The Role of Trust in the Pattern of Enrollment to a Social Health Insurance Scheme and Distribution of Healthcare Facilities in Ibadan, Southwest Nigeria

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Abstract. The National Health Insurance Scheme (NHIS) of Nigeria established in the year 2005 aims to minimize the inequity of access to quality healthcare services in Nigeria. As of the year 2017, enrollment in NHIS-accredited facilities in the southwest region of Nigeria was significantly clustered, with more than three-quarters of NHIS enrollees registered with only 10% of the available NHIS-accredited facilities in the six states of the region. This study explored the factors associated with the skewed distribution of enrollees across facilities and the influence of stakeholders. This is a descriptive, qualitative, case study design among stakeholders of the NHIS in Ibadan, Oyo State, Southwest, Nigeria. In-depth interviews were conducted between March and June, 2019, with all selected individual stakeholders as listed earlier. Data analysis was done using an inductive thematic approach. Across the board, there was a low level of trust in government and government policies among healthcare providers and enrollees. Few healthcare providers were willing to render services under the scheme at inception. The majority of the enrollees were compelled to register with the few available healthcare providers. Among the enrollees, a few personally chose healthcare facilities and providers that were perceived to render better quality services to receive care. Priority should be given to building trust among stakeholders in the NHIS as this would facilitate cooperation and better working relationship, and reposition the scheme for better performance.

INTRODUCTION

Nigeria health system performance is poor as evidenced by low average life expectancy at birth (54 years), high maternal mortality ratio (630/100,000 live births), high infant mortality rate (88/1,000 live births), and a high child mortality rate (143/1,000 live births). One of the measures taken to address this is a reform in the method with which healthcare is financed. The National Health Insurance Scheme of Nigeria (NHIS) was established close to two decades ago to enhance the equity of access to quality healthcare. The NHIS is a tripartite arrangement consisting of the following partners: the NHIS, the Health Maintenance Organizations (HMOs), and healthcare providers. The other group of stakeholders is the enrollees. While the NHIS is saddled with policy directives in the scheme, the HMOs (insurers) procure healthcare services for registered enrollees from accredited healthcare providers on behalf of the NHIS.^{1,2} However presently, national population coverage by the scheme is abysmally low; of the total population of 180 million people, only 4 million people (2.2%) and who are civil servants (formal sector) are covered. The percentage of the total population covered in the informal is sector 0.02% (80,000).² This pattern is similar in other parts of the country and, it is contrary to evidence from the literature that stipulates an average of 10 years to achieve 60–80% total population coverage,³ and a possibility of total population coverage in less than two decades as was the experience in some Latin American and southeast Asian countries.⁴ Similar encouraging results were reported in some African countries such as Rwanda^{5–7} and Ghana^{8,9} in recent times.

Different elements have been cited as facilitators and barriers to health system performance. These elements can be divided into two broad categories: the tangible and the intangible. Both tangible and intangible elements are directly associated with perceived quality of care, which in turn has been linked with the uptake of health interventions.^{10,11} While the tangible is the physical infrastructure such as health facility buildings, equipment, machines, and drugs as well as the human resources for health among others^{12,13} the intangible refers to the often-neglected level of trust engendered by the perceived quality of and satisfaction with care as well as the quality of relationship among stakeholders in the health system.^{12,14} Also, the poor state of the tangible element in any form is a recipe for low levels of trust and satisfaction in the health system among beneficiaries.^{15–19}

Largely, the degree to which a health system performs is a function of the relationship between the actors at different levels of the system—health policymakers, healthcare institutions in both the public and the private sectors, and healthcare consumers. On its own, the quality of the relationship between these actors is directly associated with the level of trust that exists among them. Trust, defined as the judgment of belief in conditions of uncertainty, matters to the performance and the “health” of the health system.¹⁶ Trust is also described as the expectation that the health system and its actors will act to protect the interest of individuals (actors),^{16,20,21} or at least not harm them especially the poorest and the least powerful.²¹ It is a requirement for the initiation, implementation, and sustenance of healthcare interventions^{22,23} as it ensures acceptance of (health interventions) and willingness to use available health services.^{21,24} Studies have shown that the flow of trust relationship between health are consumers and providers is not unidirectional;^{16,21,25} there is the emphasis of trust of providers of care in consumers as well, without which expected service cannot be rendered optimally.²⁰ A low level or lack of trust in insurers is associated with poor

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uptake of health insurance policies²⁵ and other beneficial health interventions, resulting in poor health outcomes and impoverishment.^{16,20} Mistrust has also been reported to negatively affect the relationship between enrollees and the insurer on one hand and between providers and insurers on the other hand.^{16,25,26} This is as illustrated in a previous study by Gilson in 2005.

