

Perception of Service Delivery by National Health Insurance Scheme Enrollees in South West, Nigeria

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Certification

This is to certify that Akande Lawrence Segun with matriculation number LCU/PG/001474 carried out this research work titled “Perception of service delivery by National Health Insurance Scheme enrollees in South West, Nigeria” in the Department of Information Management, Faculty of Communication & Information Science, Lead City University, Ibadan, Oyo State, for the award of Master Degree (M.Sc.) in Health Information Management and that this has not been previously submitted.

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Dedication

This research work is dedicated to God Almighty, the author and finisher of my faith.

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Abstract

National Health Insurance Scheme is recognised as viable means for achieving quality healthcare for all citizens at a cheaper rate. However, preliminary investigation has revealed that service delivery of National Health Insurance Scheme in Nigeria is perceived to be poor. These have adversely affected health service delivery which may lead to poor scheme coverage and rising dissatisfaction among enrollees. Hence, this study investigated the perception of service delivery by National Health Insurance Scheme enrollees in South West, Nigeria. Descriptive research design was adopted for this study. The population comprised of 77,321 enrollees of Federal, State and Corporate employees in Osun State. A sample size of 498 enrollees determined through Yamane sample size determinant served as the sample size of this study. Multi-stage random sample technique was used to select enrollees in selected towns. The reliability coefficient for the constructs of the study is: perception –0.85. Data collected was analysed using descriptive statistics. Findings revealed that service delivery of National Health Insurance Scheme lack quality, not always available, accessible and not generally affordable (3.14, 2.89, 2.91, and 2.94) respectively. Therefore, the study concluded that poor quality, availability, accessibility and affordability contributed to low level service delivery of National Health Insurance Scheme. In this regard, the study recommended that government should review policy on use of generic drugs, dedicated NHIS pharmacy shop, and make registration on the scheme compulsory for all private organisations.

Keywords: National Health Insurance Scheme; Service delivery; Enrolees; South West; Quality
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Chapter One

Introduction

1.1 Background to the Study

Nigeria as a nation has gone through different phases of healthcare policies in order to make health care services available, accessible, affordable and of good quality to people in grassroots and urban areas, policies such as building of teaching hospitals in 1958, later to development of Comprehensive Health care policy (1960-1975), then to Basic Health Services Scheme (1975-1985), further to Primary Health care policy in (1985), National Health Insurance Scheme, which came in force since 1999, which has now become a formidable means of achieving universal health care that is quality, accessible, available and affordable for the populace. Millennium Development Goal MDGs in 2015, all is to achieve health for all following the Alma-Ata Declaration of 1978 in Russia, "Health for all by the year 2000"¹.

Every attempt to provide adequate health care in Nigeria is bisected by many problems including; inadequate funding, inadequate manpower, poor infrastructure, these inadequacies are not always in quantity but in distribution, accessibility, and quality of the available resources. With all this trends of policies, National Health Insurance Scheme which is now being seeing as means of achieving available, accessible, affordable and quality health care service has only coverage of 5% of the Nigeria populace. This has had great effect on Nigeria economy, health status, development and growth and has deepened hardship condition of many Nigerian.

“Improving health outcomes through access to Universal Health Coverage also makes economic sense. When citizens cannot afford effective medical treatment, countries lose valuable human capital. Furthermore, as one of the largest sectors of the global economy, health drives employment creation and provides 50 million jobs worldwide, most of them for women. Not investing in sustainable and inclusive health strategies, on the other hand, carries considerable risks; including leaving countries vulnerable to the lasting social and economic impact of pandemics or health emergencies.”

National Health Insurance scheme is a social health insurance scheme aimed at providing universal health care coverage for all citizens in Nigeria, by providing ability to get health care services whenever, and wherever needed without having to pay at the time of need, either because payment has been made previously through regular contribution, by the insured or his or her employer.

At the inauguration of National Health Insurance Scheme in Nigeria, culled from the aims and objectives of the scheme, it aims at ensuring every Nigerian have access to good and standardized health care services, to ensure that every Nigerian has access to good health Services(accessibility), protecting families from the financial hardship of huge medical bills (affordability), limiting rise in cost of health care services (affordability), distributing care costs equitably among different income groups (availability),setting and monitor standards of health care delivery services (quality), ensuring effectively and efficiency in health care delivery services(quality),harnessing and improve private sector participation in the provision of health care services (accessibility),ensuring adequate distribution of health facilities within the federation (availability/accessibility),ensuring equitable patronage of

all levels of health care (accessibility),making funds to the sector for improved services (affordability)”².

What patients ought to want and are entitled to expect why registering on either national health insurance or corporate health insurance is good professional services of the highest quality of which is measured on the following: quality, accessibility, affordability, availability and equitability. Therefore, the researcher has made it a cogent purpose of this paper to evaluate health insurance scheme in Nigeria from the perspective of good health care parameters (Quality, accessibility, affordability, and availability).

Public often associates quality with unlimited access to care, and any limitation (e.g. refusal to cover certain types of care, partial coverage, refusal to refer a patient to a specialist, review of prescriptions or medical procedures), barriers to obtaining care, including waiting time and difficulty obtaining information or contacting the insurer (by phone or any other means available) is perceived by patients to strike a blow at care quality (dissatisfaction).

Despite all efforts by National Health Insurance Scheme and Health Maintenance Organization to ensure that patient on health insurance scheme are comfortable with the level of care services rendered by providers, it is becoming obvious that patients are not receiving the good services as they expect, owing to the following complaint from them: prescription of inferior drugs, lack of equitable service compare to service render to other patients who are not on health insurance scheme, non-proximity of standard health care providers, different benefits package for different category of people base on premium, introduction of copayment on some services, hostile reception from health care providers,

denial of access to some level of care at both primary and specialist level, does not reduce possibility of some diseases, disability and death as some diseases like cancer, infertility, stroke, injury from riot and high risk sport to mention but few are tagged exclusion from the scheme coverage.

Even, clients on health insurance scheme express their dissatisfaction in terms of the wards in which they were being hospitalized and foods given them during admission in the hospital shows that “all animals are not equal” there is discrimination between the manner of approach to clients on health insurance scheme and private patient on direct retainership within the hospital.

Quality is Health Insurance Scheme with robust health care benefits package, disburse by standard, competent and accredited health care providers (hospital) in the atmosphere of manner and behaviour that is acceptable according to professional norms and as perceived by the users. Health care quality is the degree to which health care services for individuals and populations increase the likelihood of desired health outcomes such as avoiding injuries to patients from care that is intended to help them, ensure effective – avoiding overuse and misuse of care, which is patient-Centered by providing care that is unique to a patient's needs, also must be timely by reducing wait times and harmful delays for patients and providers, as well as efficient through avoidance of waste of equipment, supplies, ideas and energy, and equitable by providing care that does not vary across intrinsic personal characteristics”⁴.

Quality of health care services is the fitness of the purpose and degree of excellence and worth, which should achieve what it is expected to achieve and that the process has to be one that is delivered in courteous and acceptable manner to the person concern. As the

intensity of managed care controls increase, physicians may become more dissatisfied with their jobs, and patients may experience worse quality care, creating a spurious relationship between physician job satisfaction and quality of care⁵.

Accessibility: Facilitating access is concerned with helping people to command appropriate health care resources in order to preserve or improve their health. Access is a complex concept and at least four aspects require evaluation. If services are available and there is an adequate supply of services, then the opportunity to obtain health care exists, and a population may 'have access' to services. The extent to which a population 'gains access' also depends on financial, organisational and social or cultural barriers that limit the utilization of services. Thus, access measured in terms of utilization is dependent on the affordability, physical accessibility and acceptability of services and not merely adequacy of supply. Services available must be relevant and effective if the population is to 'gain access to satisfactory health outcomes'.

The availability of services, and barriers to access, have to be considered in the context of the differing perspectives, health needs and material and cultural settings of diverse groups in society. Equity of access may be measured in terms of the availability, utilization or outcomes of services⁶.

This can be further defined as the act of equitable distribution of health insurance scheme, considering demography, composition, rural-urban combine and less privilege people, in terms of health care providers, without any categorization such as band A, B, C, D and so on which specified the category of user and restrict users from some high grade hospitals, as well as not having same health insurance scheme benefits package, as we have it in health insurance scheme in Nigeria today.

Affordability: Requires that payment for health-care services, as well as services related to the underlying determinants of health, must be based on the principle of equity, ensuring that these services, whether privately or publicly provided, are affordable for all, including socially disadvantaged groups. Equity demands that poorer households should not be disproportionately burdened with health expenses as compared to richer households⁷.

Medical care should be available at a cost that the individual and community can afford, (state of being cheap enough for people to be able to purchase at every level of development). This is achieved in different ways, such as Standard and update drug tariff presented to health care provider by Health Maintenance Organisation, Subsidy on cost of drugs and operation by government, Compulsory enrolment of all citizen on health insurance so as to provide large pool of fund for health care.

Hence, Health Insurance Scheme of high accessibility, and availability to quality health care will not be guaranteed, therefore, health insurance scheme should be at a cost that everyone will be able to afford at any stages and level of development and usage.

Availability is the quality of being able to be used or obtained or something is being easily obtainable and ready for use or improve the availability of affordable. Availability is also the state of sufficient supply of appropriate Health Insurance coverage with robust health care benefits package and standard health care providers to match the health care needs of the populace. Patients insist on equity of access to health care for all at a cost the individual and community can afford and to have opportunity to consult the same doctor each time they need medical help at a minimal waiting and appropriate time⁶.

1.2 Statement of the Problem

NHIS is a social health insurance scheme that aimed at providing universal health care coverage for all citizens in Nigeria, by providing ability to get health care services whenever, and wherever needed without having to pay at the time of need, either because payment has been made previously through regular contribution, by the insured or his or her employer. It focused at providing good professional services of the highest quality of which are measured by: quality, accessibility, affordability, availability, equitability and of good quality. However, NMA declared that less than 5% of Nigerian's population enrolled for NHIS after 15 years of the scheme's flag-off⁸.

Besides, the alarming rate of complaints from clients who are on health insurance scheme/ managed care (NHIS/corporate health insurance and state health insurance) in Nigeria and the rising chorus of concerned voices, concerning the level of care receive at various health care facilities is very high, even clients on health insurance scheme express their dissatisfaction in terms of the wards in which they were being hospitalized and foods given them during admission in the hospital.

Nevertheless, it is observed that the enrollees' experience contradicts the scheme's goal. This deterred many Nigerians from joining the scheme, which in turn has had great effect on the scheme coverage and acceptability, thereby affecting the health status, economy, productivity and growth of Nigeria as a nation. Therefore, the researcher deemed it fit to evaluate the present health insurance scheme in-force from the perspective of parameters of good healthcare service, in order to identify the appropriate intervention(s) program to put it back on track, so as to achieve the set goal(s).

1.3 Aim and Objectives of the Study

The aim of this study is to find out the perception of service delivery by National Health Insurance Scheme enrollees in South West, Nigeria, while the specific objectives are as follow:

- i. assess the perception of National Health Insurance Scheme enrollees about quality of service delivery in South West, Nigeria;
- ii. ascertain the perception of National Health Insurance Scheme enrollees about availability of service delivery in South West, Nigeria;
- iii. examine the perception of National Health Insurance Scheme enrollees about accessibility of service delivery in South West, Nigeria;
- iv. evaluate the perception of National Health Insurance Scheme end users about affordability of service delivery in South West, Nigeria.

1.4 Research Questions

The study seeks to answer the following questions:

1. what is the quality level of the present Health Insurance Scheme service delivery as expected by enrollees?
2. are planned service deliveries of Health Insurance Scheme available to enrollees on the scheme?
3. is access to Health Insurance Scheme service delivery obtainable to enrollees on the scheme as planned?

4. is Health Insurance Scheme service delivery affordable to enrollees on the scheme as expected?

1.5 Scope of the Study

This study focuses on perception of Health Insurance Scheme enrollees in South West, Nigeria as against the World Health Organization set goal of good health care delivery, which is: Quality, Accessibility, Availability and Affordability. It will also examine the causes of disparity and the factor responsible for health insurance scheme in Nigeria as well as suggestion of possible solutions to put the health insurance scheme in Nigeria back on the track.

This study is limited to Osun state, Nigeria and focused on the NHIS enrollees in the state alone due to some constraints such as wide geographical area of Nigeria, cost of travelling, risk of travelling, timeframe of the project work and insecurity of some areas.

1.6 Significance of the Study

The study will proffer a great relief to the nation as the burden of yearly earmarking huge budget on health will be reduced. It will also, boost the capital base of Hospitals as there will be pool of fund to service enrollees on the scheme which will in turn enable them to breakeven, thereby enhance quality of service to the enrollees without discrimination. The study will also enhances the nation's health status as it will make universal healthcare available to the populace. If recommendations in the study are properly implemented, it will increase National Health Insurance Scheme coverage which has been stagnant at 5% since 22 years of its inauguration. Besides, it will bring about attainment of Alma Ata

declaration of 1978 “Health for all by the year 2000, which has being a mirage in Nigeria.

The study provides way by which financial hardship and burden will be removed from families and individuals in the community. It also shows the path to achievement of attainment of Universal Healthcare for Nigeria which will in turn provides works for millions of people and increase productivity of the labour, when they are healthy. It will assist Health Insurance Regulatory body to have a workable service tariff and realistic service attainment.

In addition, this study will assist health policy makers to design an enhance a health insurance benefits package, as well as workable health insurance package system that will help health care providers, NHIS and HMO improve the quality of their clinical and administrative activities. Specifically, this will ensure that Nigeria as a nation is healthy, boost productivity and enhances improved economy as well increase the scheme coverage.

The study proffer a way out of access denial to less privilege people in accessing care in some high-earned hospitals in Nigeria as well as reducing the effect of health sector down tools (strike) on the populace as populace will be able to use other private facilities of same quality with that of government hospitals. This study will enhances provision of jobs for many Nigerian youths, women especially.

1.7 Limitation of the Study

Due to the peculiarity of Nigeria as a nation, there are some situations happening in one side of the geopolitical zone of the country that is not the same in the other part of the country, as this could have effect on the findings of this work. But because of the unrest and insecurity in the country presently, the researcher decides to limit the research to

southwest geopolitical zone; hence, this study could have been extended to all six geopolitical zones of the country to have their core views about health insurance scheme.

Besides, HMOs and healthcare providers which supposed to be part of this study, were excluded due to time frame.

1.8 Operational Definition of Terms

Services Delivery: means the furnishing of medicine, medical or surgical treatment, nursing, hospital service, dental service, optometric service, complementary health services or any or all of the enumerated services or any other necessary services of like character, whether or not contingent upon sickness or illnesses, of which purchasers, consumers expect to receive from providers, either private or public, that the care delivered by affiliated providers under the guidelines of the plan meets basic standards of quality care and expected outcome of the consumers.

Perception: is the way you think about something in order to assess the worth, performance, whether it meets the expectation.

Quality: of Healthcare Services: is the fitness of the purpose and degree of excellence and worth, which should achieve what it is expected to achieve and that the process has to be one that is delivered in courteous and acceptable manner to the person concern.

Availability is “The quality of being able to be used or obtained or something is being easily obtainable and ready for use or improve the availability of affordable.

Accessibility: “Facilitating access is concerned with helping people to command appropriate health care resources in order to preserve or improve their health.

Affordability: Requires that payment for health-care services, as well as services related to the underlying determinants of health, must be based on the principle of equity, ensuring that these services, whether privately or publicly provided, are affordable for all, including socially disadvantaged groups. Equity demands that poorer households should not be disproportionately burdened with health expenses as compared to richer households.

Health Insurance Scheme: is a type of insurance coverage that typically pays for medical, surgical, prescription drug and sometimes dental expenses incurred by the insured. Health insurance can reimburse the insured for expenses incurred from illness or injury, or pay the care provider directly. It is often included in employer benefit packages as a means of enticing quality employees, with premiums partially covered by the employer but often also deducted from employee paychecks. The cost of health insurance premiums is deductible to the payer, and the benefits received are tax-free, with certain exceptions for S Corporation Employees.

Enrollees: these are group of people or individual, who subscribe to the Health Insurance Scheme by making a prepayment of prescribed amount called premium to Health Insurance regulatory body in order to have access to healthcare services in time of need.

Perspective: is a way of regarding situations or topics etc. *Perspective* has a Latin root meaning "look through" or "perceive," and all the meanings of *perspective* have something to do with looking.

South West Nigeria is one of the geopolitical zones of Nigeria, consisting of the following states; Ekiti, Lagos, Ogun, Ondo, Osun, and Oyo State.

South West Geo-political zone in Nigeria is majorly Yoruba speaking area, with different dialects even within the same state. Climate conditions vary between the two distinct seasons in Nigeria; the rainy season (March - November) and the dry season (November - February), which usher in Harmattan dust; cold dry winds from the northern deserts.

Health Maintenance Organization (HMO): An entity that provides and manages the coverage of health services provided to plan members in return for a fixed, prepaid premium; the four types of HMO models are the group,

Point-of-Service (POS): A managed care plan that provides flexibility for an enrollee to receive a service from a participating or non-participating provider, with corresponding benefit or “penalty” of co-pay depending upon the level of benefit selected, with the goal of encouraging the use of participating providers

Preferred Provider Organization (PPO): A Preferred Provider Organization is a group of healthcare providers (professional and institutional) that agrees to provide services to a specific pool of patients at an agreed upon, fee-for-service discounted rate

Member/ client / enrollee: an individual who is enrolled in or covered by a managed care plan.

Provider: A physician or other health care practitioner who delivers health care services to individuals in health care plans.

Managed Care: defines certain types of medical care in order to better “manage” or control the provision and payment of care.

Primary Care: includes the diagnosis, treatment and management of general medical

conditions. Emphasis is on prevention through immunizations, wellness check-ups, screening services and education of patients. It is usually provided by family practice doctors, internists or general practitioners. The primary care physician focuses on wellness and providing routine care.

Capitation: A payment system in which health care providers (physicians, hospitals, pharmacists, etc.) receive a fixed payment per member per month (or year), regardless of how many or few services the patient uses.

Co-Payment: A cost-sharing arrangement in which the managed care enrollee pays a specified flat amount for a specific service (such as \$15.00 for an office visit or \$10.00 for each prescription drug). It does not vary with the cost of the service, unlike coinsurance which is based on some percentage of charges.

Deductibles: Amounts required to be paid by the insured under a health insurance contract before benefits become payable.

Fee-For-Service (FFS) Reimbursement: Payment in specific amounts for specific services rendered. Payment may be made by an insurance company, the patient, or a government program such as Medicare or Medicaid. The form of payment is in contrast to payment retainer, salary, or other contract arrangements (to Physicians or other suppliers of service); and premium payment or membership fee for insurance coverage (by the patient).

Out-of-Pocket Expense: The amount not reimbursed by insurance coverage and paid by the patient such as co-payments, deductibles and premiums.

Premium: The amount paid to an insurer for providing coverage, typically paid on a

periodic basis (monthly, quarterly, etc.).

Prevailing Charge: This is a fee based on the customary charges for covered medical insurance services. In Medicare payments for services or items, it is the maximum approved charge allowed.

Reimbursement: refers to the actual payments received by providers or patients for benefits covered under an insurance plan.

Third-Party Payment: Payment by a financial agent such as an HMO, insurance company, or government rather than direct payment by the patient for medical-care services. (b) The payment for health care when the beneficiary is not making payment, in whole or in part, on his/her own behalf.

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Chapter Two

Literature Review

This chapter reviews the literature relevant to this study. The theories relevant to the study area are also reviewed. The chapter dwells on the concept and empirical studies that discuss the perception of service delivery by National Health Insurance Scheme enrollees in South West, Nigeria. The chapter is organized as follows:

2.1 Conceptual Review

2.2 Theoretical Framework

2.2.1 Transfer of Risk

2.2.2 Moral Hazard in Health Insurance

2.2.3 Principle of Risk of No Loss (Risk Pooling)

2.3 Empirical Studies

2.4 Conceptual Framework

2.5 Summary of Gaps

2.1 Conceptual Review

Objectives of National Health Insurance Scheme designed to be achieved is in accordance with independent variables (quality, availability, accessibility and affordability) in this research work:

- a. To ensure that every Nigerian has access to good health Services.
- b. To protect families from the financial hardship of huge medical bills
- c. To limit rise in cost of health care services

- d. To distribute care costs equitably among different income groups
- e. To set and monitor standards of health care delivery Services.
- f. To effectively ensure efficiency in health care delivery Services.
- g. To harness and improve private sector participation in the provision of health care Services.
- h. To ensure adequate distribution of health facilities within the federation.
- i. To ensure equitable patronage of all levels of health care
- j. To make funds to the sector for improved services^{1,2}.

