

Health Insurance

A Viable Approach to Financing Health Care in Nigeria?

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TABLE OF CONTENTS

Acronyms	4
Acknowledgements	5
Executive Summary	7
Introduction	11
National Health Insurance Scheme (NHIS)	12
Private Health Insurance	22
Informal Prepayment Schemes Country Women Association of Nigeria (COWAN)	32
Options for Improving Access to Care	41
Conclusion	48
Notes	49
Bibliography	52
About <i>Initiatives</i>	54

ACRONYMS

CBD	-	Community-Based Distributors
COWAN	-	Country Women Association of Nigeria
FMOH	-	Federal Ministry of Health
FMOHSS	-	Federal Ministry of Health and Social Services
FFS	-	Fee-For-Service
GPI	-	Gross Premium Income
HDF	-	Health Development Fund
IGI	-	Industrial and General Insurance Company
ISI	-	International Standard Insurers
HSS	-	Health Savings Scheme
N	-	Naira
NGO	-	Non-Governmental Organization
NHIC	-	National Health Insurance Council
NHIS	-	National Health Insurance Scheme
NHF	-	National Housing Fund
NIC	-	Newline Insurance Company
NPF	-	National Provident Fund
PPFN	-	Planned Parenthood Federation of Nigeria
PrHI	-	Private Health Insurance
RIHFPP	-	Rural Integrated Health and Family Planning Program
SHIB	-	State Health Insurance Board
SIC	-	Shelter Insurance Company
SMOH	-	State Ministry of Health
VHP	-	Voluntary Health (Insurance) Plan

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Proposals for reforming health care financing in Nigeria have been under consideration for more than ten years. The need for reforms arose from government's inability to continue financing the bulk of expenditures on health care as economic recession had substantially reduced the inflow of revenues since the early 1980s, 90 percent of which was derived from the sale of crude oil. In 1992, the Federal Ministry of Health and Social Services (FMOHSS) opted for a National Health Insurance Scheme (NHIS) to be implemented in phases in four of the thirty states of the federation, beginning with workers in formal employment.

Employers in these selected states with ten or more workers, will compulsorily insure their employees under the scheme. The NHIS will be administered by a parastatal that would be supervised by the FMOHSS. It is envisaged that the NHIS will cover six million people in the first phase (about 7 percent of the population), progressing eventually to those in the informal sector and the rural populace. The decree establishing the NHIS is yet to be signed into law but the scheme has already faced tremendous opposition from various interest groups notably the labor unions, private sector employers and key professional associations in the health sector.

In the NHIS each contributor (along with his dependants) will register with only one provider and shall be entitled to comprehensive health care benefits, subject to a 'waiting period' of five months. Benefits include personal preventive services, ambulatory and in-patient care, maternity and family planning services, diagnostic services, drugs, limited dental and optical services as well as prostheses. A fee of N0 50 (about US\$0 03) per prescription shall be paid by the patient. Hospitalization in a private facility shall attract a 10 percent co-payment. Hospitalization in a public facility will not involve cost-sharing in order to encourage the preferential use of public services.

The scheme will be administered at the state level by the State Health Insurance Board (SHIB) to which payroll contributions in each state shall be

forwarded. At the federal level, overall responsibility for the scheme will rest with the National Health Insurance Council (NHIC). The SHIB will enter into contractual arrangements with primary providers which can be either public or private facilities. The latter can then contract with 'sub-providers' of various services covered by the scheme (e.g. in-patient pharmaceutical, laboratory and x-ray services).

The bulk of the reimbursements to health care providers will be capitation payments remitted quarterly by the SHIB and based on the number of persons registered with the provider at the end of that period. The rates are to be reviewed annually and must be accepted by the provider as payment in full for services delivered. Payment for hospitalization beyond twenty-one days and for treatment received in tertiary care centers, are to be borne directly by the SHIB. Primary providers will be allowed to stock drugs and dispense directly to patients. However, this service could be sub-contracted to pharmacies if so desired, in which case, the latter's bills will be settled by the primary provider. This provision has been rejected by pharmacists who remain strongly opposed to the NHIS.

Reservations have been expressed regarding the public sector's capacity to manage such an administratively cumbersome scheme, given the poor performance of most public enterprises such as the National Housing Fund (NHF) and National Provident Fund (NPF). It is further argued that for a country which has limited technical capacity in the areas of health management and financing, attempting to cover six million people from the outset would appear a somewhat ambitious undertaking that could further jeopardize the chances of success. In the absence of meaningful competition from other plans, it is feared that a monopsonistic health plan like the NHIS could become so large as to encourage mis-management of pooled funds while being insensitive to the needs of the consumer. Such a development would stifle growth, and invariably, the ability to extend coverage to those in the informal sector and rural areas within a reasonable period of time.

Private Health Insurance (PrHI), on the other hand, is just developing in the Nigerian market. Currently, there are four wholly private companies marketing health insurance plans in the country -- three of these are based in Lagos and one in Enugu. The companies offer primarily group plans

and cover employees in the highly commercial and industrial regions of the south. The pool administered by each company is very small, the largest being less than 18,000 (beneficiaries inclusive). It is estimated that only about 0.03 percent of the total population was covered by private health insurance as at July 1995.

Growth of private health insurance has been limited by a myriad of factors, including the lack of public confidence in the insurance industry, limited technical capacity for underwriting this class of risk, poor knowledge of the nation's private medical care market, high prevalence of fraud on existing schemes, and the absence of reinsurance backup. In some instances, claims have grown much faster than premium incomes, threatening the viability of private health insurance schemes. This is largely the result of fee-for-service (FFS) payment arrangements (with no fee schedules) and the absence of effective cost-sharing formulae. Mechanisms for monitoring the quality of care rendered by providers are weak and the market is not expected to witness significant growth in the foreseeable future.

Informal prepayment arrangements in the country are under-reported. As such, the potentials and limitations of this financing option are not well understood. One such scheme is managed by the Country Women Association of Nigeria (COWAN), a rural cooperative union which has operated a credit-linked Health Development Fund (HDF) since 1989. The HDF is a component of COWAN's Rural Integrated Health and Family Planning Program which is implemented using a network of 370 community-based distributors of family planning commodities. Each registered group with a membership of five to ten persons contributes monthly fixed amounts to the Credit Scheme (comprising the Daily Savings' and Trust Fund) as well as the HDF. In 1995, the monthly rates of contribution per group stood at N1,200 (US\$14) for the Daily Savings fund, N20 (\$0.24) for the Trust Fund and N10 (\$0.12) for the HDF. These contributions entitle members to credit facilities for agricultural and commercial activities, as well as loans for covering the cost of 'catastrophic' illnesses (usually involving hospitalization).

The total contribution to the HDF is very low, loan disbursements averaged around 87 percent of contributions between 1992 and 1994. Average value of loans per beneficiary was less than N4 000 and full repayment was achieved in almost all the cases within twelve months, supporting the view that the poor are credit-worthy. An interest rate of two percent per month is charged on loans after a grace period of three months.

The linkage of a credit scheme with prepayment for health care makes this an attractive model for protecting those in the informal sector of the economy, although the small size of contributions makes it inadequate for financing the basic health needs of most low income families. Furthermore, there is no mechanism in place for assessing the quality of care rendered by health care providers, and efficiency may be compromised by the adoption of the FFS reimbursements in the absence of negotiated fee schedules. A thorough evaluation is required to ascertain the adequacy and efficiency of this arrangement, and to explore opportunities for covering a wider range of basic health care benefits, such as ambulatory and maternity care.

In the light of these experiences, it is concluded that the desirable options for covering low income urban populations in the informal sector would be those that combine flexibility in payment arrangements with aspects of managed health care. Cooperative societies and unions are seen as the major vehicles for actualizing such proposals. The commercial insurance option is severely limited by the high cost of premiums and the unfavorable trends in this market at present. The potential exists for developing not-for-profit voluntary health insurance plans (VHPs) sponsored by health sector professional associations, cooperative unions and non-governmental organizations. These require formal administrative machinery and extensive consultation, but the preliminary/start-up costs could be financed, in part, through development assistance.

The promotion of credit-linked family savings schemes for health care (an extension of the COWAN experiment) also presents a feasible approach to covering low income urban populations. The level of contribution could be such that coverage for basic health services is available, although contributions could be higher than in a VHP because the element of risk-sharing is considerably less in a family savings scheme. This option would also require intensive community mobilization and education.

INTRODUCTION

Financing health care in Nigeria continues to present formidable challenges to government, academics and health policy experts operating within the country. Models of financing in existence in many developed countries are rarely applicable in Nigeria due to the limited institutional capacity, paucity of data on health status and service utilization, unstable economic and political climates (both of which profoundly influence planned reforms) and consumers' low level of awareness of health development issues. The task of identifying appropriate financing mechanisms become even more daunting with respect to low income urban populations, many of whom live in squalid conditions, have large families, and are subjected to a harsh economic environment, all of which translate into high morbidity and mortality.

