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Strategies to Improve Demand for Services in the Social Health Insurance Programme: Nigerian Enrollee Perspective

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Abstract

Globally, the World Health Organization has championed the introduction of various forms of health insurance as a means of improving the utilization of quality healthcare service which is targeted at achieving universal health coverage. Unfortunately, the operations of the Social Health Insurance Programme (SHIP) have witnessed inefficiencies in the demand for healthcare services as a result of moral hazard and this is evidenced by the non-achievement of set-out objective of the programme in Nigeria. **Design/Methodology:** The study adopted a qualitative approach which comprised of 3 focus group discussions (N=24). Key informants were purposely selected for the focus group discussion from three (3) purposively selected hospitals, one from each categorized type of facility. Content analysis was adopted and further analysis was achieved with the aid of Nvivo 11 software, which coded and categorized nodes into themes. **Results:** The focus group participants relayed their experiences in the programme which includes poor identification system, choice of only one provider except on emergency, benefit package not being comprehensive which has enabled moral hazard and suggested ways to improve it. **Conclusions:** Most of the enrollees do not show diligence in areas of demand for services and these were shown to emanate principally from economic issues around the enrollees desire to utilize the premium paid thereby leading to moral abuse. Therefore, certain measures need to be put in place so as to curtail observed market failures in the SHIP programme.

Keywords: Demand for health services; Social National health insurance programme; Moral hazard; Market failure

1 Introduction

The social health insurance programme (SHIP) was launched in May 1990 in Nigeria with the objective of improving demand for quality healthcare services and this is in line with the global trend (Onoka, Onwujekwe, Uzochukwu, & Ezuma, 2013; Osungbade, Obembe, & Oludoyi, 2014). The SHIP comprises both an informal and formal sector components. The informal sector part consists of individuals who are not in any formal employment while the formal sector part of the programme takes care of the healthcare needs of employees in both the public and private sectors. This formal sector comprises federal public servants, organized private sector workers, police, armed forces and other uniformed security outfits. In the public sector (federal civil servants), the premium is paid for by pooling 5% of employee's consolidated salary and employer's 10% contribution. In the private sector and other tiers of government, the employee pays 5% of basic salary while the employer makes 10% contribution into the pool. However, the whole contribution may be made by the employer and also, employees who may decide to use extra service will have to make extra contribution (NHIS, 2015). The market of the social health insurance programme is perceived to have performed below average standard notwithstanding the huge budgetary allocations and increasing governmental expenditures over the years. The impact of the programme on the morbidity and mortality indices in the country has not been appreciable and presently only about 4-5% of Nigeria citizens are being covered by the programme (Uzochukwu et al., 2015).

This perceived market failures in the programme has been attributed to insufficient knowledge of the health insurance activities by employees and it is seen to be one of the major causes of current coverage being below 20% of the intended population in the formal sector (Lagomarsino, Gavebrant, Adyas Otoo & Murga, 2012; Osungbade et al., 2014); enrollee misunderstanding of health insurance concept, skepticism and distrust of the health insurance programme are all affecting the social health insurance market (Katibi ,Akande, & Akande, 2003; Adewole, Adebayo, Udeh, & Shaahu, 2015). Sentiments as a result of enrollees past bad experiences with other solidarity arrangements have affected their attitude in the programme (Adewole et al., 2015). Also, enrollees have complained about inefficient service delivery and how some healthcare providers are charging extra fees for services that are ordinarily covered by the programme (Lagomarsino et al., 2012).

Other attributed factors that has contributed to failures in the market includes unfavourable experiences of the enrollees in the programme as a result of inadequate drug supply, delays in receiving required services (Onyedibe, Guyit & Nnadi, 2012; Daramola, Maduka, Adeniran & Akande, 2017; Mitiku & Geberetsadik, 2019). These unfavourable experiences among the enrollees have made them to be dissatisfied with the programme in the country and thereby have resulted in enrollee abuse.

In addition, lack of confidence in institutional capacity, ability of managers of the programme to follow through, perception, attitude and cultural resistance related to accessing healthcare services have influenced greatly the demand for health insurance services (Basaza, Criel & Van der Stuyft, 2008; Adewole et al., 2015). Individual attitude and valuation of health

insurance are fundamental challenges facing improvement in demand for services in the programme and subsequently this has a great implication in achieving the universal health insurance coverage (De Allegri, Sanon & Sauerborn, 2006).

These scenarios' have resulted in the enrollees either not seeking for healthcare services at all or seeking for it in alternative places which consequently increase out of pocket expenditure. However, the insured enrollees that seek healthcare services in the programme tend to indulge in risky behaviors which ordinarily they would not undertake if they were paying for the healthcare services themselves. This situation has led to enrollees utilizing healthcare services more than required and the cost of healthcare services transferred to the health insurance companies (Onwujekwe, Uzochukwu, Ezeoke & Uguru, 2011).

Another situation regarding enrollee moral hazard is the non-disclosure of all the relevant preexisting conditions by the enrollee to the provider (Stavropoulou, 2012; Onwujekwe et al., 2011) especially when the enrollee feels that these may bias the health insurance services they will receive from the provider.

These inefficiencies have resulted in failure in the health insurance market, hence, the purpose of this study which is therefore to deduce ways of improving the demand for health insurance services in the social health insurance programme (SHIP) in order to achieve the universal health as envisioned by the government of Nigeria.

2. Methodology

2.1 Study Area

The study was carried out in Enugu State and it has an estimated population and land mass of 3,257,298 million and 7,618 km respectively. The state is bounded on the south by Imo and Abia states, east by Ebonyi state, west by Anambra state while on the north by Kogi and Benue states (National Population Commission, 2006).

