CARE NET NIGERIA

Health Insurance Report

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SPECIAL POINTS OF INTEREST:

- **Cost of drugs, consumables, even travel to health facility act as significant barrier of access to health services.**
- **High cost of seeking treatment may be a key reason why people seek care from other sources first.**
- **Strategies to help reduce financial barriers need to be put in place if the health MDGs are to be met.**

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Financial risk protection crucial to achieving health MDGs

Poverty is a major driver of people's decision whether to access ante-natal and emergency obstetric care; immunisation; malaria treatment or other health services in Nigeria. The costs of drugs, consumables, even travel to a health facility act as significant barrier of access to the poor for services such as TB treatment, family planning or ante-natal care. This is particularly the case for young men and women for whom the costs of even socially marketed products such as condoms are too high, and thus high-risk behaviours are perpetuated. Women also frequently lack access to cash resources which are required for many services.

Household spending on malaria treatment is high at about 40% of total spending on medical treatments (approx $3 per month) including significant out of pocket expenditure on less effective preventive strategies (repellents like coils, aerosols, local remedies).

A 2004 WHO study found that the average total treatment costs for self-medication was N144, traditional practitioner N300 and clinic/hospital N1,551. The hospital costs included transport, registration fee, consultation fee, laboratory fee, drugs, and admission costs. The significantly higher costs of seeking treatment for malaria from health facilities may be a key reason why people seek care from other sources first.

The health system is as strong as its strongest link

A lot of energy and resources are being applied to making available high impact interventions directed at the health MDGs. But these efforts will amount to nothing if financial obstacles to accessing these services continue to exist.

Strategies to help reduce financial barriers that have been tried include promoting community loan schemes and community transport schemes, and promoting birth preparedness plans with advice to save money in case of emergencies. Others are Deferral and Exemptions (D&E) for payments for clinical services, vouchers or coupons for targeting vulnerable groups with specific services or commodities and community-based social health insurance programmes.

However, most of these options have not been scaled up to the point of providing enough financial risk protection for majority of poor people. Health MDGs programmes should now begin to explore these and other innovative strategies and rapidly scale-up successful approaches to achieve wide population coverage. ◊◊◊

Out-of-Pocket Payment is Regressive

According to a World Health Organisation report published in the Journal *Health Affairs* - at least 150 million people suffer financial catastrophe each year and 100 million are pushed under the poverty line simply because they have to pay for health services.

The conclusions of another study showed that Out-of-pocket spending is regressive, because lower-income groups pay disproportionately more of their income compared with higher-income groups. Low-income individuals with multiple chronic conditions are particularly vulnerable.

The jury is out: countries with large proportion of out-of-pocket expenditure are unlikely to make significant progress towards the MDGs.

Researchers in both studies have suggested that countries can reduce the extent of health-related financial catastrophe by moving away from out-of-pocket payments towards pre-payment schemes such as insurance and taxes in financing their health care systems. ◊◊◊

"Such government subsidies are better applied as insurance premiums for beneficiaries that are ring-fenced from further budgetary cuts"

Govt. Subsidy and not 'Free MCH'

A lot of interest has suddenly been shown across the country by various State governments (and also the Federal government) in providing access to vital health services for children and pregnant mothers '*free' at the point of access.*

Without exception they have all tagged it 'free MCH' programme. Yes, you guessed right. There is some political undertone to it.

However, on its merit - this policy is very welcome and about time for it to be properly institutionalized.

But the way and manner it is being implemented leaves much to be desired. It also displays a total lack of understanding of its main purpose.

Rather than execute it as a demand-side financing mechanism whereby government is seen to be providing total subsidy for the cost of treatment for targeted groups; mandated funds have been channeled into buying supplies such as drugs and consumables meant for these groups. This has not only created a parallel system within a dysfunctional commodities supply chain; but demonstrates a clear misapplication of limited funds.

In the first place the sum allocated by most States is only a fraction of what is required. But most profoundly, it is proving very difficult to explain to decision makers that such government subsidies are better applied as insurance premiums for beneficiaries that are ring-fenced from further budgetary cuts. ◊◊◊

Scared of what is ahead? You got to brace up - this is no child's play.

New Kids on the Block

By the time this issue of the *Newsletter* is published virtually all cabinet appointments into Executive Councils in the States and the Federal Government should have been concluded.

No doubt most of those that would be required to oversee the health ministries will be 'new faces'. Majority of them will have something to do with the health sector.

Some would be thorough bred and accomplished professionals in their own right. And a good number may have strong political sense and connections.

These qualities while essential may not be sufficient to lead the most complex industry in the world - the health system. Before coming to this job most of these persons would only have been exposed to some aspects of the health sector.

But the greatest hope for health improvement at the community level where ordinary citizens live, work and play; requires a deep understanding of how the entire health field works coupled with a sophisticated appreciation of its management.

To function effectively in the complex healthcare environment, true leaders require the ability to transform people, organisations, systems and their contexts.

Can these be said to be correct of the new Federal Minister and State Commissioners of Health? Time will tell.◊◊◊

NECA's Recommendations on the Future of HMO Scheme

In its desire to positively influence the direction of the Health Maintenance Organisation (HMO) Scheme for the benefit of all stakeholders in the country, the Nigeria Employers Consultative Association (NECA) held an interactive session on Thursday 15th March 2007 at Excellence Hotel, Ogba, Lagos.

The following are the main recommendations at the meeting:

Government needs to play a regulatory role and maintain consistent policies for HMO scheme, fund the tertiary healthcare and provide infrastructure for General/Teaching hospitals.

Banks should be encouraged to channel funds to healthcare

Government to institute proper accreditation of HMOs before they are allowed to come on stream.

