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Patients Experiences in Accessing National Health Insurance Services in Nigeria

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ABSTRACT

Objective: Since the National Health Insurance Scheme (NHIS) commenced operations in 2005, the coverage has remained low. This has been attributed to poor service delivery, and numerous challenges experienced by citizens in accessing care at the provider level. This study identifies challenges faced by enrollees and their levels of satisfaction with the NHIS in Nigeria.

Methods: This prospective qualitative study was conducted using enrollees of the NHIS. To elicit information from enrollees on topical issues which relate to service accessibility and satisfaction, Focused Group Discussions and interviews were employed. Data were analyzed using NVivo Qualitative Data Analysis Software Version 11 and presented in the perspective of Health Management Organizations (HMOs) and healthcare providers' levels.

Results: Availability of prescribed drugs and poor referral system were major challenges encountered by enrollees in the process of accessing health services. Some of these challenges were occasioned by the non-remittance of funds to service providers at the due time. Hence, satisfaction among enrollees was also found to be low.

Conclusion: The NHIS in Nigeria needs to strengthen its regulatory role by ensuring that HMOs comply fully with the operational guidelines and that HMOs in turn intensify their oversight and quality assurance responsibilities for healthcare providers.

Key words: Health insurance, Patient satisfaction, Health maintenance organizations, Universal health coverage, Health financing

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INTRODUCTION

Health systems in many sub-Saharan African countries are generally unsatisfactory; therefore Nigeria like most others has continued to introduce health policies to address the perceived shortcomings of her health system. The series of health policies in Nigeria have unfortunately been unable to produce the desired results to advance the health status of the population [1]. These deficiencies in health systems have further prompted a lot of developing countries to devise alternative health financing mechanisms to improve health service provision [2]. In Nigeria, like many other Low and Middle-Income Countries (LMICs), there is a clear lack of universal health coverage and little equity [3]. The resultant inaptitude of health consumers to pay for the services coupled with the largely inequitable healthcare provision has been recognized as a hindrance in service utilization [4].

The Nigerian National Health Insurance Scheme (NHIS) was one of such policies devised in 1999 and commenced formally in 2005. The major aim of the scheme was to reduce the high burden of out-of-pocket spending by families on

healthcare and ensure financial risk protection [5]. Its principal objective is to ensure that every citizen has access to quality health care services without undue financial burden [6]. Furthermore, it aims to improve the overall quality of healthcare delivery in the country [7]. These types of social health insurance programs are believed to provide alternative means of ensuring an improved health system for people in developing countries [2]. The ability of enrollees to obtain services that are client-centered without difficulty or any other undue challenges is the hallmark of responsive health insurance [8]. The generally poor state of healthcare services in Nigeria, including the rising cost of health services and the proportion of citizens dependent on out-of-pocket funding for health services, prompted the establishment of the health insurance scheme [9]. Since its inception, expanding it to cover people in informal employment has remained a challenge. The informal sector employs a huge number of people in countries like Nigeria, hence the difficulty in capturing them in the NHIS [10]. Despite this strong vision of the NHIS and its operations for about fifteen years, the coverage and utilization remain low, and the satisfaction of enrollees is very poor [11]. This is orchestrated by the poor state of primary healthcare in the country leading to an ineffective referral system which places much burden on the secondary and tertiary health facilities as enrollees with primary illnesses are often seen in secondary and tertiary healthcare facilities.

The Scheme works through the Health Maintenance Organizations (HMOs) who are the risk bearers on behalf of the NHIS whose primary role is regulatory; mainly accrediting of healthcare facilities, development, and enforcement of Operational Guidelines [9] implementation. The presence of HMOs in the health insurance is to help drive the purchaser-provider split and promote efficient utilization of resources which are often lacking in the public sector. This, it does through capitation/ fee-for-service management, and generating data through appropriate quality assurance processes of the activities of the Scheme, and reporting these to the NHIS [9].

