

Evaluating the Perception of the National Health Insurance Enrollees' on the Function of Health Maintenance Organizations in the Implementation of the Scheme

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Abstract

The study discussed different types of National Health Insurance Services in different countries of the world, the benefits and possible setbacks of Health Maintenance Organization's participation in the National Health Insurance Scheme, the impact of these NHS models of health care on users of the services, and the perceptions of enrollees on HMOs functions in the NHIS. The study made use of a quantitative method to collect data from the respondents. It employed a two-phase sampling design and stratified random sampling techniques in selecting respondents. It also captured data from a cross-sectional survey. Five HMOs were randomly selected from the twenty-five HMOs covering NHIS lives. Also, responses were obtained from a total of three hundred and eighty-four respondents working with eighteen public sector organizations in FCT, Abuja. The findings of this research showed that although the functions of HMOs in the scheme were not fully known to users of the scheme, users believed HMOs were working to ensure a successful implementation of the scheme and indicated that they were satisfied with the entire scheme, this, implying that HMOs were doing their jobs.

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Background to the Study

National health insurance is a structure of health insurance that insures a population against the cost of health care (WIKIPEDIA, 2020). Evaluating the health system of a country from the perspectives of people who use the system is important. The numerous expressions of the enrollees on their perceptions of the National Health Insurance Scheme and the functions of Health Maintenance Organizations in the scheme would aid the assessment of such a scheme. Health systems throughout the world have taken different designs and dimensions to ensure the efficiency of service to citizens. However, to promote service efficiency, many health care reforms have taken place in these countries. Healthcare reform is the process of improving the performance of existing systems of assuming efficient and equitable responses to future changes. It has also been defined as a sustainable, purposeful change aimed at improving the health sector (Omoruan, Bamidele, and Phillip, 2009). Great reforms hardly occur without [nations] paying off powerful interest (Mechanic and McAlpine, 2013) to achieve the desired health outcomes. Health reforms in countries like France, Canada, and Britain have brought about the establishment of national health systems (a form of Social Health Insurance) in these countries that are of global examples.

However, these health systems operate in different modalities. In countries where the health care reform has led to the establishment of a national health system, there has been the problem with how to establish the links between cost and service utilization and improved patient outcomes (Rodwin, 1989). Although virtually every Western country has a universal healthcare system in place, the debate on universal healthcare system has been on the cost efficiency (i.e. how to contain costs) and the concerns of quality of care (Brezekinski, 2009). In America for instance, there is a widely shared belief among policy-makers that a national program providing for universal entitlement to health care for citizens, would result in huge costs. But in response to this ,it is evident that nations that spend less than America have done better for their citizens by providing a National Health Service designed to facilitate a high level of medical care. For example, the National Health Service in Canada has been praised the most, alongside that of France, and Britain. The National Health Service in Britain particularly, although typically considered a "painful prescription" for the United States, assures all citizens full coverage for basic health services and yet spends less on health care (Rodwin, 1989). The creation of the NHS in Britain has enabled millions of people to gain access to care previously denied because of cost. However, those who could afford private outpatient consultations were more advantaged (Faden, et. al, 2009).

All of these countries have produced many leading physicians and hospitals in the world. However, there are several problems experienced in these systems (Rodwin, 1989). Central to achieving increased coverage and access, high quality, and cost control in health service delivery under the NHS, is a change in reimbursement arrangements, increase in accountability for cost and outcomes, and the criteria for rationing services based on the evidence and acceptance by all stakeholders as legitimate. The contributions sociologists' have made to these reform efforts is documenting the extent of problems and

confronting central questions around issues of accountability, reimbursement, and rationing, to help achieve meaningful reform that controls costs, expands access, and improves quality (Mechanic and McAlpine, 2013). Sociology brings to the policy board the analysis of how past structural or organizational forces influence life and how people or organizations construct their reality (i.e. how institutional or organizational forces shape how people perceive their reality and the options from which they make choices). Sociology thus provides the platform, substance and analytic tools for policymakers and citizens to understand the world they live (Light, 2004). Finding out the perceptions of enrollees on the functions of HMOs in the NHIS is very important for future health reforms.