Concept of Health Insurance (Risk Pooling)

Health Insurance is a type of insurance that covers the whole or a part of the risk of a person incurring medical expenses. As with other types of insurance is risk among many individuals. By estimating the overall risk of health risk and health system expenses over the risk pool, an insurer can develop a routine finance structure, such as a monthly premium or payroll tax, to provide the money to pay for the health care benefits specified in the insurance agreement. The benefit is administered by a central organization, such as a government agency, private business, or not-for-profit entity³.

The current HMO system erodes the quality of health care. In the following viewpoint, to remain profitable, HMOs must encourage the sick and disabled to drop out and find new, healthy members to replace them. This is an unacceptable way to cut the costs of health care. Health care is expensive and a more equitable way of distributing care must be found⁴.

In the following viewpoint, a surgeon in private practice in Virginia, greets these changes with trepidation. By searching for ways to cut costs, he contends that Health Insurance is

eroding the sacred one-on-one relationship of doctor and patient, thereby affects Quality service delivery on the scheme⁵. Other problems that have caused deterioration of old standards is third-party reimbursement which is to a large extent controlled by non-medical bureaucrats, whose concern is cost containment rather than quality of care. Every aspect of medical management is interfered with and dictated by insurance and government agencies. Eventually, putting physicians in the role of employees, who get the message that they had better fall in line, or fall out.

Policy of Moral Hazard and adverse selection of Health Insurance Scheme diminishes expected availability and accessibility on the scheme. By treating health care as a commodity, privatization has diminished the quality of services and made them less available to those less able to pay. The for-profit chains may provide quality care for some patients, but the poor, whose complex medical problems often require more expensive care, typically lose out. That is because for profit hospitals gravitate to suburban communities and prosperous regions, where the expanding population tends to be well off, young and healthy and where unions are generally weak. They prefer to treat insured patients with uncomplicated diagnoses, requiring frequently used but expensive diagnostic tests, services and drugs over those with costly chronic illnesses requiring long-term, labor intensive care or rarely used highly specialized equipment⁶.

Health Care Quality

Health care quality is a level of value provided by any health care resource, as determined by some measurement. As with quality in other fields, it is an assessment of whether something is good enough and whether it is suitable for its purpose. The goal of health care is to provide medical resources of high quality to all who need them; that is, to ensure good

quality of life, cure illnesses when possible, to extend life expectancy, and so on. Researchers use a variety of quality measures to attempt to determine health care quality, including counts of a therapy's reduction or lessening of diseases identified by medical diagnosis, a decrease in the number of risk factors which people have following preventive care, or a survey of health indicators in a population who are accessing certain kinds of care⁷.

Health care quality is the degree to which health care services for individuals and populations increase the likelihood of desired health outcomes. Quality of care plays an important role in describing the iron triangle of health care relationships between quality, cost, and accessibility of health care within a community. Researchers measure health care quality to identify problems caused by overuse, underuse, or misuse of health resources. In 1999, the Institute of Medicine released six domains to measure and describe quality of care in health:

1. safe – avoiding injuries to patients from care that is intended to help them
2. effective – avoiding overuse and misuse of care
3. patient-Centered – providing care that is unique to a patient's needs
4. timely – reducing wait times and harmful delays for patients and providers
5. efficient – avoiding waste of equipment, supplies, ideas and energy
6. equitable – providing care that does not vary across intrinsic personal characteristics

While essential for determining the effect of health services research interventions, measuring quality of care poses some challenges due to the limited number of outcomes that are measurable. Structural measures describe the providers' ability to provide high quality care, process measures describe the actions taken to maintain or improve community health, and outcome measures describe the impact of a health care intervention. Furthermore, due to strict regulations placed on health services research, data sources are not always complete. Assessment of health care quality may occur on two different levels: that of the individual patient and that of populations. At the level of the individual patient, or micro-level, assessment focuses on services at the point of delivery and its subsequent effects. At the population level, or macro-level, assessments of health care quality include indicators such as life expectancy, infant mortality rates, incidence, and prevalence of certain health conditions⁸.

Quality assessments measure these indicators against an established standard. The measures can be difficult to define in health care. The Donabedian model is a common framework for assessing health care quality and identifies three domains in which health care quality can be assessed: structure, process, and outcomes. All three domains are tightly linked and build on each other. Improvements in structure and process are often observed in outcomes. Some examples of improvements in process are: clinical practice guidelines, analysis of cost efficiency, and risk management, which consists of proactive steps to prevent medical errors.

Cost Efficiency Cost Efficiency, or cost-effectiveness, determines whether the benefits of a service exceed the cost incurred to provide the service. A health care service is sometimes not cost efficient due to either overutilization or underutilization. Overutilization, or

overuse, occurs when the value of health care is diluted with wasted resources. Consequently, depriving someone else of the potential benefits from obtaining the service. Costs or risks of treatment outweigh the benefits in overused health care. In contrast, underutilization, or underuse, occurs when the benefits of a treatment outweigh the risks or costs, but it is not used. There are potential adverse health outcomes with underutilization. One example is the lack of early cancer detection and treatment which leads to decreased cancer survival rates⁹.

The quality of the health care given by a health professional can be judged by its outcome, the technical performance of the care and by interpersonal relationships. "Outcome" is a change in patients' health, such as reduction in pain, relapses, or death rates. Large differences in outcomes can be measured for individual medical providers, and smaller differences can be measured by studying large groups, such as low- and high-volume doctors. Significant initiatives to improve healthcare quality outcomes have been undertaken that include clinical practice guidelines, cost efficiency, critical pathways, and risk management.

Technical performance" is the extent to which a health professional conformed to the best practices established by medical guidelines. Clinical practice guidelines, or medical practice guidelines, are scientifically based protocols to assist providers in adopting a "best practice" approach in delivering care for a given health condition. Standardizing the practice of medicine improves quality of care by concurrently promoting lower costs and better outcomes. The presumption is providers following medical guidelines are giving the best care and give the most hope of a good outcome. Technical performance is judged from a quality perspective without regard to the actual outcome - so for example, if a physician

gives care according to the guidelines but a patient's health does not improve, then by this measure, the quality of the "technical performance" is still high. For example a Cochrane review found that computer generated reminders improved doctors' adherence to guidelines and standard of care; but lacked evidence to determine whether or not this actually impacted patient centered health outcomes.

Risk management consists of "proactive efforts to prevent adverse events related to clinical care" and is focused on avoiding medical malpractice. Health care professionals are not immune to lawsuits; therefore, health care organizations have taken initiatives to establish protocols specifically to reduce malpractice litigation. Malpractice concerns can result in defensive medicine, or threat of malpractice litigation, which can compromise patient safety and care by inducing additional testing or treatments. One widely used form of defensive medicine is ordering costly imaging which can be wasteful. However, other defensive behaviors may actually reduce access to care and pose risks of physical harm. Many specialty physicians report doing more for patients, such as using unnecessary diagnostic tests, because of malpractice risks. In turn, it is especially crucial that risk management approaches employ principles of cost efficiency with standardized practice guidelines and critical pathways⁴.

Meaning of Access in Healthcare Delivery

Facilitating access is concerned with helping people to command appropriate health care resources in order to preserve or improve their health. Access is a complex concept and at least four aspects require evaluation. If services are available and there is an adequate supply of services, then the opportunity to obtain health care exists, and a population may

'have access' to services. The extent to which a population 'gains access' also depends on financial, organisational and social or cultural barriers that limit the utilization of services. Thus access measured in terms of utilization is dependent on the affordability, physical accessibility and acceptability of services and not merely adequacy of supply. Services available must be relevant and effective if the population is to 'gain access to satisfactory health outcomes'. The availability of services, and barriers to access, have to be considered in the context of the differing perspectives, health needs and material and cultural settings of diverse groups in society. Equity of access may be measured in terms of the availability, utilization or outcomes of services. Both horizontal and vertical dimensions of equity require consideration¹⁰.

The pursuit of equity of access to health care is a central objective of many health care systems, where equity of access has been a central focus in the National Health Service since its inception in 1948. Inequity between socio-economic groups is used as an illustrative example, and the extent of inequity of access experienced is explored in each of five service areas: general practitioner consultations; acute hospital care; mental health services; preventative medicine and health promotion; and long-term health care. The paper concludes that there appear to be important inequities in access to some types of health care in the UK, but that the evidence is often methodologically inadequate, making it difficult to draw firm conclusions. In particular, it is difficult to establish the causes of inequities which in turn limits the scope for recommending appropriate policy to reduce inequities of access. The theoretical framework and the lessons learned from the UK are of direct relevance to researchers from other countries seeking to examine equity of access in a wide variety of institutional settings.

How to make Health Insurance Scheme Affordable

The wealthy are helping to subsidize insurance for the poor. Some economists, however, predict that in the long term, the ACA will help reduce the deficit and may eventually have a positive impact on the budget. Several new taxes were passed into law to help pay for the ACA, including taxes on medical device and pharmaceutical sales. Taxes were also increased for people with high incomes. Funding also comes from savings in Medicare payments. Prescription drugs more affordable. Many people, particularly senior citizens, are unable to afford all their medications. The number of prescription and generic drugs covered by the ACA is growing every year¹¹.

Components of Access to Healthcare

Access to health care means having "the timely use of personal health services to achieve the best health outcomes. Access to health care consists of four components:

Coverage: facilitates entry into the health care system. Uninsured people are less likely to receive medical care and more likely to have poor health status.

Services: Having a usual source of care is associated with adults receiving recommended screening and prevention services.

Timeliness: ability to provide health care when the need is recognized.

Workforce: capable, qualified, culturally competent providers.

Coverage: Health insurance facilitates entry into the health care system. Uninsured people are less likely to receive medical care and more likely to have poor health status. Many

people rely on public health insurance, such as Medicaid. Public health insurance also includes Children's Health Insurance Program (CHIP), State-sponsored or other government-sponsored health plans, Medicare, and military plans. For access measures in this chart book, a small number of people were covered by both public and private plans and were included in both categories:

- Access to health care means having “the timely use of personal health services to achieve the best health outcomes.
- Access to health care consists of four components:
 - i. Insurance coverage
 - ii. Services
 - iii. Timeliness
 - iv. Workforce coverage
- Health insurance facilitates entry into the health care system.
 - i. Uninsured people are less likely to receive medical care and more likely to have poor health status.
 - ii. Many people rely on public health insurance, such as Medicaid.
 - Service
 - a. People with a usual source of care have better health outcomes, fewer disparities, and lower costs. People with a usual place of care and a usual provider are more likely to receive preventive services and recommended screenings than people with no usual source of care.

- b. Age-sex adjusted percentage of people of all ages with a usual place to go for medical care.
- c. People who were unable to get or delayed in getting needed medical care, dental care, or prescription medicines in the last 12 months.
- d. People who were unable to get or delayed in getting needed medical care, dental care, or prescription medicines in the last 12 months.

- Time

- i. Timeliness in health care is the system's capacity to provide care quickly after a need is recognized.
- ii. Timely delivery of appropriate care can help reduce mortality and morbidity for chronic conditions, such as kidney disease.
- iii. Adults who needed care right away for an illness, injury, or condition in the last 12 months who sometimes or never got care as soon as wanted.
- iv. Children who needed care right away for an illness, injury, or condition in the last 12 months who sometimes or never got care as soon as wanted.

- Workforce

Ensuring well-coordinated, high-quality health care requires the establishment of a supportive health system infrastructure (IOM, 2010). Key elements include:

1. Well-distributed capable and qualified workforce.

2. Organizational capacity to support culturally competent services and ongoing improvement efforts.
3. Health care safety net for hospital admissions of vulnerable populations¹².

The Effects of Combined Access Barriers

Interrupted Drug Supplies

Respondents complained that public clinics repeatedly ran out of drugs. For a highly vulnerable household such as Elphas's (Case HV12), the regular stock outs at his closest clinic led to 'shopping around', non-consultation and self-treatment, rather than wasting funds on transport for a fruitless trip to his local clinic. High blood pressure patients from secure households also faced regular drug shortages. As a result Ruth (Case S8) took a sample of her pills to the local chemist who sold her some without a prescription, and Phosiwe (Case S4) regularly returned to the district hospital to ensure she had the necessary supply of pills. In comparison, Elphas (Case HV12) from a highly vulnerable household who had more complex symptoms and an unclear diagnosis did not have the funds to go to the chemist or to visit the hospital¹³.

Weaknesses in the Referral System

Referrals between public clinics and hospitals were common. The general pattern was initial identification of a chronic problem at the clinic, diagnosis and prescription at a hospital, and then either continued treatment at the hospital or referral to the clinic. Across the three livelihood groups, there were more successful referrals than failures. A variety of reasons explain the failures that did occur. Most common were the lack of an ambulance, or

household inability to pay for transport and hospital fees. In one case differing diagnoses by the clinic and the hospital led to a failure of communication between the two leaving the patient confused as to where she should go for subsequent treatment (Case V3 Losta).

In another, the necessary paperwork was not completed and when the family tried to trace a patient they were told that she had been discharged, when in fact she had been referred to a hospital further away (Case V2 Nomsa). In two cases, the patients returned home without instructions to return to either hospital or clinic, despite continuing ill-health (Cases V4 Glory & V5 Vusi). Patients in this setting appeared relatively 'unempowered', unlikely to ask questions to clarify what to do next and likely to get 'lost' and give up. In particular, highly vulnerable households seemed less likely to take alternative action. For example Decan's siblings just continued to ask for TB treatment from the clinic (Case HV10), and Lindiwe resorted to not consulting and the use of herbs to control her symptoms (Case HV9). In the vulnerable group, Nomsa turned to private doctors after a failed referral (Case V2), and Glory and Losta resorted to self-treatment and faith healers (Cases V4 & V3).

Inadequate ambulance services or lack of other subsidized transport¹⁴.

The access barriers for Decan (Case HV11) and others from highly vulnerable households included the transport costs of getting to hospital. Siphon (Case HV14) had been unable to complete a previous course of TB medication due to transport costs, and during the fieldwork became critically ill. An ambulance was not available to take him to hospital or to return him back to the clinic after his inpatient stay. On the first occasion all the drivers were attending a meeting; on the second, there was no ambulance in a suitable condition to transport patients. In contrast, patients from the secure group were able to pay the taxi fare

to hospital, or use a relative's car. Thus, Phosiwe, Dorries, Nonhlanhla, and Sbusisio's mother (Cases S4, S5, S6, S7) all traveled to hospital on a regular basis to collect medication¹⁵.

Unproductive Patient-Provider Interactions and Poor Acceptability

For 13 of the 34 illnesses, respondents could not explain their illness, and did not have, or had not accepted, an allopathic diagnosis, despite seeking care, often more than once, at a public health facility. The case below shows how the lack of a clear diagnosis combined with problematic patient-provider interactions could lead to inappropriate treatment action or no action.

Kulani (an 11-year-old boy) had had difficulty breathing for several years. At one monthly visit his mother said he looked as if he had had a stroke as he was unable to straighten his fingers. The following month he fell from a sofa with a 'terrible headache', after which his leg and hand became stiff. His mother explained that neighbours said the illness was caused by vukulu (when social norms have been broken by borrowing items from the husband's relatives) while others said he had a stroke. After the fall the family consulted a prophet, a traditional healer and a clinic, which referred him initially to a local hospital, from where he was referred to a regional hospital. No family member was allowed to accompany him in the ambulance to either hospital, and with no funds for transport, the family could not talk to a doctor. They did not appear to have explanation for his illness or knowledge as to what was appropriate subsequent action. When Kulani returned in poorer health, his family saw the hospital treatment as a failure, consulted a faith healer rather than return to hospital, and the child died soon afterwards. (Case HV3).

Without sufficient knowledge of their condition or treatment, some patients switched numerous times between healers ('healer shopping'), unclear as to who could provide relief.

In most cases patients faced a combination of two or more of the access barriers distinguished above. In particular, patients who had more prolonged conditions with complex symptoms often had fewer resources, and were unable to take alternative action when faced with health system weaknesses. The combination of inability to pay the costs of seeking regular care, health system weaknesses, and unproductive interactions could lead to a breakdown in cooperation and trust between provider and patients. In the case described below, hospital staff did not understand the constraints Vusi faced due to poverty, and their unsympathetic treatment combined with weaknesses in the provision of care led Vusi to give up on public facilities.

Inability to pay is a second factor preventing access to chronic care, as repeated consultations for a chronic condition can be a costly expense for poor households. Livelihoods exhausted from previous illness and death, continuing multiple illnesses, very little or no income, and limited social networks to provide financial assistance, prevented consultation for highly vulnerable households. The findings show the monthly cost burdens for repeated trips can be exceptionally high. Those households with income, strong social networks, receiving social grants, or exemptions from public hospital fees were able to seek care regularly, incurring much lower cost burdens.

Although there is a growing international literature on the affordability of health care, as well as literature on the household impact of illness and death as a result of catastrophic diseases such as HIV, there is little published evidence on the cost burdens of recurring

chronic care. In a review of studies on the economic burden of HIV, TB and malaria in low and middle income countries, the direct costs incurred due to TB, requiring regular chronic care, were considerably higher (8–20% of annual income) than the costs incurred as a result of malaria (2–3% of monthly income). The review showed the largest cost from HIV were those associated with death, indicating regular treatment was not commonly available¹⁶.

Disease specific studies from South Africa have broadly noted that the lack of finances was an impediment to regular clinic visits, and following a prescribed diet. The cost of traveling to hospital was also found to be prohibitive, and consequently many patients ran out of medicines between hospital visits. However, there are few detailed South African studies of the costs of chronic care. Given the costs incurred as a result of repeated consultations for chronic care, policies that protect poor households from the financial burdens are crucial in facilitating access to care. Ensuring existing exemptions reach intended beneficiaries are a first step. Another would be to exempt all patients suffering from specific chronic diseases from all user fees. Decentralizing from hospitals to clinics, strengthening outreach activities, such as home visits by community health workers would also reduce the cost burdens faced by households significantly, as well as directly increasing access. The third important influence over access is the acceptability of health services, defined as the social and cultural distance between health care systems and their users¹⁶.

Universal Health Care Benefits Package is the solution to have Quality, Available, Accessible and Affordable health care. Medications, did not see a doctor when sick, or did not obtain recommended care in the past year because of cost. With the USA the only country of the seven without universal health insurance, half or more adults in Germany, the Netherlands, and New Zealand reported having rapid access to physicians, while in the

USA only 30% of adults said that could get same-day appointments with their doctors when sick. Nearly one-fifth (19%) of US adults have a serious problem paying medical bills, more than double the rate in the next highest country, while nearly one-third (30%) of US survey respondents spent more than \$1000 in the past year (2006—2007) in out-of-pocket medical expenses compared to only 19% in Australia and 12% in Canada, and the rates were even lower in the other four countries.⁸ Yet, according to the Commonwealth Fund, all these problems were occurring despite the fact that the USA spends twice what other countries spend on average. Per-capita spending in the USA in 2004 was \$6102, two to three times that of Germany's \$3005, Canada's \$3165, New Zealand's \$2083, Australia's \$2876, and the UK's \$2546 per person. While health care spending reached 16% of GDP in 2005 in the USA or 4.3 times the amount spent on US national defense, the International Organization for Economic Cooperation and Development reported that health care spending accounted for only 10.9% of GDP in Switzerland, 10.7% in Germany, 9.7% in Canada, and 9.5% in France.

The problem of rising health costs has reemerged as a national issue as some candidates in the US presidential campaign of 2008 called for universal health insurance as a panacea for resolving America's health care systematic problems. Unfortunately, by 2008, as the costs were rising, the American economy headed into a recession, the nation's budget showed a deficit rather than a surplus, and the nation was focused on the worldwide war against terrorism. Rather than allocating the monies to resolve the problems confronting the US health care system, education, transportation, and other aspects of its societal infrastructure, these funds were instead being diverted into national security and defense. Since the enactment of Medicare and Medicaid in the mid-1950s, no approach that the USA has

attempted to control rising health care costs has worked out, nor has had a lasting impact—perhaps they may have in the short term, but certainly not over the long term¹⁷.

Causes of Unequal Access to Healthcare

In terms of societal demographics, the gap between medical care for blacks and whites may be becoming smaller. Since the 1980s, many studies have documented racial gaps in health care standards, blaming economic, cultural, and even biological differences between the races. Black Americans have a much lower life expectancy and worse health outcome than white Americans. Black have less access to better doctor, hospitals, and health plans and the medical systems treats whites and black differently. In a study of the Medicare program for the elderly, published in the *New England Journal of Medicine* in August 2005, evidence appeared that racial disparities in US health care have become smaller, at least for some patients and treatments, but have not totally disappeared. Researchers looked at nine procedures, categorized according to the coding of the International Classification of Diseases, Ninth Revision (ICD-9) with exclusions and restrictions to certain coded diagnoses: abdominal aneurysm repair, back surgery, coronary artery bypass grafting (CABG), percutaneous transluminal coronary angioplasty, cardiac valve replacement, carotid endarterectomy, total hip replacement, total knee replacement, and appendectomy^{18,19}.

