The Obstetrician/Gynaecologist and The National Health Insurance Scheme

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Abstract

The Decree establishing the National Health Insurance Scheme was promulgated in 1999; however, actual implementation commenced in 2002 and has remained at a rudimentary stage. This is despite the very laudable reasons for establishing the NHIS, to provide a financial lifeline to health care delivery in Nigeria.

As stakeholders in the NHIS, obstetricians/gynaecologists have a very important role to play to ensure its successful implementation and sustenance. This is especially so in view of the unfavorable reproductive health indices in Nigeria, to which poverty is an important contributory factor.

In this article, some background information on health insurance and the NHIS deemed relevant to the obstetrician/gynaecologist is given. Subsequently, the role expected of, and the benefits to be derived by the obstetrician/gynaecologist are presented.

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Introduction

The National Health Insurance Scheme (NHIS) is a corporate body established by Decree 35 of the Federal Government of Nigeria "for the purpose of providing health insurance which shall entitle insured persons and their dependants the benefit of prescribed good quality and cost effective health services".[1] The NHIS was established against the background of deterioration of public health care services due to chronic under-funding, to mobilize resources in a sustainable manner for the provision of accessible, affordable, effective, efficient, equitable and qualitative healthcare services to all Nigerians.[2] Despite the laudable reasons for its establishment, implementation of the NHIS only commenced in March, 2002, and has remained limited in its scope.[3]

Extensive education of potential beneficiaries is essential to the successful implementation of a health insurance scheme.[4] This is especially so for the NHIS, because participation in it is voluntary.[1] Consequently, if the members of the public are not sufficiently enlightened as to the benefits they will derive from participation in it, they will decline to do so, resulting in unsuccessful implementation of the scheme.

Education of health professionals on the NHIS is especially important, because of the major role they are expected to play as health care providers in the NHIS.[5] Indeed, without their participation, the scheme could not be implemented, as there would be no one to render health care services to contributors.

The latest Nigeria Demographic and Health Survey (NDHS) in 1999 revealed the parlous state of utilization of reproductive health services by the Nigerian woman. For live births in the three years preceding the survey, it was reported that only 64% of mothers had received antenatal care during pregnancy from a trained health worker (doctor or nurse/midwife). Less than half of births, 42% were attended to by a trained health worker and only 37% of live births took place in health care facilities. There were marked disparities in these statistics between the zones, and between rural and urban areas. For instance, while 73% of deliveries in the Southwest were attended by trained health worker, only 8% of deliveries in the Northwest had a similar quality of care. Again, while 10% of urban women received no antenatal care, almost four times as many - 37% - received no antenatal care in the rural areas.[6]

Given the above findings, the high maternal mortality ratio in Nigeria, estimated at 704 per 100,000 live births[7], is not surprising. Again, marked disparities between urban and rural communities and between zones exist.

Obstetric care is not the only aspect of reproductive health care which Nigerian women lack. The NDHS also reported that only 14 and 9 percent of married men and women, respectively were using any modern contraceptive method, while the unmet need for contraception was 13.3%.[6] Reasons for low contraceptive prevalence rate adduced include low quality of services, inadequate and irregular supply of commodities.[8] Other reasons that have been reported include fear of side-effects and cost.[9]

Carcinoma of the cervix, a largely preventable disease,

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is the commonest genital tract malignancy in Nigeria, with an estimated 25,000 new cases each year.[10,11] No national cervical screening service exists in Nigeria, despite the fact that successful community based screening programmes coupled with treatment of pre-invasive disease, have succeeded in reducing the incidence of and death from cancer of the cervix in many developed nations.[12] Consequently, one of the strategies proposed for reducing deaths from carcinoma of the cervix is a routine cervical cytology service to screen every woman in the reproductive age group at least once every three years[13]. This should of course include poor women and those who live in rural areas!

