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Health Insurance Report

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SPECIAL POINTS OF INTEREST:

- Nigeria and other sub-Saharan African countries need a magnitude of resources to meet the MDGs
- Everyone suffers from the consequences of rising cost of medical care
- Aging populations, technological advances and growing expectations are driving health care cost in virtually every country

INSIDE THIS ISSUE:

Crisis in Healthcare Financing: No Country is Immune

It has long been recognised that without a magnitude of resources from other sources to augment what is currently being spent on healthcare, most developing countries will not meet the Millennium Development Goals (MDGs) by the year 2015. However, two events that took place in April this year in Europe is sounding a warning note that the issue of funding healthcare is no longer a problem of poor countries alone.

The Rich also Cry

In Britain, 900 doctors wrote to the Prime Minister, Tony Blair on poor funding of the National Health Service (NHS). They expressed their frustration in working in a system that has consistently been under funded in the past four years. The doctors suggested additional funding other than general taxation including private health insurance.

A week later German doctors took to the streets to express their dissatisfaction on how poorly they are paid. This they also attributed to poor funding. It has been noted that healthcare expenditure in the European Union (EU) member states has been growing more than the Gross Domestic Product (GDP).

The United States of America (USA) has been

Funding access to quality medicines is key to making progress towards the MDGs

having an on going battle with funding its healthcare system.

Judged to be having one of the best health systems in the world, more than 45 million of its citizens do not have any form of health insurance. About 18,000 deaths a year can be attributed to having no health insurance in this country. Apart from this the cost of medical care has been increasing, far surpassing the general rate of inflation for most years.

Middle income countries such as Brazil, Chile and South Africa who spend 6% of their GDP on health rely heavily on out-of-pocket expenditures, which account for some 40% of all health spending. Despite these high out-of-pocket payments countries, in this category are unable to raise enough revenues that can fund their healthcare needs.

Who is at risk?

The consequences of rising cost of medical care are manifold. Everyone suffers.

Businesses can pass along a portion of medical cost to their workforce in the form of lower wage increases.

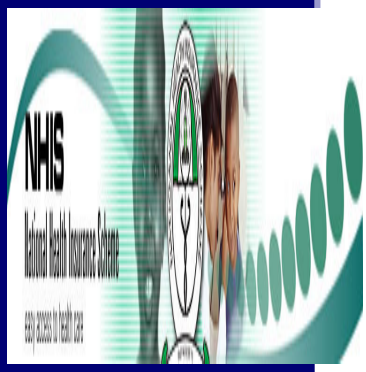
Companies can add the cost of fringe benefits including health insurance, to the price of their products and services.

Governments can tax both individuals and companies more to meet the increasing healthcare budgets.

Continued on page 3…..

Most healthcare budget goes into providing this sort of infrastructure

NHIS: Providers Adopt Creative Innovations



Goal of NHIS should be universal coverage at the earliest possible time

One of the perceived benefits of an insurance based healthcare system is the opportunity for operators to be creative either in response to market forces, competition and consumer demands; or in response to changes in the operating environment – political, economic, social, technological; or both.

This is no longer business as usual. Healthcare providers no longer see their patients as helpless victims of ill health, but rather as valuable 'customers' 'clients' or 'consumers'. More like the adage - 'He who pays the piper dictates the tune'.

……..from Sokoto

In order to serve their consumers better the Usmanu Danfodiyo University Teaching Hospital (UDUTH) has a dedicated clinic for attending to clients currently registered with the National Health Insurance Scheme (NHIS). This clinic is not only user friendly, it also gender sensitive in line with acceptable cultural practice. Rather than going through the punishing stages of navigating the care process in the hospital – enrolees of the NHIS are fast tracked right from the registration desk through laboratory, X-ray to pharmacy and other points of care. While those not on the scheme had to endure various transaction encounters with several revolving funds, NHIS clients have access free at the point of contact.

Unfortunately these patient-experiences are only available to employees of the federal government who are currently enrolled with the scheme. Speaking with the Officer who coordinates the activities of the NHIS in the hospital – Mallam Abatti Dama El-Hamzat; ***Health Insurance Report*** was reliably informed that there is clamour by employees of private companies and individuals and families who are currently on the hospital's retainership programme to join the scheme on the same terms.

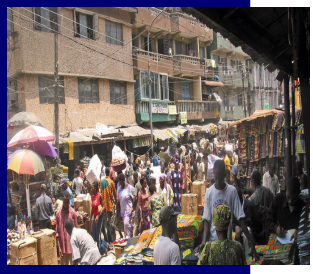
The patient-experience at the Sokoto State Specialist Hospital is even more pleasant as the stipulated 10 % co-payment for prescribed drugs is not being collected. Dr Malami B. Mohammed – the Chief Medical Director – is certain that by removing any form of barrier to access, the hospital is positioning itself to attract more clients. Apart from that the Hospital Chief Executive Officer see the NHIS as an insurance against poverty and therefore the hospital is experimenting with a model that could encourage ordinary citizens to join without any financial burden after paying stipulated premiums.

…….and Kebbi

The Federal Medical Centre at Brinin Kebbi appears to be a 'model provider' as far as the NHIS is concerned.

"Healthcare providers no longer see their patients as helpless victims of ill health but as valuable 'customers', 'clients' or 'consumers'."

Who Pays for Health Services?



