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Assessment of Moral Hazard behaviors Under the National Health Insurance Scheme in Nigeria: An Explorative Study

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Abstract

The Nigerian government established the National Health Insurance Scheme (NHIS) under Act 35 of 1999 with the aim of improving access to health care and reducing the financial burden of out-of-pocket payment for health care services. The NHIS became fully operational in 2005.

The aim of the study was to document behaviours and practices that constitute moral hazards among service providers and clients of the NHIS in health facilities in Ilorin Metropolis, North Central, Nigeria. Qualitative methods through 12 Focused Group Discussions (FGDs) and 4 individual in-depth interviews were conducted between between 21st January and 10th March 2019. Data were analysed using thematic analysis. FGDs and in-depth interviews showed that community members, health providers and NHIS officers are aware of various behaviors and practices that constitute abuse of the scheme. Behaviors such as frequent and unnecessary visits to health facilities, proxy consultation, impersonation, feigning sickness to collect drugs for non-insured persons, over charging for services provided to clients, charging clients for services not provided and over prescription were identified. All the recommendations by the respondents are quite pertinent and both NIHS and Government should see to their implementation because they will help to address most of the identified moral hazard behaviours. Cost containment strategies should be pursued to prevent or reduce financial loss to the NHIS. Minimizing financial loss ensures the smooth operation of the scheme and guarantees its sustainability which is good for all the stake holders.

Keywords: *Moral hazard, Behaviours, Health insurance, Ilorin Metropolis, Nigeria.*

Introduction

The term "moral hazard" was used for the first time in the context of health insurance by K.J. Arrow in his seminal 1963 article on medical care to characterize the fact that the insured use more health care services to treat a given illness than the uninsured (Arrow, 1963). He borrowed the expression from an industry for which he had worked in his youth (Finkelstein et al., 2016) to describe something he saw as a "practical limitation on the use of insurance" (Arrow, 1963, 961). While moral hazard in the insurance literature is taken to mean deviation from "correct" behaviour (Buchanan, 1964, 22, cited in Pauly, 1968, 535), or "failure to uphold the accepted moral qualities," (Faulkner, 1960, 327, also cited in Pauly, 1968, 535), Pauly (1968) subsequently argued that the application of this concept to health insurance was a misnomer. Pauly stated that, under an insurance contract that reduces the price at the point of use, there was nothing unethical or immoral in the response by an insured individual to use more services than when uninsured. Rather, the insured individual was simply reacting as any rational individual would (from any standard economics textbook) faced with a change in the price of a commodity for which they had tastes that could be translated into demand (conditional on their level of income). Pauly (1968, 535) opposed the value-laden view of the insurance industry in favour of what he saw as value neutral economic analysis: "It is surprising that

very little economic analysis seems to have been applied here".

Adequate and quality health care provision in low-income countries has continued to be a challenge. These countries face 56% of the global disease burden but account for only 2% of global health spending (World Bank, 2000). Additional challenges arise when providing their citizens with essential health services and financial protection against the impoverishing effects of catastrophic illness (Gottret et al, 2006). Given this serious situation, the problem of finding the most cost-effective way of financing health care continues to beleaguer governments especially in developing countries (Gilson, 1997) and this continues to be debated as resources for state health expenditure continue to decline (Copenhagen Consensus, 2006).

User fee was introduced by the Nigerian government in 1998 under the Bamako Initiative which advocated for cost sharing and community participation to increase the sustainability and quality of health care (Federal Ministry of Health, 1994). It was proposed that user fee will increase the resources available for health care and improve efficiency as well as equity to health care (Griffin, 1992; World Bank, 1987). The available evidence on the impact of user fees is equivocal. Hitherto, the bone of contention is to retain or remove user fee? (James, 2006). To improve access to health care, health insurance with the potential to increase utilization and better protect people against (catastrophic) health expenses was a preferred option to user fees (Gottret et al, 2006; Ekham, 2004). In an effort to offer health insurance, Nigeria introduced the National Health Insurance Scheme (NHIS) in 2005 as one of the financing mechanism of health care. The NHIS is aimed at reducing financial barriers to accessing health care, so as to improve health of the population.

