Group Practice & Health Insurance as synergistic tools for a quicker attainment of Universal Health Coverage (UHC)

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Turning Suggestion into Hypothesis:

Could Group Practice & Health Insurance be synergitic tools for a quicker attainment of Universal Health Coverage (UHC)?

Insights from review of capitation as provider payment mechanism under the National Health Indursnce Scheme in Nigeria

- country-wide study: 12 States (2 per geopolitical zone) purposely selected, includes large pop. Centers – Lagos, Kano, Port Harcourt, Abuja, Kaduna,

- survey of accredited Health Care Providers (HCPs) – public & private;

- extensive conversations with key stakeholders: policy makers, heads of accredited HPCs, health professional associations, beneficiries (enrollees & their dependents), & significant others

Some clarifications of the three key terms under consideration:

Group Practice***:***

Two or more doctors who provide medical care within the same facility, using the same personnel and divide income in manner agreed by the group – enjoy benefits of shorter working hours, built-in on call coverage, and access to more working capital – **may consist of providers from a single speciality or multiple specialities**.

Health Insurance***:***

A system for the financing of medical expenses by means of contributions or taxes paid into a common fund **to pay for all or part of health services specified in a health insurance policy or the law**.

Universal Health Coverage:

All people have access to the full range of quality health services they need, when and where they need them, **without financial hardship** – covers the full continuum of essetial health services, from health promotion to prevention, treatment, rehabilitation and palliative care.

Key Observations:

1. Despite its short comings, many more people in Nigeria have access to medical services, free at the point of care, due to implementation of health insurance

2. Capitation (a fixed amount paid to primary care providers every month , whether beneficiries visit the clinic/hospital or not) is the most predicatble source of revenue for all categories of participating health facilities

3. Capacity of participating clinics and hospitasl to deliver quality services enhanced in both public and private sectors across the country *"I'm using capitation to improve services …makes my system more efficient"* ~ public provider

Capitation payments have enabled health facilities to:

(i) improve hospital infrastructure including putting up new buildings besides restoring existing ones ;

(ii) improve inventory of medical equipment;

(iii) increase availability of drugs and consumables for general use, not just for NHIS clients;

(iv acquire additional human resources for health to fill critical gaps – e.g., locum doctors including specialists, and other health professionals.

4. Providers adapting delivery modes & becoming more responsive to client needs (patient-centred):

- several large public & related hospitals have established dedicated NHIS clinics

- staffed by Team of Family Doctors providing first contact care

- incorporate pharmacy and laboratory …one-stop shop for NHIS cliennts

- extended opening hours …operate evening clinics to accommodate those who choose to come during that period

- patients are chaperoned by support staff to help navigate the care pathway., when refereed to specilist clinics

5. Insituion of improved client management systems by providers to enhance patient experience:

- NHIS desk officers that interface with HMOs and referral clinics/hospitals on behalf of clients

- digitised clinical & management systems by some providers

6. Due to enrollment by 'free choice', majority of enrollees (> 80%) are registered with public teaching, military (+police), & mission hospitals as their primary care providers

7. **Though accounting for over 60% of health facilties nationwide**, *"Less than 2% of private providers have enough enrollees …we can't talk about health insurance without numbers …the aspect of assigning enrollees needs to be looked into"* ~ private provider

8. Patients chose teaching or mission hospitals because of perceived quality of care in relation to availability high-level multi-disciplinary medical professionals and personnel

Besides, "…*primary care is dead …that is why everyone is looking up to secondary and tertiary hospitals …most people choose here bacsuse it is more functional"* ~ public provider

9.. Given current capacity, many Teaching & mission hospitals are not likely to cope properly with additional enrollees - some dissatisfaction related to overcrowding & poor attention to patients needs being expressed by beneficiaries**.** *"…when I came here to register I saw a lot of crowd, so I have to go to another place… "* ~ enrollee

11. Yet, myriads of individual accredited private clinics/hospitals across the country are ready to pick up the slack & more, in particular if population covrage is increased. *"Private hospitals are struggling …they can only survive if there is an effecttive health insurance schemme …especially if majority are broght under the nest* ~ provate provider.

Some Emerging Issues:

- Nigeria has a huge medical manpower deficit - just about 74543 doctors for estimated 200 million popluation - 1:2753 or 36.6 per 100, 000 persons
- With National Health Insurance Authority (NHIA) Act seeking to provide universal health care access, country requires several multiples of this number to come close to WHO recommnedation of 1:600 doctor-patient ratio
- One option suggested to bridge this huge human resource gap is to optimise use of existing medical manpower - in particular, mass of independent private medical doctors that are curretly underutilised
- But this group at present time is poorly organised to coordinate & manage the care continuum required by large numbers of enrollees

- Meanwhile, other than budgetary allocations, health Insurance provides relaible alternative source of funding for medical services …it is vital for sustainability of health system & critical to attainment of UHC. *"…if capitation is stopped, health care facilities will be in trouble …then we should just close the hospitals and forget about health care in Nigeria"* ~ public provider
- Teaching & related hospitals are getting most benefits (improved revenue & potential for viability) from the health insurance programme – so not prepared to give up these advantages
- On account of the number and mix of associating doctors practicing in the same premises uisng the same personnel, Teaching & related hospitals are analogous (similar) to the 'concept of group practice'
- With capitation payment method, only such fully integrated systems are in better position to control all cost elements in provision of care

So, why not deliberately moblise & organise individual private medical practitioners into group practices to rapidly attain UHC in NIgeria?

Here are some propositions:

1. Developing & maintaining Group Practices should be seen by policy makers & practitioners as a 'cooperative expansion strategy' for mutual benefits & to achieve a common purpose – increase health care access for population …progress towards attainment of UHC.
2. Group Practices need to make profit (surplus) to remain viable …but they also they need to acquire values aligned with health policy objectives …improving the health & well-being of Nigerians.
3. Re-imagine how things are done in this space ….besides the usual: single speiality, multiple specialties or both; profit or not-for-profit … Group Practices could be positioned as local health systems – centralising administration while decentralising health care delivery within a geographic area rather than being physically located in one faciility

This ‘innovation turn’ could get some help from a home-grown model…

Nollywood Paradigm….where despite the difficult operating environment, a group of Nigerians reimagined how films are made that established a profitable local industry as well as being globally accliamed ….combined raw tallent with amatuer technology

https://www.managementexchange.com/story/nollywood-paradigm-new-model-progress-sub-saharan-africa

Are there any takers?

- Contemporary Nigeria Music Industry …Burna Boy, Davido, Vizkid & the rest

- who else?

…pure water locally produced, marketed & distributed has reduced diarrhoeal diseases more than all the boreholes built by government & donors,

…Multi-National Companies producing goods & services (coffee, toothpaste, phone re-charge, banking etc.) at the least currency have converted population at bottom of income pyramid to become effective consumers.

So, where are the Nollywood Paradigm moments in the health sector?