ASSESSING AND IMPROVING THE PERFORMANCE OF HEALTH MAINTENANCE ORGANIZATIONS IN THE NIGERIAN NATIONAL HEALTH INSURANCE SCHEME: THE HEALTH PROVIDER'S PERSPECTIVES.

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ABSTRACT

Quality issues are bound to occur in the complex relationship between the different stake holders in the NHIS scheme. Such issues could affect choice of HMOs among health care providers and clients. The objective of this study is to determine factors influencing mode of operation and choice of HMOs among NHIS primary health care service providers in Osogbo in southwestern Nigeria. This was a qualitative, descriptive cross sectional study was carried out among hospital workers focal persons in charge of HMOs activities. Three focus group discussions of eight eligible respondents each were performed using a focus group discussion guide. Analysis was presented in simple proportional forms. All the HMOs were reported to have good reputation with the health care providers in terms of their strong financial base and service coverage. While most offer both capitation and fee for services, very few operates only fee for services. Only few of HMOs defaults in their monthly payments, which may necessitate non provision of services to clients. Referral systems were in place by all NGOs but with weal referral feedback loop. Monitoring activities by HMOs was also been carried out. Clients have had reasons and course to apply for a change of HMOs. HMOs should always arrange an avenue with clients (or body of clients) to discuss their operations, their successes and weakness before making a choice of a HMO.

Keywords: Health maintenance organizations (HMOs), National Health Insurance scheme (NHIS), primary health care service providers

INTRODUCTION

As in many other developing countries, affordability and accessibility to health care in Nigeria has always been a matter of great concern. [1] The hope of the average Nigerian to have reliable and affordable healthcare delivery system was brightened with the take-off of the long-awaited National Health Insurance Scheme (NHIS) in 2005. [2] NHIS has been collecting premium and purchased health services for formal sector employees with the hope of diversifying in the nearest future to other sectors. [3] The HMOs is one of the gate keepers operating the NHIS, serving as interface between eligible contributors and the health care providers

As the choice of HMOs is still voluntary in Nigeria, clients have the option of choosing between the many listed HMOs with different resources and reputation. The ability of HMOs to measure up to her responsibility would determine the success or otherwise of the implementation of the NHIS, since a good working relationship between HMOs and health service provider would translate to better service provision for the consumers. Cases of

clients turned back from accessing care have been reported as a result of the HMOs to settle the bills of the hospital in question.

Over time, cases of changing from one HMO to the other have been reported. Various reasons have been given for this looking at services provision provided by the HMOs and their service provider. It is thus imperative to study quality issues and concerns considered by organizations in making a choice of HMOs in Nigeria, with a view to serve as a baseline for further evidence based information that could improve HMOs performance in Nigeria. Since many service providers use same or similar HMOs, they are important source of information on performance of HMOs, and companies could rely on such information to assess HMOs before choosing them as their health fund managers. Operating the scheme for four years, it was unfortunately discovered that NHIS was working without appreciable database, and many services were being provided by HMOs and private health facilities lack back up data. [4]

The objective of this study is to determine factors influencing mode of operation and choice of HMOs among NHIS primary health care service providers in Osogbo in southwestern Nigeria

METHODS

This was a qualitative, descriptive cross sectional study of perception of health care providers on assessment of HMOs, as well as measures to improve activities of HMOs in Osogbo in South western Nigeria. There are numerous HMOs working with the numerous registered health care facilities in the state. Eligible respondents in the study are hospital workers focal persons in charge of HMOs activities in the hospital, and would have been in such position for at lest 18 months.

Three of the four senatorial districts in the state were chosen by simple random sampling employing simple balloting. While a respondent represent one hospital, three focus group discussions of eight eligible respondents each were performed to cover the three districts. Discussions were made in both English and vernacular to ensure good understanding of the questions asked using a focus discussion guide. The use of an independent observer was employed during the discussion to further guide this focus group discussion.

Variables examined include a brief description of the strengths and weakness of HMOs activities in term of their reputation, settlement of payments, monitoring activities and referral activities. One limitation of this study is the possibility of not wanting to fully expose the negative side of some of the HMOs because of the already existing cordiality between health facility and the HMOs. This was resolved by assuring respondents of confidentiality of data to be collected. Responses were analyzed in terms of frequency and nature of responses to the questions, as well as cogency of points raised in the various questions.