Health care in Nigeria is financed by a combination of tax revenue, out-of-pocket payments, donor funding, and health insurance (social and community) (World Health Organization, 2010). Nigeria's health expenditure is relatively low, even when compared with other African countries (Babayemi ,2012). The total health expenditure (THE) as percentage of the gross domestic product (GDP) from 1998 to 2000 was less than 5%, falling behind THE/GDP ratio in other developing countries such as Kenya (5.3%), Zambia (6.2%), Tanzania (6.8%), Malawi (7.2%), and South Africa (7.5%) (Soyinbo, 2005). Achieving a successful health care financing system continues to be a challenge in Nigeria. Limited institutional capacity, corruption, unstable economic, and political context have been identified as factors why some mechanisms of financing health care have not worked effectively (Adinma, 2010).

The Nigerian government established the National Health Insurance Scheme (NHIS) under Act 35 of 1999 with the aim of improving access to health care and reducing the financial burden of out-of-pocket payment for health care services (National Health Insurance scheme, 2011).

The NHIS became fully operational in 2005. The NHIS is organized into the following social health insurance programmes (SHIPs): Formal Sector; Urban Self-employed; Rural Community; Children Under-Five; Permanently Disabled Persons; Prison Inmates; Tertiary Institutions and Voluntary Participants; and Armed Forces, Police and other Uniformed Services (National Health Insurance scheme, 2011). It is only the formal sector SHIP that is currently operational (Kannegiesser, 2011). Membership with the formal sector SHIP is mandatory for federal government employees and about 90% coverage has been achieved. The formal sector SHIP is presently extending to include all state and local government employees with Bauchi and Cross River having achieved full coverage (Kannegiesser, 2011). NHIS continues to face major challenges that threaten its long-term sustainability. Challenges regarding changes in health seeking behaviour of insured (user moral hazard) and practices of health providers (provider moral hazard), greatly influence financing and sustainability of most health insurance schemes and their ability to provide quality health care in the long-term (Mossialos, 2002). This study aimed to 1) explore behaviors and practices of service providers and consumers of the national health insurance scheme in North –Central Nigeria that constitute moral hazards and 2) To identify strategies to minimize such behaviours.

Methodology

Background: This study was conducted in Ilorin metropolis which consists of 3 Local Government areas (namely Ilorin, west east and south) in North Central Zone, Nigeria. Given the limited resources for the research the study was conducted in one out of twelve Local Government Areas in Kwara State in the zone. This was an exploratory study and much easier to do it in a known environment. ***Study design and data collection*** This study was primarily qualitative, using in-depth interviews (IDIs) and focused group discussions (FGDs) to elicit information from community members, health care providers and managers of the National Health Insurance Scheme at the General Hospital, Cortage hospital, Sobi specialist hospital, Civil service clinic, Oke-oyi heath centre and Alafia health clinic in Nigeria.

Data Collection: Six research assistants with minimum education of higher diploma and conversant in the local languages were recruited and trained to collect data for this study. Data collection occurred between 21st January and 10th March 2019. Data was collected with the aim of exploring community knowledge, perceptions and attitudes towards health insurance and behaviors that border on moral hazards. Eight focus group discussions (FGDs) were conducted with various categories of people in the local government area (LGA). Interviews were also conducted among subgroups defined by gender, age and ethnicity. Participants in the FGDs were drawn from the catchment area population of the main health facilities of the LGA. Two clusters were selected from each local government area (LGA) for the FGDs. Inclusion criteria for selection into the FGD include 18 years and above, having resided in the LGA for more than one year, enrolee of a health insurance company and ethnic indigene of the LGA. Individuals who met the inclusion criteria were then targeted for participation in the focus group discussion. Using the NHIS database, a list of twenty eligible individuals in each cluster was generated and the first ten eligible individuals who consented were invited to participate in each FGD. In addition to FGDs, four individual in-depth interviews (IDI) with at least one health worker in the main health facilities to further explore issues of client behaviors from the providers' point of view were conducted. Thus, heath workers from 6 health facilities (General hospital, Cortage hospital, Sobi specialist hospital, Civil service clinic, Oke-Oyi heath centre and Alafia health clinic) were interviewed. These facilities represent the major public and private health facilities in the LGAs. Three in-depth interviews with health insurance scheme officers were also conducted to obtain further information on the insurance scheme and the behavior of clients and service providers.

Data analysis: The FGDs and IDIs were tape recorded, transcribed verbatim and typed. Guided by the objectives of the study and the themes of the discussion, a coding list was prepared to guide the data analysis. Thematic analysis was performed.

