

The Influence of HMOs on the Efficiency of Primary Health Care Provided in the NHIS in FCT, Abuja

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Abstract. The study focused on the influence of HMOs on the efficiency of primary health care provided in FCT, Abuja. The essence was to investigate how HMOs performance or nonperformance of their duties can impact on the efficiency of primary health care providers and the National Health Insurance Scheme on the overall. The scheme is believed to have a model designed to suit the country. With HMOs as major partners in the scheme, it is believed that the scheme would function better and would facilitate the goal of covering more people within the shortest possible time. Although HMOs activities can be done by NHIS itself, the efficiency of the scheme may be threatened due to the nonchalant attitude of some public sector workers in the discharge of their duties. Usually the results of partnership are greater and more effective the world all over. If HMOs execute their duties to PHCPs properly, this would in turn positively impact the NHIS. From the data analyzed, the findings of this research showed that HMOs had significant impact on the efficiency of primary Health Care Providers at varying degrees. Also, HMOs played significant role in the scheme and had impact on the overall scheme.

Keywords: Primary Health Care Providers, Health Maintenance Organization, National Health Insurance Scheme.

1. Introduction

There are so many literatures on the types of health systems adopted by many countries of the world but none of these provides sufficient evidence of which health system supersedes the other. However, countries have continued to search for the most

appropriate methods of funding and managing basic healthcare services for citizens (Abelson & Hutchison, 1994). Even though it is doubtful that a truly perfect health system can ever be developed, the worldwide trend has been towards the universal system (Brzezinski, 2009). Some people believe that an increase in national development can be achieved mostly when there is a provision of basic healthcare for citizens of a country. Largely because, only healthy people can fulfill their various obligations to the society, the good health of the people does not only contribute to better quality of lives, but also contributes to sustainable economic and social development of their country. As a result, there is rest of mind when financial arrangements are put in place for members of the society to achieve good health care (Adewumi, 2009). The desire to extend social protection in health care is what has led many governments to find out ways to ensure that citizens have access to quality and efficient healthcare delivered to the people.

According to Macionis (2005), the government directly provides basic medical care for all citizens of socialist economies. In these countries, healthcare is viewed in the context of 'a right' which must be enjoyed by the citizenry (Erinosho, 2007). And this, is in line with the 'Global strategy' of 'Health for all' by 2000, which saw health as 'a right for all', adopted by the World Health Organization in 1982 (Macinois & Plumner, 2003). The governments pay the medical cost for the people using public funds. As a result, healthcare is heavily subsidized with national government assuming full responsibility. They pay physicians and hospitals the medical bills because access to basic medical care is seen as a right for all citizens. (Macionis, 2005). In these societies,

the state owns and runs medical facilities, and pay salaries to practitioners who are employed by the government (Macionis, 2005). Where this happens, the economies of these countries are based on *lassiez faire* like in the United States of America (Erinosho, 2007). However, in contrast to this, people in capitalist economies pay for healthcare services from their pockets. Although, some government programs underwrite a considerable share of the medical expenses for people, due to the high cost of health care (Macionis, 2005). In-between the capitalist and socialist economies are countries that accommodate strong elements of welfarism in the provision of health services for its members (Erinosho, 2007). Britain and Canada have been identified as capitalist countries with well-established 'National Healthcare Programs' that provides universal access to adequate healthcare regardless of people's ability to pay (Goodman, 1991). Countries like this, make use of the welfarist approach in the provision of health services to citizens (Erinosho, 2007). However, the analysis of Rodwin (1989), Brzezinski (2009), and Enthoven (1985) on how the NHS in France, Canada and Britain operates, have suggested that the incorporation of the services of the Health Maintenance Organizations in the structure of the NHI, is necessary to effectively and efficiently manage a 'National Health Service' or a 'National Health Insurance' programme. HMOs can effectively monitor health care services that is provided for enrollees by the network of health care providers under their supervision. HMOs, if given the necessary platform in the NHI, can perform effectively, since they represent a form of managed care that involves an effort to integrate and manage the provision of health care services to people in an unconventional structure of health-care delivery where physicians are seen as autonomous professionals (Strang, 1993).

