IMPROVING THE EFFICIENCY AND EFFECTIVENESS OF HEALTH CARE DELIVERY UNDER THE NATIONAL HEALTH INSURANCE SCHEME

Centre for Social Justice (CSJ)

Centre for Social Justice Limited by Guarantee (CSJ)
(Mainstreaming Social Justice In Public Life)

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Table of Contents

ACRONYMS

BHCPF	Basic Health Care Provision Fund
CBHIS	Community Based Health Insurance Scheme
CRF	Consolidated Revenue Fund
CSJ	Centre for Social Justice
HCPs	Health Care Providers
HMOs	Health Maintenance Organisations
NGOs	Non Governmental Organisations
MNCH	Maternal, New Born and Child Health
NHIS	National Health Insurance Scheme
Scheme	National Health Insurance Scheme
The Act	National Health Insurance Act
VAT	Value Added Tax

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EXECUTIVE SUMMARY

This memorandum sets agenda for the improvement of the efficiency and effectiveness of health care delivery under the National Health Insurance Scheme. It reviews the provisions of the National Health Insurance Scheme Act and its implementation over the years highlighting specific challenges and what can be done to remediate them. It proceeds from analysis of challenges to action points. It is focused on improving the services available to enrollees of the scheme, expansion of the scheme to cover more Nigerians and start inching towards the target of universal health coverage. It is prepared within the context of Nigeria's state obligations to respect, protect and fulfill the right to health which is inextricably linked to the right to life.

Some of the key challenges covered and for which recommendations were made include inflation of the number of enrollees and capitation by HMOs, withholding funds due to health care providers, shortchanging health benefits due to enrollees, use of substandard drugs, poor quality assurance and lack of standardization of services. Others are inequitable distribution of enrollees to HMOs, low capitation and fees, outright fraud and penalties in the law.

The recommendations include effective oversight by the regulator to drive the Scheme while commitment by HMOs and HCPs to the original vision of the Scheme is needed. It is a fundamental aphorism that a Scheme that was set up to be managed by a Policy Governing Council cannot fulfill its mission in the absence of the Council. The establishment of the Governing Council is therefore long overdue. An oversight structure that includes civil society (NGOs, professionals, etc.) is imperative. The Scheme should be energised through a complaints mechanism for enrollees to seek redress through state and zonal forums. Compensation mechanism for service failure is also needed. Effective regulation will include the development of robust online Information Technology Platform(s) that monitor in real time, payments and activities of HMOs and HCPs. Already, funds have accrued for this purpose through the deductions volunteered by HMOs. Opening NHIS dedicated accounts by HMOs and HCPs will facilitate the electronic tracking process.

Also, good and fit regulatory practices include periodic training and retraining of both HMOs and HCPs on the existing and new guidelines to bring them up to date with regulations. Enrollees should be free to choose their HMOs from the list accredited by NHIS and subject to change periodically (not exceeding one year). Naming and shaming defaulting HMOs and HCPs to ensure that stakeholders respect the rules may be deployed.

Posting NHIS desk officers in all the HCPs which number about 8000 will involve the recruitment of 8000 staff and increasing the bureaucracy. This administrative part is better left to well-managed, regulated and supervised HMOs.

The Scheme should share data with the Federal and State Ministries of Health for effective planning of health interventions across the Federation. For the realization of universal health coverage, any proposed review of the law should make health insurance compulsory for all Nigerians. If government has made vehicle insurance compulsory, then health insurance cannot be optional unless we value cars more than humans. Extant coverage of health insurance is less than 5 percent of Nigerians. We can target 70 percent coverage in ten years.

The legislature must insist on the implementation of the National Health Act's provision of not less than 1 percent CRF to the BHCPF. 50% of the BHCPF is by law to be routed to the Scheme which will use same to provide for vulnerable Nigerians and funding of MNCH. This should be a challenge for the executive and legislature to ensure that the National Health Act is made functional.

Nigeria needs a bigger pool of resources running into trillions to move the right to health care to the next level. Beyond premiums, specific national revenues should be set aside for health financing including receipts from import duties, Value Added Tax, tariffs on the use telecommunication services to be borne by the consumer, etc. Finally, we do not need to throw the baby away with the bath water. Reforms are needed to make HMOs play their designated roles in the public sector. Laws and regulations need to be enforced and lacunas plugged by the legislature. HMOs are still rendering good service in the private sector and will add value to the Scheme if properly regulated. Finally, a Health Bank, Special Health Intervention Funds and other incentives are needed to compliment the funding of the Scheme.