Ethics and consent statement: Permission to conduct the study was obtained from the officers in-charge of these health facilities. Informed consent to take part in the study was received from the participants. Participation was voluntary and participants was assured confidentiality of information received from. In addition, participants were allowed to withdraw at any stage from the study any time they wish.

Results

Moral hazard behaviors by insured members: The goal of this study is to identify behaviors

exhibited by insurance scheme members that constitute moral hazards. The FGD and IDI brought out various behaviors that insured persons engage in that could compromise the efficient operation of the scheme. Various behaviors that amount to taking advantage of the NHIS (moral hazard behaviors) were disclosed by participants. Some of the behavious exhibited by the insured include frequent visit to health facilities, clinic attendance by proxy, clinic abuse, unnecessary demand for other materials and needs outside the realm of the disease diagnosed. It was also noted that that insured persons visit the health facilities more frequently compared to the non-insured. The insured also visit different facilities within the same period with the same ailment purposely to collect more drugs than required and necessary.

The insured patients demand for more drugs than they need. Because they are insured, they believe they have the right to come to the clinic any time they wish. They are of the opinion that

the insurance scheme maybe cheating them if they do not visit the clinic as many times as they want. (FGD, Female). Some even visited other facilities for the same ailment. Even when they cannot come, some presented their medical complaints by proxy (Senior health worker, Female).

Some FGD participants are of the opinion that the insured persons are right for visiting the health facility with very little medical ailment because of the insult and abuse they received from the health workers for delay in presentation of the ailments. Health workers believe some insured waited for disease problem to become more severe and even complicated before visiting the clinic.

You will seriously be rebuked especially when insured and you delayed or failed to visit the clinic on time when sick. The rebuke will be serious most especially if you delayed and your condition deteriorate (Female FGD Participant).

The behaviour of collecting drugs and keep at home even when not needed have been identified by some Focus Group Participants. Insured persons are known for this practice most especially very close to membership expiry date. To some insured collecting drugs and keep at home is not seen as either offence or abuse because they are of the notion that they have both paid to register through premium and as well contributed monthly through month deduction from their salary. Therefore, to avoid been cheated by the insurance scheme, the insure believed they must visit the facility even when they are not sick.

Some ensured were observed to have felt cheated for not going to the clinic to collect drug simply because they are not sick. Some even said they have not visited the clinic since registration because they are not sick (Male FGD Participant). In December, the clinic is full to its capacity because this is the time the membership card expires. In addition to this some people also want to use their cards very well before the expiratory date (Female NIHS Official).

The practice of clinic attendance by proxy by the insured as well as the insured persons allowing uninsured persons to use their cards for consultation and treatment are another serious moral hazard behaviour identified. Respondents also complained that that some people go to the health facility and describe the symptoms of their sick relations or friends who do not have the NHIS cards in order to get drugs to give to them. Some FGD participants frowned at this moral hazard behaviour and even blamed the NHIS authorities for condoning or making it possible for such behaviours to occur.

Insured persons gave their cards to their uninsured friends and relations for use for consultation and treatment. I think some NIHS officials and service providers are to blame for this shady practice because they failed to use correct identities of those insured but rather decide to look the other way. For example, some pictures on some cards are not very clear or even not large enough for proper visibility and identification thus making it possible for deceit and confusion (Female FGD).

The pharmacists and clinicians also complained that some insured occasionally requested for some particular or specific drugs especially the expensive ones to be given or prescribed. Responding to the question of whether insured ask for particular drugs to be prescribed for them, one physician had this to say: *Yes, it is true some insured persons request for specific drugs to be prescribed for them even when they are not sick. I am totally against this unethical practice from the insure persons and I completely refused in all cases except those specific drugs are needed to cure their ailments before I prescribed them. Sometimes I bluntly say NO in circumstances when such drugs are not needed for their ailments (Male Physician).*

Moral hazard behaviors are not limited to only the NHIS clients. There are various practices and behaviours exhibited by some service providers that constitute moral hazards. Such practices and behaviours include material and monetary incentives, prescription of unnecessary and excessive drugs, over charging for drugs and services provided to clients, charging for services not provided, as well as inflating the number of clients provided with services for soliciting for more and unnecessary patronage through interviews with NHIS officials to identify moral hazard behaviours.

