

# Acceptability of a Pre-paid Healthcare Plan among Informal Sector Workers in Lawanson, Lagos, Nigeria

## Summary of Focus Group Findings

Private *Initiatives* for Primary Healthcare Project



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As populations increase and competition for shrinking public resources becomes more fierce, governments around the world are urgently seeking ways to maximize quality health care delivery while reducing costs. Ministries of Health in many developing countries are exploring how the private sector can meet the health needs of their growing populations. Though the private health sector operates in most developing countries, little is known about who it serves, its efficiency and effectiveness in service delivery and the quality of the services it provides. *Initiatives* was designed to examine how private providers can deliver quality basic health services to low-income urban residents and remain financially viable.

Working to strengthen the financial and institutional capabilities of local providers in Nigeria, *Initiatives* noted that marketing information, crucial to the development of a viable business, was often missing from the business planning process. Market factors such as client perceptions of quality, service pricing, location of clinic sites, competitor information, etc., frequently received insufficient attention in the planning stages. This often led to an overestimation of demand which skewed financial projections. Prompted by this knowledge, *Initiatives* commissioned marketing studies for the provider groups supported by the project to acquire accurate market information to strengthen the group's business plans.

In 1994, *Initiatives* sub-contracted Research Marketing Services, Ltd, a Nigerian market research firm based in Lagos, to conduct a marketing study for each of four local provider groups. These studies were designed to collect information on the health-seeking behavior of potential clients and their preferences for public or private care. Using this information, the groups could make informed decisions about services required at each facility, assess client willingness to pay for specific services, project clinic utilization rates and identify potential obstacles to service delivery at, and the financial viability of, each facility.

Health professionals and organizations intending to work in southwestern Nigeria will also find this information on the health-seeking behavior of men and women in this part of the country useful when planning appropriate health services to meet the needs and demands of this population. Accordingly, *Initiatives* is making this information available through a series of booklets summarizing the findings of each of the marketing studies it has sponsored. This summary of a study of the acceptability of a prepaid healthcare plan among informal sector workers in Lawanson, Lagos, Nigeria, is one of four booklets in that series. The summary was prepared by Renuka Bery, MPH.

## EXECUTIVE SUMMARY

*if there is life there is hope debt or no debt*

focus group participant

The Lawanson Health Plan, a partnership of six private clinics on mainland Lagos, planned to offer a health financing scheme to trade association members living and working in the middle-low income area of Lawanson, Lagos. Considering two financing options, participating physicians needed to learn more about the health-seeking behaviors of their target population and whether the potential clients preferred a savings plan for basic health services or a low interest loan option for catastrophic care. *Initiatives* funded a qualitative study consisting of four focus group discussions to assist the Lawanson Health Plan in its quest to guarantee access to quality health care to low income urban clients.

Health, as characterized by the quotation above, is vital to the population studied. The focus group discussions illustrated that trade association members would willingly pay for quality health care even if they incurred debts because of the belief that life has no price. The findings also showed that this population often has neither the economic means to pay for health care nor the resources to finance a loan to pay for such services. Consequently, this population would welcome any health financing mechanism that would ensure access to convenient, quality care.

Reported practices indicated that association members were discriminating when seeking health care--choosing private and public services to meet specific health care needs. Quality of care was the characteristic most important to the focus group discussants, however, the opportunity costs of waiting for service as well as the actual cost of care, availability of equipment and trained specialists, respectful and caring personnel and flexible payment options also influenced their choice. Participants generally indicated that choosing health providers was a

joint decision between husband and wife based on referrals from trusted family members and friends who had used the services previously

Health care was usually financed on a fee-for-service basis which included contributions from both the husband and wife. Most respondents did not currently have guaranteed access to health care services and expressed concern about meeting health care costs, especially during times when personal cash flow is constrained since most facilities will not provide treatment without payments in advance. Thus, a health savings plan that would cover their basic health care needs would be welcome. But, participants unanimously agreed that a low-interest loan scheme would be preferable, since people seemed most worried about catastrophic illnesses that, if untreated, could impoverish a family or result in death.

The information acquired from this study provides guidelines for designing an appropriate health financing scheme for low income clients in the Lawanson area of Lagos. Incorporating this information into a business plan will assist the Lawanson Health Plan to meet the needs and demands of its potential clients -- strengthening the viability and, ultimately, the sustainability of its private facilities serving vulnerable populations.