About 30 percent of the nation's 100 million inhabitants (mostly rural) are estimated to have poor geographical access to basic health services (UNICEF, 1996), but an estimation of the proportion with poor financial access is limited by the absence of reliable data on household incomes and expenditures and unstable medical care prices, the effect of high rates of inflation. In addition, the existence of a large informal sector makes it difficult to assess consumers' ability to pay and to institute formal contributory arrangements for health services financing. Contrary to popular perception, urban populations do experience problems with access to quality services as a result of rising medical care prices, limited savings and the varied quality of care provided in private health facilities.

This paper examines prospects and limitations of prepayment arrangements as a mechanism for financing health care among low income urban communities. Within this context, it reviews the current proposal for a National Health Insurance Scheme (NHIS), existing private health insurance plans and an informal arrangement linking the availability of credit for agriculture and commerce to health care prepayment.

Historical Background

Proposals for reforming health care financing in Nigeria have been under consideration for more than ten years. These arose from government's inability to continue financing the bulk of expenditures on health care as the economic recession had substantially reduced the inflow of revenues since the early 1980s, 90 percent of which came from the sale of crude oil. Consequently, the Federal Ministry of Health (FMOH)¹ set up a committee which, in 1985, recommended the adoption of a social insurance scheme (FMOH, 1985). This was followed in 1988 by the work of another committee which examined in greater detail, the modalities for establishing a National Health Insurance Scheme (NHIS) (FMOH, 1988).

Significant progress has since been made with inputs from external consultants sponsored by the United Nations Development Fund (UNDP) and the International Labor Organization (ILO). A draft decree which would give legal backing to the scheme was forwarded to the Federal Government in 1992. This decree is yet to be signed into law. The proposed scheme has, however, faced tremendous opposition from various interest groups, notably the labor unions, private sector employers, and key professional associations in the health sector.

What has been proposed?

As contained in the working document on the implementation of the NHIS (Phase I) (FMOHSS, 1992), the intention is to have a single compulsory health insurance fund which will be implemented in phases starting with four of the thirty states of the federation. The pilot states are Lagos, Rivers, Plateau and Kaduna. The first two are located in the southern part of the country while the latter are in the north. All the states have a large industrial and commercial base and sizable proportions of the population

are in formal employment - a criterion considered vital to the successful operation of contributory schemes. The scheme is expected to be launched as soon as the enabling decree is promulgated.

Structure and Administration of NHIS

The structure of the proposed NHIS takes into account the existing relationship between the different tiers of government, in particular the autonomy enjoyed by individual states on issues of health care. At the federal level the National Health Insurance Council (NHIC) will have overall responsibility for the scheme, while at the state level the State Health Insurance Board (SHIB) will bear responsibility. These regulatory bodies are expected to be autonomous and are to be constituted jointly by the Ministries of Health, labor unions, and key professional associations in the health sector. The Ministry of Health will serve as the supervisory agency.

It is proposed that modalities be worked out for linking the administration of the NHIS with existing social insurance funds, i.e., the National Provident Fund (NPF) and National Housing Fund (NHF) via the establishment of an autonomous central social security authority. This authority will have responsibility for coordinating social protection policies and the administration of social security funds. Proponents of this arrangement believe it will eliminate the duplication of functions that arise from the independent administration of multiple social insurance funds.

The NHIC will monitor the performance of SHIBs, issue guidelines for rate setting and establishing the viability of Boards, coordinate manpower training and undertake relevant research. The SHIB, on its part, will be responsible for strategic planning and expansion of the scheme, register contributors and beneficiaries, approve and monitor providers, and forward returns periodically to the Council. One-quarter (25 percent) of total fund contributions in each state is to be set aside for administration. Four-fifths of this amount (equivalent to 20 percent of total contribution) will be retained by the SHIB for general administration and for the provision of benefits by the Board, as discussed below. The remainder (5 percent of total) will be remitted to the Council for its prescribed functions. A General Manager and Executive Secretary will oversee the day-to-day management of the scheme at

the state and federal levels respectively. These would be appointed by the respective Boards to which the officers will be subordinate.

Coverage and Contributions

The first phase of implementation will cover individuals in formal employment. This group comprises i) civil servants, ii) employees of parastatals, iii) employees of statutory bodies and iv) employees of private companies with ten or more workers. Coverage will be gradually expanded to include those in firms employing less than ten workers, and the self-employed. The final phase will extend the scheme to the rural populace. However, the time frame for attaining national coverage remains undefined. Proponents of the scheme believe that a single health insurance scheme will be able to meet the needs of most of the population. As such, in the early phase, private insurance shall be limited to covering those segments of the population that are yet to be covered under the NHIS, and ultimately to financing only those benefits that are not covered by the scheme, e.g., payment for single wards and special meals.

Every eligible person will register (via their employer) with the SHIB and contributions will be remitted to the Board by way of payroll deductions.² This will entitle the enrollee, his spouse and four dependent children to full benefits which are uniformly prescribed in line with the principle of social insurance. Allowance has been made for the inclusion of extended family members who can be voluntarily covered at an additional cost. Given the above scenario, it is envisaged that the number of insured in the four pilot states will reach about 1.37 million, with the total number of beneficiaries estimated at over six million (about seven percent of the total population).³

Benefits Prescribed

Each beneficiary shall be entitled to comprehensive health care benefits subject to a waiting period of five months. Retirees shall also be entitled where such persons have contributed for the prescribed period. Table 1 outlines the range of benefits available in the scheme. A fee of N0.50

(US\$0.03)⁴ per prescription shall be paid by the patient. No additional costs will be borne in respect of out-patient care. However, hospitalization in a private facility will attract a 10 percent co-payment payable to the provider, hospitalization in a public facility will not involve cost-sharing, to encourage preferential use of public services, especially as many of these hospitals currently have unused bed capacity.

Selection, Reimbursement and Monitoring of Providers

Applications are to be invited from all categories of health care providers in each of the participating states, however, traditional and alternative medicine practitioners are excluded. Those that meet required standards (to be determined by the SHIB) will be registered as 'approved' providers. These will be the 'primary providers' with which the SHIB will enter into a contractual arrangement.⁵ Primary providers can then contract with 'sub-providers' of various services (i.e., laboratory and x-ray services) as are covered by the scheme. The flow of finances within the scheme is illustrated in Figure 1.

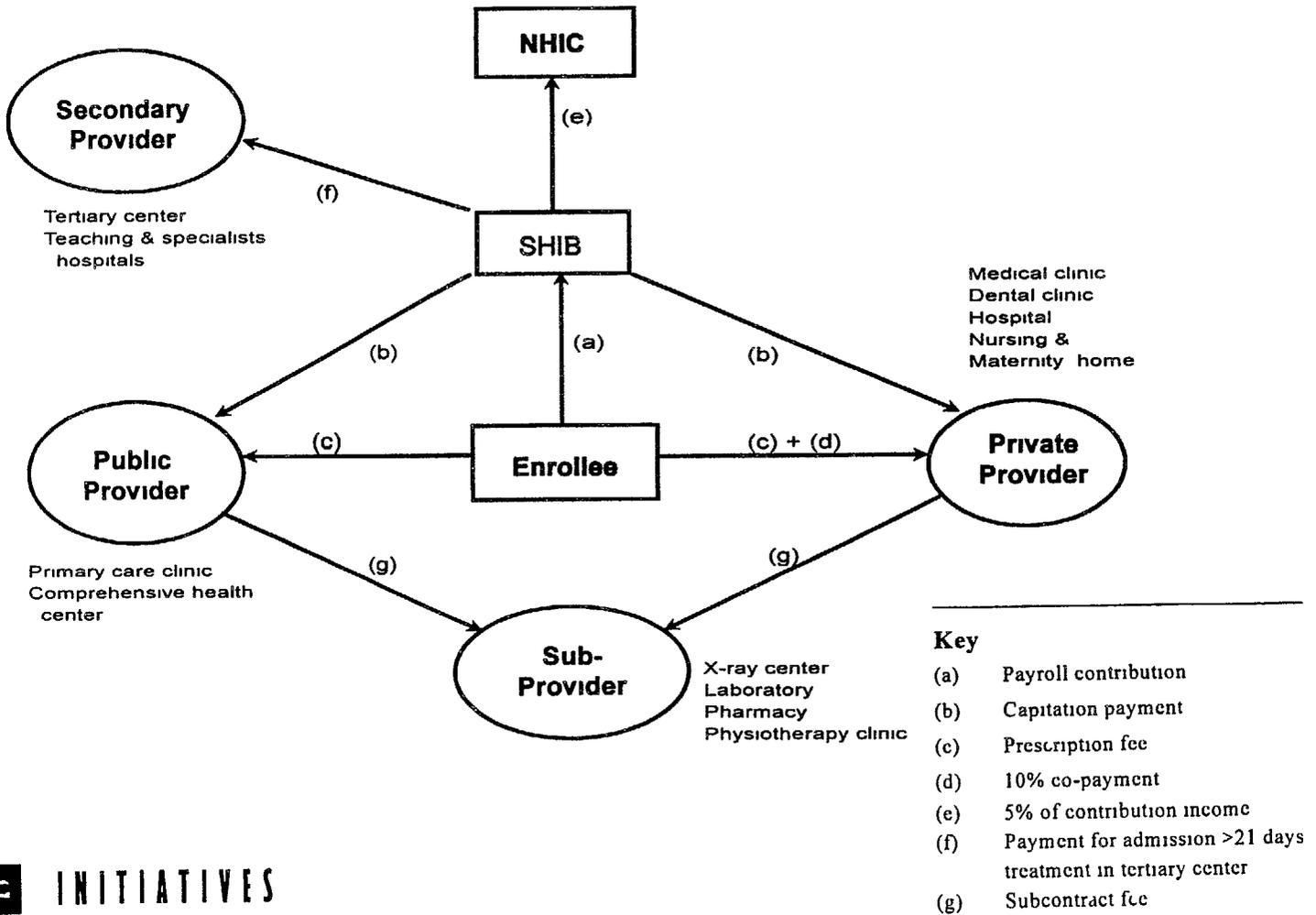
The bulk of the reimbursements to health care providers will take the form of capitation payments remitted quarterly by the SHIB, and based on the number of persons registered with the provider at the end of the period. The rates will be reviewed annually and must be accepted by the provider as payment in full for services delivered. Primary providers are expected to supply comprehensive medical care services from the payment received including up to twenty-one days hospitalization, as well as settle administrative and practice expenses. This marks a major departure from the dominant form of reimbursement in the sector which is largely fee-for-service (FFS) and which proponents of the NHIS believe will make costs uncontrollable if adopted. Payment for hospitalization beyond twenty-one days and for treatment received in tertiary care centers are to be borne directly by the SHIB. For this reason, treatment in tertiary care centers will be strictly by referral. It is expected that moral hazard⁶ will be minimized through the imposition of co-payments and that the use of capitation payments will limit over-supply of services by compelling physicians to adopt efficient practices.