1. INTRODUCTION

The long title to the National Health Insurance Act ("the Act") describes it as an Act to establish the National Health Insurance Scheme ("NHIS" or "Scheme") with the objectives of ensuring access to good health care services to every Nigerian and protecting Nigerian families from financial hardship of huge medical bills; and for matters connected therewith[1]. S.1 (1) of the Act provides that the Scheme is for the purpose of providing health insurance which shall entitle insured persons and their dependants the benefit of prescribed good quality and cost-effective health services as set out in the Act. In carrying out these noble goals, a stakeholder process is unleashed between the NHIS being the regulator, Health Maintenance Organisations ("HMOs"), Health Care Providers ("HCPs") and contributors and their dependents who are the beneficiaries of the Scheme.

In improving the efficiency and effectiveness of health care delivery under the NHIS, it will be imperative to assess the performance of HMOs and HCPs who are key stakeholders. Also, a review of the objectives of the Scheme as stated in S.5 of the Act is imperative. The objectives are to:

- *ensure that every Nigerian has access to good health care services;*
- *protect families from the financial hardship of huge medical bills;*
- *limit the rise in the cost of health care services;*
- *ensure equitable distribution of health care costs among different income*
- *groups;*
- *maintain high standard of health care delivery services within the Scheme*
- *ensure efficiency in health care services;*
- *improve and harness private sector participation in the provision of health care services;*
- *ensure adequate distribution of health facilities within the Federation;*
- *ensure equitable patronage of all levels of health care;*
- *ensure the availability of funds to the health sector for improved services.*

Further, it is pertinent to review the functions of HMOs and HCPs as stated in the Act. HCPs by S.18 (1) of the Act are under a definite obligation:

> *A health care provider registered under the Scheme shall, in consideration for a capitation payment in respect of each insured person registered with it, or for payment of approved fees for services rendered and to that extent and in the manner prescribed by this Act, provide -*
>
> - ❖ *defined elements of curative care;*
> - ❖ *prescribed drugs and diagnostic tests;*

[1] See Cap N42, Laws of the Federation of Nigeria 2004.

- *maternity care for up to four live births for every insured person[2];*
- *preventive care, including immunization, family planning, ante natal and post natal care;*
- *consultation with defined range of specialists;*
- *hospital care in a public or private hospital in a standard ward during a stated duration of stay for physical or mental disorders;*
- *eye examination and care, excluding test and the actual provision of spectacles; and*
- *a range of prosthesis and dental care as defined.*

For HMOs, S. 20 of the Act assigns the following functions:

- *the collection of contributions from eligible employers and employees under this Act;*
- *the collection of contributions from voluntary contributors under subsection (3) of section 17 of this Act;*
- *the payment of capitation fees for services rendered by health care providers registered under the Scheme;*
- *rendering to the Scheme returns on its activities as may be required by the Council;*
- *contracting only with the health care providers approved by the Scheme for the purpose of rendering health care services under this Act;*
- *ensuring that contributions are kept in accordance with guidelines issued by the Council and in banks approved by the Council; and*
- *establishing a quality assurance system to ensure that qualitative care is given by the health care providers.*

Thus, the Act expects collaboration between NHIS as regulator through HMOs as purchasers of service to actual service providers in health care providers to render quality and efficient service to the contributors and their dependents. So, where is the challenge coming from which limits efficiency and effectiveness? Centre for Social Justice (CSJ) prepared this memorandum drawing from interviews with selected beneficiaries, former staff of HMOs, health professionals and through literature review and interactions with the regulator.

The memorandum and the recommendations are drawn up against the background of the health duties of state under national and international standards and jurisprudence and these are the obligations to respect, protect and fulfill the right to health. The obligation to respect requires states to refrain from interfering directly or indirectly with the enjoyment of the right to health. The obligation to protect mandates states to take

[2] Covering four live births makes eminent sense. However, we are living in a country where families give birth to more than four children. The Guidelines also define family in terms of a monogamous union whilst polygamous unions are also recognized by law. So, there is a lacuna that needs to be filled through the interrogation and re-definition of basic concepts.

measures that prevent third parties from interfering with the right whilst the obligation to fulfill requires states to take appropriate legislative, administrative, budgetary, judicial, promotional and other measures towards the full realization of the right to health[3].

