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AN OVERVIEW OF NATIONAL HEALTH INSURANCE SCHEME IN NIGERIA: A CONTINUING MEDICAL EDUCATION

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ABSTRACT

DEFINITION / INTRODUCTION:
National Health Insurance Scheme (NHIS) is a system of healthcare financing in which funds are contributed via premium, taxes or donations into a common pool for health care expenditures. National Health Insurance is a universal health package and goes by different nomenclatures in different countries. For instance, In UK and South Korea it is called National Health Service (NHS) and National Health Insurance Cooperation (NHIC) respectively. In Nigeria, NHIS was established by Act 35 of 1999 with the objective of ensuring that patients receive quality, accessible and affordable health care. It protects patients from financial and health burdens.
The NHIS coverage rate of 5% in Nigeria is abysmal, far less than the rate reported in 2013 for Ghana (38%).Coverage rates in USA, Tanzania and Kenya are 91.5%, 16% and 10% respectively. To ensure universal health coverage in Nigeria, efforts should be made to appreciably increase the coverage rate.

KEY TERMS USED IN NHIS
For a proper understanding of the scheme, it is imperative to define some terms used repeated in NHIS. These terms include, but are not limited to the following:-

Beneficiary.
This is also called an enrollee. An enrollee is a person who is up to date with the payment and is therefore entitled to access care as covered by the scheme. An enrollee can be classified as either a Principal enrollee or a Dependent. A Principal/ Principal enrollee is an employee on whose behalf other biological members (Dependents) are enrolled.

The dependents consist of the couple and not more than 4 biological children of less than 18 years of age. The scheme provides a health coverage for an infant up to the age of 3 months.

After, this age, the child is expected to be registered as a biological dependent with the mother or father as the Principal

Health care providers (HCP):
They are primary, secondary and tertiary health facilities that are accredited by NHIS to render services to the enrollees.

Health Maintenance Organization (HMO)
They are companies registered by NHIS primarily to manage health care services via the HCP. They are classified as the managers of the scheme while NHIS offices are the regulators or coordinators of the scheme.

Benefit Package
These are health services an enrollee is entitled to. The list, is inexhaustible. Time and space will not permit a comprehensive itemization of all the services contained in the list. However, the services include diagnostic, preventive, rehabilitative and curative. Out-patient and in-patient care are also included in the benefit package. In in-patient care, an enrollee is covered up to a maximum of 21days per year to be on admission. Nevertheless, orthopedic cases and patients with stroke are covered to a maximum of 6 weeks and 12 weeks respectively as in-patients. In all these cases, the HCP pays for the first 15days via capitation while the HMO bears the financial burden of the remaining days or weeks via fee-for-service charges. More than 85% of diseases that inflict man are covered by the package. Exclusive list (Exclusion)
These are tests (investigations) and treatment of diseases that are not covered by the scheme. They include the following; -
-Antenatal, natal and post natal care after the 4th delivery.
-Care of preterm babies (in Special Care Baby Unit (SCBU)) after 12 weeks (3months) of life.
-Family planning services.

-Treatment of complications of sexually transmitted diseases (STIs)
However, treatment of active STIs is covered by the scheme.
-Treatment of victims of natural disasters
-Treatment of injuries sustained due to epidemics
-Treatment of occupational injuries
-Treatment of injuries resulting from conflicts, civil unrest, riots and wars
-Treatment of cases of drugs abuse and addiction
-Mammoplasty
-Domiciliary care
-Dental crowning and bleaching
-Dental implant
-Anti-tb treatment
-Treatment of congenital heart diseases or other congenital diseases requiring advanced care
-Post mortem examination/ autopsy.
However, items included in the partial exclusive list where patient pays 50% of the total bill and the HMO pays the remaining 50% include CT scan, MRI and dialysis for acute kidney injury (Acute renal failure) up to 6 sessions. It is disheartening to state that patients who need services that are not contained in the exclusive list are denied treatment.

Vulnerable Groups
These are cohorts of the population or group of individuals by virtue of physical or mental disability cannot engage in meaningful economic activities

Capitation:
This is a fixed monthly payment made by NHIS via the HMO's to the HCP. It is paid irrespective of whether the enrollees access care or not. All primary care services are capitated.
Antenatal care is also capitated. Authorization codes from HMOs are not required for a patient to access care in capitated services

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Fee-for-service (FFS):
These are payments made by the HMOs for secondary and tertiary services. In emergency cases, fee-for-service can also be paid to primary care providers. Services covered under FFS require authorization codes

Per diem
These are payments made by primary care providers and HMOs to secondary and tertiary providers for bed spaces. However, in emergency cases, it can be paid to primary care providers. In-pateint feeding is not covered by the scheme.

Co-insurance:
This is only applicable to benefits with partial exclusion. In this case, the patient pays 50% of the total cost while the HMO pays the remaining 50%. Examples of such services include CT scan, MRI and renal dialysis for acute kidney injury (formerly called acute renal failure) up to 6 sessions. It should be noted that co-insurance and co-payment are not the same and should not be used interchangeably.