2.2 Study Design

The study design adopted for this study is a qualitative design with a focus group discussion (FGD) component. The design is deemed appropriate for this study because it provided the respondents' opportunity to widely express their views on ways to improve demand for health insurance services in the social health insurance programme.

2.3 Sample Size/Instrument for Data Collection

FGD was chosen for this study because it rapidly generates adequate data on issues of interest (Creswell, 2009); it is regarded as appropriate method for evaluating attitudes and experiences within the field of healthcare (Barbour, 2007; Berland, Natvig & Gundersen, 2008); evidently it has the capacity to enable the participants to react to what others said and increase range of views on phenomenon of interest (Creswell, 2009).The FGD was conducted to elicit information from three purposively selected hospitals (one government hospital, one mission hospital and one private hospital). Thereafter, 24 enrollees that were registered in the selected hospitals were chosen by purposive sampling technique (government owned facility

with 9 participants, mission owned facility with 8 participants and privately owned facility with 7 participants). About 6 to 12 participants per focus group were deemed appropriate for a focus group to foster inclusion of all group members (Onwuegbuzie, Leech & Collins, 2010).

A focus group discussion guide was designed to ensure similar themes were explored in all discussions and equally used to direct focus group discussion. The discussion guide was developed based on set objective in this study and was refined inductively during data collection. The questions focused on the different modes of proper identification in the programme, issuance of authorization code for access, enrollee characteristics on attitude, provider characteristics on acquisition of diagnostic equipment, provider characteristic on availability of prescribed drug, access to chosen provider, enrollee characteristics on benefit package.

2.4 Validity of Instrument

Face and content validity technique were utilized in the study. Ambiguous statements were removed and corrections made were used to modify final statements. In the content validation, the relevance of the items were evaluated using a rating scale

2.5 Reliability of Instrument

The focus group questions were pre-tested on group of respondents from selected Government owned, missionary and privately owned hospitals in Awka, Anambra state. A test retest method at interval of 2 weeks was done for the qualitative instruments and the responses were computed using Pearson product moment correlation coefficient formula. A coefficient reliability of 0.72 was obtained for the instrument and these therefore showed that the instrument was reliable.

2.6 Procedure for Data Collection

The FGDs were held in three purposively selected stratified hospitals with a total of 24 enrollees purposively selected (government owned facility with 9 participants, mission owned facility with 8 participants and privately owned facility with 7 participants). The FGDs were held at conducive and spacious venues in the respective hospitals chosen in consultation with the participants. FGDs began by the purpose of the study fully explained to the participants; informed consent was obtained from participants for their participation and recording of the discussions. The participants were assured of confidentiality of data obtained from them, and ground rules were thereafter set. The discussions were conducted in English language. The researcher moderated the focus group discussions while an experienced research assistant based at Medserve consulting services served as a note taker. All the focus group discussions lasted about 50-60 minutes since a well-designed focus group lasts between 1-2 hours (Creswell & Clark, 2011).

After each of the three discussions, the audiotape was replayed to the participants to know whether it captured their experiences and then afterwards each audiotape discussion was saved in a pass worded computer with appropriate label and dates.

2.7 Qualitative Data Analysis

Qualitative content analysis was adopted for this study and verbatim transcription of the audiotapes of the focus group discussions were prepared so as to capture the views of participants in their own words. Inductive strategies were used to develop codes. Inductive code development was done by reading through one FGD transcript, and assigning codes to emerging themes (Boyatzis, 1998). Following removal of all personal identifiers, transcripts were imported into NVIVO 11 software (QSR International Pty LTD, 2015). Eight Nodes or containers were created respectively in Nvivo software. An initial analysis was done by performing a similar word frequency and it was depicted as a word cloud which showed the kind of words participants used and how often they were used. In addition text search command was performed resulting in creation of word tree which showed words and phrases before and after the searched word. The significant information captured was put inside a container called nodes. In vivo coding method was used to code relevant information and it involves labeling each node created, providing a brief description and documenting reflections. An expert in qualitative analysis based at Medserve consulting services validated coding process and consensus were built on areas of inconsistent coding. The codes were then categorized into big containers called parent codes based on their similarities and relationships. The big containers or themes were used to address the research topic. The findings were thereafter presented based on the themes.

2.8 Ethical Consideration

Ethical approval for this study was obtained from the Ethics Committee of State Ministry of Health, Enugu. Informed consents were gotten from the participants. Personal and institutional identifiers were removed from the transcript to ensure anonymity. Codes were used to identify participants. With the aid of ethical approval and introduction letter from the Head of Department, administrative permit was obtained from the Management of the hospitals to conduct the interviews.

3. Results

The themes that emerged from the focus group discussions were access at the point of service, enrollee income, enrollee characteristics on attitude, issuance of authorization code for access, provider characteristic on diagnostic equipment, provider characteristic on prescribed drugs, access to chosen provider and enrollee characteristics on benefit package

- Access at the Point of Service

There was a high perception among the respondents that improper identification of enrollees occasioned by non-provision of NHIS identification card has affected access to health insurance services. They mentioned that there are policies in place in the programme that warrants issuance of identification cards after the enrollee forms have been fully processed and provision of comprehensive list of enrollees to the providers. The participants believed that if policies that will allow for the use of other forms of identification like the national identification card, staff identity card were put in place they will help in reducing the difficulties enrollees experience during accessing health insurance services and it will

invariably improve enrollee demand for health insurance. A participant put it succinctly (FGD Private)

"We experience a lot of hardship because the hospitals most of the time do not have the records for proper identification of enrollees but some hospitals when any form of Identity card is shown and it is cross checked with their list they will now attend to you"