In an earlier study conducted on the activities of the NHIS in Oyo State, southwest Nigeria, it was discovered that more than three-quarters of the enrollees under the scheme registered with, and patronized just about 10% of the available NHIS-accredited facilities in the state. The study further demonstrated that the pattern of distribution of enrollees across NHIS-accredited facilities was similar in the remaining five states of the southwest region of Nigeria.¹ It is not clear why enrollment in the scheme is generally low and why some facilities have significantly few enrollees. Unfortunately, the earlier study did not provide reasons for this observation nor did any others to the authors' knowledge. This study aims to explore the factors responsible for these observations. Findings will assist in the efforts to correct the anomalies and improve the performance of the scheme. It would also be useful in other settings planning to implement similar schemes as well as those with comparable challenges.

METHODS

Study design, study area, and participants' selection.

This was a descriptive case study design among stakeholders of NHIS in Ibadan, Oyo State, Southwest Nigeria. A list of all NHIS-accredited facilities in the 11 local government areas (LGAs) of the Ibadan metropolis was obtained from the NHIS Office (in Ibadan). One facility in each LGA was selected by simple random sampling to make a total of 11 facilities across the LGAs. For the selection of study participants, a list of NHIS enrollees waiting to receive care in the outpatient section of a selected health facility was obtained from the medical records department of the facility. Simple random sampling was used to select one individual participant. An enrollee who was selected for the study and who refused to participate was replaced using the same selection process. One NHIS-designated desk officer in each of these facilities was also selected. One representative of each of the HMOs that procure healthcare services for enrollees in each of the 11 selected facilities under the NHIS was selected. Where an HMO was found to procure health services for more than one health facility, that HMO was selected only once. One of the senior official in the Southwest zonal office of the NHIS was also selected and interviewed.

Conduct of the interview. In-depth interviews (IDIs) were conducted with all selected individual stakeholders as listed earlier. The participants were assured of the anonymity and confidentiality of the information provided by them. Recording of the interviews on audiotape was done with the consent of the interviewees. The backup of the audio interviews was done through note-taking by the assigned research assistants. Interviews were conducted at a venue and time suggested by the study participants. Majority of the participants were interviewed after consultation with physicians. Those who were interviewed before consultation had enough time to grant an interview before consultation. All the interviews took place in sections of the hospital that ensured privacy.

All participants were given souvenirs as an appreciation for their time. Recorded interviews were transcribed. Ethical approval was sought and obtained from the Research Ethics Committee of the University of Cape Town (UCT) and that of the Oyo State Ethical Research Board with approval numbers HREC REF: 536/2018 and AD 13/479/596, respectively. These approvals were obtained in line with the guidance as provided in the Declaration of Helsinki at the 64th World Medical Association General Assembly in Brazil in 2013.²⁷ Written informed consent was also obtained from individual participants.

Data analysis. Data analysis was done using an inductive thematic approach.²⁸ Audiotaped interviews were transcribed, data analysts got familiarized with the data by reading through it many times during which initial codes were generated. Themes were thereafter searched for and generated from the codes.²⁹ The generated themes were reviewed first at the level of the coded data, then with the entire dataset. Key themes were identified, while coding of a few transcripts was done by two people (the lead researcher and his research supervisor), independently to develop a thematic framework. A consensus was reached about coding decisions and themes generated. Where there were disagreements between the two analysts, a consensus was reached amicably. Emerging themes were documented and analyzed accordingly. Output and reports were generated for specific codes, themes, and subthemes. Themes and narratives were interpreted within the context of the study. Themes were thereafter defined and named, after which the report was written.

