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Rapid
Assessment of
CBHIS Schemes
Lagos State



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ABBREVIATIONS

BOT	Board of Trustees (for the CBHIS)
CBHIS	Community Based Health Insurance Scheme
LCDA	Local Council Development Agency (see LGA)
LSMOH	Lagos State Ministry of Health
LGA	Local Government (see LCDA)
MHA	Mutual Health Association

EXECUTIVE SUMMARY

The Ikosi-Isheri Mutual Health Plan (the Scheme), is a community based health insurance scheme (CBHIS), launched in July 2008 as a tripartite initiative between the Lagos State Ministry of Health (LSMOH), Local Government (LGA), and the local communities (Olowora, Isheri, and Magodo). The Scheme was initiated to target the informal population in the catchment areas. The overall development and advancement of the plan is managed by the Board of Trustees (BOT) which includes representation from the LSMOH, LGA, a Technical Insurance Specialist, and members of the community predominantly from Olowora. Operational management is shared by the Provider as well as the Mutual Health Association (MHA).

Paths2 focuses on supporting the development of state systems and service delivery. The Rapid Assessment was designed to summarize the pros- and cons- of the existing CBHI schemes in Lagos State in order to provide evidence for the improvement and expansion of CBHI schemes in Lagos State, Nigeria.¹

Achievements

The Scheme has been operational for the last three years, delivering quality primary medical care to the community members who are enrolled. While there have been different providers over the Scheme's short tenure, each provider's quality gaps were analyzed and improved upon, leading to the current provider who receives excellent reviews from the community and nurses in the practice. This is an enormous achievement considering the fact that the Scheme is on the third Provider since inception².

The Scheme is extremely responsive to important quality concerns, and has accessed effective expertise to evaluate and improve the technical basis. Operationally, the Scheme collects relevant and timely data that are used to identify quality. The facility itself is very well taken care of, with the managerial oversight from the Provider and the Board of Trustees (BOT) clearly functioning.

The exceptional leadership and support from the LSMOH and the LG is both necessary and highly effective and considered a key success factor for continued growth and expansion of the concept.

Challenges

In spite of the excellent technical focus and leadership of the Scheme, analysis shows increasing member attrition rates and low representation from the Isheri and Magodo communities. The Scheme has grown to have over 10,000 members, but has been facing slow but important attrition rates, such that the current active enrolees are estimated to be 5,000. Analysis indicates that with the current product and premium levels, membership growth and retention at approximately 6,000 lives will result in reduced subsidization levels. At the same

¹ Taken from the TOR, see *Annex 1* for details.

² In an interview with the LGA, the Provider turnover was discussed and the Chairman pointed out that this was an important learning opportunity and that for new Schemes, selecting a provider with roots in the community will have a better outcome than selecting an outsider.

time, new product benefits are being considered to expand the appeal of the Scheme to the communities.

Whether with the current or an expanded product, member growth and retention is required. To reach increased membership growth and retention, two core areas emerged that can be strengthened so that the excellent current Provider's membership base can increase, thereby reducing the potential for adverse selection and need for continued government subsidization. These areas are explained in more detail in the text:

Recommendations

Level 1: Identify, Evaluate and Repair issues leading to high attrition rates

Robust Community Representation: Increase the scope of the BOT to include representation from Isheri and Magodo

Expanded Scope to attract and retain members through Premium, Product and Service modifications: Identify and price product and service modifications to increase appeal of the Scheme

Tools and approaches to address Persistency Rates/Adverse Selection: Evaluate the potential of creative methods of increasing persistency and attracting representative base of members, including a "reward" program for healthy outcomes

Increase market penetration -- New business: Create enrolment and distribution strategies for individual and group targets and evaluate cost of the strategy

Deepen bond with community -- Create a Brand: loyalty to the Scheme requires not only excellent services, but a marketing strategy to brand the concept and create loyalty and a strong emotional bond to the community

Level 2: Two pronged approach to educate and create awareness of the CBHI

Macro level sensitization: With products, services, and distribution channels identified, evaluate approaches to sensitize the community and create loyalty and a positive emotional response to the Facility.