However, in places where people patronize the HMOs to obtain health care services, the method is referred to as 'managed care'. HMOs, independent of the National Health Insurance, can operate, on their own, two models of services. The models are: (1) the staff model and (2) the network model. (1) In the staff model, doctors are hired directly by the HMOs to perform health services to patients in the doctor's own hospital facilities. (2) While in the network model, the HMO subcontracts with individual doctors, physician practice groups, and hospitals to provide health services to the patients. Some HMOs operate the mixed model. And members are not allowed to visit doctors or facilities outside the HMOs network. However, when health care services are rendered to registered patients, the doctors,

hospitals, and other health service providers submit claims to the HMO. The HMO in turn, verify these claims by checking the compliance level with the contract, the member's benefits schedule, make adjustments were necessary, and pays the provider for the services (Kumpf & Wittelsberger, 2005).

2. National Health Care Systems without the Services of the HMOs:

2.1 Britain

In 1948, Britain established its system of socialized medicine. Britain created a "Dual system" of medical service which allowed the National Health Service and private medicine to function simultaneously. In other words, they did not do away with private medicine. The establishment of the National Health Service in Britain was not to prevent citizens from accessing private medicine. Rather, citizens are allowed to use both (i.e. the National Health Service and private medicine) if they can afford it. All members of the country are entitled to the National Health Services (Macionis, 2005). In fact, Britain's NHS has been termed the master piece of pure socialism (Spicer, 1981). However, the system does not incorporate the services of the HMOs in the NHS design. According to Rodwin (1989), the ideas to promote "internal markets" and HMOs within Britain's health system were proposed by Enthoven and Maynard. Enthoven and Maynard discussed variations of HMO Plan for the NHS, which was a form of "market socialism". The ideas about introducing HMOs and elements of market competition into national health systems were suggestions to enhance the system.

2.2 Canada

Canada since 1972 has had a "single-player" model of providing health care for all Canadians. Like a massive insurance company, the Canadian government pays doctors and hospitals according to a set schedule of fees. But like Great Britain, Canada has a two-tiered system of medical service with some physicians working outside government funded system and setting fees regulated by the government (Macionis, 2005), while some other physicians work within government funded systems, also with set fees regulated by the government. Canada boasts of providing care for her citizens at a lower cost than the type of medical system provided for the elderly (Medicare), and the poor (Medicaid) in the United States. However, the Canadian System uses less state-of-the-art technology to treat patients and responds slowly to people's needs resulting to people having to wait months to receive major surgery. At

the same time, Canadians point that lower-income people are not denied medical care as is in the United States. Canada's Universal Health Care Program covers physicians' fees and fees for other medical services that were not covered before 1972. Guided by these four basic principles, (1) *Universality*, (2) *Portability*, (3) *Comprehensive Coverage*, and (4) *Administration*, the NHI program aimed to reach its heights in health service delivery. However, in the health Act of 1984, the fifth principles (5) *Accessibility*, was introduced. The first guiding principle: *Universality*, meant that the plan was to be available to all residents of Canada on equal terms, regardless of prior health record, age, income and so on, the second principle: *Portability*, meant that individuals' benefits would travel with the individual across the country, the third principle: *Comprehensive Coverage* is a plan to cover all necessary medical services, including dentistry, which required hospitalization, and the fourth principle: *Administration*. referred to the fact that the program would run on a non-profit basis. The fifth and later principle: *Accessibility*, meant that the costs of the medical plan were to be shared by the Federal and Provincial Governments in such a way that the richer provinces would pay relatively more than the poorer provinces; thus the plan would also serve to redistribute wealth across Canada (Tepperman & Curtis, 2009). The NHI in Canada, also did not incorporate the services of the HMOs. The Canadian proposal for publicly financed competition, focused on combining the supply-side efficiency of health care in a well-managed HMO-NHIS arrangements and the financial security of the system (Rodwin, 1989).