RESULTS

Low level of trust in government policies. A low level of trust in government and government policies had a major influence on the acceptance of the NHIS, among two of the three categories of stakeholders: providers and enrollees. Although there was no report of the HMOs having reluctance in accepting the scheme, healthcare providers and potential enrollees were very skeptical about the government's sincerity about the scheme. The skepticism was not unconnected with the government's failure in the implementation of previous programs. According to interviewees, previous similar programs including those outside of the health sector, for example, Mass Mobilization for Self-Reliance, Social Justice, and Economic Recovery (MAMSER), Directorate of Foods, Roads and Rural Infrastructure (DFRRI) all failed³⁰ and in recent times, the National Housing Fund (NHF),³¹ seemed to have failed. The disappointment following those experiences contributed to the difficulties that the NHIS faced in marketing the scheme to the public and some of the partners especially private healthcare providers. The majority of the private providers declined to participate in the scheme. The expressed concern by providers was the ability of the government to keep its promises on payment for the services rendered to enrollees and the scheme's sustainability. Several of the respondents cited the NHF, especially whereby workers were taxed periodically toward a housing project, which, according to reports, never materialized. Thus, when the NHIS invited providers to the scheme, the majority did not accept the offer.

" but let me pick just one, National Housing Fund that employees contributions have been consistently deducted from their salaries, people

were not benefitting, how many civil servants have benefitted from federal mortgage bank?, but they are not happy, you know (it) runs for a while and collapsed, so people were thinking maybe that is how it (NHIS) would start too and fizzle out.” (NHIS 2, Male, 56 years)

To worsen the situation, the scheme was noted for shifting the startup time, which made several of the providers lose enthusiasm about it. Eventually, when it did, many of the providers either did not believe it would be launched at the time it did or did not believe it would be a sustainable scheme. Thus, only a few of the private providers were available at inception to partner with the government. However, it was also mentioned that a few took the risk to buy into it (the scheme). It should be noted here that government hospitals were instructed to provide service for enrollees on the scheme. It is instructive to note that government hospitals did not have an option to opt out.

“ it was since the early 80’s when NHIS was mentioned the first time, . . . and we were invited to come and register but they forgot about it again, and by the time they invited people to come and register again, I didn’t believe it and I did not even go there, but some did and were registered that time, . . . and those first set of hospitals shared the enrollees among themselves.” (Hospital NHIS Desk Officer 1, Male, 41 years)

The low level of trust in government policies, and the availability of few healthcare providers collaborating with the government on the scheme, contributed to the pattern of distribution of enrollees across available healthcare facilities. An HMO representative reiterated what hospital personnel (Hospital NHIS Desk Officer) earlier mentioned. According to her, enrollees were literally assigned to a few health facilities that were available for the scheme at inception. As she explained, private healthcare providers especially did not believe it, and that the public facilities who started the scheme did because they did not have any option other than to comply with the government directive.

“But the truth is that when the scheme came on board, some people never believed in it, a lot of providers never believed it could work, . . . so the ones that believed it could work were the ones those enrollees were shared to these were mainly government hospitals and some private providers who just took the risk ” (HMO 1, Female, 40 years)

It was not only the providers who expressed reservations in the scheme; potential beneficiaries also did, citing a low level of trust. A senior NHIS official in the southwest zonal office in Ibadan talked about the nonchalant attitude of potential beneficiaries, and that it took an executive order from the president of the nation to compel them to enroll in the scheme. In the effort to explain the likely reason for the poor disposition of the people to the scheme, he cited the example of a program in the government housing sector that failed. Thus, the government had to compel the people to enroll, which resulted in the arbitrary distribution of enrollees across the few facilities that were available at the inception of the program. Spurred by the above-expected level of performance, providers who had

earlier rejected the scheme and who were in the majority than the early collaborators indicated interest. Scrambling for the few potential enrollees led to a spread (of these few enrollees) over a larger number of new facilities. Comparing the volume of enrollees across the two groups, early collaborators to whom the majority of the enrollees were assigned and the later ones who had to struggle for the few leftover enrollees, the distribution becomes skewed/lopsided. A senior NHIS official painted the picture as:

“ , Yayale Ahmed who was the Secretary to the federal government had to write letters to the ministries on one of the occasions and say if you are not registered, your salary will be withheld.” (NHIS 3, Male, 55 years)

Quality of health facility services as a factor of influence in the skewed distribution of enrollees and facilities. Some of the stakeholders expressed an alternative opinion as to why there was a skewed/lopsided distribution of enrollees across healthcare facilities exist. One of the NHIS officials interviewed believed it was the quality of service delivery in the facilities that were responsible for the observed pattern. He opined that individuals would always want to patronize healthcare facilities they perceived as having good quality healthcare. Unlike what was expressed by previous respondents, he judged potential enrollees actively searched for healthcare facilities they believed would meet their healthcare needs in terms of health personnel, medical equipment, and service delivery.