The dismal picture of the reproductive health of Nigerian women painted above, underscores the desirability of the participation of the obstetrician/ gynaecologist in the NHIS. This is more so as poverty, resulting in an inability to reach health care facilities and to pay for services there, has been implicated as an important contributory factor to maternal mortality, and other aspects of women's reproductive ill health and deprivation.[14-16]

Poverty, however, is not the only problem. The stark disparities in utilization of services and maternal mortality ratios between urban and rural women and between zones is, to a not inconsiderable extent, a reflection of the inequitable distribution of health care services. Correcting such inequities is one of the objectives of the NHIS.[3] Therefore, a synergy between the NHIS and obstetrician/gynaecologists (as individuals and hopefully, with time, as a body) will result in the extension of much needed services to areas hitherto neglected in the provision of many reproductive health services.

In light of the above, this paper has been written to give a brief introduction to the concept of health insurance, and a more in-depth insight into the NHIS, and the role the obstetrician/ gynaecologist is expected to play in it. It is hoped that this will increase awareness and knowledge of the NHIS by obstetrician/gynaecologists, and thus encourage their participation in it.

The Concept of Health Insurance

In its simplest form, health insurance may be defined as a mechanism of healthcare financing which involves individuals paying beforehand (or having paid for them), sums of money - called contributions - at regular intervals into a common pool. These payments then enable them to receive predetermined healthcare services - called the benefit package - when required, without having to pay the full price for the services at the time of delivery or use.[3]

The NHIS is a social health insurance programme. Social health insurance is the term used to describe health insurance programmes that are based on the concept of "Social solidarity". Inherent in their operations is the element of subsidization, with the rich subsidizing the poor, the healthy the sick, the young the old and single individuals, those with dependants. To achieve this end, a basic principle of social health insurance is that individuals make payments according to their means, but utilize services according to need.[10]

Programmes of the NHIS.

There are currently six programmes of the NHIS, which have been designed to cover every segment of the Nigerian society[5]. They are described below:

1. ***The Formal Sector Social Health Insurance Programme (FSSHIP)*** is expected to cover formal sector employees. These are made up of public sector employees and those of the organized private sector (OPS). Only OPS members with ten or more employees qualify to participate in this programme. The contribution rate is 15% of the employee's basic salary with the employer paying 10% and the employee 5% to make up the total. The contributor, one spouse and up to 4 children under the age of 18years are entitled to healthcare benefits. The benefit package is quite comprehensive and includes care at primary, secondary and tertiary levels. Notable exceptions to the benefit package include non-surgical treatment of malignancies and antiretroviral drugs. The programme will be financially administered by health maintenance organizations (HMO).
2. ***The Rural Community Based Social Health Insurance Programme (RCBSHIP)*** and
3. ***The Urban Self-Employed Social Health Insurance Programme (USESHIP).***

In both these programmes, 500 individuals or more are required to get together and form a "user group". This user group then elects a board of Trustees (BOT) that administers the programme. The NHIS provides technical support and plays a supervisory role but its own members essentially run the programme.

The RCBSHIP covers individuals/households who reside in rural communities, while the USESHIP covers individuals who are employed in the informal sector. To participate in the latter, individuals have to be members of occupation-based socially cohesive groups such as "the market women's association". The benefit package is "deregulated". This means that a range of primary and secondary care items (illnesses and healthcare benefits) are offered the participants, from which they choose, as a group, items they would like covered. The contribution rate is then determined by the items chosen. It is a flat rate, which everyone in the user group must pay. Families are not automatically included in the coverage unless they pay contributions individually.

4. ***The Children under Five Social Health Insurance Programme (CUFSHIP)*** is intended to cover every child aged less than five years in Nigeria. The benefit package includes coverage at primary and secondary care levels for illnesses that contribute to the majority of deaths in this age group. The programme shall be wholly funded by the Federal Government of Nigeria and administered by the NHIS.

5. ***The Permanently Disabled Persons' Social Health Insurance Programme (PDPSHIP)*** is designed for permanently disabled persons who are unable to engage in any economically productive activity, and are registered with rehabilitation centres. A benefit package covering common ailments at primary and secondary care levels is available. The Federal Government of Nigeria shall pay the contribution for participants, while the NHIS shall administer the programme.