Table 1: Schedule of Benefits and Exclusions under the National Health Insurance Scheme (NHIS)

Services Covered					Exclusions
Personal Preventive	Out-patient Care	In-patient Care	Maternity Care	Chronic Conditions	
<ul style="list-style-type: none"> • Family planning Immunization Growth monitoring Health education 	<ul style="list-style-type: none"> Consultation Laboratory/radiological investigation Drugs Limited dental Limited prostheses 	<ul style="list-style-type: none"> • Room and board Physician s fees Surgical fees Laboratory/radiological investigation • Drugs 	<ul style="list-style-type: none"> Prenatal care (including immunization) Delivery • Postnatal care • Management of abortions 	<ul style="list-style-type: none"> Hypertenstion Diabetes mellitus Tuberculosis Leprosy • Others (as would be identified) 	<ul style="list-style-type: none"> Periodic medical exam • Routine eye test • Screening for presumptive diseases • Domiciliary care • Psychiatric illness Renal dialysis Cardiac/neurosurgery Cosmetic/transplant surgery

Source FMOHSS Lagos 1992

Figure 1 Flow of Finances Within the NHIS



Providers will be allowed to stock drugs and dispense directly to patients. However, this service can be sub-contracted to pharmacies (or chemists) if desired, in which case the latter's bills will be settled by the primary provider. There will be no direct financial relationship between sub-providers and the SHIB, an issue that has resulted in major divisions amongst the dominant professional associations in the health sector.

Critical Issues

Population coverage

The administrative and technical requirements of a social insurance scheme may not have been fully appreciated by the NHIS planners. At present, technical skills in the areas of health management and finance are in very short supply countrywide and it is doubtful that adequate numbers of professional and managerial staff can be trained within a short period of time. Moreover, given the slow pace of implementing social reforms in the country, it would appear that sizable proportions of the population may not be covered by the NHIS for several decades. The delays in implementing the scheme since the proposal was passed to the FMOH in 1988, lends credence to this view.

Major equity problems also arise from the current proposition as those that will benefit most from the scheme will be largely the same socio-economic group that currently enjoy some form of employer-sponsored medical benefits and are currently enjoying better health status. In seeking to achieve full population coverage solely through a unitary health insurance scheme, proponents of the NHIS may have foreclosed opportunities for experimenting with alternative health insurance arrangements (such as voluntary health plans and community health insurance) that could prove equally efficient and perhaps more effective in extending coverage to those in the informal sector and rural populace.

Payroll contribution

Payroll deductions offer the most efficient means of collecting contributions for those in the formal sector. But payroll contributions, in the Nigerian setting, could prove highly regressive as employers, in concert with labor unions, often exclude major fringe benefits such as housing and transportation allowances from the returns filed to the internal revenue department. Declared incomes thus turn out to be much lower than the actual, with those in the top management getting the highest rebates'. Furthermore, this approach is not readily applicable to those working in the informal sector and who constitute the bulk of the population. Arriving at a fair and equitable level of contribution for this group of potential subscribers will pose a major challenge to the scheme.

Public monopsony

Public enterprises and social security schemes in the country currently face a major credibility problem because of the extreme politicization and lack of accountability that are believed to have crippled the management of these institutions over the last fifteen years. Subscribers to the NPF and more recently, the NHF, point to the failure of these institutions to fulfil the objectives for which they were established. There is reason to expect therefore, that a monopsonistic NHIS, being publicly sponsored, will suffer a similar fate. Such anxiety was expressed by the major professional associations whose views were sought in the course of this review.⁷ The proposed merger with existing social protection schemes could thus aggravate, rather than ameliorate, existing efficiency problems.

Reimbursement plan

The capitation method of reimbursing providers has become an increasingly popular tool for achieving cost-containment in health insurance practice worldwide as it discourages the oversupply of services by physicians. However, this payment option carries the disadvantage of encouraging providers to minimize workloads (for example, through frequent referrals)

and cut back on essential care particularly in situations like the Nigerian health system where provider monitoring is very weak. Moreover patient characteristics such as the proportion of children, women (especially those in childbearing age) and the elderly, as well as the number of chronically ill-patients registered with the different practices would need to be adjusted for in the computation of capitation payments as these factors significantly affect utilization rates and invariably providers' incomes. There is an ever present risk that plans that do not factor these considerations into reimbursement schedules (particularly in periods of high inflation) could leave providers little choice but to ration care at the expense of quality. Such a development is possible under the NHIS considering the paucity of empirical data on patient characteristics and consumption patterns within the Nigerian health care system.

Divisions within the health sector

Few proposals for reforming health care in Nigeria have brought about as much division among the various professional groups within the sector as the NHIS. Perhaps the most controversial of the issues is the proviso for primary providers to stock and dispense drugs within their premises. Pharmacists contend that the supply of non-emergency drugs and medications to ambulatory care patients should primarily be the responsibility of retail pharmacy outlets since this is the traditional role of pharmacists and is the practice in most other countries with well organized health insurance systems.

According to this group, the preferred arrangement would be one in which the attending physician/ nurse clinician filled out a prescription to be presented by the patient at a pharmacy registered by the SHIB. The bill for the medications supplied (less the recommended prescription fee) would then be settled directly by the SHIB. This arrangement would not only preserve the autonomy of pharmacists (who, otherwise, would have to shop around for primary providers seeking to sub-contract) it would also accommodate the interests of the major professional groups in the health sector at little additional cost. Such a harmonious relationship would be crucial to the successful operation of a scheme as complex as the NHIS.

The real issue, however, is largely economic as clinics and hospitals make substantial profits from the sale of drugs (likewise retail pharmacies or chemists) As revealed in recent surveys of drug prices at different outlets in the country,⁸ wholesale prices of government-sourced essential drugs are, on the average, approximately 60 percent of the price in the private market whereas retail drug prices could be up to three times the wholesale price in the private market (Ogunbekun et al 1995) (*Initiatives*, 1995) With the majority of health care consumers set to go the way of NHIS (by virtue of compulsory enrollment) pharmacists nationwide would have been denied sizable proportions of income and may, indeed, need to redefine their role in the emerging health care arrangement Not surprisingly, the Pharmaceutical Society of Nigeria (PSN) remains vehemently opposed to the scheme (as presently conceived) and sees no benefit in it for its members Conversely, the other four professional bodies welcome the NHIS although, they express reservations over its feasibility

As previously expressed by the author (Ogunbekun, 1993) an arrangement in which the prescriber is also the dispenser, could apart from creating perverse incentives for under or over-supply of medications (depending on the reimbursement mechanism)⁹ also eliminate a potent instrument for cross-monitoring providers' activities It would thus be more difficult to identify providers that are giving insufficient services to patients The arrangement proposed by the pharmacists undoubtedly entails a more cumbersome claims administration process however, it does promote delineation of function and makes for easier expenditure tracking on various items of service It also enhances the monitoring of the entire scheme as information generated would be better differentiated, thus allowing for valid conclusions to be reached on the state of the service

Overview

Little information currently exists on the size and scope of the private health insurance (PrHI) market in Nigeria. One source (Shaw and Griffin, 1995), estimates that only 0.4 percent of the country's population are covered by PrHI, including other forms employer sponsored medical care schemes.¹⁰ Similarly, about 0.23 percent of respondents in another recent survey (NQAI, 1994) were estimated to have been covered by formal health insurance.¹¹ The term private health insurance as used in this paper, refers strictly to those arrangements in which a consumer (or third party) pays premiums to an insurer for the purpose of obtaining health care. It excludes medical services provided directly by employers or contracted out to health care providers, reimbursements for out-of-pocket expenses incurred on purchasing medical care by employees or their dependants, cover for medical care arising from domestic and occupational accidents,¹² and supplementation for loss of income occasioned by ill-health.