During the recent period of economic decline in Nigeria, private physicians in the Lawanson area of mainland Lagos noticed a drop in service utilization. Many clients stopped coming to their clinics altogether or came late in their illness when treatment became more expensive and the prognosis for full recovery was diminished. This was especially true for women who were choosing to deliver their babies with unskilled traditional birth attendants, complications were often brought to the Lawanson physicians too late. The physicians believed that this change in client's health-seeking behavior was due to two factors: people's reduced income and the perception that private services were expensive. They believed that if they could ensure a way for patients to access care on a regular basis from qualified physicians, health outcomes would improve and the financial viability of their clinics would be strengthened, enabling them to continue to serve this vulnerable population. Focusing on the middle-low income entrepreneurs working in the informal sector in the Lawanson community, they developed the Lawanson Health Plan, an innovative health care financing scheme.

The Lawanson Health Plan—a partnership of six private clinics, proposed to provide affordable access to basic health services to local trade association members and their families. The Health Plan considered two financing options: a savings plan in which a monthly fee would be collected from each health plan member and deposited into individual health accounts at a participating local bank, or a loan scheme where low interest loans could be acquired for catastrophic care. Participants in the savings plan could visit any of the six participating clinics for basic health services at any time and the clinic would be paid a pre-established fee from the health account, payments for these basic health services were limited to the amount an individual had accrued in his or her health savings account. Participants in the loan scheme could apply for a low-interest loan from the local community bank to pay for catastrophic health care costs, using their health accounts as collateral.

The Lawanson Health Plan needed to understand whether the intended target population was interested in participating in such a health financing plan, whether the clinics were accessible to association members and their families, and which scheme was more attractive to them. By learning more about the market, the group would be able to tailor their product to maximize clinic utilization and secure the financial viability of both the clinic operations and this new plan for health care financing.

To obtain this information, a qualitative study consisting of four focus group discussions was conducted in mid-1994. The focus groups assessed the current health-seeking behavior of women and men in fifteen urban trade associations and gauged their interest in the savings and loan schemes proposed by the Lawanson Health Plan. A summary of the sample and methodology used is presented in a methodological note following the study findings.

## SUMMARY OF FINDINGS

### Current Health-Seeking Behavior

The findings indicate that trade association members and their families living and working in the Lawanson area of Lagos patronize both private and public facilities depending on their specific health needs. The most common reasons mentioned for seeking health care were basic curative/ preventive services such as treatment of headaches, malaria/ fever, immunizations, injuries and deliveries. In general, members from all groups indicated that they patronized public facilities for free preventive care such as immunizations and well baby visits. On average the participants visited a health center three to four times in the year preceding the study, however, the groups with more than six family members reported more visits (5-6 on average) than those from smaller families (2-3 on average).

### Facilities/Providers Used

In the twelve months preceding the study respondents reported seeking health services from a variety of providers. The respondents generally trusted physicians and regarded them as the preferred providers of health care, however, they also discussed their perceptions of alternative providers such as traditional healers, Alfa or traditional pastors, nurse midwives and pharmacists. One group of men indicated they might patronize traditional healers if their cash flow was limited. The women generally indicated that they used pharmacists to fill doctors' prescriptions or for treatment of minor injuries, and nurses for only the most basic health care. In addition, these women indicated that they might supplement, but not replace, visits to a physician with visits to traditional birth attendants, spiritual healers or nurse midwives in order to "ease their minds" and address spiritual ailments as well as physical ones. As one woman explained, "[The Alfa Pastors] cannot treat like a nurse or doctor, but

**Perceived Differences between  
Private & Public Sector Health Services**

<b>Provider</b>	<b>Services Sought</b>
Physicians (private/public)	malaria headache fever and general body pain injuries delivery immunization, well-baby check-ups
Nurses/midwives (private/public)	deliveries minor ailments (e.g. fever, headaches)
Traditional healers	STD treatment, pregnancy 'development' and socio-spiritual problems
Traditional birth attendants	pre-natal care, deliveries
Pharmacists	first aid minor ailments

they can pray for someone and assure him or her that the sickness will go. But you don't have to wait until that happens. Instead, consult the doctor.'

