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Article

Structural violence and policy outcomes of Lagos State Health Insurance Scheme in selected ministries, Lagos State

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Abstract: The decentralization of the NHIS's implementation to states intended to hasten progress towards universal health coverage, has not effectively addressed healthcare disparities, particularly in Lagos State. The implementation of the Lagos State Health Insurance Scheme appears to perpetuate structural violence, evident in increased out-of-pocket expenses, discrimination based on insurance type, and substandard healthcare delivery. The study therefore examined how structural violence has affected the policy outcomes of the Lagos State Health Insurance Scheme, with a specific emphasis on junior officers in grade level 01–07 in five selected ministries situated within Lagos State. Both primary and secondary data were collected using questionnaire, interview and literature search. Data gathered were analysed statistically and thematically. The findings of the study indicate that the policy outcome of the scheme has been adversely affected by structural violence, resulting in dissatisfaction, compensation claims for unresolved health issues and a shift in health insurance providers among enrolled junior officers.

Keywords: healthcare; insurance; junior officers; Lagos; structural violence

1. Introduction

The burgeoning recognition and paramount importance of health in the domains of human well-being and economic progress is gaining momentum on a global scale. Consequently, nations are augmenting their commitments and allocations towards initiatives and systemic modifications that aim to ameliorate health outcomes and advance societal progress (Health Policy Commission, 2023). However, even the most developed nations are grappling to align their fiscal frameworks with the unremitting surge in healthcare expenditures. The pervasive economic downturn further underscores the intricate complexities intertwined within the domain of healthcare expenditure (Health Policy Commission, 2023).

A World Health Organisation (2022) document publication notes that over 50 per cent of the global population faces barriers in accessing vital healthcare services, with disparities in both affordability and availability of such healthcare services persisting worldwide. While some regions have made progress in increasing the availability of fundamental health services like family planning and infant immunisation, the absence of financial safeguards has resulted in mounting economic burdens on families who must bear these expenses from their resources. This challenge is not limited to less economically developed areas; even relatively prosperous regions such as Eastern Asia, Latin America, and Europe are witnessing a rising number of individuals allocating at least 10 per cent of their household

budgets towards out-of-pocket health expenditures (World Health Organisation, 2017).

It is pertinent to note that inequalities in healthcare services, pertaining to disparities in affordability, availability, and quality, are not exclusively confined to variations between different countries. Rather, these inequalities are also notably pronounced within nations themselves. The differences in healthcare that include availability, accessibility, affordability, and quality are acknowledged as a form of structural violence. Structural violence refers to systemic ways in which social structures harm or otherwise disadvantage individuals. In the context of healthcare, this means that the inability of some individuals or communities to afford or access healthcare is not merely a result of personal financial decisions but is deeply embedded in broader economic and social systems that perpetuate inequality (Churchwell et al., 2020).

Since the mid-20th century, national governments and international organisations have committed to closing the gap between the most and least advantaged in terms of healthcare services (The Lancet Global Health, 2016). Researchers in global health have examined and delineated the distinctions between the most and least disadvantaged. Policymakers have employed this data to reduce inequalities, with some success in both high-income and low- to middle-income countries (LMICs). Nonetheless, disparities in affordability, availability, and quality of healthcare services persist. In regions like Africa, limited access to healthcare services, mainly due to financial barriers, profoundly affects disease rates and health outcomes, especially in low-to-middle-income countries (Adugna et al., 2020). Although the World Health Organisation continues to emphasise the critical role of health financing in strengthening health systems and improving overall human well-being, financial inclusion in healthcare remains relatively inadequate in Sub-Saharan countries, Nigeria included (Sarpong and Nketiah-Amponsah, 2022; World Health Organisation, 2017).

In Nigeria, a committee set up by the Ministry of Health affirmed the feasibility of health insurance in Nigeria, outlining plans for its launch by mid-1991. The NHIS outlines objectives including universal access to quality healthcare for Nigerians, protection of families from crippling medical expenses, containment of rising healthcare costs, equitable distribution of healthcare expenses across income groups, even distribution of healthcare facilities within the nation, and ensuring funds for improved services (Abiola et al., 2019). Unfortunately, evidence suggests that these objectives remain largely unmet.

The central goal of the insurance scheme is to decrease dependency on out-of-pocket payments, which disproportionately burden the less affluent and reflect inequities in the healthcare system. Initially, the NHIS covered solely federal government workers, constituting less than 5 per cent of Nigeria's population. Coverage from other insurance agencies such as private health insurance and community-based health insurance encompassed less than 1 percent (Alawode and Adewole, 2021). This points to a mere 6 per cent coverage. As a result, a striking 94 per cent had to pay for healthcare out-of-pocket. This reality contributes to the elevated mortality rate among economically disadvantaged individuals from easily preventable and treatable diseases, such as malaria.