The health service provided received payment based on the number of visits clients made to the health facility. The more clients go to the facility the more NHIS pay to the health facility service provider. By agreement a client visit the health facility two times within a week apart from

emergencies. We observed that some heath service provider encourages clients to visit the client so as to utilise the maximum number of visits they are entitled to. This is a provider moral hazard when clients are being incentivised or encouraged to visit clinic because increased frequency of clinic visit attracts more pay for the service provider (Female NHIS official).

Misclassification or change of diagnosis by health services providers was also reported. Some providers treat upper respiratory tract infections and charge the NHIS for Pneumonia which occasionally requires admission. It costs more to treat pneumonia than upper respiratory tract infections. This unethical practice is a behavioural moral hazard which is more costly to NHIS.

A situation occurred where upper respiratory tract infection was demented as pneumonia at some health facilities. To justify payment, clients are being delayed or admitted for one or two days instead of patients being treat as outpatient. At a point the affected health facility was invited for a meeting to discuss the malpractice observed and we have to threaten disengagement should such practice continue. The proportion of the malpractice got drastically reduced after some weeks of reassessment of the situation again (Head of operation, NIHS, Male).

Discussion and interview with the NIHS officials revealed that some NHIS officials collaborated with health service providers to cheat and exploit the scheme. Clinic attendance by proxy, allowing non-insured persons for consultation as well as over prescription were mention as some of the malpractices going on. These types of malpractices have negative consequences on the scheme. Some of these consequences could be poor quality service and inability of the scheme to continue to survive. The overall effect is unsustainability of the scheme.

Poly-pharmacy is a common practice. In many occasions, one client has been supplied or given up to 6 or 7 different drugs for one ailment. This issue of poly-pharmacy has been raised in many occasions with both the pharmacists and the physicians. The intention for the occurrence of this unethical practice is to justify for more pay from the NHIS scheme. The essential drugs guideline and code of health care practice and prescription in Nigeria goes against poly- pharmacy (prescription of more than 5 drugs at a time for a single ailment for a patient at a time). The NHIS agreed with the physicians and pharmacist not to reimburse for additional drugs in order to stem the tide. (NHIS Assistant Coordinator, Female)

Opinion and Perceptions of Community members on moral hazard behaviours: Community members are aware and completely against the moral hazard behaviours and their negative effects. This opinion was seriously expressed during the focus group discussions. Because of request for unnecessary drugs, health workers have resulted to given non- quality drugs to insured persons and this has discouraged some insured persons taking NHIS drugs due to lack of confidence on quality and reliability. Furthermore, some health workers are reluctant in giving insure persons many drugs due to the abuse of NIHIS opportunity. Some respondents also complained that such behaviours could lead to collapse of the scheme due to more utilization but less contribution. Effects of such behaviours also include huge financial loss for the scheme, government unwillingness to support the scheme and financial risk to the insured persons. Financial risk of the insured is also associated with poor health care, increased possibility of the ailments leading complications and finally untimely death (FGD, male member). It has been noticed by health workers that some clients come to the clinic simply to collect drugs and as a result of this behaviour they (health workers) therefore now result into being stringent and strict before giving out the drugs (FGD, male member).

Strategies to prevent or control moral hazard behaviours: Below are suggestions given by FGD and IDI participants to discourage insured persons from indulging in morally hazardous practices.

1. Immediate disengagement of enrolee for disobeying set down rules and regulations more than one time (FGD, male; IDI, male).
2. Introduction of penalty for proxy consultations (FGD, male; IDI, female).
3. Signing of agreement of undertakings by both the health service providers and NHIS officials for compliance with set rules and regulations and very stiff punishments for the offenders (FGD, female).

4. Reduction in premium and registration (FGD, female).
5. Use of instalment payment method for premium fees. (FGD, male).
6. Presentation of quality pictures during enrolment (IDI, female).
7. Serious scrutinisation of pictures on the card by the health workers before attending to patient (FGD, male; IDI, male).
8. Failure to reimburse payment for more than four drugs per ailment and maximum five for multiple ailments (IDI, male & female).
9. Low registration fee for registration and premium, (FGD & IDI, male & female).
10. Refusal to attend to proxy patients (IDI, male).