**Selecting a Health Facility/Provider**

**Who decides where and when to go for health care?** Women and men generally agreed that choosing a health provider was a joint decision between husband and wife. A few men claimed they chose a provider alone, although, no woman substantiated that claim. Instead, most men and women agreed that the woman initiated the health provider conversation. In fact, she often came to the discussion with a recommendation from trusted relatives and friends who had previously used the proposed facility. The men verified the facility's reputation before finalizing the choice.

Once the choice was made, the decision when to seek care, especially for the children, was most often made by the woman since she was

usually at or working close to home and is generally the primary care giver. As one woman said, “It is not compulsory for the father to say yes or no because he might have gone out since the morning.”

**What factors are important in making health care provider choices?**

To the Nigerians in these discussions, “health is wealth” so, not surprisingly, quality of service (which includes efficacy of treatment, caring and competent personnel and short waiting time) was the critical factor in choosing a health provider. To this population, cost influenced their decisions, but as one man eloquently said, “this life, you can’t buy it [People] don’t want to know the amount they have spent but all they want is the patient’s health.” Other important considerations included cost of services, availability of equipment and physician specialization and extended clinic hours. Though some people dismissed distance to the clinic as a factor, most respondents thought it was quite important. Women reported that short waiting time was one reason they chose private over public facilities indicating that time is valuable to them. A provider’s gender was considered irrelevant.

As mentioned previously, when considering a potential health provider, most respondents asked for referrals from trusted friends and colleagues who had first-hand experience with these facilities. Thus, they could pre-screen for quality of service indicators before making their choices.

**Why do participants change health care providers?** The reasons to change health providers were directly linked with the reasons for choosing them in the first place. If the participants perceived that the quality of their care had diminished, they would certainly switch. Distance to the clinic was also a deciding factor in changing one’s health provider, as one woman illustrated: “[If you] find a better hospital at your new place, then straight away you register there. Finally, cost might induce the respondents to change providers especially if they could find an affordable, substitute facility that offered the same or better quality of care.

**What are the perceived benefits and drawbacks of private and public health facilities?** The participants indicated that their frequency and loyalty in patronizing a private or public facility differed according to

their specific needs as well as their current economic situation. To explore the differences between private and public facilities, each group compared their perceptions of the benefits and drawbacks of the two sectors. The major findings are illustrated in the following table.

	Private Sector Care	Public Sector Care
<b>Advantages</b>	Prompt service	• Lower treatment costs
	High quality of treatment	• Availability of equipment
	Flexible and longer hours	• Comprehensive services/ trained specialists
	Caring/respectful personnel	• Free preventive care
	Available drug supply	•
<b>Disadvantages</b>	Higher treatment costs	• Long waits for service
	Little diagnostic or specialized equipment	• Little communication with and respect for patients
	Lack of specialized personnel	• Inadequate drug supply
		• Shorter, inflexible service hours

The respondents' overall perception was that private facilities offered prompt, high quality basic services that were expensive, however, one woman felt secure with her private provider because she knew she could get treated even if she could not produce cash immediately.

*As soon as you arrive at the private hospital they will receive your card and give you a prescription and treatment. Afterward a bill will follow [which can be paid later] unlike the [public hospital] where you will be sent out to buy drugs before being treated.*

Women and men both said they would patronize a public facility for free immunizations and well baby care. In addition, women, especially, noted that they would patronize public facilities if their needs were

complex and required specially trained personnel and sophisticated equipment such as surgical facilities. As one woman described a high-risk delivery

*If your case has to do with operation those doctors in private clinics cannot afford the instruments in their laboratory they have little experience and cannot diagnose your ailment they cannot tell you the condition of the child inside--but in a [public] hospital all equipments are there*

Some comments indicated a concern for health care costs which might force families to visit public facilities even though the patron might face long waits and health personnel who do not respect clients and are unwilling to discuss the diagnosis and treatment

#### **Where do participants obtain information about health?**

Respondents obtain health information from health professionals as well as from the mass media, especially television. Most women said they never purchased newspapers, but sometimes scanned the headlines if their husbands or friends brought a newspaper home. Only a few men claimed to buy newspapers regularly and these men indicated that the current economic problems prevented them from purchasing newspapers frequently. Women remarked that they receive family planning information from radio and television. Among men and women, the most popular programs on television seemed to be Yoruba drama and music programs and to a lesser extent, English dramas.