Models of National Health Services in France, Canada, Britain and Nigeria

The analysis of scholars like Rodwin (1989), Brzezinski (2009), and Enthoven (1985), on how countries like France, Canada and Britain operate their NHS, all suggests that the introduction of HMOs in a country's NHS would to a large extent, promote service efficiency and maximum use of funds in the system. However, Emmanuel (2017), revealed that the case may not be so in all situations. The responses obtained from a study on 'partnership between NHIS and HMOs' indicated that in some cases, the introduction of HMOs in the NHIS of a country may result in an additional cost burden in running the scheme. And this may not be good or necessary for the scheme. Nevertheless, if HMOs are involved in the system, the primary concern would be how to regulate the activities of the HMOs (Dent, 1995). The introduction of HMO in NHS spurs policymakers to establish policies that would facilitate a combination of regulatory controls with competition on the supply of health services. The NHS system in France, Canada, and Britain unintentionally encourage citizens to demand more for health services which may result in failure in the systems (Rodwin 1989).

The National Health Insurance in France

In France, the health system combines universal coverage with a public-private mix of hospital and ambulatory care, but carries a higher volume of service provision to citizens. In the system, consumer's health status and satisfaction are given priority and is high. Patients are allowed a wide choice of providers and this does not significantly impact the cost of running the NHI. By implication, the national expenditures on running the NHI is far lower than expected (Rodwin, 2003). The NHI operates with fee-for-service in the ambulatory care on a private practice basis and a public-private mix of hospital care. Two-thirds of all acute beds are in the public sector, while one-third in the private sector. Physicians in the ambulatory sector and private hospitals (known as *cliniques*) are repaid based on a negotiated fee plan. Physicians in public hospitals, in teaching, and research institutions, are repaid on a part-time or full-time salaried basis. About 15 percent of all physicians are allowed to set their fees. In this system however, communication between full-time salaried physicians in public hospitals and solo practice physicians working in the community are inadequate. There are no formal institutional relationships which assure continuity of medical care, disease prevention and health promotion services and referral patterns between primary, secondary, and tertiary level services even though

general practitioners in the fee-for-service sector have informal referral networks to specialists and public hospitals. The problem with this system is that it focuses only on the demand side and does nothing to promote supply-side efficiency. In response to these challenges, a proposal was developed to introduce a system of HMOs under French NHI. The concept of an HMO was translated as a *reseau de soins coordonnés* (RSC) (a network of coordinated medical services). The RSC proposal is a strategy to promote supply-side efficiency within an already existing NHI system (Rodwin 1989). If beneficiaries choose to enroll in an RSC, they would lose their coverage under traditional NHI. If all RSCs would have to accept all French NHI beneficiaries who choose to enroll, which could be 99 percent of the population, the problem of adverse selection would be reduced. Thus, RSC assumes a contractual responsibility for providing the enrolled population with all health services covered in French NHI. The patient then chooses a primary care physician who is in charge of making proper referrals and managing patient prepayment on a capitation basis. The RSC does not receive any prepaid capitated monthly fee directly in front of the beneficiary's NHI fund. The annual budget for RSC is equal to the annual capitation payment multiplied by the number of its enrollees. Within this, managers have an incentive to minimize costs and maximize patient satisfaction in order to avoid disenrollment. Capitated fee is financed directly by the beneficiary's NHI fund while consumers pay at least 15 percent of all health expenditures through co-payments (Rodwin 1989). In summary, there are public hospitals, non-profit independent hospitals linked to the public system, and private for-profit hospitals all working together to administer care to enrollees. France operates a universal health care system that has been assessed by the World Health Organization as the best in 2000. The government funded agencies pays 77 percent of health expenditure and provides care for 70 percent of its population (Wikipedia the Free Encyclopedia, 2020).