However, few participants revealed that some enrollees demand health insurance services for non-enrollees. The participants claimed that it was possible to demand for health insurance for non-enrollees because of improper identification of enrollees at the point of service. This situation has led to non-enrollees accessing health insurance services from the limited pooled resources. As stated by one of the participants (FGD, Mission)

"If the people that are not supposed to use this services continue in this regard, the programme will definitely collapse from their action"

- Enrollee Income

Majority of the focus group participants stated that there was a policy in place which states that the only payment enrollees make is the ten percent co-payment for drugs and fifty percent co-insurance for high level investigations, *'that is what we were informed severally during NHIS organized forums"* (FGD, Mission). The participants stated that hospitals usually tell them to pay for healthcare services which they do not understand the reason for the payments. However, some of the respondents agreed that the removal of every form of payment from the programme will make the hospitals not to demand for unauthorized payments and will definitely influence their demand for health insurance service. Another reason adduced by participants was that non review of their salary upwards by the government to reflect the harsh economic realities of the day will influence their demand for health insurance. As one of the enrollees observed (FGD Government).

"Whenever, l come to the hospital, they usually demand for different kinds of payments from me and as a result, l have decided to be using the services often so as to gain all they are deducting from my salary"

However, majority of the respondents believed that removing all forms of payments from the programme will lead to serious abuse by the enrollees. Therefore, they advocated for introduction of waiver system like sliding fee, fee waiver and exemption programme, voucher health cards with fixing the number of hospital visits in a year. One of the respondents captured it this way (FGD, Mission)

"If payments of any form are removed from the programme…. I can tell you my people will abuse it….. I know them"

- Issuance of Authorization Code for Access

Majority of the participants agreed that the issuance of authorization code before referral is made should be abolished because it takes a long time before the pre authorization codes are granted by the HMOs. However, the participants noted that for hospitals that have both

primary and secondary levels of care, they usually access secondary treatment without waiting for authorization codes. One of the participants captured the situation aptly (FGD, Mission)

"Most of the time when I come to the hospital it takes between one or two days for me to get the authorization codes for treatment and the hospitals will not treat me until they see the authorization code"

Another participant put it this way (FGD, Private)

"I believe, it is better for all the cases to be on fee for service, so that the authorization codes will not be needed again and the hospitals will be paid whenever an enrollee goes to hospital"

Similarly, another participant stated thus (FGD, Government)

"Let the hospitals use a point of service based machine (POS) so that when a patient comes to hospital and slots the identification card it registers the services the enrollee accessed immediately with the HMO"

Also, majority of the participants believed that the complete removal of authorization codes will lead to abuse by the enrollees. The participants stated that even now that all cases are authorized before referral, some enrollees and hospitals connive and treat the cases and subsequently revert to HMOs many days or weeks after treatment. As observed by a participant (FGD, Mission).

"Our people have abused many government programmes, so this one will not be an exception. It is better we continue with the authorization of cases but the regulatory body should sanction defaulting HMOs"

It was agreed upon by most of the participants that it is best to use POS based machine and equally fix the number of hospital visits in a year.

- Enrollee Characteristics on Attitude

There was a consensus among the participants that the demographic characteristics of the enrollees have affected the demand for health insurance services. The participants emphasized that the attitude of the enrollees were not encouraging especially the less educated ones in the government hospitals, *'' they will not wait for their names to even be cross checked with the list or cross checked with the HMOs to be sure that their names are correct"* (FGD, Government)

The participants adduced that maybe the less educated enrollees were not conversant with the operational guideline or are not sanctioned by the relevant authorities. One of the participants said (FGD Private)

"If these enrollees know that if they are not behaving properly in the programme, they will be penalized severely, they will not be behaving this way"

Also, the participants noted that the non challant and pessimistic attitude of the less educated

enrollees toward the programme extends to presenting non-enrollees for treatment and frequent hospital visitation .As stated by one of the participants (FGD, Private)

"I learnt that the hospitals are supposed to send an encounter data to the HMOs on a monthly basis…. I can tell you that if you check the data the names of the less educated enrollee will constitute more than 50% of enrollees that frequent the hospitals"

The participants unanimously agreed that the attitude of the enrollees is key to improvement in the demand for health insurance services. The participants therefore advocated for a pay for performance initiative for the enrollees. The participants believed that this will motivate the providers to improve in their attitude. As captured aptly by one of the participants (FGD, Mission)

"Rewarding the enrollees that have behaved well in the programme will go a long way in making them to work better and equally influence other enrollees"

Similarly, the participants advocated for strict monitoring of enrollee demand for health insurance service by the regulatory body through the use of encounter data. In addition, the application of the penalties for abuse of health insurance services should be put in place.

- Provider Characteristics on acquisition of Diagnostic Equipment

It was agreed among the groups that the hospital especially the private ones have not done well in the area of having the required diagnostic equipment and the manpower to operate them, *''it is a pity that most of the private hospitals do not have the most basic diagnostic equipment"* (FGD, Private). The discussion revealed that for the demand for health insurance services to be improved, the hospitals must have diagnostic equipment operational at all times and the operators of that diagnostic equipment must have requisite skills to operate them. The discussants noted that the enrollees frequently demand for referral to secondary and tertiary hospitals because the private providers do not have the basic equipment and the manpower to operate them. The discussants therefore believed this have led to abuse from both the enrollees and the providers. As captured by one of the participants (FGD, Private).