Health workers and NHIS staff should be blamed and held accountable for this issue of moral hazard behaviours. If the health workers have not encouraged these behaviours and condone by some NHIS staff, the problem would have been nip at the bud before escalation. NHIS ns government should conduct regular monitoring and supervision and accountability frame work instituted for culprits (IDI, male).The pharmacists (medical assistants) interviewed suggested a ceiling on the number of times an insured member could visit a health facility per week, month and year as well as the maximum number of drugs to be issued per prescription and per patient and per visit.. We pharmacists should not be blamed since we have to issue the drugs prescribed by the doctor. Hmmmm---- blame the doctors (pharmacists, male and female (Pharmacists, male & female).

Counselling on rational behaviour and health education are key tools in mitigating these morally hazardous behaviours from insured members and health providers according to NHIS officials

These behavioural problems can be corrected on the part of the clients using the following approach:

Health education on the importance of not abusing clinic visits. The clients should be educated or convinced that they own facility and that they should not abuse it because when it collapses it is them that will suffer from the consequences arising from the collapse. The providers should be educated also that there is prescribed punishment for providers who engage in malpractices and that offenders will be punished to serve as deterrent to others" (NHIS Coordinator, Female).

NHIS officials are of the opinion that there should be training on treatment protocol and standard prescription practice. This measure will help to address the issue of poly-pharmacy.

The NHIS official have to be given some basic training on some common ailment, the way they prescribe medications for treatment so that we be able to address some of the providers moral hazard behaviours. The training is essential because when you observed something strange and you try to raise it with doctors, pharmacists or other health workers but instead of listen to your complaints, they feel infuriated and start saying do you want to be teaching them their work. And that if you want be a doctor you have to go and read medicine and medical practice is not by apprenticeship. Given us basic training on medicine, pharmacy and nursing is the only way we can address some of these issues (NHIS official, female).

Discussion

Health care in Nigeria is financed by a combination of tax revenue, out-of-pocket payments, donor funding, and health insurance (social and community) (WHO, 2009). Nigeria's health expenditure is relatively low, even when compared with other African countries. The total health expenditure (THE) as percentage of the gross domestic product (GDP) from 1998 to 2000 was less than 5%, falling behind THE/GDP ratio in other developing countries such as Kenya (5.3%), Zambia (6.2%), Tanzania (6.8%), Malawi (7.2%), and South Africa (7.5%) (Soyinbo, 2005). Achieving a successful health care financing system continues to be a challenge in Nigeria. Limited institutional capacity, corruption, unstable economic, and political context have been identified as factors why some mechanisms of financing health care have not worked effectively (Adinma, 2010). The charges levied for health care services are referred to as user fees.

The scope of user fees is quite variable and can include any combination of drug costs, medical material costs, entrance fees, and consultation fees (Lgarde et al 20060. By removing user fees payment at the time of seeking care, the financial barrier to health care access is removed thus making it much easier for people to seek care (Comelius et al 2015).

Indeed, the increased attendance at health facilities since the introduction of the scheme strongly suggests that access to health care has been enhanced. However, the operation of the national health insurance scheme has faced various challenges which border on the behavior of insured persons, service providers and scheme officials. These abusive behaviours contribute to high health care expenditures that threaten the sustainability of the scheme (Comelius et al 2015). Community members in the focused group discussions and in-depth interviews emphasised the significant impact of the national health insurance scheme in enhancing access to health care, especially for the poor. Unfortunately, some people are still poor and are unable to pay the premiums and register with the scheme. Inability to pay the premium or registration fees has been identified by other studies as a major barrier in enrolment into a health insurance scheme (Alatinga et al, 2011; Dalaba et al 2014). There has been a lag in the expansion of NHIS to achieve a considerable coverage since it became operational. A World Bank survey in 2008 reported that about 0.8% of the population was covered by NHIS (World Bank, 2008). This has attracted a lot of censure since many people are left out and not benefiting from it. The act that set up the NHIS makes it optional, and this has been pointed out to be one of the reasons many Nigerians are not benefiting from it (Ogbonnaya, 2010). The NHIS is focused on making the scheme mandatory for every Nigerian and aims to get every Nigerian enlisted by December 2015 (Ogbonnaya, 2010). Other factors such as poor medical facilities, shortage of medical personal, lack of awareness, and poor funding have been identified as challenges that affect the efficacy of NHIS in Nigeria (Mohammed et al, 2011) stakeholders have also raised issues about the potential mismanagement and bureaucracy that may affect the scheme (Kannegiesser, 2011).