2. KEY CHALLENGES AND ACTION POINTS

A. Inflation of Number of Enrollees and Capitation

Analysis: The HMOs are known to inflate the number of registered enrollees under their care and at the end of the day, make false claims for payment of capitation which is borne by the NHIS. The Executive Secretary, NHIS, Usman Yusuf, disclosed that the Scheme had removed about 23,000 ghost enrollees[4]. One can imagine the billions of naira that had been stolen from the system through this kind of false claims and inflation. This will definitely be at the expense of real life enrollees. Those who enrolled the ghosts were third parties who sought to interfere with the enjoyment of the right to health of the enrollees and as such, the protection duty of the state was right to fish them out.

On the flip side of it, HMOs report that they have enrolled only 450,000 Nigerians under private insurance schemes since inception. This figure is too low and seems to be underestimated. There is a perverse incentive to under report the numbers enrolled considering that they are required to pay a certain percentage of the premium to NHIS. This is most likely the case considering that before the advent of health insurance in Nigeria, many blue chip companies, individuals and organisations were running retainerships with private health service providers and majority of the retainers were converted to private insurance schemes[5]. This is validated by the submission of a HMO, AXA Mansard Health that total premium size in the private sector health insurance scheme in the form of employer sponsored insurance is about N50 billion covering 2.5 million lives[6].

Action Point: To prevent the repetition of padding and under reporting in the future requires strong deterrence through criminal prosecution and stronger penalties in the Act. It is recommended that registration with the Scheme or private health insurance should be linked with Bank Verification Numbers and the National Identity Card Scheme. Those responsible should not simply be slapped on the wrist but made to pay

[3] See the Maastricht Guidelines on Violation of Economic, Social and Cultural Rights adopted on the occasion of the 10th anniversary of the Limburg Principles on the Implementation of the International Covenant on Economic, Social and Cultural Rights.
[4] https://www.nhis.gov.ng/nhis-fishes-out-23%2C000-ghost-enrollees/
[5] See *Relationship Management between HMOs and Service providers: Matters Arisin*g by Dr. Olanike Adeniba, former President, Health Care Providers Association of Nigeria.
[6] Memorandum submitted to the Deputy Clerk, House of Representatives Committee on Health Care Services in June, 2017.

a heavy price to deter others in future. Beyond this, those involved should be named and shamed and possibly blacklisted.

B. HMOs Withholding Funds Due to HCPs

Analysis: The Scheme is stated to be previously paying HMOs three months capitation upfront to enable them provide timely, standard and qualitative healthcare services to the enrollees through timely and regular payments to HCPs; but the HCPs are not paid timely and are owed a lot after rendering services[7]. The prepayment has now been reduced to one month in advance.

Action Point: Reports from HCPs should be sent to the regulator which should investigate and if found to be true, follow up with administrative and punitive sanctions to deter future offence. The penalties in the Act should be applied but the Act should be amended for stiffer penalties.

C. Shortchanging Health Benefit Package of Enrollees

Analysis: The HMOs mostly do not offer their enrollees the list of health benefit packages known to be approved by the NHIS. Enrollees have been denied basic treatment packages by various HCPs. The HCPs only respond to the enrollees based on the type of agreement signed with the HMOs. In most reported cases where enrollees are denied some health benefits that is supposed to be in their package, the HCPs confirmed that such benefits were not in the agreement between them and their HMOs. This goes against one of the functional parametres of the right to health which is availability of services to attend to those in need of curative care.

Action Point: Full blown sensitization of enrollees on their rights and entitlements under the Scheme as stated in the enrollee bill of rights on the website of the Scheme. The sensitization should be the duty of the Scheme, HMOs, professional associations in the health sector, and health related civil society organisations. This will ensure information accessibility as a component of the right to health. Again, penalties should be stated in the law and by administrative action of the regulator to whip into line recalcitrant HMOs and HCPs. The rights are stated to be:

- *Right of access to medical treatment as covered by the benefit package under the Scheme.*
- *Right to choose a provider of his/her choice as long as such a provider is accredited by the Scheme.*
- *Right to be issued with an NHIS identity card after being registered with the Scheme.*

[7] See the House of Representatives Motion of December 8, 2016.

