

# STRATEGIC PURCHASING FOR UNIVERSAL HEALTH COVERAGE: A CRITICAL ASSESSMENT

## THE FORMAL SECTOR SOCIAL HEALTH INSURANCE PROGRAMME



RESEARCH BRIEF | Financing research theme

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With universal health coverage included among the health-related Sustainable Development Goals, the issue of how to finance health for all remains at the centre of global policy debate. A core function of healthcare financing is purchasing – the process by which funds are paid to healthcare providers to deliver services. If designed and undertaken strategically, purchasing can promote quality, efficiency, equity and responsiveness in health service provision and, in doing so, facilitate progress towards universal health coverage.

The RESYST Consortium, in collaboration with the Asia Pacific Observatory on Health Systems and Policies, has critically examined how healthcare purchasing functions in ten low and middle-income countries to identify factors that influence the ability of purchasers and other key actors to take strategic actions.

This summary provides an overview of how health service purchasing functions in the Formal Sector Social Health Insurance Programme (FSSHIP) under the National Health Insurance scheme (NHIS) in Nigeria, which is designed to cover public sector employees and the organised private sector. It examines the Health Maintenance Organisations (HMOs) as purchasers and their relationship with three key groups; the NHIS another (higher) layer of purchaser, healthcare providers and members.

The brief compares the actual purchasing practices under the programme with the ideal purchasing actions to identify gaps and associated influencing factors. Finally it makes policy recommendations for what needs to be done to improve strategic purchasing under this mechanism in Nigeria.

Figure 1: Description of the FSSHIP in Nigeria

<b>Purchaser</b>	Multiple HMOs. They receive funds from the national government through the NHIS to purchase healthcare packages. The HMOs also run private healthcare plans predominantly for employees of the private sector
<b>What services are purchased?</b>	A common benefit package covers several types of service ranging from primary to tertiary care. However, there are partial exclusions from high technology investigations (CT scan, MRI, dialysis for acute renal failure) and total exclusions from occupational diseases, family planning and epidemics. The packages are the same for all enrollees and are decided by the NHIS.
<b>Who uses the services?</b>	Federal civil servants and organised private sector (5% of the Nigerian population). Formal private sector organisations with more than 10 employees are referred to as the “organised private sector”.
<b>Who provides services?</b>	A mix of public, private and faith-based organisations.
<b>How are providers paid?</b>	Health services are reimbursed through capitation for primary care and fee-for-service for secondary and tertiary care.

### WHAT IS STRATEGIC PURCHASING?

The purchasing function of healthcare financing involves three sets of decisions:

1. Identifying the interventions or services to be purchased, taking into account population needs, national health priorities and cost-effectiveness.
2. Choosing service providers, giving consideration to service quality, efficiency and equity.
3. Determining how services will be purchased, including contractual arrangements and provider payment mechanisms.

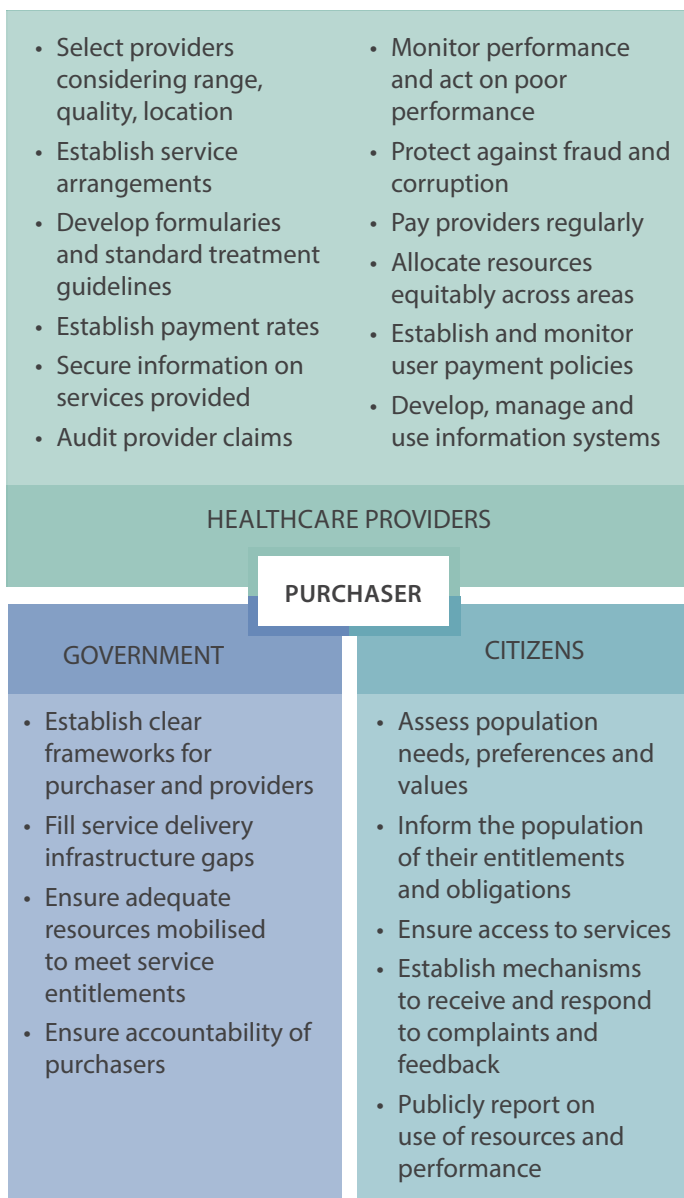
A critical factor in health system performance is the extent to which purchasing decisions are linked to provider behaviour and encourage providers to pursue equity, efficiency and quality in service delivery. This is strategic purchasing.

