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After 5 decades of post-colonial independence in sub-Saharan Africa (SSA), funding for vital services in many countries such as clean water, essential health-care, basic education and affordable housing for its teeming population that is now approaching the one billion mark like India and China, is still a major challenge.

While governments' revenues have failed to match the growing needs of their citizens, supplementary international development assistance, which often comes with conditionalities has been inconsistent, fragmented and not dependable.

Philanthropy and corporate social responsibility (CSR) deriving from multinational companies

(MNCs) operating in the region, although useful - barely scratches the surface, compared to the magnitude of need.

Transfer of competences that have enabled some of these companies exploit the mineral wealth of Africa, to their host countries - helping them to generate enough resources to fund basic services has not happened.

Meanwhile, as the search for alternative solutions to bridging the intractable funding gaps that exist in financing social services in SSA continues; one approach that is getting everyone thinking is 'impact investment', which aims to solve social and environmental problems in developing countries, while returning profits for investors. As noted by the Monitor Group in its re-

port, *Promise and Progress: Market-Based Solutions to Poverty in Africa, May 2011*; "Many of these funds are structured like private equity funds in mature markets, promising returns, albeit modest, to investors, as well as annual fees to the fund managers".

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Doing well by doing good - a new balancing act

NCDs will break the bank in SSA

The growing incidence of non-communicable diseases (NCDs) globally, which is almost reaching an epidemic proportion has got everybody talking. The United Nations Assembly this year is focusing on four leading conditions - diabetes, cancer, heart and lung diseases that together now cause more than half of all deaths in Sub-Saharan Africa (SSA).

While many of these conditions can be controlled and managed, they persist for a long period,

thus require some form of medical maintenance for years or even decades. Consequently, the cost of managing these chronic medical conditions, which have the same economic and social parallels with HIV/AIDS, especially in resource constrained environments such as SSA, is astronomical.

With tight government health budgets that could hardly meet basic health care needs, and without adequate health insurance cover for the population; individuals, families and society

have to bear the huge cost burden of caring for people with NCDs.

Nonetheless, for the emerging health insurance industry in Africa, this presents a massive opportunity rather than a major threat, depending on how it views the NCDs crisis. By acting appropriately, and with the interest of consumers in mind - health insurance companies including HMOs, providers and regulators can create the right framework for providing financial risk protection for individual sufferers, their families and communities. ◇◇

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Your Feedback...

...still on the National Health Bill and the Primary Health Care Fund.

Dear Tarry,

Thank you for the publication. I have been educated on both the National Health Insurance Scheme and the National Health Bill.

When I was DG at the FMOH, my Personal Assistant had the job of going through the daily press and cutting out all and every article that referred to the health issues of Nigeria, pasting them in a scrap book for my attention. I had the responsibility appraising the Minister of Health and ensuring appropriate response both to the author and to the issue. Minister Ransome-Kuti and I did not regard our duty as just defending government positions, but rather of appropriate response even when that involved admitting allegations that were facts.

The trouble is that these days, it seems no one in a position of responsibility in the health sector is aware or cares about press comments on health issues. We work hard to bring out salient facts in constructive criticism, but nothing comes of it. The same omissions and commissions just go on regardless. This is very discouraging. I suppose we too must go on regardless!

Kind regards

~ **Prof Shima Gyoh** - Former DG, Federal Ministry of Health & Chair, Medical and Dental Council of Nigeria is Professor of Surgery at Benue State University .

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Tarry,

Thanks for the incisive write-ups and responses. There is no doubt that the battle for accountable, available, acceptable, affordable and accessible healthcare for Nige-

rians will be won or lost in the field of PHC Strengthening and Financing. What comes across reading this edition is that there is a need for health promoters to step out and engage the public space for enlightened debate. Health is development, security and wealth and it is the primary social-welfare responsibility that any serious government must guarantee her citizens but often denied on the pretext of other contending national priorities. The politics of health may be the starting point.

With all due respect to our senior colleague Prof S.K. Gyoh, the National Health Bill is one of the most talked about, debated and circulated bill from the Health Sector in recent times from when it was first proposed by the FMOH in 2004 to the passage in 2011. One will not be surprised about the challenges Prof had in accessing a copy of the bill from FMOH which is due to what is often called Nigeria factor but actually means lack of continuity and commitment, poor data management, overlook of knowledge management processes, resistors and resistance to change and poor reading culture.

~ **Dr Ben Ayene** - Chairman, Health Reform Foundation of Nigeria (HERFON) & Policy Advisor to Partnership for Revitalizing Routine Immunization in Northern Nigeria (PPRRINN) Programme funded by UK Department for International Development.

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Dear Editor,

Thank you for bringing this issue of the debate on the Primary Health Care Fund to the network at such an early point.

As recently observed in the New England journal of Medicine, health care costs have been kept lower in other OECD countries more than in the USA mainly because of system wide regulation of spending.

The Nigerian Health Care Bill being an executive policy should guide policies at lower levels of implementation, therefore

clearer guidelines should emanate with context specific guides at lower levels from professionals managing PHC at these levels, however there should be a system wide protocol including basic health requirement catalogues specifying cost limits to be used by the PHC which should align with the goals of the funds so that the objectives can be tracked with outcomes based on expenditure.

