of an economy; and thereby provide a theoretical background for using health variables in conditional convergence analysis. The positive relationship between health and percapita output is first shown in the standard neo-classical growth framework where the health status is exogenously given.

In the human capital development theory, the more educated and healthy are more productive. This imply that productivity of country's labour force is driven by her status of health capital and education (Kalemli-Ozcan,Harl and Weil,2009). According to the authors, a healthy and educated workforce is expected to contribute positively to the effectiveness and hence productivity of a nation. Based on these assertion, we can express percapita equation as:

$$PERCAPITA_t = K_t^{\varsigma} H_t^{\eta} E_t^{\lambda} L_t^{1-\zeta-\eta-\lambda} A_{it} \quad \ldots\ldots\ldots\ldots\ldots\ldots\ldots\ldots(1)$$

where (H) health and education (E) are two components of human capital and assumption of constant returns to scale (CRTS), the augmented aggregate productivity function could be expressed as:

$$(PERCAPITA) = \left(\frac{K_t}{L_{\varsigma}}\right)^{\frac{\varsigma}{1-\varsigma-\eta-\lambda}} \left(\frac{H_t}{L_t}\right)^{\frac{\eta}{1-\varsigma-\eta-\lambda}} \left(\frac{E_t}{L_t}\right)^{\frac{\lambda}{1-\varsigma-\eta-\lambda}} A_{it}^{T} \quad \ldots\ldots\ldots..(2)$$

The expression of relation in equation (2), labour productivity measured by worker's output is a function of physical, health and education capitals per unit of labour services. For example:

$(K/L) = k^{\frac{\varsigma}{1-\varsigma-\eta-\lambda}}, (H/L) = h^{\frac{\eta}{1-\varsigma-\eta-\lambda}} and\ (E/L) = e^{\frac{\lambda}{1-\varsigma-\eta-\lambda}}$,respectively

A total factor productivity is measured by the technological index of the country A_{it}^{T} therefore taking the log of equation (2) yields:

$$Ln(PERCAPITA) = \frac{\varsigma}{1-\varsigma-\eta-\lambda}Lnk + \frac{\eta}{1-\varsigma-\eta-\lambda}Lnh + \frac{\lambda}{1-\varsigma-\eta-\lambda}Lne + LnA_{it}^{T} \quad \ldots\ldots,,,,,,,\ldots(3)$$

In line with the technological diffusion of Bloom,Canning and Sevilla(2001)in a model of a country's aggregate productivity index A_{it}^{T} ,we have that:

$$\Delta Ln(A_{it}^{T}) = \phi Ln(A^{*}_{it} - A_{it}^{T}) + \varepsilon_{\varsigma t} \quad \ldots\ldots\ldots\ldots\ldots\ldots(4)$$

where $\varepsilon_{\varsigma t}$ represents a random shock; Nigeria has a ceiling level of TFP given by A^{*}_{it} ,the country's TFP adjusts towards this ceiling at a rate ϕ . The ceiling specific level of a country's productivity is determined by worldwide technological frontier, proxy by GDP ratio and sets of country specific variables that affects productivity. We therefore specify as follows:

$$Ln(A^{*}_{it}) = \theta Ln(W_{it}^{T}) + Ln(WWT) \quad \ldots\ldots\ldots\ldots\ldots\ldots(5)$$

It is noted that technology gaps are not observed directly, we utilised the fact that lagged productivity level can be derived from equation(4) so we specify the equation as:

$$Ln(A_{it}^{T}) = \omega Ln\{s(k)\}_{t-1} + \xi Ln\{s(h)\}_{t-1} + \xi Ln\{s(e)\}_{t-1} - \gamma Ln[n+g+\delta]_{t-1} - (LnPERCAPITA)t-1 \quad \ldots\ldots\ldots\ldots(6)$$

Differencing the equation (6) yields

$$\Delta Ln(PERCAPITA) = \omega\Delta Ln\{s(k)\} + \xi Ln\{s(e)\} - \gamma Ln[n+g+\delta]\Delta LnA_{it}^{T} \quad \ldots\ldots\ldots\ldots(7)$$

Substituting $\Delta Ln(A_{it}^{T})$ using equation (4) and (5) gives the following labour productivity function:

$$\Delta Ln(PERCAPITA) = \omega\Delta Ln\{s(k)\} + \xi Ln\{s(h)\} + \xi Ln\{s(e)\}$$
$$-\gamma\Delta Ln[n+g+\delta] + \phi\begin{bmatrix} Ln(WWT) + \theta Ln(W_{it}^{T}) + \omega Ln\omega Ln\{s(k)\}_{t-1} \\ +\xi Ln\{s(h)\}_{t-1} + [\xi Ln\{s(e)\}]_{t-1} \\ -\gamma Ln[n+g+\delta]_{t-1} - Ln(PERCAPITA)_{t-1} \end{bmatrix} + \varepsilon_{\varsigma} \quad \ldots\ldots\ldots(8)$$

We envisage in this study that healthy-labour force (LABFORCE), government's expenditure in agriculture (AGRICULT), government's investment in health (HEALTH) and in education (EDUCATIO), influence labour productivity. Thus, our labour function becomes:

$$\Delta Ln(PERCAPITA) = \omega\Delta Ln\{s(k)\} + \xi Ln\{HEALTH\} + \xi Ln\{EDUCATIO_{t}^{E}\}$$
$$-\gamma\Delta Ln[n+g+\delta] + \lambda Ln[LABFORCE] + \varpi Ln[AGRICULT] \quad \ldots..(9)$$
$$+\phi\begin{bmatrix} Ln(WWT) + \theta Ln(W_{it}^{T}) + \omega Ln\omega Ln\{s(k)\}_{t-1} \\ +\xi Ln\{s(h)\}_{t-1} + [\xi Ln\{s(e)\}]_{t-1} \\ -\gamma Ln[n+g+\delta]_{t-1} - Ln(PERCAPITA)_{t-1} \end{bmatrix} + \varepsilon_{\varsigma}$$

However, this modelling approach encompasses the estimation of the labour productivity function in first differences as advocated by Lee, (1982) and Umoru and Yaqub (2013).