HMOs need to do more in respect of policy and advocacy and quality control for all their service providers

Transparency on the part of the three parties (HMOs, Service Providers and all User organisations) in relating with each other in the scheme.

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Essential Package of Care should determine minimum benefits

Certainly - but make sure it arrives in one piece.

Nigeria's health system is failing to provide even the most basic health services for most people, particularly the poor and is the major cause of deteriorating health status. This situation has caused health sector managers usually prompted by donors to resort to short-term service delivery "quick wins" which are high impact and clearly directed at reducing the major causes of morbidity and mortality.

Although this approach is needed to bring about tangible change in health service delivery that will restore the public's confidence in Nigeria's health system and make an impact on the MDG targets, paradoxically it has been observed to undermine the health system itself.

But the development of needs-based and rational planning around an essential care package is needed and could enable leverage of resources for pro-poor service development. In planning universal coverage the National Health Insurance Scheme (NHIS) should demand the delivery of a defined Essential Package of Care (EPC) as the minimum benefits package to be provided by Health Plans and district health systems.

Essentially the EPC brings together high impact interventions aimed at the health-related MDGs into a consolidated package, which is delivered through a primary health system linked to an effective referral system.

The advantage of this is to share the use of inputs and therefore reduce the cost of obtaining services. The package links treatment, prevention and promotion activities and does not view them in isolation of one another. Packaging also makes it easy to identify and coordinate the necessary technical, administrative and educational resources that are required. Finally, the EPC would provide the means for measuring the performance of district health systems and Health Plans. ◊◊◊

"The Essential Package of Care would provide the means of measuring the performance of Health Plans"

D&E Schemes require dedicated funding

Deferral and Exemptions (D& E) schemes are one of the approaches designed to overcome financial barriers in accessing basic health services by the poor, vulnerable groups such as children under five years, pregnant women, and those with irregular incomes.

Payment for health services is deferred for those who are able and willing to pay while those who are considered to be too poor to pay are exempted.

In Nigeria, experience show that D&E schemes have been unsuccessful because they do not have sustainable source of funding.

In most cases they have been funded mainly from a certain mark-up on drug sales linked to Drug Revolving Funds (DRFs) at facility level. This in fact tends to de-capitalise the DRFs when there is massive default in deferred payments or where the proportion of people needing exemptions are high.

In order for these schemes to become a sustainable mechanism for financial risk protection for the poor, they have to be financed separately either as government targeted subsidy for the poor and vulnerable or from pooled funds obtained from several sources with the intention of providing financial access to these groups. ◊◊◊

NECA's Recommendations.....Cont'd

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Improved standard of medical practice i.e. machinery, ethics, personnel, conduct, reliance on evidence based medicine etc.

Capacity building, sensitization of the populace about the benefits of the scheme.

Litigation could help to shape the operation of the scheme if any party falls short of its contractual obligation.

HMOs and the service providers should bridge the existing gap in their relationship in order not to create problems for User organisations.

Economic growth and well being of Nigeria depend on a healthy workforce

Improvement in the quality of facilities of service providers.

Creation of enabling environment for retention of health staff in the country.

Incentives for health workers to move to the rural areas.

Healthcare should indeed be made accessible and affordable for all.◊◊◊

EDITORIAL

Markets for Healthcare: the unending debate

For a long-time we have been made to believe that healthcare is about ideologies. Public versus private, profit versus non-profit, social solidarity versus capital gain, poor versus rich, preventive versus curative and the list can go on and on.

Given the chronic malfunctioning of healthcare systems the world over, it may appear to depend on only one element – and that is *choice* exercised by the individual consumer. This is the fundamental basis of markets. It therefore calls for a major paradigm shift to allow healthcare to function within a market framework – which has absolutely nothing to do with ideologies.

Some left leaning economists will quickly point out the market failures inherent in healthcare, but this is mainly because the healthcare market has not been allowed to work as a market should.

We are all aware of the "empowered patient" who must live with chronic conditions – such a patient it has been shown do much better than those who maintain a passive role. Even in developing countries, thanks to globalisation and the ICT revolution, the internet promises to be a major empowering tool for healthcare consumers.

In Nigeria for example, consumers are already voting with their feet by spending more out of pocket resources in the private sector where the public sector is seen to be providing relatively poor quality care.

Therefore, despite the complicated information, healthcare consumers should be able to successfully navigate the healthcare market as has happened in other markets – such as savings and investments.

This would allow healthcare providers to compete on service quality rather than the present monopolistic tendencies in certain markets. As advocated by *the Economist* contrary to traditional argument healthcare "is too important not to be exposed to the markets". ◊◊◊

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Last Words...notices...announcements...

PAN AFRICAN HEALTH CONGRESS 07

Here is announcing PAHC whose theme remains ACCESSING AND MANAGING HEALTHCARE FUNDING, which comes up September 18 - 19 2007 in Sandton, Johannesburg, South Africa.

Registration fee for the two-day event is $900. Registrant would be assisted to procure Visas.

HMOs, Providers and everyone interested in healthcare financing are advised to attend.

Professor Babatunde Osotimehin - Director NACA shall be making a lead presentation while Malaria will take centre stage.

All interested persons are requested to forward their names (as in their passports) with $900 registration fee plus N10,000 for Visa procurement on or before 31st July, 2007 to Mrs Nduka-Ubah, Executive Secretary, Health & Managed Care Association of Nigeria (HMCAN), c/o Multishield Ltd (HMO), 322 Ikorodu Road, Anthony, Lagos. Cellphone: 0805 256 4575. E-mail: hmcansec@yahoo.com.

Special package covering airfare and hotel shall also be sourced.