"I have frequently demanded to be referred to the teaching hospital to do simple tests….. I rather demand to be referred as often as possible than die in these private hospital"

Also, the participants agreed that there should be routine and strict quality assurance to be performed by the NHIS/HMO officials and subsequent removal of the accreditation given to offending providers and suspension of erring enrollees from the programme. One of the participants summarized it thus (FGD Mission)

"It is important that these equipment are available and functioning so that people will not frequently abuse the referral system due to lack of diagnostic equipment and manpower"

- Provider Characteristics on Availability of Prescribed Drugs

Most of the focus group participants indicated that they were not given all the drugs especially in the government owned hospitals and even the ones given were of poor quality. According to them, this accounted for one of the main reasons for the demand for health

insurance services. The participants revealed that by visiting the government owned providers frequently, all the medications they required will completely be given to them. As captured aptly by one of the participants (FGD, Mission)

"I have to be going to the hospitals often and if possible bring my relatives to collect drugs too, so as to cover the money they collect from my salary"

Similarly, it emanated from the group that hospitals request the participants to pay fully for drugs if they want quality drugs. As stated by one of the participants (FGD, Government)

"For demand for health insurance services to be improved…. Strict monitoring of the way drugs are given must be done by the relevant bodies….. if not the situation of things now will keep getting bad'

However, the participants unanimously agreed that there is a need for strict monitoring and evaluation of quality of drugs by the NHIS/HMO officials so as to improve the trust the enrollees have on the health insurance programme which will invariably impact on their demand for services. One of the participants captured it succinctly (FGD, Private)

"If the relevant authorities do their work diligently, the abuse will reduce drastically"

- Access to Chosen Provider

The respondents were aware that only one provider is chosen but can access other providers on emergency. The participants observed that the use of only one provider have limited their demand for health insurance services. They advocated for enrollees to access any provider anywhere and whenever services are needed. As captured by one of the participants (FGD Private)

"Because l chose a hospital near my place of work, whenever any of my family members or l is sick in the house, we usually do not demand for health insurance services. I therefore pay from my pocket to treat them because my chosen provider is far from my house"

Due to this limited choice of providers, the participants revealed that they frequently claim to be having emergency conditions and often present as emergencies to the providers and thereby leading to more demand for health insurance services. A participant stated thus (FGD, Government)

"Since they limited us to one hospital, we will continue to frequently present as emergencies to the hospitals"

The participants advocated for enrollees to access any provider anywhere and whenever services are needed. They advised on the need to introduce point of service (POS) based machine which will function in monitoring and keeping records of demand for health insurance services. As one participant puts it (FGD, Government)

"The use of point of service (POS) based machine have changed the banking system in Nigeria…… I believe its use in health insurance will do the same"

- Enrollee Characteristics on Benefit Package

There was a unanimous agreement across the focus group members that benefit package captured most of the disease conditions. However, the participants still advocated for the services which excluded many services for female enrollees to be removed. They mentioned that the excluded services should be limited only to cosmetic surgery and treatment of epidemics because these will invariably improve demand for health insurance services. As a participant said (FGD Government)

"Since the government is the one paying for the programme, let all disease condition be treated and this will definitely improve the demand for these services in the health insurance programme"

Also, majority of the participants pointed out that the female enrollees who demand for health insurance services tend to have health conditions that are partially or totally excluded. As a result, these female enrollees tend to demand for health insurance services for their relatives, this is an attempt to utilize the money they deduct from their salary. One of the participants put it this way (FGD, Private)

"I need to recover all the money they deduct from my salary even if it involves using my relatives to do it"

However, the participants suggested that in removing the exclusion, the number of hospitals visits should be fixed. As stated by one of the participants (FGD, Government)

"Let them remove the exclusion and fix the number of hospital visits in a year"

