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Growth of health maintenance organisations in Nigeria and the potential for a role in promoting universal coverage efforts

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ABSTRACT

There has been growing interest in the potential for private health insurance (PHI) and private organisations to contribute to universal health coverage (UHC). Yet evidence from low and middle income countries remains very thin. This paper examines the evolution of health maintenance organisations (HMOs) in Nigeria, the nature of the PHI plans and social health insurance (SHI) programmes and their performance, and the implications of their business practices for providing PHI and UHC-related SHI programmes. An embedded case study design was used with multiple subunits of analysis (individual HMOs and the HMO industry) and mixed (qualitative and quantitative) methods, and the study was guided by the structure-conduct-performance paradigm that has its roots in the neo-classical theory of the firm. Quantitative data collection and 35 in-depth interviews were carried out between October 2012 to July 2013. Although HMOs first emerged in Nigeria to supply PHI, their expansion was driven by their role as purchasers in the government's national health insurance scheme that finances SHI programmes, and facilitated by a weak accreditation system. HMOs' characteristics distinguish the market they operate in as monopolistically competitive, and HMOs as multiproduct firms operating multiple risk pools through parallel administrative systems. The considerable product differentiation and consequent risk selection by private insurers promote inefficiencies. Where HMOs and similar private organisations play roles in health financing systems, effective regulatory institutions and mandates must be established to guide their behaviours towards attainment of public health goals and to identify and control undesirable business practices. Lessons are drawn for policy makers and programme implementers especially in those low and middle-income countries considering the use of private organisations in their health financing systems.

1. Introduction

Low and middle income countries (LMIC) setting a goal of universal health coverage (UHC) should have effective health financing strategies and organisations (WHO, 2010). Unfortunately, the public organisations which are critical to UHC are weak in many LMICs (including Nigeria), prompting an interest in private organisations (WHO, 2011). In many LMICs, private organisations provide private health insurance (PHI), especially to formal private sector employees (Bitran et al., 2008; Campbell et al., 2000; Drechsler and Jutting, 2007; Sekhri and Savedoff, 2005; Zigora, 1996). In some countries, they also support publicly-funded health financing programmes (Devadasan et al., 2013; IFC, 2007).

One way in which private firms provide PHI is by integrating the financing and provision functions through a set of affiliated and/or owned health providers, in order to enhance efficiency and effectiveness. Such systems, referred to as "managed care" systems or health plans, include Health Maintenance Organisations (HMOs), Preferred Provider Organizations (PPOs) and Point-of-Service Plans (MedlinePlus, 2010).

HMOs emerged in Nigeria in 1996 to provide PHI primarily to formal private sector employees, like their counterparts in the USA (Awosika, 2007; Onoka et al., 2014). Currently, these HMOs provide PHI, but the coverage is still quite limited (0.48 million people, 0.3% of the population) (Awosika, 2012). They also act as purchaser for the Social Health Insurance (SHI) programmes of the National

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Health Insurance Scheme (NHIS), including the Formal Sector SHI Program (FSSHIP) for public sector employees, and the Tertiary Institutions' SHI Program (TISHIP) for higher education students, which represent publicly-financed vehicles for expanding coverage in Nigeria. About 5 million Nigerians (3% of the population, mainly federal government employees and their dependants) are reportedly covered under the FSSHIP (Dutta and Hongoro, 2013; JLN, 2013), though the figure may be as low as 2.35 million (Onoka et al., 2014). Although private firms are allowed to enrol with the FSSHIP, they have continued to opt for the PHI plans of the HMOs. Having influenced the enactment of legislation that makes their enrolment in the FSSHIP voluntary, these private employers have greater trust in HMOs to handle their funds (Onoka et al., 2014). TISHIP coverage is unknown. HMOs therefore have a central role in the plans for UHC in the country.

The aim of this paper is to understand the potential for HMOs to play a role in a national health financing system that seeks to progress to UHC, by reviewing the evolution of HMOs in Nigeria, the nature of their health plans and their performance. The paper then analyses from a public health perspective the implications of their business practices in providing PHI and UHC-related, publicly funded SHI programmes in Nigeria.