“ because a lot of these enrollees too, they have done their groundwork or research to find out which hospitals are good, which hospitals have the capacity in terms of workforce and terms of equipment because what makes a hospital is not just the building, it is also in terms of the amenities available and also the human capital, so they have done their research, so that is why you see a lot of people streaming towards a lot of these hospitals that are perceived to have the capacity and they neglect those that don’t have capacities” (NHIS 1, Male, 43 years)

The earlier statement corroborated the interview with some of the enrollees where they claimed that distance does not matter as much as the quality of healthcare and that they had come to receive care in the facility where they did purposely because of the quality of care in these facilities

“From the beginning, we did not consider the distance. For a person like me, am looking at a facility or hospital that will be able to cater through the NHIS for my needs . . .” (Enrollee 4, Male, 57 years)

In another interview, an enrollee stated a similar reason that resonates the importance of quality healthcare and how distance takes the back seat when it comes to choosing a healthcare facility for care.

“you see, distance is nothing compared to the treatment that I am getting here, . . . because I am the type that likes seeing the doctor whenever I want, I don’t just like doing self-medication, and coming here they don’t they don’t usually waste my time here, unlike other hospitals . . . we have so many

hospitals that they waste your time, and at the end of the day you will not be able to see any doctor, so I like here . . .” (Enrollee 7, Female, 39 years)

DISCUSSION

It is noteworthy that the health sector is not a standalone system, but exists and interacts with other sectors within a common contextual environment. Consequently, the experience of policies in different sectors in the contextual environment positively or otherwise affects each other.

Inconsistencies in policy implementation in the health system in previous times, failure of continuity of policies even in other sectors outside of the health system among others could discourage the public and other stakeholders, and give them enough reasons to doubt the sincerity of the government in subsequent social policies including in the health sector. For example, a private healthcare provider stated that the social health insurance under the NHIS failed to commence at the given time, with subsequent postponements.

Outside of the health sector, cases of failed government programs were also common in Nigeria. One example that kept coming up during the interviews was a scheme that was established to cater to the housing need of the masses, the NHF. However, the promised deliverables under it (NHF) failed despite many years of financial contribution through deductions from workers' salaries by the government. There was also an allegation that subscribers were not refunded. This unsatisfactory experience in the NHF was a contributory factor to the opposition faced by the government getting the buy-in of the labor union leaders at the inception of the health insurance scheme.² In Nigeria, this unpleasant experience was not limited to the housing sector alone. Previous other interventions in the agriculture and public works sectors such as the MAMSER and DFRRI also failed.^{2,30,31} These events resulted in the loss of trust in government policies and poor enrollment in the scheme.

However, civil servants were compelled to enroll in the few healthcare providers who agreed to collaborate with the scheme at inception. It is noteworthy to note that majority of these facilities were government-owned facilities that did not have a choice to opt out. A few of the facilities that collaborated at the inception of the scheme were privately owned.

The reluctance to join the scheme was not limited to healthcare providers. Enrollees too showed a high degree of reluctance to join the scheme. At the inception of the scheme, especially, the majority of these enrollees were literally assigned to the few available healthcare providers. Enrollment in the scheme was made compulsory by the federal government for employees in federal (national) government ministries, departments, and agencies. The directive also threatened that noncompliant workers risked forfeiting monthly wages.

Quality of services in a facility, distance, and other geospatial attributes associated with the relationship between health facilities and the location of consumers are some of the commonly cited factors ascribed to the choice and distribution of healthcare facilities.^{11,32–34} However, contrary to these commonly cited factors, trust, as an intangible element, is hardly considered as a factor that can influence the choice and distribution of healthcare facilities and that of healthcare

consumers that patronize such facilities and the overall performance of the health system.^{14,16,25}

Trust has been referred to as a relational concept, and that it is the “backbone” that sustains working relationships in organizations, institutions, and systems, including the health (system).²¹ An unpleasant or unsatisfactory, previous relationship experience with or within a system especially with some level of breach of trust could result in noncooperation in subsequent projects, for example, the Tuskegee Syphilis Study that was adjudged to deliberately affect American blacks negatively.^{20,35} Related examples were allegations of the deliberate injection of children with HIV by volunteer healthcare workers in a hospital in Libya in the 1980s.³⁶ Likewise, the violence that followed Ebola control in the Democratic Republic of the Congo in the recent past, accentuated by underlying distrust in the political system, was misconstrued as a ploy to inject people with deadly substances.³⁷ In Nigeria, the effect of an improperly implemented health intervention in the northern part of the country resulted in fatalities among study participants and subsequently led to a later rejection of polio immunization the especially in the northern part of Nigeria as a result of a loss of confidence in government to protect them from harm.^{38,39}