The researchers found that racial differences in the rates of use of the nine procedures among black and white persons enrolled in Medicare between 1992 and 2001 did not narrow meaningfully during this decade. The rates of procedures performed were greater among whites than among blacks for every procedure examined. Racial differences in these rates widened for five procedures, narrowed for one (surgical repair of the abdominal aortic

aneurysm, and that rate was due to the disproportionate receipt among whites of a procedure involving newendovascular techniques instead of the traditional surgery for repair of an abdominal aortic aneurysm), and the rates remained statistically unchanged for three.

There were no hospital referral regions by 2001 (79 for black men and white men and 79 for black women and white women, or a total of 158 regions) where racial differences in care were completely eliminated, especially in regard to hip replacement, CABG, and carotid end arterectomy. (The rates for these three procedures changed significantly in 22 hospital referral regions, widened significantly in 42, and were not significantly change in the remaining hospital referral regions). Evidence of Disparity in health care access between health insurance schemes compare to direct patients. Numerous other studies have shown that gaps in care represent, in part, both underuse among black persons and overuse by white persons. Research concluded that new efforts toward a better understanding ofand closing of these gaps in care between black persons and white personsHowever, disparities in health care are relevant not only to blacks and whites but among all ethnicities and racial group in the USA.

Background of Rising Cost of Health Insurance Scheme:

- a. Managed/corporate health insurance cannot bring affordability

Managed care and the threat of the Clinton health reform plan appeared to have had a dramatic effect on the rate of increase in private health spending in the mid-1990s, but by the late 1990s it was increasing again, reaching double-digit rate of increase by 2001. In summary, regulation, voluntary action by the health care industry, and managed care and

market competition have not had a lasting impact on our nation's rising health care costs.

b. Quality Best Medical treatment is not cheap

In the case of Medicare, private health insurance policies like Medigap supplement the benefits and costs which Medicare does not cover. And these health insurance premiums are rising faster than inflation. In addition to the previous payments, out-of-pocket health care expenditure by Medicare beneficiaries are high and are expected to keep rising. Older Americans spend two other health Insurance package comes with higher premium.

Some believe that the rationing of medical care is the possible solution for controlling health care costs. Others state that the obvious failure to control health care costs is really a reflection of the American people who want to have the very best and latest innovations in health care treatment, but try small corrections at the edges of the system, complain about rising costs, and ultimately will do nothing but pay the bill, perhaps feeling helpless in not knowing what they can do as lay consumes to control these spiraling expense. Some believe that the federal government is the answer to resolving our health cost problems through universal health insurance.

Thus, if a family does not have the ability to save very much or must cut back on food or heating, not only might their bill like rent or mortgage be unpaid but the absence of heating or reduced food intake can affect their physical health detrimentally as well. This situation, in turn, might increase the amount of the medical bills owed if they seek medical attention for their illness and if they do not seek medical attention their physical condition might become worse, if not possibly fatal, perhaps costing them even more monies than if they had initially sought medical attention.

The Public not only experiences the costs of health care through increase state and local taxes to pay for Medicaid but also more of its federal tax dollars are going to the federal share of Medicare and Medicaid costs, for health care costs through the premiums it pays for health insurance and tough health insurance cost sharing, that is, the deductibles and copayments that it must pay at the time it receives care.

First, health insurance premiums have consistently increased faster than inflation or the earnings of workers in recent years. Between 2002 and 2007 the cumulative growth in health insurance was 76% compared with a cumulative inflation of 17% and a cumulative wage growth of 19%. Second, although the share of total premiums that workers pay had stayed fairly stable (16% for single coverage, 28% for family coverage in 2007) over the recent past, the rapid increase in overall premium levels means that workers are paying much higher amounts than they did a few years ago. Third, the amounts people pay out-of-pocket for health care services are affected by several factors, including the quality of their health insurance (if any) and the kind and amount of services they use. For people with health care expenses, the average share of total health costs that are paid out-of-pocket was 34% in 2004. Because many insurance plans have limits on out-of-pocket expenses, people who experience high total spending have relatively low out-of-pocket shares. For example, in 2004 the 1% of the people with the highest health spending (total costs of \$39 688) on average paid 6% of their costs out-of-pocket²⁰.

Corporate Health Insurance Premium is not Affordable for Common Masses

Health insurance premium growth has outpaced the growth in workers' earnings almost every year except for a short period of a short period of time in the mid-1990s. While premium increases have registered between 8% and 14% per year since 2000, inflation and

changes in worker's earnings are generally in the 3-4% range. This generally means that workers have to spend more of their income each year on health care to maintain coverage. Again, these effects may be direct, through increased worker contributions for premiums or reduced benefits, or indirect, such as when employers reduce or limit wage increases to offset increases in premiums.

Rising medical care Costs are not a new dilemma. Medical care costs have generally outpaced other cost-of-living components. The roots of the problem are complex and intertwined. For example, the multitrillion-dollar-a-year health care industry has been slow in adjusting to the increasing demand by the public for its services. This demand increased suddenly and immensely, by the establishment of Medicare and Medicaid in 1965. But these programs are not the only explanation for rising costs. The industry's scientific advances have outpaced its management capability²¹.

Physicians and hospitals can accomplish much more than they once could, but they continue to be impeded by a lack of adequate space, personnel, and equipment. Additionally, rising incomes and the prevalence of private health insurance increase the ability of the public to pay for the health care they desire. Thus, the demand for health care services far exceeds the nation's capability to provide them. The availability of more expensive, state-of-the art drugs and technological services spurs health care spending not only because the development costs of the products must be recouped by industry but also because they generate consumer demand for more intense, costly services, even if they are not necessarily cost-effective.

Private insurers have difficulty in keeping up with rising service charges as they attempt to cover needed services. As additional benefits are provided, the costs of insurance are

inflated even more. Increasingly, requests by health insurers from state insurance commissions for rate increases are meeting more and more resistance. In fact, some decisions as to the relevancy of such increases are being brought into courts of law for review²². As a result, health insurance prepayment plans, commercial insurance companies and some state governments are beginning to support the concept of a federal national health insurance mechanism to replace, wholly or partially, private health insurance programs.

Today, the working population is not only confronted by escalating private health insurance rates, but is also faced with:

1. Increased state and local taxes to pay for Medicaid
2. More and more of employees' federal tax dollar going to the federal share of Medicaid and Medicare costs
3. More out-of-pocket costs to cover employees coinsurance portion of higher and higher medical charges
4. More out-of-pocket costs for rapidly rising charges for largely uninsured health services such as dental care when the dentist is not a member of the plan and does not accept its reimbursement schedule as payment in full.

Improve Accessibility and Availability of Health Insurance through Technology leads to High Healthcare Cost

Insurance coverage has spread. When government subsidizes health coverage, this action also has an impact on cost levels and potentially cost growth. Tax subsidies for health insurance and public coverage for certain groups such as the poor, disabled, and elderly

reduces the cost of health care, encouraging consumers to use it more frequently. Some also argue that the expansion of health insurance encourages the development of health technology because those developing new technologies know that insurance will pay for a substantial share of new costs.

The development and adoption of new medical technology (e.g., drugs, devices, treatment, and techniques) are said to be responsible for a substantial portion of the increase in health expenditures. As a nation becomes more successful and wealthier, its population wants more health care and health care suppliers, providers, and institutions have successfully provided an increasing variety of new products and services that meets society's demand. This steady improvement in medical capacity means that the nation has an increasing amount of medical interventions to treat disease that can potentially deal with a growing list of health care issues and conditions as the health care issues and conditions as the health care community continues to learn more about human health and health care conditions²³. Health care experts point to the development and diffusion of medical technology as a principal factor in explaining the continuous difference between health spending and overall economic growth, with some arguing that new medical technology may account for about one-half or more of real long-term spending growth.

Developing ways to assess and weigh the costs and benefits of new technologies is a promising approach, although such actions present serious and philosophical challenges. One example would be a policy that provides payment through insurance (public and private) only for new medical interventions that demonstrate benefits that exceed costs. On a practical basis, the very steep volume and pace of medical advances would present difficulties to judge many important challenges before they were made a part of medical

practice. On a philosophical basis, medical assessment requires people to make difficult decisions about whether a medical benefit is worth the cost.

Addressing the Rising Cost in Health Insurance Scheme

The amount of monies that the USA spends on health care per person is large, especially when compared to the smaller amounts other nations spend per person on their own health care services. In addition, the rate of increase in health care expenditures in the USA relative to other fields like education and transportation has shown rapid growth and has done so for decades. So how does the USA reduce the rate of growth in costs and spending levels or costs at a point in time, both at the same time?

Some approaches may lessen the level of health care spending but not the rate of its growth. Many policies under discussion for payers of health care services include Initiatives such as increasing the use of electronic medical records and improving medical information technology; better identification and management of high cost and chronically ill the introduction of wellness programs and incentives; provider pay based upon performance whereby providers are rewarded for appropriate and high quality of care reducing payment rates to providers; instituting high cost sharing in health policies; consumer-directed health care like health savings account which use increased out-of-pocket reliability, with tax incentives more information on health care alternatives to encourage consumers to be more cost-conscious and better information on health making health care decisions; or disease management²⁴.

The purpose of all of these polices is to improve the efficiency with which care is delivered.

Disease management is a system that coordinates preventive, diagnostic, and therapeutic

efforts and whose purpose is to deliver cost-efficient, quality health care for a patient group that is at a risk for a specific chronic illness or medical condition. In addition, many states have enacted laws to reduce medical malpractice judgments to reduce premium burdens on providers and lower overall costs. While these policies may reduce on average what consumers may pay for care, they are not likely to reduce in the longer term the rate at which costs are growing as a share of the economy. Assuming medical errors can be reduced to more optimal levels and may reduce the amount consumers pay for medical care, costs are likely to increase, although from a lower level, at previously observed rates. Increasing the use of medical records or reducing the differences in health practices across regions and providers may have similar effects.

Problem of Quality Healthcare Delivery in Health Insurance Scheme

Although the government, principally through Medicare and Medicaid, has ventured into paying some of the medical bills of those least able to pay - the elderly' and the poor - many problems remain for those groups in terms of obtaining the quality of care they seek. The Centers for Medicare and Medicaid. Why Branded drug is not initially accommodated in the health insurance scheme:

a. Branded name versus Generics drugs: Differences and cost:

To understand drug costs, it is first necessary to know the differences brand-name and generic drug. First, it is important to discuss basic scientific principles. Every drug is identified by three names – chemical, generic, brand.

A drug's chemical name is descriptive of its chemical structure, based rules of standard chemical nomenclature. A drug also has a shorter, simpler established or official or generic

name. It may or may not be an abbreviated form of its chemical name. It is name most commonly used in scientific literature, by which many pharmacists and physicians learn about a particular drug during professional schooling and training. The brand name is the name the company gives its product to distinguish the medicine from competitive products, which may be identical insofar as active ingredients are concerned.

As an illustration, a five-grain acetylsalicylic acid tablet (chemical name), more commonly known as an aspirin (generic name) tablet, represents a kind of class universally prescribed and used for the relief of aches and pains. Currently, aspirin is marketed under several brand names, such as Bayer and St. Joseph, and they all have the same molecular identity. When the quality of brand-name drugs versus drugs is debated, at least two important scientific issues are raised: chemical equivalency and therapeutic equivalency. Drug are said to be chemically equivalent if they contain the same active ingredients and are identical in strength, dosage form, and route of administration, and meet existing physicochemical standards in the official compendia²⁵.

But they may differ in characteristics such as color, taste, shape, packaging, expiration time, and, within certain limits, labeling. Drugs are said to be therapeutically equivalent when they are chemically equivalent and when administered in the same amounts, they will provide the same biological physiological availability as measured by such criteria as their rate of absorption into the blood stream. The absorption rate can be influenced by differences among the same product in terms of particle size and the methods used in their formulation, as well as in their granulation and tablet compression pressure. Yet, each product contains the same chemical equivalents from a dosage standpoint.

The brand name is used to advertise a drug to the medical profession, although the generic

name must appear in advertising and labeling in letters at least half as large as those of the brand name. It is a popular conception, though wrong, that brand-name drugs are only manufactured by large, well-known firms, while generics are produced by small, unknown companies. A small drug company can place a brand name on its product just as a large company can sell a drug under its generic name. And many large drug firms distribute, under the brand names, products that have been produced, packaged, and labeled by firms that manufacture generic drugs. Some drug makers may manufacture a drug and sell it under a trade name and a generic name. In other instances, large firms may manufacture the final dosage form from drugs purchased in bulk from other companies.

While some drug authorities claim that chemically identical prescription drugs are not necessarily therapeutically equivalent — that is, they may not have the same curative effects — Dr. Donald Kennedy, former commissioner of the Food and Drug Administration (FDA) during the Carter administration, has testified in Congress that ‘we find no evidence of widespread differences between the products of large and small firms or between brand-name or generic drugs.’

All drugs have a generic name. If the FDA permits the manufacturer of a newly discovered drug to market that drug and the drug is patented, that manufacturer has the sole right to sell the drug until its patent has expired. Under the present US patent law, manufacturers are granted patents that give them the exclusive marketing rights on a new drug for up to 20 years from the date a drug patent is filed, as opposed to the date on which the patent is issued, and during which no one else can copy this formula. These patents are listed in the FDA’s ‘Orange Book’ registry. In some instances a patent holder may give other firms the right, usually in return for the payment of a royalty, to produce and sell the patented drug.

While the drug is under patent protection, its manufacture will establish a price that will allow it to recoup its research, production and marketing costs.

It should be noted that, because pharmaceutical experts believe that companies obtain a patent well before the FDA approves the drug, some pharmaceutical experts believe that companies have a marketing window of about 10 years to do so. However, once the patent has expired, other firms may make and sell the drug. Since the original manufacturer's research information is now known to other firms and the generic manufacturers do not have to invent the drug, it is cheaper for the generic drug manufacturer to make the drug and sell it under its generic name or in some cases different brand names.

This is why there is such a price difference between generic and brand-name drugs. Because the generic drug must be identical to the original, the FDA approval process is much simpler and less costly. The FDA does not require the generic drug sponsor to perform again the costly animal and clinical research on ingredients or dosage forms which have already been approved for safety and effectiveness. Rather, companies simply submit an abbreviated new drug application to the FDA for approval²⁶.

How to Contain Drug Cost in Health Insurance Scheme

One public program which may not be well known became effective in August 1976 when the US Department of Health and Human Services (DHHS) initiated its new drug program, named maximum allowable cost (MAC). The program sets a price ceiling on prescription drugs at the lowest price for which that drug is widely and consistently available; for drugs whose patents have expired, which are manufactured by more than one company and which are covered by Medicare, Medicaid, and Maternal and Child Health programs. Although

MAC applies to all three programs, government savings were expected to be derived almost exclusively from Medicaid because as of 1976 Medicare did not yet have a program that paid for out-of-hospital medications and most hospitals do enforce their own cost controls on inpatient drugs.

Under the MAC program, the US DHHS sends lists of drug comparisons to physicians and pharmacists in order to encourage them to reduce patient drug costs. Before a ceiling on drug payments is set forth, the FDA will study the drug to make sure there are no quality and therapeutic equivalency problems. Under DHHS regulations, manufacturers of generic drugs with known variations must match the effectiveness of the standard drug or withdraw the drug from the market. If the price of a drug product, for which a MAC limit has been established, increases or declines in the marketplace because of an increase or decrease in its supply, then, after an appropriate review by DHHS, the MAC ceiling can be adjusted upward or downward as the situation may require. Consumers who qualify for maternal and child health programs, Medicaid, or even Medicare may find that the government will pay for the entire cost of drugs their physician prescribes or, perhaps, may pay the difference between the MAC the government pays and the remaining cost the pharmacist charges.

Another source for saving money on prescription drugs is an innovation in the pharmaceutical industry called drug management companies or pharmacy benefit managers (PBMs). These PBMs serve as middlemen between health plans and drug manufacturers. Originally, the PBMs were established to process insurance company claims. Today, PBMs operate mail-order pharmacies which allow members to obtain significant discounts over standard retail pharmacies. The PBMs also contract with large employers to provide drugs

at discount prices to insurance-covered employees through networks of retail pharmacies that promise savings to patients if they purchase their medications at participating stores. The drugstores are reimbursed by the drug management companies. These management companies develop lists of medicines approved for coverage based on the assessment of their cost and effectiveness. Thus, PBMs are not only drug plans but also organize the purchasing, dispensing, reimbursement of medicines for health insurers or other large purchasers of health care such as employers and unions.

How to control high drug price:

Another form of cost savings is mail-order pharmacies, which use large processing centers across the country that, automated with state-of-the-art computers, store information about each patient and dispense prescriptions based on that patient's insurance coverage, medical needs, and the frequency with which the person tends to use a drug. Cost savings, analysts say, come from bulk purchasing. Also, according to some analysts, to reduce the costs of prescription medicines some insurers are asking physicians in some cases to change prescriptions to less expensive generic brands or to prescribe similar brand-name counterparts.

Some doctors have criticized this 'switching strategy' that some mail-order pharmacies use, stating that can lead to drug substitutions that are not appropriate and that in some instances can cause patients to experience adverse reactions. Mail-order pharmacies state that they can often change to a generic brand without contacting a doctor but that they must receive a doctor's approval before changing to similar, but not identical, substitutes. Doing anything less, they state, could make the companies legally responsible if the substitute led to a bad reaction. That is why when comparing mail-order and retail pharmacies, consumer-

patients must take into consideration which is best in terms of costs, the monitoring of drug use and drug interactions, ease of obtaining prescription refills, and other elements that constitute quality pharmaceutical services²⁷.

Creation of drug limit of liability brings high cost and increase rent of pocket

Out-of-pocket drug costs for Medicare beneficiaries: “When Medicare became effective January 1, 2006, the average national monthly premium under the standard Medicare prescription drug was \$32 a month, or \$384 per year, with some plans offering premiums below that amount and others above that amount for their drug coverage. After the beneficiary meets the \$250 deductible for the program, Medicare would pay 75% of the drug costs up to \$2250 (or \$1687, with the patient paying the remaining \$53 out of pocket). If the beneficiary then incurs annual drug costs of \$2250 and \$5100, the patient will pay the total amount of \$2850 out of pocket under the national standard Medicare drug plan because the Medicare program does not cover this cost gap, also known as the ‘doughnut hole’.

That is a gap that is built into the program. When the annual drug costs or expense reach \$5100 or more, the Medicare program will pay 95% of the beneficiary’s drug bill and the beneficiary will pay the remaining 5% out of pocket at this catastrophic cost level. In other words, once beneficiaries accumulate \$3600 in annual drug bills out of their own pocket, the catastrophic drug coverage begins under the Medicare program. The \$3600 expense limit does not include the cost of their monthly premium for the Part D prescription drug program but does include deductibles, copayments, any out-of-pocket expenses beneficiaries pay for drugs while they are in the \$2850 gap, and any payments a friend or member of their family made in buying drugs, as well as any charitable groups or state

pharmacy assistance plan that did the same.

But in instances, only payments for those drugs that the beneficiary's plan covers, including exceptions the beneficiary receives, count toward the \$3600 limit. Payments that are not involved in the \$3600 out-of-pocket expense limit include the beneficiary's plan does not cover; payments an employer, union, or other third-party payer like the federal government or the beneficiary's own insurance plan makes; and drugs the beneficiary buys from Canada or other foreign countries which are not considered 'creditable'. In August 2008, the Henry J. Kaiser Family Foundation released a study that noted that in 2007 about 3.4 million Americans enrolled in Medicare Part D reached the gap in the prescription drug coverage also known as the 'doughnut', with the result that some stopped taking their medications²⁸.

Solution to Out-of-pocket on drug

In an effort to assist seniors who fall into the 'doughnut' in terms of prescription drug expenditures and bear the entire cost of their prescriptions medicines out of their own pocket, the Obama Administration and the US drug industry announced an agreement on June 20, 2009 whereby the drug industry over the ensuing decade would spend \$80 billion improving drug benefits for seniors. The drug companies would pay 50% of the cost of brand-name drugs for seniors who find themselves in the doughnut hole: a gap in coverage that is a feature of many plans providing prescription drug coverage under Medicare Part D.

In other words, seniors will receive 50% discount on these drugs. In addition, the entire cost of the drug would count toward patients' out-of-pocket costs, meaning their insurance coverage would cover more of their expenses than otherwise would be the case. While none

of the changes in the prescription drug program would directly lower government costs, several officials also stated that the industry agreed to measures that would provide the US Treasury with more money under federal health programs. In particular, officials stated that drug companies would likely end up paying higher rebates for certain drugs under Medicaid, the program that pays providers health care for the poor. Other sources of drug payment assistance, if a person is receiving free drug from a pharmaceutical drug manufacturer's patient assistance program the person can but only as long as the drug manufacturer keeps operating the program for Medicare beneficiaries. The federal government will still make certain that there is drugs are covered in that particular region.