3. Health Care Systems with the Services of the HMOs:

3.1 The United States of America

The United States does not have a universal health care coverage for all its citizens (Henslin, 2010), rather, health care received its first Federal aid in 1946. This was the Hill-Burton Act which provided subsidies for building and improving hospitals particularly in rural areas. The major change came when a two wide raging government assisted, compulsory health insurance plan for the elderly and the poor was enacted. The two programs are Medicare and Medicaid (Schaefer, 2008). Medicaid, a noncontributory Federal and state assisted insurance plan, is for the poor and helpless destitute, while Medicare, pays only a portion of the medical cost for the elderly above sixty-five years. For Medicaid, both the state and the Federal government

provide for medical cost per individual through revenues generated and it vary from state to state (Andersen & Taylor, 2005). Although the United States does not have a universal health care coverage for all its citizens (Henslin, 2010), it still plans to establish one. According to Erinoshio (2007), health care is left almost entirely in the hands of entrepreneurs in the United States. A primary controversy in the United States is whether medical care should be seen as a commodity or a right? And because medical care is seen as a commodity, it becomes easily accessible only to the rich, that have access to particular types of automobiles, clothing and other items. Medical care is obviously a commodity for sale in the United States. If medical care is seen as a right, then everybody in the society would have equal access to similar medical care. The question to whether it is a right or a commodity makes it very clear that it is not the rights of citizens. Those who have more money will continue to have access to quality health care while those with limited income would continue to have less access or none to quality health care (Henslin, 2010 and Goodman 1991). Quality health care is obtained at a very high cost, and is easily accessible to the highest bidder (Erinoshio, 2007). In short, "there are discrepancies to accessing health care in the United States" (Andersen & Taylor, 2005). "Health is important to everyone. Yet by making health a commodity, capitalist societies allow health to follow wealth." This then makes the accessibility and affordability to good health care a serious issue (Macionis, 2005). In America however, the services of HMOs have been incorporated in the provision of health services for the elderly (Medicare), and the poor (Medicaid) (Brzezinski, 2009).

3.2 Nigeria

Nigerians health system had its origin from the British Army medical services. The Army provided medical services to colonies and protectorates that were under it. At that time, medical services were limited only to those in the army and colonial service officers. Non-officers hardly benefited (Campbell, 2007). Medical service was introduced to meet the health needs of British settlers who were civil servants and missionaries that came into the country at the start of British colonialism and the colonial model is still intact (Erinoshio, 2007). There was also the presence of missionaries and few private hospitals which provided health care services in form of dispensaries and maternity centers for people (Campbell, 2007). This model brought with it a system of bureaucratization in the practice of medicine in the public sector which continued to

undermine professional ethos, job satisfaction, and quality care. The problem of economic recession also added to the crises in the Nigerian health system (Erinosh, 2007). Nigeria's health system allows for both public and private medicine. However, she adopts a welfarist approach in the provision of health services. In 1999, Nigeria adopted socialized medicine. The country established a National Health Insurance Scheme for her citizens (NHIS, Operational Guidelines, 2005). The scheme existence however does not prevent the practice of private medicine. Nigeria adopted the HMOs in its NHIS to ensure efficiency of services in the scheme and pays the HMOs for this. The HMOs are expected to encourage the cooperation of various professionals and providers under one management and ensure prompt and high standard services to the insured (Edozien, 2007). Also, HMOs would bridge the gap of the scarcity of private sector activities in the provision of health care services to the public through better collaborative activities (Anyene, 2012). Effective collaboration between Health Maintenance Organizations and Health Care Providers serves as key to the success of the NHIS (Ogundimu, 2011).

So, in Nigeria, 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 dynamic to running the scheme due to the administrative complexities involved in managing the scheme's enrollees. The effectiveness of Health Maintenance Organizations' in the performance of their roles in the scheme, will lead to the achievement of the country's overall goal of providing health services to its citizens (Ibrahim, 2011). HMOs are expected to work effectively with health care providers and other stakeholders in the scheme. They are to render services to the HCPs and the insured on behalf of NHIS. Where this is not done, the implementation of the scheme may not be successful (Emmanuel, 2017). In summary, the ability of Health Maintenance Organizations to measure up to her responsibility can determine to a large extent the success of the Scheme (Adebimpe & Adebimpe, 2010; Ogundimu, 2011).