Nigerians in search of fair financing for healthcare

In our situation here in Nigeria, as well as in many other developing countries ordinary citizens pay close to 70% of healthcare spending – and this is usually out-of-pocket. One source states that in 1998, the percentages spent on health service were 10 percent by Federal Government, 4 percent by State governments, 1 percent Local governments, 3 percent by private companies (such as Coca Cola), 13 percent by donors, and the remaining 69 percent from peoples' own pockets. By 2002 government "contributions" had increased proportionately, with 12 percent from federal, 8 percent from States, 2 from Local governments, 6 from companies, only 6 from donors and the remaining 66 percent from private pockets.

It has been observed that unless additional sources of funding are found, the current level of public spending on healthcare will leave a large segment of the population without access to health service. ☺☺☺

Crisis in Healthcare Financing….continued from page 1

Cost effective interventions such as immunisation require priority funding

What is fuelling the crisis?

The long-term sustainability of financing healthcare in many countries is coming under growing pressure as a result of a steady proportional increase of aging populations, fast technological advances and the growing expectations of citizens for high quality and more accessible care.

For developing countries there is the added burden of residual problems such as infectious and communicable diseases, natural population growth, failing health systems and new or emerging health concerns such as avian flu.

However, most of the attention on the healthcare crisis falls into two categories – coverage problems and rising cost. Obviously, the two are interrelated.

As a result of rising costs more people are without financial protection against catastrophic illness. Likewise lack of coverage means that a lot of people do not have access to healthcare. But in order to solve problems of coverage, the issue of rising cost must first be dealt with.

Counting the costs

Take the situation in Nigeria for example, at a conservative estimate, there are well over 50 teaching and specialist hospitals across the country, 500 general hospitals, 40,000 primary health centres, 100,000 private clinics and several thousand other facilities.

These services are there whether they are used or not. These facilities are labour intensive – and the labour is highly skilled and command more than average wages. It has been noted that salaries and benefits of healthcare personnel account for over 70% of total healthcare costs to the system.

It should also be noted that most of the healthcare budget goes into providing infrastructure or healthcare services. And the costs of most of these services are fixed.

So once a hospital is built, commissioned and opens its doors for business, costs such as salaries, utilities, rent - are incurred whether the beds are occupied or not.

But most of the population in any given year are not using health care despite the fact that most of these are shared services.

In essence, it is the supply of services rather than demand that is driving healthcare costs at least in the short term.

Nevertheless, we can also assume that everyone wants healthcare services – Emergency room, Midwife, Intensive care – to be available whenever they are needed. So the system must find a way to pay for the persons using the services now. ☺ ☺ ☺

….once a hospital opens its doors for business, costs such as salaries, utilities, rent - are incurred whether the beds are occupied or not.

Critical inputs: the system must find ways to ensure steady supply

NHIS: Providers Adopt Creative Innovations

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Through visionary leadership provided by Dr (Mrs) R.Y. Hassan (Medical Director) – this provider is employing relevant tools at the cutting edge of available technology to facilitate the client-experience. All personal data of NHIS enrolees have been captured on computer including their photographs. Information Technology (IT) is also being employed at other points to care to provide a seamless service to clients. This has the added advantage of making the tasks of care givers less cumbersome and more interesting while also making huge savings for the hospital.

According to the HMIS Manager – Olatunji Abdulmajid- the further development of the hospital information system would enable the organisation to integrate clinical and financial information linked to health outcomes.

At the Sir Yahaya Memorial Hospital, – named after Sir Yahaya, 17th Emir of Gwandu (1938 – 1954) who established the hospital - separate folders have been produced for all NHIS clients.

Medical records of beneficiaries are arranged in such a manner that the records of immediate dependants are placed within that of the contributor (the employee). This ensures prompt attention, special care and a user friendly disposition to enrolees. The 10% co-payment for prescription drugs has also been waived at least for the first year of operation. ☺ ☺ ☺

Health Insurance Report is a monthly Newsletter, linking Health Systems and Healthcare Providers in Nigeria.

CARE-NET, publishers of *Health Insurance Report*, hope that it will provide information, education and guidance to all stakeholders – government regulators, doctors, nurses, pharmacists and professions allied to medicine, employers, labour unions and patients about their responsibilities and rights in an insurance based health care system.

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Editorial

Health Insurance Report

What about Health Insurance for the poor?

While Health Insurance is not a cure all for many of the health financing challenges outlined this issue – it is a key approach in expanding coverage for a larger proportion of the population and containing the ever increasing cost of healthcare.

In Nigeria the organised private sector (employers) has been the primary source of health insurance covering less than 2% of the population. But the Federal and State governments are now beginning to provide coverage for significant proportion of the population both as an employer and by paying premiums for some target groups (Pregnant women, children under five years, elderly persons over 65 years) through emerging public health insurance programmes.

Even for rural folks, urban poor and all others of low income, health insurance promises to be the most effective means of improving access to healthcare that is of acceptable quality. These groups should also be allowed to benefit from the same advantages as the insured staff of companies and government employees. Any thing short of that would be patronising and be seen as second rated programme. This is a clear departure from conventional thinking of community based health insurance schemes that are difficult to sustain.

There are various mechanisms that can allow these groups to pre-pay premiums. Most donor funds should be directed to funding this rather than tinkering with the supply side of public health systems that has not yielded any benefits for the poor. All 'Free Medical programmes' of State governments should be converted to Social Health Insurance Funds (SHIF). These should be consolidated with earmarked funds for target groups and premiums for government employees. These Funds can then contract with healthcare providers in both the public and private sectors to offer services to beneficiaries.

Signed: ***Tarry Asoka***
Editor