- *Right to change Primary Healthcare Provider after three (3) months of initial access.*
- *Right to immediately change his/her provider if the facility is closed, relocated or the employee is on transfer to another town.*
- *Right to complain to the HMO about any act of negligence on the part of the Healthcare provider.*
- *Right to access medical care for spouse and four (4) biological children.*
- *Right to give constructive criticism of the operational methods of the Scheme.*
- *Right to be referred for specialised investigations or care. Referral means sending a patient for a range of specialized investigations or care through the recognized three levels of services:*
    - *Referrals made by primary healthcare provider to the secondary provider.*
    - *Referrals made by the secondary provider to tertiary provider.*
    - *Lateral referral from one specialist to another within the same level.*

D. Enrollees are Restricted to Substandard Drug List

Analysis: The HMOs offer only generic drugs, to their enrollees instead of branded drugs. There is an approved drug list in the National Health Insurance Scheme. Although, the NHIS drug list does not provide for some certain level of quality required by the enrollees, this needs to be reviewed to meet up with the health standard. It is the duty of the HMOs to recommend standard drugs for their enrollees, though this might attract some extra cost. HCPs are under obligation to provide prescribed drugs and diagnostic tests. For healthcare to meet the adequacy criteria, health facilities, goods and services must be scientifically and medically appropriate and of good quality.

Action: The Scheme should review the drug list to infuse greater quality in the dispensation of drugs.

E. Poor Quality Assurance to Enrollees

Analysis: The HMOs are supposed to provide proper oversight and quality assurance system to ensure that qualitative care is given by HCPs to their enrollees. This entails that the HMOs resolve queries promptly and investigates cases of medical mal-practices on their enrollees. However, due to the poor agreement between the HMOs and the HCPs, the HMOs have been derelict in this core duty of offering proper quality assurance to their enrollees as expected under a managed health care scheme. This has led to loss of confidence in the Scheme. As a result, some enrollees prefer to pay out of their pocket to get quality treatment despite being registered under the Scheme. In most cases, because treatment of enrollees under the managed health care has been pre-paid, the HCPs concentrate their efforts in attending to private patients outside the health insurance scheme. This leads to discrimination between patients coming from the Scheme and those paying out of pocket with the latter being better treated.

The foregoing is also linked to the implementation of S. 13 of the National Health Act which mandates the issuance of a certificate of standards to all health establishments within 24 months of the coming into force of the National Health Act[8].

Action Point: Enhanced oversight of HMOs by the NHIS to ensure that they fulfill their obligation on quality assurance. The Federal Ministry of Health should set in motion the process of obtaining certificate of standards for all health establishments. Certification and accreditation should not be a one off event but should be reviewed periodically.

F. Lack of Standardization of Services Rendered to Consumers

Analysis: Users across the country receive different levels/standards of service across hospitals depending on the facility, town or state one visits. This is the challenge of a national accreditation system that would independently assist and grade hospitals not being in place. If the reverse were the case, it would make it easier for HMOs to pay hospitals according to their 'rating'[9]. There is also the slow pace in the accreditation of healthcare facilities by NHIS.

Action Point: Using quality assurance, NHIS should standardize the care received by enrollees across the federation and ensure high standard of healthcare delivery services as provided in the objectives of the Scheme.

G. Inequitable Distribution of Enrollees

Analysis: For the purpose of maximizing cost, the HMOs are known to push the majority of their enrollees under particular HCPs. This is done to facilitate easy cost agreement for capitation with the HCPs. The HCPs are known to sign off agreements with HMOs where they are given large number of enrollees. The effect of this lopsidedness stretches the use of facilities and personnel in the HCPs. This results to poor treatment and attendance of enrollees by the HCPs.

