

POTENTIALS FOR MICRO HEALTH INSURANCE IN THE NIGERIA HEALTH FINANCING SYSTEM

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Oladimeji Olawale Joshua (Obafemi Awolowo University)

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OUTLINE

- Introduction
- Health Financing Systems in Nigeria
- Micro Health Insurance :The Nigeria Experience
- MHI Co-existing with NHIS
- Challenges of MHI
- Pathways Ahead
- Conclusion

Introduction

- Micro Health Insurance (MHI) schemes are informally organized risk-sharing groups with voluntary enrolment, the objective of which is to improve members' access to care by lowering the out-of-pocket (OOP) price at the time of purchase.
- Nigeria, being a developing country by WHO standard would benefit most from MHI.

Introduction

- Nigeria is a country with an estimated population of about 140 millions individuals.
- It is divided into six geo-political zones.
- Each of the zones have different characteristics and challenges.

- Each of the zones have rural and urban sectors.
- About a third of Nigerians live below 2 USD daily.
- The rural sectors are the predominant sectors in every zone in Nigeria with most of its populace being very poor.

Health Indicators

- Maternal mortality is 950 per 100,000 live births
- Life expectancy at birth, total (years) 52
- Mortality rate, infant (per 1,000 live births) 97.2
- Prevalence of HIV, total (% of population ages 15-49) 3.1

These health indicators have not changed significantly over the years though different conscientious efforts and policies.

Health Financing System in Nigeria

- National Health Insurance Scheme
- User Fees
- Public Sector
- NGOs and Donors

Health Financing System in Nigeria

- PRE-HEALTH INSURANCE ERA

- HEALTH INSURANCE ERA

PRE HEALTH INSURANCE ERA

- Period between 1960 and 2005
- Funding Health in Nigeria is from a variety of sources that include budgetary allocations from Government at all levels , Loans and grants, private sector contributions and out of pocket expenses.

- According to World Bank source, the public spending per capita for health is less than USD 5 and can be as low as USD 2 in some parts of Nigeria. This is a far cry from the USD 34 recommended by WHO for low-income countries within the Macroeconomics Commission Report.
- Federal Government recurrent health expenditure as a share of total Federal Government recurrent expenditure stood at 2.55% in 1996, 2.96% in 1997, 2.99% in 1998, declined to 1.95% in 1999 and 2.5% rose in 2000.

- As a result of low and unstable tax revenues (in addition – squandering of oil revenues in Nigeria) and cut backs in public budgets the original goal of ‘free’ or heavily subsidized health services was not possible.
- The adoption of userfees as a cost recovery strategy by healthcare providers caused considerable negative impact on equity and access in addition to healthcare utilisation and public health.

- People do not show up at a health facility unless they are seriously ill. When admitted to a hospital people often turn up only after several days because they needed time to organise the money from relatives or out of other sources.
- Delays in seeking care and the diminished healthcare utilisation especially by vulnerable groups like pregnant women and children result in adverse effects on public health.

- Evidence indicates that private health spending accounts for about 64% of total health expenditure and could be more than US\$ 23 per capita.
- This provides the impoverishing effect of healthcare payments on households.

HEALTH INSURANCE ERA

The National Health Insurance Scheme (NHIS) is a social health insurance programme designed by the Federal Government of Nigeria to complement sources of financing the health sector, and to improve access to health care for the majority of Nigerians. It was instituted 2005

NHIS

The Nigerian National Health Insurance Scheme (NHIS) was established by Decree No 35 of 1999. The Decree states that “there is hereby established a scheme to be known as the National Health Insurance Scheme (in this Decree referred to as "the Scheme") for the purpose of providing health insurance which shall entitle insured persons and their dependants the benefit of prescribed good quality and cost effective health services as set out in this Decree”.

Challenges of NHIS

- Some segments of the populace are left out: those employed in the informal sector, those not living in urban areas, the retired senior citizens to mention some.
- There is also the problem from the healthcare provider who does not make essential medicines available or provides poor quality service.

- The HMO who deliberately delays/withholds capitation.
- Many of the consumers grapple with the bottlenecks associated with accessing healthcare under such an administratively cumbersome scheme.
- Perhaps the greatest problem facing the NHIS is the monopoly it enjoys as lack of competition stifle growth and birth mediocrity.

- There is also the problem of inadequate human capacity grounded in healthcare financing to drive the NHIS.
- Another major area is the lack of a functioning regulatory framework. The NHIS Decree 35 of 1999 that was rejected by most operators and healthcare providers has not been

MHI in Nigeria

In the past,

- COWAN – Country Women Association Of Nigeria's Health Development Fund
- LAWANSON COMMUNITY PARTNERS FOR HEALTH
- JAS COMMUNITY PARTNERS FOR HEALTH
- IBUGHUBU UNION

- These all existed between 1989 and 1997.
- Had a partnership established between health care providers and surrounding communities
- They operated as a social support system for all their members.
- They had support from donors and international agencies

Presently, MHI exist effectively in two states in Nigeria:

- LAGOS STATE (2008 and 2009)
- KWARA STATE(2008)

Kwara State

- Hygeia Community Health Plan is the name of the scheme.
- **Hygeia** (a Health Maintenance Organisation) in partnership with **PharmAccess International**, a Dutch NGO and with the donor support of the **Dutch Health Insurance** and **Kwara State Government** established the scheme, which subsidises health insurance premiums for low and middle-income communities.