Majority of those unregistered are the poor and vulnerable who are least able to pay for health care when they need it. It is therefore important to strengthen the exemption policy for the poor and vulnerable to enable them benefit from the scheme so as to achieve the equity goal of the NHIS and also accelerate universal health coverage ((Comelius et al 2015). Community members, health care providers and NHIS officers were aware of various behaviours and practices that constitute abuse of the scheme (moral hazard). In the FGDs and in-depth interviews, behaviours such as frequent and un-necessary visits to health facilities, poly-phamacy, proxy consultation, impersonation, collecting drugs for non-insured persons, over charging for services provided to clients, charging clients for services not provided and over prescription were identified. These moral hazard behaviours have been similarly identified by a previous study ((Comelius et al 2015). As expected, hardly any respondent admitted to personally engaging in these practices. Participants acknowledged the existence of these moral behavioural practices; some are even ready to mention names of people involved but for the purpose of confidentiality of given information they were not allowed to do so. Previous studies have also reported moral hazard behaviours by clients such as the insured persons offering their cards for use by the uninsured persons in order to have access to health care (Dalijong et al, 2012).

Recommendations on how to minimize abuse of the NHIS were offered by community members, health providers and NHIS officials. These recommendations include:

1). Ceiling on the number of times one can visit the clinic within a specified time period.

2). Payment of premium by instalment.

3). Reduction of premiums and registration fees.

4). Monitoring and supervision by NHIS and Government officials.

5). Verification of membership cards of insured persons.

6). Counselling and education to change behaviours that abuse the scheme, 7) Increase the clarity and quality of pictures, 8). Refusal to attend to impersonators.

Generally, if people are well informed on the concept of social health insurance such as the Nigeria NHIS and the in-built principle of cross-subsidization, moral hazard behaviours may change. For instance, with cross-subsidization, membership is based on ability to pay, and the rich will pay more while the poor pay less, thus the rich cross-subsidize the poor and vulnerable, the healthy cross-subsidize the sick (MOH, 2004). Some moral hazard behaviours by providers such as diagnosing upper respiratory tract infection as pneumonia, over charging for

drugs and services provided to clients, charging for services not provided, inflating number of clients provided with services and over prescribing have also been reported by respondents in this study by NHIS officials. Basic training on some common ailment, the way they prescribe medications for their treatment have been suggested by NHIS officials as a way to address some of the providers' moral hazard behaviours. Capitation payment mechanism is being contemplated to augment the current payment mechanism to address some of these moral hazards from the health care providers' side and to reduce operational cost of NHIS (Debpuur et al, 2015). A fee for service type of provider payment mechanism was used to reimburse accredited health service providers. However, this type of payment mechanism (fee for service) was reported to be low for providers to cover their cost of operation, especially the private providers and it also involved a lot of paperwork as they are required to provide detailed information on all services and charges for claims (Dalinjong et al, 2012; Martin, 2009). In general, fee for service payment methods create the enabling environment for providers to provide unnecessary services to maximize profits (Agyepong et al, 2011). Because medicines at all levels continue to be under itemized fee for service, there is strong potential for moral hazard behaviors and consequently cost escalation (Agyepong et al, 2011).

Limitations of the study

Being a qualitative study, it is not possible to estimate how prevalent the various behaviours and practices that undermine the scheme are in the study area. The study LGA is not representative of all other LGAs in Nigeria; therefore, the generalizability of the findings is limited. Since the operations of the NHIS in the study LGA are the same with that of NHIS operations in other LGAs, the results obtained in this study provide useful insights on the situation in the other LGAs.

Conclusions

NHIS is a means to ensure universal health coverage. However, there are various challenges undermining the efficiency of the scheme that need to be addressed. Appropriate sanctions and punishments for various forms of abuse of the scheme should be identified and rigorously applied. Punishing or sanctioning people who engage in behaviours that negatively affect the scheme will serve as a deterrent to others and help minimize the occurrence of such behaviours. On the other hand, mechanisms for rewarding individuals who regularly renew their membership for a specified time period without consuming un-necessary health care services should be instituted. There is the need for further studies to cover more LGAs so as to identify moral hazard behaviours in other LGAs which would inform the NHIS on how to address these issues in order to improve the operation of the scheme. As NHIS takes steps to improve its efficiency, it will be more difficult for clients and providers to engage in the various moral hazard behavioural practices identified in this study.

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