

Health Insurance and Managed Care in Nigeria

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INTRODUCTION

Insurance is a veritable tool for healthcare financing that comes in different models. It has been used by most advanced countries in its various forms to fund healthcare. Insurance in one form or the other remains a veritable and sustainable tool for financing the hardware, delivery structure and systems of healthcare. It is only recently being applied by poorer developing nations to address the glaring problem of inadequate healthcare provision, which was hitherto financed exclusively from public taxation.

The health sector can be subdivided into two main categories, healthcare infrastructure and healthcare financing. Health care delivery and infrastructure may be described as the hardware, people and information structures. Healthcare financing is about the wherewithal without which the former can neither be provided nor sustained. Health funding relates directly to all production and financial activities and resources expended on goods and services consumed by or provided to the human population for the purpose of improving health.

Ever since Emperor Otto Von Bismarck of Germany enacted the mandatory legislation on the "sickness funds" for working Germans in 1883, different models of health insurance have continued to evolve worldwide albeit with the same general principles.

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INSURANCE

Insurance is a risk transfer mechanism wherein the proposer (the insured), agrees to make small periodic payments called premium to another person (the insurer) in return for the payment of a larger sum (benefit) on the occurrence of a specified event.

The basis for insurance is to protect the individual from the financial consequences of events with a low probability of happening but with the potential to cause substantial loss. Health Insurance is a social device for pooling the health risks and costs of an exposure unit with view towards predictability. However in Health Insurance, the probability of illness is not low hence the actuarial determinations allow for more variance.

In the context of Health Insurance, the Premium is the amount charged by the insurance company with the promise to pay for any eventual "covered medical treatment" for the designated coverage.

Consequently, health insurance makes it possible to substitute a small but certain cost (premium) for a large but uncertain loss (claim) under an arrangement in which the healthy majority compensate for the risks and costs of the unfortunate ill minority. Pooling of health risk is a fixture of every society and takes many forms. It was even practiced in our traditional societies. The overall contributions are placed into a pool of funds from which payment is made.

PRINCIPLES

Insurance is based on the principle of probability and all parties predicate its sustainability on the law

of large numbers and the meticulous observation of the principles of insurance. From the small contributions of the large numbers, the few who access the system for services are paid for. The following practical principles guide insurance:

- Insurable Interest.
- Utmost Good Faith
- Indemnity
- Underwriting.

Insurable interest: This is the legal right to insure. It defines the relationship that must exist between the insured and the subject matter of insurance. The insured must have something to benefit by the continued existence of the contract and something to lose by the loss of the contract.

Utmost Good Faith: There must be transparency on the part of all parties. All information about the risk being introduced (insured) and about the cover being provided and contract wordings (insurer) must be disclosed. Where there is evidence of fraud or deceit, the contract will be void. In health insurance, the terms, conditions and exclusions in the policy are clearly stated.

Indemnity: The principles of indemnity are centered on Contribution and Subrogation. The contribution or premium must be actuarially sound and enough to provide the scope of cover and prevent under-insurance, which may lead to market failure. What is promised must be delivered.

Underwriting: This is the method by which the contribution and access to the insurance scheme are determined. The premium must reflect the degree of risk introduced into the scheme. The numbers of insured may determine the level of individual contribution such that, the larger the numbers in the insured pool, the less the individual premium.

Enrollment: For determination of eligibility the applicant must supply photographs for self, spouse and eligible dependants (as applicable). The Insurance Company provides ID card for members of the scheme.

Time of enrollment and renewal: Enrollment periods may be open or closed. Group enrollment may be effected at any time of year while Non-group enrollment may only be effected at specified periods.

Waiting period: Services will be made available to registered and pre-paid members and/or beneficiaries after a specified waiting period of one month or more. Access to certain services may be excluded for up to one year.

Every Insurance scheme or HMO providing health cover must operate according to these principles in order to ensure prompt delivery to services covered and the consequent claims settlement to health care providers.

The Parties in a Health Insurance Scheme

- The Regulator
- The HMO
- The Providers
- The Payers
- The Users

In indemnity type insurance, the insurer reimburses the patients for their medical expenses; in prepayment systems, including managed care, all participants regularly pay a fixed amount and in turn receive defined package of health benefits. In government sponsored social-security insurance, there is a mandate that covers public employees and may include other members of the society. Private employers of labour may also provide health care through health maintenance organisation.

Traditional indemnity insurance has evolved during the past few decades into what is now generically known as managed care.

Benefits to Medical Provider

- Investing in Long-term solution to practice funding.
- Pre-payment affords better planning
- Improved cash flow.
- As volume increases, higher % of patient panel derives from pre-paid schemes.
- Restructuring of practices for levels of care.