Medigap policies with prescription drug coverage, if individuals have a Medigap plan that pays for prescription drug coverage, they can: (1) retain their current Medigap plan but get rid of its prescription drug coverage and sign up for the part D plan; (2) select another Medigap plan that does not include drugs so that can sign up for the part D plan; or (3) keep their current plan with prescription drugs, but people who already have such policies will be allowed to continue them indefinitely.

Medicaid prescription drug coverage, if Medicaid was paying for a patient's prescription drugs, after December 31, 2005 Medicaid no longer covered the patient's drugs if a prescription drug plan covered the same drugs. Rather, the person's prescription drug benefits are now the responsibility of Medicare Part D. If any elderly Medicaid recipient did not choose a Part D plan by December 31, 2005 then Medicare selected a plan for that person. But the problem with this process is that the selected program may not cover the drugs the person is being prescribed and the person would have to return to his/her own doctor to obtain a prescription for a different drug or change the prescription drug plan to

another Part D plan that does cover the patient's drugs. If a person decides to go into a new plan, the person has to fill out a new application and that will take time to get into a new plan²⁷.

Access and availability limitation, through categorization of hospital and benefits package:

Limited benefit policies concentrate on providing cover for the more important or expensive types of treatment, such as in-patient costs and day case treatment, but in the lower priced hospitals. To limit costs, treatment for psychiatric and addictive disorders is usually excluded, along with more common procedures for non-Life-threatening conditions, such as the extraction of impacted wisdom teeth.

Out-patient benefit is either totally excluded or very limited. Insurer may limit out-patient benefits in a number of different ways, for instance by:

1. restricting cover to hospitals within one particular hospital group;
2. imposing a low financial limit on the cost of out-patient treatment provided in any policy year; and
3. by restricting cover to only those out-patient consultations that are either necessary following surgery, or lead directly to surgery.

Benefit limits

Most PMI policies are supported by a table of benefits, which is a schedule of the type of medical services that are covered under the policy and the total benefits that may be claimed daily, weekly, annually or per procedure.

The purpose of the table is to clarify to the member the scale of cover provided under the

contract. This is then illustrated in an easily understood format so that each party (the member, the insurer and the provider(s) of medical services) understands the scope and limitations of the medical cover available under broad categories of medical services. An extract from a typical benefits table, with the various limits, is provided. Benefits available under the majority of healthcare insurance policies are for specialist treatment, with primary care from a GP usually excluded. Some policies may offer private cover with a GP as an option for an additional premium. Whilst appendix 1 is an extract from a typical benefits table, it could be that a special benefits table is constructed for a corporate scheme to include higher or lower limits and additional medical services, such as alternative medicine.

Why Benefit Limit on Long-term Ailment under Health Insurance Scheme

Limits are included within the policy for a number of reasons. However, they are chiefly imposed to at limit the exposure of the insurer where prolonged treatment is required for repeated occurrences of ill-health. Healthcare insurance policies are principally aimed at the alleviation of acute conditions. They are not intended to cover long-term chronic conditions, as the cost of such product offerings would not be commercially viable.

The limits to the cover provided for specialist's fees indicate to the medical profession the insurers view of a reasonable charge for the services provided and set de facto charging guidelines. The majority of specialists will, keep their fees within the benefit limits set by healthcare insurance providers. Allowances are made in the fees schedule for multiple procedures (where two separate m linked procedures may be performed through the same incision) and also for situations where medical complexity is encountered. However, some insurers do provide full cover for surgeons and anaesthetists' fees, arguing that the onus for

ensuring that the surgeon does not overcharge should rest with the insurer.

Segregated Benefits Package discourages people from joining Health Insurance Scheme

Under a pre-funded policy, the customer pays regular premiums or a single premium into an insurance policy. This happens while the insured is still in reasonable health, able to look after themselves and has no immediate need for specialist care. The level of monthly benefit is fixed at outset and can either be paid throughout life or for a limited period of time. However, if the insured never has a need for specialist care they will receive no benefit from the policy and the premiums paid will effectively be lost. This has resulted in many people deciding not to purchase LTC insurance. Currently, it is estimated that around one in five people will require long-term care. As the premiums for LTC insurance are quite high, many people have decided that there are more urgent priorities on which to spend their money.

Preventive health care cover is not covered on the health insurance scheme:

Private Medical insurance does not usually cover the cost of preventive medicine or health checkups, which are usually known as health screening. Some insurers give a discount on the fee for health screening, provided this is carried out either by their own company's screening service or a recommended alternative. Screening is generally carried out every two years and if any previously unknown medical condition is diagnosed then any treatment costs will be covered by the patient's health insurance (subject to the terms and conditions of the policy). This service can be used by both personal and group insurance policyholders.

Some health cash plans now include a payment towards the cost of a health screen and

screening may also be covered under some comprehensive PMI policies. As a result of their preventative effect, it is likely that more insurers will offer health screening benefits and services in future.

Basic Principles of Medical Insurance

The basic principle of medical insurance is that many members will pay premiums for the benefit of those members who will actually need private medical attention. Each member pays an identical basic age-related premium, and is entitled to treatment under healthcare insurance in the event of ill-health. However, the relatively high incidence of claims and their associated costs have made a considerable impact on medical insurance premiums in recent years and there is a need to ensure that all members are treated fairly. Since people with a history of ill-health are obviously more likely to require future treatment than people in good health, it would be unfair for them to receive medical insurance on the same terms.

The method commonly employed across the industry to deal with this is the exclusion of pre-existing payment. A pre-existing condition is an illness physical condition already diagnosed or treated before the individual sought medical insurance cover with the insurer. The effect of such an exclusion is that there is no insurance cover to pay for the treatment of this particular medical condition. However, there is full cover for the treatment of other, unconnected conditions that may arise. Where an applicant with a pre-existing condition is considering changing from one insurer to another it is important to identify if the new insurer will provide the same cover for the condition as the existing provider²⁹.

It may be helpful to understand why medical insurers impose such exclusions from benefit payment, instead of accepting the risk and increasing the standard premium rate according

to the risk posed by that member, as is common in life assurance. In life assurance, a specific amount of insurance is provided to cover the mortality risk of dying, an event that only happens once. Mortality is the term for the statistics that are used to estimate the probable life expectancy of a member. Medical insurance, however, has to cover the morbidity risk that the insured will need medical treatment involving unspecified costs: a need that may arise often during the insured's life. Morbidity is the term for the statistics used to estimate:

- the probability of the occurrence of certain medical conditions; and
- the frequency with which these conditions may affect a member during their expected life.

Limitation of Hospital Access:

PMI insurers negotiate voluntary annual pricing agreements with hospitals for each bed category, with prices fixed against mutually agreed limits. Frequently, package deals are agreed where all hospital costs, and sometimes specialists' costs for a routine procedure, are included in an overall price. Some policies allow patients to only use hospitals with which specially negotiated agreements have been made.

Quality is being Sacrificed for Cost in Health Insurance Scheme:

PMI insurers are structuring their benefit tables to produce a financial incentive for specialists to undertake more day case surgery, thus avoiding expensive overnight stays. These incentives may include paying a supplement to a specialist undertaking a surgical procedure as a day case. There may also be incentives for patients to use day case surgery.

PMI insurers have employed medical professionals to develop clinical guidelines sometimes known as protocols. These record the usual treatment of, and expected duration of, the most frequently encountered medical conditions. Clinical consensus panels and medical advisory boards are formed to agree clinical norms. These consist of representatives from the healthcare insurers and eminent specialists representing the medical profession. Insurers are then able to monitor claims costs against the mutually agreed clinical norms and highlight any divergence. Frequently, conferences and symposia are held to foster understanding between insurers and specialists. At these, data on an individual specialist's performance against the industry norms may be shared confidentially with them, in this way peer pressure is used to minimize unnecessary expenditure (for reducing the length of stay in hospital).

Managed care is cost containment:

The adoption of many of the above measures to control the continuing rise in medical costs has not been enough and premium increases have continued. Healthcare insurers have viewed the situation seriously; without intervention, the demand for healthcare insurance could be reduced because of the unacceptably high cost of premiums.

PMI insurers have begun to adopt principles of managed care. This originated in the USA where many of the health insurance organisations have exerted their control and influence directly on the medical profession and have laid down obligatory pre-approval procedures. The US healthcare model, where the health insurers exert a great deal of power and influence over healthcare deliverers, is different from that developing in the UK. There are some parallels, however, and many healthcare insurers in the UK have sought to implement some aspects of the managed care principles that have been used in the USA.

Managed care is a generic term that lacks a precise definition. However, in principle it aims to extend early intervention in the decisions surrounding medical care so as to ensure that all the procedures undertaken are necessary and that alternative and less extent. Medical help-lines may be set up through which prospective patients can be made aware of alternative treatments and so possibly avoid surgery. These may be voluntary, but they may be compulsory for corporate group schemes where the employer is equally enthusiastic about managing claims costs and therefore keeping premiums down.

Denial of Availability of Quality Hospital on Health Insurance Scheme:

Customers may be encouraged or directed to use particular hospitals or specialists with whom favourable pricing arrangements have been negotiated in return for promises of large numbers of patients. Second opinions from specialists may be offered to confirm and reassure the member that the treatment recommended is suitable and will alleviate the medical condition. Where treatment is pre-authorized, limits may be set on the amount and the cost of treatment. Medical providers may also be asked to seek further approvals where complications are encountered that require further treatment or an additional time in hospital. Close monitoring may be exercised for some conditions, such as those needing psychiatric care where clinical norms are hard to establish and the cost of treatment expensive. Home nursing may be suggested, to encourage an early discharge from hospital.

Some healthcare insurers are considering employing medical specialists on a session basis, so that a greater number of treatments can be delivered for a fixed cost³⁰.

Limit Access and Availability of Healthcare Facilities:

All of these strategies may be undertaken under the broad banner of managed care. Early signs are that managed care is here to stay in the healthcare insurance industry. The introduction of these techniques has been supported by members of both personally paid and company-paid healthcare insurance schemes. However, it can be argued that managed care techniques can reduce the choice for healthcare insurance members. This can both be in terms of the type of treatment available and where they are treated. Despite some initial resistance, it does seem likely that medical professionals will co-operate with healthcare insurers in the innovations incorporated in managed care.

Claims where treatment is carried out by a known provider: increasingly such claims may be paid directly to the supplier e.g. an optician or dentist. This avoids the customer having to pay all of the costs upfront (although the customer will still be responsible for any costs over and above the insured benefit level³¹).

Gag Rules and Trade Secrets in Managed Care Contracts, attainment of quality, accessibility and affordability in Health insurance scheme“ Gag rules clauses in managed care contracts that prevent physicians from disclosing information that the plan may find disparaging, but that could relate directly to the patient's health have recently been the subject of ethical condemnation and legislative prohibition. Another serious problem in managed care contracts, trade secrets, or guidelines and quality assurance mechanisms that are imposed on physicians while their origins are shrouded in proprietary secrecy, have by contrast received little attention. Responses to these ethical challenges to the physician's integrity must involve individual physicians, managed care organizations, professional

organizations, and public policymakers.

Non Disparagement Clause

Non-disparagement language requires a physician to refrain from making statements that could undermine patient, employer, union, or public confidence in the health plan. Such clauses may have a penalty, such as termination, attached. For example, one contract contained the following language: The plan may terminate this agreement immediately, if the Specialty Provider acts in such a way that undermines or may undermine the confidence of Members, potential members or the public in [the plan] or in the quality of care which Members receive.

According to HMO industry representatives, non-disparagement clauses are meant to protect a plan's business interests by requiring that physicians dissatisfied with an HMO complain to the HMO and not to the patient. In May 1996 testimony before the Subcommittee on Health and Environment, House Committee on Commerce, the President and CEO of AAHP testified that "the primary purpose of an anti-disparagement clause is simply to prevent a provider from involving patients in disputes and disagreements between physicians and health plans.

However, AMA and several other medical associations we met with believe that the non-disparagement language could preclude physicians from expressing disagreement with the plan's coverage or utilization decisions regarding a course of treatment. Physicians told us that, if broadly interpreted, this clause could prevent physicians from criticizing or questioning a plan's rulings on behalf of the patient.

The health care attorneys we surveyed had varied opinions on non-disparagement clauses.

Sixty-four percent of attorneys representing physicians reported that such clauses could have a moderate to great effect on a physician's discussion of patient treatment options, while 25 percent of those representing HMOs took this position, and 46 percent of those working with both groups agreed with this statement.

Non Solicitation Clause

A non-solicitation clause bars physicians from providing patients with information that might encourage them to enroll in another health plan. For example, a contract may state that the Physician shall not directly or indirectly engage in any action, which Health Plan may reasonably interpret to be signed to persuade a Member to discontinue his/her relationship with Health Plan, to dis-enroll from a plan or provider covered by a contract with Health Plan, or to encourage a Member to receive healthcare services from physician on a fee-for-service basis." Such a clause would preclude a participating physician from informing patients about the benefit coverage offered by a competing health plan or that the physician's health plan affiliation has changed.

The managed care industry believes that health plans should be able to prohibit physicians in their networks from soliciting patients to join a different plan that the physician also works for or will be leaving to work for. However, some physician associations expressed concern that such a clause could constitute "patient abandonment." In their view, it is essential to notify patients in the course of treatment that their physician will not be able to continue their care under that plan.

Most health care attorneys responding to our survey indicated that non-solicitation clauses would have little or no effect on physician discussions of treatment options. Among the

attorneys representing HMOs, 89 percent believed non-solicitation clauses were not a problem for physician-patient medical communication; among those working with physicians, 68 percent shared this opinion, as did 75 percent of those representing both groups.

Although infrequent, some non-solicitation clauses specify that, if the agreement between the plan and the physician is terminated, the physician is prohibited from communicating with plan members concerning the termination, the options available to members to join other plans or to switch to another doctor in the same plan, or that the physician "will no longer be the member's health care provider."

Any such communication by a physician with a member or any attempt "directly, indirectly, or by implication, to advise or encourage" a plan member to dis-enroll from the plan, to switch to another plan, or to change providers is a breach of contract.⁸ According to the AMA, this type of contract provision has strong potential for inhibiting discussion of treatment options between a physician whose relationship with the plan has been terminated and his patients.

Although the plan agrees to notify members at least 30 days in advance of the physician's termination, it is not clear that this will always be possible because the contracts in which this clause appears also provide that the plan may terminate the physician immediately in the event that any one of a dozen events occur.

Business Confidentiality clause

Business confidentiality clauses require physicians to maintain the confidentiality of such proprietary information as the plan's payment and incentive structure, medical management

criteria, and clinical practice protocols. One such clause reads "You agree to treat as confidential, this Agreement (including the compensation provisions herof), all provider and Covered Person listings, utilization data, reports and procedures, quality assurance procedures, credentialing procedures, and all other procedures, programs and protocols of [the plan] or Program Sponsors and You agree not to disclose any such information to anyone unless such disclosure is authorized in writing by [the plan] or required by applicable law."

The HMO industry believes this type of contract clause protects their business interests. Testifying before the Subcommittee on Health and Environment, House Committee on Commerce, in May 1996, the President and CEO of AAHP stated that it is appropriate for health plans to restrict the disclosure of specific coverage decision procedures and compensation amounts because "the competition among health plans is intense, and the release of such information about one plan can give its competitors an unfair advantage and eliminate the incentive to find more effective methods for delivering care."

Some physician associations argue that such contract provisions prevent physicians from telling a patient that the HMO financial arrangements may penalize them for making referrals to specialists. Nevertheless, most of the attorneys responding to our survey believe that confidentiality clauses are unlikely to restrict discussions of treatment options. Among attorneys representing physicians, 68 percent of those took this position, compared to 83 percent of those representing HMOs and 77 percent of those representing both groups.

In March 1996, HCFA announced rules requiring managed care plans under Medicare and Medicaid to disclose financial arrangements for physicians to the agency and patients. In *Shea vs. Esenstein*, the court held that the failure of an HMO providing services for an

employee benefit plan to disclose financial incentives that discourage referrals is a breach of its fiduciary duty³².

National Health Insurance Scheme Coverage:

“ABUJA – Nigerian Medical Association, NMA, has decried the enrolment of less than five per cent of Nigeria’s population into the National Health Insurance Scheme (NHIS) after 15 years of the scheme’s flag-off, saying the statistics are not only unfortunate but shameful.

NMA President, Dr Francis Faduyile, stated this on Monday in Abuja at a World Press Conference to herald the 2nd National Health Summit. Faduyile, who also lamented Nigeria’s failure to maintain a sustainable primary healthcare system, said the national health summit will serve as a platform for proffering solutions to the myriad of problems facing the nation’s health sector.

He noted that the first national health confab by the association held in Delta state in 2013 formed the template for the eventual enactment of the National Health Act; the Basic Healthcare Provision Fund (BHCPF), and the association’s strategic plan among others.

“It is unfortunate that after 15 years of the NHIS, we still have less than five per cent enrolment. Whereas, neighbouring countries like Ghana have encouraged over 40 per cent of their population to be enrolled in its health insurance scheme,” he lamented.

While urging the new ministers of health to ensure a more robust implementation of the NHIS program to boost enrolment, Faduyile also called on them “to also work closely with

the 36 states and FCT to increase funding for health and ensure the primary healthcare centres across the country are functional⁸.

Universal Health Coverage must be High Quality to improve Patients' Health Outcomes:

Shakina lives in a developing country. Although there is a public hospital near her home, she chooses to travel four hours by bus to go to a well-liked, private hospital in the city. She has heard from her friends and neighbors that they were pleased with the care they received at this hospital and to her they seem healthier and happier when they get back. She has heard bad stories from other friends who went to the closer, more affordable, public hospital - they returned home sicker than when they left.

Shakina's story reminds us that all people, regardless of socioeconomic class and means, want high-quality healthcare and that they will often choose higher quality care even if it is more expensive and less accessible. Under the World's Health Organization's definition of universal health coverage, all people and communities can use the promotive, preventive, curative, rehabilitative and palliative health services they need, of sufficient quality to be effective, while also ensuring that the use of these services does not expose the user to financial hardship. The concept of quality has only recently been built into universal health coverage policies and has not yet been sufficiently addressed. If health investments are to lead to the emergence of more productive and equitable societies and economies, countries need to focus on improving quality.

The three priorities of health care delivery – cost, quality, and access – need not be at odds with each other. Greater use of health care facilities due to lower costs and shorter

distances to travel will only lead to better health outcomes if quality of care is guaranteed. Therefore, we must make high-quality healthcare services affordable and accessible in order to effectively implement universal health coverage. Simply providing access for more people to lower quality care won't achieve universal health coverage.

Poor-quality care is wasteful, costly, and dangerous. It is estimated that between 5.7 million and 8.4 million people die each year in low- and middle-income countries due to poor-quality care. In other words, in many countries, a person has a greater chance of dying from receiving poor quality care than from going without care entirely. In addition to the human cost, poor quality also has an economic cost. Poor productivity and wastefulness, resulting from poor quality of health care, costs these countries around \$1.4 trillion to \$1.6 trillion per year. Poor-quality care proves costly for societies when unhealthy adults are less productive at work and unhealthy children cannot perform well at school.

High-quality care is cost-effective and leads to an earlier and higher return on investment. Approximately 15% of hospital expenditures in high-income countries are used to correct preventable complications of care and patient harm. This is a price that is an inconvenience to high-income economies and completely unaffordable for low- to middle-income countries. In addition, poor-quality care affects the poor and vulnerable disproportionately. While investing in higher quality health systems costs more upfront, costs are lowered over the long-term through more efficient workflow; fewer medical errors and preventable complications; elimination of ineffective treatments and procedures; fewer duplicated services; and less waste overall.

Improving quality requires a holistic approach. Countries that want to improve quality of care need to consider interventions across different domains (leadership, information, patient and population engagement, regulation and standards, organizational capacity, models of care) across different levels of the health care system. Building a national strategy for quality is an important first step to agree on a clear set of goals, define suitable interventions and tools and align different stakeholders' efforts to improve quality of care. Shakina chose to travel a long distance for high-quality care instead of taking her chances on accessible, poor-quality care. We need to make it easier for Shakina to receive the high-quality care she deserves, at a reasonable distance from her home, from a skilled health professional that puts her at the center of her care. By doing this, we will see that in the end, high-quality care really does pay off³³.

Out-of-Pocket Costs hit the Poorest Hardest:

Every year, over 900 million people face severe hardship and 90 million are tipped into extreme poverty for seeking medical treatment. With the rising costs of out-of-pocket health care expenditures, currently estimated at half a trillion dollars globally, the number of people affected by this trend is expected to increase further, improving not just access to Universal Health Coverage, but also its quality. Providing financial protection contributes to reducing inequality, a core principle of the Sustainable Development Agenda. It means providing quality health care even for those without deep pockets. Unless the current situation is addressed, however, soaring out-of-pocket payments risk undermining global efforts to reduce poverty as this trend tends to hit the poorest people hardest³⁴.