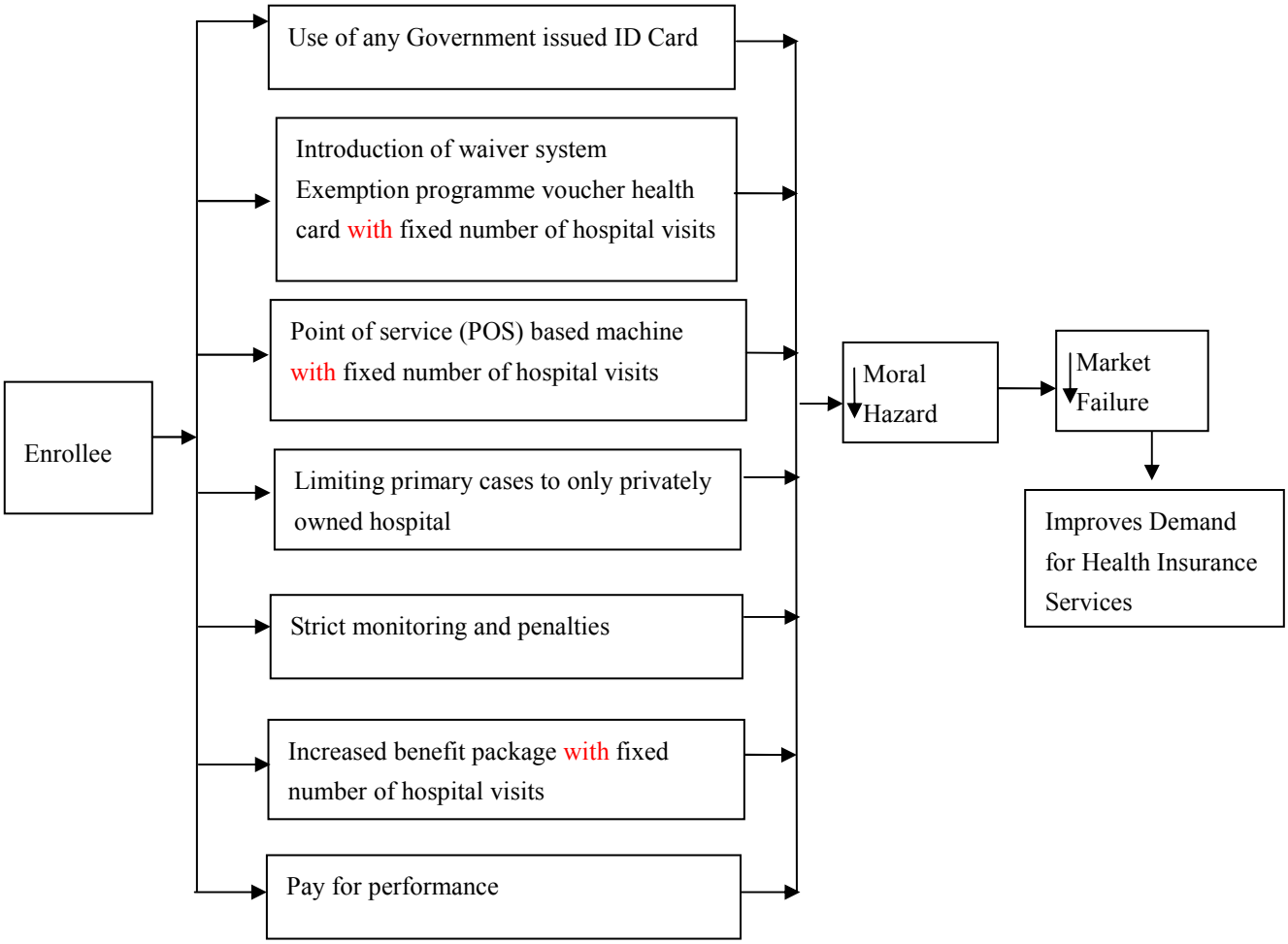

Figure 1. FGD Participants' Proposed Strategies on Improving the Demand for Health Insurance Services

This conceptual framework was developed from the responses of the participants in the focus group. In the conceptual framework, the participants concluded that to improve the demand for health insurance services in the social health insurance programme (SHIP), a major cause of market failure in health insurance in health insurance industry, which is moral hazard must be eliminated or reduced. The following measures were advocated by the participants in the study

- Use of other Government issued Identity card

The participants advocated for the use of government issued identification. They advocated that the use of National ID card, Staff ID card will not only eliminate inaccessibility to health insurance services but also improper identification. It emanated from the participants that due to improper identification of enrollees in the programme, non-enrollees access health insurance services in connivance with the enrollees who are their relatives.

So, proper identification will eliminate moral hazard caused by both inaccessibility to health insurance services and improper identification with attendant reduction in non-enrollees accessing healthcare thereby reducing market failure and subsequent improvement in demand for health insurance services.

- Point of Service (POS) Based Machine and Fixing of Hospital Visitation

Similarly, according to the participants The POS based machine will help in tracking enrollees demand for health insurance services with any provider. As indicated by the participants, limiting the enrollees to one provider have led to the enrollees presenting frequently to providers as emergencies.

The participants therefore proposed use of the POS based machine which will track enrollee presentation at any hospital and fixing number of enrollee hospital visitation in a year. These will greatly reduce the frequent presentation at the provider thereby eliminating moral hazard which will subsequently lead to reduction in market failure and then improve the demand for health insurance services

- Introduction of Waiver System, Exemption Programme or Voucher Health Card and Fixing Number Hospital Visits

The introduction of waiver and exemption system with corresponding fixing number of hospital visits according to the participants will help the enrollees to offset the coinsurance and copayment considering the fact that their income is fixed with no increment for a long time. However, the participants' advocated fixing number of hospital visits in a year with the application of the waiver system, exemption programmes or voucher health card. This will reduce the incidence of moral hazard with attendant reduction in market failure and subsequently improve demand for health insurance.

- Strict Monitoring and Penalties

The participants proposed strict monitoring of enrollee demand for health insurance by the regulatory bodies which can be influenced by enrollee demographic characteristics and using the encounter data to monitor enrollee frequent request for drug treatment. The participants advocated for application of appropriate punishment to erring enrollees which will serve as a deterrent to others.

All these will help in the elimination of moral hazard incidences and subsequently reduce market failure and then lead to improvement in demand for health insurance services.

- Increasing the Benefit Package with Fixing of Number of Hospital Visits

Increasing the benefit package with fixing of number of hospital visits in a year was advocated as one of the measures to eliminate moral hazard which will lead to a reduction in market failure and then subsequently improve demand for health insurance services. Enrollees were said to have presented non-enrollees to demand for health insurance services because their own health challenges were under partial or total exclusion and as a result non-enrollees were presented to utilize the services so as to offset deductions in their salary.

- Limiting Primary Care Services to only Privately-owned Providers

Providers' ownership was revealed to have greatly influenced the enrollment into chosen provider. The mission-owned and government-owned providers tend to have majority of the enrollees leaving out the privately-owned providers with little or no enrollees. These enrollees frequently demand for health insurance services at the mission-owned and government-owned providers because of the availability of many specialist healthcare workers. This situation has resulted in abuse by the enrollees. Therefore, the participants proposed limiting primary care services to only privately-owned providers as a measure to counteract it. This will lead to elimination of moral hazard in the system and subsequently reduce market failure and thereafter improve demand for health insurance services.

- Pay for Performance

This measure is an attempt to motivate the enrollees that behaves well in the course of demanding for health insurance services. As the well behaved enrollees are rewarded for their action, it will then serve as an inspiration for other enrollees and then subsequently will lead to elimination of moral hazard which will then be followed by reduction in market failure and finally improvement in demand for health insurance services.

