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Utilization and perception of Community Health Insurance Scheme services by enrolees in Obio Cottage Hospital, Port Harcourt, Nigeria.

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KEYWORDS

Healthcare, Community Health Insurance, Perception, Utilization.

ABSTRACT

Background: Community Based Health Insurance Scheme is a social service organized at community level. It is a mutual health organization or micro-insurance scheme that targets informal sector and applies the basic principles of risk-sharing and pooling of funds for healthcare. As part of her corporate social responsibility. Shell in collaboration with four communities in Obio-Akpor LGA, Port Harcourt, started a Community Health Insurance Scheme in February 2010. An evaluation of enrollees' utilization and perception of the services provided was done.

Methodology: Quantitative data were collected by the use of structured interviewer questionnaire. Two hundred and fifty enrollees who utilized the health facility before and after the introduction of the scheme were selected and interviewed. Also a two year review of monthly out-patients and ante natal attendance records before and after the Scheme was introduced were done. The quantitative data was analyzed using SPSS version 17 and presented as contingency tables and bar charts for comparisons.

Results: A high proportion (80.9%) of the respondents said they were satisfied with Community Health Insurance services provided at the hospital. Consultations by the doctors had the highest rate (91.7%) of client's satisfaction followed closely by the laboratory services. The staff attitude to patients had the least (76.2%) satisfaction rate. Over 75% of the enrollees felt that the various services being rendered now are better than what they had before the introduction of the scheme. A month after the introduction of the scheme out patients' attendance doubled while ante natal clinic attendance tripled.

Conclusion: Most of the enrollees said that they were satisfied with all the services provided in the Health Insurance Scheme. There was a sharp increase of healthcare utilization with the introduction of Community Health Insurance Scheme. There is the need for the employment of more staff and expansion of existing infra-structure to accommodate increasing patronage. Re-orientation of staff for better attitude to work and patient relationship is advocated.

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INTRODUCTION

Shell Petroleum Development Company (SPDC) supports health service provision in 27 health facilities in the Niger Delta, which includes Obio Cottage hospital located in Obio-Akpor LGA of Rivers State. The supportive healthcare services provided to these health facilities are implemented by the Community Health Department of SPDC. Obio Cottage Hospital was a Primary Health Care facility that had one visiting doctor before it was upgraded for the Community Health Insurance scheme (CHIS) implementation in 2010. The services provided before the introduction of the scheme were mainly Maternal and Child welfare services and also Out-patients clinics but without in-patients. With the upgrading of the health facility more doctors and other healthcare providers were

employed.

Unfair financing is likely to make healthcare out of the reach for some and also universal coverage not feasible for the system.[1-3] The basic functions in financing healthcare are resource collection, pooling and purchasing. The Primary Health Care (PHC) was conceptualized to bridge this gap by providing affordable and accessible healthcare among others but failed to do same due to inadequate funding for infrastructure, provision of drugs, consumables and basic hospital facilities for qualitative service delivery etc. As a result, communities lost faith in the concept of PHC which eventually became moribund. The enunciation of the National Health Insurance Scheme (NHIS) was received with a sigh of relief as the way out to easy access to healthcare for all at an affordable cost. However, its implementation remained in the formal sector. Community Health Insurance Scheme is therefore designed to cover the major part of the informal sector.

A major benefit of CHIS is the fact that the poor have increased access to basic health services.[3, 4] Studies have shown that CHIS provides some financial protection by reducing out-of-pocket spending, improves cost-recovering and could lead to improvement in quality of services.[5,6] The scheme will help to improve financial access, utilization, and quality of health care services through cooperative and community efforts.[3,7]

An annual health premium of N7,200.00 was fixed for individuals and N41,760.00 for family. The Community set aside 15% of her Global Memorandum of Understanding (GMoU) fund as statutory funds to subsidize premium for indigenes by 50%. Therefore indigenes paid N3,600.00 premium for individuals and N20,880.00 per family/annum i.e. husband, wife and four biological children.