2.2. Theoretical Framework

2.2.1. Transfer of Risk

The conventional explanation for purchasing insurance is to transfer risk. Psychologists, however, have shown that this explanation does not match actual behavior. They find that people generally prefer the risk of no loss at all to the certainty of a smaller actuarially equivalent loss, a situation exactly opposite to the one represented by the purchase of insurance. Nevertheless, people do purchase insurance, so there must be an explanation other than risk transfer for purchasing it. Of the explanations so far advanced, however, none have yet developed a wide acceptance. Regardless of risk issues, people will be more likely to purchase insurance when the premium is low compared to the value of the coverage to the consumer. Moral hazard raises the premium, as does adverse selection. The presence of either makes the purchase of insurance less likely. With health insurance, the tax subsidy can reduce the effective premium to less than the actuarially fair cost of insurance. This would increase the likelihood that health insurance is purchased. Finally, because of the value we place on our health, we desire access to a full range of health care. Health insurance is often the only affordable way of gaining access to this care, given the high costs of many of these procedures³⁵.

2.2.2 Moral Hazard in Health Insurance

The focus of the moral hazard literature has instead been on what is sometimes referred to as “ex post moral hazard”. That is, on the responsiveness of consumer demand for healthcare to the price she has to pay for it, conditional on her underlying health status^{36,37}. In that sense, the use of the term “moral hazard” is a bit of an abuse of the “hidden action”

origin of the term. The “action” that is, the individual’s healthcare utilization is in fact observed (and contractible), and the asymmetric information problem may be more naturally described as a problem of “hidden information” (regarding the individual’s health status). Yet, to stay consistent with decades of abuse of terminology in the entire health insurance literature, we use the term in a similar way and by “moral hazard” refer to how consumer demand for healthcare responds to the out-of-pocket price the consumer has to pay for that care.

Throughout this paper, we follow decades of health insurance literature and use the term “moral hazard” to refer to the responsiveness of healthcare spending to insurance coverage. Consistent with the notion of hidden action, which is typically associated with the term “moral hazard,” it has been conjectured that health insurance may induce individuals to exert less (unobserved) effort in maintaining their health. For example, an author modeled health insurance as reducing individuals’ (unobserved) effort in maintaining their health; because health insurance covers (some of) the financial costs that would be caused by poor health behaviors, individuals may have less incentive to avoid them they may exercise less, eat more cheeseburgers, and smoke more when they have insurance coverage^{38,39}.

However, this so-called “ex ante moral hazard” has received very little subsequent attention in empirical work from the literature. This may be because it is not empirically relevant in many contexts the increased financial cost associated with poor health is not the only cost, and probably not the most important cost of being sick.

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healthcare to the price she has to pay for it, conditional on her underlying health status. In that sense, the use of the term “moral hazard” is a bit of an abuse of the “hidden action” origin of the term. The “action” that is, the individual’s healthcare utilization is in fact observed (and contractible), and the asymmetric information problem may be more naturally described as a problem of “hidden information” (regarding the individual’s health status). Yet, to stay consistent with decades of abuse of terminology in the entire health insurance literature, we use the term in a similar way and by “moral hazard” refer to how consumer demand for healthcare responds to the out-of-pocket price the consumer has to pay for that care^{36,37}.

Consumer cost-sharing is the typical name used for determining the out-of-pocket price the consumer has to pay for healthcare. Because the set of healthcare services is broad, and the price of each service could vary, insurers often specify coverage as a percentage share of the total healthcare spending. The share of total healthcare spending paid by the individual is referred to as “consumer cost-sharing”; the remaining share is paid by the insurer. For example, a 20% consumer co-insurance or cost-share means that for every dollar of healthcare spending, the consumer pays 20 cents out of pocket and the insurer pays 80 cents.

Typical health insurance contracts are annual and do not specify a constant consumer cost-share. Rather, they specify the consumer cost-sharing as a function of the cumulative (over the covered year) amount of healthcare spending. This function is typically concave. Figure 1 shows a stylized example of a typical contract. This example shows a concave, piece-wise linear schedule with three “arms”. In the first the deductible range the individual faces an out-of-pocket price of 100%; every dollar of healthcare spending is paid fully out

of pocket. After the deductible is exhausted, which in this example occurs at \$500 in total spending, the individual enters the “co-insurance” arm, where she faces a price of 10%; for every dollar of healthcare spending. Finally, once the individual has spent a total of \$3,500 out of pocket (or \$30,500 in total spending), she reaches the “out-of-pocket maximum” (also known as “stop loss” or “catastrophic coverage”) arm, at which point she faces no cost-sharing and has complete insurance coverage.

Moral hazard is of economic interest because it creates an obstacle to the consumption-smoothing purpose of insurance. Insurance is valuable because it creates a vehicle for transferring consumption from (contingent) states with low marginal utility of income (e.g., when one is healthy) to states with high marginal utility of income (e.g., when one is sick). The first best insurance contract would equalize marginal utility across different states; the existence of moral hazard makes it infeasible to obtain the first best. If individuals’ healthcare utilization responds to the price they have to pay for it and the underlying health status is not contractible, the cost of providing insurance will rise and individuals may no longer be willing to pay the break-even price of full insurance. Therefore, the presence of moral hazard leads optimal insurance contracts to be incomplete, striking a balance between reducing risk and maintaining incentives⁴⁰.

A declining out-of-pocket price schedule is a natural way to optimally trade off the goal of combating moral hazard through higher consumer cost-sharing with the goal of providing risk protection through lower consumer-cost sharing. Since the value of insurance is increasing in the total spending, it makes sense to provide a policy that provides greater protection when spending is greater. Although this concave feature is common in many

health insurance contracts in the United States, we will also discuss in what follows settings where contracts deviate from this pattern.

The existence, magnitude, and nature of the moral hazard response is thus a key input into the optimal design of private or public health insurance contracts. This is a natural reason for the study of moral hazard to attract the considerable theoretical and empirical attention that it has. However, moral hazard in health insurance has also attracted academic and policy interest for the potential it raises that higher consumer cost-sharing could help reduce the high and rising levels of healthcare spending as a share of GDP in most developed countries. This has prompted, for example, policy interest in high-deductible health insurance plans in the United States as a way of reducing aggregate healthcare spending levels. The majority of healthcare spending, however, is accounted for by a small share of high-cost individuals whose spending is largely in the “catastrophic” range where deductibles and co-payments no longer bind. This suggests that for meaningful impacts on health care spending the incentives for health insurance for providers rather than for consumers may be more important; we discuss this briefly in the conclusion.

Is There Moral Hazard in Health Insurance?

We now know what moral hazard in health insurance is (or at least what we have all come to call it) and why it could be important for affecting the optimal design of health insurance contracts. But does it exist? Does health insurance actually increase healthcare spending? Health insurance, by design, lowers the price individuals pay for their medical care. First-year economics teaches us that demand curves tend to slope down, that when we make something cheaper, people tend to buy more of it. So the answer may seem obvious. Yet, in the context of healthcare, there are (at least) two views that are less sure.

One view holds that healthcare cannot be analyzed like any other good. Demand for healthcare, in this view, is determined by “needs”, not by economic factors, or as an economist might put it, the demand for healthcare is completely inelastic with respect to its price. Gladwell has expressed this view forcefully in a New Yorker article tellingly entitled “The Moral Hazard Myth”. Expounding his central premise that the “myth” of moral hazard in health insurance is a singularly American obsession that has created our singular lack of universal coverage he writes “The moral hazard argument makes sense only if we consume healthcare in the same way that we consume other consumer goods, and to [some] this assumption is plainly absurd. We go to the doctor grudgingly, only because we’re sick.”

There is also a second view, according to which the demand for healthcare in fact slopes up! One version of this conjecture is that health insurance will improve people’s health by increasing timely and effective medical care (e.g., preventive care or better management of chronic conditions), and that this improved health will in turn reduce healthcare utilization. Another version points to the efficiency of healthcare use as a channel through which healthcare spending will fall when insurance coverage becomes more generous. For example, although most healthcare providers in the United States can choose whether or not to see patients, emergency rooms cannot; the Emergency Medical Treatment and Active Labor Act (EMTALA) requires that hospitals provide emergency medical treatment to all patients.

There is therefore widespread speculation that one of the benefits of providing health insurance to previously uninsured individuals is to get them out of the expensive emergency room and into cheaper primary care⁴¹. Indeed, this idea that insuring the

uninsured will reduce expensive (and presumably inefficient or unnecessary) emergency room visits has been a leitmotif of advocates of expanding health insurance coverage in the United States. For example, in making the case that Michigan should expand Medicaid coverage under the Affordable Care Act, Republican Governor Rick Snyder's policy team argued "Today, uninsured citizens often turn to emergency rooms for non-urgent care because they don't have access to primary care doctors—leading to crowded emergency rooms, longer wait times and higher cost. By expanding Medicaid, those without insurance will have access to primary care, lowering costs and improving overall health.

Thus, there are three widely circulated competing claims: health insurance increases, decreases, or does not change healthcare spending. Research allows us to move from rhetoric to reality. Ultimately, the existence and sign of any moral hazard effects of health insurance is an empirical question. It is a challenging empirical question because people who have more generous health insurance presumably differ in other ways from people with less generous health insurance, and these differences may be correlated with expected healthcare spending. Indeed, the basic theory of adverse selection suggests that those who have more health insurance are on average in worse health (and hence face higher expected healthcare spending) than those with less health insurance. How to separate such potential selection effects from the treatment effect of interest, namely moral hazard?

Describing the evidence from two randomized evaluations of the impact of health insurance on healthcare spending: the RAND Health Insurance Experiment from the 1970s, and the 2008 Oregon Health Insurance Experiment. We review the evidence from each, which shows that moral hazard exists: health insurance increases healthcare spending. We then describe quasi-experimental evidence of moral hazard that uses the existence of

“bunching” at a convex kink in the budget set created by the health insurance contract to also establish the presence of moral hazard (i.e., a behavioral spending response to the contract). We discuss the institutional setting for the RAND Experiment and the “bunching” estimator in some detail, since we will describe further analyses of both these settings in more depth in subsequent sections⁴².

2.2.3. Principle of Risk of No Loss (Risk Pooling)

“The pooling of risk is fundamental to the concept of insurance. A health insurance risk pool is a group of individuals whose medical costs are combined to calculate premiums. Pooling risk together allows the higher costs of the less healthy to be offset by the relatively lower costs of the healthy, either in a plan overall or within a premium rating category. In general, the larger the risk pool, the more predictable and stable the premiums can be.

Is the size of a risk pool the only factor? No. Although larger risk pools are typically more stable, a large risk pool does not necessarily mean lower premiums. The key factor is the average health care costs of the enrollees included in the pool. Just as a pool with healthy individuals can result in lower-than-average premiums, a large pool with a large share of unhealthy individuals can have higher-than-average premiums. What is “adverse selection”? Adverse selection describes a situation in which an insurer (or an insurance market as a whole) attracts a disproportionate share of unhealthy individuals. It occurs because individuals with greater health care needs, when given the opportunity, are more likely to purchase health insurance and to purchase health insurance with richer benefits than individuals with fewer health care needs.

Why is adverse selection a problem?

Adverse selection increases premiums for everyone in a health insurance plan or market because it results in a pool of enrollees with higher-than-average health care costs. Adverse selection is a byproduct of a voluntary health insurance market in which people can choose whether and when to purchase insurance coverage, depending in part on how their anticipated health care needs compare with the insurance premium charged.

The higher premiums that result from adverse selection, in turn, may lead to more healthy individuals opting out of coverage, which would result in even higher premiums. This process typically is referred to as a “premium spiral.” Avoiding such spirals requires minimizing adverse selection and instead attracting a broad base of healthy individuals, over which the costs of sick individuals can be spread. Attracting younger adults and healthier people of all ages ultimately will help keep premiums more affordable and stable for all members in the risk pool⁴³.

Why do premiums depend on who buys coverage?

Health insurance premiums are set to pay projected claims to providers, as well as insurers’ administrative expenses, taxes, and profit. The largest component of health insurance premiums is the medical spending paid on behalf of enrollees. As a result, health insurance premiums reflect the expected health care costs of the risk pool. Because health spending is skewed—that is, a small share of consumers account for a large share of total health spending—if a risk pool attracts a disproportionate share of unhealthy individuals, premiums will be higher than they would be if the risk pool attracted an average population.

How does risk pooling currently work in the individual market?

The Affordable Care Act (ACA) requires that insurers use a single risk pool when developing premiums. The single risk pool includes all ACA-compliant plans inside and

outside of the marketplace/exchange within a state. In other words, insurers must pool all of their individual market enrollees together when setting the prices for their products. This means that the costs of the unhealthy enrollees are spread across all enrollees.

How does the Affordable Care Act protect against adverse selection?

The Affordable Care Act includes a number of provisions that are intended to broaden participation in the individual market. Among the more significant of these are the individual mandate, premium and cost-sharing subsidies for low-income individuals, and a limited open-enrollment period. The Affordable Care Act rules also support a level playing field. That is, the rules governing the insurance market regarding issue, rating, and benefit requirements apply equally to all insurers. In addition, the Affordable Care Act includes a permanent risk adjustment program that transfers payments among insurers in the single risk pool based on the relative risk of their enrollees.

By limiting the adverse selection in the market as a whole and mitigating the effects of enrollee risk profile differences among insurers, the single risk pool requirement, uniform market rules, risk adjustment program, and provisions to encourage enrollment work together to facilitate market competition and the Affordable Care Act's pre-existing condition protections.

What if more flexibility were allowed in the Affordable Care Act market rules?

If insurers were able to compete under different issue, rating, or benefit coverage requirements, it could be more difficult to spread risks in the single risk pool. Currently, risk adjustment is used to calibrate payments to insurers in the single risk pool based on the relative risks of their enrolled populations. By reducing insurer incentives to avoid high-cost enrollees, risk adjustment helps support protections for those with pre-existing conditions.

Some changes to market rules, such as increasing flexibility in cost-sharing requirements, could require only adjustments to the risk adjustment program. Other changes, such as loosening or eliminating the essential health benefit requirements, could greatly complicate the design and effectiveness of a risk adjustment program, potentially weakening the ability of the single risk pool to provide protections for those with pre-existing conditions.

What if some plans were allowed to avoid ACA rules altogether?

If some plans were allowed to avoid the ACA rules altogether, then plans competing to enroll the same participants wouldn't be competing under the same rules. Noncompliant plans would likely be structured to be attractive to low-cost enrollees, through fewer required benefits, higher cost-sharing, and premiums that vary by health status.

Higher-cost individuals would tend to want the broader benefits and pre-existing condition protections of ACA-compliant coverage. Rather than having a single risk pool, in which costs are spread broadly, there would be in effect two risk pools—one for ACA-compliant coverage and one for noncompliant coverage. As a result, average premiums for ACA-compliant coverage could far exceed those of noncompliant coverage, thereby destabilizing the market for compliant coverage. The instability would be exacerbated if market rules facilitate movement of people between the two pools (e.g., if people with noncompliant coverage can easily move to compliant coverage when health care needs arise).

By transferring payments among insurers based on the relative risk of their enrollees, the ACA risk adjustment program can reduce premium differences resulting from some insurers attracting more costly enrollees than others. However, risk adjustment programs transfer payments within the same risk pool, but not between pools, especially when the different pools have different issue and rating rules. Therefore, in a market with separate

risk pools for compliant and noncompliant coverage, costs would no longer be spread over the broad enrollee population. In addition, for risk adjustment to work properly, the benefit coverage requirements need to be fairly similar across plans. Even if the compliant and noncompliant plans were pooled together for risk adjustment purposes, the potentially large differences in underlying benefits between compliant and noncompliant coverage would make risk adjustment extremely difficult to implement. And any resulting risk transfers from noncompliant plans to compliant plans would be very high, thus negating much of the premium advantages of noncompliant coverage. Instead of using risk adjustment to mitigate the higher premiums needed for compliant coverage, external funding could be directed to the compliant pool, for instance in the form of a reinsurance program. However, the funding for such a program would have to be substantial and permanent.

This paper work, concur with the principle of Risk of No Loss (risk pooling in Affordable Care Act) as against the principle of Risk transfer, Moral Hazard, and Adverse Selection. Therefore, it is working towards health insurance scheme that will have universal health care benefits package, of a coverage that will include all health care needs of Nigerian at a barest minimum premium that will reflect the capacity of poorest person in the nation. This will also include enacting law for enforcement of citizen enrolment on health insurance scheme⁴⁴.

2.3 Review of Empirical Studies

A study titled “Nigeria National Health Insurance Scheme (NHIS): An Overview revealed that NHIS is a long awaiting scheme to improve the health status of Nigeria by rendering financial cost and create access for people and that it is the scheme that guarantees the

provision of needed health services to families. The study recommended that based on the challenges faced by the health insurance scheme, the initial way forward is to put the scheme in good light by educating Nigerians on what health insurance is all about, its operations and the many benefits. Proper education and awareness programs especially among people outside the formal sector should not be overlooked and abuses of the system by the service providers and the enrollees can also be checked by proper education. The government should make health a priority and be committed to the course of improved healthcare delivery. Descriptive survey was used; however, the study did not evaluate the effectiveness of the scheme, but only consider the overview of the scheme⁴⁵.

In an article published in 2020, with the title “Healthcare must be affordable and accessible, but also high quality” it was revealed that quality health services make health systems resilient. They are prepared for anything, can maintain core functions amongst changing situations, and are informed by lessons learned, constantly adapting and improving. Even in a crisis during times of political unrest, or during an epidemic, resilient health systems can rely on their basic processes to deliver high-quality services⁴⁶. Further, another study stated that the dissatisfaction of healthcare providers is as a result of intensity control and cost containment of Health Maintenance Organisation in health insurance scheme is the factor affecting the quality of health care delivery and concluded that for primary care patients with pain or depressive symptoms, primary physician job satisfaction is associated with some measures of patient-rated quality of care but not health outcomes⁴⁷.

A book titled “The Health Crisis: Opposing viewpoints”, here the author revealed that there are different thought and views concerning health insurance scheme, in which it was discovered that health insurance is cost containment, it does not value quality of care given,

also base its access and availability on cost, however, the author does not carry out a primary research work into detail of different opposing views raised against health insurance scheme, rather leverage on the secondary data gathered from different authors⁴⁸. Another study titled “An evaluation of National Health Insurance Scheme (NHIS), the findings in this study show that only 24% of adults are enrolled in the scheme most of whom are government employees between the ages of 18 and 40 years. 58% of respondents were aware of the existence of the scheme and 61.5% have benefitted from the scheme. Of the 24% enrolled in the scheme, 61.5% were satisfied while 26% expressed dissatisfaction with the services received in the scheme. Notably, 41% of respondents preferred the NHIS to the fee for service system while 54% preferred the NHIS to private insurance schemes. Only 14% preferred private insurance or the fee for service to the NHIS. Another 44% would prefer an increase in their contributions from 5% to 7.5% or 10% to allow inclusion of other services excluded in the benefit package. Yet another 52% opines that the contribution for NHIS is a worthwhile venture. The study only considered the availability of services as factor hindering the effective coverage of National Health Insurance Scheme only, not including corporate and state health insurance scheme in the study⁴⁹.

A study on Performance Evaluation of a Health Insurance in Nigeria using Optimal Resource Use: Health Care Providers Perspectives, found that the fewer the number of enrollees with the providers, the better the claims review. However, a possible explanation could be that providers who are overcrowded with enrollees tend to have difficulties with the claims review, which might in turn lead to negative effects on the monitoring mechanism of the insurance scheme. This study demonstrates that better availability of information on full entitlement, leads to a better active monitoring mechanism in the

insurance scheme. The findings also revealed that negative consequences due to poor capitation payment resulted in a negative effect on the claims review⁵⁰. Also, another study titled “The response of providers to Capitation payment: a case study from Thailand Health Pol.” discovered that health insurance benefits package is not robust enough to take care of the citizen health needs, so also, is that capitation paid for enrollees on the scheme is not commensurate to the utilization rate of enrollees on the scheme, the study did not look into the principle of pooling of risk and affordable care Act in solving the capitation and other tariff issues, rather it focus on what can motivate providers so as to provide quality, accessible, and available care⁵¹. Further, a study titled “What does access to health care mean?” revealed that that the extent to which population gain access to healthcare services on health insurance, depends on financial, organizational and cultural barriers which limit the utilization of services. It also measures equity of access in terms of the availability, utilization or outcome of services, however, the study only consider the access and availability of care without considering the factor that will be responsible for it in detail⁵².