#### **Financing Health Care: Who pays?**

Paying for health services was considered the responsibility of the male head of the household by the men, however the women claimed that they usually shared health care expenses with their husbands. Women often provided financial support to their husbands as a loan or a donation to the household expenses. Although some men said they obliged their working

wives to contribute by not repaying them, most men, if they had the means, fully or partially reimbursed the women. One woman's observation clearly illustrates this dynamic:

*If I see that I have enough money to pay the bill I will pay and I won't ask [my husband] because it is for my benefit. So we should be assisting each other. But if the money that I paid is too much I will [hand him the receipt and say] this is the amount they collected. And if he has the power to repay he will pay and if he can't well [so be it].*

A few respondents reported that their employers contributed to their health care costs, but this seemed to be rare among the members of these trade associations.

**How do participants pay for health services?** Most respondents indicated that they paid for health care on a fee-for-service basis before treatment was administered; however, respondents also participated in several alternative payment schemes. Few discussants said their employers reimbursed them for health payments, others described a billing system at some private clinics where patrons had a week and sometimes up to a month to pay their outstanding health bills. Further probing revealed that respondents would welcome a three-month grace period in which to settle their health care bills. A few association members described special arrangements with their private health care providers such as a family card or paying their bills on a monthly basis. Discussants revealed that for partial payments, many private facilities only supplied part of the treatment such as an injection or the most critical treatment while ancillary drugs and follow-up treatments were withheld until the bill was paid in full. One woman said, "When we go for treatment, you pay as much of the bill as you can, and pay the balance when you return for injection. Nobody will pay for you."

The findings indicate that one trade association in this sample currently offered some health benefits to its members--benefits which did not extend to the members' families. Association members contributed biweekly to a health fund which would reimburse a member's health costs for injuries sustained on-the-job or for treatment of malaria--an

illness which severely limits productivity One other trade association was considering a similar health benefit which had not yet been implemented

### **Health Care Costs and Willingness to Pay for Services**

A family's estimated expenditure for health services in the one year preceding this study was influenced by frequency of visits and family size, the more visits and family members, the more respondents spent In general, women quoted lower annual expenses than men, but, women might not have included health costs incurred by their husbands' clinic visits The stated annual costs ranged from N700-N15,000, however, the most common responses were between N1,000 and N2,000 It is not clear how accurate these estimates are since the men's responses seemed grossly inflated

Most respondents indicated that they had paid, or were willing to pay, for most primary and reproductive health care and more complex curative services such as treatments for cancer, tuberculosis, typhoid fever and sexually transmitted diseases They expected certain services such as immunizations and well baby care to be free

## PROPOSED HEALTH PLAN CONCEPT

The discussants were given a description of the Lawanson Health Plan concept (*see Appendix*) and told where the participating clinics would be located. The focus groups were asked to comment on both the savings plan and loan schemes and then to discuss which scheme would better serve their health care needs.

### Reactions to Savings Plan Scheme

The respondents generally favored the savings plan as a way to secure basic health services effectively and efficiently. Assuming that the quality of service in the participating clinics was as good or better than their current health provider, most respondents indicated that they would switch to the plan because the clinics were more conveniently located. The discussants also assumed that since the plan was private, they would be treated promptly. They also liked the concept of guaranteed primary care services for their families without paying for each visit, ‘ you have a saving for your treatment. There is no room for panicking for lack of money, one has to go and receive treatment with [the] presentation of [a health plan] card ’. Some members believed associations might gain strength and attract new members by offering a health savings plan option such as the one proposed.

The respondents understood the implications of contributing each month in exchange for future security, eventually, they might need acute care and not have the cash on hand to pay for it. The discussants likened the savings plan to the cooperative society in which members pay dues and receive benefits, and to an *esusu*, a voluntary revolving savings plan to which most traders in Lagos contribute. Although most respondents could not identify disadvantages to the proposed savings plan, some discussants were concerned about the monthly payment contribution. They suggested instituting a flexible payment schedule designed to address the needs of the individual participants, either weekly, biweekly,

monthly, quarterly or annually. In addition, some respondents wanted to ensure that guidelines and penalties for non-payment were carefully constructed and presented to every prospective client. Another concern voiced was whether the family could continue to use the savings plan if the participating association member died. Such an arrangement seemed reasonable to the respondents provided the spouse or the member's children continued to make the requisite payments into the savings plan.