In strategic purchasing, a purchaser is an organisation that buys health services for certain groups or an entire population. The purchaser can use levers to influence the behaviour of providers to improve quality and efficiency in health service provision and facilitate equity in the distribution of healthcare providers.

However, purchasing mechanisms operate within each country’s regulatory framework and, in strategic purchasing, government is required to play a stewardship role by providing a clear regulatory framework and appropriate guidance to ensure that public health priorities are linked to resource allocation and purchasing decisions.

As the purchaser buys health services for people, it is important for the purchaser to ensure there are effective mechanisms in place to determine and reflect people's needs, preferences and values in purchasing, and hold health providers accountable to the people. The key strategic purchasing actions are shown in Figure 2.

**Figure 2: Strategic purchasing actions relating to healthcare providers, government and citizens**



## KEY FINDINGS

### 1. STRATEGIC ACTION BY PURCHASERS IN RELATION TO PROVIDERS

#### *Mechanisms by which purchasers choose appropriate providers*

- Providers are assessed by the NHIS, accredited and registered and then recommended to enrolees. Criteria for selection are based on human and structural capacity and a viable referral system. Following accreditation an “agreement” document, which contains the various levels of services, packages of care and tariffs, is signed. This can be said to be functioning well because it is regular and facilities are reassessed for accreditation annually.

#### *Mechanisms to ensure equitable delivery of services*

- Only accredited facilities are registered to provide services irrespective of where they are located. This does not ensure geographic equity in service provision. However, within facilities, efforts are made to provide all services within the package of care and to refer patients to appropriate services.

#### *Monitoring provider performance*

- There is no clear monitoring of the clinical aspects of provider performance by the NHIS and most respondents of the research were not aware of having been visited by monitoring or quality assurance personnel. However, NHIS do make ad hoc visits to facilities to speak directly to the enrolees about once a year. While the NHIS rarely visits facilities, they more regularly check providers’ accounting or financial departments - one large provider receives visits from the zonal office weekly, and from the national head office once a quarter.

*“They should actually have people on ground [to] come, go through the case notes, see what this person has been using, discuss with the doctor because he is your client. He needs satisfaction, they need to come and monitor. But they are not interested – all they are interested is in: ‘send bill and we will do’. But they are not really doing the work of the HMOs. They are not credentialing, that is, they are not into the practice, they not into the supervision, although they are supposed to supervise.”*  
(Private Provider)

#### *Provider payment, funding and accountability mechanisms*

- The transfer of funds from some HMOs to providers is problematic due to differences in payment timings; funds to HMOs come on a quarterly basis and payments to primary healthcare providers are monthly, thus giving HMOs incentives to invest money in non-health activities. As a result, funds are often not available for timely reimbursement of provider claims.

- In other instances, HMOs would like to ensure timely payment to providers but there are delays due to slow submission of claims forms to the HMO. Furthermore, occasionally HMOs need to verify some aspects of the claims, a process that can take months, and can also delay patient treatment. Presently, there are no regular audit systems in place to counter these delays despite the fact that regulations are in place to demand that auditing is carried out by the NHIS.

*"I believe if the monitoring body, NHIS, will be fair to put a time limit on claim returns. Like state categorically that if after 90 days or 60 days or after a month, you don't submit your claims, you're not going to be paid, I believe the hospitals will sit up. But there is no limit, whenever you submit, the HMOs will process and pay."*

(NHIS Purchaser)

## 2. PURCHASER - GOVERNMENT RELATIONSHIP

### *Governance, policy and regulatory framework*

- The NHIS has regulatory frameworks which include the minimum requirements for accreditation of HMOs and their organisational and management structure. The NHIS acts as a higher layer of purchaser in that it carries out oversight functions to the HMOs as well as purchasing tertiary services directly. Auditing functions are also carried out by the NHIS. However, perceived political interests of the NHIS governing board, which has overall control of the scheme, hinder implementation of these regulatory frameworks. Further, NHIS has limited capacity to monitor the performance of HMOs and providers effectively.