Operations of the NHIS

Every enrollee under the NHIS scheme is entitled to register a maximum of five dependants; their spouse and four biological children [6]. A monthly capitation of 750 Naira (USD 2) per enrollee is paid to participating healthcare facilities to cover for all primary illnesses while the Health Maintenance Organizations (HMOs) receive 112.5 Naira (USD 0.3) per enrollee for secondary and tertiary levels of diseases. Enrollees are required to visit their primary healthcare providers (HCPs) when ill, while the HCPs, in turn, provide services to these enrollees from the received capitation. In the event of the secondary and tertiary level of illnesses, the HCPs are required to obtain an authorization code from the HMOs to either proceed with secondary care or refer to a higher healthcare facility. The bills for these secondary and tertiary services are then sent to the HMOs for reimbursement as fee-for-service [3].

Despite the availability of health insurance in the country with its key objective of ensuring that every citizen is provided with good healthcare services, as well as minimizing the financial burden of medical bills [9], the scheme is ridden with series of problems that hinder the actualization of its goal. Though well delineated, there remains a huge population that pays for services out-of-pocket [12]. Additionally, the provision of health insurance in Nigeria is yet to cover those employed in the informal and some in the private sectors as only those employed by the federal government benefit from the scheme [3]. This is besides the low-coverage and a myriad of challenges encountered by enrollees in accessing services that are theoretically covered under the scheme. The research explores the various challenges encountered by the enrollees in accessing care, to ascertain their level of satisfaction with the scheme and proffer solutions.

METHODS

This was a prospective qualitative study aimed at uncovering the factors that hindered registered enrollees from accessing the services of the NHIS. Primary data was obtained through focused group discussions (FGDs) and interviews of NHIS registered enrollees. Additional data was obtained through the review of relevant literature from official government sources, such as the NHIS Operational Guidelines.

Three HMOs were randomly selected and thereafter, enrollees were selected randomly

from the database of the NHIS list sent to the HMOs. The nature of the study was fully explained to them, and 12 agreed to participate in the study.

Ethics

Consent was sort from identified enrollees and consenting individuals were included in the study. Inclusion criteria included being an enrollee with a good understanding of the English Language, having utilized NHIS services within the past six months, and being willing to participate in the study.

Data collection

A total of twelve (12) enrollees consented and were interviewed. A subset of six (6) was involved in two FGDs. The essence of the FGDs was to gain further understanding of the views expressed via the interviews.

The interview data were then transcribed manually and FGD recordings were also transcribed verbatim. A thematic methodology was adopted and allowed key themes and patterns to be identified. The entire data generated were then analyzed using the NVivo Qualitative Data Analysis Software Version 11.

Analysis

The analysis of the challenges encountered by NHIS enrollees in accessing care was analyzed in the context of those that were due to the bureaucracy at the HMO level, those at the healthcare provider, and those that were a product of the gaps in the NHIS Operational Guidelines and other regulatory failure.

RESULTS

Examination of the different factors that hindered access and utilization of healthcare services under the NHIS revealed that enrollees' challenges could be grouped into three themes: the national health insurance scheme, the health maintenance organizations, and the provider level.

Problems encountered at the healthcare facilities

The major drawback for enrollees benefitting from the services of the scheme as expressed by all participants was the availability of drugs. One of the enrollees explained:

"It seems to be everywhere, my former hospital had the problem so I changed to another facility but the problem continues. When I see a doctor and he tells me to go and collect my drugs at the pharmacy, on getting there, I am often told that the drug is not available".

This kind of complaint was heard throughout the interviews and the FGDs. Though from the participants' discussions, it seems some hospitals were involved in hoarding drugs and giving them to mostly out-of-pocket patients. As one middle-aged woman explained:

"I was having an abdominal problem so decided to utilize my insurance in a private hospital. On getting there, I didn't have a problem seeing a doctor and carrying out investigations, but on getting to the pharmacy to collect my drugs, I was told the drugs were not available, but I decided to hang around. Not long a self-paying patient came and was given the same drug I was earlier told was not available".

She further hinted that if it were true that the drugs were not available, she could have felt better, but denying her access to drugs based on being an NHIS enrollee did not go down well with her.