- For as little as N200 (\$1.3) premium, an enrollee in Kwara State for instance, is qualified to enjoy free health services at designated hospitals for one full year
- This care is provided by designated private and public hospitals and clinics in areas near the targeted communities.

- Members of the communities are able to enjoy these low premiums because 90-95 per cent of the rates are paid for by the Dutch Health Insurance Fund.
- The Kwara State government deployed a lot of resources to the public health centres for them to meet the standard.

In the 1st year and as at end December last year, we had enrolled 24,362, over 70% of our target enrolment and witnessed over 24,368 patient encounters in Kwara state",

The centres are:

- Shonga Main Primary Healthcare Centre,
- Bacita Health Care,
- Ogo-Oluwa Hospital and
- Alaafia Kwara Health Point.
- The referral centres for the state include Sobi General Hospital, University of Ilorin Teaching Hospital and Ola-Olu Hospital, Ilorin.

Lagos

Governor Babatunde Fashola of Lagos State launched the state pilot community-based health insurance scheme, called the Ikosi-Isheri Mutual Health Plan, which he noted signaled the beginning of a new order in the creation of a formalised welfare system for the provision of sustainable healthcare coverage for the citizens of the state.

The scheme has been specifically designed to provide financial access to healthcare for members of the Olowora, Isheri and Magodo communities, through a prepayment system in which contributions from families in these communities are collected and pooled together into a fund, managed by the community and the fund would be used to provide healthcare services for members registered under the scheme thereby, ensuring the accessibility of qualitative and affordable health care services to the people.

- Within six months of operations, the Isher-Ikosi Scheme's uptake had increased by 112 per cent from 567 registrations at inception to 1,200 with a steady build up of the direct community enrollee population such that they constitute 70 per cent membership.
- The premium subsidy level by the State Government is slightly over 60 per cent

Hygeia Community Health Plan

- The pilot scheme of the Hygeia Community Health Plan are also available for some market women communities in Lagos State
- The HCHP offers access to good quality basic healthcare to individuals and families in these communities for subsidized premium rates ranging from N800 per person per year.
- This care is provided by designated private and public hospitals and clinics in areas near the targeted communities. Members of the communities are able to enjoy these low premiums because 90-95 per cent of the rates are paid for by the Dutch Health Insurance Fund.

The hospitals being used in Lagos are:

- Surulere General Hospital,
- Agege General Hospital.
- R-Jolad Hospital, Bariga,
- Salvation Army, Lagos Island,
- Heals Specialist Hospital, Isolo
- May Clinics, Ilasamaja.
- Others are Topaz Clinics, Surulere, Crystal Hospital, Akowonjo, Oshuntuyi Medical Centre, Agege and Lagoon Clinic, Victoria Island.
- The referral centres in Lagos are Lagoon Hospital, Apapa and Ikeja and the Lagos State University Teaching Hospital.

MHI CO-EXISTING WITH NHIS

Roles of MHI in the NHIS:

- Insure the informal sector and rural dwellers
- Eliminate the administrative complexities
- Ensure that all the necessary parties are involved – Community, Healthcare Provider and the Government.

- There is a greater coverage and access to health at minimal cost which would go along way to complement the NHIS.
- There is also social protection which the NHIS have not been able to provide
- Health education, advocacy and Community efforts can be achieved for disease prevention and prolongation of life

- There is no 3rd party needed in handling the finances, so no delay in payment
- Donor agencies can have direct involvement in community development and also monitor it.
- Each community and group can determine what form of health development they should focus on based on existing needs

Challenges of MHI in Nigeria

- Lack of enough knowledge on how MHI should be operated
- The perspective of keeping illness as something personal, not to be disclosed to the public
- Low political backup and will

- Poor financial base
- Members not ready to share risk with each other readily
- Finally, the manner of implementation of the NHIS.

Pathway Ahead

- Specific training is required for managers in administrative and accounting procedures, record keeping, and funds management
- Concentration on the those sectors of the population—the informal sector and rural communities.

- Legislation to enable MHOs to acquire legal or corporate status through registration, to offer protection for members who subscribe and pay dues
- Community awareness on the concept of resource pooling and risk sharing

- Government involvement to help support financially and also motivate the people.
- Donor agencies should be encouraged to have direct link with community and groups

CONCLUSION

- Evidence so far indicate that there is potential for micro-healthinsurance organisations to both improve access to healthcare and reduce poverty, provided that insurance protection can be extended to large number of people.
- The strategy therefore is combine it with the existing NHIS and let the country reap the benefit of both simultaneously

**THANKS FOR
LISTENING**