Model Specification:
Assuming a linear relationship between our dependent variable and independent variables, our equation using the multiple regression analysis can be shown as follows:

$$PERCAPITA = F(HEALTH, EDUCATIO, AGRICULT, LABFORCE, EXCHR, INF) \ldots\ldots \ldots\ldots (10)$$

We included exchange rate and inflation variables in the linear equation to ascertain impact of inflation and exchange rate on labour productivity during the period under review. Econometrically, the equation could be stated as follows:

$$PERCAPITA = \beta_0 + \beta_1 LABFORCE + \beta_2 HEALTH + \beta_3 EDUCATIO + \beta_4 AGRICULT + \beta_5 EXCHR + \beta_6 INF + \mu_t \ldots\ldots (11)$$

Given that the estimation is a time series analysis, we incorporate the time factor thus;

$$PERCAPITA_t = \beta_0 + \beta_1 LABFORCE_t + \beta_2 HEALTH_t + \beta_3 EDUCATIO_t + \beta_4 AGRICULT_t + \beta_5 EXCHR_t + \beta_6 INF_t + \mu_t \ldots\ldots (12)$$

where PERCAPITA is the output proxied by labour productivity, LABFORCE is the Labour force, HEALTH government expenditures on health, and EDUCATIO is the expenditures of government on education, AGRICULT for government expenditure on agriculture EXCHR for exchange rate and INF for inflation

Estimation Procedures

Unit root test
To test for stationarity or the absence of unit roots, this test is done using the Augmented Dickey Fuller test (ADF) with the hypothesis which states as follows: If the absolute value of the Augmented Dickey Fuller (ADF) test is greater than the critical value either at the 1% , 5% ,or 10% level of significance , then the variables are stationary either at order zero, one ,or two. The Augmented Dicky Fuller test equation is specified below as follows: $\Delta \hat{u}_t = \beta \hat{u}_{t-1} + \sum_{i=1}^{k} \Delta \hat{u}_{t-1} + \varepsilon_t \ldots\ldots\ldots (13)$

Cointegration test procedure
In time series analysis, we often encounter situations where we wish to model one non-stationary time series (Y_t) as a linear combination of other non-stationary time series $(X_{1,t}, X_{2,t}, \ldots\ldots X_{k,t})$. In other words:

$$Y_t = \beta_0 + \beta_1 X_{1,t} + \beta_2 X_{2,t} + \ldots\ldots \beta_k X_{k,t} + \varepsilon_t \ldots\ldots\ldots (14)$$

In general, a regression model for non-stationary time series variables gives spurious (nonsense) results. The only exception is if the linear combination of the (dependent and explanatory) variables eliminates the stochastic trend and produces stationary residuals.

$$Y_t + \gamma_1 X_{1,t} + \gamma_2 X_{2,t} + ... + \gamma_{k,t}\ 1(0)$$ …………………………………………….(15)

In this case, we refer to the set of variables as cointegrated. It is only in this case that we can look at regression as a reasonable and reliable model. Cointegration means that, while many developments can cause permanent changes in the individual variable $(i.e. X_{i,t})$, there is some long-run equilibrium relation tying the individual variables together, represented by some linear combination of them.

The presence of unit root econometrically promotes the investigation for a long run relationship among the variables. Co-integration tests are therefore meant to ascertain the existence of co-integration between the dependent and explanatory variables. The co-integration specification is given as:

$$\left[\eta_m \log Y_t = \alpha_0 + \sum_{i=1}^{p} \alpha_i \eta_m Z_i - \left[\eta_m \log Y_t - \sum_{i=1}^{p} \beta X_{i-1} + \nu_{1t}\right]\right]$$ ………………………..(16)

where [$\eta_m \log Y_t - \sum_{i-1} \beta X_{t-i}$] is the linear combination of the co-integrated vectors,

X is a vector of the co-integrated variables.

This is necessary as the Granger Representation theorem notes that cointegrated variables are related through an error correction mechanism.

The equation is specified as follows"

$$\Delta y_t = Lagged(\Delta y_{t,} \Delta x_t) - \lambda u_{t-1} + \varepsilon_t$$ …………………………………………….(17)

where

u_{t-1} = the disequilibrium error

$y_t = \beta_0 + \beta_1 x_1 + u_t$

λ = the short adjustment parameter

The Johansen maximum likelihood procedure begins by expressing a process of N I (1) variables in an Nx1 vector x as an unrestricted auto regression:

$$X_t = \lambda_1 + X_{t-1} + \lambda_2 X_{t-2} + ... + \lambda_k X_{t-k} + \mu_t$$

with t = 1, 2, …, T and μ_t being the random error term. The long-run static equilibrium is given by Π_x = 0, where the long run coefficient matrix Π is defined as:

$$\Pi = 1 - \Pi_1 - \Pi_2 - ...... - \Pi_k$$

where I is the identity matrix and Π is an nxn matrix whose rank determines the number of distinct cointegrating vectors which exist between the variables in x. Define two nxr matrices α and β, such that:

$\Pi = \alpha\beta'$

with the rows of β′ to form the r distinct cointegrating vectors. The likelihood ratio statistic (LR) or trace test for the hypothesis that there are at most r cointegrating vectors is: $\text{LR or TRACE} = -T\sum_{i=r+1}^{n} \ln(1-\lambda i)$

where λr + 1, … λn are n-r the smallest squared canonical correlations between the residuals of xt–k and Δxt series, corrected for the effect of the lagged differences of the x process. Additionally, the likelihood ratio statistic for testing at most r cointegrating vectors against the alternative of r + 1 cointegrating vectors, namely, the maximum eigenvalue statistic, is given as: $\lambda MAX = T \ln(1 - \lambda r + 1)$

Both statistics have non-standard distributions under the null hypothesis, although approximate critical values have been generated by Monte Carlo methods and tabulated by Johansen and Juselius (1990) procedure.