Apart from the availability of drugs, many of the study participants expressed concerns about the brand of drugs that are not covered under the scheme. One respondent explained:

"I think the NHIS is not working and the main problem is the access to drugs. Every time we access the care we are either told the drug is not available or the NHIS does not cover the particular brand that is prescribed, so we should pay for it. How can I be covered under insurance and still be paying?"

"If I am, to sum up, the problem I have with NHIS, it is drugs, drugs and drugs" explained another participant.

Referral problems

Many of the participants complained about hospitals referring them even when they can treat the problem. This, they said leads to a lot of difficulties as the hospitals they are referred to often deny them services making them stranded. A participant explained:

"I registered for antenatal care (ANC) at my primary provider here in Abuja and attended all the sessions, but close to my delivery, I was informed that I would require a Caesarean

section (CS), and so I will have to be referred. I asked for the reason and was told that the amount paid for by NHIS for CS was too small. I was shocked really how can you refer me when all my medical records are with you? Without an option, I had to go to the hospital I was referred to".

Others believe some hospitals are not being forthright by referring cases they are capable of handling, as another participant added: "A lot of hospitals just refer for no reason. Some of these hospitals collect money from HMOs but refer all cases out, even the ones they should be able to handle….I do not feel comfortable with that".

Problems encountered due to health maintenance organizations

All the study participants expressed that the HMOs were not doing enough in facilitating their access to care. One of the major challenges was getting authorization codes for referral and secondary treatments. One enrollee admitted that the time it takes for HMOs to send codes was too long: "I was at my primary provider in the morning after a referral was generated; they told me I will require an authorization code from the HMO. I was there till afternoon before a code came in". Another said: "it is very annoying that HMOs do not send code and when you call them, they will not pick their calls". To all these participants, time was very important. One young woman explained: "If I am going to spend the whole day in the hospital waiting for a code from the HMO then I better pay from pocket because time is very important to me".

Non-payment by HMOs

Participants expressed problems with receiving care services at the provider due to HMOs not reimbursing the fee-for-service owed to facilities. According to the participants, hospitals complain that HMOs owe them and so cannot provide secondary services until those outstanding bills are settled.

When I got to my hospital last week, they refused to attend to me outrightly. The NHIS desk officer told me that until my HMO settles all outstanding bills, I will not be attended to. I didn't even know what to do.

Another enrollee added, "We are not getting the desired services under NHIS, and whenever we complain, the hospitals say it's because the HMOs are not paying…..the NHIS needs to address these problems".

Overall quality of care

Participants were asked to rate the NHIS services based on their overall level of satisfaction. Most rated the satisfaction as poor. "I am not satisfied, to be honest….I think people should have the liberty to choose if they want to remain in the scheme or not" one participant expressed. Another participant said, "On a scale of 1 to 10, I will score the NHIS 5; there are just too many things that are wrong with the scheme".

One middle-aged woman expressed "Hospitals that segregate NHIS enrollees from those paying out-of-pocket must be sanctioned; sometimes they make you feel sub-human"

DISCUSSION

Participants expressed their desire to continue to utilize NHIS services but admitted that in its current form, there were a lot of challenges hindering effective utilization.

Availability of drugs

The main challenge at the healthcare facility level was the non-coverage of certain drugs. This was consistent with the findings of Asakitikpi [1] who observed that certain drugs and diseases are not covered in the insurance, meaning that NHIS enrollees will still have to pay out-of-pocket in certain situations. Participants were unanimous about the problem of the non-availability of drugs at their healthcare facilities. This finding was similar to the earlier study conducted by Obikeze [13] who observed that many enrollees complained about the non-availability of drugs, and being separated from self-funded patients in some cases. This complaint was more evident in enrollees receiving care for primary illnesses under capitation than those for fee-for-service. This could be attributed to the fact that drugs categorized under fee-for-service are paid for by the HMOs while the funds for capitation are domiciled with the healthcare providers. It has been observed that drug availability was consistent with enrollees' satisfaction; enrollees that were provided drugs at the healthcare facilities rated the scheme higher than those who purchased the drugs out-of-pocket [14,15]. This trend was also noted in other African countries with enrollees having difficulty getting

prescribed a drug which was the most universal complaint associated with low satisfaction [15].