Canada's National Health Insurance

Canada has a national health insurance also known as Medicare (Ridic, et. al, 2012). In Canada, the government finances health insurance. The reimbursements for health services are done by the government to health care providers with the ministry of health in each province, saddled with the task to control the cost of medical care (Ridic et. al, 2012). The government pays for 70 percent of all spending on health care (Aaron, 2017). Under Canadian NHI, coverage for drugs is far less than in France. There are no co-payments; there is first-dollar coverage for hospital and medical services. Physicians in ambulatory care are paid mainly on a fee-for-service based on a fee schedule already negotiated between physicians' associations and provincial governments. It allows for a few private for-profit hospital participations similar to French clinics. The system promotes the overuse of an oversupply of health services due majorly to patients' perceptions of the first-dollar coverage as tax free benefits. There is no incentive to choose cost-effective forms of care. For instance, when there is a need for urgent care, patients do not have incentives to use community health centers rather than rushing to the emergency room. Also, physicians lack incentives to make efficient use of hospitals (Rodwin, 1989). In the Canadian health system, the problems of proper coordination of financial activities arises. That is, "financing without organization". In order to maintain

good relationship with providers, Canadian provinces adopted a 'pay the bills' philosophy, in which decisions on health service provision became the legitimate domain of physicians and hospital administrators. There has been no effort to devise new forms of medical-care practice, e.g. HMOs or new institutions to handle certain challenges in the system. Rather, the system has only ended up supporting the traditional organizational structures (Rodwin, 1989).

Britain's National Health Services

In Britain, the government finances health insurance spending up to 80 percent of all spending in health care (Aaron, 2017). The British healthcare system is known as the National Health Service or NHS. The system is arranged in a pyramid-like structure consisting of primary care at its base. Only patients enrolled with a GP can have access to the NHS services. Ambulatory care and referrals are overseen by general practitioners (GPs) who also serve as gatekeepers for access to the rest of the system. And all patients must have a referral from their GPs in order to see a specialist. Doctors are paid through capitation or a set amount of funding per patient while specialists are paid through a negotiated contract (Brzezinski, 2009). Britain's National Health Service is financed through taxation usually accountable to the Department of Health and Social Security (DHSS) and Parliament. Access to health services is free to all Citizens in the country and legal residents. But there are problems of equity and efficiency of resource allocation in the health sector. However, to solve the problems of equity, the Resource Allocation Working Party (RAWP) formula was developed in 1976 for the allocation of NHS funds between regions. The problem of efficiency remained (Rodwin, 1989; Brzezinski, 2009). Enthoven and Maynard tried to develop ideas to promote "internal markets" and HMOs within the existing health system. They also proposed variations of all HMO Plan for the NHS, a form of "market socialism" (Rodwin, 1989) a .The idea about introducing HMOs and elements of market competition into national health systems with universal entitlement looks promising. Whether it is the French RSCs, or the Canadian proposal for publicly financed competition, or the ideas about internal markets and HMOs in Britain, all of these focuses on combining the supply-side efficiency in a well-managed HMO-NHIS arrangements with the financial security of the system. The extent, to which this model can work in practice, would go a long way to provide more realistic models for many countries (Rodwin, 1989).

Americas Medicare and Medicaid

America does not have a universal health care system for all her citizens (Enthoven, 1985). And many employers in America do not offer health insurance because they see it as expensive (Light, 2004). In 1965, the American government began financing Medicare (a health insurance for the elderly) and Medicaid (a health insurance for the poor) programs via taxes. Medicare is a system comprising different parts. Part A covers hospital services, Part B covers physician services, Part C or "Medigap" covers some who fall into a gap of non-coverage. Part D contains a prescription drug plan was later introduced into the system. Medicaid, although a federal programme, is operated by individual states. Providers receive payment or reimbursement for services rendered in several different

