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Proposed PHC Fund in Nigeria Ambushed by Vested Interests

A National Health Bill, which has been in the works for the past 6 years has proposed the setting up of a National Primary Health Care (PHC) Fund, which among other sources will have - at least 2% of the consolidated funds of the Federation of Nigeria.

The Bill notes that this PHC Fund will be used to finance PHC activities across the entire country through the National Primary Health Care Development Agency (NPHCDA) and the National Health Insurance Scheme (NHIS). However, as the Bill is not explicit about how these funds are to be used and managed, and does not state clearly who does what - it has become open to capture by several vested interests.

Consequently, there has been several interpretations of this provision from the perspective of organizations mentioned in the Bill, in relation to the proportion of funds that they may have control over or influence the disbursement.

The NPHCDA is expected to disburse about half of the funds to States but can only do so through State Primary Health Care Development Agencies. Many States are now taking position and hurriedly setting up these agencies in order to have access to the PHC funds. Meanwhile, they have failed to resolve critical establishment issues whereby PHC workers are currently engaged by several agencies within the States that have made the management of human resources for health problematic.

The Council of the NHIS is of the opinion that since 50% of the PHC Fund is ear-marked for paying for health care services, this chunk of the fund should naturally be overseen by it. And given its current mode of operation, working through Health Maintenance Organizations (HMOs) as third-party administrators - all manner of persons and organizations have set up HMOs waiting to have a slice of this piece of 'national cake'.

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Waiting for access 'free' at the point of delivery

Prepaid mechanisms save lives

The payments that are needed to be made at the point of accessing health services prevent large majority of the population from seeking medical care.

As observed, all across sub-Saharan Africa, the poor utilization of modern health services usually reverses and begins to improve, reaching a tipping point as soon as there is confirmed indication that 'treatment charges' in health facilities have been removed.

This goes to prove that any mechanism, which enables people to access care 'free at the point of delivery' will not only increase service utilization but also improve treatment for life-threatening conditions such as malaria and as a result save lives.

A recent free medical check-up campaign to promote a new community-based health care programme in a high density area in Port Harcourt, Rivers State, Nigeria - noted that close to 30% of those who were seen had classical symptoms and signs of malaria that have not been treated for at least 2 days. So what could have happened to such persons especially children if this event did not take place at that particular point in time? Your guess is as good as mine.

This is 'no-brainier', and does not require elaborate plans to be put in place. What is needed is the capacity to scale up existing options such as

Your Feedback ...

Editorial: Reducing Fragmentation of Funding Pools

Dear Tarry,

I couldn't agree better with the Editorial! The Nigerian NHIS has been a success story. We need a good plan to build on and sustain this success. The editorial captures the direction such a plan should be going.

It would be great if the members of the NHIS Board and the supervising committees in the National Assembly would read and take the message in this editorial seriously.

Keep up the great job.
Best wishes

Martin Meremikwu
Calabar, Nigeria

Dear Editor,

Thanks for sharing your magazine with me/us. The challenge facing all stakeholders in Nigeria is how to promote synergy between vertical and horizontal programmes for the well-being of the people. I am afraid, all our stakeholders are inclined to pursue their personal interest or concerned about their pocket than do something in this direction. I cannot agree more with your editorial.

Regards.

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Dear Editor,

A functional and universal health insurance scheme is the way to go and one important advantage of this, is that it will hold health care providers to account to operate within a minimum acceptable standard. In Nigeria, good things happen slowly; evil leap frogs and gallops.

Abiye Hector Goma in his characteristic incisive manner said it all : *it is better light a candle than curse the darkness.* I remain an incurable optimist on the future of Nigeria and I believe we will get there, even in our indices.

Nimi Briggs

Port Harcourt, Nigeria

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Moving up to Scale with Pre-payment Options

The World Health Organization (WHO) in its seminal annual World Health Report for 2010 focused its attention on universal coverage through fair financing of health systems. The report, *Health Systems Financing : the path to universal coverage* - identified continued reliance on direct payments, including user fees, as by far the greatest obstacle to progress. It noted that, there is abundant evidence, which shows that raising funds through required pre-payments is the most efficient and equitable basis for increasing population coverage. And experience has also shown that this approach works best when pre-payments come from a large number of people, with subsequent pooling of funds to cover everyone's health care costs.

But we know that in many parts of the developing world, especially in sub-Saharan Africa most of the successful pre-payment models operate on a very limited scale. Going up to scale is sensitive to national context, as well as the type of pre-payment option adopted. It also happens in different ways.

In a populous country such as Nigeria (150 million), a funding pool that is operated at a scale would be defined as covering at least 'one million persons'. This is about 5 times the current operating capacity of the largest Health Maintenance Organizations (HMOs) doing business in the country. If this scale is applied to a country the size of Rwanda, with a population of 10 million people, it will equate to one in ten residents. So a scale at a lower threshold may apply here.

Going up to scale is sensitive to national context, as well as type of pre-payment option. It also happens in different ways.

Similarly, scale is easily reached when serving low-income segments of the population as they tend to be several times more in number. But as this portion of the population is mainly engaged in informal activities and subsistence agriculture, the pre-payment options have to be such that it would be relatively easier to get hundreds of thousands or millions to sign on.

Furthermore, scaling up of pre-payment options could occur in different ways. The essential ingredient being that no one in need of health care, whether curative or preventive should risk financial ruin as a result. Consequently, apart from traditional sources of wage-based insurance contributions that go to fund social health insurance programmes; additional funds from government general revenues are needed to be injected into countries' health financing systems.