To overcome the challenge of limited coverage within the NHIS and ensure healthcare accessibility for all social strata, the NHIS decentralised the implementation of the country's social health insurance programme to the states in 2014. This initiative aimed to accelerate the nation's progress toward achieving universal health coverage (Alawode and Adewole, 2021). Subsequently, in 2014, the Lagos State government introduced its health financing policy, giving rise to the Lagos State Health Insurance Scheme (LSHIS). The expected policy outcome of the scheme is that all residents of the state enjoy equal, accessible, affordable, and quality healthcare services. However, individuals enrolled in the scheme continue to face challenges, including restricted healthcare access, higher out-of-pocket expenses, discrimination by healthcare providers due to the use of state-provided insurance, prescription of lower-quality medications, and preferential treatment for those paying directly or through private insurance (Shobiye et al., 2021). Furthermore, beneficiaries of the scheme often do not fully leverage the provisions of the scheme and at times must make out-of-pocket payments for effective healthcare services due to the limited amount of financial coverage (Shittu and Afolabi, 2020). Moreover, the cost of the premium, necessary for benefiting from the health insurance scheme, is deemed too high for those in lower income brackets, including junior officers in the civil service on grade levels 01–07 (Partner, 2018). Consequently, this study aims to examine the effects of structural violence on the policy outcomes of the Lagos State Health Insurance Scheme and offering alternative strategic policy options for effectively implementing the Lagos State Health Insurance Scheme to reduce structural violence and improve health outcomes.

1.1. Concept of structural violence

Structural violence is a form of violence embedded within a society's social, political, and economic structures (Rivera, 2022). It is a phenomenon that hinders individuals, groups, and societies from achieving their full potential by imposing limitations that are rooted in the structures of power. Macassa et al. (2021) similarly defined structural violence as the social, economic, legal, political, religious, and cultural structures that obstruct the realisation of fundamental human needs. According to Galtung (2023), structural violence represents a deliberate deprivation of these needs by powerful actors, a process that unfolds through the gradual erosion and ultimately the destruction of human life. In a study by Rylko-Bauer and Farmer (2016), structural violence is established to be inherent in the political and economic structures of society and is characterised by the infliction of harm on individuals who are not responsible for perpetuating these inequalities. Unlike physical violence, structural violence results from institutionalised and systemic inequalities that exist within society. The authors argue that individuals may cause significant harm to others inadvertently, as they perform their regular duties within the structures of society. The constitution of societal structures, such as medical services, jobs, transportation, food, and shelter, are closely linked to the material resources available to individuals (Kraus and Torrez, 2020). Jackson and Sadler (2022) note that unequal access to these resources, as well as political power, education, health

care, or legal standing, constitutes forms of structural violence that cause harm to individuals.

In the context of this study, structural violence is concerned with includes inequity, discrimination, and continuous out-of-pocket expenses experienced by enrolled junior officers in the Lagos State Health Insurance Scheme due to the actions and inactions of other stakeholders involved in the implementation of the scheme.

1.2. Concept of policy outcomes

According to Mavrot and Pattyn (2022), policy outcomes are the actual results of policy interventions, which can include both intended and unintended consequences, as well as direct and indirect effects on individuals, groups, and society as a whole. Similarly, Knill and Tosun (2020) see policy outcomes as the results or consequences of the policies that are implemented by the government or other entities. Berglund et al. (2022) hold that these outcomes may be intended or unintended, positive or negative, short-term or long-term, and tangible or intangible. Hupe and Hill (2021) support this point of view, asserting that the intended outcomes are those that policymakers aim to achieve when they design and implement policies, while unintended outcomes are the unanticipated consequences that arise from the implementation of policies. Amidst the various definitions proposed, in the context of this study, policy outcomes specifically denote the unintended consequences that emerge from the execution of a particular public policy on its intended beneficiaries.

1.3. Theoretical framework

Formulated in 2008, Martha Fineman's Vulnerability theory asserts that vulnerability is not a sporadic or tangential feature but an intrinsic, ubiquitous, and deeply rooted facet intertwined with the very essence of the human experience. As elucidated by Fineman (2018), the significance of this theory lies in its refusal to restrict vulnerability to specific demographics; rather, it underscores its relativity, profoundly influenced by a complex interplay of societal, economic, cultural, and historical dynamics. In essence, vulnerability theory dismantles the prevailing tenets of liberal ideology that champion individual self-sufficiency and autonomy.

The pressing nature of this theory is heightened by its clear insistence on the imperative need for a thorough overhaul of societal structures. According to vulnerability theory, this overhaul necessitates the dismantling of institutional frameworks that sustain inequality and favouritism (Fineman, 2018). It unequivocally demands the establishment of novel social systems dedicated to championing both equity and impartiality. This theory boldly aligns itself with an unwavering commitment to the relentless pursuit of social justice, advocating for the creation and cultivation of structures that embody the essence of fairness. Vulnerability theory emphasises the need to recognise and address the universal human needs of society such as care, autonomy and security, while also probing the underlying values, norms, laws, and complex social structures that both shape and are shaped by society. The theory magnifies the urgency for societal introspection, the reimagining of policy paradigms, and the conscientious dismantling of

oppressive structures. In this context, vulnerability theory provides a piercing lens through which the interplay between human vulnerability and systemic dynamics can be discerned, fostering a more just and inclusive society.