2. Conceptual framework

The analysis was guided by the structure-conduct-performance (SCP) paradigm that has its roots in the neoclassical theory of the firm (Bain, 1956; Mason, 1939), and which has been modified to indicate bidirectional relationships between the SCP elements (Scherer and Ross, 1990; Shepherd, 2004). As applied here, market structure considers the number of firms and their shares of the total products sold in the market (summarised as market concentration), how homogenous their products are, and the market entry conditions (Ferguson and Ferguson, 1994; Morris et al., 2007). The business conduct element includes the strategies adopted by HMOs in shaping their products and premiums. HMO performance was analysed in terms of profitability, functionality and efficiency (ILO, 2007). Functionality reflects the firm's ability to carry out the health insurance function and is assessed by member growth rates, premium collection rates and renewal rates. Administrative cost computed as a percentage of total expenditure and as a share of total revenue (Mathauer and Nicolle, 2011), and claims ratio (which indicates the ability to provide insurance with the funds generated) (ILO, 2007) serve as proxies for efficiency.

3. Methods

This exploratory study of the HMO industry in Nigeria used an embedded case study design with multiple subunits of analysis (Yin, 2009) and mixed (qualitative and quantitative) methods to achieve a comprehensive understanding (Creswell, 2009). Case study designs have previously been used to study healthcare and health insurance markets (Denton et al., 2007; Doonan and Tull, 2010; Harkreader and Imershein, 1999; Lee et al., 2001). At the primary level of analysis (industry), market structure elements were considered using quantitative data about HMOs' membership and qualitative information about entry conditions and accounts from interview respondents of HMOs' behaviours. The second level of analysis focussed on the reported business practices and performance of three HMOs (embedded sub-units of analysis) that were purposively selected following initial interactions with officials of the industry association, the Health and Managed Care Association of Nigeria (HMCAN), and policy makers. These HMOs had large membership, the needed quantitative data, and long-term experience. Information about their behaviours was gathered from self-reports and reports of the behaviour of other firms in the market. Financial information was obtained from interviews and from relevant documents, and is presented here in Naira and US$ at an average conversion rate of 1US$ = ₦157 over the period of data collection (October 2012 to July 2013). Table 1 shows the methods for data collection and analysis. Interviewees and HMOs gave informed consent and the study received ethics approval from the London School of Hygiene and Tropical Medicine (Ref: 6233), and the Federal Ministry of Health, Nigeria (NHREC/01/01/2007–26/09/2012).

4. Findings

4.1. Growth and structure of HMOs in Nigeria

The earliest HMO in Nigeria emerged in 1996 to supply PHI to private firms. Between 1996 and 1999, three more HMOs were established as interest in a proposed FSSHIP of the NHIS grew (Onoka et al., 2014). HMOs were required to register only with the Corporate Affairs Commission of Nigeria to operate as private entities. In 1999, a military decree that established the NHIS (NHIS, 2012) also recognised HMOs and legitimised the subsequent accreditation of 12 HMOs as operators of the FSSHIP in 2004 (Onoka et al., 2014). They were reportedly given this role because policy makers believed that as private organisations, HMOs would implement the SHI programme more efficiently and effectively than the existing weak public systems. To encourage their participation, a primary accreditation requirement of a share capital of 100million naira (US$ 0.64million) was waived. However, the waiver also allowed the accreditation of HMOs that *"had no* (private) *products to sell but were developed because the NHIS had some lives to distribute"* (Policy maker), and whose interest was to *"acquire public lives"* (Policy maker). Subsequently, more HMOs were registered at the discretion of the NHIS, which in 2009 suspended further registration because it considered many of the existing HMOs *"weak"* (NHIS official).

In 2011, the NHIS introduced more stringent accreditation requirements for HMOs. Existing and new HMOs were required to demonstrate a share capital of 400 million (US$ 2.5 million), 200 million (US$ 1.27 million) and 100 million naira (US$ 0.64 million) to be categorised as a national, regional or state HMO, respectively (NHIS, 2012). They also had to establish offices, staffed with personnel having a prescribed set of competencies, in their operational areas. At the end of the accreditation process in 2013, additional HMOs had been registered bringing the number to 76. Mergers or acquisitions were not reported. Five HMOs were licensed as sub-national HMOs, while others were considered national HMOs (NHIS, 2013). Most of the interviewees believed that the requirements *"made way for people* (such as politicians) *who have money and not necessarily the technical expertise,"* (HMO manager) and those with undesirable business practices (such as copying of proposals, health plans and premiums, and predatory pricing) to enter or remain in the industry. To HMOs, the focus on share capital suggested a lack of technical capacity in the NHIS to effectively regulate the industry. This position was further corroborated by NHIS officials:

> *A more appropriate requirement should have been to ask for reserves amounting to the level of incurred but not yet reported claims that are in tandem with the size of the business, to take care of catastrophes if they occur within your enrolment population based on the size of their enrolee base, and not just saying 400million.* (HMO manager)