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Managed care was once seen in the United States of America as a cost-effective way of providing quality health care. During the past decade, the attractiveness of this approach faded for many employers who had no clear alternatives to replace them. These developments caused many payors in America to look in other directions for approaches to containing healthcare expenses, which, in turn resulted in an apparent rise in consumer-driven health plans.[1] That, however, is not the focus of this paper.

Healthcare policy in many nations is increasingly influenced by cost considerations. Advances in health science and the delivery of care continue to expand the capabilities of treatments. The ability of nations and communities to pay for this care is a major subject of debate. One of the primary objectives of managed care is to increase the role of the private sector in the provision of health care services to groups who are willing and able to pay the full costs of health care, capitalizing on public/private partnerships. This article aims to explore the Nigerian experience in the development of healthcare policy and reform and the role managed care is playing in this regard.

I. MILLENNIUM DEVELOPMENT GOALS 4, 5, & 6

Since the Millennium Declaration in 2000, the Millennium Development Goals (MDGs) have become important tools for monitoring human progress across nations. Eight goals have been set for 2015 including: to eradicate

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1. *See* Ronald Lagoe, Deborah Aspling & Gert Westert, *Current and future developments in managed care in the United States and implications for Europe,* 3 HEALTH RES POLICY SYST. 4, 15 (2005), *available at* http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1079919/pdf/1478-4505-3-4.pdf.

extreme poverty and hunger; to achieve universal primary education; to promote gender equality; to reduce child mortality; to improve maternal health; to combat HIV/AIDS, malaria and other diseases; to ensure environmental stability; and to develop a global partnership for development.[2]

The 2006 MDG Report[3] indicates strong prospects for three of the eight goals in Nigeria—achieving universal basic education, ensuring environmental sustainability, and developing global partnership for development—while the health MDGs 4, 5 and 6 present daunting challenges for Nigeria. Poor funding and weak management of public health resources pose a serious challenge, not the least of which is a lack of skilled and motivated medical staff and hospitals with adequate drugs and equipment. Thus, in the communiqué issued at the end of the 2009 Nigeria National Health Conference, one of the observations made was that:

> Despite investments in the health sector, the health system remains weak, as evidenced by lack of coordination, fragmentation of services, dearth of resources, including drug supplies, inadequate and decaying infrastructure, inequity in resource distribution and access to care and very deplorable quality of care. Lack of clarity of roles and responsibilities among the different levels of government has compounded the situation. The MDG funding is seen as a replacement of regular government funding, which should not be the case.[4]

II. HEALTHCARE POLICY IN NIGERIA

Healthcare is provided for in section 17 of the 1999 Constitution of the Federal Republic of Nigeria as follows:

> (3) The State shall direct its policy towards ensuring that -
>
> (c) the health, safety and welfare of all persons in employment are safeguarded and not endangered or abused;
>
> (d) there are adequate medical and health facilities for all persons;[5]

This phrase constitutes national health policy in Nigeria. With no clear

2. *See* United Nations Development Programme, http://www.ng.undp.org/nigeriamdgs.shtml.

3. *See* GOV'T OF FED. REP. OF NIGERIA,MILLENIUM DEVELOPMENT GOALS REPORT (2007), *available at* http://www.ng.undp.org/reports (click on 'mgd report').

4. *See* Primary Health Care In Nigeria: 30 Years After "Alma Ata," NIGERIAN NAT'L HEALTH CONF. COMMUNIQUE (NHC, Akwa Ibom, Nigeria), Jun. 10, 2009, at 2.

5. *See* CONSTITUTION, SEC. 17 (3) c-d (1999) (Nigeria).

central policy to drive structured health provision, no defined roles or responsibilities for health delivery by the different tiers of government—federal, state or local government—the result has been a duplication of health initiatives by these different tiers of government lacking coordination and collaboration.