ways. Fee-for-service (payment per hospital visit), can apply to both physicians and hospitals. Hospitals may be reimbursed on a per diem basis, paying for all services delivered in one day. Reimbursement by episode of illness is one sum for all services rendered during illness. Capitation is payment made for each patient's treatment within a month or a year. Salaries for providers and global budget reimbursement for hospitals are the available payment options. Physicians and hospitals were traditionally paid on a fee-for-service basis before the advent of managed care such as Utilization Review, Preferred Provider Organizations (PPO), and Health Maintenance Organizations (HMO) (Brzezinski, 2009). Managed care organizations currently dominate healthcare delivery within the United States (Anarado, 2002). Managed care also includes PPOs Organizations in which insurers contact with a limited number of physicians and hospitals who agree to care for patients, usually on a discounted fee-for-service basis with utilization review. HMOs require their patients (except in emergencies) to receive care from providers, physicians and hospitals, within the organization. Medicaid and Medicare payments and insurance plans are quite confusing. Choosing an insurance plan becomes extremely complex. Since patients can enter the system by seeing a secondary and tertiary specialist without the referral from a primary care physician PCP, such patients will never be educated on preventive measures for chronic diseases and will always utilize reactionary medicine (Brzezinski, 2009; Hofer, et. al, 2011). The structuring of a country's healthcare system can have extraordinary effects on the quality of services experienced by patients (Brzezinski, 2009). In America, HMOs have been targets of many lawsuits and sources of much complaint. HMOs are blamed for restricting patient choice of healthcare providers and interfering with patient-doctor relationships thereby producing some negative changes in the American healthcare sector (Anarado, 2002).

Nigeria's National Health Insurance Scheme

Nigeria's National Health Insurance Scheme provides for a complex mechanism to curb the cost of healthcare for citizens of the country while improving the accessibility and quality of health services. The scheme is structured in a way that creates a participant triangle consisting of the insured persons, health maintenance organizations, and healthcare providers- all of whose actions are government regulated. As private and public HMOs play the role of "middlemen" between healthcare providers and insured participants, the government on their part, executes regulatory function (Anarado, 2002). The NHIS was established in 1999 as part of government effort to address the problems facing the health sector (Omoruan, et. al, 2009). The Nigerian National Health Insurance Scheme is a single or national health insurance scheme with different categories (i.e. the formal, informal and the exemption) groups. It utilizes the services of health maintenance organizations (HMOs) as health managers, for collecting revenues and distributing health services (Omoruan, et. al, 2009). Under the NHIS, participants are expected to register with a Health Maintenance Organization (HMO), pay a premium to the same (Olanrewaju, 2011), select the hospital of their choice and payment for health services is done by NHIS through the HMOs to healthcare providers (Leo and Okafor, 2012). Enrollees of the scheme are entitled to obtain health benefits from any health provider of their choice (irrespective of the location), upon the provision of an adequate

identification. All resources collected by the HMOs are pooled together to the NHIS, who regulates activities of the HMOs and disburses compensation to health providers through the HMOs (Omoruan, et. al, 2009). For the Public (federal) sector participation, the employer pays 3.25 percent while the employee pays 1.75 percent, representing 5 percent of the employee's consolidated salary. While for private sector participation, the employer pays 10 percent while the employee pays 5 percent, representing 15 percent of the basic salary (Olanrewaju, 2011; NHIS Operational Guidelines, 2005). However, the employer may decide to pay the entire contribution. The employer may also undertake extra contributions for additional benefits of the package. Entry into the program is via the primary healthcare facility. The services under the primary care are usually paid for by the NHIS in capitation form. While services under the secondary and tertiary care are paid for through fee- for- services. Treatment is administered as recommended by the guidelines and cases that require specialized attention are referred from the primary to secondary and tertiary levels following the laid down guidelines. However, with HMO approval, offering specialized care due to referral is made possible. But the HMO involved must be notified within 48 hours except an emergency situation (NHIS Operational Guidelines, 2012). Approval takes the form of an authorization code.

