Care Net Nigeria

Health Insurance Affairs

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INSIDE THIS ISSUE:

Tax Man or Insurance Company....who can you trust?

As a result of increasing cost of providing healthcare, health systems all over the world are under pressure to build better health services for their people. Several factors are responsible for this: populations are living longer, rising cost of doctors, nurses and other health service inputs, advances in medical technology, and high patient expectation of what the health service should offer.

In the past half century several models of funding health services have been tried by many countries particularly in Western Europe and North America. For several reasons many others especially those in the developing world have adopted these models as they move towards a market-led economy with or without full political democracy. Nonetheless, in the face of limited resources there has been a tendency to balance increasing demands for more and better healthcare against the resources needed to meet the health needs of majority of the population. This has led to re-opening of the health financing debate specifically pitching the 'tax-funded system' versus the 'health insurance model'.

Money determines access to healthcare. Head or Tail....can you win?

This is not an argument about the merits or de-merits of any particular system but how these approaches meet current realities - those who make contributions (pay) want to be certain that the money goes into healthcare, and they also want to see real improvements in service delivery. Fundamental to these conditions are some principles, in particular: equity, transparency, choice and competition. How far have these systems been able to satisfy these present realities?

The publicly funded tax-based healthcare as represented by the National Health Service (NHS) in Britain is a broadly equitable system although some people have faster access than others. It meets three public goals - it is comprehensive, universal and 'free' at the point of use.

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TEN YEARS OF MANAGED CARE IN NIGERIA

Health and Managed Care Association of Nigeria (HMCAN) - the industry organization of Health Maintenance Organisations (HMOs) in the country always like to pride itself as having pre-dated the National Health Insurance Scheme (NHIS).

There were initial concerns about the feasibility of HMOs in Nigeria given the level of poor performance of the Social Security Fund - National Provident Fund and the Commercial Insurance Industry. But with health policies that favoured private sector participation in the financing and provision of health services, a suitable environment for the growth of HMOs was created. Supported by the desire to find an alternative source of financing healthcare other than government funding and the need for employers to contain their medical costs, the concept of managed care was widely accepted. This was followed by the implementation of the formal sector programme of the NHIS that allowed HMOs to flourish.

No doubt members of the association have been at the forefront of developing a health insurance based healthcare system in the country. Nonetheless, the lack of capacity to grow the market and increase coverage of the population over the current level of less than 2% appears to be a scandal. Some have tried to incorporate community based programmes but the models being adopted are not sustainable as they are tied to donor funds. The challenge therefore for HMOs in the next decade is how the experience of the last ten years can be used to achieve wider coverage ◊◊◊

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One year of Hygeia Community Health Plan: what lessons?

Community-based health insurance programmes have been operating in sub-Saharan Africa (SSA) for sometime now - as one of the mechanisms of providing access to healthcare for the poor. While many of these schemes have been donor driven, they have relied on a community pooling model patterned after traditional social health insurance but without the same level of financial and management sophistication. For this and other reasons such as low capacity to raise revenue due to the low incomes of contributors, and limited capacity to redistribute risk, many of these schemes have not been viable.

In response to some of these issues the Dutch Government through a Dutch Foundation - Health Insurance Fund (HIF) since 2006 began to pilot a subsidy type community health insurance programmes in rural communities in SSA with subsidies as high as 95%.

The rationale for this approach is to allow low income families benefit from the same advantage as insured local staff of multinational companies and government employees.

In Nigeria , along with a local implementing partner - Hygeia Nigeria Limited, HIF has piloted this model called "The Shonga Model" for one year at Shonga and neighbouring communities in Kwara State, and among Lady Mechanics and Market women in Lagos State. While there was no independent evaluation of the programme, data from the programme managers for year one show as follows: over 30, 000 enrolees; 27,470 encounters including 358 normal deliveries and 2333 ante natal visits in Kwara State, and a total of 10,700 encounters in Lagos State;

Affordable rural access critical to achieving health MDGs

increased utilisation rates; and increased capacity of providers. But some information appear to be missing: what was the total cost for providing care for these numbers? What was the minimum contribution of beneficiaries and how affordable was it? Who contributes and who benefits? What was the level of subsidy? And finally what is the cost of administering the scheme? It was also observed that the donation of equipment to providers as reported by the programme managers is a not financing function and could therefore distort assessment for potential viability of the programme.

Nonetheless, based on the testimonials of some beneficiaries, and providers, the "The Shonga Model" could hugely improve access and quality of care as well generate enough revenue that is 'fit for purpose'. However, it is not clear how possible it is to spread the risk of falling ill among community members in a fairer manner and how much longer this risk pool can stand alone without being incorporated into a larger pool as the disease pattern of the community changes. No one has also come forward to stand in for the Dutch government when its funding stops. No. Not even the Lagos State and Kwara State Governments. So an exit or sustainability strategy may be lacking ◊◊◊

Backlash Against HMOs in Port Harcourt

What appears to be a 'cat and dog fight' between Health Maintenance Organisations (HMOs) and Healthcare Providers over the phased implementation of the National Health Insurance Scheme (NHIS) has escalated into an open war.