When the discussion leaders suggested varying the fee schedule depending on family size--where families larger than six members would pay more per month (N150)--most respondents supported a flat monthly rate (N100) for all families. The higher rate was considered too economically burdensome for many association members to afford. One respondent reported, however, that he contributed N40/month for the workers' compensation scheme offered by his association that covered only himself in case of injury or malaria.

### **Reactions to the Loan Scheme**

*The interest [on the loan] you are talking about is equally good because it has already yielded good health*

The respondents unanimously favored the loan plan over the savings plan as a way to pay for catastrophic care without losing everything, especially one's life. One woman explained that a person's illness might limit his or her ability to work and earn money, in which case, by the time acute care services are needed, the patient would have even fewer financial resources than before. The other advantages highlighted by the groups included convenience and flexibility in securing a loan to pay for acute care, and low-interest rates which would reduce outside debts to family members, friends or money lenders.

Some people expressed concerns about a borrower's ability to repay the loan--especially if the borrower were to die during treatment. The groups wanted to know how delinquent loan repayments would be penalized and who would assume the debt if the patient dies.

## DISCUSSION

The concept that “health is wealth” dominated the health seeking behaviors of these urban trade association members and their families. If they could afford them, most respondents preferred using private facilities despite paying higher costs for treatment. They perceived that the quality of service they received from private providers was better than in the public facilities where the staff was often disrespectful and the waits for service were long. In addition, those with a family health card for a private provider felt more secure, since they could receive curative care without pre-paying cash for services. In contrast, respondents, especially women, preferred public health facilities when their health needs were complex and they needed more specialized equipment and skilled personnel such as diagnostic or surgical services<sup>1</sup>. They felt private providers could not afford such specialized facilities or training. Women and men also reported visiting public facilities for free immunizations and well baby care, suggesting that they have limited financial resources and seek free services for preventive care when available. In addition, the benefits derived from communicating with other women as well as the free health education given can be seen to minimize the cost of waiting for services.

This population--unable to predict monthly earnings in advance--seemed economically unstable. When asked which providers they patronized, some respondents replied they might visit traditional healers if they could not afford to visit a public or private medical provider. Moreover, women often shared household health expenses, indicating that two incomes were needed to meet family health care costs. Financial insecurity was also confirmed by the respondents’ concerns about the monthly dues suggested for the health savings accounts. In several instances, respondents suggested flexible payment options to meet association members’ differing financial conditions. The discussants believed this flexibility and a flat rate would enable more people to participate in a program they felt was valuable and important. In fact, they believed it might also encourage new members to join the associations to benefit from this health care financing scheme.

Respondents valued their health, but could neither anticipate their health care needs nor predict their health care costs. The findings illustrated that a need exists for a health plan such as the one proposed which would offer peace of mind to its members as well as a range of health care options. Guaranteed access to health care was clearly an issue of importance since not everyone had cash on hand to pay for services. As one woman said, 'It is not so important to wait for the husband [when] he is not around and in so much as one possess a card, she can leave for the hospital.' All participants were interested in the proposed health plans which would assist them to save financial resources over time and guarantee them, and their families, access to quality health care.

The respondents' unanimous preference for the loan scheme over the savings plan suggests that respondents were most worried about protecting themselves and their families against a serious illness or injury. Illness can be a life or death proposition especially when improperly managed or left untreated. Respondents worried about the consequences of contracting a serious illness, especially since their income is unpredictable and hospitals in Lagos, public and private, usually demand cash before beginning any treatment. In order to meet this obligation families often have to borrow from their relatives and friends or take out high-interest loans. Indeed, gathering these resources takes time and energy which may delay treatment and/or divert the attention of the only other person in the family generating income. Thus, the possibility of a low-interest loan to cover the costs for these times of acute illness was very attractive to this population. Another fact to consider is that having a health savings account might encourage people to seek treatment early rather than forcing them to wait until they become debilitated by illness which, when finally treated, might be more complex and costly with a poorer prognosis for a full recovery.

Although cost is a consideration to this population, they seemed willing to pay higher fees for better services suggesting that the opportunity costs of poor treatment and long waits at public hospitals would be far greater than the money spent on what is perceived to be better treatment in private facilities. This further indicates that discussants believed that paying for basic health care as needed was within their reach.