The National Insurance Supervisory Board (NISB) the agency that regulates insurance practice in the country, was unable to provide information regarding the composition and performance of this sub-market. This is partly because PrHI is currently marketed under the cover of other classes of insurance business and as such, premium incomes and claims are submerged. Also, a number of companies currently marketing this product are believed to be operating without appropriate authorization. Therefore identification of companies underwriting¹³ health insurance and the types of plans offered nationwide, proved to be very difficult.

Available evidence (largely based on informal sources within the industry) indicate that less than ten of the over 150 insurance companies operating in the country as at the end of 1995 offered PrHI policies. Of these only four were identified as having independent schemes - others are largely believed to co-insure.¹⁴ The number is consistent with that reported in 1994 (Olowude 1994). A profile of the companies is provided in Table 2.

Newline Insurance Company (NIC) the first to start marketing private health insurance policies in Nigeria, is only just resuscitating the scheme, having suspended this business for about two years. Apart from the companies listed in Table 2, several others are believed to be at different stages of planning for the introduction of private health insurance schemes.

Table 2: Profile of Companies Underwriting Health Insurance in Nigeria					
Company§	Location	Began marketing health insurance	Type of policy sold (Individual/ Group)	Benefits covered	No covered as at July 1995 (dependents included)
Industrial and General Insurance Company Ltd (IGI)	Lagos Lagos State	1993	Individual and Group	Ambulatory care and hospitalization medications diagnostic services (laboratory/radiological investigations)	700
International Standard Insurers Ltd (ISI)	Lagos Lagos State	1993	Group only	Ambulatory care hospitalization (up to one week) medications diagnostic services	17 447
Newline Insurance Company Ltd (NIC)	Lagos Lagos State	1989	Individual and Group	Hospitalization costs only	Not available
Shelter Insurance Company Ltd (SIC)	Enugu Enugu State	1991	Group only	Ambulatory care hospitalization medications diagnostic services preventive health*	7 500

§ All are commercial carriers and are wholly private

* Limited to pre-employment and routine medical checks

Sources: The respective companies January 1996

Market Composition and Operations

Market size

Available data on the size of the PrHI portfolio suggest that this class of business accounts for only a small proportion of all businesses underwritten by the various companies. This may partially explain why it is not marketed as a separate line business. At Industrial and General Insurance Company (IGI) for example, premium income from health insurance accounted for only 0.2 and 0.9 percent of the gross premium income (GPI) realized by the company in 1993 and 1994, respectively. Similarly, at International Standard Insurers (ISI), the 1993 figure stood at 1.4 percent, although, this rose markedly to 12 percent in 1994 - the result of aggressive marketing. For Shelter Insurance Company (SIC) however, health insurance premiums accounted for around 17 percent of the GPI in the two years mentioned.

Statistical data on Newline Insurance Company (NIC) could not be obtained, as the company declined to provide financial information regarding its operations. The experiences of the company in terms of premium income may, however, not have been different from the others. Indeed, of the three companies for which data were available, SIC recorded the highest premium income of N1.85 million in 1993 (health insurance portfolio only). Considering that the GPI of the entire insurance market in Nigeria was around N6.55 billion in that year,¹⁵ the size of the PrHI market is not large.

Population segments covered

Most plans currently target employers (private companies and parastatals) because this strategy lowers administrative and sales costs. As such, coverage by PrHI is virtually limited to only the people resident in urban, highly commercial/industrial areas. Geographically, the existing schemes cover mainly those resident in the South-western and South-eastern parts of the country - more specifically, the cities of Lagos, Port Harcourt and Enugu. Only ISI covers sizable numbers outside these regions due to the fact that the large companies covered have branches in various parts of the country.

and these branches extend the same benefits to employees in the various locations. Individual plans are rarely sold (a total of nine policies were sold by IGI, and none by ISI and SIC as at July 1995).

Considerable variation exists in the size of groups covered by the different carriers. For instance, SIC currently administers fifteen group plans covering about 7,500 people (dependants included), whereas, ISI covers twelve groups with over 17,000 people. IGI covers eight groups with beneficiaries numbering less than 700. Assuming these were all the people covered (since NIC is just reactivating its scheme), then only 0.03 percent of the population would have been covered by private health insurance as at July 1995. This estimate may, however, be prone to errors as a result of incomplete reporting by insurance companies. For similar reasons, it is difficult to determine the income profiles of the insured since the majority are in group plans covering various cadres of employees. However, only the very affluent are believed to purchase individual policies, since premiums are very high (see below), and the plans often provide for treatment abroad.¹⁶

Premiums and benefits

PrHI premiums are currently very high – in the range of 35-50 percent of the cover limit. This is partly due to the small pool of subscribers, absence of reliable data on patterns of consumption of private health care, and the limited experience of local underwriters of health insurance plans. Premiums are usually paid by lump sum and are adjusted annually. The default rate is reported to be very low, partly because most insurance companies strictly observe the ‘no premium – no cover’ clause governing insurance contracts as stipulated in the Insurance Decree of 1991 (FGN, 1991).

Essentially, policies cover the insured, one spouse and a maximum of four dependent children aged below eighteen years (up to twenty-one years if still in full-time education). The benefits offered under a standard policy are shown in Table 2. Minor surgical operations by authorized providers are also covered, but major surgical operations, preventive health services, optical services, maternity and dental care are only provided as supplementary benefits subject to payment of additional premiums. Pre-existing or chronic illnesses, dreaded diseases (such as AIDS), cardiac or cosmetic

surgery are excluded from all the plans. Cover limits vary considerably from one insurance company to another and usually depend on the amounts of money employers are willing to spend on medical benefits in any given year. In other words, the cover limit is informed by two factors - the premium rate charged by the insurer and employer's health budget. NIC, however, offers two plans - Emergency Medical Evacuation with a limit of N30,000 per annum and Full Major Medical Expenses with a limit of N50,000 per annum.

Claims

Most of the PrHI plans are 'service' rather than 'cash-indemnity' plans. In the former arrangement, the fee for medical services consumed by the insured or his beneficiary (less co-payments and deductibles) is remitted to the provider on receipt of a bill or claims form by the insurer. In the case of the latter, the consumer first settles the bill and is later reimbursed by the insurer, usually after verification of the claim. The former process has the advantage of simplifying claims administration while also affording the insurer the opportunity of interacting with the provider. Claims administration is either manual or computerized depending on the volume of business handled by the company, although all expressed preference for computerized systems as these improve efficiency markedly.

Available statistics indicate that on the average, claims are growing much faster than premium incomes. Loss ratios (ratio of claims paid out to premiums received) have also been climbing steeply since 1993, suggesting that this market may be passing through difficult times. The total value of claims in one of the companies studied rose by 122 percent between 1993 and 1994 (about twice the official rate of inflation), whereas premium income during the same period increased by only 40 percent. The Loss Ratio for the health insurance portfolio was observed to be just 40 percent, while the average value of claims rose from N17,904 in 1993 to N45,833 by the end of the second quarter of 1995 (over 150 percent increase)¹⁷. The amounts paid out per claim varied considerably from one company to another depending on the limit of cover purchased by the employer. Insufficient financial data limited inter-company comparison of claims experiences.

Cost-sharing in the form of co-payments and deductibles played a minor role in the financing of benefits, and this might be one reason why claims have been rising. IGI applies a standard co-payment rate of 10 percent whereas at ISI, cost-sharing accounted for just around 4 percent of total amounts paid out to providers between 1993 and 1994. SIC only applies a nominal deductible averaging 0.5 percent of claims and has no co-payment. In general, providers are paid on FFS basis. Presently, there are no established fee schedules for reimbursing providers of care, claim settlement is, quite often based on what each company's medical advisors consider as customary and reasonable fees for various disease conditions treated by the provider¹⁸. The exception is SIC which reports reimbursing provider fixed rates which are jointly negotiated, annually.

Some plans restrict clients to a list of preferred providers whereas others place minimal restrictions on patients' choice of provider. The latter believe the wider the range of providers available the more attractive the scheme is and as such strive to offer consumers a wide range of (orthodox) practitioners - usually hospitals manned by skilled medical personnel and with facilities for in-patient care as well as biochemical and radiological investigations. One of the companies receives bills from over 120 hospitals nationwide, and it is doubtful if effective monitoring of the quality of care provided is ever achieved. By contrast NIC uses the services of four private providers and teaching hospitals only. However because the organization of private medical practice in Nigeria promotes duplication and under-utilization of services insurers (and subscribers to health insurance plans) could in fact be subsidizing the inefficiencies of the medical care system.

Challenges to Private Health Insurance

Image problem

A major obstacle confronting the growth of PrHI in Nigeria is the negative attitude demonstrated by the public toward insurance, based on the perception that insurance companies generally try to dodge settlement of claims, and payment, where effected takes too long. There is little motivation therefore, to insure except where this is mandatory as is the case with

motor vehicle insurance. This credibility problem is believed to have played a role in stalling the actualization of the Armor Group Medicare Plan, a private-for-profit health plan that targeted formal and informal sector workers and was to be co-insured by a number of insurance companies in Lagos. This apart, potential subscribers to the plan (members of trade associations/cooperative societies) preferred to have their money (premium) refunded in instances where they did not consume health services in any given year.¹⁹

In addition, knowledge of health insurance principles and practice is generally lacking among health care providers and also within the insurance industry, a situation not helped by the dearth of information on existing PrHI schemes. Considerable effort would, therefore, be required to create awareness on the mechanisms of health insurance and restore public confidence in the insurance industry.