Example: Understanding that health insurance is "sold" rather than "bought" , to "Create a Brand" as indicated above, consider introducing a community contest to "Name the Facility" (e.g., House of Healthy Peace) including a catchy motto and song that the community can sing when there is an educational seminar or something similar.

Micro level sensitization: With new distribution and operational channels identified and considered in premium adjustment (.e.g., Collector, Mobile banking, etc. and related impact on administrative costs), create the message and marketing materials required.

SECTION 1: INTRODUCTION

1.1 History of the scheme development

The Ikosi-Isheri Mutual Health Plan, launched in July 2008, is a tripartite initiative between the Lagos State Ministry of Health (LSMOH), Local Government (LGA) of Ikosi-Isheri (representing approximately 7% of the catchment population) and the local communities (Olorowa, Isheri, and Magodo). There is an annual meeting held every July. While the Local Government Development Agency built the Primary Healthcare centre for the scheme, and ensures maintenance and security of the facility; the LSMOH equipped the facility and most importantly provided the technical support for the design of the scheme. A feasibility study was conducted to define the benefit package and premium to be paid by enrollees/members; it also conducted a two weeks mobilization campaign to sensitize people to join the CBHI scheme; and the training/capacity building of members of the BOT and MHA.

The Ikosi-Isheri Mutual Health Plan scheme was initiated as a pilot Community-Based Health Insurance Scheme targeting low income people and those working in the informal sector such as self-employed, artisans, traders, market women, etc. This is linked to the overall government's strategy/vision to provide social health protection coverage for all citizens in the state.

1.2 Background to the Assignment

The purpose of this assignment is to assess and summarize the pros- and cons- of the existing CBHI schemes in Lagos State in order to provide evidence for the improvement and expansion of CBHI schemes in Lagos State, Nigeria. This activity follows a request by the Lagos State Ministry of Health to PATHS2 to provide TA to complement the work of their own staff, by bringing independent and external insights to enrich the outcome of the review.

1.3 Structure of the Report

This report includes five sections: (1) Scheme, which includes general information on the organization and governance and recommended next steps for the Ikosi-Isheri Scheme; (2) Membership/Enrolment, which describes issues surrounding increasing and maintaining membership levels, (3) Premium, which provides detail on the current pricing structure and considerations moving to expanded product offerings; (4) Benefit package considerations for growth; and (5) Financial analysis including a revenue/ expense breakdown to provide economies of scale. Finally, a brief comparison of the Ikosi-Isheri plan to the Lekki plan is provided.

SECTION 2: METHODOLOGY

2.1 Approach

A multi-disciplinary approach included assessments from three core perspectives: (1) Lagos specific influences in terms of product design, distribution channels, and sensitization; (2) CBHIS experts evaluating the context of the State program in comparison to other successful programs, and; (3) sustainable health insurance key success factors from an international perspective and application to the Lagos State context.

During the two week evaluation, specialists outlined interviews and questionnaires designed to create multi-dimensional perspectives of the issues. The team included three core approaches:

1. Interviews with stakeholders at managerial and operational levels
2. Focus Groups Discussions with the three communities including enrollees, non-enrollees, and defaulters
3. Evaluation of important documents and studies

Annexes 2 through 6 describe the core approach to the process including the outline of questionnaires and interviews, scheduled meetings, detail on the Focus Group Discussions, documentation reviewed, and the scope of work.