This practice suggests an astute population with a long range vision that will certainly grasp the benefits of a pre-paid health plan. The price ranges people were willing to pay for services were not conclusive in this study, especially noting the discrepancy reported between the men's and women's annual health expenditures. Thus, prior to establishing a fee schedule, prospective health care providers must conduct a competitive analysis of the market.

Traditionally, women are shrewd shoppers. The findings showed that women in this population generally researched health providers by asking their friends and relatives for referrals. Then, when discussing where to go for health care with their husbands, these women proposed the recommended providers. Moreover, this study showed that economically independent women created opportunities to initiate discussions about family health care and participated more fully in choosing providers because they contributed to the family's health expenses. In fact, some families might be able to benefit from a health plan scheme only because the woman was a member of a participating association.

Women stayed or worked close to home, thus, all agreed that they were responsible for family health care, especially regarding children. As one man said, "The people at home would take her to the hospital before my arrival and when I am back I will settle the bills." This statement also supports the men's claims that the head of the household is responsible for paying for the health care expenses, however, this conflicts with reality according to the women who share the health care costs with their husbands when they can because "we are helpers to each other." Still other women explained that sometimes they paid the clinic bills because their husbands did not have any money to repay them.

The findings suggest that women are particularly important targets for health care providers entering the market who are seeking clients and advertising their facilities. Moreover, since quality is an important issue, especially to men, and women indicated that they valued prompt service as well, these attributes should be incorporated into any private

clinic planning to operate in a busy urban area Health is wealth, but, time is money Indeed, people also said that they would immediately switch providers if they found one closer to their home or work place who could offer the same or better quality of service

Some respondents seemed concerned about the guidelines for participating in the health plan implying that, though they favored the idea, they wanted to know the details of membership before joining They raised provocative questions about loan repayment, defaulting on a loan and repayment responsibilities in the event of a patient's death indicating that all plan rules and regulations must be clear before the plan is offered to the public Finally, of particular concern was the respondents' desire to continue offering the health plan to a member's spouse and/or children in the event of his or her death This concern with transferring plan ownership again highlights the need for a secure and viable health 'insurance' scheme

Able to see the long range benefits of a health plan, but short on cash, this population seemed to be an ideal candidate for the type of health financing scheme proposed by the Lawanson Health Plan The fact that two associations already offer or are considering a form of workers compensation, indicates that this community needs some protection The proposed health plans (both the savings plan and the loan scheme) offer more than currently exists, because all family members living in the household would be covered Although the findings illustrated that larger families used health services more often, most discussants strongly advocated a flat rate rather than a two-tiered system in which larger families contributed more per month, the higher rate, they felt, would be too burdensome for a large family and might prevent them from participating It is interesting to note, however that one man paid almost half the proposed family premium for a workers compensation plan that only covered himself in case of injury or malaria Thus, a higher monthly premium as well as a two-tiered system, though not desired by the respondents, might, in fact, be feasible, especially if it could be paid in weekly installments

Architects of health financing schemes such as the Lawanson Health Plan must closely examine service costs and utilization rates against people's willingness to pay for care. While a flat rate may be desirable to trade association members -- regardless of family size -- this amount may not be sufficient to adequately cover the costs incurred by the physicians to deliver the services required. A closer analysis of service delivery costs at the participating facilities against people's willingness to pay for the Health Plan will be necessary to ensure that the clinics remain financially viable while providing access to quality care to this needy population.

## CONCLUSION

It is clear from these focus group discussions that association members both need and favor a health care financing scheme that will guarantee them and their families access to quality health services. The success of a health plan will depend on the extent to which the planners incorporate the needs of their potential clients into the design. The respondents prefer the low-interest loan scheme which can be used for catastrophic care, however, respondents were also interested in options that would provide greater access to a range of basic health care services.

While the loan plan could be designed as a unique option, a more comprehensive health financing scheme might be developed that would offer elements of both the savings and loan plans. Pursuant to Lawanson Health Plan's proposal in this third option, each member would pay a monthly fee into a medical savings account which would be used as collateral for a low-interest loan to pay for catastrophic care. In addition, since respondents indicated they might be able to afford their own annual health costs for basic care, association members enrolled in the health plan would receive a family health card to use at the local participating clinics. This card would guarantee the member and his or her family immediate service for basic care provided the costs did not exceed the amount accumulated in the member's health savings account. These expenditures for basic care would have to be fully repaid within a prescribed time period (for example, one month). If a member defaulted on this commitment, his or her medical savings account would be used to settle the bills; however, the member's ability to borrow against his or her medical savings account would be jeopardized until that member had returned to good financial standing with the health plan.