4. Discussion

Market failure involves the inability of the health insurance system to efficiently meet up with its set out objectives. These objectives are therefore the delivery of quality and efficient services to the consumers and the non-abuse of these services by the consumers (Onwujekwe et al., 2011).

The participants in this study identified inaccessibility to health insurance services due to non-provision of NHIS identification card and improper identification of enrollees as a factor affecting the demand for health insurance services and have contributed significantly to the moral hazards in the market because non-insured individuals are utilizing the services in the programme in connivance with the insured. Hence, they advocated for the use of any government issued identification card in the programme. The responses elicited in this study tallies with Khorasani, Keyranara, Eternadi, Asad, Mohammadi and Barati (2011) findings in Iran that examined insurance company's point of view toward moral hazard using a qualitative research method. Sample was selected through purposive method and comprised all the experts in basic healthcare insurance agency. Data were collected through semi-structured interviews and analyzed using inductive and thematic technique. The findings from the study showed that uninsured people were freely making use of insured people insurance identification in requesting for physicians' prescription of medication and this have significantly led to the moral hazard experienced in the industry which subsequently led to failure in the market. However in contrast, the study recommended that the role of religious beliefs should be highlighted in the society and the introduction of waiver and exemption system should be encouraged.

According to Onwujekwe et al. (2011), another cause of market failure is the providers overbilling of services rendered to the enrollees which is not stipulated in the tariff structure

approved for the programme. Similarly, the respondents in this study complained of making a lot of payments in the course of accessing healthcare services and it has greatly affected their demand for health insurance and subsequently makes them to utilize the services more frequently so as to exhaust the premium paid for their coverage. This situation has invariably impacted negatively on the health insurance market resulting in the market not achieving the targeted objective. Hence, the respondents advocated for total removal of all forms of fee payment. In the same vein, Bajari, Hong, Khwaja and March (2005) in Pakistan examined moral hazard, adverse selection and health expenditure using a two-step semi – parametric approach to identify and estimate failure in health insurance market. The result indicated a significant evidence of moral hazard due to unplanned healthcare expenditures but evidence of adverse selection was lacking in their findings. The study therefore concluded that consumers who demand the least health insurance services within a stipulated health plan are the most elastic with respect to paying co-payments for services rendered to them.

Also, the responses elicited in this study concurs with the findings of Bitran and Giedion (2003), Witter (2009) and Opwora et al., (2015) which showed that majority of the low and middle income countries (LMIC) in their various studies were still using user fees as a means of funding their healthcare systems. These studies indicated that the problem these groups of countries encounter were usually issues around equitable access to healthcare services and this have led to the failures in their health insurance markets. In addition, it was observed that countries that have implemented different forms of waiver system like sliding fees, fee waiver and exemption programmes, vouchers, health cards and health equity fund have successfully eliminated user fees (Bitrain & Giedian, 2003; Witter, 2009) unlike countries that have introduced fee reduction policies which have become unsuccessful (Opwora et al., 2015). All these programmes have been shown to have addressed the challenges from moral hazard and invariably impacted positively on demand for services.

The focus group respondents unanimously agreed that there are serious delays in Health Maintenance Organizations (HMOs) authorization of cases for secondary and tertiary referrals and have led to abuses in the industry. This finding is consistent with the opinion of the in-depth interview participants in Onoka, Hanson and Mills (2016) who also observed delays and difficulty accessing HMOs to obtain preauthorization codes for their enrollees. The focus group advocated for removal of all forms of authorization while Onoka et al., (2016) findings concluded on strict adherence to the NHIS operational guideline and penalty for defaulting HMOs. In the course of finding solutions to the problem of moral abuse in the demand for services, Meesen (2018) showed that the management of the insurance scheme has been made more efficient through the use of digital technologies that support enrolment, referral, renewal, claims and feedback. The insurance management information system (IMIS) specifically addresses the insurance challenges in both the formal and informal sector and is flexible to meet different user needs and technical requirement. This finding is therefore consistent with the opinion of the respondents in this study.

Okoronkwo, Onwujekwe and Ani (2014) in their finding showed that majority of their respondents agreed that the provision of essential health service packages which consist of mostly cost effective packages have made them to demand for more health insurance services.

The study tallies with the findings in this study that indicated that the respondents agreed that the benefit package captured most of the disease conditions but however fails to capture disease conditions peculiar to women. Hence, fewer number of the focus group discussants still want coinsurance to be removed from the partially excluded services and that total excluded services should be limited to only cosmetic surgery and epidemics. The views of the group were that these actions will improve demand for health insurance services in the country with consequent reduction in the incidence of moral hazard.

Again, the NHIS (2015) operational guideline states that enrollees will access only one provider for health insurance services but can access any provider during emergency. However, contrary to the stipulations of the NHIS operational guideline (2015), the focus group discussants indicated that demand for health insurance service will improve if access to more than one healthcare provider is allowed. They alluded that their frequent demand for emergency services is occasioned by access to only one provider. They therefore advocated for enrollees to access any provider anywhere and whenever services are needed. Findings from Onoka et al., (2014) indicated that having several providers might impact negatively on the monitoring of utilization and cost reduction. However, Meesen (2018) showed that using digital technologies for referral, renewal, enrolment, claims and feedback can be used to improve monitoring.

