PUBLIC–PRIVATE PARTNERSHIP: HOW SUCCESSFUL IS THE NHIS – HMO COLLABORATION IN HEALTH CARE DELIVERY IN NIGERIA?

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Abstract
Collaboration between the National Health Insurance Scheme (NHIS) and Health Maintenance Organizations (HMOs) is a form of public-private partnership in health care delivery in Nigeria. National Health Insurance Schemes’ adoption of Health Maintenance Organizations to manage NHIS enrollees is seen as an effective and efficient means of running the scheme. The effective performance of Health Maintenance Organizations’ role in the scheme, leads to increased access to health care services and ensures the overall achievement of NHIS goals. These organizations work on certain intricate modalities that do not allow HMOs to set their prices in managing NHIS enrollees but are still expected to ensure that enrollees are properly managed based on the agreed modalities for collaboration. If the scheme is successfully managed by the HMOs, there is the likelihood that the goals and objectives of NHS would be achieved. And if not, NHIS goals would not be achieved. This is why the paper sought to investigate how this form of collaboration operates and the challenges that could result from collaboration. To achieve this therefore, a review of literature was done to highlight the functions of HMOs in Nigeria’s NHIS, and the possible challenges that could come with this form of collaboration. In undertaking this study, nine in-depth interviews were conducted with representatives of participating organizations. At the end, the study discovered that HMOs played a prominent role in ensuring that the scheme is well implemented. The study therefore recommended that there should be constant review of the modalities on which the two organizations work as partners.

Keywords: Public-Private Partnership, National Health Insurance Scheme, Health Maintenance Organization

Introduction
The National Health Insurance Scheme is a corporate body established under Act 35 of 1999 to provide and regulate health insurance to Nigerians. Under the scheme, health care services are paid for from a common pool of funds contributed by the participants (NHIS Operational Guidelines, 2012). NHIS was established amidst the poor health facilities and health situations in the country with the intention to ameliorate these conditions (Omoruan, Bamidele, & Phillips, 2009). However, for the scheme to achieve its goals, HMOs would play vital roles to ensure enrollees of the scheme are well managed. In other words, there has to be strong partnership between NHIS and HMOs to ensure a smooth and successful implementation of the scheme. The NHIS and HMOs operate as a public private partnership in health care delivery. This model is a public private partnership that is directed towards providing accessible, affordable and qualitative health care for all Nigerians (NHIS Operational Guidelines, 2012). Public-private partnership (PPP) is a form of accord between a government and a private unit to undertake a common project within a long contractual period. During this period, they both invest jointly in the provision of public services and a significant economic, procedural, and operational risks is borne by the private sector who is held responsible for certain outcomes. The public-private partnership approach can be applied to a wide range of healthcare system needs such as building of health amenities, supplying of medical equipment, and the delivery of healthcare services across a wide range of care. Although the PPP model is usually simple (i.e. build, finance, maintain and transfer), the design sometimes can take a more complex, more ambitious form or model where the private partner is required to deliver all clinical services in one or more primary, secondary or tertiary health facilities. The public-private partnership (PPP) model in health services is increasing the world over (Global Health Sciences, 2016). The collaboration between NHIS and HMO is a form of public – private partnership in health service delivery that is not common to many countries of the world (NHIS, 2011). The scheme has HMOs involved in a way that is rare (Adebimpe & Adebimpe, 2010). It is designed to include the participation of the HMOs, the healthcare providers and the insured persons with the government regulating their activities (Anarado, 2002). The NHIS - HMO model requires that HMOs perform certain tasks that are vital to the survival of the mainstream NHIS in Nigeria (NHIS, 2011).