Co-payment:
Is a tool used to ensure commitment and prevent abuse of the scheme by the enrollees. Co-payment simply means the 10% the enrollees pays for prescribed drugs. Enrollees that belong to the vulnerable Group Social Health Insurance Programme (VAGSHIP) and Tertiary Institution Social Health Insurance Programme (TISHIP) are exempted from co-payment.

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NHIS ORGANOGRAM & LEVELS OF CARE:

NHIS OFFICES
(National, Zonal and State)

HEALTH MAINTENANCE ORGANIZATIONS
(HMOs)

HEALTH CARE PROVIDERS
(Primary – Secondary – Tertiary)

ROLES OF THE DIFFERENT LEVELS:

NHIS
-Enrollment of Lives (enrollees) into the scheme
-Remittance of funds to HMOs for payment of capitations and fee-for-service (FFS) charges.
-Sets and review operational guidelines and coordinates the activities of the scheme. In fact, in a nut-shell, they are categorized as the coordinators of the scheme.
-Health education and sensitization of the HMOs, health care providers and the patients.
-Accreditation of HMOs and Health facilities for the scheme.
-NHIS also seeks for technical support when necessary.

HMOs
-Collection of payment and timely remittance to the appropriate pools.
-Health education and sensitization of the enrollees.
-Timely payment of health facilities
-Efficient processing of claims
-Issuance of authorization codes to patients via the health facilities.

Health care providers (HCP):
These are facilities that provide primary, secondary and tertiary cares to enrollees. Timely and two way (2-way) referral is sine qua non for effective service delivery. Efforts should be made at all times to reduce waiting time at the primary and secondary care levels. Issuance of authorization codes in cases of referred cases must be prompt and should not be unduly prolonged. Authorization codes are consents and approval given by the HMOs in expression of their willingness to pay for secondary services that would be received by the enrollee. The roles of the HCP are preventive, curative, rehabilitative and diagnostic.

REFERRAL IN NHIS
Effective and prompt referral system is one of the major factors in the efficient running of NHIS. Referral simply means the transfer of patients' care from one level to another. It can also be defined as the transfer of care from one medical doctor to another. It must be prompt and 2-way referral. Two-way referral implies that when an enrollee is referred for secondary or tertiary care, at the completion of treatment at that level, same patient must be sent back to the primary care giver (who is adjudged as the owner of the patient) for continuity of care. Treatment of referred cases must be specific. This means that if a patient is referred for hypertension (with the appropriate authorization code) and was observed to have another disease as co-morbidity in the course of treatment, treatment must be targeted at the disease which had authorization code (complicated HBP) and referral made after treatment to the primary care giver, who either treats the co-morbid condition or generate a second authorization code for referral with respect to the second (co-morbid) disease. Where there is a breach, the HMO is not legally bound to pay for the treatment given for the co-morbid condition. This is a common practice in most Nigerian centers and could serve as a financial waste pipe. May I also add that horizontal referral from one secondary care to another or a vertical referral from a secondary care giver to a tertiary care provider should be discouraged. Such referrals must be done via the primary care provider who subsequently refers to another secondary care provider or a tertiary care provider. Suffice it to say that every referral (with the exception of referrals made by a secondary/tertiary care provider to a primary care provider and emergencies) must be done by the primary care provider after an authorization code has been obtained.
Inappropriate referrals usually lead to financial losses

TYPES OF NHIS

National Health Insurance Scheme in Nigeria is broadly divided into 2; social and private. In Social Health Insurance Scheme, the risk is shared between the managers of the scheme and the enrollee. However, in Private Health Insurance Scheme, the risk is borne absolutely by the patient. The social health insurance is classified into the following;-

-The formal sector social Health Insurance Program (FSSHIP)
-The Informal Sector Social Health Insurance Program (ISSHIP) and
-Vulnerable Group Social Health Insurance Program (VASHIP).

The formal sector social health insurance program (FSSHIP) is the most patronized in Nigeria and covers the health needs of the following groups;

-Public / Civil Servants
-Organized Private Sector with up to or more than 10 employees.
-Armed forces, police, civil defense and other uniform groups.
-Students in tertiary institutions (Tertiary Institution Social Health Insurance Program (TISHIP).

The Tertiary Institution Social Health Insurance Program (TSHIP) is meant for students in tertiary institutions. This scheme is operational in Nigeria. As part of the school fees a premium of a token amount is added. As obtainable in the vulnerable groups social health insurance program, no co-payment is made for drugs. The implementation of this scheme is done by a TISHIP Management Committee which is headed by the Medical Director of the health facility. Other members are the representatives of the HMO, student's body, bursar and a member from the legal department of the institution. The HMO does the registration at the beginning of each academic year. An enrollee exits the scheme at the completion of the academic program, withdrawal or expulsion from the institution.

THE INFORMAL SECTOR SOCIAL HEALTH INSURANCE

-The Voluntary Contribution Social Health Insurance Program (VCSHIP)

This was created to carter for the health needs of patients who are not in the formal / public sector, retirees from the formal sector who wish to continue with the program, political office holders and organized private sectors with less than 10 employees.