THE NATIONAL HEALTH INSURANCE SCHEME

A national health insurance scheme was first proposed in Nigeria in 1962 under a bill that was introduced to Parliament in the same year by then Federal Minister of Health, Dr. M. A. Majekodunmi. The scheme was to commence in Lagos area and provide health services through salaried doctors. Issues that led to the failure of the Bill in parliament are highlighted in Fig .1.

Fig 1:

The main opposition to the bill at the time was from the Nigeria Medical Association whose membership was influenced by Private medical practitioners in Lagos (the Bill proposed salaried doctors for delivery). The NHIS idea was resurrected again in 1988 by another Minister, Prof. Ransome-Kuti. This effort resulted in the Eronini Report (1989) on the NHIS which formed the template of the present day scheme. The scheme had been be-devilled with lack of political will by the successive governments and inter-professional rivalry within the ranks of stakeholders. However concrete steps were taken with the passage of Decree 35 (National Health Insurance Scheme) of 1999 by the government of then General Sanni Abacha and the first launch of the scheme took place. This was followed by a period characterized by administrative fumbling and pilot schemes that were ill advised and not backed by legislation.

However, the private sector wherein most

of the activity in health takes place took the bull by the horn and launched private health insurance schemes

in 1998. There are now over 13 HMOs providing private health insurance schemes in Nigeria (Fig4). The pressure from the private sector and other stakeholders along with the enthusiasm of the incumbent Federal Minister of Health, Prof. Eytayo Lambo led to the present new-launch of the formal public sector programme of the NHIS in June 2005.

The present-day NHIS shall be a regulatory body providing oversight functions to the organs that will be involved in direct delivery of services to members i.e. HMOs and Providers.

The NHIS shall have several programmes aimed at different segments of society. The health care providers under the scheme shall be a mix of public and private facilities in the spirit of Public/Private partnership. The members shall be free to choose to obtain services at any one of such registered health care providers.

Health Care Benefits to be provided on the National Health Insurance Scheme

The following benefits are standard components of coverage:

- i. Curative care by a provider
- ii. Out-patient diagnostic and treatment services
- iii. Short-term rehabilitation and physician therapy
- iv. Paediatric and adult immunisation services
- v. Family planning
- vi. Ante-natal and post-natal care
- vii. Eye examination but not the provision of spectacles
- viii. Consultation with specialists
- ix. Hospital care in a public or private hospital in a standard ward during a stated duration of stay for physical or mental disorders.
- x. Emergencies in and out of the HMO service area.
- xi. Detoxification and treatment of substance abuse

- xii. Diagnostic and therapeutic radiology services
- xiii. Primary Dental care as defined- pain control, extractions, amalgam fillings, etc.

All benefits contemplated or offered or provided under the Scheme shall be provided or administered or made available in Nigeria only.

MANAGED CARE

Managed care is a general term that refers to systems for organising doctors, hospitals and other providers into groups to enhance the quality of health care services. These groups also contain health care costs by discounting the price of services and controlling utilisation of services. With managed care, quality health care services are delivered in a cost-efficient manner. Managed care organisations coordinate all aspects of the delivery system in order to manage all the costs in the system.

Rather than bill patients on a fee-for-services basis, managed care systems set pre-arranged fee structures and utilisation review procedures agreed upon by **contract** between health care providers and the managed care organisation.

The essential principles that govern the delivery of managed care are:

1. Selective provider contracting – using only providers on the preferred network .
2. Utilisation management – enrollment, pre-authorization, encounter data etc.
3. Negotiated payment – capitation, procedures, specialist, per-diem, case payments
4. Quality management – standard treatment guidelines, disease management guidelines etc

Managed care organisations combine the various roles of insurer, provider manager and care provider.

Health Maintenance Organisation (HMO):

HMO is an organisation that offers **pre-paid**, comprehensive health care coverage for doctors' and hospital services. The financial burden of risks of over-using health services are borne by the HMO, its service providers or a combination. The mem-

ber must receive health care from HMO - approved provider.

Other major characteristics of HMOs are:

- They assume contractual responsibility for assuring the delivery of a stated range of health care services including at least in-patient hospitalisation and ambulatory care services.
- They serve a voluntarily enrolled population.
- The premium is fixed, regardless of utilisation.
- There may be a fixed co-payment (direct or indirect) for use of certain services.
- The HMO assumes some of the financial risk or gain.

HMOs could be staff model, group model or a mix of both. They could also be for-profit or not -for- profit.

Staff model HMO's own their clinics or hospitals and employ their own full-time medical staff.