HMOs in Nigeria are private and public incorporated companies registered solely to manage the provision of
health care services to NHIS enrollees through a network of health care providers accredited by the NHIS (NHIS operational Guidelines, 2005). HMOs were established to support the NHIS (NHIS, 2011). This simply means that, in Nigeria, HMOs were exclusively created to facilitate the National Health Insurance Scheme (NHIS Operational Guidelines, 2005). HMO is an idea which started in America in the 1970s (Rodwin, 1989, Casey, Knott, & Moscovice, 2002). They are a type of health organization that combines the provision of health insurance together with the delivery of health care services (Thomas, n.d) to an enrolled population. It is a system organized to finance certain health services to a defined, voluntarily enrolled population through a network of providers who are held accountable for cost control and quality health outcomes (Campbell, 2007). It renders distinctive services which is a form of managed care. And managed care is a concept which refers to systems for organizing and coordinating activities of doctors, hospitals and other providers into groups to enhance the quality of health care services. HMOs manage rather than provide health care for clients. They try to control health care cost by reducing the price of services and controlling access to health services and cover a wide range of services at a significantly lower cost. HMOs can also provide health services to clients on requests through health care professionals employed by the HMO itself. Health maintenance organizations are alternatives to traditional health care plans offered by conventional insurance companies (Campbell, 2007).

In 1962 when the first framework of the health bill for the NHIS was drawn, it did not provide for the use of HMOs to run the scheme. But after it was reviewed in 1997, it brought in Health Maintenance Organizations as implementing partners (NHIS Annual Report, 2006) to enable rapid achievement of its goals. According to Akande and Babatunde (2011), the National Health Insurance Scheme was redesigned to incorporate the involvement of stakeholders such as the Health Maintenance Organizations, Health Care Providers etc to facilitate increased and rapid access to health care through the scheme for all Nigerians irrespective of their social status. So, Health Maintenance Organizations were solely created for the National Health Insurance programme (NHIS Operational Guidelines, 2005) to effectively manage enrollees of the scheme (NHIS, 2011). The involvement of Health Maintenance Organization is seen as an effective way of running the scheme due to the managerial intricacy involved in managing NHIS enrollees. The belief is that Health Maintenance Organizations’ effective performance of its duties in the scheme, would lead to increase in access to health care services and at the end, the achievement of universal coverage (Ibrahim, 2011) which is one of the goals of the NHIS. As indicated by Adeibimpe and Adebimpe (2010), the ability of Health Maintenance Organizations to measure up to their responsibilities would determine to a large extent the successful implementation of the National Health Insurance Scheme. But if they are not able to measure up to their responsibilities, the likely conclusion would be that the scheme is not well implemented hence an impediment to achieving the scheme’s goals in the nearest possible time. This is why an inquiry into this mechanism of health service delivery is necessary to ascertain its workability and success.

Statement of the problem

Implicit within the operation manual of the NHIS is the notion that HMOs involvement in the scheme would meet its goals of improving the country’s healthcare delivery system (Anarado, 2002), and facilitate access to health care for Nigerians (Ibrahim, 2011). But more than six years after it started with the Health Maintenance Organizations as vehicles for implementing Nigeria’s social health insurance program, only three percent of Nigerians working in formal sector organizations have been enrolled, beneficiaries have been limited to employees of the federal and states government, and large corporations (Anyene, 2012), and views are divided among Nigerians on the scheme addressing the health problems in the country due to reports of the continual poor health situation (Agba, Ushie, & Osuchuckwu, 2010). Although it is believed that the involvement of HMOs in any country’s health system would improve the existing health system and provide a more efficient and standard way of health care delivery (Strang, 1993), many are still not accessing care through the scheme in Nigeria (Muanya, 2011). Those who have benefited from the scheme are about 6.8 million Nigerians (Ibrahim, 2011). This number is a very small fraction when compared to the larger population of Nigerians who are not yet benefitting from the scheme. Moreover, since the designing of the scheme to use the services of the HMOs in the mainstream delivery of healthcare suggests that the use of managed care (i.e. the HMOs) would improve the state of the country’s healthcare delivery (Anarado, 2002) more people should have been enrolled into the scheme six years after its commencement. This is why the study sought to investigate how successful the NHIS – HMO collaboration in health care delivery in Nigeria has been. A study on this subject is timely because of the need to expand coverage among citizens of this country. And research on this area would lead to the formation of new policies for better functioning of the scheme and stimulate other researchers to undertake similar studies in future.
The functions of HMOs in Nigeria’s NHIS
Health Maintenance Organizations have been involved in the National Health Insurance Scheme since its commencement of operations in the country in 2005. The scheme was officially flagged off by President Olusegun Obasanjo with the formal sector programme for employees in public and private sector (NHIS Annual Report, 2006). The functions of HMOs in Nigeria’s NHIS vary according to the programmes designed by the scheme. The programmes are designed basically for the formal sector, the informal sector and the Vulnerable Group (NHIS operational Guidelines, 2012). Those in the formal sector consist of the following groups; (a) the Public Sector, (b) the Organized Private Sector, and (c) the Armed Forces, Police and other Uniformed Services. Other programmes under the formal sector are the Tertiary Institutions Social Health Insurance Programme (TISHIP) for students in public or private tertiary institutions in Nigeria, and the Voluntary Contributors Social Health Insurance Programme (VCCHIP) for individuals (i.e. employees in organizations with less than ten staff) not covered in any of the NHIS programmes or those who may not have been satisfied with the existing health care services. Those in the informal sector consists of employees of companies employing 10 or less people, artisans, voluntary participants, rural dwellers and others who are not covered under the formal sector and vulnerable group. The social health insurance programmes for those in this category are; (a) the Community Based social health insurance programmes and (b) the Voluntary Contributors social health insurance programmes (NHIS operational Guidelines, 2012). Those under the Vulnerable Group (a) Physically Challenged Persons, (b) Prison Inmates, (c) Children Under Five, (d) Refugees, Victims of Human Trafficking, Internally Displaced Persons And Immigrants Social Health Insurance Programme (e) Pregnant Women and Orphans.