The research work titled “Equity of access to health care services: theory and evidence from the UK” revealed that there is inequality in access to some types of health care in United Kingdom, It also draws that theoretical frame work and lesson learn from the United Kingdom are directly relevant to research from other countries, seeking to examine equity of access in a wide variety of institutional setting, and that social-economic group has influence on health care access and equity of care given in the scheme, however, the research work concluded by saying that the evidence to the methodology is inadequate, therefore, making it difficult to draw firm conclusion, which in turn limit the scope for recommending appropriate policy to reduce inequity of access⁵³. A study titled “Gag Rules

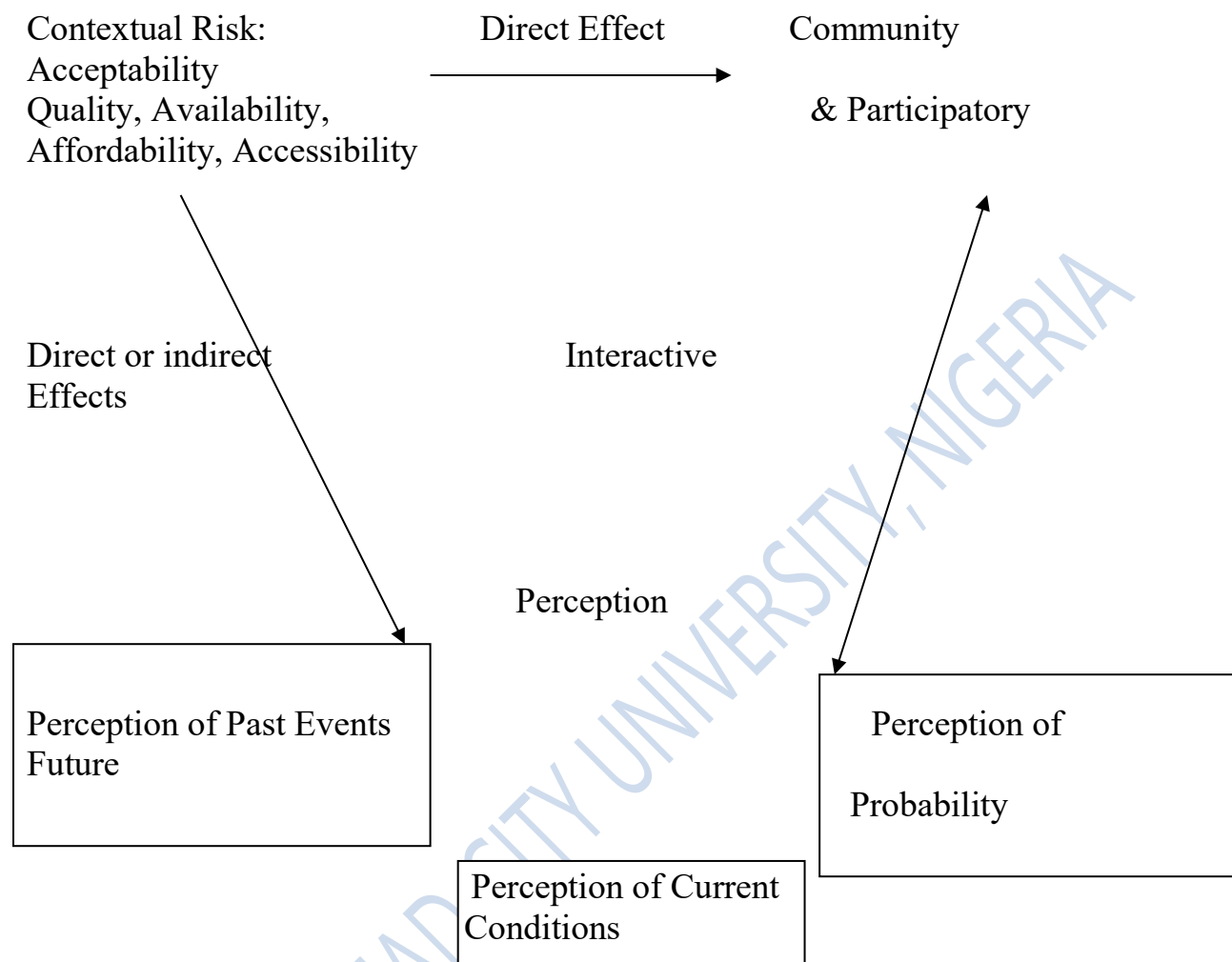
and Trade Secrets in Managed Care Contracts Ethical and Legal Concerns” find out that managed care cannot achieved quality, accessibility, availability and affordability in its healthcare delivery, just because of some Gags Rules Clauses embedded in managed care contract, the study only examine and identify some secret rules and clauses in contract of managed care between Health Maintenance Organisation and Healthcare Providers, which hinders attainment of quality, availability, accessibility and affordability in healthcare services to be rendered to patient who are on health insurance scheme⁵⁴. Another study titled “Affordability, Availability and Acceptability Barriers to Health Care for the Chronically Ill: Longitudinal Case Studies from South Africa” showed that health care is not being sought for a substantial proportion of chronic illnesses, with many of those who have sought care not receiving regular care. Poor case identification and under-treatment have been shown to be important in other South African studies. Only 46% of those in need are receiving anti-retroviral treatment for AIDS; evidence from rural South Africa suggests the health service identifies only 70% of TB cases. Internationally, evidence shows high levels of mortality due to uncontrolled chronic disease. A recent study comparing data across 23 low and middle income countries reported death rates from chronic diseases 54% higher for men, and 85% higher for women, than in high income countries. Availability of chronic care services is a first, and obviously central, factor influencing identification of illness and access to care. Respondents in the study faced a series of problems that included: insufficient clinical services at the clinic level necessitating referral, interrupted drug supplies, referrals that were hampered by a lack of ambulances, and weaknesses in administrative processes. Various South African studies on the quality of care provided at public facilities for hypertension and diabetes, for example, identify similar factors: nurses with insufficient knowledge to treat a particular chronic condition, a lack of functional

equipment (such as baumanometers, broad BP cuffs, or equipment of measure blood glucose levels) leading, for example, to hypertensive patients being referred to hospital to initiate treatment, medicine shortage, and inadequate patient record keeping⁵⁵. Findings from a research titled “Health Economics” showed that Universal Health Care benefit package is the solution to having quality, accessible, available and affordable healthcare services in Health insurance scheme. It also stated that causes of unequal access and non-affordability of some care services are as a result of principle of Moral Hazard, Adverse selection. Furthermore, it was deduced that corporate health insurance scheme is not cheap in term of premium and cost of services. The reason for use of generic drugs on health insurance was also analyzed. The gap in the study is that it did not pinpoint which of the parameters of healthcare services is lagging behind in the health insurance scheme⁵⁶.

Findings from another study showed that for health insurance to be quality, accessible, available and affordable, enrolment on health insurance scheme must be made mandatory for all populace, there must be universal benefits package which address the health needs of the populace, and at a bearable premium that is commensurate to the economic status of masses, using the principle of Pure Risk of no loss. Consequences of mandatory enrollment of citizen on the health insurance scheme is not being research on, considering the aspect on human right to make choice. Also, the issue of tax sharing and dedication of huge tax to healthcare is not research on. The effect of subsidy, as it is in Premium Motor Spirit, Electricity Power Subsidy in Nigeria setting was not been considered⁵⁷.

2.4 Conceptual Framework





Source: Researcher's work (2022)

2.5 Summary of Literature Reviewed

Literatures relevant to this study has been reviewed in this chapter, it highlights scholars' opinions about the topic of this research which is the Perception of Service Delivery by National Health Insurance Scheme Enrollees in South West, Nigeria. National Health Insurance Scheme (NHIS) is a long awaiting scheme to improve the health status of Nigeria by rendering financial cost and create access for people and that it is the scheme that guarantees the provision of needed health services to families, this paper work has find

out that the present health insurance scheme has not improve the health status of Nigeria, neither has the financial burden and expected access level has been achieved. This paper is in support of another scholar who stated that for any healthcare services to be of standard, it must be quality, accessible, available and affordable. Further, the dissatisfaction of healthcare providers as a result of intensity control and cost containment of Health Maintenance Organisation in health insurance scheme is the factor affecting the quality of health care delivery, this was supported in this study that people are dissatisfied with the present health insurance scheme owing from their complaints about the scheme quality of drugs, as well as treatment rendered.

It was find out that there is decline in quality of care rendered under health insurance care compare to services rendered to those on direct fee for service or direct retainership which is in support of the findings in this research work. Non-availability of required services in the benefit package of Nigeria Health Insurance Scheme as well as delay in receiving required services has affected the coverage of the scheme in Nigeria which was also confirmed from the findings in the study. Sequel to that, a study revealed that there are different thought and views concerning Health Insurance Scheme, in which it was discovered that health insurance is cost containment, it does not value quality of care given, also base its access and availability on cost, this was reflected in the study as the rate at which people supported their treatment on the scheme is significant from the test hypothesis. The poor tariff for some of the services in health insurance scheme has a great effect on the quality of care as well as accessibility to available health care services, this was supported by the study as there is significance difference in the accessibility, quality and availability level of the health care services on the scheme. Having confirmed in the study's recommendation that malaria should be removed from the capitated care services as

their work focus on health insurance benefits package, that it is not robust enough to take care of the citizen health needs, so also, is that capitation paid for enrollees on the scheme is not commensurate to the utilization rate of enrollees on the scheme. Often than not, there is stock out of drugs at the health insurance scheme pharmacy store, it also find out that there is always non-success to ambulance or other means of transportation during referral, and that the relationship between patients on health insurance and some health care providers are not all that smooth as it were between those on direct fee for service and them. This was in line with the findings that drugs are not always available at the NHIS pharmacy of healthcare providers.

Health Insurance Scheme is the means of facility entry or access to healthcare system and that many people depend on public health insurance. This was in contrary to the findings of this study, which says the present health insurance scheme has not created the expected access level. Universal Health Care benefit package is the solution to having quality, accessible, available and affordable healthcare services in Health insurance scheme. It also stated that causes of unequal access and non-affordability of some care services are as a result of principle of Moral Hazard, Adverse selection. Furthermore, it was deduced that corporate health insurance scheme is not cheap in term of premium and cost of services. One of the findings in this study is in line with the Braverman work, as the amount to register for the scheme is significantly difference in the test of hypothesis using sample one t-test. Also the findings show that the solution to the present health insurance scheme is universal health care package. The study reiterate on improving quality of care which is in accordance with another findings which stated that improving the quality requires a holistic approach. Countries that want to improve quality of care need to consider interventions

across different domains (leadership, information, patient and population engagement, regulation and standards, organizational capacity, models of care) across different levels of the health care system. Building a national strategy for quality is an important first step to agree on a clear set of goals, define suitable interventions and tools and align different stakeholders' efforts to improve quality of care.

From all the previous research works, it has been discovered that none has extends his or her research work to cover the six geo political zones of Nigeria, what makes other countries to have the whole solutions and generalized principles in attainment of quality, accessible, available and affordable in their health insurance scheme was because they were able to examine and address the whole problems at once. America for instance, whereas, Nigeria as a nation need it most to look at this topic as a whole, covering all areas at once.

Less work has been done researching on the effect of population coverage on the attainment of quality, accessibility, availability, and affordability, knowing that health insurance policy hinges on number of enrollees, the higher the number of enrollees the more the scheme will be affordable, the more those high earned hospital join the scheme and barrier of accessibility and availability of good hospital will be, as well as quality of health care. This will also, remove the wall of partition created by Health Maintenance Organisation through the demand of hospital to dictate the category of enrollees that can attend their hospital. This is done by creating Bands for Hospitals regards their tariffs of care. (Band A, B, C, and D) which is directly proportional to the premium paid by the enrollee.

Also, this has great effect on the quality of care rendered to any enrollees in their facility, because if the number of enrollees that enroll with certain hospital is very low, the hospital

will not be able to break even with such small number, based on health insurance principle that “you treat from the pool of resources not as an individual. Therefore, hospital will not be able to give quality drugs, and care to such enrollee.

Besides, the factors affecting (hindering) the enforcement of citizen enrollment on health insurance scheme in Nigeria has not been well look into, considering the fact that it will be the path to universal benefits plans as well as affordability and accessibility and availability of good health care services. (can it work, can it not work, where do we go from there).

What causes the backlash behaviour of Health care providers (hospital) vis-a-vis with the challenges of Health Maintenance Organisation on health Insurance Scheme?, such as commensuration the premium, fee for service tariff for secondary care, capitation for primary care, drugs tariff, laboratory investigation tariff with economic reality in the country and the maintenance of affordable, available, accessible and quality care to the poor masses.

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Chapter Three

Methodology

This chapter encompasses the way in which the study is intended to be carried out under the following:

3.1 Research Design

Descriptive survey design focuses on the service delivery by National Health Insurance Scheme to enrollees in South West, Nigeria, considering the following dependent variables Quality, Availability, Accessibility and Affordability. The researcher decides to use structured questionnaire with close ended questions to obtain information from his target population (clients who are on health insurance scheme federal, state or corporate).

3.2 Population of the Study

The study population of the study consists of 77,321, which is the combination of Federal, and State Government staff (who are also enrollee on NHIS) as well as corporate organization in Osun State.

Table 3.1: Study Population of Enrollees of Health Insurance Scheme in Osun State

Information	Number	Sources
Number of Federal Government staff in Osun State	3,321	Bureau of Public Service Reform
Number of former and informer staff register on Osun State Health Insurance Scheme (OHIS)	74,000	Osun State Health Insurance Scheme (OHIS)

Source: Civil Servants in Federal Government employ,” 89-511, (November 2019): <https://www.vanguardngr.com/2015/12/89-511-civil-servants-in-fgs-employ-by-nov-2018-dg-bpsr/>

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3.3 Sample and Sample Techniques

Sample size is 498 enrollees who have registered on the scheme for at least a year and half.

This was gotten by using Yamane Sample Size determinant formula.

Since it was not possible for the researcher to carry out the study on the whole population of people who are on health insurance scheme in Nigeria, in order to utilize available resources (time, money, material and manpower) more efficiently, and for better accuracy of the analysis of the collected data, researcher decide to use Multistage Sampling technique in which Nigeria was divided into strata, six Geo political zones-North West, North East, North Central, South East, South West and South-South geopolitical zones. Thereafter, Convenience sampling method was adopted in the selection of South West

geopolitical zone out of the six geopolitical zones, because of constraints such as wide geographical area of Nigeria, cost of travelling around her, risk of travelling because of the present insecurity in the nation, and time frame of the research work.

Furthermore, Purposive sampling methods was used to select Osun State out of six states in the South West of Nigeria, based on the fact that she has set up their own state insurance scheme called Osun State Health Insurance Scheme (OHIS), as this will enable the researcher to examine the performance of state health insurance scheme along in the study.

Furthermore, Purposive Sampling method was used in selection of respondents in Osun. The researcher introduce design stage confounding control by using restriction at the design stage to restrict participation in the study to individual who are on health insurance either private or public and have been on the scheme for at least two years, so as to get accurate result.

In addition, Yamane sampling size determinant was used to know the accurate sampling size.

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

where n is appropriate sampling size to be used, N is the population of people registered on Health Insurance Scheme in Osun State (both public and private health insurance scheme)= 77,321, while “e” is the precision level. 0.5% is used.

$$n = \frac{77,321}{1 + 77,321(0.5)^2} = 398 \text{ approximately}$$

Therefore, my sample size is 398, However, I decided to add 100 (25%) more to it, making it 498, to make up for estimated proportion of the attribute present in the population (those

who have being on health insurance scheme for at least two years). So, 500 structured questionnaires were shared in the state, from which 498 were returned.

Multistage sample technique is implord in this study, in which Nigeria population is first divided into subgroups (or strata: six geopolitical zones) who all share a similar characteristic of subscribers federal, state and corporate health insurance as well as have all tribes represented). This is used because there are reasonably measurement of interest to vary between the different subgroups, and the researcher want to ensure representation from all the subgroups, furthermore, convenient and purposive sampling were used. Questionnaires were then shared among the selected communities in OsunState to cut across all the 56 Health Maintenance Organisations, to ensures a more realistic and accurate estimation of the outcomes.

3.4. Instrument for Data Collection

The instrument used in the study is a standardized scale based on the United Theoryof Acceptance and Use of Technology and the Use of institutional Repositories Structure questionnaire was used to gather data from the respondents because it analyze the structured questions and responses easily to achieve the study objectives. The study adopted Likert scale design which allowed the researcher in listing options where respondents choose from. The instrument comprises five sections.

Section A contains the demographic information of respondents which is self-developed. The bio-data of the respondents was measured through nine (9) factors such as: gender of the respondents, tribe, level of education, marital status, occupation, registration

on the scheme, type of the scheme, HMO name, and how long respondents has been on the scheme.

Section B the measure of quality of service delivery of Health Insurance Scheme (HIS) which consist of nine (9) items were measured through 1 dimension; using five point such as 5. Very good – the health insurance scheme fully meets and exceeds requirements and expectations; the program requires little or no improvement; the scheme is brilliant and fully implemented,

4. Good – the scheme meets requirements and expectations; however it requires a normal degree of improvement; the scheme is solid and accurate implemented, fulfilling its dream.

3. Fair–the scheme does not always meet standards or expectations; it requires more than a normal degree of correction, improvement and supervision,

2. Bad–the scheme routinely fails to meet expectations; requires a disproportionate amount of correction, improvement and rigorous supervision; it demonstrates a lack of adequacy and achievement, and

1= Not applicable - that is, I have not use such services in Health Insurance Scheme before.

Example of statement is, the extent to which health benefits package in my subscribed health insurance address my health need, The content validity ratio is 0.43, while the reliability coefficient score is 1, using Lawshe’s Method and r_{KR20} respectively after carrying out a pilot study at Redeemer’s University, Ede Osun State.

The respond option provided in this study’s questionnaire followed the 5 point Likert type scale of 5 = very good, 4 = good, 3 fair, 2 bad, and 1 not applicable. In addressing the following questions: What is Quality of drugs given to me at hospital when I visited

hospital on the scheme? What is the quality of hospital standard available on the scheme for me to choose from? What is the quality of hospital ward in which I am admitted into? Quality of hospital staff behaviour to me at the hospital, Quality of treatment given to me in the hospital, Quality of Laboratory and x-ray test done on me compare with modern age standard, Quality of food, water served me while on admission on the scheme, The extent/level to which health benefits in my subscribed health insurance package address my health needs. Equity in service rendered to me while in hospital compare to that of private patient(s)

Section C measures availability of service delivery of Health Insurance Scheme (HIS) which consist of seven (7) items were measured through dimensions; as it applicable to section B of the questionnaire. Questions like, what is the availability of good drugs and other consumables at NHIS Pharmacy when I need drugs? Availability of standard treatment for me at every stage of healthcare need (primary, specialist, and teaching hospitals), Availability of qualified doctors, nurses, and other health workers attending to me in hospital, Availability of HMO call centre, in giving authorization code for me to access care at the referral centre or to receive secondary care in terms of their response to phone calls. Availability of ambulance vehicle for me when I need it, Availability of specialist treatment in getting treatment for infertility, cancer, heart disease on the scheme, Availability of good and portable water, electricity and other social amenities in hospital. The content validity ratio is 0.43, while the reliability coefficient score is 1, using Lawshe's Method CVR formula and r_{kr20} respectively after carrying out a pilot study at Redeemer's University, Ede Osun State.

The respond option provided in this study's questionnaire followed the 5 point Likert type scale of 5 = very good, 4 = good, 3 fair, 2 bad, and 1 not applicable. This is to assess the rate at which drugs and other consumables such as gloves, intravenous fluid are readily useable to enrollees on Health Insurance Scheme.

Section D scale with five point type scale were used as it was in section A, which was used to measure accessibility of service delivery of Health Insurance Scheme (HIS) which consist of seven (7) items was measured through one dimension; frequency, consist of the following statements: What is the time spent in waiting for approval code to be given me to see specialist or being referred? Distance from my house to the nearest hospital accredited on the scheme that I can use, Distance to referrals centre I was referred to for specialist care, Access to uninterrupted healthcare service on the scheme without paying till I get well, Access to standard hospitals on the scheme when I need to make a choice of hospital, Access to good and quality drugs when I need it at the NHIS pharmacy, Access to specialist/consultant on the scheme without denial when I need their services. The respond option provided in this study's questionnaire followed the 5 point Likert type scale of 5 = very good, 4 = good, 3 fair, 2 bad, and 1 not applicable. This is to examine how readily are Health Insurance Scheme services are accessible to enrollees on the scheme, considering distance, and access to uninterrupted service delivery, especially during secondary care referral.

Section E measures rate of affordability of service delivery of Health Insurance Scheme (HIS) not in terms of registration fee but in rate at which out-of-pocket fee was made in the cause of needed services and treatment as well as drugs. The section consists of six (6) items which were measured through one dimensions; as applicable to all other sections

above with five points. Statement like, what is the rate of amount require to register on the scheme/ procure the health insurance, Rate at which I spend my money to support the treatment rendered to me at hospital, Rate and cost of copayment I made on drugs, laboratory test, and operation when I need specialist care, Treatment of chronic diseases like infertility, asthma, diabetes, cancer is cheap in cost, When I have been referred to teaching hospital, I don't spend a dime to access care. Drugs and other consumables are available to me at NHIS pharmacy without extra cost.