Granger causality test procedure

In order to ascertain the significance of the second objective which is to determine the direction of causality between the health and labour productivity in Nigeria, a granger causality test is carried out. The procedure adopted in this study for testing statistical causality is the "Granger-causality" test developed by C.W.J. Granger in 1969. The Granger causality tests determine the predictive content of one variable beyond that inherent in the explanatory variable itself.

The study uses two most common choices of information criteria: Akaike Information Criterion (AIC) and Schwarz Information Criterion (SIC) to ascertain significance of the results estimates.

Granger causality test rely on two basic equations:

$$\mathrm{X}_t = \Upsilon_0 + \sum_{i=1}^{k_3} \Upsilon_i H_{t=1} + \sum_{i=1}^{k_4} \lambda_i X_{t=1} + \omega_t \quad \text{..(18)}$$

$$H_t = \alpha_0 + \sum_{i=1}^{k_1} \alpha_i H_{t-1} + \sum_{i=1}^{k_2} \beta_i X_{t=1} + \sum{}_t \quad \text{..(19)}$$

$where:$

X = an indicator of PERCAPITA,

H = an indicator of HEALTH capital

t = current values

t-1 lagged values

Source of data

Data for this study were from secondary sources. The estimation period is from 1970-2013. The data used in this study are from the statistical bulletin of the CBN (2013), CBN Annual Report and Statement of Account for various years.

Econometrics software

The E-view econometrics packages was utilized in analyzing the data while excel worksheet was used in imputing the data.

Results

Table1: Unit root test

Augmented Dickey-Fuller Test Equation, for the model				
ADF TEST				
Variable	**order zero**	**probability**	**order one**	**probability**
PERCAPITA	0.649497	0.5198	-4.465192	0.0001
HEALTH	2.111422	0.0412	-3.596858	0.0009
EDUCATIO	2.364256	0.0231	-4.195933	0.0002
AGRICULT	-0.941206	0.3524	-7.298729	0.0000
LABFORCE	1.727920	0.0919	-0.823451	0.4154
EXCHR	1.257219	0.2160	-3.653538	0.0008
INF	-2.024056	0.0497	-6.514957	0.0000

The Unit root test result shows that five of the variables, PERCAPITA, LABFORCE EDUCATIO, AGRICULT and D(HEALTH) are not stationary at level (order zero) as they all drift far apart from equilibrium in the short-run. Only one variable, INF is stationary at level. In effect, it shows that there is no propensity for the variables to move together towards equilibrium. However, on application of the tests to the first differences of the series, the tests indicate that the variables under consideration, PERCAPITA, D(HEALTH), EDUCATIO, AGRICULT,EXCHR and INF are stationary and integrated of order one I(1) at 5% level of significance in the ADF statistics; only the LABFORCE variable is not stationary. Having established the order of integration of the series, we employed both the Johansen‟s and Juselius‟ Maximum Likelihood (LM) co-integrating techniques under the trace and maximum Eigen value test statistics to explore the possibility of long-run equilibrium between the variables under study.

Cointegration Test

To establish whether long-run relationship exists among the variables or not, cointegration tests are conducted by using the multivariate procedure developed by Johansen (1988) and Johansen and Juselius (1990). The cointegration tests include: PERCAPITA D(HEALTH) EDUCATIO AGRICULT D(LABFORCE) EXCHR INF which includes one lag in the VAR. The results of the conducted Johansen tests for cointegration among the variables are specified in table below:

Table2: Cointegration result

Series: PERCAPITA D(HEALTH) EDUCATIO AGRICULT D(LABFORCE) EXCHR INF

Lags interval: 1 to 2

Eigenvalue	Likelihood Ratio	5 Percent Critical Value	1 Percent Critical Value	Hypothesized No. of CE(s)
0.988924	460.8772	109.99	119.80	None **
0.964314	280.7568	82.49	90.45	At most 1 **
0.863193	147.4371	59.46	66.52	At most 2 **
0.627199	67.86990	39.89	45.58	At most 3 **
0.338370	28.40143	24.31	29.75	At most 4 *
0.250526	11.87948	12.53	16.31	At most 5
0.008566	0.344105	3.84	6.51	At most 6

*(**) denotes rejection of the hypothesis at 5% (1%) significant level

The results indicate that there are at most five cointegrating vectors. Using the trace likelihood ratio, the results point out that the null hypothesis of no cointegration among the variables is rejected in favour of the alternative hypothesis up to five cointegrating equations at 5% significant level because their values exceed the critical values. This means there are at most five cointegrating equations, which implies that a unique long-run relationship exists among the variables and the coefficients of estimated regression can be taken as equilibrium values.

Granger Causality Test

Table3: Granger Causality Test result

Null Hypothesis:	Obs	F-Statistic	Probability
D(HEALTH) does not Granger Cause PERCAPITA	**41**	5.60083	0.00762
PERCAPITA does not Granger Cause D(HEALTH)		7.13623	0.00245
EDUCATIO does not Granger Cause PERCAPITA	42	0.61721	0.54491
PERCAPITA does not Granger Cause EDUCATIO		5.64528	0.00725
AGRICULT does not Granger Cause PERCAPITA	42	0.68108	0.51230
PERCAPITA does not Granger Cause AGRICULT		3.24182	0.05043
D(LABFORCE) does not Granger Cause PERCAPITA	41	0.88110	0.42307
PERCAPITA does not Granger Cause D(LABFORCE)		0.91087	0.41124
EXCHR does not Granger Cause PERCAPITA	42	9.61579	0.00043

PERCAPITA does not Granger Cause EXCHR		0.42775	0.65516
INF does not Granger Cause PERCAPITA	42	0.48365	0.62037
PERCAPITA does not Granger Cause INF		0.71145	0.49753

The result above indicates a bilateral causality existing between D(HEALTH) and PERCAPITA income. There exists a unilateral causality from EDUCATIO to PERCAPITA. The unidirectional causality means that the PERCAPITA has to grow first before the effect reflects on the education expenditure. There is unilateral causality existing between PERCAPITA and AGRICULT variable. From the result table, there is no direction of causality existing between D (LABFORCE) and PERCAPITA. A unilateral causality exist from EXCHR to PERCAPITA. From the result table, no causality direction exists between PERCAPITA to INF.