*"In a year we were supposed to carry out monitoring and accreditation of about three thousand facilities per zone. You'd found out that you can't go to some facilities even once [in that time]."*

(NHIS policy maker)

### *Accountability mechanisms*

- The limited transparency in business practices of HMOs, especially with regards to their private plans, undermines the capacity of NHIS to regulate them. NHIS requires the submission of data and statistics on HMO public and private plans but information from private plans is not usually made available.

### *Sources and adequacy of funding*

- Beneficiaries of the scheme are supposed to contribute towards its operation. However, in practice enrolees do not pay their counterpart funding as stipulated in its

design. This is because the labour unions have prevented payment until they are confident that the funds will be safely managed. Nevertheless, the amount of funding that the scheme receives appears to be adequate, although there are concerns that the situation may change in future with increased utilisation of services.

*"They [government] have been funding without anybody contributing. That also tells us that if it is sustained on 10% contribution by the government, if we have additional 5% from the civil servants, there'll be a lot of fund to cover even more of those thing that are put under exclusion."*

(NHIS purchaser)

## 3. STRATEGIC PURCHASING ACTIONS IN RELATION TO CITIZENS

### *Engagement with citizens*

- Staff from HMOs visit the ministries and parastatals and organise regular seminars and interactive sessions to discuss the schemes' benefit package, rights and privileges with new and existing enrolees. During these sessions they also inform enrolees about what facilities are available to enable them to decide who to choose as a provider. However, this information doesn't reach all members: the frequency and timing of the seminars are not harmonised amongst the HMOs, and not all enrolees are able to attend. The over reliance on face-to-face meetings means that there are likely gaps in educating citizens about the scheme.

*"If the information can be translated or put down on a paper, in a summarised form; give it the cleaners, to the gatemen that will not be there when you are having that big interactive session. I think that will make the information get to the grassroots; because everybody needs the information."*

(NHIS purchaser)

### *Updating service entitlements*

- Initial service entitlements and benefits have been revised and updated as a result of feedback from enrolees to the HMOs and onward to the NHIS during the interactive sessions. Coverage has been extended to include fibroid operations, up to four live births and the cost of hospital investigations.

### *Mechanisms for identifying eligible citizens*

- HMOs are allocated federal ministries and parastatals by the NHIS - which they are mandated to cover. This constrains enrolees in exercising their choice of HMO

Many eligible and potential enrolees remain uncovered because they are sceptical about the scheme.

### *Mechanisms for feedback and complaints*

- Some mechanisms exist for scheme members to make complaints. Enrolees can submit written complaints to the state NHIS offices who in turn send memos about the complaint to the zonal NHIS offices, which are sent to the head office for follow up and handling of the matter. HMOs also advise enrolees to register their complaint with the front desk officer while they are still in hospital. HMOs also provide numbers of call centres that enrolees can call if they have a complaint. An identified gap here is the over centralisation of the complaints procedure by the NHIS, which leads to delays.

## CONCLUSION AND POLICY IMPLICATIONS

Healthcare purchasing under the FSSHIP mechanism in Nigeria is currently not strategic and steps need to be taken to move towards strategic purchasing. In particular efforts are needed to strengthen monitoring and accountability of both providers by HMOs, and HMOs by the NHIS.

### *Recommendations for HMOs:*

- Develop specific indicators to monitor provider performance.
- Strengthen mechanisms to ensure that payments are made to providers in a timely manner. This can be done by incorporating strict timelines for movement of funds and attendant sanctions for non-adherence.

### *Recommendations for NHIS:*

- Better monitor HMOs, by introducing specific criteria to assess their performance, and to ensure that HMOs are accountable to beneficiaries.
- Decentralise NHIS administration in handling complaints by beneficiaries to avoid delays and improve the quality of services provided.

## ABOUT THE BRIEF

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### Further information

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### Related resources

Ibe O. et al (2016) **Strategic purchasing for Universal Health Coverage: the public integrated health system in Enugu State, Nigeria** RESYST research brief. Available at: <http://resyst.lshtm.ac.uk>

RESYST topic overview and fact sheet (2014) **What is strategic purchasing for health?** <http://resyst.lshtm.ac.uk/resources/what-strategic-purchasing-health>

Hanson K. (2014) **Researching purchasing to achieve the promise of Universal Health Coverage**. Presentation at the BMC Health Services Research Conference, London. <http://www.slideshare.net/resyst/researching-purchasing-to-achieve-the-promise-of-universal-health-coverage-37722050>