But these are best applied on the demand side, in the form of premium contributions for vulnerable groups or premium subsidies for low-income persons. Other mechanisms may include, 'specialized health funds' that cover the health care cost of specific groups; as well as funding a guaranteed package of essential health care for the entire population ◊◊◊

Preaching and Practicing

...Expanding financial access to health care at community level

> No consideration should be given to setting up any scheme unless health services of acceptable quality and well regarded by the target population is available nearby.

As nearly 80% of the population in most countries of sub-Saharan Africa lack social protection in health care, community-based health insurance has been the usually prescribed option for providing financial coverage in the event of sickness or accident.

We prefer to use the term adopted by the International Labour Organization (ILO), 'health micro-insurance' to refer to a variety of these schemes. They include: mutual health organizations, which are autonomous associations based on the solidarity and democratic participation of their members; pre-payments schemes organized and managed by health care providers (hospitals and clinics); as well as health insurance schemes set up by other actors such as NGOs, micro-finance institutions, cooperatives and unions.

What all these schemes have in common is that they operate on the basis of the insurance mechanism - relying on the prior payment of premiums, the sharing of risks and the notion of a guarantee. Meanwhile, experience has shown that many of these initiatives have been undertaken in situations where they lack the hindsight and knowledge needed for an accurate determination of the financial risk they face. As noted, the financial safeguards of such schemes - reserves, reinsurance and their promoters' level of competence are presently still limited.

We have also observed that apart from health micro-insurance schemes, there are other alternatives such as health savings accounts, equity funds, health credit, and clinic vouchers that could assume partial or total responsibility for the expenses incurred in connection with the utilization of health services. And some of these may rival the effectiveness of health insurance. But again the sustainability and viability of these options have to be defined in particular context.

Therefore, there is the need to develop and test all these models in different settings - with an open mind and without any preconceived notion as to what type of scheme to create or what type of benefits to provide. But having in mind the single objective of integrating the financing and provision of health care at the community level. This is because, the fact that a health micro-insurance scheme is operating in the country, or in the state or even in the next village does not mean that it is well suited to the needs and characteristics of the target population or to the context of another type of scheme under consideration.

However, no consideration should be given to setting up any scheme unless health services that meet the principal health needs of the target population are available nearby, present an acceptable level of quality, and be well regarded by the target population.

On this basis, we (Care - Net Limited) have moved on from not only preaching but also practicing what we preach. In this instance, we have set up a community-based health facility in a highly densely populated area (Marine Base) in Port Harcourt - around which various models of financial risk protection would be developed, tested and scaled up. Our aim is to strive to discover the facts, connect the dots, follow where they lead, and determine how best to fix the problems they present; and then shape events and persuade people to embrace the results ◊◊◊

Proposed PHC Fund in Nigeria Ambushed...

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Even the foremost national health authority - the Federal Ministry of Health, despite its inability to absorb current commitments to implement health programmes, is hoping to keep 5% for 'national health emergency and epidemic response' that should have been provided for in its regular appropriations.

As it stands, it would appear that the culture of 'following the money' has set in once more to spoil a good thing. At the present moment, many observers and stakeholders have started to have serious reservations of the need to go ahead with this Bill, since they now consider it as a piece of 'bad legislature'.

But there is more in the National Health Bill other than the PHC Fund. The most significant is the clarity of roles and responsibilities between the tiers of government that the Constitution of the country failed to provide. Another important provision is the legal backing now given to the National Council on Health, making it the highest decision making body on health in the land that had previously been advisory in function It is hoped that this institutional transition of the National Council on Health would allow for a more collaborative decision making that would be binding on all stakeholders, especially the federating States.

'The Nigerian Factor'....still an impediment to progress

In the meantime, both the Federal House of Representatives and the Senate have passed separate versions of the Bill. What is required now is for some harmonization of the two versions before the President of the country can sign it into law. Major disagreements as we now observe should take us back to the drawing board. And this will mean unnecessary delays in the country's plans towards achieving universal coverage inn the near future ◊◊◊

Health Insurance Affairs is a quarterly Newsletter, linking Health Systems in Nigeria and the rest of Sub Saharan Africa.

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

Absence of Markets for Health Insurance Deters Progress Towards Universal Coverage in SSA

Irrespective of the scale of operation or model adopted, unless a market for a health insurance is well established - it would be very difficult for health insurance to take proper root in Sub-Saharan Africa (SSA) as a viable financing mechanism for health care.

A health insurance market occurs when individuals and insurance companies communicate with each other to buy and sell health insurance. On the demand side - individuals who wish to buy health insurance do so in order to maximize their 'utility'; while on the supply side - insurance companies who wish to sell health insurance do so to maximize their 'profits'. And both sides communicate with each other through the medium of health insurance premiums.

The failure to allow this basic arrangement to happen in SSA has given rise to all sorts of programmes and projects that have never left their pilot stages. Meanwhile, as countries continue to explore the promise of health insurance as a significant alternative source of funds for health care, many have been led to undertake schemes that do not take this very perception into account.

Contrary to common knowledge, health insurance is 'not a health intervention', rather it is a 'financial instrument' that allows easy access to health care. Part of this misunderstanding, stems from pressure by donors who are in turn pressurized by their home governments to make development assistance in health care sustainable. But the main reason for not encouraging countries in SSA to develop health insurance markets is because of the notion of wide spread poverty in the sub region.

But we know that even for poor people, market-based solutions have proved to be delivering much better value to them than traditional approaches. Manufacturers of fast-moving consumer goods and Mobile Telephone companies in SSA who are already profiting from this knowledge have managed to turn this group into effective consumers for their products and services ◊◊◊

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