Specifically, the Federal government should have annual or 2yearly priorities for the PHC fund with measurable outcomes expected from funding at each level to meet these priorities. In addition, the FED should limit the type of technology required and acquired for achieving these objectives and codify these requirements and their costing limits in a catalogue, coordinate the budget process for procuring the needs and how payment is made, through a uniform or negotiated method of procurement at the different levels.

Ordinarily, the LGAs should be the fulcrum of PHC activities, but we know the type of governments Nigeria is producing currently at LGAs, which are seen by state governments as conquered territories. If this process is left completely in their hands, we might as well close shop.

So while autonomy and differentiation is important in our governance, this early consciousness of coalitions with strong distributional consequences must be controlled by some form of regulation or organizational controls from the top.

~ **Dr Anthony Umunna** - Member, Nigeria Public Health Network, United Kingdom

Impact Investment...Cont'd

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'Doing well by doing good' is not a new concept, as this has been the mantra of many development professionals. It has also been the business model of development finance institutions such as the International Finance Corporation (IFC) - the private sector arm of the World Bank. But this time around, this idea, which combines self-interest and caring for others, is attracting both mainstream philanthropies, foundations, as well as commercial investors.

Apart from notable individuals in the likes of Bob Geldof and George Soros and others from Europe and North America who are backing this paradigm shift in development assistance from outright grants and donations to focusing on both social impact and financial return; Africa too is taking some responsibility. Tony Elumelu, a Nigerian ex-banker who helped to build the United Bank for Africa (UBA) with presence in many countries on the continent, has set up a foundation that bears his name - for the purpose of

..this idea, which combines self-interest and caring for others is attracting both mainstream philanthropies , foundations, as well as commercial investors.

investing in projects ranging from education to social enterprises using this method.

Along these lines, several observers are hopeful that this surge of capital that is available on such terms constitute a useful path towards financial sustainability for the health sector in Africa - if the money could be well deployed. ◇◇

The tortuous journey of the National Health Bill in Nigeria

If anyone really wants to know how well the nascent democracy in Nigeria has taken root, the experience of the National Health Bill in its journey through the Nigerian Federal Parliament - the National Assembly, comprising a Senate and a House of

Representatives is a good place to start.

With information provided by the Health Reform Foundation of Nigeria (HERFON), we have presented below the major milestones up until this moment. ◇◇



The National Assembly - where the National Health Bill spent over five years in gestation.

<p>2004</p> <ul style="list-style-type: none"> • First Drafted and Amended 	<ul style="list-style-type: none"> • Public Hearing by House Committee on Health • Public Hearing by Senate Committee on Health 	<ul style="list-style-type: none"> • Amended
<p>2005</p> <ul style="list-style-type: none"> • Approved by Top Management Committee, Federal Ministry of Health • Advocacy to States by Federal Minister of Health • Amended • Approved by National Council on Health (NCH) • Retreat in Kaduna for National Assembly (Senate and House of Reps) Committees on Health 	<ul style="list-style-type: none"> • Review by Senate Committee on Health in Port Harcourt • Approved by National Economic Council <p>2007</p> <ul style="list-style-type: none"> • Passed by House of Representatives • Senate (2004 - 2007) failed to pass the bill 	<p>2009</p> <ul style="list-style-type: none"> • Passed by Senate and House of Representatives • Vetted by Legal Department of National Assembly • Referred back to National Assembly to rectify conflicts with existing regulations • Amended
<p>2006</p> <ul style="list-style-type: none"> • Vetting by Federal Ministry of Justice • Amended • Approved by Federal Executive Council (FEC) 	<p>2008</p> <ul style="list-style-type: none"> • Resurrected and Reviewed by National Assembly • Reviewed by Senate Committee on Health in Accra, Ghana • Reviewed by House Committee on Health 	<p>2010</p> <ul style="list-style-type: none"> • Reviewed by Senate and House of Reps to produce a harmonized bill • Harmonized version passed by Senate on May 19th • Presidential assent awaited <p>2011</p> <p>Awaiting Presidential assent</p>

Health Insurance Affairs is a quarterly News-letter, linking health financing to the business of health care in 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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How HMOs can make the next great leap forward in Nigeria

In a health-insurance based healthcare system, insurance companies in whatever form or guise are the real game changers - since they arrange and manage the finance that drives the entire system. In Nigeria, the most common types are Health Maintenance Organisations (HMOs) that are supposed to 'integrate the financing and provision of healthcare' for subscribers.

Attracted to outsourcing the administration of medical benefits of their staff to outside firms capable of managing both costs and clinical care, employers in the organized private sector in Nigeria embraced these organisations - and thus created a market for health insurance. But with the formal introduction of the National Health Insurance Scheme in the country a decade later, HMOs abandoned the market approach and largely became third-party administrators, catering for public sector employees of the Federal Government. At less than 5% coverage out of a total population of over 100 million, a fundamental change is needed for the vast majority of Nigerians to benefit from modern medical care - and HMOs are in the best position to make this happen.

In reverting back to market-based solutions, HMOs have to ensure that the wholesale application of the concept of health insurance as practiced elsewhere in the world has to be modified to become economically, socially and culturally acceptable. Following that, HMOs will need to develop, test, and roll out differentiated 'Health Plans' targeted at different segments of the population, as well as various types of medical services.

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