6. ***The Prison Inmates' Social Health Insurance Programmes (PISHIP)*** will cover all inmates of prisons, remand homes and borstals nationwide. The benefit package includes coverage for ailments responsible for most of the ill health of these inmates. The programme is to be administered by the NHIS and the contributions paid by the Federal Government of Nigeria.[5]

Role of the Obstetrician/Gynaecologist in the NHIS

The NHIS defines a health care provider as "either a government or private health care practitioner or facility approved by the NHIS for the provision of prescribed health benefits to contributors and their dependants. This can either be a primary health care provider or a fee-for-service health care provider". Included in the list of fee-for-service health care providers are specialist doctors.[11] Specialist doctors who are expected to participate in the NHIS include obstetricians and gynaecologists.[12]

Requirements for the Registration of Obstetrician/Gynaecologists with the NHIS.

To be registered with the NHIS, the obstetrician-/gynaecologist is required to possess both a basic medical qualification, and a specialist qualification in obstetrics and gynaecology. In addition, registration of both the primary and specialist qualifications with the Medical and Dental Council of Nigeria (MDCN) is required. Possession of a current license to practice from the MDCN is a *sine qua non* for registration with the NHIS.[12] The obstetrician/gynaecologist is also required to have malpractice insurance as may be determined from time to time by the NHIS Council.[11]

Other requirements for registration with the NHIS include possession by the obstetrician/gynaecologist of facilities, equipment and staff deemed appropriate by the NHIS for rendering standard practice in obstetrics and gynaecology. Facilities that may be utilized by the obstetrician/gynaecologist include private hospitals, general hospitals, specialist hospitals, federal medical centres and teaching hospitals, as long as they meet the requirements for registration by, and are registered with, the NHIS. In addition to the above, the premises must be registered by the government of the state in which it is located.[12]

Procedure for Registration with the NHIS

To be registered with the NHIS, an obstetrician-/gynaecologist who fulfills the requirements for registration is required to write a letter of application for registration to the NHIS. (S)he will then be supplied with, and expected to complete and submit, the relevant application form, together with supporting documents such as photocopies of professional certificates. Following the afore-mentioned, staff of the NHIS will inspect the facility to ensure compliance with NHIS requirements for registration. Report of this inspection will then be forwarded to the NHIS Council through its management, and the Council may then approve registration for a defined period if the inspection report is favorable. Subsequently, the obstetrician-/gynaecologist will enter into a contractual agreement with the NHIS, and, after payment of required fees for registration and NHIS sundries, be deemed to be registered with the NHIS for one year in the first instance. The agreement is then subject to renewal at regular intervals on such terms as the parties may mutually agree.[12]

Contractual Agreements Involving the Obstetrician/Gynaecologist

As already stated, the obstetrician/ gynaecologist is required to enter into a contractual agreement with the NHIS. In order to participate in the FSSHIP, USESHIP and RCBSHIP, the obstetrician/ gynaecologist will also have to enter into contractual agreements with the financial managers of those programmes. These are the HMO for the FSSHIP, while the BOT serve a similar function in the RCBSHIP and USESHIP. These contractual agreements shall cover, amongst other issues, the provision of professional services by the obstetrician/ gynaecologist to contributors with reasonable care, skill and attention. Also included in the agreement are the obstetrician/gynecologist's hours of operation, and her/his provision of information to the NHIS as required.[12]

Service Provision by the Obstetrician-/Gynaecologist in the NHIS:

In the NHIS, the obstetrician/ gynaecologist is expected to provide specialist care at secondary and tertiary levels, in a public or private health care facility. Thus,

except in emergency cases, her/ his services can only Be accessed by referral, which should emanate from the primary health care provider from other specialists, or from the general outpatient department of the same health care facility. Referred cases must be sent back after completion of treatment to the referring physician with a medical report and instructions for follow-up management. Referrals are restricted to the nearest specialty facility registered with the NHIS.[13,14] The obstetrician/ gynaecologist may receive patients from the following categories: formal sector employees in the public and private sector, urban self-employed persons, permanently disabled persons and rural community dwellers.[11] However, the range of services offered will depend on the healthcare benefits to which the contributor is entitled.