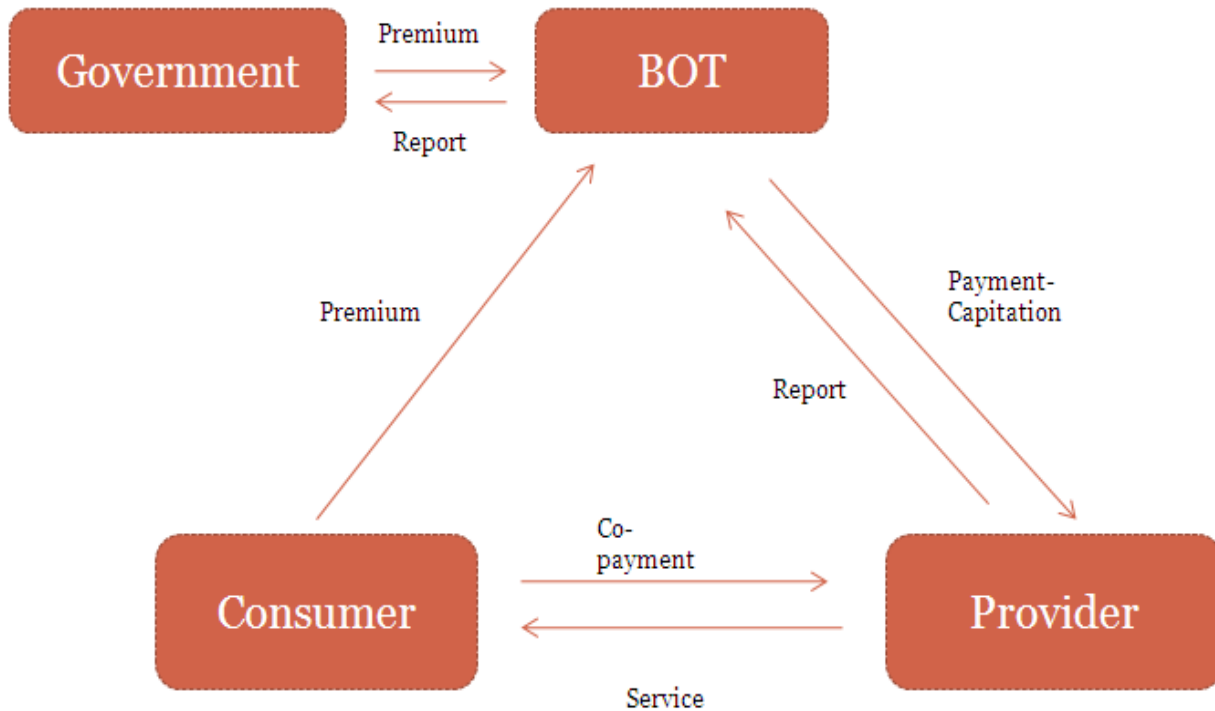
2.2 Limitations

The team had two weeks on the ground in Lagos to create the context of the study, identify and interview respondents, as well as obtain and read documents. Some of the documents were difficult to obtain due to approval processes. Traffic in Lagos impeded the teams' ability to make good use of time, so setting up interviews was often based on geographic location.

Organizing the Focus Group discussions was complicated due to the timing. The BOT and Paths2 Lagos were instrumental in helping select and organize the meetings in the three communities, and distribution of the members, non-members and defaulters appeared representative of the community. However, specific selection of the participants was not scientific (not a random sample methodology, due mainly to time constraints); therefore the comments may not be representative of the entire community. Instead they fairly reflect the comments and opinions of those contacted, and those who noticed the meeting taking place and joined.

SECTION 3: SCHEME

The following graphic depicts the general organization and overview of the Scheme's funding.



3.1 Governance

The scheme is made of two principal organs, the Board of Trustees (BOT) and the Mutual Health Association (MHA).

3.1.1 Board of Trustees (BOT)

The BOT that oversees the management of the scheme is made of 7 people, including:

- Chairman
- Secretary
- Medical Officer of Health, Ikosi Isheri LCDA
- Chairman of the Lagos State Government
- Technical Advisor (Doctor from private insurer, Total Health Tust)
- Representative of the communities
- Representative of the LSMOH

Major functions performed by the BOT include the oversight of the scheme, provider management, scheme marketing and management of members' complaints.

Currently the community perceives low representation of the Isheri and Magodo communities, which may be due in the distance of the Oloworo facility to them. While these communities are very close and share resources, there may be an opportunity to locate specific additional residents from those communities to participate in the BOT at some level. Current membership rates in Isheri and Magodo are also lower than that of Olowora.

The Chairman of the BOT is extremely dedicated and committed to the Scheme. His guidance and advice has contributed immensely to the success of the Scheme.