Not all types of care are provided for in the benefit package. While many ailments are treated in the guidelines, some others are totally excluded. (NHIS Operational Guidelines, 2012). The NHIS pays in ahead, through the HMOs (Leo and Okafor, 2012), pays fees called 'capitation' to registered healthcare providers for services rendered to the insured (Anarado, 2002), and fees called 'fee-for-service' to health providers for secondary and tertiary care (Leo and Okafor, 2012). All fees in the scheme has been agreed upon and fixed by the NHIS. The NHIS gives 'capitation' and 'fee-for-services' to the HMOs who in turn pay the healthcare providers (HCP) both for health services provided. The HMOs are paid a fixed amount per head for administrative charges on all enrollees. With this, the system is made to check unnecessary demand for health services by the users and excessive supply of health services from health providers. The Scheme is designed to allow HMOs monitor the activities of facilities providing health services for participants, while the NHIS check the activities of the HMOs so that fraud and malpractices are minimized. Before payments for health services are done by the HMOs, they scrutinize every bill that comes to them from the HCPs to make sure all unnecessary interventions are removed from the bill, and pay for genuine treatments or bills only (Leo and Okafor, 2012).

The Nigeria's' NHIS is designed to prevent private HMOs from setting their own price for NHIS enrollees. Where the HMOs cannot keep to agreed procedures, are allowed to opt-out of the scheme or remain in the scheme and comply. In some cases, an HMO may be tempted to opt-out of the Scheme or choose cost saving measures. However, if they opt-out, they are left with clients not registered with the NHIS. Despite the difference in healthcare laws between the Nigeria and the United States, the chances of Nigerian HMOs employing American-like, cost-cutting measures may likely result introducing similar dissatisfaction within Nigeria's health sector. And the dissatisfaction would

emanate from the insured participants and the healthcare providers (Anarado, 2002). Nigeria's NHIS have been accused of being too restrictive to produce national change (Anarado, 2002), and might face the challenge of poor implementation (Omoruan, et. al, 2009). However, finding out enrollees perceptions on the functions of HMOs in the NHIS is paramount to a proper evaluation of the possibility of the scheme achieving its set goals.

Research Methodology

The quantitative method was used in this study to assess the knowledge of beneficiaries about the relationship between the NHIS and the HMOs, and the roles HMOs play in the implementation of the NHIS. The method followed a cross sectional survey design and questionnaires for the survey were administered to NHIS beneficiaries registered with selected and accredited HMOs in the FCT.

Population of the Study

The study population comprised: (1) All NHIS enrollees in the FCT under the public sector; and (2) All HMOs managing NHIS lives in the FCT as at 2011. The NHIS lives in the FCT were 244, 992 while the HMOs covering these lives on behalf of the NHIS in FCT were 25. For proper coordination and ease of administration, the NHIS allocated the various public sector organizations in the FCT to 25 HMOs to manage enrollees. The allocation was done so that the payment of capitation for all the employees of such organization to Primary Health Care Providers can be done through the HMO responsible for that organization. The NHIS lives that formed the population of study were distributed across the various ministries, agencies and parastatals in the FCT. A list of NHIS enrollees managed by a given HMO was made available with the NHIS Desk Officer in all the organizations. The twenty-five (25) HMOs covering NHIS lives in the FCT were assigned various organizations by the NHIS.

The FCT was purposively chosen for this study because it houses the administrative/operational headquarters of the NHIS, as well as the administrative head offices and/or operational base of all the HMOs covering NHIS public sector lives/enrollees in the country. More so, the FCT as the administrative capital of the country captures many of the NHIS public sector lives/beneficiaries. In fact, the National Health Insurance scheme began its operations with the public sector workers in the federal civil service in the FCT before extending its services to the other states of the federation. When compared with other states in the country at the moment, the FCT has the highest number of NHIS public sector enrollees/beneficiaries. The FCT therefore provides a platform for the NHIS to demonstrate/show case their unique public-private partnership with the HMOs in the delivery of the social medicine model in the country. Thus, the FCT is best suited to be used as a case for a focused study, to better understand, and empirically evaluate the impact of the collaborative efforts of the NHIS and HMOs and to assess the role the HMOs have played and/or are playing in the implementation of the National Health Insurance scheme in the FCT. A success or failure in the FCT could provide a good picture of same for the whole country, and this may necessitate or trigger further investigation/research and help direct government policy and programs.