Implications for the health of women

The scope of benefits offered under existing health insurance plans (being mostly group plans) have major implications for the health of women. Firstly, most employer-sponsored medical benefits schemes (whether insured or uninsured)²⁰ recognize only one spouse, women in polygamous families (many of whom also tend to be low income) are thus at risk of being left uncovered. This is not the case with individual PrHI plans, as coverage for additional beneficiaries can be obtained with the payment of extra premiums. However, the necessity of purchasing such plans places additional burden on an already vulnerable group.

Secondly, the exclusion of maternity benefits from 'standard' packages offered by private health plans, an extension of the usual practice of excluding the cost of delivery from employee medical benefits schemes, means that the bulk of the cost of pregnancy is borne by the individual, thus weighing disproportionately against low income workers. (The cost of a normal delivery in a moderately priced hospital in Lagos State was up to N2 000 in 1992, approximately 13 percent of average annual household income for urban dwellers²¹). Unfortunately, not all health plans offer a rider for maternity care (and none covers family planning services)²²

Pregnant women are thus compelled to seek maternity care from a less expensive public or private hospital where the care provided may be sub-standard. This invariably results in the discontinuity of care and duplication of services, especially clinical investigations.

However, insured employee medical benefits schemes confer an advantage over uninsured schemes -- the spouse of an insured female worker is usually covered under the former arrangement, but this is often not the case with uninsured schemes. At a time when economic recession is threatening family cohesion and pushing more males (the traditional 'bread-winners') out of formal employment, the availability of health plans that extend coverage to 'dependent' (male) partners could serve as a valuable social safety net.

Private insurance and low income populations

Existing private insurance plans are strictly for-profit. As such, there is a tendency to skim off the 'good' risks -- those whose health status is stable enough to minimize consumption of health services (claims), and who possess the ability to pay. Furthermore, individual policies are more expensive to administer than group policies, and this usually translates into higher premiums that may be beyond the reach of low-income populations, the majority of whom are in the informal sector, have low levels of insurance awareness, and whose health status predispose them to high claim rates. Given the present economic realities and trends in the private insurance market, restructuring existing PrHI schemes to accommodate the needs of low income populations without imposing major restrictions on benefits provided will be an uphill task. Insurers may not find this a worthwhile venture as the same level of effort could yield larger profits with other classes of insurance business.

Public policy and market developments

As mentioned above, the prospect of a future NHIS threatens the growth of private health insurance since both primarily target the same population and socio-economic groups. This issue does not appear to generate anxiety.

ety among insurers as there is currently very little interest in venturing into the health insurance business, given its highly technical nature and the near certainty of claims arising. Perhaps, the greatest obstacle confronting the future of this market is the unfavorable claims experience of local carriers of PrHI mentioned previously -- a situation that has arisen from the high rates of inflation in the medical care market, the lack of deterrents to the excessive consumption of care (the result of inefficient cost-sharing arrangements), undue reliance on expensive private hospitals, infrequent use of acquired data for monitoring and decision-making, and the absence of negotiated rates for provider reimbursement.²³ Underwriting costs may thus continue to outstrip premium incomes while investment returns in the domestic economy may not be large enough to offset rising claims.

Insurance fraud

The problems of insurers are compounded by the prevalence of insurance fraud which claims managers rate as 'moderate to high'. This is also the case with uninsured employee medical benefits schemes.²⁴ Fraud commonly takes the form of over-supply of services and over-billing by providers, the use of services by unauthorized persons (such as the uncovered relations or friends of the insured) and sometimes the 'conversion' of medical benefits to cash at the request of the insured. Most insurers attempt to limit these problems by subjecting claims to thorough verification by in-house (and occasionally external) medical assessors, the use of personalized identification cards to restrain unauthorized 'beneficiaries', review of patients' case files where disputed claims arise, and continued interaction and communication with (preferred) providers. These however may not have proved very effective.

Reinsurance

The absence of reinsurance²⁵ cover for PrHI poses another major challenge to companies underwriting this class of business. All five reinsurance companies operating in the country have been approached to provide cover for the existing PrHI schemes but the evidence to date indicates that only one company (SIC) has succeeded in obtaining the necessary cover. Even in

this instance, the scheme is covered as part of the General Accident portfolio. This limiting the reinsurer's liability. The effect of not having reinsurance back-up is that health plans become vulnerable to heavy claims that could endanger the entire portfolio. Thus is one reason why companies seeking to underwrite health insurance policies opt for 'co-insurance' as an avenue for further spreading of risks.

Reinsurers cite the high 'moral hazard' element in the health insurance business and limited underwriting expertise as major reasons why they approach this class of risk with extreme caution.²⁶ Other insurance managers interviewed consider the level of technical expertise within the industry sufficient to underwrite health risks profitably but attribute the problems confronting the market largely to the fraudulent practices of health care providers (in collusion with beneficiaries) and the limited understanding of the health care market in Nigeria'. However, it is likely that a combination of these factors may be responsible for the unfavorable trends emerging from this market.

INFORMAL PREPAYMENT SCHEMES: COUNTRY WOMEN ASSOCIATION OF NIGERIA (COWAN)

Overview

COWAN is an organization predominantly for, and run largely by rural people. The Association was founded in Ondo State in 1982, and by 1985 had expanded to other neighboring states. It was established to economically empower women and promote self-sufficiency among the underprivileged, building on the existing framework of communal contributions and revolving credit arrangements known as 'esusu', 'ajo', etc. The Association was registered as a cooperative union by the Ondo State Government in 1986 and is a member of the state Federation of Cooperative Unions. It functions as a non-governmental organization (NGO) and as such, its transactions are tax-exempt.

Membership has grown steadily over the years with 21,710 members registered by the end of 1994 - an increase of 25 percent over the 1992 figure (Table 3). Although membership was open to both sexes from the outset (but with an emphasis on women) it was not until the 1990s that an appreciable number of men joined. As seen in Table 4 there were approximately thirty-one women for every man registered in Ondo State in 1994 compared with the 1992 ratio of 53:1. The rule, however, is that a female:male ratio of not less than 4:1 should be maintained in all the groups. Low-income urban dwellers (mostly market women) also participate in the scheme, and are believed to constitute about 20 percent of the membership.

Administrative Structure

The functional unit of the cooperative is a group of five to ten individuals, all of whom are bound by a common interest. Within any one cooperative there may be many such groups. These could be persons involved in the same kind of trade or art within a village or could even be members of a family but the tie is usually economic. The groups are then clustered in

Table 3: COWAN, Ondo State Branch - Enrollment, Contributions and Loans, 1992-94

Credit Scheme	1992	1993	1994
No of individuals enrolled - Female	17 100	19 220	21 030
Male	320	560	680
All	17 420	19 780	21 710
No of groups registered	572	580	650
Total contribution / savings (naira)	342 548	1 360 800	3 067 200
No of loan applications approved	171	189	426
Value of loans disbursed (naira)	513 824	945 000	2 130 000
Health Fund			
Total contribution (naira)	68 640	69,600	78,000
No of loan applications received	20	30	45
No of loan applications approved	15	20	33
Value of loans disbursed (naira)	55 000	72 500	60 000
Where patient was treated			
a Private facility	4	4	7
b Public facility	10	16	26
No of loan defaults	0	0	0
Shortest repayment period (months)	3	3	3
Longest repayment period (months)	10	13	12
No of states operating health fund	10	10	10
No of states offering family planning program	2	2	2

Source COWAN Akure March 1996

zones for administrative purposes, although functionally and financially each group still retains its independence. In Ondo State for example six administrative zones exist each comprising at least three Local Government Areas. The state branch of COWAN is headed by a Chairperson who need not be literate but the day-to-day management of the Association is vested in the State Coordinator who is assisted by other members of the Executive Committee. The position of Chairperson and other elective offices, such as the General Secretary and Treasurer, are contested every three years.

Zonal Coordinators in conjunction with Program Officers monitor the activities of the groups in various zones and report to the State Coordinator. Each state secretariat is required to forward returns on activities and

accounts to the national secretariat located in Akure, Ondo State. As at December 1995, COWAN operated in ten of the thirty states of the federation: Ondo, Oshun, Oyo, Ogun, Lagos, Rivers, Anambra, Delta, Plateau and Kwara States. Most of these states are situated in the southern part of the country, with only two of the ten implementing states (Plateau and Kwara) located outside this region. This observation may not be unconnected with the origin of the scheme in the south, a part of the country.

Table 4: COWAN, Ondo State Branch - Enrollment, Contributions and Loans, 1992-94 Ratios

Credit Scheme	1992	1993	1994
Female : male ratio	53 : 1	34 : 1	31 : 1
Loans as percent of total contribution	150.0	69.4	69.4
Average value of loan per application (naira)	3,005	5,000	5,000
Health Fund			
Health Fund contribution as percent of total (Credit Scheme) contribution	20.0	5.1	2.5
Health Fund loan disbursement as percent of total loans disbursed	10.7	7.7	2.8
Health Fund loan disbursement as percent of Fund contribution	80.1	104.2	76.9
Percent of loan applications approved	75.0	66.7	73.3
Average value of loan per beneficiary (naira)	3,667	3,625	1,818
Where patient was treated	2 : 1	4 : 1	3 : 7 : 1
Public : Private facilities			

Source: COWAN, Akure, March 1996.

populated by peasant farmers, artisans and traders, many of whom are already accustomed to regular (joint) contributions as a form of personal savings as well as for financing communal projects.

