

Health Maintenance Organizations (HMOs) in Nigeria:

One of the reasons why there is considerable interest in the Health Maintenance Organisations (HMOs) as a Health financing strategy is that the current practice - retainership or employer-sponsored clinics - in financing and providing healthcare for employees in the formal sector suggests that the introduction of HMOs is feasible within this market niche. Apart from this, the interest shown by various stakeholders in this approach in addressing some of the short comings of the current system show that there is a need to change to a system that is not only accountable and transparent but one that will be sustainable independent of government patronage.

Dr OO Ogunbekun, a Health Policy expert with the African Development Bank has advocated for private financing in particular both as a resource substitution option and also as a means of widening consumers' choice. The need for a change in policy direction in favour of private financing is based on the following reasons.

- There are existing contracts between employers and private healthcare providers who provide coverage for employees both in the organised private sector and government parastatals.
- Policies favouring employers buying healthcare services rather than operating their own facilities could promote the development of a private health insurance market including HMOs. Such a policy may include the granting of additional tax consensus to companies who provide comprehensive medical benefits to their staff.
- The private sector given the right incentives such as the provision of soft loans, equipment leasing, joint use of public healthcare resources such as theatre, laboratory and X-ray facilities could facilitate the extension of healthcare services to rural and under served communities. This will in some extent address the issue of equity
- Employers will have the added advantage of providing a comprehensive healthcare benefit package for their employees without the burden of administering the scheme, which in itself consumes a lot of productive resources.
- Finally, there is the opportunity for innovation and creativity either in response to market forces resulting from competition and consumer demand or in response to changes in the environment - political, economic, social and technological.

How Feasible?

But despite all these advantages of private financing and provision of healthcare, the feasibility of HMOs in Nigeria can be assessed by analysing the present situation and forecasting the operational environment against events which have taken place but are likely to have an impact in the future.

We can also learn from other developing countries that have introduced HMOs and other related schemes with the recognition that Nigeria is different in many respects. We can then test our decision on how we take things forward by looking at how the worst possible and the best possible setback past experience could lead us to expect.

Social Security and the Insurance Industry

Previous experience with the Social Security Fund - the National provident Fund, showed that billions of Naira (Millions of Dollars) which were built up on behalf of civil servants could not provide pensions and a safety net for incapacitated workers. Funds were supposedly diverted to unspecified uses. Another concern was the high administrative cost of managing the fund. While reforms are on going to sanitise the system, a large proportion of working people - those who are self-employed, traders and the vast majority in the informal private sector do not have provision of suitable pension plans.

The commercial insurance itself has been thrown into a lot of difficulties. As a result of low solvency ratios, poor claims settlement records, and unsatisfactory reinsurance arrangement, the National Insurance Commission has continued to threatened to revoke the licenses of insurance companies that have failed to effect re-capitalization directive given underwriters in the country by the insurance regulator.

In the past four private wholly commercial insurance companies underwrote health risk - three based in Lagos and one in Enugu with an estimated coverage of 0.03% of the population as at July 1995. These companies offered group plans for employees in these two southern cities. Despite the low population covered by these private health insurance underwriters in the country, their experience and that of private doctors currently under capitation programmes are very useful for operators of HMOs in Nigeria. Although much of these have not been studied and reported in the country, Dr Ogunbekun noted that the prevalence of

Health is life, be wise.

fraud is rated as moderate to high. This he stated could take the form of oversupply of services, over-billing by healthcare providers, the use of services by unauthorised persons – uncovered relations or friends of the insured, and the conversion of medical benefits to cash at the request of the insured.

We can also draw on the experience of prepayment schemes in sub-Saharan Africa where there was high utilisation among subscribers leading to financial insolvency of the providers, selection of high-risk individuals and lack of equity. But there could be potential for success where there is accountability and participation of the beneficiaries in negotiating price and quality of care. As noted by Professor Tayo Lambo, a health economist, who formerly worked for the WHO and now director for the UK Department for International Development (DFID) Change Agents Programme in Nigeria – there are critical factors which are likely to lead to the success of prepayment schemes in Africa. The list include, appropriate institutional context, level and management structure; low collection and administrative costs; appropriate premium to cover the costs of providing benefits, adequate population size to facilitate risk pooling; integration of the scheme into the national, provincial, or district health system; and sound financial management. Others are no or limited *adverse selection*; no or limited *moral hazard*; cost containment; adequate backup support; high quality of services; social cohesion among subscribers and conducive economic environment.

Politics and the Economy

After fifteen years of continuous military rule and disjointed political process, Nigeria finally installed a democratically elected government on May 29, 1999. The new government has begun to institute measures that emphasise transparency, accountability and respect for the rule of law. The civil crises in the Niger Delta, which resulted from inequitable distribution of social amenities in the oil producing communities, are also been addressed. Already, construction work on roads, bridges, canals and other projects that may enhance transport and communication in this difficult terrain has commenced. In the year 2000 alone, one of the multinational partners of the Federal government – Royal Dutch/Shell, the main victim of civil disruption in the Niger Delta tried to dampen local anger by spending about \$50m on community development across all the approximately 1500 communities in its operational area.