Analysis of regression estimates

Table4: The regression result

Dependent Variable: PERCAPITA
Method: Least Squares
Date: 07/26/15 Time: 11:28
Sample(adjusted): 1971 2013
Included observations: 43 after adjusting endpoints

Variable	Coefficient	Std. Error	t-Statistic	Prob.
C	-1230.358	1721.479	-0.714710	0.4794
D(HEALTH)	0.254014	0.124924	2.033356	0.0494
EDUCATIO	0.099682	0.044821	2.223994	0.0325
AGRICULT	-0.219848	0.078425	-2.803271	0.0081
D(LABFORCE)	0.001417	0.001217	1.164361	0.2519
EXCHR	353.5920	34.05712	10.38232	0.0000
INF	-36.46121	41.51925	-0.878176	0.3857

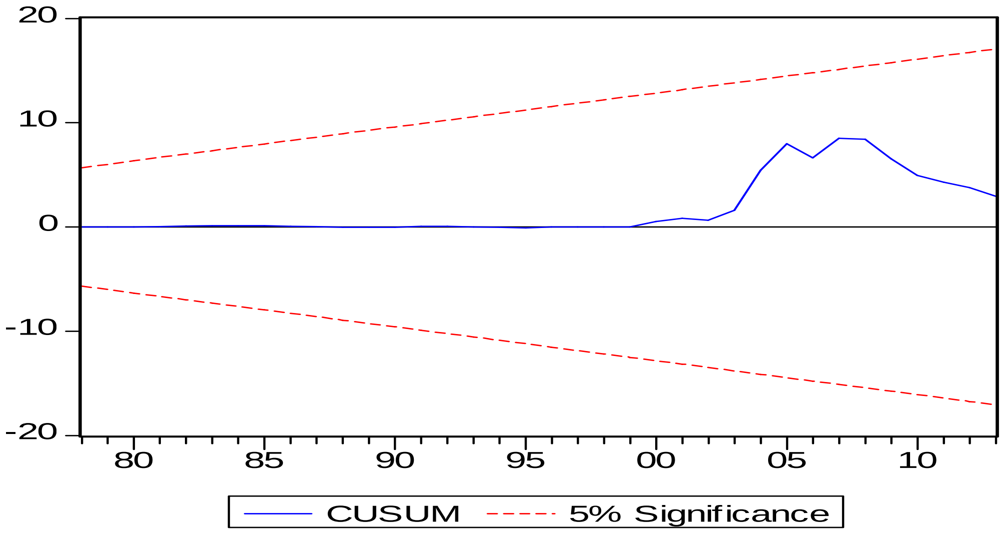
R-squared	0.977201	Mean dependent var	19605.81
Adjusted R-squared	0.973401	S.D. dependent var	24996.80
S.E. of regression	4076.762	Akaike info criterion	19.61189
Sum squared resid	5.98E+08	Schwarz criterion	19.89860
Log likelihood	-414.6557	F-statistic	257.1698
Durbin-Watson stat	1.517835	Prob(F-statistic)	0.000000

The result from regression estimates shows a positive coefficients of the D (HEALTH), EDUCATIO, D (LABFORCE) and EXCHR variables. Thus, the labour productivity effect of healthy-labour and educated labour is highly remarkable. The empirical evidence therefore strongly indicates that an educated, healthy-labour force are among the key determinants of labour productivity in Nigeria. Accordingly, the results indicate that increase in the health and education expenditures and healthy-labour force are factors that determines productivity. The result is supported by a strong statistical significant at 5% level of significance. The positive coefficient of EDUCATIO variable equally indicate that during the period under review, the government expenditure on education improved upon the percapita income in Nigeria during the period under review. It also indicates that a unit increase in government expenditures in education increases productivity by 0.09 percent. The result also shows that AGRICULT variable exhibit negative sign. It implies that a unit increase in expenditures on agriculture declines productivity by 0.2 percent. The exchange rate variable (EXCHR) shows a positive sing with a strong statistical significance. The result above equally indicates that INF exerts negative influence on percapita income growth in Nigeria during the period under review.

Statistically, the R^2 (0.977201) =0.97 % shows that the independent variables explain the dependent variable to the tune of 97 %.From the regression results, the t-values of the variables under-consideration indicate strong statistical significance for the following variables. D(HEALTH)= 2.033356, EDUCATIO =2.223994, AGRICULT=-2.803271, and EXCHR=10.38232. The F-values obtained are as follows: F (6, 43) =257.1698while tabulated value is given as follows F (6, 43) = 2.45 Decision: Since the F –calculated is greater than the F- tabulated, we reject H_O and conclude that the overall estimate of the regression is adequate statistically. The DW = 1.517835 which is greater than the adjusted R^2 = 0.97 % shows that the entire regression is statistically significant.

Stability and Residual Diagnostic Tests Results
A plot of the sample autocorrelation function (AC) against different lags yielded the correlogram of the regression residuals. The correlogram portrays an explicit representation of stationary residuals adjudged on the ground that the autocorrelations at various lags drift around zero, that is, the zero axis as indicated by the solid vertical line(see table in appendix). The CUSUM and CUSUMSQ test results reveals satisfactory plot of the recursive residuals at the 95% significance level. Remarkably, cumulative sum of square residuals reveals that none of the parameters falls outside the critically dotted lines. This empirically dismisses any trace of inconsistent parameter estimates. The results of the CUSUM tests are provided in the graph below:

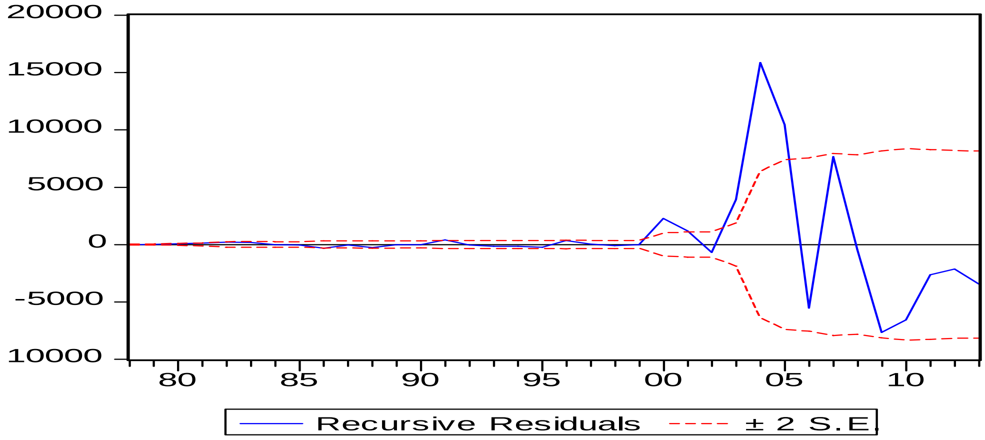
Figure2: CUSUM test result



Evidently, stability hypothesis is validated for the period under analysis. The validity of stability of the regression relationships over time further enhances the standard significance of the conventional test statistic(s) without trace of nuisance parameters obtained in the study.

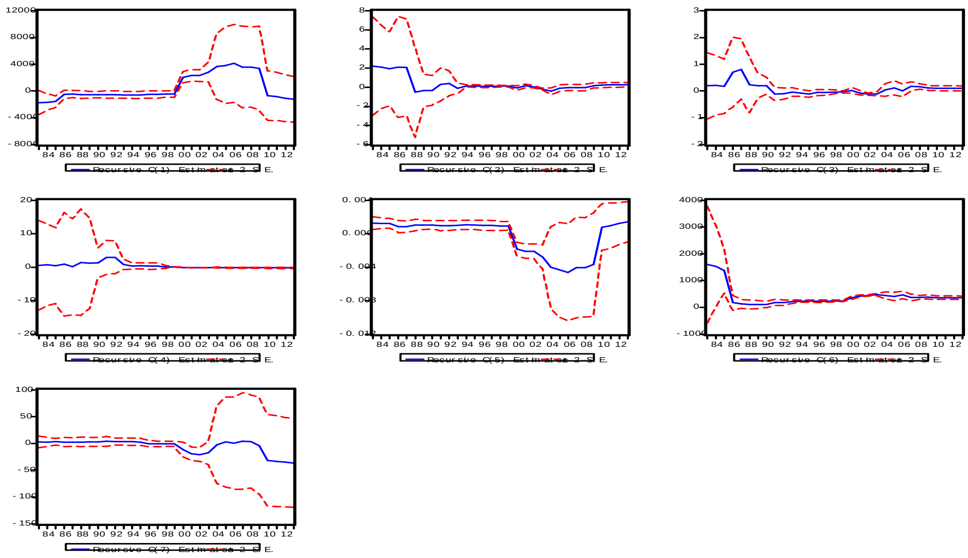
Model stability is further established in this study given the empirical evidence that the recursive residuals in the regressions persistently drift within the error bounds [-2 and +2]. This facilitated the adaptive configuration of the cusum test parameters thereby correcting any trace of endogeneity and or simultaneity bias and serial correlation. The graph below depicts recursive residual estimates result:

Figure3:Recursive residual test



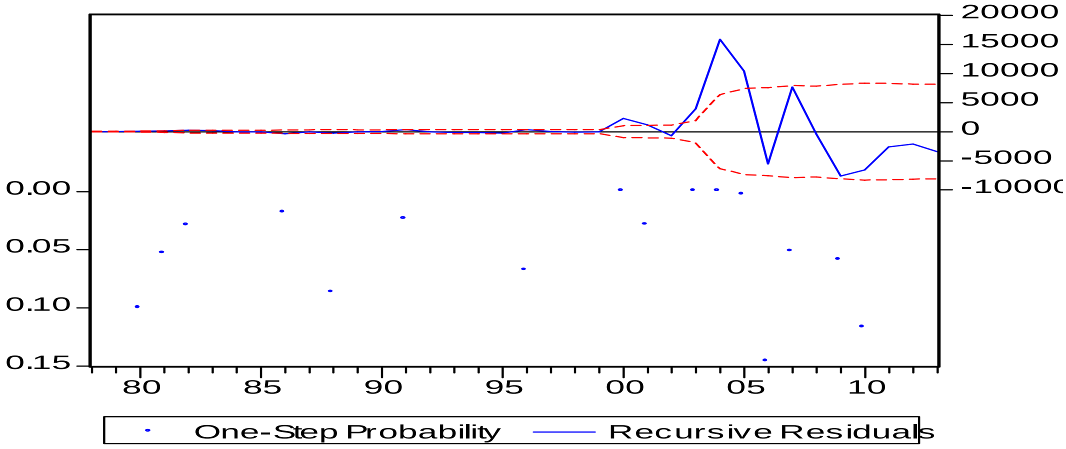
Thus, the recursive residuals are the *expost* prediction error for all regressands in the study. This is because estimation utilized only the first $_{t-1}$ observations.