As noted earlier, poor funding has been a major factor in the deplorable Nigerian health indices. Statistics from the World Health Organization (WHO) reveal that maternal mortality in Nigeria accounts for 10% of global maternal mortality, and 40% of global obstetric fistulae occur in Nigeria. Only 23% of Nigerian children receive a full course of immunization against childhood diseases. Sadly, Nigeria is ranked 197 out of 200 in global system ranking. Furthermore, per capita spending on health is less than $10. The WHO minimum is $34; less than 5% of total budgetary expenditure goes to health (WHO minimum is 15%); 66% of healthcare financing comes out of household budgets, while only 22% comes from all tiers of government; donors provide 6% and the remaining 6% is provided by corporations.[6]

Nigeria's healthcare system consists of a mix of public and private healthcare facilities. The public healthcare system consists of hospitals and health centers. The private sector consists of traditional and modern practitioners. A number of government interventions aimed at reforming the health sector have recently led to a sea of change in healthcare delivery in Nigeria. Most importantly, a National Health Bill underwent its third reading in the National Assembly in May 2008, but is yet to be passed into law. It seeks to establish a National Council on Health that would be the highest policy-making body on health in the country.

III. NATIONAL HEALTH INSURANCE SCHEME (NHIS)

The National Health Insurance Scheme Act, Chapter 42, Laws of the Federation of Nigeria, 2004, is an Act establishing the National Health Insurance 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."[7] The NHIS therefore aims to provide universal healthcare coverage in Nigeria in the form of social health insurance, wherein the healthcare services of contributors are paid for from the common pool of funds contributed by participants of the Scheme. Perhaps for historical purposes, it is apt to point out that a national health insurance scheme was first proposed in Nigeria in 1962, by then Minister of Health, Dr. M. A.

6. *See* World Health Organization, Statistical Information System, http://www.who.int/whosis/en/index.html.

7. *See* Nat'l. Health Ins. Scheme Act (2004) Cap. 42, § 42 (Nigeria).

Majekodunmi. Since then, successive administrations have striven to revive and entrench the concept of insurance as a veritable and sustainable tool for financing the provision of health care.[8]

The present-day NHIS is a regulatory body providing oversight functions to the organs that are involved in direct delivery of healthcare services to member Health Maintenance Organizations (HMOs) and health insurance (HI) companies and providers. Healthcare services under the NHIS include preventive, wellness and curative services aimed at different segments of society. Three levels of care are covered under the NHIS—primary, secondary and tertiary. The healthcare providers under the scheme are a mix of public and private facilities in the spirit of public/private partnerships; members are free to choose to obtain services at any one of such registered healthcare providers. Coverage under the NHIS is aimed at two broad sectors of the society, namely: the formal sector (i.e., the public sector, consisting of federal, state and local government civil servants, tertiary institutions, military, police, and other uniformed services and organized private sector players) and the informal sector (consisting of rural communities, the urban self-employed, voluntary participants, retirees and other vulnerable groups).

One of the primary purposes of managed care is to encourage those who are willing and able to pay for health services to do so, and then to use 'freed' government subsidies to increase the level of subsidies available to the poor. In the formal sector, contributions are made to the National Health Insurance Fund (NHIF), which are employment-based and wage-related—15% of the employee's basic salary, with the employee contributing 5% and the employer making up the rest. The funds are then pooled in a single NHI Fund from where they are disbursed to members to fund healthcare services. The enrollee is required to make a co-payment of 10% for the cost of drugs.

Every employer in the formal (or public) sector is required to register with the NHIS, at which time they are allotted a registration number by the Scheme. In addition, every employer in the formal sector is required to appoint an NHIS-registered HMO of their choice. There are at present, fifty-two HMOs registered with the NHIS participating in the Scheme. In the informal sector, membership is for interested individuals who are not currently covered by any form of social health insurance. Thus, any Nigerian who is self-employed or retired, and living abroad, and any employer with less than ten employees in its service may make contributions to NHIS-accredited HMOs. Registered participants are then registered with the primary healthcare provider of their choice who has

8. *See* Dr. Ladi Awosika, *Health Insurance and Managed Care in Nigeria,* 3 ANNALS OF IBADAN POSTGRAD. MED., 40, 42 (Dec. 2005).

contracted with the HMOs.

IV. HEALTH INSURANCE COMPANIES

In Nigeria, there is an increasing shift from traditional indemnity insurance to managed care plans. Companies such as Unic Insurance and Liberty Blue have made significant inroads into the managed care market, offering employees and the general public the option to enroll in managed care plans that fit their income. Enrollees pay a premium that entitles them to healthcare coverage from a selected group of providers. The extent of coverage available to enrollees depends on the type of plan they choose. Traditional insurance plans have moved toward managed care by adopting features of HMOs such as utilization controls. As a result, the border between these two types of insurance has become blurred to the point of being almost non-existent.