Economically, the country has suffered two decades of stagnation. The problems are legion – years of mismanagement by the past military government, low price of oil (crude oil accounts for 95% earnings), rising unemployment, near collapse of the country's infrastructure and so on. All these and many others

have lead to a fall in the per capita income from a peak of \$1000 to about \$300. Consequently, earnings from oil fell from \$14.9bn in 1997 to \$9.3bn in 1998 while the current account trade balance, which stood at a surplus of \$1.9bn dropped to a deficit of about \$3.1bn over the same period. It is noted that a 0.8% fall in gross domestic product (GDP) is forecasted for this year, while the estimated external debt stood at \$28.5bn as at the end of last year, including \$22bn owed to the Paris Club creditors.

However, some of the gains in the political scene seem to have presented a light at the end of the economic tunnel. In 1999 Royal Dutch/Shell set out an \$8.5 bn plan to revitalise the Nigerian petroleum industry with one of the most ambitious integrated oil and natural gas development projects in the world. The board of directors of the Nigeria Liquefied Natural Gas (NLNG), which includes representatives of the Federal government, Shell, Elf Aquitaine of France and Agip of Italy launched a third production train, which is almost completed at its Bonny island plant in Rivers State. A final investment decision for the fourth and fifth production trains was also made in March this year. In the same vein we also see some signs of Foreign Direct Investments in some other sectors notably – hotels and tourism, brewery, telecommunication and Information Technology just to mention a few.

These efforts together with the abundant talent, energy, and creativity of the well over 120 million Nigeria should be able to turn around Nigeria's economic fortunes. As noted by Dr Pat Utomi – a Director of the Lagos Business School – “ the unrecorded economic activity from metal bashing to bun selling in the streets is already producing double the output of the more formal non-oil part of the economy”.

The government is also limiting its role in the economy by the privatization of government owned companies and encouraging the development of the private sector, even in the social sectors – education and healthcare. The licensing of Private Universities and the contracting of management of the National Hospital at Abuja to a private firm are cases in point.

Overall, the national economy is sufficient to allow for the growth of the health sector. This is more so for the private sector, which can identify new markets and operate efficiently. The health of working people both in the formal and informal sectors will be a priority in a growing economy as productivity depends on them. Other health problems that will become increasingly important are chronic and non-communicable diseases such as accidents – road traffic and industrial, diabetes, asthma, mental illness and so on. Care of the elderly will also assume prominence as life expectancy of the population increases owing to improved standard of living.

Infrastructure and Institutional Capacity

Apart from the traditional role of business support, the role of management information system in an insurance – based healthcare environment need not be over emphasized. Current efforts at record keeping and dissemination of information in the healthcare sector are very dismal. Incomplete records and information is a real issue, so also is the problem of integrating records from large Teaching and government owned General Hospitals with that of private clinics and HMOs. At present the infrastructure to develop, update and maintain both healthcare and financial information is lacking.

While there is possibility of harnessing the resources and skills of the growing Information Technology (IT) industry in Nigeria, the information systems of both the HMOs and healthcare providers are expected to be weak for some time. It is also doubtful how quickly private sector providers could easily adopt IT to improve efficiency considering the high cost of system acquisitions and maintenance. But if there is good system design, low per capita costs and strong incentives, then the private providers and HMOs could improve their information systems by taking advantage of IT. It is also possible that new firms may emerge to cash in on this opportunity – to provide administrative services for the HMOs and providers.

In the same vein, the availability of trained staff in the right numbers, with the right skills to operate the HMOs is a major concern. Despite the claim that there are many universities and other institutions of higher learning turning out graduates every year, shortages of trained personnel in marketing, cost accounting and finance for this niche market exist. Salaries in the healthcare sector are generally poor. Recent salary increases in the public sector has put considerable pressure on the private sector in terms of attracting and retaining quality health professionals and managers that can sustain the operations of HMOs.

Similarly employee management practices in the healthcare sector are very discouraging. Doctors who in most cases do not have any form of management training usually fill senior management positions.

Some other factors that contribute to lack of job enrichment in the healthcare industry include poor supervision of staff, failure to recognise good performance and lack of advancement.

Regulatory Environment

It has been argued that since HMOs provide both health insurance and healthcare, there is the need for them to meet both all-financial and clinical requirements. Therefore supporting the separation of the duties for overseeing the financial aspect from that of the clinical one. Under the current arrangement the Council of the NHIS is solely responsible for the regulation of HMOs in the country. This has been contested by some states, which have set up parallel regulatory bodies for HMOs in their jurisdiction. For example, in Rivers State there is an Authority set up by law to regulate Private Health Institutions including HMOs. There is also the issue of the Council registering and accrediting healthcare providers, which hitherto has been the responsibility of State Ministries of Health.