FGD RESULTS

Reputation: All participants claimed that their health facilities had relationship with an average of four to six different health maintenance organizations and these were cross cutting. All the HMOs were reported to have good reputation with the health care providers in terms of their strong financial base, facility and service coverage and process of registration and renewal of registration with the HMO. While most offer both capitation and fee for services, very few operates only fee for services. One of them operates only capitation as form of payment of health care among clients in the national health insurance scheme.

Payments: Respondents reported that most of the HMOs pay on time like on monthly basis once they receive their bills. Only few of HMOs defaults in their monthly payment for one reason or the other and this has been affecting cordiality of relationship between the care providers and the HMOs as well as provision of services to clients. Most health facilities say they have had course to turn back clients or suspend provision of health care to clients whose HMOs defaults payments for a long time.

Referral Systems: All the HMOs have referral systems in place in case there is need to refer clients to other or higher equipped facilities for further service provision. However about half of the HMOs require to be contacted before a referral for major health services could be made for clients. All health facilities claim that the same patient management standard was being used for all clients from all the HMOs, and services were not usually denied any clients at the referral centre (except otherwise stated from any organization based on the type of programme chosen -be it either gold, platinum or diamond). However most HMOs require the service providers to seek approval from the HMO before effecting the referrals, which in most cases lack referral feedback loop..

Monitoring and Mentoring: All the HMOs was reported to carry out regular mentoring and monitoring visit to the health facilities, as well as monitor standard of services rendered and quality of waiting time by clients. All have forum to hold regular meeting between the HMOs and the health facilities.

Improving Service Provision: All health care facilities wanted HMOs to pay regularly to care providers, broaden their services to cover more services and the informal sector, perfect a two way referral that would guarantee prompt processing and receipt of referrals and close monitoring and supervisory visits to health care providers as ways of improving cordiality of relationship between HMOs and health facilities..

Perceived Client's View: On assessment of clients satisfaction with HMOs activities, health facilities respondents felt that clients should have good quality of waiting time with minimal time wastage, that they be allowed to take part in annual meeting between HMOs and health care facilities on invitation, usually asked health facilities to computerize their operations most especially administrative aspects, allowed to switch health care providers on request and were usually happy with the pattern of referral system on ground though there

are rooms for improvement. Clients were usually frustrated when turned back by care providers as a result of default in settlement of bills by their HMO, and this has prompted many of them to change from one HMO to the other

DISCUSSIONS

Reputation and ability of HMOs to promptly pay health care providers is a very important factor for organizations to consider before choosing a HMO for their staffs. HMOs with weak financial base may not be able to pay capitation or fees charged per services at when due. Ultimately clients may be turned back or refused treatment, a situation that could be frustrating to clients. It is thus important for HMOs to improve their financial base, and move away from the one man business that many of are as at present. Privatizing the ownership of HMOs is a veritable way of raising money from the open market, thereby improving their operations. Health care providers are also enjoined to turn in their bills on time for prompt settlement by the HMOs. Thus clients should access reputation of HMOs and their payment pattern and modality before they entrust their funds into the hands of a HMO.

An effective referral system is crucial to health care provision by primary health care providers who may not have all necessary facilities. Many referrals may not be complete thus putting the client at a risk of incomplete treatments and suffering. Such referrals could have been verbally done or not using the appropriate referral tool or forms. Referrals should be done on time, with the appropriate form, and clients should be followed up for feedback. HMOs should always stress the importance of a complete referral loop with strong feedback components during their supervisory visit to health care facilities.

Health care providers needs to be monitored from time to time by HMOs to ensure a steady availability of the basic minimum package and equipments by the primary care providers, to ensure that there is no element of discrimination to clients and to ensure that waiting time is reduced to the bearest minimum. Clients may want to put this into consideration when choosing a HMO to assist in managing their health insurance funds. In conclusion and as a matter of routine practices, HMOs should always arrange an avenue with clients (or body of clients) to discuss their operations, their successes and weakness. This would serve as basis for more fact findings that may culminate into a choice of one HMO or the other.

REFERENCES

1. Yohersor A (2004). Social health Insurance scheme that works: Recommendation to NHIS. Abuja: Vast Communications Publishers.

2. Dotun, A (2009). NHIS. The Nigerian Doctor, April 2009.

3. NHIS (2001). National Health Insurance Scheme: Operational Guidelines, National Health Insurance Scheme Abuja, Nigeria.

4. Ogbonnaya, R (2010). NHIS: meeting health challenges amidst obstacles.. This day 24th January 2010.