Group model HMOs operate with independent providers at all levels.

The Mixed model HMOs share group and staff model characteristics. For the NHIS, regulation prescribes that HMOs be Group model.

The HMO is responsible for collection and disbursement of contributions; provision of care; and administration of providers.

FUNCTIONS OF HMO

- Register employers/employees.
- Collect contributions of above
- Register providers, after ensuring they meet minimum NHIS standards
- Ensure qualitative and cost effective health care services to contributors through Health Care Providers (HCPs).
- Ensure proper adherence to referral procedures
- Payment of capitation fees and fee-for-service to HCPs
- Render returns to NHIS
- Maintain ethical marketing strategies
- Put in place effective quality assurance systems
- Ensure smooth change of provider (if requested by the contributor) within the stipulated period
- Organize risk management enlightenment for contributors and providers
- Health promotion and education

Developmental Issues in History of the NHIS

1963	1999	2005
<p>1. <i>Mandate</i> Compulsory nature of scheme was the reason for opposition by people of Lagos</p>	<p>Scheme is voluntary Decree 35 of 1999</p>	<p>To be mandatory in stages</p>
<p>2. <i>Localisation in one part of the country</i> The scheme was for the capital city of Lagos alone. Paliamentarians from other parts of the country, particularly the North opposed the idea.</p>	<p><i>Localisation in pilot zones of the country</i> Scheme is nation wide but it is beign wrongly presented as being restricted to certain parts of the country. Pilot projects on CHI in zones.</p>	<p><i>Nationwide</i> Nation wide but commencing in stages with the core Federal civil servants.</p>
<p>3. <i>Scope of cover</i> a. It was claimed that the Bill did not lay enough emphasis on preventive care and sanitation. b. Merging of Lagos City Council with other health services was predicted to reduce level of preventive care.</p>	<p><i>Managed care</i> a. Benefits include preventive care and H.M.O's will have to deliver such care to contain their cost. b. Scheme does not affect existence of Public Health Depts. or Primary Care Agency.</p>	<p>HMOs use managed care tools and payment incentives to encourage disease prevention. The issue of Public Health still remain remit of government.</p>
<p>4. <i>Rates of contribution</i> Rates if contributions prescribed compulsorily in the Bill were said to be far higher than the estimated expenditure of the people of Lagos on health.</p>	<p><i>Rates of contribution</i> Rates not prescribed compulsorily in the Decree.</p>	<p>Community rating. Flat rate to be used at commencement.</p>
<p>5. <i>Private Practice</i> Banning of "private practice" (in section 15 (5)) was opposed by doctors.</p>	<p><i>Private Practice</i> "Private Practice" not an issue.</p>	<p>Public and Private providers to be used.</p>
<p>6. <i>Consultation with NMA</i> i Minister - Dr Majekodunmi stated that the Health Bill was based on deliberations of NMA(formally BMA Nigeria Branch) during the period of 12 years that he was the Hon. Secretary. ii. Two factions of NMA emerged in the middle of the argument with the minister</p>	<p><i>NMA and Stakeholders</i> i NMA was invited to health summit in 1995 but did not turn up to present position paper. ii. Invited to and participated at numerous seminars held thereafter. iii. NMA President present at 1997 'launching" of the scheme and the seminar which followed it. iv. Opposition from NMA concerning the use of HMO's and composition of NHIS council.</p>	<p>All stakeholders in health involved but information and issues not passed down to membership. Still issues that need to be thrashed out about operational modalities and health care professionals.</p>

Roles of NHIS

- i. Registration of HMOs and Providers
- ii. Setting standards
- iii. Ensure compliance with standards
- iv. Mobilisation and sensitisation of all stakeholders
- v. Defining the minimum benefit package
- vi. Actuarial determination of premium
- vii. Drawing up contracts between stakeholders
- viii. Training
- xi. Monitoring and evaluation

Preferred Provider Network:

The use of the provider network for access and secondary referrals is a useful tool for controlling costs and maintaining viability. Provider payment mechanisms are agreed in the contract between HMOs and Providers. Referral to specialist care follows guidelines that are managed accordingly.

PROVIDER PAYMENTS

A major goal in establishing a network is agreement on a method and rate of payment for providers on some basis other than billed charges, which are inherently inflationary. The major payment mechanisms currently in use are:

Fee-for-service Payments to doctors, hospitals, and other providers are based on the bill they charge for specific services rendered or products provided. These fees are based on a fee schedule that represents an upper or lower limit on the prices that may be charged.