Sampling Technique

In this study, the respondents for the cross-sectional survey interview were selected by systematic random sampling, so that each respondent had equal chances of being selected into the sample for the survey. The HMOs in the survey were selected by simple random sampling proportionate to size; this was done to allow each HMO in the FCT to have equal opportunity/chance of being chosen into the sample. Since simple random sampling and systematic sampling are probability sampling methods, it is hoped that the findings derived from this study can be generalized into the population i.e. for the whole 25 HMOs covering NHIS lives in the FCT and the entire 244,992 public sector lives covered by the HMOs for the NHIS in the FCT. Essentially, the design was a two-stage sampling design.

In the first stage, the HMOs were selected by simple random sampling with replacement. Out of the 25 HMOs covering lives on behalf of the NHIS, 5 were selected for the study. A list showing the names and number of HMOs managing NHIS enrollee was obtained from the NHIS headquarters in FCT, Abuja. The list had a total of 25 HMOs managing NHIS enrollees. Each of the 25 HMOs were written on separate pieces of papers, each of the pieces was closed up and wrapped, put in a box, mixed together and shaken. After this was done, a piece was drawn out from the box at a time, but replaced back to the box prior to another (the next) selection. Note: The box was shaken after every replacement and before each selection. This procedure was done five times to select the five HMOs for the study. These selected HMOs represent 20% i.e. one-fifth of the 25 HMOs covering NHIS lives in the FCT. The rationale for sampling with replacement is to ensure that independent events are produced. Sampling with replacement allows repeated member/items to be sampled more than once. In the second stage, the respondents were selected by systematic random sampling (systematic sampling is a statistical method involving the selection of elements from an ordered sampling frame. It provides equal probability of selection to all subjects/units in the population. It is a probability sampling method).

Method of Data Collection

In the survey method, the instruments used for data collection was a semi structured questionnaire. The survey instrument was subjected to face validity, and scrutiny to check if the instruments were actually measuring what they intend to measure in order to ascertain that the universe of all questions or items included in it were duly included. Also, the reliability of the survey instrument was calculated using the Crombach Alpha statistics to ascertain whether there is internal consistency in the questions in the questionnaire, and to verify the consistency of results if similar studies are carried out afterward using the same instrument. An item analysis was also done to examine the items/questions in the questionnaire to ascertain if certain questions should be dropped, retained or replaced depending on the resulting Crombach Alpha coefficient of the supposed item/question if it was deleted.

Results

Objective: To evaluate the perception of National Health Insurance enrollees to the function of Health Maintenance Organizations in the implementation of the scheme.

Table 1: Responses on What They Know About Health Maintenance Organization

What do you know about Health Maintenance Organization (HMO)?	Total Health Trust Ltd	HealthCare International Ltd	Maayoit HealthCare Ltd	Princeton Health Ltd	Managed HealthCare Services Ltd	Total
They are organizations responsible for the provision of healthcare services to public servants at a subsidized rate	3 2.4%	1 .6%	0 .0%	1 7.1%	1 2.0%	6 1.6%
They mediate between the NHIS, my workplace and the hospital. They also process claims from the hospital to NHIS for payment. They are administrative linkages	13 10.2%	11 6.2%	2 13.3%	4 28.6%	2 4.0%	32 8.3%
HMOs are the institutions who pay the hospitals the enrollee's medical bills. They manage NHIS funds.	5 3.9%	11 6.2%	0 .0%	2 14.3%	4 8.0%	22 5.7%
They manage healthcare provisions for enrollees on behalf of NHIS. They also organize referrals.	7 5.5%	22 12.4%	6 40.0%	1 7.1%	7 14.0%	43 11.2%
They receive complaints on behalf of the enrollees	3 2.4%	0 .0%	0 .0%	0 .0%	0 .0%	3 .8%
Don't know	53 41.7%	63 35.4%	1 6.7%	0 .0%	17 34.0%	134 34.9%
No response	43 33.9%	70 39.3%	6 40.0%	6 42.9%	19 38.0%	144 37.5%
Total	127 100.0%	178 100.0%	15 100.0%	14 100.0%	50 100.0%	384 100.0%