Figure4: Recursive test result



Given that the recursive estimation is computed for subsequent observations beyond the sample period, it therefore portrays the one-step prediction error graphically depicted as one-step probability recursive residuals as shown in the graph below:

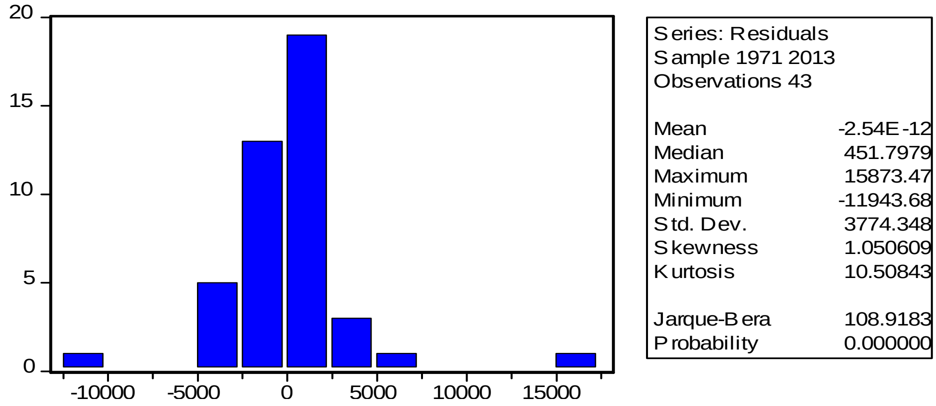
Figure 5: One-step probability recursive test result



The adequacy of the specification was therefore established on the basis of the satisfactorily robust test statistic(s) obtained from the diagnostic tests conducted on the regression residuals.

However, the empirical distribution test for model residuals also provides evidence of non-normality of the variables with a Jarque-Bera test statistic of 108.9183. The graph below depicts the non-normality of the distribution:

Figure6: Jarque-Bera test statistic



Conclusion

In this study, we estimated the impact of health on labour productivity in Nigeria applying the standard neo-classical growth framework. The data was estimated using annual time series data from 1970 to 2013. From the OLS test result undertaken, the empirical evidence strongly indicates that increase in health and education expenditures ,as well as healthy-labour force are factors that determine productivity in Nigeria. Based on the findings of this study, the following recommendations are therefore made for policy considerations: The influence of health on labour productivity growth should be re-investigated to confirm the results obtained. The Federal Governments as well as the authorities in every states of the country must focus on the improvement of labour productivity if they wish to raise the standard of living of people in Nigeria. There is need for an increase in health and education expenditures at all levels of government in Nigeria in order to enhance development

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Appendix

Augmented Dickey-Fuller Test Equation, for the model				
ADF TEST				
Variable	**order zero**	**probability**	**order one**	**probability**
PERCAPITA	0.649497	0.5198	-4.465192	0.0001
HEALTH	2.111422	0.0412	-3.596858	0.0009
EDUCATIO	2.364256	0.0231	-4.195933	0.0002
AGRICULT	-0.941206	0.3524	-7.298729	0.0000
LABFORCE	1.727920	0.0919	-0.823451	0.4154
EXCHR	1.257219	0.2160	-3.653538	0.0008

INF	-2.024056	0.0497	-6.514957	0.0000

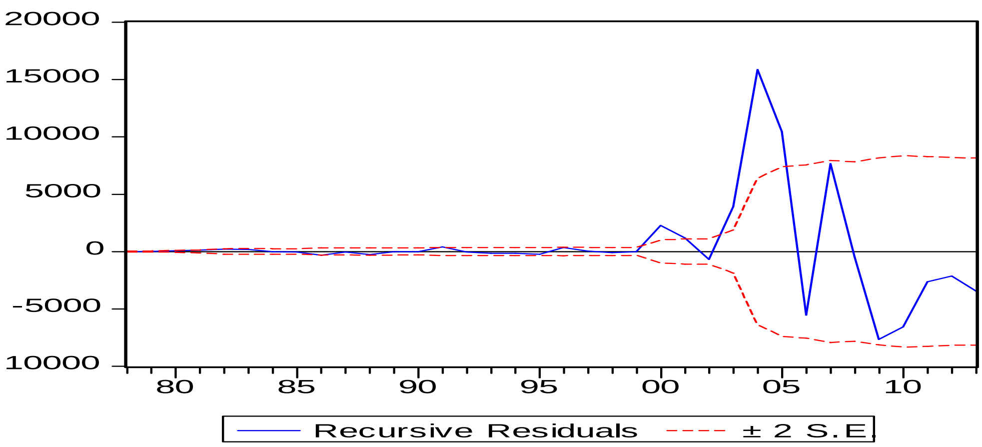
Granger Causality Tests

Pairwise Granger Causality Tests
Date: 07/26/15 Time: 11:34
Sample: 1970 2013
Lags: 2

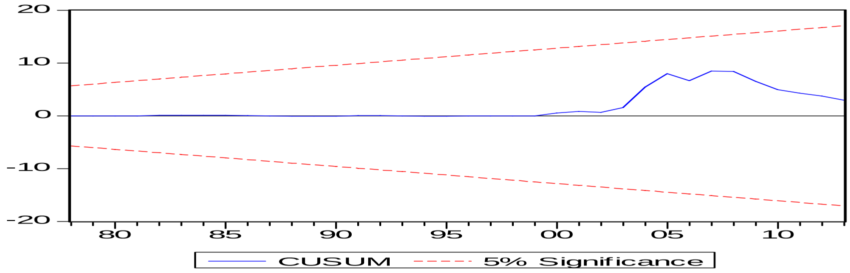
Null Hypothesis:	Obs	F-Statistic	Probability
D(HEALTH) does not Granger Cause PERCAPITA	41	5.60083	0.00762
PERCAPITA does not Granger Cause D(HEALTH)		7.13623	0.00245
EDUCATIO does not Granger Cause PERCAPITA	42	0.61721	0.54491
PERCAPITA does not Granger Cause EDUCATIO		5.64528	0.00725
AGRICULT does not Granger Cause PERCAPITA	42	0.68108	0.51230
PERCAPITA does not Granger Cause AGRICULT		3.24182	0.05043
D(LABFORCE) does not Granger Cause PERCAPITA	41	0.88110	0.42307
PERCAPITA does not Granger Cause D(LABFORCE)		0.91087	0.41124
EXCHR does not Granger Cause PERCAPITA	42	9.61579	0.00043
PERCAPITA does not Granger Cause EXCHR		0.42775	0.65516
INF does not Granger Cause PERCAPITA	42	0.48365	0.62037
PERCAPITA does not Granger Cause INF		0.71145	0.49753
EDUCATIO does not Granger Cause D(HEALTH)	41	2.23606	0.12152
D(HEALTH) does not Granger Cause EDUCATIO		3.79443	0.03197
AGRICULT does not Granger Cause D(HEALTH)	41	2.11325	0.13559
D(HEALTH) does not Granger Cause AGRICULT		0.26449	0.76908
D(LABFORCE) does not Granger Cause D(HEALTH)	41	5.47344	0.00840
D(HEALTH) does not Granger Cause D(LABFORCE)		9.73530	0.00042
EXCHR does not Granger Cause D(HEALTH)	41	3.60156	0.03751
D(HEALTH) does not Granger Cause EXCHR		0.86979	0.42766
INF does not Granger Cause D(HEALTH)	41	0.62614	0.54037
D(HEALTH) does not Granger Cause INF		0.60800	0.54994
AGRICULT does not Granger Cause EDUCATIO	42	2.00195	0.14944
EDUCATIO does not Granger Cause AGRICULT		6.51798	0.00376
D(LABFORCE) does not Granger Cause EDUCATIO	41	3.99591	0.02709
EDUCATIO does not Granger Cause D(LABFORCE)		11.9729	0.00010
EXCHR does not Granger Cause EDUCATIO	42	3.51319	0.04009
EDUCATIO does not Granger Cause EXCHR		0.93654	0.40107
INF does not Granger Cause EDUCATIO	42	0.23015	0.79554