METHODOLOGY

The study was carried out in November 2012 in Obio Cottage Hospital. For the quantitative data generation a minimum sample size of 250 clients was considered for interview. This number was arrived at by sampling 75% of daily average attendance in the hospital over five days in a week (all services provided at the facility are spread over the five days in a week). Only those who utilized healthcare services at Obio Cottage Hospital before introduction of CHIS and registered for the Scheme and consented to the study were considered. They were selected daily in their sitting arrangements in Out patient's Clinics and Maternal and Child welfare Clinics daily until the required number was achieved. The healthcare services were the same services provided before the introduction of the CHIS. For the retrospective data, all available clients' files from February-November 2010 were retrieved and relevant information collected. Attendance records of daily healthcare services from January 2009 - November 2010 were compiled for analysis. To validate the data that were entered a sizable number of entries were randomly selected at intervals as the data entry process was in progress. Cross-tabulated tables and diagrams were generated using SPSS 17.0 windows software.

Results The respondents were predominantly (94.1%) women who utilized mainly ANC and under-five clinic services. 31.6% of the respondents were unemployed followed by 27.7% petty Traders. A month after the introduction of the scheme out patients attendance more than quadrupled and ante natal clinic attendance also more than tripled the previous year's. A month after starting CHIS patients turn-out tripled in all services except immunization. Deliveries in the health facility doubled after two months. High proportion (80.9%) of the respondents was satisfied with the service received at last visit. Consultations by the doctors had the highest rate (91.7%) of service satisfaction followed closely by the laboratory services. The staff attitude to patients had the least rating (76.2%). Over 75% of the enrollees felt that the various services being rendered now are better than before the introduction of the scheme.

Table I. Distribution of enrollees' perception of CHIS services they utilized

S/N	Services	CHIS services			Total
		Satisfied Freq. %	Fair Freq. %	Not satisfied Freq. %	
1.	Service at last visit	207(80.9)	28(10.9)	21(8.2)	256
2.	Service at Reception/Records	206(81.4)	33(13.0)	14(5.5)	253
3.	Services by the Nurses	224(87.8)	26(10.2)	5(2.0)	255
4.	Services by the doctors	232(91.7)	17(6.7)	4(1.6)	253
5.	Services at the Pharmacy	226(90.8)	18(7.2)	5(2.0)	249
6.	Laboratory services	222(91.4)	17(7.0)	4(1.6)	243
7.	Ante Natal services	154(84.2)	20(10.9)	9(4.9)	183
8.	Delivery services	65(87.8)	3(4.1)	6(8.1)	74
9.	Post Natal services	70(84.3)	8(9.6)	5(6.0)	83
10.	Immunization services	111(83.5)	15(11.3)	7(5.3)	133
11.	Staff attitude to patients	195(76.2)	54(21.1)	7(2.7)	256

Table II. Distribution of enrollees' perception of CHIS compared to previous services

S/N	Services	CHIS compared to previous healthcare			Total
		Better Freq. %	No Difference Freq. %	Worse Freq. %	
1.	Out patient's services	169(81.3)	34(16.3)	5(2.4)	208
2.	Ante Natal services	125(78.1)	30(18.8)	5(3.1)	160
3.	Laboratory services	161(79.3)	35(17.2)	7(3.5)	203
4.	Pharmacy services	163(80.3)	34(16.7)	6(3.0)	203
5.	Immunization services	98(79.7)	21(17.1)	4(3.2)	123
6.	Circumcision services	57(76.0)	14(18.7)	4(5.3)	75
7.	Nurse's Attitude	170(82.9)	28(13.7)	7(3.4)	205
8.	Doctor's Attitude	176(85.9)	25(12.2)	4(1.9)	205
9.	General Staff Attitude	164(79.6)	36(17.5)	6(2.9)	206
10.	Quality of service	170(82.5)	29(14.1)	7(3.4)	206