The possibility of the workability of a model designed to involve the activities of the NHIS, HMOs, the HCPs, and the insured, all in one structure, if successful, would go a long way to providing a more realistic model for other countries (Rodwin, 1989). If the NHIS-HMO arrangement facilitates the achievement of the NHIS objectives,

then, HMOs are likely influencing the PHCPs positively.

4. Methodology

A quantitative method was used in this study. The quantitative method followed a cross sectional survey design. The survey questionnaires were administered to NHIS beneficiaries registered with some selected and accredited HMOs in the FCT to assess the knowledge of beneficiaries about HMOs and the NHIS, the relationship between the NHIS and the HMOs, the impact of the HMOs on the NHIS, as well as the roles the HMOs are playing in the implementation of the NHIS scheme. The study population comprised: the NHIS lives in the FCT which were 244, 992 and the 25 HMOs covering these lives on behalf of the NHIS in FCT as at 2011. The study's target groups were the NHIS lives (enrollees/ beneficiaries) in the public sector in FCT and the registered/ accredited HMOs covering/managing these lives.

For ease of administration, the NHIS allocated the various public sector organizations in the FCT to 25 HMOs to manage enrollees. The allocation was done so that the payment of capitation for all the employees of such organization can be done through the HMO responsible for that organization. However, the employees are expected to personally enroll to benefit from the scheme. So, for the purpose of this study, the NHIS lives that formed the population of study were distributed across the various ministries, agencies and parastatals in the FCT. A list of NHIS enrollees managed by a given HMO is available with the NHIS Desk Officer in all the organizations. There are twenty-five (25) HMOs covering NHIS lives in the FCT. Each of these HMOs is managing some enrollees assigned by the NHIS. The following are the number of public sector lives under the care of each HMO in the FCT as at 2011 when this data was collected from the NHIS headquarters in Abuja: The FCT was purposively chosen for this study because it houses the administrative/operational headquarters of the NHIS, as well as the administrative head offices and/or operational base of all the HMOs covering NHIS public sector lives/enrollees in the country. More so, the FCT as the administrative capital of the country 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. 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.

The Location of the study is Federal Capital Territory, Abuja. The Federal Capital Territory is the home of Abuja, the capital of Nigeria. The territory was formed in 1976 from parts of former Nasarawa, Niger, and Kogi States and it is in the central region of Nigeria, bordered to the north by Kaduna State, to the east by Nassarawa State, to the south-west by Kogi State and to the west by Niger State. The Federal Capital Territory lies between latitudes 8° 25'N and 9° 20'N and longitude 6° 39' N. Phase 1 of the city is divided into five (5) districts - Central, Garki, Wuse, Maitama, and Asokoro. Phase 2 is divided into five (5) districts - Kado, Durumi, Gudu, Utako and Jabi. Phase 3 districts are divided into four (4) districts - Mabuchi, Katampe, Wuye and Gwarimpa.

The National Health Insurance Scheme (NHIS) has its corporate headquarters located in the Utako District of the Federal Capital City in Abuja Municipal Area Council of the FCT. From there it supervises its operations and activities in the FCT and other states of the federation. Also, all the Health Maintenance Organizations (HMOs) covering NHIS lives/enrollees have offices in the Federal Capital City of the Federal Capital Territory (FCT). Their coverage area is the entire FCT i.e. anywhere in the FCT where the lives assigned to them by the NHIS to manage can be found. HMOs manage these lives through Primary Healthcare Providers scattered all over the FCT.

The study required sampling at two levels: (1) the HMOs covering NHIS lives in the FCT (by simple random sampling with replacement), (2) The lives covered by the HMOs on behalf of the NHIS (by stratified sampling proportionate to size). At the first level of selection, 5 out of 25 HMOs were selected while at the second level of selection, a total of 384 NHIS enrollees were selected.