In particular, private doctors in Port Harcourt through their professional organization - Association of General and Private Medical Practitioners of Nigeria (AGPMPN), has issued an order instructing their members to withdraw their participation in the Managed care programmes of the HMOs in the organized private sector on or before 15th August 2008.

> "The doctors insist they have to act in this manner to protect their patients and prevent an imminent collapse of the scheme"

The main complain of the Medical Practioners is what they term 'high handedness' of the HMOs in their dealings with them. In particular the setting of tariffs that are grossly arbitrary, inconsistency in the payment of capitation and lack of communication. This behaviour they noted was due to 'weak regulatory capacity' of the NHIS.

While the healthcare providers are happy with how the formal sector programme as its affects Federal Government employees is doing so far despite some failings, they are totally opposed to what they perceive as unguided operations of the HMOs.

The doctors insist they have to act in this manner to protect their patients and prevent an imminent collapse of the scheme ◊◊◊

States Demand Greater Autonomy to Manage Affairs

Short of undertaking to operate individual health insurance schemes separate from that of the Federal Government, the States of the Federation are satisfied with working within the framework of a national programme. Nevertheless they are totally opposed to being 'micro-managed from the center.

They argue that healthcare is still a cottage industry, where services are demanded and produced locally. And much of the health care services necessary to improve and maintain better health status are already being provided at this level. Apart from that, many States in the country are not able to allow a Federal Agency manage what they term to be States funds, which have been earmarked to pay for personal healthcare of their citizens - not being fully aware of peculiarities of the situation in the States.

They particularly frown at the attitude of the NHIS that has failed to re-orientate itself to focus on being a regulator than assuming the role of an operator as well as a provider and fund manager all at the same time. According to one State official, even the use of language by NHIS staff '..of the need to fold in States into the national programme....' was seen to be very offensive.

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Rivers State sets up Health Insurance Fund

For the past eight years the Rivers State Government (RVSG) has been running a programme that reimbursed hospitals that provided medical treatment for certain groups of persons who ordinarily cannot afford to fully pay for the cost of healthcare. When the programme was launched in May 2000, it was targeted at children under six (6) years and elderly persons above sixty (60) years of age.

However, overtime the target groups were expanded to include pregnant women needing emergency caesarean operations, accident victims requiring emergency medical treatment for the first 24 hours, in-mates of motherless babies homes and homes for the elderly, widows of ex-service men, retired clergy and their wives, Rivers State Traffic Marshalls, their spouses and 4 children and other categories of vulnerable children.

While the programme was erroneously called "Free Medical Care Programme" (FMCP), it was indeed a form of health insurance scheme similar to the Medicaid / Medicare programme in the USA. With this recognition and the increased demands from other population groups, including rural dwellers and government employees for fair financing of their own healthcare, government adopted health insurance as the main form of sustainable healthcare financing in the State. Indeed, this was the key resolution of a Conference on Health Insurance convened for stakeholders by the State Ministry of Health on the 27th and 28th of May 2008.

Consequently, the Government of Rivers State has put in motion processes for the establishment of the Rivers State Health Insurance Fund (RSHIF), which is scheduled to take off in the last quarter of this year. According to the State Commissioner for Health, Dr Sampson Parker, the Free Medical Care Programme which has been noted to be a form of health insurance for vulnerable groups in the State will be the springboard from which the Rivers State Health Insurance Scheme will be launched.

It is expected that the model will be 'social health insurance', focusing on the principles of social solidarity but with shared responsibility. Apart from making counterpart contribution for its employees, government will fully pay the premium of vulnerable groups such as children under 6 years, the elderly above 60 years and others, while providing generous premium subsidy for rural dwellers and those in the informal sector. Both public and private providers of healthcare would be contracted by the 'Fund' in providing care. The programme aims to achieve 'universal coverage within the shortest possible time ◊◊◊

2% of Consolidated National Budget to Fund NHIS and PHC

The recently passed National Health Bill of the Senate of the Federal Republic of Nigeria will establish the National Primary Health Care Development Fund. If all goes well with the harmonization of this bill with that earlier passed by the House of Representative , "the Fund" shall be funded from an amount not less than two per cent of the consolidated fund from the Federation account. Although other sources of funds such as grants from international development partners would also be included.

The Senate Health Bill stipulates the following disbursement formula: 50% for the provision of basic minimum package of health services to all citizens, in primary health care facilities through the National Health Insurance Scheme (NHIS); 25% to provide essential drugs for primary healthcare; 15% for the provision and maintenance of facilities, equipment and transport for primary healthcare; and 10% for the development of Human Resources for Primary Health Care.

> "…..States of the Federation are hoping that the NHIS component would be used to set up a National Health Insurance Fund (NHIF) that….."

Meanwhile, the States of the Federation are hoping that the NHIS component would be used to set up a National Health Insurance Fund (NHIF) that would then disburse the funds through State Health Insurance Boards as in the case of primary health care. This allows the current NHIS to be transformed into a proper regulatory body, perhaps a 'Commission' - noting that the National Health Insurance Scheme refers to the 'system of health insurance' in the country encompassing several organisations rather than one institution as presently perceived ◊◊◊

States Demand Greater Autonomy….Cont'd

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The States insist that their preferred state of affairs is one where States can set up and manage their own 'Health Insurance Funds' and purchase services for their citizens from providers either by themselves or through 'third party administrators' while a Federal Regulatory Body oversee that they are doing the right thing and meeting national health goals and objectives.