The focus group discussants concluded that the attitudes of the enrollees were not encouraging and observed that it may be because the enrollees were not sanctioned by the relevant authorities and in addition advocated for the introduction of incentive mechanisms in the programme. This finding is consistent with Eljkenaar et al (2013) study that similarly proposed a pay for performance initiative and also involves having a legal arrangement with hospital staff to render a range of specified health services to a group of people. This form of incentive invariably motivates the enrollees who thereafter improve interpersonal relationship with the providers which subsequently impacts on demand for health insurance services.

Finally, availability of the prescribed drugs in the hospitals will definitely improve the demand for health insurance (O'Malley, Fletcher, Fletcher & Earp, 1993; Brawley, 2000; Akande, Omotosho & Nurudeen, 2005; Daramola et al., 2017) and this is collaborated by Akeem, Adedoyin and Olasunmbo (2014) in their findings that showed majority of the respondents in their study indicated their willingness to demand for health insurance services due to the improvement in the quality and availability of drugs. Similarly, both studies respectively advocated for strict monitoring and measurement of quality of drugs by NHIS/HMO so as to improve the trust the enrollees have on the health insurance program which invariably will impact on their demand for services.

5. Conclusion

The findings in this study revealed the challenges encountered by the focus group discussants in the programme which includes poor identification system, restriction on provider useage except on emergency, incomprehensive benefit package, inefficient referral system, inadequate diagnostic equipment and all these have led to their various reactions as depicted.

A conceptual framework of participants proposed framework for limiting the market failure resulting from moral hazard (abuse) was developed and it includes the use of POS-based machine, pay for performance, use of waiver and exemption system, use of other forms of identification, making the benefit package more comprehensive and strict monitoring of the activities of other stakeholder. The findings in this study will therefore serve as a guide, implementation tools, and reference documents to the Government of Nigeria and National Health Insurance Scheme (NHIS) while reviewing, formulating and implementing relevant strategies on how to improve the demand for health insurance services by the enrollees in the programme which eventually will reduce the perceived market failures in the programme

6. Recommendation

Following the result of this qualitative study and the conclusion arrived from the study, the following actions are recommended:

1) The government will need to initiate policies to strengthen extant polices that will allow for the use of other forms of identification like the national identification card or staff identity cards, so as to reduce the problem encountered as a result of non-provision of NHIS identification card.

2) To increase demand for health insurance, the policy makers or the government will put measures to check for unauthorized payments made by the enrollees in the programme.

3) There should be maintenance of quality assurance and removal of accreditation of offending providers. This is to encourage improvement in the demand for health insurance services.

4) Government should ensure checks that will promote the availability and quality of prescribed drugs. This will also improve the demand for health insurance.

5) The benefit package to be made more comprehensive by including some presently excluded services. This will improve the demand for health insurance by the enrollees.

6) Also, use of technology (Point of service based machine) should be encouraged to enhance efficiency in the areas of referral, enrolment, claims, identification of enrollees.

7) Similarly, waiver system, exemption and pay for performance programmes with fixed number of hospital visits should be introduced so as to encourage improvement in the demand for health insurance services.

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References

Adewole, D. A., Adebayo, A. M., Udeh, E. I., Shaahu, V. N., & Dairo, M. D. (2015). Payment for healthcare and perception of the national health insurance scheme in a rural area in Southwest Nigeria. *American Journal of Tropical Medicine and Hygiene*, *93*(3), 648–654.

https://doi.org/10.4269/ajtmh.14-0245

Akande, T. M., Omotosho, I. M., & Nurudeen, H. (2005). Perception of patients on quality of health care services at a teaching hospital in Ilorin, Nigeria. *European Journal of Scientific Research*, *11*, 1.

Akeem, A. A., Adedoyin, S., & Olasunmbo, O. (2014). Artisan reactions to national health insurance in Lagos state, Nigeria. *Journal of Global Health System*, *4*, 1–3.

Bajari, P., Hong, H., Khwaja, A., & March, C. (2009). Moral hazard, adverse selection and health expenditure: a semiparametric analysis. *Cambridge Journal Online*, *4*, 24–30.

Barbour, R. (2007). *Doing focus groups*. Thousand Oaks, CA: Sage Publications. https://doi.org/10.4135/9781849208956

Basaza, R., Criel, B., & Van der, S. P. (2008). Community health insurance in Uganda: why does enrolment remain low? a view from beneath. *Health Policy*, *87*, 172–184. https://doi.org/10.1016/j.healthpol.2007.12.008

Berland, A., Natvig, G. K., & Gundersen, D. (2008). Patient safety and job-related stress: a focus group study. *Intersive Critg Care Nurs*, *24*(2), 90–97. https://doi.org/10.1016/j.iccn.2007.11.001

Bitran, R., & Giedion, U. (2003). *Waivers and exemptions for health services in developing countries*. *Social Protection Discussion Papers Series* Paper no. SP 0308. Washington, D.C.: The World Bank. Retrieved August 17, from http://documents.worldbank.org/curated/en/763021468761984508/Waivers-and-exemptions-for-health-services-in-developing-countries

Boyatzis, R. E. (1998) *Transforming qualitative information: Thematic analysis and code development*. Thousand Oaks, CA: Sage Publications.

Brawley, M. (2000). The client perspective, what is quality health care service. *Medwell Journals*, *4*(2), 143–148.

Creswell, J. W. (2009). *Research design: Qualitative, quantitative, and mixed methods approaches.* Thousand Oaks, CA: Sage Publications.

Creswell, J. W., & Clark, V. L. P. (eds.) (2011). *Designing and conducting mixed methods Research*. Thousand Oaks, CA: Sage Publications.

Daramola, O. E., Maduka, W. E., Adeniran, A., & Akande, T. M. (2017). Evaluation of patients, satisfaction with service accessed under the national health insurance scheme at a tertiary facility in North Central, Nigeria. *Journal of Community Medicine and Primary Health Care*, *29*, 1.