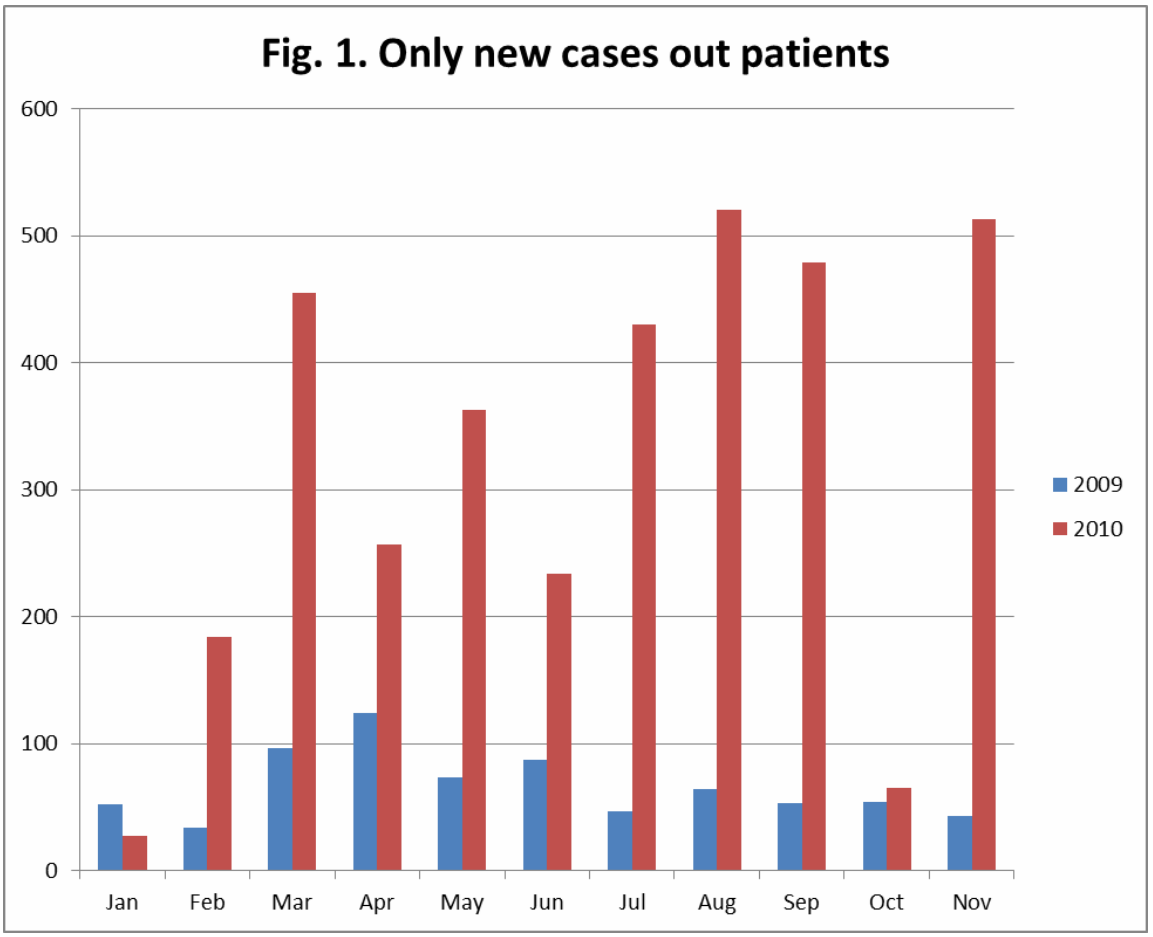
Fig. 1. Only new cases out patients
600
500
400
300
200
100
0
Jan
Feb
Mar
Apr
May
Jun
Jul
Aug
Sep
Oct
Nov
2009
2010