Expressions in support and against the NHIS – HMO collaboration
Many people believe that health care institutions and finance mechanisms affect their personal health and this is why they are concerned with these institutions and mechanisms employed to deliver health services. In America, one major reason why Health Maintenance Organizations expanded rapidly was the interest in affordable quality health care. HMOs have succeeded at enrolling a large fraction of the American population, and overall quality of care for HMO enrollees is good. In the beginning they were seen as a way to escalate costs of health care and yet deliver quality care (Davidson and Moore, 1996). But they have been found to render a wide range of services at a reduced cost (Campbell, 2007). The fact remains that some Health Maintenance Organizations do a more aggressive advertising, and allow patients to retain their personal physicians. Many people have joined Health Maintenance Organizations due to government support. Other perceived incentives for enrolling in Health Maintenance Organizations are their immediate accessibility, comprehensiveness, relatively low cost. Another advantage with the Health Maintenance Organizations practice, is its ability to make patients go to the hospital less frequently than with traditional insurance plans and have fewer deductibles for surgical and hospital costs. Also, people’s medical records are usually easy to locate in a central place readily available to all physicians. And subscribers do not encounter the paperwork and reimbursement delays that occur when non-health maintenance organization physicians file insurance claims (Davidson and Moore, 1996). Health Maintenance Organizations provide their services through the following prepayment systems; fee for service, capitation and copayment. Today, questions about the efficacy and efficiency of Health Maintenance Organizations abound (Casey, Knott, and Moscovice, 2002).

The arguments in favour of the NHIS – HMO practice are that: (1) some people believe that effective collaboration between Health Maintenance Organizations and Health Care Providers would serve as the answer to the success of the scheme (Ogundimu, 2011), (2) others assume that public – private partnership such as this would prevent the lassiez faire attitudes of public sector workers towards effective discharge of their duties, (3) the paucity of private sector activities in the provision of health care services would be bridged through better collaborative activities between Health Maintenance Organizations and other stakeholders in the scheme (Anyene, 2012), and (4) HMOs would encourage the cooperation of various professionals and providers under one management and ensure that valuable, quick and high standard services are rendered to the insured in a friendly environment (Edozien, 2007). The arguments against the NHIS - HMO model of social health insurance are anchored on the following; (1) some believe that Nigeria is not yet ripe for the scheme itself because it lacks the social infrastructure to successfully implement it (Aderere, 2010), (2) Health Maintenance Organizations practice what is called private or commercial health insurance while a National Health Insurance practices what is called social health insurance. Commercial health insurance is private, voluntary and involves individual risk-rating in most cases, having an objective to meet the individual’s health need. While social health insurance is generally mandatory, involves membership, and contribution is based on community risk
Theoretical framework

A theory is a statement used to explain how and why specific facts are related. It can be used to explain real world situations (Macionis, 2005). In this work, attempt is made to explain partnership between NHIS – HMOs using Transaction theory and Resource Dependency theory. These theories are used in organizational sociology to explain medical organizations (Flood & Fennell, 1995).

