Health Insurance report

A QUARTERLY HEALTH INSURANCE JOURNAL

March 2003 | A CARE-NET Limited Publication | Vol. 2 No.1

Health insurance For The Poor - moving up to scale

It is now a well-known fact that the economic development of any country is closely related to the health status of its population. Consequently an efficient and equitable health care system that responds to the needs of its people is an important instrument that can break the vicious circle of poverty and ill health. Despite this close linkage adequate emphasis on the critical contribution of access to healthcare and to health sustaining goods and services to economic growth and poverty reduction has not been made.

Era of User fees

In sub-Saharan Africa as a result of low and unstable tax revenues (in addition – squandering of oil revenues in Nigeria) and cut backs in public budgets the original goal of 'free' or heavily subsidized health services was not possible. This situation was worsened by the world economic recession in the 1980s and consequent macroeconomic adjustment prompted by the neo-liberal reforms of the World Bank and IMF. These events led to a marked deterioration in the quality of existing services with poorly paid and demotivated staff and shortage of drugs and medical equipment among others.

Under these pressures of mobilising additional resources for health care services both public and NGO health facilities resorted to collection of user fees at the point of use. The adoption of user fees as a cost recovery strategy by healthcare providers caused considerable negative impact on equity and access in addition to healthcare utilisation and public health. It was noted that people do not show up at a health facility unless they are seriously ill. When admitted to a hospital people often turn up only after several days because they needed time to organise the money from relatives or out of other sources. Delays in seeking care and the diminished healthcare utilisation especially by vulnerable groups like pregnant women and children result in adverse effects on public health. Furthermore, the contribution of user fees were too insignificant to cover even the recurrent costs of most providers as considerable proportion of patients leave the hospitals after recovery unable to pay their bills.

While structural adjustments and poor economic growth have pushed labour into the informal and small-scale agriculture sectors, where livelihoods are often insecure – such households often need comparatively more healthcare, which they have relatively weaker capacity to access. It has been observed that in most sub-Saharan African countries – even the most donor dependent ones – the biggest source of finance for the health sector is out of pocket expenditure and the poor in these countries spend a disproportionately higher percentage of disposable household income on healthcare. Most of this expenditure it has been noted is mainly in the private sector or unofficial user fee in the public sector, which does not protect the poor from the economic cost of catastrophic illness nor do they appear to get value for money.

Herein the need to innovate and devise ways of insuring access of quality healthcare for the poor. Health insurance while not seen as the total solution is being considered as an ongoing activity that secures health status by securing access to healthcare services.

Health Insurance as an Agency against Poverty

For most people leaving in poor rural or urban slums in developing countries ill health still represents a permanent threat to their ability to earn income. Apart from the direct cost for treatment and drugs, indirect costs such as loss of productive man-hours, and transport still have to be borne by the households. Given that alternative mechanisms for health care financing such as user fees have failed to meet desired goals, the option of health insurance seem to be a promising alternative. Through risk pooling and transferring unforeseeable healthcare costs to fixed premiums there is the possibility of improving poor peoples' access to healthcare that is of acceptable quality.

Several attempts in the past have tended to innovate ways of including the poor in formal health insurance by finding means of accommodating the irregular incomes of those in the informal sector. Similarly,

other approaches have focused on already existing community based credit associations as a means of developing informal health insurance systems. While community based health Insurance may appear to be the best way forward, evidence from those schemes that have been studied show that there are real problems around sustainability and financial viability. There has been too little attention paid to these schemes by both national governments and development agencies. The commercial private sector has also not seen the opportunity in investing in this non-traditional health market. It has been suggested that low, affordable premiums or pre-payments are likely to expand the potential coverage of target populations if payments of premiums are stress free, such as by tying them to income cycles.

The challenge as noted by Dr Ken Grant of the Institute for Health Sector development in a recent paper presented to the ***Internationa Health Summit***, December, Miami 2002 – is to emphasise large-scale interventions that can reach a significant proportion of the poor. The focus here should be overall population coverable by a multiple of schemes looking at those same issues as those of more sophisticated social and private health insurance schemes – building up adequate reserves, health plans being informed purchasers, consumer education, re-insurance etc.

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Role of the National Health Insurance Scheme (NHIS)

In Nigeria as elsewhere were social health insurance schemes are being developed for the formal sector there is a need for these schemes to be ***linked*** to community based health insurance. This is the consensus by most commentators on this subject matter. The reason being that such formal schemes could serve as a vehicle through which external development partners could channel funds. The NHIS of Nigeria has made that linkage and in some cases initiated these schemes. However there are concerns that the approach of the agency is not addressing the issues raised above. Secondly there is no relationship between external donors and the scheme. It is yet unclear were government funding is currently going, as there seemed not to be direct subsidy of the community- based schemes.

Another major area is the lack of a functioning ***regulatory framework***. The NHIS Decree 35 of 1999 that was rejected by most operators and healthcare providers has not been revised. Thanks to the unstable legislative environment in the country during the past three years.

Since financial viability of community based insurance schemes is a key obstacle to sustaining these schemes another role for the NHIS will be to provide a safety net for them. Clearly the option here is ***re-insurance*** whereby the NHIS agrees to cover medical expenses above an agreed threshold in return for a small contribution from the community based or Micro health insurance units.

"If I had my own way I'd make health catching instead of disease."