Programs Offered

COWAN's activities cover a wide socio-economic spectrum and are directed toward groups rather than individuals. The activities are integrated and all registered groups are involved in each, although emphasis may be

placed on specific activities depending on the priorities identified by the group (and agreed to by the Zonal Coordinators) Program Officers are assigned to each of the following activities

Credit Scheme—This scheme forms the core of the Association's activities, being a cooperative union. It is financed from the monthly contributions pooled from all groups and the proceeds accruing from investment of funds. Although credit is provided in the name of a specific group, the credit facility could be used for either individual or group projects.

Agricultural Development—Assistance (by way of credit) is provided to groups undertaking joint agricultural projects, such as group farms. The loans can be used to purchase required inputs like seedlings and fertilizers, or hire equipment such as tractors to enhance agricultural production.

Technology and Food Processing—Direct payment is made to local fabricators of equipment who, in turn, supply the items to the groups receiving credit. In most instances, this machinery is used to process local food crops such as maize and cassava. In cases where equipment is not available locally, it is bought from the open market and supplied to the groups on hire-purchase terms. The 'loan' is offset from the groups' monthly contributions. This arrangement is referred to as 'loan in kind'.

Health Care and Family Planning—This program focuses on family planning, health education and the operation of a 'Health Development Fund'. This fund is discussed in greater detail below.

Option Life Program for COWAN Youths—As of 1994, every registered member is required to enroll an offspring between twelve and twenty years of age as a member of the youth wing. These young people undergo training in various crafts and trades similar to those in which their parents are engaged for up to three months. Upon graduating, each youth wing member is provided a start-up grant of N5,000 - 10,000 (US\$59 to \$118)²⁷ to begin a business. This amount is larger than the average value of loans per individual adult member (Table 4) because credit to the latter are regarded as supplemental to already established businesses.

Training—All aspects of the COWAN program have a training component which include the training of community-based distributors (CBDs) of family planning commodities, seminars and workshops on credit management and record-keeping, and demonstration exercises in basic maintenance of equipment used

Credit Scheme

Contributions and benefits

At inception, each group is charged a uniform fee of N200 (being the share capital) and a registration fee of N50, all of which must be paid in full before registration is effected. This was followed (pre-1993) by the payment of monthly dues of N60 per group. Of this, N30 (50%) is marked for program administration and office maintenance, N20 (33%) for the cooperative's Trust Fund and N10 (17%) for the HDF. The Trust Fund is an interest yielding account held in the name of the cooperative union (in this case COWAN) and kept in the local branch of the Cooperative Bank. Deposits to this account attract an interest of 1 percent per month. In 1993 the monthly dues were replaced by the Daily Savings of N600 per group per month while a separate amount of N20 per month per group was also deposited in the Trust Fund. The 'Daily Savings' was increased to N1 200 per group in 1995 with the expectation that each individual within the group (assuming there are five individuals per group) should be able to set aside a minimum of N8 daily without difficulty hence the label 'Daily Savings'. These daily savings of N1 200 per month per group are held in an account with a commercial bank. Apart from the contributions to COWAN, it is not uncommon to find individual members still participating in other *esusu* arrangements as desired.

After contributing for three months, a group becomes eligible for credit of N10 000 per annum. There are no specified preferences (by sector or type of activity) in the disbursement of loans, each group identifies its own project which is assessed by the Program Officer in charge. Apart from these group loans individuals could also obtain credit to meet (non-medical) needs such as children's school fees. Such loans can be as high as N20 000 and are sourced from the Trust Fund. A profile of contributions

made and loans disbursed in Ondo State between 1992 and 1994 is presented in Table 3. Total contributions rose by almost 800 percent between 1992 and 1994 to stand at N3,067,200, while loan disbursement in 1994 was put at N2,130,000 - an increase of 315 percent over the 1992 figure²⁸

Loan repayment

The repayment period for group loans is twelve months. No moratorium is granted except in instances where loans are provided for technology acquisition. These attract a moratorium of three months, while repayment can be stretched over a period of eighteen months in view of the larger sums involved. The monthly contributions continue upon receipt of the loan. By 1995, each group was expected to contribute a total of N14,400 within twelve months, leaving a balance of N4,400 after the deduction of the N10,000 credit. Personal loans, on the other hand, are payable within six months, at an interest of 2.5 percent per month. All contributions (individual and group) are documented in standardized ledgers and statements of accounts.

The value of loans disbursed is not determined by the amount already contributed by the group at the date of application, but the amount expected to be contributed by the end of the period, a group may only have contributed for three months (amounting to N3,600) but could withdraw the N10,000 loan thereafter. The balance is often sourced from the Trust Fund. The default rate is reported to be very low. Grants are received from the Ford Foundation and other donor agencies to help sustain the scheme.

Rural Integrated Health and Family Planning Program (RIHFPP)

Origin

COWAN originally embarked on a family planning program in 1986 to check the high fecundity (with little or virtually no spacing) observed among members of the cooperative. This initiative was supported at the outset by the Planned Parenthood Federation of Nigeria (PPFN) which assisted in the training of community-based distributors (CBDs) and the supply of family planning commodities (oral pills and barrier devices only). By the

end of 1994, 370 CBDs had been trained to dispense these commodities. CBDs refer clients seeking other forms of contraception (such as IUCD and injectables), and complications arising from contraceptive use, to public and private facilities designated by the Federal Ministry of Health and PPFN. COWAN's family planning program later expanded to incorporate other services, a move that was motivated by the unfavorable mortality and morbidity of individual members and their families, particularly in the areas of maternity care and child nutrition. Lack of access to finance was identified as a major reason for observed delays in seeking appropriate care. This led to the establishment of the Health Development Fund (HDF) in 1989.

Environmental health and nutrition education also form an essential part of the RIHFPP and facilitators (usually volunteers experienced in various fields) assist in this program. Continued education and mobilization have helped to minimize male resistance to family planning while the utilization of this service is said to have remained impressive, more especially as the health program is integrated with the credit scheme.

Health Development Fund

Contributions and benefits

Monthly contributions to the HDF are banked separate from contributions to the credit scheme. HDF contributions are also mandatory and amount to N10 per group per month. This entitles members to loan assistance should they or their immediate family suffer 'catastrophic' illnesses²⁹. There is no waiting period and the onus lies on the family to decide the level of assistance required, although loans cannot exceed the actual cost of care. Loans can be guaranteed by relatives where the Association member is the patient.

As seen in Table 3, only a few loan applications are received yearly, about 70 percent of which are approved. Applications are usually rejected where the amount sought is considered very small and the illness is not serious. Program Officers usually advise such applicants to raise the amounts required from within the community. In a few instances though, Program Officers have actually been the ones to identify very ill members and package the necessary loan assistance from the HDF.

Total contributions to the HDF are usually very low, with only N78,000 contributed in Ondo State in 1994 this represents a 25 percent increase over the amount contributed in 1992 The average value of approved loans per beneficiary for the period 1992-94 was well below N4,000 (Table 4) Disbursements averaged 87.1 percent of contributions, although, the lag between inflow of contributions and disbursement of loans sometimes necessitate that funds be transferred from the credit scheme

Loans for medical care are also payable within twelve months but are interest free for the first three months after which interest of 2 percent per month is charged Loan diversion is uncommon because of the verification process and the existence of the credit scheme which caters for the commercial needs of enrollees The default rate is reported to be very low and consistent with the experience of the People's Bank of Nigeria (which reported a 92 percent repayment rate for its loan portfolio) (Sokenu, 1994), supporting the view that the poor are credit-worthy Groups are not paid any interest for contributions to the HDF unless the group has made no claims for ten years, after which an interest of 1 percent monthly accrues This proviso, understandably, is intended to protect the fund which could easily be depleted

Reimbursement of providers and quality of care

On the average, beneficiaries are three times more likely to opt for public rather than private facilities, largely because of the popular perception of the former as being better staffed and equipped, and as such being able to handle difficult cases more competently than the private sector Also, the COWAN program supports predominantly rural populations As such, member access to private care is limited in these areas The RIHFPP operates as a cash-indemnity plan and there is no direct interaction with health care providers An exception to this are the public hospitals that have developed an 'understanding' with COWAN and accept the membership card as a form of 'credit card' Information on morbidity patterns is not kept at present hence, patterns of health care consumption cannot be identified

Medical care loan applications are treated as emergencies to ensure that patients are not denied timely access to care. However, Zonal Coordinators and health Program Officers still have to authenticate all claims filed. There is no vetting of bills from health care providers as there are no fee-schedules in existence, the choice of provider is entirely left to the patient and it is presumed that parameters such as the quality and cost of care delivered in the facility would have been factored into this choice. This is a setback considering that health care consumers (especially the poorly educated) are not empowered with information that enables them to make valid judgments regarding the efficiency and quality of services they receive. Indeed, efforts are made not to disclose the involvement of a 'third-party' in the payment arrangement as this could invoke price inflation on the part of private providers. However, there are plans to establish a formal relationship between COWAN and the Association of Proprietors of Private Nursing and Maternity Homes in Ondo State - a twenty-five member association with independent facilities offering integrated primary health care services.