4.1 Method of Data Collection

In the survey method, the instruments used for data collection was a semi structured questionnaire. The survey instrument was divided into sections with a section designed using summated differential scale (Likert scale). It was further subjected to face validity, i.e. the instrument was given to the thesis supervisor and other authorities for scrutiny to check if the instruments were actually measuring what they intend or are supposed to measure and to ascertain that the universe of all questions or items included in it were duly included. Also, the reliability of the survey instrument was calculated using the Crombach Alpha statistics to ascertain whether there is internal consistency in the items/questions in the study instrument and to verify to what extent the instrument produced the same results or replicate consistent results if similar studies are carried out afterward using the same instrument. Also, an item analysis was done to examine the items/questions in the questionnaire to ascertain the desirability of dropping, retaining or replacing any of them depending on the resulting Crombach Alpha coefficient of the said item/question if it was deleted. In addition to the above, difficult or inappropriate questions discovered from the response of the respondents/interviewees was deleted, replaced or rephrased.

Coefficient alpha, an internal consistency measure was computed for survey instruments. The estimate for survey instrument was .92. The coefficient indicates good reliability of the survey instruments. The estimate shows that there was good internal consistency in the items/questions used in the survey instrument. Values of .70 and above are acceptable values for Crombach's alpha (α), but values below this indicate unreliable scale. The use of Likert Scale otherwise known as summated differential scale in the design of the survey instrument was occasioned because the scale is usually of the interval type and thus can be summed up and used as a continuous variable which allows for the use of parametric tests/methods analyses that follow normality.

5. Results

Demographic Profile

In the survey, the male respondents were 203 (52.9%) while the female respondents were 177 (46.1%). Responses from ages 26-45 were highest in the survey, this indicated that majority of the respondents were adults. The married respondents were 319 (83.1%) while the singles were 50 (13.0%)

other i.e. those separated were 4 (1.0%), Divorced 1 (0.3%) and widowed 7 (1.8%) for educational qualification, 210 (54.7%) of the respondents had first degree, those with a diploma qualification were 81 (21.1%) while masters and PhDs were 52 (13.5%) and 2 (0.5%) respectively. The study discovered that majority of the respondents were highly educated and their responses could be relied upon in response to certain questions asked. 360 (93.8%) respondents were registered with the scheme while 22(5.7%) where not registered with the scheme. The group not registered claimed that they were benefiting from the scheme already through their spouse. On whether they knew the name of their HMOs or not, majority

299(77.8%) did not know their HMOs while 74(19.3%) knew their HMOs.

Hypothesis:

Health Maintenance Organizations are not likely to influence the efficiency of Primary Health Care Provided in FCT.

A comprehensive cross tabulation analysis was conducted to determine if Health Maintenance Organization (HMOs) are likely to influence the efficiency of Primary Health Care Providers (PHCP) in the FCT. The table below is the result of the two-way contingency table analysis.

Table 1: HMOs Influence on the Efficiency of Health Care Providers

HMO	Effective	Uncertain	Not Effective	Total
Total Health Trust Ltd	59 (75.4) [46.5%]	58 (45.3) [45.7%]	10 (6.3) [7.9%]	127 [100.0%]
Health International Ltd	112 (105.7) [62.9%]	58 (63.5) [326%]	8 (8.8) [4.5%]	178 [100.0%]
Maayoit Health Care Ltd	13 (8.9) [86.7%]	2 (5.4) [13.3%]	0 (.7) [.0%]	15 [100.0%]
Princeton Health Group	13 (8.3) [92.9%]	1 (5.0) [7.1%]	0 (.7) [.0%]	14 [100.0%]
Managed Health Care Services Ltd.	31 (29.7) [62.0%]	18 (17.8) [36.0%]	1 (2.5) [2.0%]	50 [100.0%]
Total	228 [59.4%]	137 [35.7%]	19 [4.9%]	384 [100.0%]

() Expected count; [] % within HMO

Pearson $\chi^2=22.441$; Degree of Freedom=8;P-Value=.007; Cramer’s V=.165; N=384; Crammer’s V=.242;N=384.