Items covered by the NHIS in obstetrics and gynaecology at the secondary and tertiary levels include antepartum, intrapartum and postpartum care for high-risk pregnancies such as the first pregnancy, and for complicated cases such as multiple gestation. It is also expected that ectopic pregnancies, complicated pelvic inflammatory disease, and screening for and management of gynaecological malignancies, will also be handled at the secondary/tertiary levels. Other items covered at these levels include caesarean sections and other obstetric and gynaecological surgical procedures, with the exception of manual vacuum aspiration for incomplete abortion, which it is expected will be handled at the primary health care level. Insertion of implants for family planning, and surgical contraception will also be handled at the secondary/tertiary levels. Ideally, all such cases should be managed by obstetrician/ gynaecologists.[12]

Payment of the Obstetrician/ Gynaecologist in the NHIS

Obstetrician/gynaecologists participating in the formal sector social health insurance programme will be paid by the "fee-for-service" method. The fee-for-service method of provider payment is one in which the health care provider (HCP) is paid for each treatment act or product provided,[15] for example, the obstetrician/gynaecologist gets paid for a surgical procedure done. This payment is made after the service has been provided. The fee to be paid for such services as rendered by the obstetrician/gynaecologist is not arbitrary. The NHIS has produced "fee schedules" upon which payment of the fee-for-service HCP will be based.

The fee schedules in the NHIS have two functions. The first is to inform people about the acts and services that are covered by the NHIS, and the second is to inform people of the price of these acts and services.[15] It is expected that the NHIS fee schedules will be updated regularly after consultation with HCP. The obstetrician/gynaecologist is expected to send her/his bills to the HMO with whom the patient is registered, who will then pay her/him.

Obstetrician/ gynaecologists providing care for beneficiaries in any of the other NHIS programmes will be paid by the "capitation payment" mechanism. In this case, the HCP is paid a prearranged sum of money - the capitation fee in advance, to render services to beneficiaries of the NHIS over a certain period. This fee is paid whether the beneficiaries for whom it is paid use the services or not. It is based on the pooling of risk by the HCP as some insured persons will not use the services at all during the given period, while some will use services that cost more than the capitation fee.[15]

Conflict Resolution Involving the Obstetrician/ Gynaecologist in the NHIS.

Where a contributor is not satisfied with the services received from her HCP, she is expected first of all to complain to the HCP dealing directly with her care. If, however, she is not satisfied with the outcome of her complaint, she can make a formal complaint, in writing, to the HMO (or the administrator of the NHIS programme she is involved in), giving as much information as possible. If she is still dissatisfied, she now takes the complaint to the Arbitration Board. In serious cases, she may make her complaints directly to the Arbitration Board. State Health Insurance Arbitration Boards in each state of the federation and the Federal Capital Territory shall consider complaints by all aggrieved parties. Guidelines for the composition of these Arbitration Boards have been stipulated in the Decree establishing the NHIS.[1,11,16]

In conclusion, the obstetrician/gynaecologist has a vital role to play in the NHIS. Such involvement provides contributors to the NHIS with healthcare delivery by skilled specialists, while it provides the obstetrician/ gynaecologist with a regular source of income. Regular dialogue between all parties involved in this multilateral relationship should be encouraged, to ensure that they remain satisfied with their participation in the programme. Hopefully, universal implementation of the NHIS with full involvement of obstetrician/gynaecologists, will result in a steady and sustained drop in the dismal maternal mortality and morbidity indices in Nigeria, which have so far, to a large extent, defied intervention. It should also improve access to qualitative reproductive health services to all Nigerian women.

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