2. Materials and methods

The population of this study comprised junior officers in the Lagos State Ministries of Health; Women Affairs and Poverty Alleviation; Youth and Social Development; Works and Infrastructure; and Establishment, Training and Pension. **Table 1** provides a breakdown of the population of junior officers in the selected ministries. Furthermore, other stakeholders such as facility managers in Lagos State University Teaching Hospital (LASUTH), Lagos University Teaching Hospital (LUTH), Gbagada General Hospital, and officials of the Lagos State Health Management Agency were included in this study.

Table 1. Population of junior officers in the selected ministries.

Ministries	Population
Lagos State Ministry of Health	321
Lagos State Ministry of Women Affairs and Poverty Alleviation	50
Lagos State Ministry of Youth and Social Development	104
Lagos State Ministry of Works and Infrastructure	348
Lagos State Ministry of Establishments, Training and Pensions	77
Total	900

Using Krejice and Morgan sample size determination table, it was observed that for a population of 900, a sample size of 269 was deemed appropriate. Given that the population included in the study falls within the aforementioned threshold, a sample size of 269 was deemed appropriate to ensure uniform distribution of the questionnaire. This study employed proportional stratified sampling technique to determine how 269 copies of the questionnaire were distributed across the five selected ministries. The use of proportional stratified sampling technique is justified by the need to ensure that each subgroup within the population is adequately represented. This technique involves dividing the population into homogeneous subgroups (strata) based on certain characteristics (ministry affiliation) and then randomly selecting samples from each stratum in proportion to their sizes in the population.

This study adopted convergent mixed method of data collection. The convergent mixed method approach was adopted for its ability to provide a comprehensive understanding of the research problem by combining both quantitative and qualitative data. Firstly, two types of data sets were collected concurrently, and secondly, they were analysed independently using quantitative and qualitative analytical approaches (Clark, 2019; Schoonenboom and Johnson, 2017; Shorten and Smith, 2017; Wisdom and Creswell, 2013). The quantitative data consisted of data collected via a structured questionnaire. The questionnaire was administered face-to-face to the junior officers in the Lagos State Ministry of Health, Lagos State Ministry of Women Affairs and Poverty Alleviation, Lagos State

Ministry of Youth and Social Development, Lagos State Ministry of Works and Infrastructure, and Lagos State Ministry of Establishments, Training and Pensions, to elicit responses from them as it pertains to the subject matter or intent of the study.

In contrast, the qualitative data was collected through a semi-structured interview guide. The semi-structured interview was conducted using purposive sampling on health administrators in the Lagos State University Teaching Hospital (LASUTH), Lagos University Teaching Hospital (LUTH), Gbagada General Hospital, and officials of the Lagos State Health Management Agency officials (LASHMA) respectively. This approach enabled an in-depth exploration of the research problem and established a good rapport between the researcher and the respondents. Secondary sources of data collection were adopted in this study. The secondary data were sourced from peer-reviewed journals from databases like Scopus, Web of Science, and Science Direct among others. The use of multiple data sources helped to achieve the research objectives and provided a comprehensive understanding of the research problem. Cronbach's alpha reliability analysis was conducted using SPSS Statistics to establish reliability as suggested by Vaz et al. (2013). The use of Cronbach's alpha was preferred because it indicates the extent to which a set of test items can measure a single latent variable. From the Cronbach analysis, the value of 0.81 was realised indicating an acceptable consistency.

The data collected for this study were analysed descriptively and inferentially. Firstly, a basic data check was done on the returned copies of the questionnaire, that is, checking for errors such as removing and separating all copies of the questionnaire not properly filled by the respondents. Any questionnaire that was deemed incomplete due to the respondent's inability to provide answers to some or all of the questions was set apart from the ones that were satisfactorily filled. Subsequently, the filled data were coded. Ordinal regression analysis was employed to test the null hypotheses of the study at a 0.05 level of significance. These analyses enabled the study to investigate the effect of structural violence on the policy outcomes of the Lagos State Health Insurance Scheme. The information gathered through one-on-one interviews was transcribed and analysed using thematic analysis to complement the results from the questionnaire. Thematic analysis facilitated the identification and interpretation of patterns in the data, enabling a deeper understanding of the research problem.

3. Results and discussion

3.1. Background characteristics of respondents

Table 2 reveals the frequency distribution of respondents' background information such as gender, age, marital status, highest educational qualification, place of work, and length of service.