Another factor that has played a role in the pattern of distribution of healthcare facilities and enrollees in the study area is the perceived quality of services rendered in them. Quality of healthcare, and the distance between the residence of healthcare consumers and the healthcare facility, on the other hand, are two of the most important factors that influenced the choice of provider. Although, studies differ on which of the two factors, quality of care and distance, that takes higher precedence. A study by Qian and others in China,⁴⁰ rated proximity to residence as the more important determinant of choice of healthcare facilities, however, Yao and Agadjanian (2018) in Mozambique posited service quality to be consistently critical to the choice of healthcare facility than the distance of health facility to.¹¹ Other studies believed that distance and quality of care take preeminence differently in different individuals at different times and in different health conditions.^{41,42} When the illness is perceived to be severe, quality of care takes preeminent status while the effect of distance pales.^{43,44} However, when a health condition is deemed less serious, the reverse could be the case.^{11,41,45} Overall, quality of care as a factor takes preeminence in the choice of facility patronized by individuals.^{11,33,34,43,46} Studies have shown that facilities with highly qualified personnel, drugs, and equipment are less likely to be bypassed.⁴¹ This is also supported by other studies in recent times.^{17,42,47} Healthcare facilities could receive poor patronage or outrightly abandoned as a result of perceived poor quality of service.^{15,48} This invariably affected pattern of distribution of healthcare consumers across facilities.

Loss of trust in the scheme, reluctance of, and the subsequent forced distribution of enrollees, who were mainly civil servants, across the few health facilities that were available at inception was mainly responsible for the lopsided distribution (of enrollees and healthcare facilities). In addition to the effect of loss of trust and its overall impact on the distribution of enrollees and that of healthcare facilities, choice of healthcare facilities as a result of perceived quality of care has contributed in some way, albeit very little as those who had the opportunity to choose were from the informal sector, which

constitutes a minute fraction (0.02%) of total population coverage. This study considers the issue of quality as a factor of influence in the choice of facilities, as a trust issue on its own, as healthcare consumers only patronize facilities that are perceived as trustworthy enough to deliver quality service.

One of the approaches to win the trust of the public and get them to accept health interventions is through the implementation of policies that are perceived as beneficial.⁴⁹ It is advocated that such should be done with the active involvement of the beneficial communities as equal partners throughout the life cycle of such interventions to ensure sustainability.⁵⁰ Examples of interventions that have increased the trust of the people in government abound in many countries in Africa. For example, a maternal and child health program in Nigeria,⁵¹ distribution of insecticide-treated bed net in Tanzania,⁵² and provision of potable water that reduced diarrheal diseases in Latin America Mexico⁵³ have all been acknowledged to increase the trust of the public in political leaders and social policies implemented by governments. In Rwanda, a series of policies in different sectors including the health system has facilitated a reduction in inequity of access to beneficial social interventions and, these have been adjudged to have contributed in no small measure to the healing process after the 1994 nation-wide crisis in that country.⁵⁴ In England, the implementation of the National Health Service after World War II (WWII) played a tremendous role in correcting the poor public perception of the government following a failed promise at the end of WWI.⁵⁵

In conclusion, though both the intangible software factor of trust, and the hardware factor of quality of healthcare played roles in the observed distribution of healthcare facilities and the enrollees across the study area. However, in this study, we want to posit that the overall determinant of the pattern of distribution of enrollees across accredited health facilities is trust. This is more so as the perceived quality of care as a determinant of choice in itself is about trust in the services of certain health facilities.

There is a need to build trust and sustain it among major stakeholders, and between them and the beneficiary communities. For the stakeholders, one of the important steps should be directed toward building a platform for better interaction for strong relationships and a resilient system. This will enhance better management of the scheme and improved performance. The system needs to gain and sustain the trust of the public through a more responsive healthcare service delivery. This is likely to strengthen the trust of the public in the system^{52–55} and a likely increase in enrollment in the scheme.

This is a qualitative study; therefore, generalizing the findings to other parts of the country should be done with commensurate caution. Similar studies incorporating other zones of the country are necessary for better generalization of the study findings. In addition, more studies should be conducted among the uninsured in the efforts to improve population coverage of the scheme.

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