V. HEALTH MAINTENANCE ORGANIZATIONS

Currently, there are fifty-two HMOs accredited by the NHIS participating in the Scheme. An HMO is defined under the Scheme as: "an organization registered under section 19 of this Act and includes institution, body corporate or a provident association registered by the Council[9] to utilize its administration to provide health care services through health centers approved by the Council."[10]

The functions of the HMOs include:

(i) The collection of contributions from registered employers and employees;

(ii) The collection of contributions from voluntary contributors;

(iii) Payment of capitation to primary providers and fee-for-service, per diem, case payment to secondary and tertiary providers;

(iv) Rendering to the Scheme monthly returns on its activities within 30 days of the following month;

(v) Contracting with healthcare providers accredited by the Scheme for the purpose of rendering healthcare services;

(vi) Ensuring that contributions are kept in the Scheme's accredited banks;

(vii) Establishing a quality assurance system for the provision of quality healthcare by healthcare providers;

9. "Council" is defined by the NHIS Act to mean the Governing Council established under section 2 of the Act for the Scheme. *See* Nat'l. Health Ins. Scheme Act (2004) Cap. 42 (Nigeria).

10. *See* Nat'l. Health Ins. Scheme Act (2004) Cap. 42, § 49 (Nigeria).

(viii) Rendering accounts to the NHIS as required;

(ix) Marketing in accordance to NHIS *Guidelines*; and

(x) Carrying out such functions as are contained in the *NHIS Act* and the *Guidelines*.

Only NHIS-accredited HMOs are permitted to operate in Nigeria. Payment to healthcare providers is by capitation. This is made on a monthly basis and fourteen days in advance of the due date (beginning of each month). Secondary and tertiary providers are paid through negotiated fee-for-service on completion of service and presentation of bills.

Every HMO registered with the NHIS is required to remit 3% of the 15% contribution of every enrollee to the NHIS (1% for administrative costs and 0.5% for Reserve Funds, while 1.5% is used to defray the administrative costs of the HMO). Any excess funds (after the payment of capitation, per diem, fee-for-service payments, administrative costs for NHIS and the HMOs and the mandatory payment into the Reserve Fund) must be paid by the HMO into a separate NHIS Stabilization Fund Account. To contain costs, HMOs in Nigeria are no different from the rest of the world in that they employ utilization controls such as utilization of hospital care, physician gate-keeping and pre-authorization mechanisms.

VI. CONCLUSION

Indeed, the Nigerian model can be categorized as a hybrid between the American and the British healthcare systems. The public/private component of the NHIS is juxtaposed with the concept of universal coverage and governmental administration. Oversight responsibility is entrusted to the NHIS (a governmental agency) and not to private agencies. Managed care as a model for providing quality healthcare in a cost-effective manner has gained a foothold in Nigeria. Currently, the most active proponents of managed care as a tool for healthcare reform in Nigeria are the HMOs, which provide an example of the inevitable challenges of implementing this model of healthcare reform.

Tariffs continue to be a bone of contention between HMOs and providers; there are also issues with case management, pre-authorization and utilization data collection. Admittedly, if the administrative organization only pays government rates that are below those necessary to cover the full costs of providing services, the cross-subsidization objective of managed care is unlikely to be met. Arguably, for any reform to be effective, it must take into account numerous contextual factors, including institutional factors, such as the government's capacity to establish and enforce a regulatory framework, as well as market factors, such as the ability and willingness among consumers to pay for managed care benefits

and the profitability of managed care to healthcare providers and managed care organizations such as HMOs.[11]

In conclusion, for a managed care system to be viable, key institutional and economic conditions must be met. These conditions involve all of the key stakeholders in the healthcare sector, including households, the government, private providers, managed care organizations, and international donors and banks. If any of these groups lack the capacity or willingness to participate in managed care financing, the chances of success are greatly diminished.

11. *See* David R. Hotchkiss et al., *Indonesian Health Care and the Economic Crisis: Is Managed Care the Needed Reform*, 46 HEALTH POLICY 195, 96 (1999).