Table 2 reveals the frequency distribution of the respondents by gender, age, marital status, highest educational qualification, place of work and length of service. According to the **Table 2**, 114 (43.5%) were male, while only 148 (56.5%) were female respondents. This is because the majority of those who responded were females compared to males. Furthermore, the frequency distribution of respondents' age shows that the majority of the respondents (75.2%) are within the age range of

36–50 years, 18.0% are within the age range of 20–35, 6.8% fall between the age range of 51–65 years. The frequency distribution of the respondent's marital status reveals that most of the respondents (74.0%) are married, 16.8% are single, 3.8% are divorced, and 5.3% are separated. In addition, as seen in **Table 2**, the majority of the survey respondents (74.8%) hold an SSCE, while 33.3% have an ordinary national diploma, and 1.90% obtained a higher national diploma.

Table 2. Background characteristics of respondents.

		Frequency	**Percentage**
Gender	Male	114	43.5
	Female	148	56.5
	Total	262	100.0
Age	20–35 years	49	18.0
	36–50 years	197	75.2
	51–65 years	16	6.8
	Total	262	100.0
Marital status	Single	44	16.8
	Married	194	74.0
	Divorced	10	3.8
	Separated	14	5.3
	Total	262	100.0
Highest educational qualification	SSCE	196	74.8
	OND	61	23.3
	HND	5	1.90
	Total	262	100.0
Place of work	LSMOH	94	35.9
	LSMOWAPA	13	5.0
	LSMOYSD	30	11.5
	LSMOWI	102	38.9
	LSMOETP	23	8.8
	Total	262	100.0
Length of service	Less than 5 years	45	17.2
	5–10 years	215	82.1
	Above 10 years	2	0.7
	Total	262	100.0

The frequency distribution of the respondent's place of work reveals that a higher percentage of respondents (38.9%) are employed in the Lagos State Ministry of Works and Infrastructure, 35.9% are employed in the Lagos State Ministry of Health, 11.5% are employed in the Lagos State Ministry of Youth and Social Development, 8.8% respondents are employed in the Lagos State Ministry of Establishment, Training and Pension, while 5.0% are employed in the Lagos State Ministry of Women Affairs and Poverty Alleviation. Furthermore, the frequency distribution of the respondents' length of service shows that the majority of the

respondents (82.1%) who are SSCE and OND holders have worked for 5–10 years, 17.2% have worked for less than 5 years, while 0.7% have worked above 10 years.

Hypothesis one:

Ho: The denial of quality healthcare services among enrolled junior officers in the five selected ministries has not significantly affected the policy outcomes of the Lagos State Health Insurance Scheme.

$$POLHI = \beta_0 + \beta_1 DEN + U$$

Table 3 shows a parameter estimate of a positive coefficient between the denial of quality health care service and policy outcomes of LSHIS. This means that for every one-unit increase in denial of quality healthcare service, there is a predicted increase of 2.901 in the log odds of being a higher level on policy outcomes of LSHIS. Also, the parameter estimates show that the denial of quality healthcare services has a significant effect on the policy outcomes of LSHIS. Therefore, the hypothesis which states that the denial of quality healthcare services among enrolled junior officers in the five selected ministries has not significantly affected the policy outcomes of the Lagos State Health Insurance Scheme is rejected.

Table 3. Parameter estimates.

		Estimate	Std. error	Wald	Df	Sig.	95% confidence interval	
							Lower bound	Upper bound
Threshold	[Quality = 1.75]	2.334	0.471	24.540	1	0.000	1.411	3.258
	[Equity = 1.81]	3.375	0.472	51.121	1	0.000	2.450	4.300
	[Accessibility = 1.88]	4.338	0.494	77.200	1	0.000	3.371	5.306
	[Affordability = 1.94]	4.625	0.502	84.992	1	0.000	3.642	5.608
Location	Denial of quality	2.901	0.276	110.638	1	0.000	2.360	3.441

The representatives from the Lagos State Health Management Agency emphasised that the failure to provide high-quality healthcare services contradicts the essence of the programme. They elaborated that although the scheme promises quality healthcare services for its participants, some individuals are unable to fully benefit due to the actions of certain healthcare providers, hindering the effective achievement of the scheme's objectives. This implies that the scheme is not accomplishing its goals adequately for all participants. Furthermore, they acknowledged the scheme as a commendable initiative with achievable objectives. However, they noted that the denial of quality healthcare services by some providers has impacted the overall outcomes in terms of prolonged illnesses, abandonment of the scheme, and unwillingness to renew insurance, among others. According to the interviewees from LASHMA, "…to ensure quality healthcare for all participants, everyone needs to fulfil their responsibilities." The representatives lamented that blame is often directed at their agency without recognising the broader scope of the scheme. They emphasised the involvement of various stakeholders whose actions can influence the scheme's outcomes either positively or negatively.