EDUCATIO does not Granger Cause INF		0.63613	0.53503
D(LABFORCE) does not Granger Cause AGRICULT	41	0.46313	0.63301
AGRICULT does not Granger Cause D(LABFORCE)		9.55348	0.00047
EXCHR does not Granger Cause AGRICULT	42	3.70371	0.03418
AGRICULT does not Granger Cause EXCHR		1.10772	0.34102
INF does not Granger Cause AGRICULT	42	0.34999	0.70700
AGRICULT does not Granger Cause INF		0.58111	0.56430
EXCHR does not Granger Cause D(LABFORCE)	41	3.05688	0.05940
D(LABFORCE) does not Granger Cause EXCHR		0.81917	0.44884
INF does not Granger Cause D(LABFORCE)	41	0.34729	0.70894
D(LABFORCE) does not Granger Cause INF		0.08334	0.92022
INF does not Granger Cause EXCHR	42	0.70877	0.49881
EXCHR does not Granger Cause INF		0.57409	0.56816

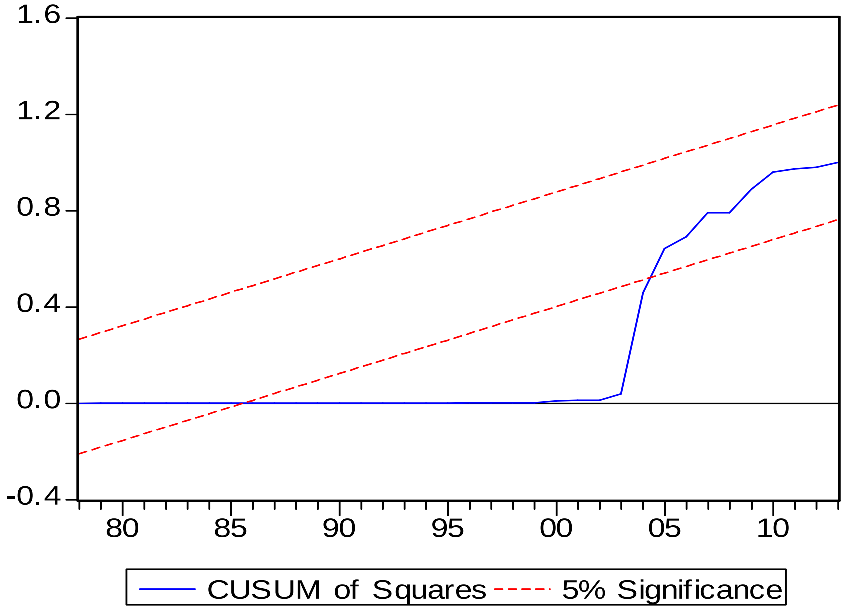
RECURSIVE ESTIMATES



CUSUM TEST

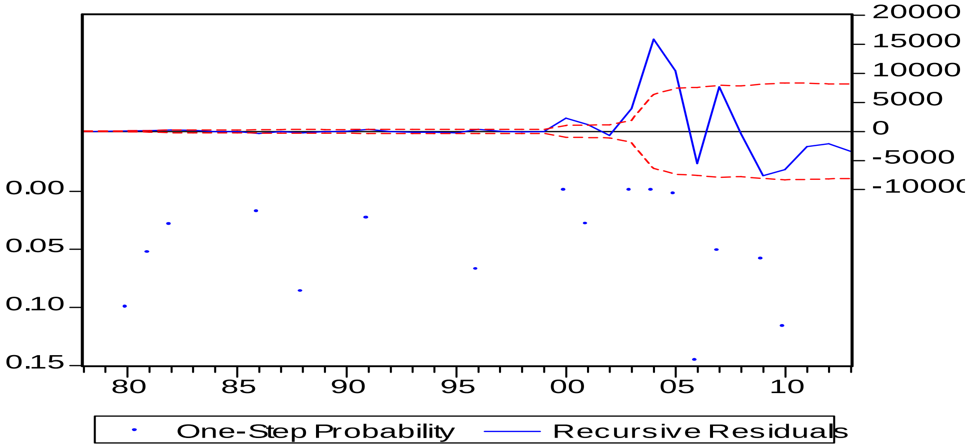


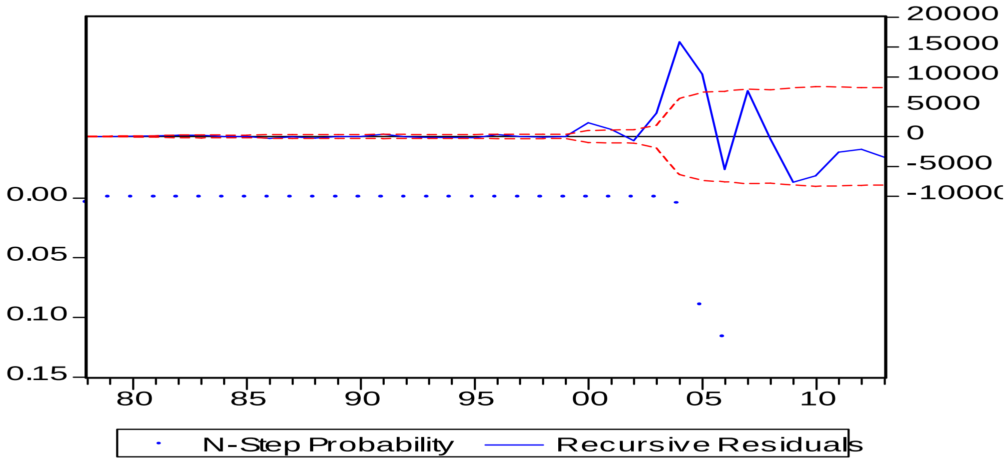
CUSUMQ



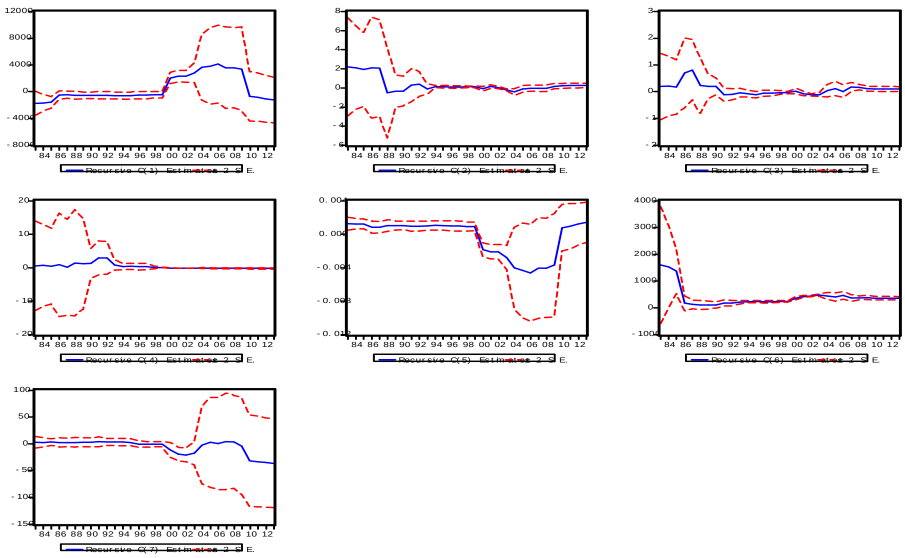
RECURSIVE PROBALITY

FORCAST ERROR

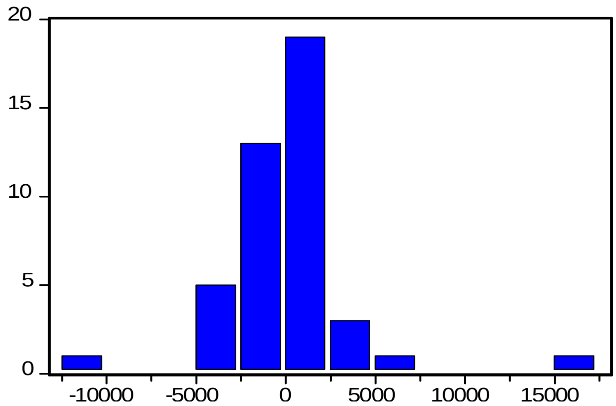




RECURSIVE COEFFICIENTS



NORMALITY TEST



Series: Residuals	
Sample 1971 2013	
Observations 43	
Mean	-2.54E-12
Median	451.7979
Maximum	15873.47
Minimum	-11943.68
Std. Dev.	3774.348
Skewness	1.050609
Kurtosis	10.50843
Jarque-Bera	108.9183
Probability	0.000000

108.9183

RESIDUAL TEST