Transaction theory postulates that organizations are systems created for managing exchanges or transactions. It explains the when and why organizations integrate with other organizations and states that there are costs benefits involved in any negotiation or exchange. Organization can benefit from incorporating other organizations internally depending on the extent to which transactions are frequent and critical to the organization (Flood & Fennell, 1995). Therefore, partnership between NHIS and HMOs can be viewed from the perspective of transaction theory. This theory, when applied to the study, indicates that the NHIS model in Nigeria was designed to incorporate the services of the HMOs to ensure proper implementation of all NHIS programmes. The NHIS pays the HMOs for services they render to it (Leo, & Okafor, 2012), and allows the HMOs to make profits from other private health insurance programmes designed by the HMOs themselves. Partnership became necessary because of the need to reach a wide coverage of users of the scheme, with the accompanying voluminous and complex administrative task involved in running a national health services. Also, other variables as ensuring the control of the overuse and under use of services provided by the scheme, as well as checking the oversupply and undersupply of health services from healthcare professionals and facilities all culminates into the reasons for partnership between NHIS and HMOs. The scheme assigned roles and responsibilities to HMOs to avoid duplication of health services to enrollees.

Resource Dependency theory is another theory that seeks to explain when and why organizations form a link with other organizations (Flood & Fennell, 1995). The theory was developed in 1978 by two Americans, Pfeffer, and Salancik (Delke, 2015). Since then it has been widely used to assess organizational environmental relationships and strategic collaborative alliance. The theory argues that organizational interdependence is influenced by the environment and resources of the organizations. Interdependency is usually a result of organizations not achieving certain desired outcomes. In essence, interdependency becomes necessary to bridge the gap and overcome the shortcomings of each other. Therefore, organizations collaborate in areas of strength to ensure that various organizational goals are achieved respectively. However, the degree of interdependency is anchored on the extent to which resources are important, the extent to which the interest group has discretion over it, and the extent to which there are limited alternatives. Using the power variable to further explain this, the organization in control of the resources has power over the actors in need of the resources. This means that the organization which has control over the resources determines certain activities of the other organization in need of the resources (Delke, 2015). Although the theory is often used to explain financial relationship between two or more organizations, the focus cuts across human resources, and long-term collaborative inter organizational relations which is similar to that of the NHIS – HMOs partnership. This could imply that partnership between NHIS and HMOs became necessary due to envisaged lapses that could occur in managing NHIS enrollees without the services of the HMOs. In addition, HMOs need for resources to support their other organizational activities may lead them to depend on NHIS for resources hence fostering collaboration.
Research methods
The study made use the qualitative method. The qualitative methodology is generally associated with interpretative epistemology and tends to be used to refer to forms of data collection and analysis which rely on understanding (interpretive understanding), with an emphasis on meanings (inter-subjective communications and interpretation of meaning derived from intuition and leading to subjective but well reasoned out judgment) (Scott and Gordon, 2005). The qualitative method that was used in this study was the In-depth Interview. Nine in-depth interviews were conducted with officials of NHIS, HMOs and HCPs each. That is, three with NHIS officers, three with Officers working with HMOs under the NHIS, and three with officials of Health Care Facilities accredited by NHIS to represent the Primary Health Care Providers. Respondents for the interview sessions (IDIs) were selected by convenience sampling.

The qualitative data collected from the in-depth interview was analyzed, and transcribed according to important areas in the guide. All the nine interviews were conducted in Abuja. The location for the study was the FCT which is the administrative capital of the country and captures many of the NHIS public sector lives/beneficiaries. In fact, the National Health Insurance scheme began its operations with the public sector workers in the federal civil service in the FCT before extending its services to the other states of the federation. When compared with other states in the country at the moment, the FCT has the highest number of NHIS public sector enrollees/beneficiaries because it houses many federal government organizations. The FCT therefore provides a platform for the NHIS to demonstrate/show case their unique public-private partnership with the HMOs in the delivery of the social medicine model in the country. Thus, the FCT is best suited to be used as a case for a focused study, to better understand, and empirically evaluate the impact of the collaborative efforts of the NHIS and HMOs and to assess the role the HMOs have played and/or are playing in the implementation of the National Health Insurance scheme in the FCT. A success or failure in the FCT could provide a good picture of same for the whole country, and this may necessitate or trigger further investigation/research and help direct government policy and programs.