Getting prompt attention

Results from this study reveal that enrollees under NHIS have difficulties getting prompt attention from the healthcare providers which agrees with the findings of Mohammed et al [2]. In this regard, all the participants agreed that HMOs could do better in ensuring that enrollees have easy access to health care. Few of the participants further believed the delay in accessing care was not just an HMO problem, but also due to the number of patients accessing care at those facilities. This was similar to the findings of Adesanya [16] who observed that the waiting time in public hospitals was longer than in private hospitals due to a large number of patients in the government facilities. Delays in the issuance of authorization codes were a major contributory factor in the lack of prompt medical attention from NHIS enrollees. This also agrees with research by Mohammed et al [17,18] who observed delays in receiving approval codes from HMOs to offer secondary services or refer patients to better levels of care.

To other participants, this delay in accessing prompt medical services is due to the lack of an appropriate referral system seen in health facilities across the country. These delays could be avoided but for the poor referral system in many health facilities. Consequently, many of the participants admitted dissatisfaction with the services under the scheme. This was consistent with the studies done by Mohammed et al [2] and Adeniji [19] who observed that enrollee satisfaction was low in terms of promptness of care. Daramola [15] observed a high level of dissatisfaction in waiting time to see a doctor and noted that the practice of HMOs providing authorization before referrals could be raised or care provided reduced the effectiveness of the scheme. Another challenge is the delays in healthcare provider reimbursement by the HMOs resulting in lost revenues thereby affecting the ability of the healthcare providers to develop and maintain their facilities [14].

Treatment denials

This study observed that in some instances, enrollees were denied services with complaints of HMOs owing providers. This agrees with recent studies conducted by Nicole [19] which stated that late reimbursement of insurance funds to healthcare providers results in administrative inefficiency and affects the running of those facilities. Indeed, this has been a major problem in the scheme which prompted the NHIS to ask HMOs for letters of non-indebtedness from healthcare providers before carrying out the 2018 accreditation.

Interviewees generally revealed that many enrollees are not convinced about the role of HMOs in easing their access to care, and many rated HMOs low. This corresponds with Obikeze [13] who noted that the presence of HMOs harmed the running of the scheme. To these enrollees, there is often an exaggeration of the premiums deducted from them on one hand, and underwhelming care services received or even denied. The belief is that HMOs are the real beneficiaries of these funds.

Quality of service

The general belief is that enrollees under the NHIS receive less quality of care compared to out-of-pocket patients. Akinbode [7] observed that the workings of the scheme were similar to the usual lack of prompt attention experienced by patients who are not enrolled in the NHIS. The findings of this study corroborate others which showed that, from the reception, there is a delay in attending to NHIS enrollees [2] receiving low-quality drugs [13] but differed from the study by Daramola [15] on the overall attitude of staff towards the enrollees. This study observed discrimination between NHIS enrollees and out-of-pocket patients in many healthcare facilities, which discouraged many of the participants from accessing care under the scheme.

CONCLUSION

This study evaluated the challenges of patients and their levels of satisfaction in utilizing services under the NHIS in Nigeria. It revealed that enrollee challenges were mainly due to the HMO bottlenecks. The low-quality of services from healthcare providers and the selectivity in attending NHIS enrollees compared to self-paying patients was another challenge. These factors have resulted in a low level of satisfaction among NHIS enrollees and have contributed to low-service utilization and an overall lack of interest in the scheme. The NHIS needs to strengthen its regulatory role by ensuring that HMOs comply

fully with the operational guidelines, to minimize complaints of delay in issuance of authorization codes. The Scheme could also eradicate problems of non-remittance of funds to the healthcare providers by disbursing funds directly to the facilities. The HMOs in turn intensify their oversight and quality assurance responsibilities for the healthcare providers by ensuring that funds disbursed to the healthcare facilities are appropriately utilized to provide prompt and quality healthcare to the enrollees, including making available all essential drugs. Healthcare facilities that fail to meet these operational standards could have their NHIS accreditation revoked and the enrollees transferred to other healthcare providers.

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CONFLICT OF INTEREST

The authors declare that there is no conflict of interests.

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