The responses of respondents on what they know about HMOs are provided in table 1 according to the HMO under study. From the table, the following were outlined as responses given on what HMOs do; (1) they are organizations responsible for healthcare provision for public servants at a subsidized rate, (2) they are intermediaries between NHIS, the Health Care Providers and the enrollees, (3) they are institutions that pay medical bills for enrollees, (4) they engage in managed care, and (5) they receive complaints from enrollees.

For Total Health Trust Ltd, 3 (2.4%), 13 (10.2%), 5(3.9%), 7(5.5%) and 3 (2.4%) totaling 31 (24.4%) of the respondents sampled under this HMO, all gave their responses in favor of options one, two, three, four and five respectively in response to the question asked. The number of those who did not know what HMO is all about were 96 (75.6%) in number. For Healthcare International Ltd, 1 (0.6%), 11 (6.2%), 11 (6.2%) and 22 (12.4%) making a total of 45 (25.4%) all gave their responses as options one, two, three and four respectively. But 133

(74.7%) did not know what HMOs do. This when compared with the 178 persons surveyed under this HMO, is high. For Maayoit Healthcare Ltd, 2(13.3%) and 6 (40.0%) of the respondents gave options two and four respectively in response to the question asked. Those who didn't know what HMOs did were 7 (46.7%) in number. The total number of those surveyed under this HMO was 15. For Princeton Health Ltd, 1 (2.0%), 4 (28.6%), 2 (14.3%) and 1 (7.1%), making a total of 8(52.0%) gave their responses as option one, two, three and four respectively. Those under this HMO who indicated that they did not know what HMOs did, were 6 (42.9%) in number. The total respondents surveyed under this HMO were 14 in number. While for Managed Healthcare Ltd, 1 (2.0%), 2 (4.0%), 4 (8.0%) and 7 (14.0%) making a total of 14 (28.0%) gave their responses in as options one, two, three and four respectively. But 36 (72.0%) indicated that they did not know what HMOs did. Those surveyed under this HMO were 50.

Going by the percentages, 53.3% of the respondents under Maayoit Healthcare Ltd had more knowledge about HMOs. This was followed by 52.0% of respondents from Princeton Health Ltd, while others under Managed Healthcare Services Ltd, Healthcare International Ltd, and Total Health Trust Ltd were 28.0%, 25.4%, and 24.4% respectively. Respondents who expressed high levels of knowledge about HMOs were those under Maayoit Healthcare Ltd and Princeton Health Ltd which had people working with the University of Abuja and those with the National Universities Commission respectively. These groups of people are considered as highly educated people capable of providing useful information about the subject matter. Those who didn't know what HMOs did were 75.6%, 74.7% and 72.0% for Total Health Trust Ltd, Healthcare International Ltd, and Managed Healthcare Services Ltd respectively. Other figures were 46.7% and 42.9% for Maayoit Healthcare Ltd and Princeton Health Ltd. The highest number of those who did not know what HMOs did was from Total Health Trust Ltd.

A summary of the responses on knowledge about HMOs is given as this: although 6 (1.6%), 32 (8.3%), 22 (5.7%), 43(11.2%) and 3 (0.8%) of the respondents had clearly shown that they knew about HMOs from their responses, majority i.e. 134 (34.9%) and 144 (37.5%) still did not know what HMOs did. They may have indicated earlier that they had heard of the Health Maintenance Organizations before this study but did not know in details what they do. This implies that the functions of HMOs in the scheme were not fully known to users of the scheme either because HMOs are not working or that users had not had any course to require their services.