Before enrolling members, health plan rules and regulations must be carefully constructed and clearly presented. The focus group discussants raised some issues such as defaulting on a payment or a loan, but certainly other issues will surface that require clarification. To prevent

delinquent dues/loans the health planners must work closely with the associations' leadership. Indeed, the leadership might also be able to enforce repayment through collective pressure, a strategy successfully used in revolving loan funds for income generating purposes. Should the Lawanson Health Plan move into the formal sector in the future, membership in the Health Plan may be encouraged by persuading employers to contribute to their employee's monthly premium. Marketing strategies to attract these employers should stress how an employer's modest investment into an employee's health plan that would reduce the number of days lost from illness or caring for family members who are ill, translates to greater organizational productivity and financial returns in the long run.

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## Notes

<sup>1</sup> This claim is supported by another *Initiatives*-sponsored study of midwives in Ghana. This study found that women preferred to deliver their babies at a hospital rather than a midwives' facility because the hospital had the equipment available in case of an emergency or unforeseen complications during delivery.

**Focus Group Composition**

A qualitative study using focus group discussions was designed to assess the health seeking behaviors of trade association members in the Lawanson area of mainland Lagos. Four discussions were held: two exclusively with male association members and two with an even mix of female association members and wives of association members. Additional criteria for allocating participants to the focus groups included family size and whether they used private or public facilities most often.

Each group had an average of nine participants. Members from approximately fifteen trade associations participated in this sample which included, market traders, taxi drivers, photographers, electricians, vulcanizers, small motor repair persons, etc.

Focus Group Composition by Family Size, Gender, and Type of Service Most Frequently Used		
	3-6	Over 6
Women	Private	Private
Men	Private	Public

**Discussion**

The focus group leaders read a description of the Lawanson Health Plan to the participants who were asked to discuss it (*see Appendix*). Following the discussion, the description was expanded to include participa-

tion in the savings plan. Focus group leaders then read a description of the loan scheme and asked participants to comment on it. Finally, the participants were asked to explain whether they preferred one plan over the other, and why.

Discussion leaders conducted the men's focus groups in English which elicited responses in English and Yoruba. The women's groups were conducted almost exclusively in Yoruba.

## Description of the Proposed Savings and Loan Plans

***Savings Plan*** Your monthly payment, along with the payment from other association members, would go into an account at the Lawanson Community Bank. This account would grow bigger every month as members contribute their monthly payments. If a participating association member, or someone in his or her family needs basic, outpatient health care, he/she can go to one of six clinics in Lawanson/Surulere. He/she does not pay the doctor for that service. Instead, the Community Bank will pay the doctor a set fee out of the funds saved from your payments.

***Expanded description of the Savings Plan*** Each member would pay every month, regardless of how much or how little he used the services. The services are available based on need, not based on the amount contributed.

***Loan Plan*** The Lawanson Health Plan only pays for basic health services. It will not pay for acute care services if you get very ill and need hospitalization or surgery. But the Lawanson Health Plan can help you pay for these services. If an association member, or someone in his/her family needs acute care, he/she can borrow money from the Community Bank at a low interest rate. The member can use the Lawanson account as collateral/guarantee, so the bank can more easily lend the money.

## BIBLIOGRAPHY

1 *Initiatives Perceptions of Care Provided by Private Midwives in Ghana Summary of Focus Group Findings* Arlington, VA JSI Research & Training Institute (forthcoming)

Private Initiatives for Primary Healthcare (*Initiatives*) is a project funded by the U S Agency for International Development (USAID) and managed through a cooperative agreement with JSI Research & Training Institute. The project promotes access to quality basic health services in developing countries by strengthening local private groups' abilities to provide basic health services. The project specifically targets low-income residents of urban and peri-urban areas.

Working in Ecuador, Guatemala, Nigeria and Ghana, *Initiatives* strengthens the financial and institutional capabilities of local provider groups. In these countries, the local groups encompass a range of service models, including independent physicians and nurses, networks of providers, and traditional and non-traditional insurance schemes. *Initiatives* provides technical assistance through business development workshops and individual consulting in the areas of strategic, business and financial planning, marketing assistance and capital acquisition.

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