The BOT has access to considerable reporting from the MHA and the LSMOH, however discussions with some BOT members suggested not all reports were available. For example there was awareness of the Actuarial Report completed in March 2010, but the BOT had not yet seen it. Additionally, the electricity and water bills are the responsibility of the Local Government (LGA), yet that responsibility was not understood by the LGA (see Annex 7 for MOU outlines).

In terms of sensitization, the core communication with constituents occurs at the Annual General Meeting (AGM), and additional sensitization is primarily adhoc due to funding constraints.

3.1.2 Mutual Health Association (MHA)

The MHA ensures the day to day management of the scheme. There are currently three administrative staff in the MHA deployed by the Ikosi-Isheri Local Council Development Agency (LCDA) , including the manager, the registrar, and the account officer. Major functions performed by the MHA include registration, premium collection, scheme reporting, and patients' complaints management. ID card printing is done in the Ministry and collected and distributed by the MHA. A challenge with the civil service tenure is the potential to be pulled from the MHA assignment when other LGA needs arise. This occurred during the visit as the supervisor for the MHA was pulled from his position at the MHA to help in a different LGA capacity, leaving the remaining MHA without a properly trained supervisor and no transition plan in place.

Registration of members is computerized with issuance of membership card which carries the photograph of the principal enrollee and names of all other dependents.

The MHA manages receipt of capitation payment manually at the MHA office at Olowora. When an enrollee presents at the Facility, he/she must present receipt of capitation payment prior to receiving care. This is required so that the MHA is certain that the premium for that member for that month has been received.

The Focus Group participants were asked about how and where to complain about an issue with the Scheme and some were unsure.

Pros and Cons

The current organization is successful from a structural perspective. It effectively manages the overarching management of the Scheme and facility, as well as the day to day operational issues at the member level. There is a high level of engagement from the BOT and the MHA in terms of quality. Key success factors are:

- It's important not to force the same Scheme structure on each CBHIS. When the supervisory group is organized, ensure that the community needs and infrastructure alternatives are well considered.
- Identify communities that can share resources and have some level of open communication.
- Representation and active participation from all communities
- Effective government leadership and participation

The disadvantages of the current management structure are the low representation of the Isheri and Magodo communities in the BOT, some confusion regarding financial responsibilities, and the low sharing of some internal reports within the BOT.

When representation is more inclusive at the BOT level, increased sensitization of the Scheme can be undertaken to engage the three communities and create a more active involvement in the decisions. At the operational level, there are opportunities to streamline select procedures to increase the effectiveness and efficiency of the processes. Additionally, the current Ikosi-Isheri MHA staffers are State employees, which can pose operational quality issues without a strong transition plan in place.

Recommendations

To position the Scheme for further expansion, the following governance topics can be reviewed:

Item	Expected Impact
1 Increase BOT involvement with each community to ensure visible representation from each.	Increase loyalty and trust
2 Increase BOT knowledge of other CBHIS in the region by sending the BOT Chairman to observe another successful CBHIS in the region (Rwanda, Ghana, etc.)	Increase operational and managerial know-how
3 Share external studies with the BOT (e.g., Actuarial Study in 2010)	Increased transparency on issues and answers
4 Communicate MOU responsibilities with all the stakeholders to ensure common understanding (specifically LGA in regard to electricity and water)	Increased transparency on responsibilities
5 Modify Member Registration process to remove requirement of having capitation payment receipt and instead MHA provides a monthly list of PAID CAPITATION members to the Facility's Receptionist	Reduce the obstacle of member required to carry current premium receipt
6 Create and communicate a Complaints process	Increase ability to respond to issues from all communities methodically
7 Consider changing MHA staff to private hires financed by the LGA instead of LGA hires (civil servants) Training and transitioning hires is complex in health administration. During the site visit the MHA supervisor was taken from his role into another LGA role without warning	Health administration is complex and takes time to understand. The funding from the LGA is valuable, however, to ensure quality administrative services, private hires might offer longevity
8 Increase frequency of communication with constituents	Increase loyalty and trust with the individual communities