The respond option provided in this study's questionnaire followed the 5 point Likert type scale of 5 = very good, 4 = good, 3 fair, 2 bad, and 1 not applicable. This is to ascertain the rate of out-of-pocket made for covered services on Health Insurance Scheme, during referral and in getting good and standard drugs as well as treatment.

3.5. Validity of the Research Instrument

Validity explains how well the collected data covers the actual area of investigation. Validity basically means "measure what is intended to be measured". Face validity is a subjective judgment on the operationalization of a construct. Face validity is the degree to which a measure appears to be related to a specific construct, in the judgment of non-experts such as test takers and representatives of the legal system. That is, a test has face validity if its content simply looks relevant to the person taking the test. It evaluates the appearance of the questionnaire in terms of feasibility, readability, consistency of style and formatting, and the clarity of the language used. In other words, face validity refers to researchers' subjective assessments of the presentation and relevance of the measuring instrument as to whether the items in the instrument appear to be relevant, reasonable, and

unambiguous and clear. Considering the rating of my questionnaire, very good, good, fair, bad, and not applicable

CVR =content validity ratio; ne = Number of panel members indicating an item ‘essential’;
 N = Number of panel members
 Lawshe suggested the transformation (from proportion to CVR) was of worth as it could readily be seen whether the level of agreement amongst panel members was greater than 50%. CVR values range between -1 (perfect disagreement) and +1 (perfect reement) with CVR values above zero indicating that over half of panel members agree an item essential. However, when interpreting a CVR for any given item it may be important to consider whether the level of agreement is also above that which may have occurred by chance².

Lawshe’s Method:
$$CVR = \frac{(ne - (N/2))}{N/2}$$

Therefore,
$$CVR = \frac{(5 - (7/2))}{7/2} = 0.43$$

Therefore, Content Validity Ratio of this study questionnaire is 0.43.

Criterion or concrete validity is the extent to which a measure is related to an outcome. It measures how well one measure predicts an outcome for another measure. A test has this type of validity if it is useful for predicting performance or behavior in another situation (past, present, or future).

3.6. Reliability of the Instrument

Reliability concerns the extent to which a measurement of a phenomenon provides stable and consistent result. Reliability is also concerned with repeatability. For example, a scale or test is said to be reliable if repeat measurement made by it under constant conditions will give the same result⁷⁴¹.

This is achieved by choice of only people who are on health insurance. (sampling frame) to avoid confounding factors, in order to ensure the internal validity of the research work, by introducing Design Stage Restriction on (those who are not on health insurance). Also, pilot test for the instrument is carried out at Redeemer's University Health Centre, Ede, Osun State.

The Reliability Coefficient of the pilot test is as follow:

$$\text{Reliability Coefficient} = r_{KR20} = \left(\frac{K}{K-1} \right) \left(1 - \frac{\sum p \times q}{SD^2} \right)$$

Where: K= number of items in the questionnaire, P = proportion of the sample who answer each item correctly, Q = is the proportion of the sample who answer each item wrongly, S D² = variance

Since the whole sample of either correct or wrong is 1, therefore, p + q = 1

Therefore, K = 38, P = 0.71, q = 0.29, S D²=15.69, p x q = 0.2059

$$\left(\frac{38}{38-1} \right) \left(1 - \frac{0.2059}{15.69} \right) = (1.0270) (1-0.0132) = 1.0270 \times 0.9868$$

Therefore, $r_{KR20} = 1.01344$ approximately = 1

Therefore, Reliability coefficient is acceptable.

3.7 Administration of the Instrument and Method of Data Collection

Primary method of data collection was used by the researcher in which structure questionnaires were administered by the researcher directly to Osun State populace, who are on health insurance scheme, cutting across about 31 accredited Health Maintenance Organisations in Nigeria, which after it has been filled by the respondents were collected translated to quantitative form during the analysis of such data using simple percentage of Test Application package of Statistical Package for the Social Sciences (SPSS) version 20.0.

3.8. Method of Data Analysis

The method of data analysis is quantitative analytical method, in which data analysis was done using Simple percentage Test of Statistical Package for the Social Sciences (SPSS) version 21.0 as a tool to analyze the data to determine whether the present service delivery of Health Insurance Scheme are quality, available, accessible and affordable from perception of registered enrollees.

Endnotes

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Chapter Four

Results and Discussion of Findings

This chapter is devoted to data analysis and interpretation of findings and making of descriptive summary, in such that it will make sense of numerical data that has been collected. This is to assist layman to have full understanding of raw data form collected in the course of the study under the following sub headings:

4.1 Demographic Data of Respondents

Table 4.1: Demographic Data

VARIABLES	FREQUENCY	PERCENTAGE	
GENDER	no response	3	0.6
	Male	217	43.6
	Female	278	55.8
	Total	498	100
ETHNICITY	Yoruba	229	46
	Hausa/ Fulani	102	20.5
	Igbo	155	31.1
	Efik	5	1
	Irobo	3	0.6
	Tiv	4	0.8
	Total	498	100
	Level of Education	no response	14
Primary	8	1.6	
Secondary	38	7.6	
NCE/OND	188	37.8	
HND/BSC	197	39.6	
Master	32	6.4	
PHD	21	4.2	
Total	498	100	
Marital Status	no response	29	5.8
	Single	92	18.5
	Married	348	69.9
	Divorce	16	3.2
	Widow/widower	10	2

	Single mother/father	3	0.6
	Total	498	100
	Civil Servant	357	71.7
	Corporate Firm	31	6.2
	Force/Para Military	83	16.7
	Student	18	3.6
	Others	9	1.8
	Total	498	100
Are you on health insurance scheme	Yes	498	100
	Total	498	100
Type of health insurance: private/cooperate	Private/ Corporate Insurance	100	20.1
	NHIS	223	44.8
	State HIS	175	35.1
	Total	498	100
when did you register	Just registered	5	1
	A year plus	49	9.8
	Two years plus	444	89.2
	Total	498	100

Sources: Descriptive Survey, Perception of Health Insurance Scheme service delivery by enrollees, 2021

From the Table 4.1, it shows that 217 males and 278 females participated in the research study, the ethnicity distribution are Yoruba 229, Hausa/Fulani 102, Igbo 155, Efik 5, Irobo 3, and Tiv 4. Also, educational levels of the respondents are as follow: Primary 8, Secondary 38, NCE/OND 188, HND/B.sc 197, Masters 32, PhD 21, while about 14 did not respond to the question.

In addition, marital status of the respondents is as follow: Single 92, Married 348, Divorce 16, Widow/widower 10, single mother/father 3, while 29 did not respond to the question.

From the view of occupation, 357 are civil servants, 31 are private/corporate firm staff, 18 are students, 83 are force/paramilitary, while 9 respondents are categorized into others.

Furthermore, all the 498 of the respondents are on health Insurance. In addition to make the study more valid and realistic, length of registration on the scheme was being asked for, of which the following data were gathered, 5 respondents just registered on the scheme, while

49 have been on the scheme for a year plus and 444 have registered for two years and above.

Also, about 100 respondents are on Corporate /Private Health Insurance Scheme, 223 are on national Health Insurance Scheme While 175 are on State Health Insurance Scheme, with 37 people who did not respond to the question.

Besides, the distribution of questionnaire were unconsciously cut across respondents from about 31 Health Maintenance Organisations (HMOs), this good for the study, in the sense that it shows that the result is not limited to one Health Maintenance Organization, but cut across to avoid skewed results.

4.2 Presentation of Research Questions

4.2.1 Research Questions

Research Question One:What is the quality level of the present Health Insurance Scheme service delivery as expectedby enrollees

Table 4.2: Quality of service delivery of NHIS Summary

Questions	Very good	Good	Fair	Bad	Not Applicable	Mean
Quality of drugs given to me at hospital when I visited it	0 (0%)	187 (37.6%)	303 (60.8%)	8 (1.6%)	0 (0%)	3.36
Quality of hospital standard available on the scheme for me to chose from	14 (2.8%)	161 (32.3%)	309 (62.0%)	14 (2.8%)	0 (0%)	3.35
Quality of hospital ward in which I am admitted into	12 (5.8%)	86 (17.3%)	356 (71.5%)	28 (5.6%)	16 (3.2%)	3.08
Quality of hospital staff behaviour to me at the hospital	29 (5.8%)	212 (42.6)	200 (40.2%)	53 (10.6%)	4 (0.8%)	3.41
Quality of treatment given to me in the hospital	4 (0.8)	277 (55.6%)	199 (40.0%)	18 (3.6%)	0 (0%)	3.54
Quality of Laboratory and x-ray test done on me compare with modern age standard	4 (0.8%)	114 (22.9)	303 (60.8)	67 (13.5%)	10 (2.0)	3.07
Quality of food, water served me while on admission on the scheme	0 (0%)	106 (21.3%)	286 (57.4%)	95 (19.1%)	11 (2.2%)	2.86
The extent/level to which health benefits in my subscribed health insurance package address my health needs.	0 (0%)	38 (7.6%)	380 (76.3%)	73 (14.7%)	7 (1.4%)	2.90
Equity in service rendered to me while in hospital compare to that of private patient(s)	0 (0%)	60 (12.0%)	297 (59.6%)	138 (27.7)	3 (0.6%)	2.77

Sources: Descriptive Survey, Perception of Health Insurance Scheme service delivery by enrollees, 2021

Average Mean value = 3.14,

$N-1/N = 4-1/4 = 0.75$

Very Good = 1-1.75

Good = 1.76–2.51

Fair = 2.56–3.31

Bad = 3.32 – 4.07

Decision Rule: since the overall mean value of service delivery of NHIS is 3.14 which fall into “Fair” category, it shows that availability use of service delivery of NHIS by enrollees is (Fair–the scheme does not always meet standards or expectations of quality in its service delivery to enrollees, therefore, it requires more than a normal degree of correction, improvement and supervision), according to the initial rating guideline specified in the questionnaire.

From Table 4.2, the mean value of quality of drugs is very high (3.36) this means enrollees on NHIS are highly dissatisfied about the quality of drugs dispense to them as part of the service delivery, followed by the standard of the hospitals accredited on the scheme with mean value of (3.35), this indicates that service delivery some of the hospital/providers rendered on the scheme to enrollees are below expected quality, also, behaviour of some of hospital staff to enrollees on Health Insurance Scheme which is part of their psychological service delivery is sub standard as the mean value is (3.41), besides, quality of treatment given to enrollees on the scheme is also poor considering the mean value at (3.54), as well as the mean value of quality of Diagnostic investigations such as laboratory test, x-rayetc (3.07), whereas, Quality of food, water served while on admission on the scheme, The extent/level to which health benefits in my subscribed health insurance package address my health needs and Equity in service rendered to me while in hospital compare to that of private patient(s) are fair as their mean valueis (2.86, 2.90 and 2.77) respectively.

However, going by the overall rating of the research question one with mean value 3.14 shows that the quality of the service delivery of National Health Insurance Scheme is of

low quality, which has form major part of the contributing factors to scheme poor coverage, considering the initial interpretation of the scale used by the researcher on the questionnaire with which the respondents make a choice of their answers to the various questions asked: (Very good – the health insurance scheme fully meets and exceeds requirements and expectations; the program requires little or no improvement; the scheme is brilliant and fully implemented.

Good – the scheme meets requirements and expectations; however it requires a normal degree of improvement; the scheme is solid and accurate implemented, fulfilling its dream.

Fair–the scheme does not always meet standards or expectations; it requires more than a normal degree of correction, improvement and supervision.

Bad–the scheme routinely fails to meet expectations; requires a disproportionate amount of correction, improvement and rigorous supervision; it demonstrates a lack of adequacy and achievement). This shows that the Service delivery of the scheme needs serious interventions in the area of quality service delivery.

Research Question Two: Are planned service deliveries of Health Insurance Scheme

available to enrollees on the scheme?

Table 4.3: Availability of service delivery of NHIS Summary

Questions	Very good	Good	Fair	Bad	Not applicable	Mean
Availability of good drugs and other consumables at NHIS Pharmacy when I need drugs	4 (0.8%)	59 (11.8%)	371 (74.5%)	58 (11.6%)	6 (1.2%)	2.99
Availability of standard treatment for me at every stage of healthcare need (primary, specialist, and teaching hospitals)	2 (0.4%)	61 (12.2%)	365 (73.3%)	70 (14.1%)	0 (0%)	2.99
Availability of qualified doctors, nurses, and other health workers attending to me in hospital	15 (3.0%)	159 (31.9%)	283 (56.8%)	12 (2.4%)	19 (3.8%)	3.20
Availability of HMO call centre, in giving authorization code for me to access care at the referral centre or to receive secondary care in terms of their response to phone calls.	6 (1.2%)	144 (28.9%)	189 (38.0%)	142 (28.5%)	17 (3.4%)	2.95
Availability of ambulance vehicle for me when I need it	18 (3.6%)	139 (27.9%)	91 (18.3%)	96 (19.3%)	154 (30.9%)	2.52
Availability of specialist treatment	4 (0.8%)	107	108	87 (17.5%)	192	2.28

in getting treatment for infertility,		(21.5%)	(21.7%)		(38.6%)	
cancer, heart disease on the scheme						
Availability of s/amenities in	26	166	260	22 (4.4%)	24	3.29
hospital	(5.2%)	(33.3%)	(52.2%)		(4.8%)	

Sources: *Descriptive Survey, Perception of Health Insurance Scheme, service delivery by enrollees 2021*

Average Meanvalue = 2.89,

N-1/ N = 4-1/4 = 0.75

Very Good = 1 - 1.75

Good = 1.76 – 2.51

Fair = 2.56 – 3.31

Bad = 3.32 – 4.07

Decision Rule: since the overall mean value of service delivery of NHIS which is 2.89 falls into “Fair” category, it shows that availability use of service delivery of NHIS by enrollees is (Fair—the scheme does not always meet expectation of enrollees; so it requires more than a normal degree of correction, improvement and supervision), as indicated initial on the rating guideline specified in the questionnaire.

Extract from Table 4.3, assessing availability of good drugs and other consumables on the scheme is not easily obtainable to enrollees on the scheme as the mean level is (2.99), followed by the mean value (2.99) of availability of standard hospital on the scheme as some enrollees agreed that some of good hospitals in town are not available for use.

Furthermore, of qualified health workers are not easily come by at some of the hospital to NHIS enrollees on the scheme just because of bottle neck of pre-authorization code introduced by the regulatory body (HMO), as indicated by mean value of (3.20). Mean value (2.95) for availability of HMO call centre in response to enrollees’ request is also

poor.

Besides, availability of ambulance services to enrollees on the scheme with mean value of (2.52) is not easily come by as some of the enrollees even concur that it is not available at all. Also, mean value (2.28) of chronic ailment treatment such as infertility, cancer treatment and the likes are not obtainable on the scheme as this is categorized under exclusion in the scheme benefits package. The mean value of availability of good food and other social amenities to enrollees on the scheme, while on admission is also poor with mean value of (3.29).

Everything put together, from the decision rule the grand mean calculated (2.89) for availability of NHIS service delivery to enrollee on the scheme needs a lot of intervention as the it fall into the category of “Fair”in the rating, which means (Fair–the scheme does not always meet standards or expectations; it requires more than a normal degree of correction, improvement and supervision)

Research Question Three:Is access to Health Insurance Scheme service delivery obtainable to enrollees on the scheme as planned?

Questions	Very Good	Good	Fair	Bad	Not Applicable	Mean
Time spent in waiting for approval code to be given me to see specialist or being referred	6 (1.2%)	191 (38.4%)	165 (33.1%)	120 (24.1%)	16 (3.2%)	3.09
Distance from my house to the nearest hospital accredited on the scheme that I can use	12 (2.4%)	104 (20.9%)	266 (53.4%)	109 (21.9%)	7 (1.4%)	3.00
Distance to referrals centre I was referred to for specialist care	0 (0%)	35 (7.0%)	339 (68.1%)	106 (21.3%)	18 (3.6%)	2.78
Access to uninterrupted healthcare service on the scheme without paying till I get well	0 (0%)	30 (6.0%)	323 (64.9%)	119 (23.9%)	26 (5.2%)	2.71
Access to standard hospitals on the scheme when I need to make a choice of hospital	0 (0%)	156 (31.3%)	222 (44.6%)	98 (19.7%)	22 (4.4%)	3.02
Access to good and quality drugs when I need it at the NHIS pharmacy	2 (0.4%)	23 (4.6%)	365 (73.3%)	94 (18.9%)	14 (2.8%)	2.79
Access to specialist/consultant on the scheme without denial when I need their services	2 (0.4%)	66 (13.3%)	372 (74.7%)	47 (9.4%)	11 (2.2%)	2.99

Sources: Descriptive Survey, Perception of Health Insurance Scheme service delivery by enrollees, 2021

Average Mean value = 2.91,

$$N-1/N = 4-1/4 = 0.75$$

$$\text{Very Good} = 1 - 1.75$$

$$\text{Good} = 1.76 - 2.51$$

$$\text{Fair} = 2.56 - 3.31$$

$$\text{Bad} = 3.32 - 4.07$$

Decision Rule: The level of use for accessibility of service delivery of NHIS as perceived by enrollees which is 2.91 shows that the scheme does not always meet expectation of enrollees in terms of expected access level; so it requires more than a normal degree of correction, improvement and supervision), as indicated initial on the rating guideline specified in the questionnaire.

Culled from Table 4.4, the overall access level of NHIS service delivery is very low as indicated from the decision rule where the grand mean is (2.91) is in category of “ fair” as interpretation for fair service delivery is that “(Fair–the scheme does not always meet standards or expectations; it requires more than a normal degree of correction, improvement and supervision)”. This is initial interpretation on the question given to respondents while filing the questionnaire as yardstick for answering the question.

Above is supported with the various questions mean value such; mean value (3.09) for Time spent in waiting for approval code is very fair, also, mean value in response to proximity of accredited hospitals to enrollees on the scheme is very far as indicated by the study, Mean value of (3.00). In the same vein proximity of tertiary/secondary providers/ hospital on the scheme is far as well, as some of them are not accessible to people living in grassroots area, even at urban areas as the mean value is (2.78).

In addition, mean of (2.71) for access to uninterrupted services to enrollees on the scheme

without asking them to pay or giving them any excuse on why they cannot have one type of care is very poor, as well as the access to standard hospitals on the scheme is also poor, just because some of standard hospital are not on the scheme and those that are accredited on the scheme refuse to accept enrollees with meager premium, thereby leading to Grouping of hospital in Bands according to enrollees' premium and ability to pay for their services (Band A, B, C, and D), which mean is 3.02.

Besides, accessto good and branded drugs on the scheme to enrollees is poor with mean value (2.79) indicated, following the scheme policy of generic drugs. Also, access to specialist consultation without denial is not guarantee on the scheme as the mean value shows 2.99.

Research Question Four: IsHealth Insurance Scheme service delivery affordable to enrollees on the scheme as expected?

Table 4.5: Affordability of NHIS service delivery of NHIS Summary

Questions	Very Good	Good	Fair	Bad	Not Applicable	Mean
Amount require to register on the scheme/ procure the health insurance	178 (35.7%)	237 (47.6%)	80 (16.1%)	0 (0%)	3 (0.6%)	1.05
Rate at which I spend my money to support the treatment rendered to me at hospital	4 (0.8%)	38 (7.6%)	396 (79.55)	48 (9.6%)	11 (2.4%)	2.94
Rate and cost of copayment I made on drugs, laboratory test, and operation when I need specialist care	4 (0.8%)	213 (42.8%)	185 (37.1%)	93 (18.7%)	3 (0.6%)	3.16
Treatment of chronic diseases like infertility, asthma, diabetes, cancer is cheap in cost	4 (0.8%)	45 (9.0%)	186 (37.3%)	71 (41.3%)	192 (38.6)	2.19
When I have been referred to teaching hospital, I don't spend a dime to access care.	0 (0%)	6 (1.2%)	251 (50.4%)	238 (47.8%)	3 (0.6%)	2.41
Drugs and other consumables are available to me at NHIS pharmacy without extra cost.	4 (0.8%)	24 (4.8%)	360 (72.3%)	83 (16.7%)	27 (5.4%)	2.78

Sources: Descriptive Survey, Perception of Health Insurance Scheme service delivery by enrollees, 2021

Average Mean value = 2.94,

$N-1/ N = 4-1/4 = 0.75$

Very Good = 1 - 1.75

Good = 1.76 – 2.51

Fair = 2.56 – 3.31

Bad = 3.32 – 4.07

Decision Rule: since the mean value of service delivery of NHIS as perceived by enrollees is 2.94, therefore, the scheme' affordability level is a thing of concern to enrollees, thereby shows that the scheme is not cheap at long run, thereby needs intervention..