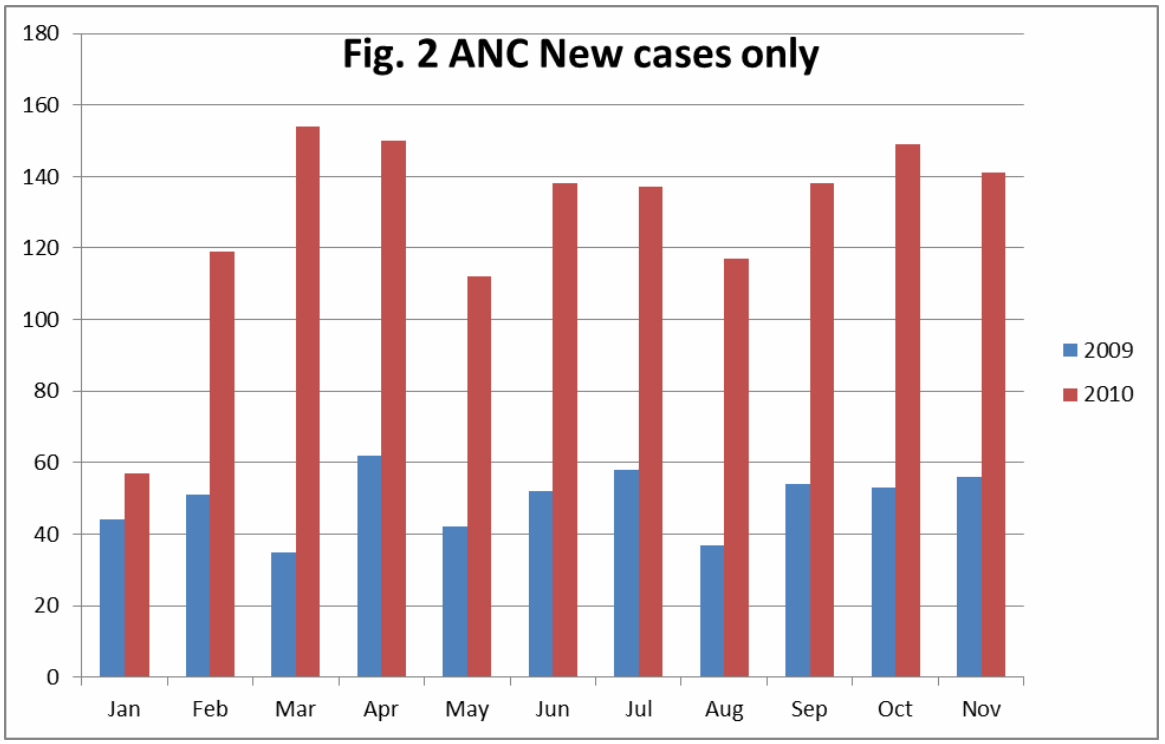
Fig. 2 ANC New cases only
180
160
140
120
100
80
60
40
20
0
Jan
Feb
Mar
Apr
May
Jun
Jul
Aug
Sep
Oct
Nov
2009
2010

Discussion

The unemployed constituted the highest (31.6%) number of the enrollees into the scheme followed by Traders (27.7%). This meets the main objective of the community insurance scheme which provides for those in the informal sector who are self employed and do not enjoy any government organized package for healthcare. Most of the respondents were satisfied with the various services they received under the scheme (Table 1). This shows the level of acceptance and embracing of the new scheme by the community members. Over 75% of the healthcare services rendered in the hospital are Maternal and Child Health. This is very pertinent in addressing the Millennium Development Goals (MDGs) 4 and 5 towards reducing infant and maternal morbidity and mortality.

Out of the 256 respondents interviewed 189 (73.8%) felt that healthcare before they enrolled in CHIS was expensive see. A high proportion (82.3%) of the enrollees felt that the CHIS was less expensive compared to their previous healthcare expenses (Table 2). A month after the introduction of CHIS in February 2010, attendance as compared to 2009 in the out patients more than quadrupled (Fig. 1) while the ANC attendance more than tripled (Fig. 2). This trend was maintained for most of the months peaked in August and March for out-patient new cases and ANC respectively. However there was a dip in October for the out-patients which was said to have resulted from some HMO policies that disenfranchised enrollees (registration point was moved away from the health facility to the HMO Head quarters).

Past studies have shown that those who utilized fee-for-service healthcare appreciate cost of CHIS and consider it better. [6] This has been demonstrated in this case. A major benefit of CHIS is the fact that the poor have increased access to basic health services.[3] CHIS therefore provides some financial protection by reducing out-of-pocket spending, improves cost-recovering and could lead to improvement in quality of services.[7] SPDC through this pilot intervention has demonstrated its feasibility and should be replicated in other communities if the informal sector should be reached with affordable and equitable essential health services to complement government effort in attaining health for all.

Acknowledgement

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