Table 2: Responses on Whether HMOs Are Working in FCT, Abuja by HMOs

Do you think the HMOs are working in FCT?	Total Health Trust Ltd	HealthCare International Ltd	Maayoit HealthCare Ltd	Princeton Health Ltd	Managed HealthCare Services Ltd	Total
Yes	53 41.7%	78 43.8%	8 53.3%	14 100.0%	21 42.0%	174 45.3%
No	47 37.0%	45 25.3%	4 26.7%	0 .0%	14 28.0%	110 28.6%
Don't know	2 1.6%	2 1.1%	0 .0%	0 .0%	0 .0%	4 1.0%
No response	25 19.7%	53 29.8%	3 20.0%	0 .0%	15 30.0%	96 25.0%
Total	127 100.0%	178 100.0%	15 100.0%	14 100.0%	50 100.0%	384 100.0%

Table 2 shows figures for responses obtained from the respondents on their views on whether HMOs are working or not. Responses were displayed according to respondents' HMOs. For Total Health Trust Ltd, 53 (41.7%) said they believed HMOs were working, 47 (37.0%) said HMOs were not working, 27 (21.3%) said they had no idea if HMOs were working or not. The number of respondents sampled under this HMO was 127 (100.0%). For Healthcare International Ltd, 78 (43.8%) said they believed HMOs were working, 45 (25.3%) said HMOs were not working. While 55 (30.9%) said they did not know if HMOs were working or not. 178 respondents were sampled under this HMO. For Maayoit Healthcare Ltd, 8 (53.3%) said HMOs were working, 4 (26.7%) said HMOs were not working, 3 (20.0%) said they did not know if HMOs were working or not. The total respondent sampled for this HMO was 15. Under Princeton Health Ltd, all 14 (100.0%) of the respondents indicated that HMOs were working. For Managed Healthcare Ltd, 21 (42.0%) said HMOs were working, 14 (28.0%) said HMOs were not working. However, 15 (30.0%) others said they did not know if HMOs were working in FCT, Abuja.

Going by the percentages, those who said HMOs were working, were highest in Princeton Health Ltd. There was a 100% declaration that HMOs were working. Other responses from the respondents in the other HMOs were 53.3% for Maayoit Healthcare Ltd, 43.8% for Healthcare International Ltd, 42.0% for Managed Healthcare Services Ltd and 41.7% for Total Health Trust Ltd. Those who said HMOs were not working, were highest in Total Health Trust Ltd with 37.0% followed by 28.0% for Managed Healthcare Services Ltd, 26.7% for Maayoit Healthcare Ltd and 25.3% for Healthcare International Ltd. Since Princeton Health Ltd had 100% indication that HMOs were working, it simply means respondents in this group enjoyed the services of their HMO and by implication, HMOs were working. The figure for those who said HMOs were not working, were lower than those who said HMOs were working. By implication most respondents believed and agree that HMOs were actually working in FCT, Abuja, irrespective of the fact that many did not know their HMOs.

The general opinion of the respondents on HMOs can be summarized as this: 174 (45.3%) of the total respondents said HMOs are working. 110 (28.6%) said HMOs were not working. While 4 (1.0%) said they didn't know if HMOs were working or not. The rest 96 (25.0%) respondents did not indicate their response to this question maybe because they did not know. Those who said HMOs were working, were in the majority. Responses on this question reflect the fact that if users are satisfied with the scheme, it meant HMOs was doing their jobs.

Conclusion

The study discussed different health systems of the world and how these impacts on users. It provides analysis on perceptions of the HMO-NHIS collaboration in health care. It made use of quantitative method to collect data from the respondents. It employed a two-phase sampling design and stratified random sampling techniques in selecting respondents. It also captured data from a cross sectional survey. Five HMOs were randomly selected from the twenty-five HMOs covering NHIS lives. Also, responses were obtained from a total of three hundred and eighty-four respondents working with eighteen public sector organizations in FCT, Abuja. The findings of this research showed that although the functions of HMOs in the scheme were not fully known to users of the scheme, users believed HMOs were working to ensure a successful implementation of the scheme. their opinions indicate that since they were satisfied with the entire scheme, this meant HMOs were doing their jobs.

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