The inequitable distribution affects the referral system in Nigeria as an expert has noted that:

> *"A situation where the tertiary health institutions in the form of teaching hospitals and federal medical centres have over 70% of the enrollees domiciled in them is an aberration, an abuse of operational framework and a precipice for predictable failure. The teaching hospitals should have nothing to do with primary healthcare. They should*

[8] It is submitted that all health establishments in Nigeria are operating illegally in view of this section and the fact that not a single health institution has undergone the process of certification.
[9] See https://www.avonhealthcare.com/press/guardian-12-may-2016-how-to-improve-health-insurance-coverage-in-nigeria-by-ukiri/

stay back and await referrals from the primary/secondary care units as propagated by the private investors"[10].

The foregoing does not guarantee appropriate patronage of all levels of healthcare as contemplated in section 5 of the Act on objectives of the Scheme. Again, the low capitation demands large volumes of enrollees to incentivize HCPs and for them to break even financially. The break-even or sustainability point is defined as 5000 lives. This is not available to many HCPs. Finally, enrollees seem to be denied of their right to choose a doctor or HCP of their choice. They are rather posted to HCPs by HMOs.

Action Point: The Regulator and HMOs should ensure the equitable distribution of enrollees to encourage HCPs to render effective services. Subject to enrollee choice, NHIS should consider placing a moratorium on HCPs that have what may be termed excess enrollees whilst redistributing to others with sufficient capacity to absorb new ones. Enrollees should, *ceteris paribus,* be concentrated at primary health care providers while secondary and tertiary providers receive referrals.

H. Inequitable Spread/Distribution of HMOs

Analysis: Most HMOs are concentrated in big cities such as Lagos and Abuja to the neglect of smaller cities and the rural areas. This leaves so many parts of the country and the population un-serviced and un-reached. This runs against the grain of one of the objectives of the Scheme which is to ensure equitable distribution of healthcare services within the federation[11].

Action Point: There should some form of decentralization where there could be regional HMOs licensed to operate within specific geopolitical zones of the country.

I. Access to Services during Crisis Periods

Analysis: Coordination during crisis periods to guarantee enrollees access to services is very poor. This is usually the case during periods of strike by public sector medical professionals. The subsistence of a valid insurance contract based on the payment of premium is most times not respected during the crisis.

Action Point: Alternative arrangements should be worked out between the Scheme and HMOs for enrollees to get access to quality health care services even during periods of emergency and crisis.

[10] *Health Insurance and Managed Healthcare Financing: the Nigerian Experience* by Dr. Iyke U. Udoh, Medical Director Meridian Hospitals.
[11] See section 5 (h) of the Act detailing the objectives of the Scheme.

J. Low Capitation and Fees

Analysis: HCPs have raised complaints about the low level of capitation currently standing at N750 and fees of N112.50. They complain that this cannot allow a diligent service provider to break even and continue in a meaningful business of saving lives. However, capitation is paid whether the insured uses the service or not. But the capitation covers not just the doctors consultation alone but a wide range of prescribed drugs, diagnostic tests, hospital care in a ward for 15 days, services, etc. And this is further tied to the inequitable distribution of enrollees and subsequent low enrollee numbers in some HCPs. There are also complaints about fees being too low.

Action Point: It may be imperative for the Scheme to periodically review the capitation and fees taking cognizance of extant macroeconomic realities in terms of the value of the naira, inflation, purchasing power, etc. This should be done after a fixed period of time and after calling for inputs from stakeholders including HMOs, HCP, the monetary and fiscal authorities in the Finance Ministry and Central Bank of Nigeria, organized labour, etc. Capitation should not punish through underlining a financial loss but encourage a diligent service provider to recover his costs with a little margin to continue the service. Fees should be reflective of actual cost of services by a reasonable physician.

K. Waiting Period for New Enrollees

Analysis: According to the Operational Guidelines, there is *a processing/waiting period of ninety (90) days before a participant can access healthcare services*. This is something that takes less than a month for private health insurance. This bureaucracy is not necessary.

Action Point: Reduce the waiting period to one month.

L. Outright Fraud

Analysis: Sometimes, hospitals present forms for services rendered to enrollees to sign without crossing out the other unpopulated spaces and when the enrollee signs, they go and populate the forms for services not rendered and claim the money.

Action Point: This speaks to the need for HMOs to put proper checks and balances in place to prevent operators from cheating the system.