Issues

Linking a credit scheme with prepayment for health care makes this arrangement an attractive model for protecting those in the informal sector. However, using the findings of a World Bank review which estimated annual per capita costs for covering basic health services within low income economies at \$12 (Bobadilla et al, 1994), the limited contributions make it inadequate for financing the basic health needs of individual families. As discussed previously, efficiency may be compromised where providers are paid a FFS without an agreed fee schedule and there are no mechanisms for assessing the quality of care rendered by providers. More detailed evaluation is required to assess the adequacy and efficiency of this arrangement, and to explore opportunities for covering a wider range of basic health care benefits such as ambulatory care and maternity services.

OPTIONS FOR IMPROVING ACCESS TO CARE

The foregoing discussion highlights the potentials for, and limitations of, various approaches to prepayed health care in different communities in Nigeria. While the discussion is not exhaustive as other existing forms of prepayment might not have been identified³⁰, it raises concern about the extent to which policy developments in the nation's health care system effectively address the diverse needs of her population. There is strong likelihood that the problem of access to care confronting low income urban populations may not be fully appreciated by policy makers, especially considering that the concentration of health care resources (private and public) within urban communities could easily be construed as evidence of ready access to services. But with medical care prices rising steeply in the face of continuing job losses in both public and private sectors, an increasing number of families may be becoming medically indigent.

It becomes imperative, therefore, that suitable models of prepayment be devised such that the burden of ill-health does not weigh too heavily on individuals and families in the low income bracket. Such risks could be minimized where families have good access to personal preventive services and low-cost curative (primary) care, but as Arhin observed, undue emphasis tends to be placed on the provision of catastrophic cover in the search for health insurance alternatives that suit the needs of low income populations (Arhin, 1995). Experiences from other developing countries support the view that community based risk-sharing arrangements for low income groups are actually feasible when they are structured along existing lines of community organization and management (Arhin, 1995) (Adeyi, 1989) (Chabot et al., 1991). Although recent experiments relate more to health care financing within rural populations, the approaches used may be replicated among low income urban communities, particularly where some form of communal contributory system already exists.

Identified options for covering the low income urban populations through prepayment schemes are summarized in Table 5. They represent approaches that are considered feasible in the light of prevailing social and

economic circumstances, but there are other considerations that potentially limit the applicability of each of the proposed arrangements. Whatever the approach favored, it is advisable that the scheme be initially restricted to a small group of providers and the minimum permissible number of infor-

Table 5: Options for Extending Health Insurance/Prepayment Arrangements to Low Income Urban Populations— Individuals and Groups in the Informal Sector

Option	Prospects	Limitations
<p>A</p> <p>Support expansion of commercial health insurance</p>	<p>Some private plans with required legal framework already identified</p> <p>Machinery for premium collection and claims administration established</p> <p>Experience data available to assist in premium computation</p> <p>Risk pool already exists— low cost plans can be built around such pool allowing for wider risk spreading</p>	<p>Existing private plans may not be operating efficiently</p> <p>Profit motive could ultimately override service objective resulting in escalating premiums</p> <p>NHIS could skim off good risks leading to collapse of PrHI scheme where large numbers of low income groups are covered</p> <p>Designing policies for low income groups may not be attractive to private insurers</p> <p>Limited technical expertise in health insurance underwriting is available locally</p> <p>Reinsurance cover may not be available</p>
<p>B</p> <p>Support development of Voluntary (non profit) Health Plans VHP</p>	<p>NHIS unlikely to cover informal sector for several years hence conflict is minimized</p> <p>Provides needed competition for the NHIS</p> <p>Premiums should be lower than in commercial plan</p> <p>Concept of non profit VHP is endorsed by key professional associations in health sector</p> <p>NGOs in the country have built up impressive record of performance plans could be readily embraced by wide segments of the populace</p>	<p>Defining criteria for registration of plans could be difficult absence of such criteria could result in multiple schemes generating high administrative costs for the health system</p> <p>Requires a sound administrative organ</p> <p>Establishment of fee schedules would be necessary</p> <p>Intense public enlightenment is required</p> <p>Could conflict with provisions of insurance decree</p> <p>Scheme may not secure reinsurance cover statistical basis for premium computation lacking</p> <p>Technical expertise in the management of prepayment schemes not readily available locally</p>

Table 5 (con't): Options for Extending Health Insurance/Prepayment Arrangements to Low Income Urban Populations— Individuals and Groups in the Informal Sector

Option	Prospects	Limitations
<p>C</p> <p>Promote credit linked Health Savings Scheme</p>	<p>Informal methods of contribution widely practiced in different parts of the country</p> <p>Formal cooperative network is very extensive some are already financing health care (e.g. COWAN)</p> <p>Does not require elaborate administrative systems</p> <p>Insurance carrier is not required</p> <p>Does not conflict with NHIS Initiatives currently assisting provider groups these could serve as nucleus of proposed arrangement</p>	<p>Determination of adequate levels of contribution and fee schedules require expensive professional input</p> <p>Urban situated health care providers may not accept low reimbursement rates</p> <ul style="list-style-type: none"> • Requires extensive consultation and sustained communication with various interest groups

mal groups Resources should be invested in the first two to three years of such schemes to generate reliable data on various aspects of service provision before expansion should be contemplated The information so derived could go a long way in instructing project managers about the best approaches for achieving efficiency and long term sustainability

Option A— Support expansion of commercial health insurance

This option appears attractive in that there are presently PrHI plans in existence that already have risk pools around which low-cost plans could be built In addition, useful data on claims experience is already available to assist actuaries (and underwriters) in the computation of premium rates although claims experience alone is an insufficient basis for premium computation Furthermore the problems confronting existing schemes could be mitigated by having a larger pool of subscribers (such as members of trade groups or cooperative societies), strengthening the technical capacity of managers of health plans identifying and instituting effective cost-control measures (such as the design of fee schedules and appropriate man-

agement information systems), and assisting plans to secure necessary reinsurance back-up

However, this approach suffers many drawbacks, not the least of which is the profit motive of private enterprise which could, over time override service objectives and push premiums beyond the reach of low income groups. The other limitation to this proposition is the NHIS which is targeting the same socio-economic group currently covered by private insurance and which could skim off the 'good risks', leaving the insurer with an unbalanced portfolio that could result in bankruptcy. Private insurers are unlikely to continue marketing low cost plans given such developments, and may switch instead to marketing products exclusively for the upper class (which is what many of the companies started out with in the first instance). Assuming these limitations could be overcome, the commercial insurance option could have a better chance of succeeding in locations outside cities like Lagos and Port Harcourt, where administrative costs tend to be substantially lower and the profit drive not so intense.

Option B - Support development of Voluntary (non-profit) Health Plan - VHP

The realization that the proposed NHIS may not be an adequate arrangement for financing health care in the country is a major reason why professional associations in the health sector favor private initiatives that complement government's effort in this direction. The key professional associations welcomed the idea of voluntary (not-for-profit) health insurance plans - VHP - as a supplement to the NHIS. The exception was the Pharmaceutical Society of Nigeria which endorsed this option as a substitute for the NHIS, for reasons disclosed previously.

The advantages conveyed by instituting not-for-profit health plans are numerous, so are the challenges. Because it is a non-profit arrangement, incentives for premium escalation should be limited, although such a scheme is expected to be self-financing. Informal groups (trade associations, cooperative societies) and small scale businesses of less than ten workers not immediately covered under the proposed NHIS represent a potential pool of subscribers to the scheme. The VHP could be organized and managed by

health sector professional associations (many of which have signaled their preparedness to participate in such an arrangement) cooperative unions and NGOs

One strategy would be to network urban cooperative societies through the State Federation of Cooperative Unions and encourage them to establish separate 'Health Funds' similar to the COWAN arrangement. The level of contribution to this fund would be such that it will be sufficient to cover the premium for each enrollee and a specified number of dependants. The cooperative societies can then pay the VHP lump sums annually as the premium for their members. This will entitle beneficiaries to a basic package of health services (personal preventive services, ambulatory and maternity care, and a limited number of in-patient days). The VHP will operate as a 'service' plan, but a loan can be obtained from the cooperative society to pay providers out-of-pocket where the treatment required exceeds what is provided for under the arrangement.

Paying premiums in a regulated (managed care) plan could prove more attractive than meeting the full cost of quality health service in an urban setting. To be efficient, and remain sufficiently attractive in the long term, fee-schedules would need to be established and reviewed annually by a multi-party committee. Preference would have to be given to enlisting only low-cost providers (clinics/hospitals, nursing and maternity homes), machinery for effective monitoring of providers would need to be put in place, and adequate cost-sharing arrangements built into the plan. The VHP could choose to register as an insurance company, in which case it could seek to minimize its loss exposure by securing reinsurance cover.