Rather than have an open confrontation with the Federal Government on this issue some of the 'frontline States' on this matter such as Rivers, Lagos, Bayelsa and Delta are taking the initiative to resolve this impasse through dialogue.

Their interests are better protected within this framework. But...they require more say.

At the time of writing, a Team from Rivers State, led by Prof Abiye Obuoforibo - Chairman, Technical Advisory Committee on Health (TACH) is planning consultative meetings with NHIS, House Committees on Health of the National Assembly, HMOs, Community-Based Health insurance programmes and other Stakeholders, with the aim of ensuring that better relationships among key stakeholders are developed as the State go about setting up its programme in a place where two-thirds of the land area is not accessible due to difficult terrain ◊◊◊

Health Insurance Affairs is a quarterly Newsletter, linking Health Systems and Healthcare Providers in Nigeria.

CARE-NET, publishers of *Health Insurance Affairs*, 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.

Readers are invited to contribute views, articles, and letters. Opinions and views expressed in letters and articles do not necessarily reflect the views of CARE-NET. Information supplied in *Health Insurance Affairs* is checked as thoroughly as possible, but cannot accept responsibility should any problem arise.

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EDITORIAL

" The old order changeth giving way to a new, so that one good system would not corrupt the world".

Although I cannot remember who said this quote, but it was very popular with my old school principal especially during periods of change. Such is the case of this Newsletter that has just changed its name from *Health Insurance Report* to *Health Insurance Affairs* with the aim of being published in perpetuity. But most importantly, there is the need for this sort of 'knowledge resource' at this period when every health system in the world is searching for optimal means of financing health care. And therefore, the need to provide information and evidence on global best practice that can be applied to our situation in Nigeria. Also, given the sort of 'collaborative federalism' being practiced in the country, and the diversity of the people - 'one size cannot fit all'. We expect 'many flowers to bloom' and thus confirming the need to provide useful and practical information for all stakeholders especially decision makers.

We insist that 'pre-payment mechanisms' irrespective of the mode of financing is the best option for the country. How we go about it, is in the details. As usual this Newsletter will bring to the fore, critical success factors for making progress towards universal coverage that guarantees comprehensive healthcare for every citizen, 'free at the point of use'.

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However, this system is quite expensive and costs about $180 billion every year and so it can't pay for everything. Therefore there is rationing of some care. The National Institute for Clinical Excellence (NICE) draws the line on the basis of cost and clinical effectiveness.

The main attraction of the NHS is the network of General Practitioners (GPs) who act as 'gate-keepers' protecting the system from inappropriate use and minimize waste.

Nevertheless, the NHS is more of a monopoly and a highly centralized organization with heavy dose of bureaucracy. This organizational structure limits it from overcoming inertia and carry out innovations in service delivery. Though some reforms have been tried to stimulate choice and internal competition through the separation of purchasers of care from providers, it has not worked as well as envisaged. This is mainly due to the constrains put by central funding through taxation on the structure and organization of the NHS.

On the other hand, the private health insurance model as illustrated by the health systems in United States of America (USA), where there is more money for doing more with technology. Although this system provides more choice, and the health maintenance organisations - the health insurance companies - compete both on cost and quality, there is chronic imbalance. Over 44 million people in USA do not have any form of health insurance cover. Many of these people turn up at Emergency Rooms of Public Hospitals with common problems since they do not have anywhere else to go. Therefore, choice and equity can be in conflict. There is also gross wastage of resources because patients have unlimited access to specialist care. The paper work is huge. Some providers - doctors and hospitals - sometimes have to deal with over 20 different payers with their specific billing systems.

How important is primary care within this system? Though a lot of attention is paid to the gate keeping role of frontline practitioners and the need for continuity of care, there are multiple specialists acting as primary care providers. Other than General Practitioners or Family Physicians as they are best called in the United States, other specialists notably Peadiatricians, Internal Medicine specialists and Obstetricians also undertake primary care. And increasingly due to shortage of medical manpower especially in underserved areas, Family Nurse Practitioners with Masters Degrees are allowed to do primary care, working mainly from community health centres. But this sort of fragmented care arrangement is not usually optimal for ensuring continuity of care for a defined population.

In the meantime, variants or hybrids of these systems are being applied across the globe. And due to the short comings of each system, reforms on either side of the funding debate appear to be preserving what is good of a particular approach as well as adopting what is useful of the other system. As some commentators have noted: The NHS general taxation model is moving closer toward the health insurance mode of operation in terms of more choice and competition while the American model is seeking to achieve better public goals of comprehensive care and universal coverage.

Clearly there is no closure on this issue but it is likely that the political economy of a particular country, which generates the social structures that lead to one type of funding or the other is key to understanding and applying these systems in a given situation. How are these systems being applied in the States of Nigeria? ◊◊◊