On the other hand, respondents from LASUTH and LUTH explained that the healthcare provided for insured individuals, particularly junior officers under the scheme, is deemed relatively satisfactory. They acknowledged the inherent

challenges in delivering quality healthcare services, emphasising the need to work within existing resource constraints. Despite not being able to offer quality care due to limited resources, they highlighted their ongoing efforts in providing subsidised healthcare services. The interviewees emphasised that the costs associated with healthcare services without insurance exceed those covered by health insurance. They clarified that their provision of subsidised services is contingent on the government reimbursing them for the gap between the actual cost and the subsidized amount. In the face of economic challenges, they underscored the financial constraints they face in maintaining the desired quality of healthcare. The respondents acknowledged the trade-offs involved, expressing that while they may not always have the necessary resources to provide optimal care, they are committed to delivering a standard that is better than nothing. They clarified that it is the denial of quality healthcare is due to the limitation in the resources available to meet every expectation. They argued that if individuals desire additional or specialized services beyond what the insurance covers, they may need to bear the associated costs. Furthermore, the interviewees addressed instances where certain illnesses might not be covered by insurance, leading to additional charges for treatment. They further explained that as healthcare needs become more complex or require specialist attention, additional expenses may arise, and it is unrealistic to expect these to be covered entirely by insurance.

Respondents from Gbagada General Hospital clarified that the negative impact of denial of quality healthcare services is evident in the avoidance of care and continued habit of self-medicating. The interviewees insisted that this negative effect is not attributable to anyone's fault. The provision of quality healthcare is contingent on resources, which are limited for both the hospital and the patients. While insurance is available, its extent is constrained, as witnessed in cases where individuals present with various ailments, including minor ones. The hospital faces challenges in sustaining care for such cases due to the associated costs. Despite the hospital's commitment to providing care regardless of the degenerative nature of a patient's condition, past experiences have been less than ideal. According to the interviewees, although the hospital is government-owned, the funds received are crucial for its operations, necessitating the imposition of service charges even in public healthcare settings. The interviewees emphasised the importance of funds in sustaining hospital operations and pointed out that, while they believe in the efficacy of insurance coverage, they are constrained within the agreed-upon terms. The hospital strives to communicate this limitation effectively to patients, emphasizing that they cannot go beyond the scope outlined by insurance coverage. They stressed that the hospital's primary goal is to provide care within the established parameters, and any deviation from this would incur additional costs that could not be absorbed without financial consequences.

Hypothesis two:

Ho: Inequity in healthcare service provision among enrolled junior officers in the five selected ministries has not significantly affected the policy outcomes of the Lagos State Health Insurance Scheme.

$$POLHI = \beta_0 + \beta_2 IQU + U$$

Table 4 shows a parameter estimate of a positive coefficient between inequity and policy outcomes of LSHIS. This means that for every one-unit increase in inequity, there is a predicted increase of 2.144 in the log odds of being a higher level on policy outcomes of LSHIS. Also, the parameter estimates show that the inequity has a significant effect on the policy outcomes of LSHIS. Therefore, the hypothesis which states that inequity in healthcare service provision among enrolled junior officers in the five selected ministries has not significantly affected the policy outcomes of the Lagos State Health Insurance Scheme is rejected.

Table 4. Parameter estimates.

		Estimate	Std. error	Wald	df	Sig.	95% confidence interval	
							Lower bound	Upper bound
Threshold	[Quality = 1.75]	0.779	0.373	4.367	1	0.037	0.048	1.510
	[Equity = 1.81]	1.696	0.352	23.279	1	0.000	1.007	2.385
	[Accessibility = 1.88]	2.554	0.354	52.137	1	0.000	1.861	3.248
	[Affordability = 1.94]	2.803	0.357	61.591	1	0.000	2.103	3.504
Location	Inequity	2.144	0.223	92.123	1	0.000	1.706	2.582

As per the statements from LASHMA interviewees, they assert that there is no inequity in the registration or provision of insurance. Eligibility is based on submitting necessary data and paying the premium. However, the interviewer raises concerns about the objective of the scheme to provide accessible, affordable, equal, and quality healthcare, questioning if economic constraints for some junior officers contradict this objective. Interviewee 2 responded, stating that as long as individuals are employed, affordability is assumed, and monthly deductions from salaries are compulsory: "…these deductions make healthcare insurance coverage available to all, regardless of financial capacity." The interviewee emphasised that healthcare is not free, but the scheme aids individuals in obtaining it at a subsidised rate. The interviewee acknowledged claims of denied access, disparities in care quality due to financial factors, age and misuse of insurance, emphasising that such issues are frowned upon and thoroughly investigated for appropriate action. The repercussions of inequity in the implementation of the scheme, including an absence of trust, accessibility problems, and instances of substandard care, were highlighted. They also observed that the absence of trust has undermined the overall effectiveness of the policy by discouraging enrollment and participation. Moreover, individuals now perceive that the scheme does not fulfill its promise of equitable healthcare, and question the legitimacy and fairness of the entire system.

According to LASUTH and LUTH interviewees, the issue of inequity in healthcare provision is complex. While there may be challenges in providing care for certain individuals, the primary factors are resource availability and the nature of illnesses. Financial capacity is a crucial consideration, as it affects the level of care provided. The interviewees acknowledged that there might be instances where individuals are required to pay more, as some sicknesses may not be fully covered by insurance or government funding. They emphasised the importance of examining the government's financial contributions, insurance coverage, and the specific illnesses

included in the scheme. However, there are cases, albeit not extensively discussed, where some healthcare providers may exhibit bias. Instances of individuals with insurance coverage facing challenges in receiving adequate attention, while those with more financial means receive preferential treatment, have been observed. The interviewees were cautious not to extensively criticize such practices but acknowledged the existence of certain cases where individuals might not be treated fairly based on their financial capacity or other factors.