M. Penalties in the Law

Analysis: The penalties in the extant law are too liberal for offenders and encourage impunity. The major penalty is S. 28 of the Act which states that:

> (*I) Any person who -*

(a) fails to pay into the account of an organisation and within the specified period any contribution liable to be paid under this Act; or

(b) deducts the contribution from the employee's wages and withholds the contribution or refuses or neglects to remit the contribution to the organisations concerned within the specified time, commits an offence.

(2) A person guilty of an offence under subsection (1) of this section is liable on conviction-

(a) in the case of a first offence, to a fine of Nl00,000 or 500 per centum of the amount of the contribution involved, together with accrued interest on the contribution, whichever is higher, or imprisonment for a term not exceeding two years or less than one year or to both such fine and imprisonment; and

(b) in the case of a second or subsequent offence, to a fine of N200,000 or 1,000 per centum of the amount of the contribution involved together with accrued interest on the contribution, whichever is higher, or imprisonment for a term not exceeding five years or less than two years or to both such fine and imprisonment.

Action Point: More offences should be created and stiffer fines of a minimum of 1000 percent of the withheld sum and four to five years jail terms prescribed. In terms of more offences, the provision of the Bill before the Senate to repeal the NHIS Act is instructive.

***57.** (1) Any person who –*

(a) fails to pay into the account of the Commission and or a health insurance fund or HMO and within the specified period any contribution liable to be paid under this Bill; or

(b) deducts the contribution from the employee's wages and withholds the contribution or refuses or neglects to remit the contribution to the appropriate Health Insurance Fund or an Organization concerned within the specified time; or

(c) fails to remit capitation to Healthcare Providers after receiving such from the Health Insurance Fund within the specified period indicated in the Operational Guidelines; or

(d) fails to settle fee-for-service or other claims from the Healthcare Providers after receipt and verification within the stipulated time allowed in the Operational Guidelines; or

(e) deliberately manipulates the enrollee register for the benefit of other parties before or after the release of the register by the Health Insurance Schemes;

(f) deliberately refuses to provide care to a duly registered enrollee after receiving payments from the relevant organization on behalf of such enrollee; or

(g) deliberately issues dud cheque(s),

shall be guilty of an offence.

3. CONCLUSIONS AND OTHER RECOMMENDATIONS

A. Effective Regulation: Effective oversight by the regulator is needed to drive the Scheme while re-commitment by HMOs and HCPs to the original vision of the Scheme is needed. It is a fundamental aphorism that a Scheme that was set up to be managed by a Policy Governing Council cannot fulfill its mission in the absence of the Council. The establishment of the Governing Council is therefore long overdue.

An oversight structure that includes civil society (NGOs, professionals, etc.) is imperative for the Scheme. The Scheme should be energised through a complaints mechanism for enrollees to seek redress through state and zonal forums. Compensation mechanism for service failure is also needed. Effective regulation will include the development of robust online Information Technology Platform that monitors in real time, payments and activities of HMOs and HCPs. Already, funds have accrued for this purpose through the deductions volunteered by HMOs. Opening NHIS dedicated accounts by HMOs and HCPs will facilitate the electronic tracking process. Also, good and fit regulatory practices include periodic training and retraining of both HMOs and HCPs on the existing and new guidelines to bring them up to date with regulations. Enrollees should be free to choose their HMO from the list accredited by NHIS and subject to change periodically (not exceeding one year).

Name and shame defaulting HMOs and HCPs to ensure that stakeholders respect the rules. Posting NHIS desk officers in all the HCPs which is about 8000 will involve the recruitment of 8000 staff and increasing the bureaucracy. This administrative part is better left to well-managed, regulated, supervised and resourced HMOs. The Scheme should share data with the Federal and State Ministries of Health for effective planning of health interventions across the Federation.

B. Beneficial Ownership and Improved Transparency: Nigerians need to know the beneficial owners of these HMOs so as to know who to hold responsible in the event of a breach of rules and regulations beyond the “bad guys” hiding behind the veil of incorporation of a company.