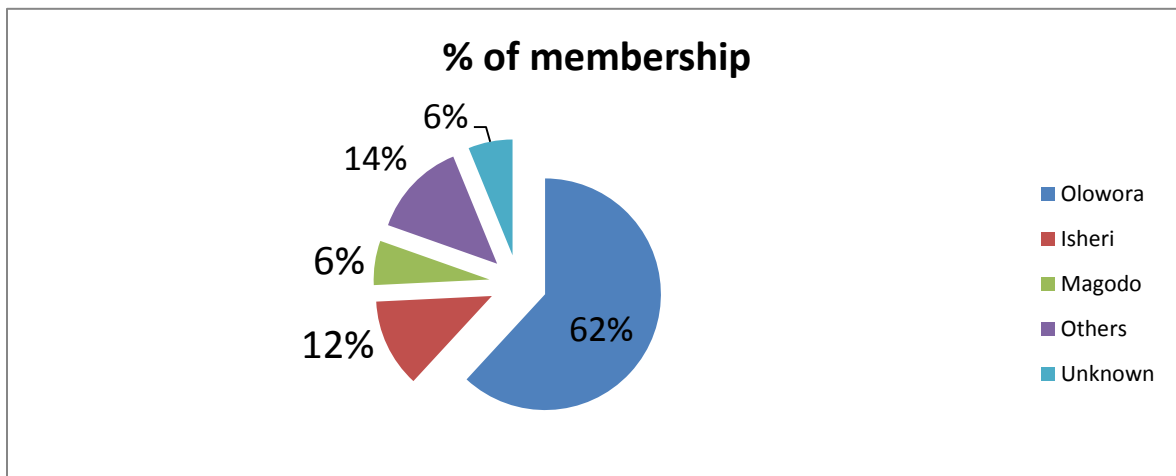
3.2 Membership/Enrolment

The preferred mode of enrolment is by household/family unit of up to six members. However individual membership is also allowed, though the premium is N400 versus N133 for an individual in a family of six. New enrollees/beneficiaries observe a waiting period of one month before accessing services.

By April 2011, Ikosi-Isheri Mutual Health Plan had a total number of 792 members (families) who were up to date in their premium dues (292 from communities and 500 subsidized by the LCDA). Therefore the scheme has around 4752 beneficiaries; equivalent to a penetration rate of about 7% of the catchment area.

Membership comes primarily from the three communities of Olowora, Isheri and Magodo. However, membership is also opened to other people from other communities/wards of Ikosi-Isheri Local Government Area. The current membership is mainly in the Olowora community as depicted in the graph below:

Figure 1: Membership Distribution per Community (January 2011)



Since its launching in 2008, the scheme has registered a cumulative number of 3,121 new enrollees and a total number of 12,668 beneficiaries. The retention and regular payment of premium has been an issue, given that only half of the beneficiaries (5,000 beneficiaries) are up to date in the payment of the monthly premium at any given time of the year.

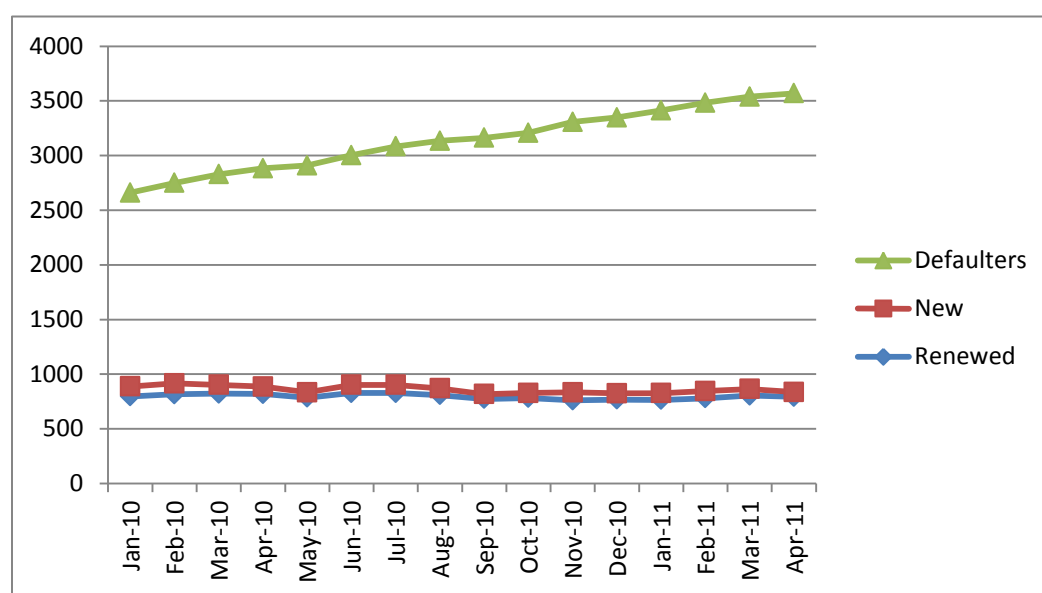
Over time, the membership of the Scheme has been deteriorating based both on slow new business development as well as lacklustre renewal rates. Consider the following table:

Table 1: Overview of the Olowora Scheme renewal rates³

Renewal Type	Year 1	Year 2	Goal
Due Date Renewal rate	18.95%	10.7%	75%
Monthly Renewal rate	30.9%	24.96%	75%

Additionally, consider the following enrolment trends:

Figure 2: Ikosi-Isheri Enrolment Trends 2010-2011



These data point to an increasing incidence of lapsed policies which may be attributed to the high cost of the premium for individuals, the distance from the farther communities of Isheri and Magodo to the MHA payment center in Olowora, important medical treatment for primary diabetes and hypertension not being covered⁴, as well as the challenge of the 7th day of premium payment falling on a weekend.⁵ Slowed new membership uptake may be contributed to a variety of factors including members of farther communities being unaware of the Scheme and benefits to the community, elderly in the community being able to receive free care at the

³ Provided by the LSMOH 3 June 2011

⁴ Currently both diabetes and hypertension are treated at the secondary level. Discussions with the provider and BOT suggest that primary care treatment of managed members is possible. A critical component of diabetes management is lifestyle coaching. The facility could play an important role in education, and aim to control the incidence of uncontrolled diabetes and hypertension. However, these kinds of education require specific training, as well as an understanding of the availability and adequacy of testing.

⁵ Notes from Defaulter Focus Group, Isheri Community, 1 June 2011

public facilities, cost to get to the Scheme, and the availability of free primary care on Wednesday in Magodo or the Primary Care Center in Isheri⁶.

Focus Group participants from Magodo indicated the distance to Olowora for premium payment was inconvenient and asked for flexibility and creativity in keeping individuals informed of upcoming premium payments including text messaging, as well as flexible collection locations.

Finally, a few participants indicated that they would like to receive some kind of a discount for not having any claims in the year. The CHBIS Scheme document indicates the opportunity for a discount after 6 months, but this does not seem to be operational or well known in the community.

500 fully subsidized Local Government (LGA) members

Initially the LGA worked with the local communities to select 500 Families (estimated 3,000 enrollees) in need of primary health care access. These 500 Families were required in order for the Scheme to be registered in Abuja, therefore they were given the coverage without any out of pocket expense. These 500 Families receive 100% subsidization from the LGA.

The Focus Group discussions yielded some comments about the 500, including some in Isheri who believed that these Families were politically selected. One participant said that he was initially offered the opportunity to be one of the “500” but he lost favor and did not receive it. He commented with dissatisfaction that he won’t pay for something that he could have gotten for free – suggesting he has the ability to afford the premium, which seems contrary to the initial goal of the selected Families. One way to avoid this kind of potential community friction is to follow an approach used in China, where the communities vote on the selection of those who are in need of subsidization. In any case, communication and transparency regarding the selection process will contribute to community trust in the process, which is important to long term member retention.

Today the 500 fully subsidized members account for about 60% of the total membership and that put high pressure on the plan to attract members who are able to afford the cost of the premiums. From a strategic perspective, it is important to expand the coverage of the plan to include these other groups.

The Lekki Scheme also provides subsidized premiums, but required the individual or family to pay a portion of the premium to move them toward the idea that healthcare is not free.