De-Allegri, M., Sanon, M., & Sauerborn, R. (2006). To enrol or not to enrol? a qualitative investigation of demand for health insurance in rural West Africa. *Social Science and Medicine*, *62*, 1520–1527. https://doi.org/10.1016/j.socscimed.2005.07.036

Eljkenaar, F., Emmert, M., Scheppard, M., & Schoffski, O. (2013). Effects of pay for performance in healthcare: a systematic review. *Health Policy*, *110*(23), 150–180.

Katibi, I. A., Akande, A. A., & Akande, T. M. (2003). Awareness and attitude of medical practioners in Ilorin towards the national health insurance scheme. *Sahel Med J*, *6*, 3. https://doi.org/10.4314/smj2.v6i1.12819

Khorasani, E. J., Kegvanara, M., Etemadi, M., Somayeh, A., Mhammadi, M., & Barati, M. (2011). Insurance companies' point of view toward moral hazard incentives. *Journal of Medical Ethics and History of Medicine*, *9*, 12.

Lagomarsino, G., Garabrant, A., Adyas, A., Muga, R., & Otoo, N. (2012). Moving towards universal health coverage: health insurance reforms in nine developing countries in Africa and Asia. *Lancet*, *380*(9845), 933–943. https://doi.org/10.1016/S0140-6736(12)61147-7

Meesen, B. (2018). The role of digital strategies in financing healthcare for universal health coverage in low and middle income countries. *Global Health Science and Practice*, *6*(1), 29–40. https://doi.org/10.9745/GHSP-D-18-00271

Mitiku, K. K., & Geberetsadik, S. M. (2019). Household satisfaction with community-based health insurance scheme and associated factors in piloted Sheko district, Southwest Ethiopia. *Plos One*, *14*(5). https://doi.org/10.1371/journal.pone.0216411

NHIS. (2015). *Annual report of the national health insurance scheme*. Abuja, Nigeria: National Health Insurance Scheme.

NPC. (2006). *National census figures*. Abuja, Nigeria: National Population Commission.

Okoronkwo, I. L., Onwujekwe, O. E., & Ani, F. O. (2014). The long walk to universal health coverage: patterns of inequities in the use of primary healthcare services in Enugu Southeast Nigeria. *BMC Health Services Research*, *14*, 132. https://doi.org/10.1186/1472-6963-14-132

O'Malley, Fletcher, S., Fletcher, R., & Earp, J. (1993). Measuring patient waiting time in a practice setting: a comparison of methods. *Journal of Ambulatory Care Management*, *6*, 20. https://doi.org/10.1097/00004479-198308000-00006

Onoka, C. A., Hanson, K., & Mills, A. (2016). Growth of health maintenance organization in Nigeria and the potential for a role in promoting universal coverage efforts. *Social Science and Medicine*, *58*, 70–74. https://doi.org/10.1016/j.socscimed.2016.06.018

Onoka, C. A., Onwujekwe, O. E., Uzochukwu, B. S., & Ezumah, N. N. (2013). Promoting universal financial protection: constraints and enabling factors in scaling-up coverage with social health insurance in Nigeria. *Health Research Policy and Systems*, *11*, 20. https://doi.org/10.1186/1478-4505-11-20

Onwuegbuzie, A. J., Leech, N. L., & Collin, K. M. T. (2010). Innovative data collection strategies in quality research. *The Qualitative Report*, *15*(3), 696–726.

Onwujekwe, O. E., Uzochukwu, B. S., Ezeoke, O. P., & Uguru, N. P. (2011). Health insurance principles, models and the Nigeria national health insurance scheme. *International*

Journal of Medicine and Health Development, *16*, 1–3. https://doi.org/10.4314/jcm.v16i1.8

Onyedibe, K.I., Goyit, M. G. & Nnadi, N. E. (2012). An evaluation of the national health insurance scheme in Jos, North Central Nigerian City. *Global Advanced Research Journal of Microbiology*, *1*, 1.

Opwora, A., Waweru, E., Toda, M., Noor, A., Edwards, T., Fegan, G., … Goodman, C. (2015). Implementation of patients charge at a primary care facility in Kenya: implications of low adherence to user fee policy for users and facility revenue. *Health Policy Plan*, *30*(4), 508–517. https://doi.org/10.1093/heapol/czu026

Osungbade, K. O., Obembe, T. A., & Oludoyi, A. (2014). Users satisfaction with service provided under national health Insurance scheme in South Western Nigeria. *International Journal of Tropical Disease and Health*, *4*(5), 595–607. https://doi.org/10.9734/IJTDH/2014/7280

Stavropoulou, C. (2012). The doctor-patient relationship: a review of the theory and policy implications. In *The LSE Companion to Health Policy* (pp. 314–326). Cheltenham: Edward Elgar Publishing Limited.

Uzochukwu, B., Ughasoro, M. D., Etiaba, E., Okwuosa, C., Envuladu, E., & Onwujekwe, O. E. (2015). Health care financing in Nigeria: implications for achieving universal health coverage. *Niger J Clin Pract*, *18*, 437–444. https://doi.org/10.4103/1119-3077.154196

Witter, S. (2009). Service- and population-based exemptions: are these the way forward for equity and efficiency in health financing in low-income countries? In D. Chernichovsky & K. Hanson (Eds.), *Innovations in Health System Finance in Developing and Transitional Economies* (pp. 251–288). Bingley: Emerald Group Publishing Limited. https://doi.org/10.1108/S0731-2199(2009)0000021013

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