Two variables were cross-classified in the contingency table 2. The HMO has levels namely: Total Health Trust Ltd, Health Care International Ltd, Maayoit Health Care Ltd, Princeton Health Group, and Managed Health Care Service while the second variable, HMO Influence on the Efficiencies of Primary Health Care Providers has three levels: Effective, Uncertain and Not effective. This two varieties were significantly associated Pearson $X^2(8, N=384) = 22.441$; $P = .004$. The observed relationship is not a chance relationship, as it is a highly significantly one, $P < .01$. The effect size, that is the strength of the observed relationship is however small, Crammer’s $V = .17$, even though, it is significant, $P < .01$. The proportion of HMOs influence on the efficiency of Primary Health Care Providers from the HMOs were .47, .63, .87, .93, and .62 respectively. The result showed that HMOs had positive influence on the PHCPs irrespective of the fact that only 74(19.3%) of the respondents knew their HMOs as earlier stated above. This implied that HMOs, whether known to the enrollees or not, were effectively performing their duties towards the PHCPs and the scheme on the overall.

Follow-up pairwise comparisons were conducted to determine the difference among these proportions that is to ascertain if there is significant variation in the impact level of the HMOs. Ten pairwise comparisons were carried out. The Holm’s Sequential Bonferroni Correction method was used to control for Type 1 error at the 0.05 level across all the ten comparisons. The table below presents the result of the pairwise comparisons using the Holm’s Sequential Bonferroni method.

Table 2: Pair wise comparison for the Hypothesis (Health Maintenance Organizations are not likely to influence the efficiency of Primary Health Care Provided in FCT).

Pairwise Comparison	Pearson Square	Chi-	P-Value (Alpha)	Crammer's
Total Health Trust Ltd Vs Princeton Health Group.	*70.892		.004(.005)	.278
Total Health Trust Ltd Vs Maayoit Health Care Ltd.				
Health Care International Ltd Vs Princeton Health Group.	^{ns} 8.779		.012(.006)	.249
Total Health Trust Ltd Vs Managed Health Care Services Ltd.	^{ns} 8.355		.015(.006)	.166
Total Health Trust Ltd Vs Health Care International Ltd.				
Health Care International Ltd Vs Managed Health Care Service Ltd	^{ns} 5.150		.076(.007)	.164
Health Care International Ltd Vs Maayoit Health Care Ltd.	^{ns} 4.863		.088(.008)	.276
Princeton Health Group Vs Managed Health Care Service Ltd.	^{ns} 4.473		.107(.010)	.159
Maayoit Health Care Ltd Vs Princeton Health Group.				
Maayoit Health Care Ltd Vs Managed Health Care Service Ltd.	^{ns} 3.528		.171(.013)	.135
	^{ns} 3.264		.196(.017)	.224
	^{ns} .299		.584(.025)	.102
	^{ns} .757		.685(.050)	.058

*P-Value ≤ Alpha; ^{ns}P-Value > alpha

Table 2, the only pairwise comparisons that was significant was between Total Health Trust Ltd and Princeton Health Group, Princeton Health Group was 1.99 (approximately 2) times more likely to influence the efficiency of primary health care providers than total health trust ltd. This implies that Princeton health group was significantly more likely to influence the efficiency of Primary Health Care Providers than Total Health Trust Ltd, Pearson X² (2, N=141) = 10. 892; P <.005; the effect size is of a medium size, Cramer's V=.28, AV. The other pairwise comparisons were non-significant, thus, indicating that the pairs had the same level of influence on the efficiency of Primary Healthcare Provider in the FCT.

6. Conclusion

The study focused on the influence of HMOs on the efficiency of primary health care provided in FCT, Abuja. The main thrust of the study was to investigate HMOs impact on Social Health Insurance which is known as the National Health Insurance Scheme in Nigeria while discharging their duties to PHCPs in the scheme. The scheme is believed to have a model designed to suit the country. With HMOs as major stakeholders in the scheme, it is believed that the scheme would function better and would cover more people within the shortest possible time. Although HMOs activities can be done by NHIS itself, the efficiency of the scheme may be threatened due to the nonchalant attitude of some public sector workers in the discharge of their duties. Usually the results of partnership are greater and more effective the world all over. If HMOs execute

their duties to PHCPs properly, this would in turn positively impact the NHIS.

From the data analyzed, the findings of this research showed that HMOs had significant impact on the efficiency of primary Health Care Providers but at varying degrees, however played significant role in the scheme and had impact on the overall scheme.

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