C. Compulsory Health Insurance: For the realization of universal health coverage, any proposed review of the law should make health insurance compulsory for all Nigerians. If government has made vehicle insurance compulsory, then health insurance cannot be optional unless we value cars more than humans. Extant coverage is less than 5 percent of Nigerians. We can target 70 percent coverage in ten years. The proposal is as follows:

> *Subject to the provisions of this Act, any person -*
>
> *(a) who is ordinarily resident in Nigeria;*
>
> *(b) who has attained the age of 18 years;*
>
> *(c) whose total income whether derived from salaried or self-employment is not less than the minimum wage*
>
> *shall be liable to contribute to the Scheme, at such rate and in such a manner as may be determined from time to time, by the Council provided however that persons contributing under State and Private Health Insurance Schemes are not liable to double contribution.*

For public sector employees already under the Scheme, it is important that their leadership enters into good faith negotiation with the Federal Government to start contributing to the Scheme beyond their employers contributions.

D. Kick-start the Basic Health Care Provision Fund: The legislature must insist on the implementation of the National Health Act's provision of not less than 1 percent CRF to the BHCPF. 50% of it is by law to be routed to the Scheme which will use same to provide for vulnerable Nigerians and funding of MNCH. This should be a challenge for the executive and legislature to ensure that the National Health Act is made functional. According to the NHA in S.12 (3) - (4): *(3) Money from the fund shall be used to finance the following:-*

> *(a) 50% of the fund shall be used for the provision of basic minimum package of health services to citizens, in eligible primary/or secondary health care facilities through the National Health Insurance Scheme (NHIS);*
> *(b) 20 percent of the fund shall be used to provide essential drugs, vaccines and consumables for eligible primary health care facilities;*
> *(c) 15 per cent of the fund shall be used for the provision and maintenance of facilities, equipment and transport for eligible primary healthcare facilities; and*
> *(d) 10 per cent of the fund shall be used for the development of Human Resources for Primary Health Care;*
> *(e) 5 percent of the fund shall be used for Emergency Medical Treatment to be administered by a Committee appointed by the National Council on Health.*

(4) The National Primary Health Care Development Agency shall disburse the funds for subsection 3(b), (c) and (d) of this section through State and Federal Capital Territory Primary Health Care Boards for distribution to Local Government and Area Council Health Authorities.

E. Energise Community Based Health Insurance: The Community Based Social Health Insurance Scheme (CBHIS) is a non-profit health insurance programme for a cohesive group of households/individuals or occupation based groups, formed on the basis of the ethics of mutual aid and the collective pooling of health risks, in which members take part in its management. The Scheme should put more efforts to organize this community scheme. NHIS should collaborate with the states and local governments nationwide to set up the CBHIS. The Scheme, states and local government should embark on community mobilization and sensitization on benefits of the CBHIP to members of the community and set up low cost premiums that are affordable and renewable annually. The funding of CBHIS should be subsidized by the larger pool of NHIS funds.

F. Bigger Pool of Funds Needed Including Special Dedicated Public Funds: We need a bigger pool of resources running into trillions to move the right to health to the next level. Beyond premiums, specific national revenues should be set aside for health including receipts from import duties, Value Added Tax, tariffs on the use telecommunication services to be borne by the consumer, etc. The bigger pool of funds will be used for vulnerable groups and for MNCH to the poor.

G. HMOs are still Needed: We do not need to throw the baby away with the bath water. Reforms are needed to make HMOs play their designated roles in the public sector. But their focus must move away from profit maximization. Health is not just a business but a right of citizens. One of the objectives of the Scheme in section 5 of the Act is to improve and harness private sector participation in the provision of healthcare services. Laws and regulations need to be enforced and lacunas plugged by the legislature. Some HMOs are still rendering good service in the private sector and can do same in the public sector[12]. But the administrative cost accruable to HMOs should be reduced from the current 10% to not more than 5%.

H. Special Intervention Funds and Incentives: To compliment the NHIS financing which is mainly for curative care, FGN should consider the establishment of a Health Bank to offer long term single digit interest loans for capital and recurrent costs of health establishments. Considering health as business to compete with other sectors in need of funding in the traditional banking system is to deny the rights nature of healthcare. Nigeria has doled out various intervention and bailout funds which did not benefit the health sector. Special Health Intervention Funds are needed for long term single digit financing. Finally, if power, agriculture, mining, etc. can get import duty waivers, health is more than over qualified for import duty waivers.

[12] Out of 67 accredited HMOs, 27 do not cover federal government lives and only collect premiums from the private sector.