- Robert Green Ingersoll

NEWS

Community-Based Schemes take off

The National Health Insurance Scheme (NHIS) has formally launched community-based schemes in the six geo-political zones of the country. The Head of the Public Enlightenment and Mobilisation of the organisation Alhaji Abdullah Ojuolape disclosed this while speaking to *Health Insurance Report.*

The communities where the programme has kicked off include:

- Jada in Jada LGA, Adamawa State (North-East);
- Ijah in Tafa LGA, Niger State (North-Central);
- Aba – self employed shoe makers user group - Abia State (South-East);
- Ibogu-Ola Ogun in Ifo LGA, Ogun State (South-West);
- Waraki in Owan East LGA, Edo State (South-South) and
- Zaga Aya in Igabi LGA, Kaduna State (North-West).

Speaking further the Alhaji Ojuolape who is also a Principal Manager in NHIS stated that the programme is open any interested communities and/or user groups such as self-employed persons in both the formal and informal sectors of the economy. According to him what is needed is the formation of an association of not less than 500 members who can then approach the NHIS for accreditation and support. The group will be assisted to choose a benefit package based on their health needs and a healthcare provider. In communities where no healthcare provider is present the schemes builds and transfers a health facility to the members after some time of operation. *Health Insurance Report* is informed that while members contribution is a monthly premium currently at abound 120 to 150 Naira; the communities and user groups who elect a seven member Board of Trustees (BOT) manage these programmes.

Doctors prepare their practices to meet NHIS guidelines

Pending the full implementation of the NHIS doctors in the country have started to put in place necessary facilities and equipment to meet the minimal requirements of the NHIS. This assertion was made by a group of doctors in Port Harcourt the Rivers State capital during a panel discussion on the implications of the NHIS for private medical practitioners organised by Care-Net Ltd the publishers of this newsletter.

It will be recalled that improving the standard of care in both public and private facilities is one of the key objectives for setting up the NHIS.

Clinics and Hospitals plan to offer insurance products

Frustrated by dwindling profit margins and suspicious of the embryo Health Maintenance Organisations (HMOs), hospitals and clinics in the country may begin to offer health insurance products directly to employers. Mr Faye Gabriel, Clinic Administrator of Marine Clinic in Bonny Island, Rivers State says that this has become necessary in order for private clinics to reposition themselves in the emerging health care market. According to him the private clinics fear that they may be 'short changed' by HMOs whose interest is only to make profit while the private clinics continue to give bear the full risk of providing care. He claims that the clinics have comparative advantage since they already have a direct relationship with private employers, he however disclosed that given the financial requirements of such a venture, one option being considered by the clinics is to form their own HMO or Independent Practice Association (IPA) that can negotiate profitable contracts on their behalf.

Christian Health Association of Nigeria (CHAN) plans to set up a Health Maintenance Organisation (HMO)

With over 3,000-health facilities belonging to its members, the Christian Health Association of Nigeria (CHAN) has discovered a niche in the health care financing market of Nigeria. Dr Akin Akinyemi, the Executive Secretary gave this hint that CHAN will float an HMO that will serve the needs of its members while at that same time ensuing access to quality health care for isolated and under served people that its members are trying to reach.

This has become necessary because 'fair financing of healthcare service is one of the key ingredients of a health system that is performing well' says the chief executive officer. Given that most of its members have operational difficulties that are mainly financial CHAN is embarking on this project as a way of responding to the needs to its members in addition to contributing to a sustainable healthcare delivery system in the country. A major workshop to articulate this project and take things forward is being planned for May 2003.

AIDS

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Improving access to health and reducing poverty

With free public health services no longer provided and access to social insurance denied, one possible option available to poor rural population and population in the informal urban sector is the formation of locally organised autonomous health insurance schemes at the local level. The main purpose of these *micro-health insurance organisations* is to pool resources of a whole group of socially excluded individuals in order to provide protection against the financial effects of healthcare since they are all exposed to diseases and accidents.

By joining together into a group the financial costs of healthcare can be distributed among the members with each member paying a minimum premium. What this means is that a manageable group of people at the local level, most of whom know one another, pay a contribution in cash or kind to the association, from which specific treatment and/or drug costs can be fully or partially paid for by the micro-health insurance organisations if one of the members falls ill. This prevents poor households from the very high costs of treatment that would otherwise throw them into poverty or even deepen it. In this way micro-health insurance organisations do not only improve health status of the poor by securing health access but also helps to fight poverty at the local level.

In spite of the development of micro-health insurance organisations in West Africa only a small proportion of the population is benefiting from locally organised insurance schemes. While it is necessary to mobilise the population's resources to set up these insurance organisations, the possibility of this happening in the informal sector and rural areas is limited. Initial experience with schemes initiated by the National Health Insurance Scheme (NHIS) in Nigeria show that external support is needed to begin with especially to cover the initial costs. Up until now, only a limited number of donors (none in Nigeria) have been supporting micro-health insurance organisations.

Evidence so far indicate that there is potential for micro-health insurance organisations to both improve access to healthcare and reduce poverty, provided that insurance protection can be extended to large number of people. The strategy therefore is to target whole population coverage with multiple of schemes, which could improve access to healthcare for the poor. It also useful that external support, especially from donors and development agencies, is provided in promoting the establishment of micro-health insurance organisations at the local level, where possible, in collaboration with government.

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