This approach has potential in that members of cooperative societies are already accustomed to making regular, albeit small contributions into communal funds. These contributions can be moderately increased to cover payments for health care. The problem of non-affordability of premiums would be reduced because enrollees would not be required to make lump sum payments which often create financial difficulties for low income families. The scheme would also provide the needed competition for the NHIS. The VHP could escape the stigma of an 'insurance' plan (even where it operates as one) since the scheme will be co-sponsored by the cooperative movement and credible professional associations in the health sector.

However, this option is not without major challenges, the obvious being that it would require an organization with a competent team of professionals and managers to actualize such a plan. Guidelines must also be defined for establishing similar schemes to avoid plans mushrooming in the future³¹. In addition, technical support and training in the management of health insurance funds would be required, as would further research on service utilization and costs in the Nigerian private health care subsector to guide the computation of premiums and fee-schedules. Mobilizing the key players and educating potential subscribers on the advantages inherent in this arrangement would require considerable investment in time and money.

Another limitation to this arrangement is that in seeking to operate like an insurance scheme, the VHP may be required to fulfill the statutory provisions of the insurance decree (FGN, 1991). This becomes even more relevant if reinsurance cover is to be sought. However, an independent self-financing health plan could overcome these limitations but subscribers would have to pay substantially more to sustain such a scheme. Development assistance could be channeled toward offsetting the start-up costs, while utilization data, generated from other *Initiatives*-supported projects in the country could prove useful in the construction of fee schedules³².

Option C - Promote Credit-Linked Health Savings Schemes (HSS)

A third approach to improving access for low income families is to promote the establishment of 'health savings schemes' (HSS) similar in many respects to COWAN's HDF and Singapore's 'Family Savings Scheme' (Phua, 1986) but incorporating some of the attributes of Option B. The administration of this scheme will be retained within the cooperative society and each member of the society will operate an account similar to the normal contributory (credit) scheme. The level of contribution will, however, be such that it can finance basic health services and create reserves, where feasible to be used as loans for 'catastrophic' illnesses.

Medical care will be obtainable from a list of preferred providers. Payment for services will be in the form of FFS using fee-schedules that are jointly negotiated between providers and the cooperative unions. This ar-

arrangement will operate strictly as a cash-indemnity plan with no co-payments or deductibles. Where a family exhausts its savings but needs to pay for catastrophic care, a loan payable at the usual rate of interest, can be obtained from the cooperative subject to proper verification by the administering officer.

The HSS is a simplified prepayment arrangement (an extension of COWAN's HDF) that circumvents the complexities and stigma, of an insurance plan. Contributions towards the scheme should also be more acceptable than paying premiums as members would still have their contributions intact where services are not consumed in any given period (unlike the case with insurance premiums), and it should be feasible, if so desired at a future date, to upgrade the scheme to, or merge with, a voluntary health plan. As is the case with the VHP, resources would need to be committed for community mobilization and advocacy, and to determine contribution levels and fee-schedules to ensure financial sustainability and make it attractive enough for providers to remain in the scheme and deliver quality care.

CONCLUSION

Opportunities exist within the health and financial sectors in Nigeria for low cost health insurance plans that suit the needs of low income urban populations, but the challenges that arise are great. Social insurance provides one avenue by which the burden of ill-health could be distributed equitably over large segments of the population, but the current proposal for national health insurance in Nigeria is constrained by errors of design, which could make this an ineffective instrument for extending coverage to groups outside the formal sector.

Commercial health insurance, on the other hand, is restricted by the high cost of premiums, limited underwriting expertise available in the country, and inadequate control over the medical care market. Therefore, only those that fall within the high and upper medium income levels (and especially those in formal employment) are likely to obtain protection via this avenue in the foreseeable future. Non-profit, private health insurance plans and credit-linked family savings schemes however present feasible approaches to covering low income urban populations where these are networked with existing cooperative schemes.

Emphasis should be placed on providing coverage for basic preventive and curative health services delivered by low cost providers, with appropriate cost-sharing arrangements and other disincentives for excessive consumption of care built into the scheme. Whatever the approach favored implementation must be preceded by intense community mobilization to sensitize and educate potential subscribers about the mechanisms and benefits of prepayment schemes for health care.

¹ Renamed Federal Ministry of Health and Social Services (FMOHSS)

² Payroll contribution has been actuarially computed at 10.5% of employee's gross earnings with the employer paying three-quarters (76 percent of premiums). The NHIS is to be financed largely through this means although nominal co-payment and prescription charges are incorporated in the financing arrangement.

³ Each insured person is expected to bring an average of 4.5 persons.

⁴ Average rate of exchange in 1992 = US\$1.00 = N17.30

⁵ Private or public sector health clinics, comprehensive health centers, and hospitals (excluding tertiary centers) qualify to be registered as primary providers. Maternity and nursing homes may be so considered depending on State regulations but these must engage full-time physicians.

⁶ Moral hazard is the tendency for insured persons to adopt unsafe or unhealthy lifestyles by virtue of their being covered. This often translates into heavier use of medical services since the insurance cover promotes access to care by eliminating or reducing financial barriers at the point of consumption.

⁷ The professional bodies are: i) Nigerian Medical Association, ii) Association of General and Private Medical Practitioners of Nigeria, iii) Guild of Medical Directors, iv) Pharmaceutical Society of Nigeria, and v) National Association of Nigerian Nurses and Midwives.

⁸ These were ad-hoc surveys conducted in July 1994 and August-September 1995. The samples were very small and no effort was made to control for confounding variables. Caution should therefore be exercised in the interpretation of the findings.

⁹ Providers are likely to oversupply medications in a fee-for-service reimbursement plan whereas they could under-supply in a capitation arrangement in which the cost of drugs is already included in the negotiated payment.

¹⁰ Using 1991 population estimate of 88 million and annual growth rate of 3 percent, about 370,000 people would have been covered by private health insurance as at 1993.

¹¹Seventeen percent of the respondents were from social classes A B C - upper and middle income bracket

¹² These risks are usually covered under General Accident Insurance and Workmen s Compensation Scheme respectively

¹³Underwriting is the process of assessing the degree of risk involved in any insurance proposal the object being to determine whether or not the risk is worth accepting and if so the premium payable

¹⁴ Co-insurance in industry parlance refers to joint underwriting of a particular risk by two or more insurance companies (as distinct from co-payment or cost-sharing) The premiums are shared according to the proportion of risk borne by each company and claim settlement is also in the same proportion Sometimes a company may underwrite policies that primarily cover other classes of risks (e g marine) but which incorporate provision of sickness benefits even though the company does not manage a health pool The medical component of the risk will usually be co-insured with other companies underwriting medical risks

¹⁵ Source Insurance Year Book 1994 Nigeria Reinsurance Corporation Lagos

¹⁶ Such policies are jointly underwritten with health insurance carriers based outside the country (commonly the United Kingdom) and premiums are remitted in foreign currency Newline Insurance Company and IGI actually started their health schemes with this product

¹⁷ Computations are based on the statistics supplied by the companies the accuracy of reporting could not be verified

¹⁸ The high rates of inflation make it difficult for providers to accept reimbursement rates that are binding for more than a few months and although the Guild of Medical Directors (an association of proprietors of private hospitals) had in the past attempted to set rates for medical services this has not proved very popular even amongst doctors

¹⁹ Personal communication with Mrs E O Olubusi, Managing Director Armour Insurance Company Ltd Lagos 1996

⁰ Uninsured schemes refer to employee medical benefits schemes that do not involve an insurance company (e g services provided through employer-owned health facility)

¹ Estimated from schedule of fees drawn up by the Guild of Medical Directors and survey data compiled by the Federal Office of Statistics

² IGI covers maternity care at 15 percent extra premium whereas SIC and NIL do not have such rider

- Sources within the industry speculate that existing PrHI schemes will face major financial pressures in the foreseeable future

⁴ This subject is yet to be adequately researched and documented in the country

⁵ Just as individuals seek protection by taking insurance policies against different kinds of risks insurance companies also insure themselves against heavy losses on any particular risk The risk thus becomes reinsured the cover being provided by Reinsurance companies

²⁶ The reinsurance companies surveyed are i) Nigeria Reinsurance Corporation ii) African Reinsurance Corporation iii) Continental Reinsurance Company iv) Globe Reinsurance Company and v) Universe Reinsurance Company - all have their head offices in Lagos

²⁷ Exchange rate in 1995 is estimated at about US\$1 N85

⁸ The accuracy of financial entries could not be verified as such these figures must be used with caution

⁹ Catastrophic illness is described as an episode of infirmity or accident usually necessitating hospitalization the cost of which often exceeds the family's immediate financial capability

¹⁰ Few published works exist on community health insurance and informal prepayment arrangements for health care in Nigeria An in depth study of the subject could prove beneficial

¹¹ The emergence of numerous voluntary health plans (sickness funds) could dilute the element of risk-pooling and increase administrative costs within the entire health system

³ Four (4) pilot facilities under the umbrella of the Nigerian Private Nurses and Midwives Association Osun State have since January 1996 commenced implementation of health information administrative and financial control systems designed to strengthening business management practices It will be possible over time to generate reliable information that can be used for pricing services at this level of care and for this category of providers The systems could be replicated in selected physician-owned practices to generate similar information

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ABOUT *INITIATIVES*

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.