From Table 4.5 it has shown that the cost of registration (premium paid) to join the scheme is very cheap with the mean value of 1.05, which is in category of "Very Good" whereas, the cost incurred while on the scheme in gaining access and making available quality service delivery is very poor as indicated from the overall calculated mean of (2.94) for research question 4, indicates that the scheme is not affordable at long run. This is justified as the mean value for rate at which one spent his or her money to support the treatment is (2.94), mean value for rate of copayment made on drugs and consumables is (3.16), out of pocket made on treatment of chronic ailments such as hypertension, diabetes, asthma is very high with mean value of (2.19), while value of (2.14) shows that when enrollees are referred to tertiary/secondary service centre they spend a lot from their pocket.

Also, culled from the table, the rate at which enrollees on the scheme make payment or source for drugs that are not available at NHIS Pharmacy shop is poorly rated as mean value indicated (2.78). Therefore, the scheme is not affordable at long run.

Table 4.6: Descriptive summary of research question on service delivery of NHIS by enrollees

Items	Mean value
What is the quality level of the present Health Insurance Scheme service delivery as expected by enrollees?	3.14
Are planned service deliveries of Health Insurance Scheme available to enrollees on the scheme?	2.89
Is access to Health Insurance Scheme service delivery obtainable to enrollees on the scheme as planned?	2.91
Is Health Insurance Scheme service delivery affordable to enrollees on the scheme as expected?	2.94

Sources: Descriptive Survey, Perception of Health Insurance Scheme service delivery by enrollees, 2021

Average Mean value: 2.97

Very Good = 1 - 1.75

Good = 1.76 – 2.51

Fair = 2.56 – 3.31

Bad = 3.32 – 4.07

Decision rule: Since, mean for overall service delivery of NHIS by enrollees is 2.97, which is in “Fair” category, it shown that the level of use of NHIS service delivery, therefore, it requires more than a normal degree of correction, improvement and supervision), as indicated initial on the rating guideline specified in the questionnaire. It further shows that the use of service delivery of NHIS as perceived by enrollees put together are sources of concern to them, thereby leading to complaint they are having on the scheme which has also hinder those who are not on the scheme fell reluctant to join.

4.3 Discussion of Findings

According to one of the authors “that the dissatisfaction of healthcare providers as a result of intensity control and cost containment of Health Maintenance Organisation in health

insurance scheme is the factor affecting the quality of health care delivery”¹. This was supported in this study that people are dissatisfied with the present health insurance scheme owing from their complaints about the scheme quality of drugs, as well as treatment rendered, as shown from the table 4.2 decision rule, where the mean value for research question one is 3.14.

It was find out that there is decline in quality of care rendered under health insurance care compare to services rendered to those on direct fee for service or direct retainership². This is in support of the findings in this research work.

Corroborating findings in table 4.3, about availability of service delivery to NHIS enrollees, in one of authors’ work their paper’s findings made it, that non availability of require services in the benefit package of Nigeria health insurance scheme as well as delay in receiving required services has affected the coverage of the scheme in Nigeria which was also confirmed from the findings in the study as the overall mean for research question two is 2.89³.

Research question three as addressed by table 4.4 which discussed the level of access to NHIS service delivery (2.91) findings in the study is supported by author work, that often, there is stock out of drugs at the health insurance scheme pharmacy store, it also find out that there is always non-success to ambulance or other means of transportation during referral, and that the relationship between patients on health insurance and some health care providers are not all that smooth as it were between those on direct fee for service and them. This was in line with the findings that drugs are not always available at the NHIS pharmacy of healthcare providers⁴.

To support the findings in table 4.5 in this study, and addressing research question four; the mean value of (2.94) is in line with the findings of in his work that “Every year, over 900

million people face severe hardship and 90 million are tipped into extreme poverty for seeking medical treatment^{5,6}. With the rising costs of out-of-pocket health care expenditures, currently estimated at half a trillion dollars globally, the number of people affected by this trend is expected to increase further, improving not just access to Universal Health Coverage, but also its quality⁷.

This means the present health insurance in force fall short of attaining the expected quality, availability, accessibility and affordability⁷. It shows that the scheme failed to alleviate the insured financial burdens as some still spend their money heavily while on the scheme. In addition, access and availability of good drugs are nothing to write home about on the scheme^{8,9}.

Complaint of poor quality drugs are confirmed from the analysis. The researchers then decide to identify the main items that contributed to falling short of standard by present health insurance scheme from the quality perspective, it was shown that quality of drugs dispense to clients on the scheme is one of the main contributing factor, as some are not satisfy with the recommended generic drugs by the scheme regulator, in term of potency, and efficacy^{10,11,12}.

Respondents also, complaint of poor attitude of health care providers workers towards them being on health insurance as if they came begging for free health services¹³. Despite the satisfactory response of the observed population in health insurance benefits package on one hand, they still complain of non-availability of essential drugs on the scheme this is reflected in the findings¹⁴.

Furthermore, it was affirmed that, the scheme lack luster to prevent possibility of reducing terminal diseases and disability, which elongate people's live and makes them to live better life, such ailments as cancer, infertility, injury sustained from extreme sport and injury

from riot are not covered on the scheme¹⁵.

Lack of proximity of some of primary care providers, diagnostics centres, especially referral hospitals (tertiary health institutions) as shown in the analysis, as well as exclusion of some services which are essential to human healthy living, are termed exclusion on the scheme, has made the scheme service delivery poorly accessible and available to enrollees¹⁶.

On examining the affordability parameter, although the amount to subscribe for the scheme is relatively meager, however, the study revealed that when one is sick, the financial burden is just too much as if one is not on any health insurance scheme, due to high rate at which one make out of pocket payment while in the hospital, also cost of treating chronic ailments such as asthma, hypertension, diabetes, cancer and chronic heart disease, are burdensome as some essential drugs in treating these ailments are not always available at health Insurance pharmacy shop or those available are not effective in handling the present stage at which the ailments is^{17,18}.

Also, some diagnostics investigations needed to ascertain the extent of these ailments are not always available as well as diagnostics investigations such as CT scan, endoscopy, EEG and the rest, this happened when the residence hospital will complaint that there is no electricity power or the machine is faulty, thereby asking enrollees to source for those services elsewhere on their own¹⁹.

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Chapter Five

Conclusion

This chapter presents the summary of the findings, conclusions and recommendations as well as contributions to the body of knowledge and areas for further study based on the data analyzed in the previous chapter, perception of service delivery of Health Insurance Scheme by enrollees on the scheme from perspective of (quality, accessibility, availability, and affordability), so as to ascertain the level of service delivery of Health Insurance Scheme by enrollees' in order to proffer a possible intervention to put the scheme back on track, as outlined:

5.1. Summary of Findings

The study is conducted in the South West geo-political zone of Nigeria. The respondents were citizens, who are registered on health insurance scheme (Corporate/Private, National Health Insurance Scheme or State Health Insurance Scheme, have been on the scheme for nothing less than a year plus). They were selected using Stratified and purposive Sampling. The researcher employed quantitative cross sectional research methods. Pertinent data were obtained through the structured questionnaires. The statistical tool used, are descriptive analysis using SPSS version 21.

According to the statement of problem in chapter one, based on the complaints of some of the enrollees on health insurance scheme in Nigeria, that the quality, accessibility, availability and affordability of the scheme as stated by World Health Organization for a worthy healthcare services are being jeopardized, the findings from this study is in support, This reveals that the present health insurance scheme in Nigeria needs intervention program to put it back on track in achieving the set goal.

5.2. Conclusion

Base on the indicated findings, the following conclusion were drawn:

This study has shown that the service delivery of present Health Insurance Scheme fall short of enrollees' expectation from their perception of its quality, availability, accessibility and affordability. It was also shown that although the package is cheap (affordable) but the whole in built operation in delivering good health care services is costly and characterized by unavailability of drugs, poor quality of drugs, too much out of pocket payment as some covered services are not always available or accessible due to unwarranted excuses, lack of proximity of health care providers especially tertiary institutions and diagnostics centres (secondary care providers).

Besides, exclusion or denial of some treatment of diseases and high cost investigations from the scheme which are life determinant is also notice.

Finally, the study concluded that the four priorities of health care services are cost (affordability), quality, access and availability need not to be in contrast with each other. Therefore, it only when standard hospital within the reach with quality care, and availability of qualified personnel, and equipment is accessible at affordable cost, that Nigeria Health Insurance Scheme can achieve her aim of 100 % universal health care coverage, which will improve economy, boost citizen health status, increase productivity and reduce wastages of funds which could have been used on laudable projects will be achieved.

5.3. Recommendations

1. To address the dwindle quality of service delivery of NHIS in Nigeria, following recommendations are put forward for consideration:

- i. Participation in Health Insurance Scheme should be part of the compulsory conditions for registration, establishment, approval, as well as accreditation of Health care providers (hospitals, pharmacy, diagnostic centres and others) to practice in the country. This will enable standard hospitals and diagnostic centres as well as pharmacies to register as provider on the scheme, which will in turn boost quality of NHIS service delivery.
 - ii. Adequate monitoring of drugs and consumables at health care facility should be enforced.
 - iii. Regular review of drugs, treatments and investigation tariff by National Health Insurance Scheme as regulatory agency to suit the present market price vis-a-vis health insurance premium and clients' population, as this will allow patients on health insurance to have access to good and quality drugs and have access to needed diagnostics machines.
2. Addressing the challenges of availability in the study research objective two, the study recommends that:
- iv. Provision of health insurance subsidy be made by government, this can be earned from increasing the tax of the people with high income, tax from medical devices, and pharmaceuticals sales, this will make some of the service that are not available to enrollees with less premium on the scheme.
 - v. Creation of dedicated NHIS Pharmacy, and other facilities as well as creation of hospital categorization (Bands) by Health Maintenance Organisations' on corporate plans should be scraped, as this is encouraging access denial, segregation, fraud and non-availability of services, all patients should used same facilities.
 - vi. Regulatory agency should increase coverage for more screenings and preventive care in the benefits package, as this will lead more availability of some services on the scheme.
3. To reduce complaint about access level of NHIS service delivery:

- vii. Limit of liability/ time limit, waiting period, surcharge of preexisting condition policy need to be removed from the by regulatory agency, this will increase the access level of service delivery to the enrollees..
- viii. Review of Health Insurance Scheme benefits package to accommodate ailments such as cancer, infertility, accident from riot, extreme sport activities, long standing ailments, among others, without extra cost will make access level good.
- ix. Regulatory agency should embark on more accreditation of standard hospitals on the scheme. They should also make it part of conditions for hospital practicing registration procedure, as this will lead to proximity of hospitals
4. Since Health Insurance Scheme is base on principle of Risk Pooling and in order to make NHIS service delivery affordable to enrollees:
- x. Enforcement of mandatory registration of all citizens on Health Insurance Scheme by Federal, State and Local government should be put into consideration (attach registration to National Identity Card Registration, driverslicense, opening of bank account, admission to higher institution, part of offenders' clearance, registration of company at corporate Affairs Commission, marriage registry and so on), (this can start with all private organizations with at least 3 staff). As well as development of universal benefits health care package that will be realistic in coverage of ailments in the country, this will make funds available, to providers to buy quality drugs, make available and create access to standard and quality diagnostic equipment at affordable price and, brings an end to complaints of providers' of not break-even on the scheme with the number of enrollees given to them.
- xi. Provision of health insurance subsidy be made by available to less privilege citizen bygovernment, this can be earned from increasing the tax of the people with high income, tax from medical devices, and pharmaceuticals sales, this will make some of the service

that are not affordable to enrollees with less premium on the scheme.

5.4. Contribution to Knowledge

This study has the following the following contribution to the body of knowledge:

The study involves all the three forms of health insurance scheme in Nigeria (Corporate/Private, National Health Insurance Scheme or State Health Insurance Scheme) and find out that it is not only NHIS that has short comings regards the attainment of the parameters of good healthcare services as against some of the past studies which always consider only NHIS in their studies.

Also, the study went further to look beyond coverage issues,as the practice of some researchers, who have worked on the evaluation of health insurance scheme in Nigeria, to look into the reasons behind the poor coverage, as the researcher went further toinvestigate the basis for complaints of people on the scheme, which has created a clog on the wheel of the health insurance scheme coverage in Nigeria.

Besides, the studies reveals the possible means of enforcement of registration on the scheme without much hurt to citizens, formal and informal sectors, as well as ensure participation of healthcare providers.

Also, the researcher took the study into another dimension by conducting the research in the south west geo political zone of Nigeria as against some past studies which were done in either North or South East of Nigeria.

The study has also shown the main contributing factor that is responsible for the complaints of the people who are registered on the scheme, which has serve as a defense for those who are not on the scheme and are not willing to join any soon, as well proffer possible solution to it.

In addition, review of benefits package, in line with what should be covered under primary care services vis a vis appropriate tariff in the face of present economic status of Nigeria and prevalence malaria ailment.

5.5. Areas for Further Research

The areas for further studies considered in this paper is to conduct a research on why many standardized healthcare providers refuse to participate in health insurance scheme in Nigeria, especially state and national Health Insurance.

Also, the work needs to be done on reason(s) for health care providers' categorization by some Health Maintenance Organization on their providers' network.

In addition, study needs to be carried out on which of the health insurance scheme type is lagging behind in attaining the parameters of good healthcare services in Nigeria.

The role of Spirituality, Religion, and Culture&believesinhealth insurance scheme coverage in Nigeria, as a nation.

The causes and effect of healthcare providers' dissatisfaction in health insurance scheme in Nigeria can as well be look into.

Also, study on those who are not on the scheme need be carried out on why they are not willing to join on the scheme.

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Abbreviations

NHIS	National Health Insurance Scheme
HIS	Health Insurance Scheme
HMO	Health Maintenance Organisation

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Appendixes

**Lead City University
Ibadan, Oyo State Nigeria.
Faculty of Communication and Information Sciences
Department of Information Management**

**Questionnaire on Perception of Service Delivery of Health Insurance Scheme by
Enrollees on the Scheme**

Dear sir/ma, please answer all the questions as it applies to you, information given is purely for academics as well confidential and to assess health insurance scheme in Nigeria.

Thank you.
Lawrence Segun AKANDE

Section A: Bio-Data of Respondents

1. **Gender:** Male Female
2. **Tribe/ Ethnicity:** Yoruba Iba/Fulani Igbo others please specify:

3. **Level of education:** Primary Secondary NCE/OND HND/BSC
Master PhD
4. **Marital status:** single married divorce dow/widower
single mother/father
5. **Occupation:** please specify Civil servant force/paramilitary private firm
student
6. Are you on health insurance scheme Yes No
7. Type of health insurance: Private/Corporate HMO NHIS
State Health Insurance

What is the name of your HMO

.....

8. How long have you register on the scheme: just register a year plus two years & above

Sir/Ma, the following descriptions are to serve as guide for evaluation rating scale in filling this questionnaire. Thank you.

5. Very good – the health insurance scheme fully meets and exceeds requirements and expectations; the program requires little or no improvement; the scheme is brilliant and fully implemented.

4. Good – the scheme meets requirements and expectations; however it requires a normal degree of improvement; the scheme is solid and accurate implemented, fulfilling its dream.

3. Fair–the scheme does not always meet standards or expectations; it requires more than a normal degree of correction, improvement and supervision

2. Bad–the scheme routinely fails to meet expectations; requires a disproportionate amount of correction, improvement and rigorous supervision; it demonstrates a lack of adequacy and achievement.

1= Not applicable - that is, I have not use such services in Health Insurance Scheme before.

Quality: this is healthcare outcome that meet the expectation of patient, by achieving what

it is expected to achieve in an atmosphere of acceptable process to individual patient.

S/N	Items	VERY GOOD	GOOD	FAIR	BAD	NOT APPLICABLE
1.	Quality of drugs given to me at hospital when I visited it					
2.	Quality of hospital standard available on the scheme for me to chose from					
3.	Quality of hospital ward in which I am admitted into					
4.	Quality of hospital staff behaviour to me at the hospital					
5.	Quality of treatment given to me in the hospital					
6.	Quality of Laboratory and x-ray test done on me compare with modern age standard					
7.	Quality of food, water served me while on admission on the scheme					
8.	The extent/level to which health benefits in my subscribed health insurance package address my health needs.					
9.	Equity in service rendered to me while in hospital compare to that of private patient(s)					

Availability: the degree of being able to be used or obtained at every stage of

development.

S/N	Items	VERY GOOD	GOOD	FAIR	BAD	NOT APPLICABLE
1.	Availability of good drugs and other consumables at NHIS Pharmacy when I need drugs					
2.	Availability of standard treatment for me at every stage of healthcare need (primary, specialist, and teaching hospitals)					
3.	Availability of qualified doctors, nurses, and other health workers attending to me in hospital					
4.	Availability of HMO call centre, in giving authorization code for me to access care at the referral centre or to receive secondary care in terms of their response to phone calls.					
5.	Availability of ambulance vehicle for me when I need it					
6.	Availability of specialist treatment in getting treatment for infertility, cancer, heart disease on the scheme					
7.	Availability of good and portable water, electricity and other social amenities in hospital					

Accessibility: ability of a designed program that is useable by people within the widest

possible range of operation within the widest possible range of situation.

S/N	Items	VERY GOOD	GOOD	FAIR	BAD	NOT APPLICABLE
1.	Time spent in waiting for approval code to be given me to see specialist or being referred					
2.	Distance from my house to the nearest hospital accredited on the scheme that I can use					
3.	Distance to referrals centre I was referred to for specialist care					
4.	Access to uninterrupted healthcare service on the scheme without paying till I get well					
5.	Access to standard hospitals on the scheme when I need to make a choice of hospital					
6.	Access to good and quality drugs when I need it at the NHIS pharmacy					
7.	Access to specialist/consultant on the scheme without denial when I need their services					

Affordability: this means inexpensive (state of being cheap enough for people to be able to

buy/procure), availability at a cost that individuals and families can afford at every stages of development, and at any situation.

S/N	Items	VERY GOOD	GOOD	FAIR	BAD	NOT APPLICABLE
1.	Amount require to register on the scheme/ procure the health insurance					
2.	Rate at which I spend my money to support the treatment rendered to me at hospital					
3.	Rate and cost of copayment I made on drugs, laboratory test, and operation when I need specialist care					
4.	Treatment of chronic diseases like infertility, asthma, diabetes, cancer is cheap in cost					
5.	When I have been referred to teaching hospital, I don't spend a dime to access care.					
6.	Drugs and other consumables are available to me at NHIS pharmacy without extra cost.					

Your general view about Health Insurance Scheme in Nigeria

.....

.....

Thank you, sir/ma, for your time.

Bio data

Personal Data:

Full Name: Lawrence SegunAKANDE
Sex: Male
Marital Status: Married
Date and Place of birth: Adeoyo Hospital, Yemetu Ibadan, Oyo State / 15th August, 1976
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Name of next of kin: Mrs. AkandeAdebola Esther (wife)

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Higher National Diploma (HND) in Health Records & Information Management (Upper credit) School of Health Information Management University of Ilorin Teaching Hospital (UITH) Ilorin, Nigeria. 2004
Diploma in Computer Science (Distinction) College of Education Ilorin, Kwara State, 2003 Nigeria
Certificate in Health Records Science, Vital & Health Statistics, School of Hygiene Eleyele, Ibadan, Nigeria 2000
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January 2007: Monitoring and evaluation procedure and knowledge about AvianFlu (ARI) AdeyemiBaro Hall Lagos State Government Secretariat, Alausalkeja, Lagos.

September 2008: Database Management Nigeria Institute of Management (chartered) Idowu Taylor street Victoria Island, Lagos.

December 2010: Building effective Electronic Document and Records Management System Nigeria Institute of Management (chartered) Idowu Taylor street Victoria Island, Lagos.

April 2017: Certificate in Data Analysis Using SPSS 23 Edition (Statistical Package for Social Science, Advance Digital Appreciation Program for Tertiary Institutions (ADAPTIDigital Bridge Institute & International Centre for Information & Communication Technology Studies) in collaboration with Nigeria Communication Commission (NCC).

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1999: Obafemi Awolowo University Teaching Hospital Complex, Ile-Ife.

- 2001:** University College Hospital, Ibadan.
2003: University College Hospital, Ibadan.
2004: University of Ilorin Teaching Hospital, Ilorin
2018: Babcock University Teaching Hospital, Ilisan Remo, Ogun State.

Honour(s)

2000 Graduating Student: Best student in Anatomy & Physiology
School of Hygiene, Eleyele, Ibadan, Nigeria

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Associate Member of Institute of Personality Development & Customer Relationship
Management (IPD-CRM)

Signature

Date

University Compliance Certification

This is to certify that this Thesis by **Lawrence Segun AKANDE** with Matriculation Number LCU/PG/001474 in the Department of Information Management, Faculty of Communication & Information Sciences, Lead City University, Ibadan, Oyo State is in full compliance with the approved university format and style.

Signature

Date