As such it is questionable if the oversight mechanisms presently being instituted could be enforceable. While the Council claims that no HMO has been registered by it. There are now over five HMOs having been incorporated by the Corporate Affairs Commission (CAC) as health management companies already receiving premiums from employers and have contracted with providers to provide an agreed package of care to their employees. It has also been noted that the NHIS has by-passed the HMOs and commenced direct implementation of community based health insurance schemes. Dr Awosika – the Vice Chairman of the Association of Managed Care Companies, the industry association for HMOs made this assertion following the re-launch of the scheme at Ijah Community, Tafa LGA in Niger State by the wife of the President on March 22, 2002.

Given this situation there are bound to be problems with co-ordination and communication both within the regulatory framework and with bodies such as HMOs and providers being regulated. In addition, these complexities will greatly increase the administrative cost of running the scheme. Government bureaucracy, which has been inherited by the NHIS, will also add another cog in the wheel of the scheme's success.

KEY NHIS MILESTONES

- **1984** – National Council on Health under the then Health Minister, Admiral Patrick Kosboni, set up a committee under Prof. Victor Diejomaob to advise government on the scheme. Panel recommended NHIS as a viable funding mechanism for healthcare in country.
- **1985** – Dr Emmanuel Nsan as Health Minister, set up an NHIS review committee, under Mr. L. Ljaju. Also submitted that the scheme was viable.
- **1988** – Health Minister, Prof. Olukoye Ransome-Kuti set up another committee, Dr Emmanuel Umez-Eronini to recommend a more realistic and acceptable model for the implementation of the scheme.
- **1991** – The Federal Government of Nigeria signed an agreement with the United Nations Development Programme (UNDP) and the International Labour Organisation (ILO) for the planning and implementation of the scheme.

- **1993** – Dr Christopher Okojie, the Health Secretary in Interim National Government (ING) presented a memorandum to the Traditional Council (TC) asking for immediate take-off of the scheme.
- **1995** – Maiden Health Summit held in Abuja recommended private sector involvement with the introduction of Health Maintenance Organisations (HMOs).
- **1997** – Former Head of State, Late Gen. Sanni Abacha launched the scheme on October 15th
- **1999** – Former Head of State, Gen. Abdulsalam Abubakar signs NHIS Decree 35 in May.
- **2000** – House of Representative Committee on Health of the National Assembly held a Public Hearing on NHIS between February 21st – 24th necessitated by calls for amendments to the enabling laws (NHIS Decree No. 35 of 1999).
- **2001** – Extraordinary National Council on Health with NHIS as sole agenda item held in July at Port Harcourt.
- **2002** – Re-launch of NHIS by Mrs. Stella Obasanjo, wife of the President of the Federal republic of Nigeria (FRN) at Ijebu community, Tafa LGA, Niger State on March 22nd.

Editorial

Health Maintenance Organisations (HMOs) have gained popularity among developing countries including Nigeria as an option for financing and providing healthcare. This has largely resulted from health reform policies that favour market-oriented health insurance.

It has long been suggested that capitation schemes such as HMOs have some potential in developing countries, which can originate either as private sector initiative or as a government stimulated scheme with spill over effects to the private sector. As we are already aware, a key feature of the National Health Insurance Scheme (NHIS) in Nigeria is the involvement of the private sector through the participation of HMOs. As envisaged by the policy makers, this approach shifts the role of running the scheme from the public to the private sector, which will now provide the financial resources in operating the scheme. It is also hoped that it will encourage competition and cost consciousness not only among healthcare providers but also among HMOs and Private Health Insurance Companies (PHICs). While the private sector has been brought in to operate the NHIS via the introduction of HMOs in order to make it more viable, doubts have been raised about the capability of a capitation option such as the HMOs concept being carried out in Nigeria.

Presently there are about five odd HMOs operating (collecting premiums from employers and contracting with healthcare providers) in the private commercial sector in preparation for integration into the scheme. There are also practical moves by the professional association of private doctors to setting up an HMO to negotiate contracts on their behalf. Other institutions, groups and agencies and even communities from the public and the private sectors have also shown interest in HMOs as a purchaser of healthcare services for defined populations. In addition there are several state government health initiatives, which can interface with the HMOs as an alternative vehicle for delivering services to target groups, especially the poor and vulnerable groups. Notable among these is the 'Free Medical Treatment for the Elderly and Children under Five years of age' of the present Rivers State Government. This shows that the introduction of HMOs within the scheme is a useful element. It is therefore essential that all stakeholders ensure that these organizations succeed.

However, the rate at which Nigeria transits from the current healthcare system to one that is competitive and cost conscious will depend on several factors. Among these the political and economic considerations have greater bearing on the successful implementation of HMOs in Nigeria. The effects of economic liberalization and political reforms currently taking place in the country present enormous risks and opportunities for these organizations. The challenge is how the *leadership* of these organizations are able to manage this change process and sustain progress made in this emerging healthcare market.

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