Capitation A negotiated per-capita (or per-member) rate is paid to the provider, who is then responsible for delivering or arranging for the health services required by the beneficiary over a certain period irrespective of utilisation.

Global Budget. A given amount is paid to the provider(s) as a whole, who are then responsible for covering the total cost of services consumed by beneficiaries during a given period of time; the providers will agree among themselves how they will divide the total budget given to them.

Per Diem. A daily rate is paid to the provider(s) to cover all services and expenses of the

patient per day of confinement, sometimes adjusted according to type of institution.

Case Payment. A flat rate or “budget” is agreed upon for the treatment of a particular illness, or illnesses in the same category or “diagnosis-related groups” (DRGs). If the cost of treatment is greater than the agreed flat rate, then the provider incurs a loss. If the cost of treatment is less than the agreed flat rate, then the provider makes a profit. This method is generally used for specialist or tertiary services.

Insurers choose a payment method that is acceptable to providers and consistent with its administrative capabilities and a level of payment which is sufficient to attract its preferred network. They use a fixed level of payment for each service or package of services and agree on limits on increases in prices from year to year.

Drug formularies

A formulary is a list of drugs which the providers in a program may prescribe at all times. The formulary is developed in collaboration with representative group of the providers using detailed information on the relative costs and effectiveness of specific drugs.

Generic drugs. Generally brand name drugs patented by the manufacturer are always relatively expensive. On the other hand generic drugs with the same chemical composition and effect are usually cheaper. In developing countries Generic drugs are the major constituents of the Essential Drug List and are usually available and can be substituted for brand name drugs thereby providing affordability. Where members prefer brand-name drugs then they are made to pay the cost-difference in form of a co-payment.

Utilization Management

Utilization management tools are tools and protocols developed to ensure that all services received are appropriate, medically necessary and provided in the most economical cost setting.

Utilization management programs and protocols include:

- Procedures the patient must follow in seeking care (for example, the patient is required to choose one provider as their primary care

provider and have all care by other providers approved in advance by that primary provider)

- Procedures the provider must follow in approving care (for example, the provider may be required to receive approval from the health plan before performing surgery on any patient except in an emergency).
- Procedures the plan may utilize to review care to ensure that providers and patients are complying with plan protocols (for example, the plan may review all emergency hospital admissions to ensure that they were true emergencies)

Regulation

Government has a great role to play in the operation of managed care. Experiences in other nations have however confirmed that the role should be limited to regulation and provision of the enabling environment. A substantial proportion of healthcare is privately provided but the capacity of government to develop and enforce regulations to ensure adequate quality of care is very limited. It is also known that enforcement of complex regulations is associated with high transaction costs. Therefore the importance of informal institutional arrangements such as professional norms and networks are mechanisms that have to be relied upon.

Regulation, Monitoring, Quality assurance processes and administration of the care to the disadvantaged sectors of the population are the main remit of the NHIS. The HMOs actuary procedures must be subject to scrutiny to prevent market failure.

Providers and HMOs

- Affiliate with one or more HMOs
- Sign contract with HMO
- Supply evidence of ability to provide health benefits
- Supply other relevant information to HMO
- Participate in meetings of planning committees
- Provide Encounter data for quality of care and Utilisation measureme

Providers and Subscribers

- i. Subscribers will select Provide HMO list.
- ii. Providers will offer quality services to the contributors
- iii. Subscribers may be required to make co-payment for certain services
- iv. A subscriber has the right to change provider on the network
- v. A subscriber has the right to seek for redress where not satisfied with services.

Working Capital

Managed care organisations are operated essentially as thrifts. Private sector management techniques are required for making managed care work efficiently.

In order to operate well, they need to be properly capitalised. There is need for adequately trained or trainable professionals to fill the operational organograms of these organisations. Seminars, Conferences and other training programs require a lot of funds. The personnel of managed care organisations are highly mobile and such need to be well paid. The computerization for data collection, analysis and provider monitoring is very capital intensive.

The operating margin for HMOs is indeed very small, between 1% and 4%. It cannot therefore be overemphasized that adequate working capital must be provided to cover the first four to five years of operation. This becomes more necessary when the enrollment figures are still low.

Managed health care has arrived in Nigeria after several years of meticulous planning. There are more than fifteen managed care organisations operating under the umbrella of the Health Insurance and Managed Care Association of Nigeria (HIMCAN). We are at the beginning of a revolution in the provision of affordable and qualitative medical services to Nigerians.

Managed care is not about micromanaging doctors as they practice medicine or about putting profits above patient care. Instead, it is about introduction of business models and management tools into delivery of health care which initially threatens the status quo, but will ultimately raise the quality of health care to everyone. It is about a new system