As per the insights from Gbagada General Hospital interviewees, inequity, particularly as regards socio-economic status has significantly impacted the outcomes of the policy. Individuals who cannot afford additional payments beyond insurance coverage, especially those dealing with severe illnesses that progress over time are unable to access adequate healthcare services. The interviewees note that unhealthy lifestyles prevalent in Nigeria contribute to various abnormal health conditions, beyond common ailments like high blood pressure or diabetes. Certain critical illnesses, requiring specialized attention and potential surgery, may not be covered under the insurance scheme. This presents a dilemma for individuals who need specialized care but lack the financial means to cover the extra expenses. Despite the availability of government hospitals in Lagos, the financial constraints faced by patients can hinder their ability to receive necessary treatments. The interviewees emphasised that while they strive to provide essential services for covered illnesses, challenges arise during the reimbursement process. Delays or inadequate funding from the government can disrupt the balance between expenditures and revenue. This, in turn, affects the hospital's ability to procure essential supplies and maintain optimal care standards. Issues of delayed reimbursement impact the hospital's budget, affecting the availability of vital medications such as malaria drugs. The interviewees highlight the importance of a balanced financial equation for sustaining hospital operations and providing optimal care. These challenges underscore the complexity of providing comprehensive healthcare under the insurance scheme.

Hypothesis three:

Ho: Discrimination in healthcare service provision among the enrolled junior officers in the five selected ministries has not significantly affected the policy outcomes of the Lagos State Health Insurance Scheme.

$$POLHI = \beta_0 + \beta_3 DIS + U$$

Table 5. Parameter estimates.

		Estimate	Std. error	Wald	df	Sig.	95% confidence interval	
							Lower bound	Upper bound
Threshold	[Quality = 1.63]	3.208	0.855	14.063	1	0.000	1.531	4.884
	[Equity = 1.75]	5.140	0.755	46.378	1	0.000	3.660	6.619
	[Accessibility = 1.81]	6.137	0.758	65.545	1	0.000	4.651	7.623
	[Affordability = 1.88]	7.141	0.776	84.763	1	0.000	5.621	8.662
Location	Discrimination	3.982	0.391	103.734	1	0.000	3.216	4.748

Table 5 shows a parameter estimate of a positive coefficient between discrimination and policy outcomes of LSHIS. This means that for every one-unit increase in discrimination, there is a predicted increase of 3.982 in the log odds of being a higher level on policy outcomes of LSHIS. Also, the parameter estimates show that discrimination has a significant effect on the policy outcomes of LSHIS. Therefore, the research hypothesis which states that discrimination in healthcare service provision among the enrolled junior officers in the five selected ministries has not significantly affected the policy outcomes of the Lagos State Health Insurance Scheme is rejected.

According to statements from LASHMA interviewees, challenges within the health insurance system manifest not during the acquisition stage but rather when enrolees attempt to utilise their coverage. This issue has deterred some enrolees from consistently using the scheme. Discrimination against state-based and private insurance coverage has resulted in unequal access to healthcare services, impacting the equitable enjoyment of coverage. The consequence is a hindrance to receiving timely and appropriate care, potentially preventing individuals from fully utilising the benefits offered by the health insurance scheme. Moreover, this discriminatory practice has instilled a sense of hesitation among some enrolees. Due to concerns about potential bias from healthcare providers, individuals delay seeking medical attention until their conditions worsen, leading to underutilisation of health services. Importantly, the mandatory renewal of health insurance, whether used or not, adds to the financial burden on enrolees. In response to the interviewer's prompt, Interviewee 2 concurred with the colleague's remarks, emphasizing that this issue has created a significant gap in healthcare access. The hesitation observed among enrolees extends to preventive care, with individuals only seeking medical help when their situations become critical. Financially, enrolees are adversely affected when faced with demanding healthcare providers seeking additional monetary compensation. This discriminatory practice not only places a heavier financial burden on individuals with insurance coverage but also undermines the effective implementation and enforcement of health insurance policies. The interviewee highlighted cases of inconsistent treatment reported, raising doubts about whether healthcare providers adhere to stipulated processes.