It is also appropriate for expatriates resident in Nigeria. Instead of paying for extra dependents and accommodating them in the Formal Sector Social Health Insurance Program (FSSHIP), it is advisable to enroll them in VCSHIP. For efficient service delivery, better funding and sustainability, VCSHIP has recently been replaced by Group Individual and Family Social Health Insurance Scheme(GIFSHIP)

-Community based social health insurance program (CBSHIP)

In CBSHIP, there is a collective pool of risks and contributions are made by a group of households, individuals or occupational groups. Donations and grants can be sort and used to fund the scheme. The money recovered during launching can also be used to fund CBSHIP. Issuance of ID Cards to members is a sine qua non. The NHIS regulates the program via the Board of Trustees (BOT) or the program Managers. The BOTs are usually community representatives that manage the scheme. They also function as program managers. The CBSHIP is the least patronized in Nigeria as at 2020.

REGISTRATION OF LIVES/ENROLLEES

This can be classified into two; as a member/employee in a formal sector (e.g staff of an institution) and as an individual (in the case of VCSHIP). An employee who wasn't captured during the group registration can also be registered as an individual.

In the first option, upon the selection of the Health Maintenance Organization (HMO) through due and transparent process by the institution, a team from NHIS is invited by the management of the institution for staff capturing. During this process, all the necessary information (DBO, GL, date of retirement, number of dependants and their ages, department etc) are recorded. The enrollee is allowed the choice of a health facility. Details of his/her spouse and 4 biological children not more than 18 years of age are also documented. The choice of a Health Maintenance Organization (HMO) is not for the enrollee as the management of the institution has ab initio made the choice on behalf of all the staff of the institution.

A staff who was absent during the process is permitted to present for the exercise at the State NHIS office with the appointment letter, current pay slip, staff ID card, passports of his/her dependants etc for capturing. This second process is also recommended for enrollees who do not belong to any formal sector and wish to register as an individual (e.g VCSHIP). However, while the choice of the health facility belongs to the enrollee, that of HMO is the prerogative of the NHIS.

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PROCEDURES FOR REGISTRATION/ACCREDITATION OF HEALTH FACILITIES (HCP)

1. Application letter stating interest to participate in the scheme should be raised. Service(s) of interest must be defined (primary, secondary, tertiary or combination of services). If interest is on secondary or tertiary services, the letter must be specific on the area of interest (for instance, be it gynaecology, surgery, psychiatry, ophthalmology, internal medicine, ENT etc).
2. Non refundable fee of N50,000/ service for registration and accreditation should be paid.
3. Accreditation visit by the NHIS team is made after the application must have been screened
4. If \satisfied by the appraisal, a provisional accreditation is granted for 2 years.
5. Within the 2-year period, NHIS pays two compulsory quality assurance visits.
6. At the expiration of the provisional accreditation, a re-accreditation visit is paid. During this visit, emphasis would be paid on the deficiencies observed during the first visit.
7. If the re-accreditation visit is successful, a full accreditation is granted. However, if not successful, the initial accreditation is withdrawn

PROBLEMS ASSOCIATED WITH NHIS IN NIGERIA:

Several problems are militating against the smooth running of the scheme. These problems are encountered at the levels of NHIS, HMOs and Facilities and some are patient-based

NHIS:

-Poor funding and politicization of the scheme.
-Accreditation of poorly equipped HMOs and health facilities due to ambiguous interests.
-Protraction in the review of the NHIS guidelines. Since health and diseases are dynamic, the review of guidelines on funding, contribution by enrollees, drug lists, benefit packages etc should be regularly reviewed. The present NHIS operational guideline was reviewed in the years, 2012.
-Poor sensitization of HMOs, Health workers and patients on the scope, expectations and aims of the scheme. Surprisingly, some enrollees misinterpret the scheme as Free Medical Outreach due to poor sensitization.
-Perceived corrupt practices such as misappropriation of funds

HMOs:

-Poor adherence to the contents of the operational guidelines, including benefit package
-Delay in the generation of authorization codes for referred cases.

-The HMOs also have important roles to play in the sensitization of health workers and patients on the modus operandi and scope of the scheme. Rarely do they carry out this responsibility
-Delay in payment, denial of payment and high level of indebtedness

HCPs (Health Care Providers):

-Poor adherence to the 2-way referral system.
-Too many bureaucratic bottlenecks resulting in long waiting time.
-Missing patients' folders and poor documentation
-Recurrent strike action by health workers leading to punctuation in service deliveries
-Inadequate facilities & man-power.
-Drug out of stock syndrome. This is a serious issue militating against the smooth running of the scheme. On no account should an enrollee be made to procure drugs by himself/herself
-"Forced" out-of –pocket payment for services that are covered by the scheme
-Sharp practices such as fraudulent claims, over-billing and denial of services
-Billing enrollees for covered services, especially emergencies

PATIENTS

-Abuse of the scheme by patients is a common but regrettable denominator in most Nigerian hospitals
-Impersonation is equally common
-Unnecessary and unrealistic detection of treatment modalities and medications by patients is another patient-based factor.
-Lack of cooperation and harassment of health care providers by patients have also been severally reported in some centers.
-Poor knowledge of the scheme and her operational guidelines such as requesting for services that are not covered by the scheme.

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