Results and discussion
The socio-demographic characteristics of respondents in the IDI sessions
The respondents in the in-depth sessions were seven males and two females. And their age category ranged from ages 35-55 years. Eight of the respondents were married with children and one of the respondents was not married. All the respondents occupied important positions in the organizations where they worked.

Responses from the IDI sessions on the NHIS - HMO partnership
Responses from the IDI Sessions on HMOs Involvement in NHIS are that;

Mr. A: Health Maintenance Organizations are fund managers in the scheme”. They handle payment/settlement of claims to healthcare facilities and conduct quality assurance.

Mr. B: HMOs are responsible for certain administrative task which shifts the burden of management away from the government. The scheme is a Public-Private Partnership.

Mr. C: HMOs effect payment of capitation and fee for services to health providers.

Mr. D: Our participation facilitates the payment of Health Care Providers. The system we adopted is the best. If NHIS alone should manage the scheme, they will kill the scheme.

Mr. E: We complement the role of NHIS in achieving their aims and objectives. We do paper work.

Mrs. F: Before now i.e. before the advent of NHIS, HCPs do retainership where government just pays for all bills sent. But this has stopped with the coming of NHIS. This was also one of the reasons why our government came up with NHIS. HMOs have made the scheme easier. HMOs are paid for their services by NHIS. Unpaid capitation and fee-for- services are returned back to the government i.e. back to NHIS especially when the hospital does not exist any longer.

Mr. G: They help to curtail excesses so that the scheme will not be abused by the users and the HCPs.

Mr. H: HMOs are more businesslike, they ensure that there is improved facilities and corresponding improved quality of service. There is no way NHIS can do it alone and be efficient.
Mrs. I: They are intermediaries between the government, the hospitals and the enrollees. They give approval for secondary services. They organize workshop and seminars for health facilities to help them improve services to enrollees.

When respondents were asked about the disadvantages with the NHIS – HMO collaboration, they gave the following answers:

Mr. B: The involvement of HMOs has increased the cost of the scheme. HMOs should be restricted to private health insurance and community health insurance.

Mr. C: Their task can be done by the NHIS itself.

Discussion of the findings
A clear picture of the success or failure of the NHIS – HMO collaboration can be seen from the responses provided by respondents in the study. The effective discharge of HMOs duties in the scheme can go a long way to procure success for the NHIS in Nigeria. And highlights from the responses showed that HMOs are on top gear of implementing the scheme. With this, it can be concluded that partnership between NHIS and HMOs is possible, practicable and largely successful in the face of the problems plaguing the country’s health system. However, the model is certainly expensive to maintain.

Conclusions
Partnership between the National Health Insurance Scheme (NHIS) and Health Maintenance Organizations (HMOs) is a form of public-private partnership in health care delivery in Nigeria. The adoption of Health Maintenance Organizations to manage the enrollees of National Health is considered an effective way of running the scheme. HMOs performance of their roles in the scheme leads to increased access to health care services and ensures the achievement of NHIS goals. However there are certain intricate modalities on which both organizations work together as partners. The designing of the NHIS does not allow HMOs to set their prices in managing NHIS enrollees but are still expected to ensure that enrollees are properly managed. If the scheme is successfully managed by the HMOs, the goals and objectives of NHIS would be achieved. But if not, NHIS goals would not be achieved. From the interviews conducted in the study, it was discovered that partnership between these organizations is vital to the overall success of the scheme and HMOs are performing their responsibilities in the scheme.

Recommendations
It therefore recommended that there should be constant review of the modalities on which the two organizations work as partners to promote efficiency of services on the part of HMOs and all stakeholder organizations in the scheme.

References