According to the interviewee from LASUTH, while there is no intention to discriminate, the reality is that the hospital tends to prioritise individuals who can afford to pay, whether out of pocket or through private insurance. The admission is made that private insurance is often more comprehensive and expensive than government insurance. Despite expressing hesitance in divulging such information, the interviewee emphasised the need to address these disparities, especially if it contributes to the research being conducted. The interviewee refuted claims of avoiding disabled individuals, clarifying that the limitations lie in the coverage provided by the insurance scheme. Not all conditions related to disabilities are covered, and the ability of the hospital to assist is constrained by the availability of funds. The interviewees insisted on a commitment to non-discrimination but acknowledged the practical consideration that hospitals, including government ones, need to generate some profit to sustain operations. The interviewees explained that hospitals naturally gravitate towards treating conditions that are more manageable

and financially viable. Complicated cases that require extra payment may pose challenges, as some individuals may be unwilling or unable to cover additional costs. This prioritisation based on financial capacity has inadvertently impacted the accessibility and quality of healthcare for those who cannot afford premium services. The interviewee suggests that while the hospital may assist in finding interim solutions or medications for cases beyond insurance coverage, there are limitations to the extent of support that can be provided.

As per the interviewee from Gbagada General Hospital, while the term "discrimination" may seem weighty, certain occurrences cannot precisely be labelled as discrimination. The interviewee acknowledged witnessing various situations, but sometimes it becomes necessary to overlook certain aspects. The discrimination arises due to differences in insurance coverage, with some coverages being more extensive and costly, particularly in the case of private health insurance. The interviewees clarify that they are not implying a preference for attending to individuals based on insurance coverage. Instead, they emphasised the pragmatic need to make decisions based on available resources. The constraints in resources mean that there is no intentional discrimination; rather, decisions are influenced by practical considerations, especially when dealing with cases that go beyond the available resources. Also, the need for profit has influenced decision-making, potentially leading to the prioritization of financially viable and more manageable cases over others.

Hypothesis four:

Ho: Continuous out-of-pocket expenses among enrolled junior officers in the five selected ministries have not significantly affected the policy outcomes of the Lagos State Health Insurance Scheme.

$$POLHI = \beta_0 + \beta_4 OPP + U$$

Table 6. Parameter estimates.

		Estimate	Std. error	Wald	df	Sig.	95% confidence interval	
							Lower bound	Upper bound
Threshold	[Quality = 1.81]	1.092	0.339	10.384	1	0.001	0.428	1.756
	[Equity = 1.88]	1.925	0.343	31.505	1	0.000	1.253	2.598
	[Accessibility = 1.94]	2.164	0.347	38.882	1	0.000	1.484	2.844
	[Affordability = 2.00]	2.328	0.350	44.161	1	0.000	1.642	3.015
Location	Out-of-pocket payment	1.501	0.184	66.620	1	0.000	1.141	1.862

Table 6 shows a parameter estimate of a positive coefficient between out-of-pocket payment and policy outcomes of LSHIS. This means that for every one-unit increase in out-of-pocket payment, there is a predicted increase of 1.501 in the log odds of being a lower level on policy outcomes of LSHIS. Also, the parameter estimates show that out-of-pocket payment does have a significant effect on the policy outcomes of LSHIS. Therefore, the hypothesis that states that continuous out-of-pocket expenses among enrolled junior officers in the five selected ministries have not significantly affected the policy outcomes of the Lagos State Health Insurance Scheme is rejected.

The interviewees from LASHMA emphasised that the financial burden imposed by the scheme has resulted in reduced satisfaction and negatively impact the well-being of enrolees. In instances where certain required care is not covered by the scheme, obtaining medical attention might become challenging, acting as a barrier to essential healthcare access. Not all enrolees may be willing to bear additional healthcare costs, leading to potential delays or even forgoing necessary care. Another significant concern raised is the high out-of-pocket expenses, which has resulted in non-adherence to recommended treatment plans or medications. This non-compliance poses a risk to the effectiveness of the health insurance policy, particularly in managing chronic conditions and preventing complications. If the perceived unaffordability of out-of-pocket expenses associated with the health insurance scheme persists, there is a risk that the policy may be deemed ineffective in achieving its primary goals of enhancing overall health and reducing financial barriers to healthcare.

The LASUTH interviewee clarified that, realistically, relying on out-of-pocket payments is unavoidable unless one imagines a perfect world. They highlighted the government's role in sponsoring certain medical procedures, using the example of a patient requiring brain tumour surgery that may not be covered by the existing insurance. The interviewee emphasised the need for the government to expand the scope of the health insurance scheme to encompass a broader range of illnesses, considering the diverse and often unforeseen health issues individuals face. The interviewee argued that the current focus on common illnesses might not address the full spectrum of health challenges recorded in people's medical histories. They suggested that expanding the coverage could lead to more affordable healthcare services for those with insured conditions. However, for individuals dealing with extreme or uncovered health conditions, the feasibility of affordability is compromised. In such cases, the necessity of paying out of pocket remains, making it challenging to achieve universal affordability within the current framework.

The interviewees from Gbagada General Hospital explained that when it comes to out-of-pocket payments for prescriptions, there are instances where patients need to obtain the prescribed medications externally. This is often due to the unavailability of certain medicines within the hospital's inventory. In such cases, the hospital issues a prescription for patients to purchase the required medications elsewhere. The interviewees stressed that this circumstance is beyond their control, as they provide what is available in their inventory. They emphasised that the absence of certain medications does not imply a failure on their part, as they would gladly provide the necessary treatment if the required medicines were in stock. Additionally, if a particular illness is not covered under the health insurance scheme, the hospital is constrained in its ability to address that specific condition. In such instances, individuals may need to find alternative means, such as paying out-of-pocket, as the hospital did not create limitations in the coverage.