obs	Actual	Fitted	Residual	Residual Plot
1971	166.800	-576.547	743.347	| . |* . |
1972	176.300	-123.745	300.045	| . * . |

1973	201.300	-346.032	547.332
1974	335.900	-361.991	697.891
1975	383.500	-1244.23	1627.73
1976	471.800	-472.166	943.966
1977	537.000	-134.000	671.000
1978	561.600	-194.707	756.307
1979	638.400	115.184	523.216
1980	722.800	181.398	541.402
1981	711.600	-338.347	1049.95
1982	700.400	20.2409	680.159
1983	757.000	-535.189	1292.19
1984	815.600	-1107.59	1923.19
1985	900.000	189.207	710.793
1986	850.900	726.081	124.819
1987	1172.70	1390.90	-218.203
1988	1551.60	876.016	675.584
1989	2349.40	1897.60	451.798
1990	2628.50	3485.49	-856.995
1991	3210.70	3750.46	-539.757
1992	5068.40	5298.31	-229.914
1993	6376.90	7898.67	-1521.77
1994	5784.90	6721.05	-936.146
1995	5824.10	7071.80	-1247.70
1996	6105.80	8427.17	-2321.37
1997	6128.10	9855.16	-3727.06
1998	6150.00	9487.25	-3337.25
1999	26224.0	28183.2	-1959.24
2000	36509.3	41053.5	-4544.16
2001	42712.8	45140.3	-2427.54
2002	41599.5	53543.2	-11943.7
2003	53885.7	49623.0	4262.72
2004	69367.5	53494.0	15873.5
2005	61626.6	57651.1	3975.50
2006	47742.6	52472.8	-4730.19
2007	61626.6	55412.6	6214.04
2008	54684.6	51659.3	3025.28
2009	58155.6	60654.5	-2498.86
2010	56420.1	55870.5	549.577
2011	57287.8	58312.1	-1024.28
2012	56854.0	57842.2	-988.206
2013	57070.9	60179.9	-3108.97