3.2. Recommendations

The following recommendations are based on the findings of the study:

1) The Lagos State Government should broaden the coverage of the Lagos State Health Insurance Scheme to include a broader range of medical conditions. This expansion should be accompanied by needs-based surveys conducted by LSHIS administrators to ensure that no critical aspect of essential healthcare is overlooked in service provision. Furthermore, active engagement with key stakeholders such as healthcare providers, community representatives, policy experts, and civil society organisations is essential to gather insights and perspectives on healthcare priorities and areas requiring attention. Based on the needs assessment and stakeholder input, a robust policy framework should be developed, outlining the criteria for expanding coverage to a wider spectrum of medical conditions. This framework should include clear guidelines on eligibility criteria, covered services, benefit packages, and funding mechanisms, ensuring an inclusive approach to healthcare provision under the LSHIS.

2) The Lagos State Government, in collaboration with LASHMA, should establish and enforce rigorous quality assurance measures specifically designed to monitor and evaluate the performance of healthcare providers operating within the Lagos State Health Insurance Scheme. These measures should include regular audits, performance reviews, and outcome assessments to maintain and enhance service standards. A regulatory framework should also be developed, outlining standards and guidelines for healthcare providers participating in the LSHIS. This framework should cover criteria for service quality, patient safety, ethical practices, and compliance with relevant laws and regulations. Regular inspections of healthcare facilities within the LSHIS should be conducted by LASHMA officials to assess their adherence to quality standards, including infrastructure, staffing levels, equipment maintenance, infection control practices, and treatment protocols. Systematic performance reviews for healthcare providers should be implemented, including assessments of clinical outcomes, patient satisfaction levels, wait times, adherence to treatment guidelines, and continuity of care. These reviews can be facilitated through surveys, patient feedback mechanisms, and data analysis. To ensure compliance with quality standards and regulatory requirements, robust enforcement mechanisms should be put in place. Clear protocols should be established for addressing non-compliance, including warnings, corrective action plans, fines, suspension of services, and potential expulsion from the LSHIS network for persistent violations.

3) The Lagos State Government should allocate more resources to address the financial constraints impacting the Lagos State Health Insurance Scheme's optimal functioning. This includes investing in infrastructure, human capital, technological advancements, and capacity-building programs to improve the scheme's efficiency. A strategic resource allocation plan should prioritise investments in critical areas such as costly patient healthcare, infrastructure enhancement, human capital development, technological upgrades, and capacity-building initiatives. Funds should be designated for enhancing and expanding healthcare infrastructure within the LSHIS framework, including constructing new healthcare facilities, upgrading existing ones, and ensuring they are well-equipped with necessary medical tools.

4) The Lagos State Government should introduce and strictly enforce an anti-discrimination policy within the LSHIS framework to promote inclusivity and

fairness in healthcare delivery. The policy must be clear and thorough, prohibiting discrimination based on financial capacity, age, or health conditions. This policy should align with national and international healthcare equity standards, ensuring legal enforceability within the LSHIS. To embed these policies effectively, legislative adjustments or regulatory directives may be necessary. Training sessions and awareness campaigns for all LSHIS stakeholders are essential, educating them on anti-discrimination importance, identifying discriminatory practices, and understanding non-compliance repercussions. Furthermore, monitoring mechanisms should be robust, including reporting channels for discrimination complaints and regular audits to ensure policy adherence. Sanctions for violations should be defined clearly, ranging from fines to provider accreditation revocation. Also, procedures for addressing complaints and providing remedies must be established, ensuring fairness and accountability.

4. Conclusion

This study constitutes a scholarly undertaking, systematically interrogating the complex dynamics of structural violence and its consequential effect on the policy outcomes of the Lagos State Health Insurance Scheme. The study reveals how increased out-of-pocket payments, inequity, inaccessibility, and discriminatory practices create latent barriers that hinder the realisation of equitable and inclusive healthcare outcomes. The findings highlight critical issues within the LSHIS, including resource constraints, disparities in access to healthcare, and discrimination against individuals with state-based and private insurance coverage. These issues result in significant financial burdens, substandard care, hesitancy among enrollees to seek timely medical attention, overdependence on traditional medicine, increased compensation claims, non-adherence to treatment plans, and a negative perception of the scheme. Additionally, the emphasis on common illnesses and the prioritisation of financially feasible cases intensifies the challenges faced by individuals with severe or uncovered health conditions. Thus, this scholarly pursuit transcends a mere academic exercise; rather, it functions as a resounding call to action directed at policymakers, healthcare professionals, and researchers. The collective imperative is to engage in concerted efforts aimed at dismantling structural impediments and cultivating a healthcare system that embodies genuine equity, accessibility, and justice.

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