Pros and Cons

The current product is a primary care plan that is focused on attracting individuals to the center to manage health issues proactively rather than waiting until the situation is complex and requires more intensive secondary care treatment. The current membership appears highly satisfied with the provider, amenities, and treatment at the facility. This high quality is a coveted achievement that is important to acknowledge.

⁶ Notes from Non-Members Focus Group, Magodo Community, 1 June 2011

Key success factors for member growth and retention include:

- High perceived fairness of services and costs
- Ease of premium payment and information sharing
- Strong sense of loyalty to the facility and community (creating a personal bond)
- Majority of members are engaged in the community and able to pay for the coverage

There are two areas that can be addressed to increase membership growth and retention, specifically, increasing operational and management transparency, and reducing operational barriers to stay in the plan. Increasing transparency can be achieved in regard to the current 500 fully subsidized members, and a BOT review of the source of these individuals to ensure they are a fair representation of the needy of the three communities. Reducing operational barriers to participation can be introduced through new quality processes that reduce the burden of travelling to the Facility for premium payments, or approaches to track and manage complaints and requests. Part of this is being addressed in the “Scratch Card” option of paying for premiums through mobile phones.

Recommendations

Item	Expected Impact
<p>1 Create Enrolment Strategies (and Distribution Channels) per Community non-enrollees and defaulters when issues have been resolved (e.g., incentives for low utilizers to stay in the plan)</p> <p>Discuss the opportunity for government employees to be capitated to the Scheme (as is done in Lekki).</p> <p>Distribution channels include Collectors and possibly MFIs (though the current status of MFIs in Nigeria is not high)</p> <p>These strategies focus on two components: Community Marketing, Individual Marketing</p>	<p>When product, service and representation issues have been resolved, begin a targeted mobilization and sensitization project</p>
<p>2 Review the “500” Families and evaluate the impact of modifying the benefit from 100% subsidization to 50% subsidization</p>	<p>Increase community acceptance of the concept as well as helping Families understand that there is still some out of pocket expense associated with it.</p>

Item	Expected Impact
Consider community elections for the “500”	
<p>3 Introduce local premium notification and collection either through:</p> <ul style="list-style-type: none"> - Mobile banking/SMS alerts (the NHIS is developing this approach; “Scratch Cards”) - Utility companies - Use of Collectors - MHA staff remotely stationed in Isheri and Magodo for 3 days a month 	<p>Increase ease of premium payment and tacitly encourage low utilizers that it is convenient to stay in the plan</p> <p>Increase opportunity to market directly to the community</p>
<p>4 Increase loyalty and services with low utilizers by:</p> <ul style="list-style-type: none"> -giving them a free full check up or wellness benefit - creating a “rewards” points system⁷ that can be traded in for something of value 	<p>Increase loyalty from the low utilizers in the community</p>
<p>5 Create a “Positive List” that is shared with the community</p> <p>Include the advantages of membership, the reduced maternal mortality rates, and other positive results that came from membership in the Scheme</p>	<p>Community sensitization of the outcomes of the Scheme and Facility</p>
<p>6 “Name the Facility”, a catch phrase, and a song</p> <p>The goal is to increase brand awareness of the Facility’s message beginning the process of individual sensitization</p>	<p>Brings the communities together and lets them select the name of their facility (e.g., Loving Healthy House, Peaceful Place, etc.).</p> <p>Songs are a strong way for the individuals to relate to the Facility and carry the message</p>

⁷ *Discovery Health South Africa* studied the impact of a rewards program for members (Vitality) performing active healthy actions including HIV/AIDs tests and regular exercise. Points are accumulated so that individuals can trade them in for small rewards like movie tickets. The study suggests that this program attracted healthier risks into the pool rather than changing the behavior of higher risk individuals.

Item	Expected Impact
This could bind the communities if you create a community “contest” and the winner is selected by the communities and gets a free month of premium or something of value	of it with them. It’s important to create an emotional attachment to the good work that is being done.

3.3. Health Care Provider

The Ikosi-Isheri LCDA/scheme contracted a private provider to run the facility, hence making the scheme a kind of Public-Private-Partnership initiative. This provider has extensive experience in successfully managing clinics in Lagos State. The provider provides drugs, consumables, and all the staff. There are currently 3 doctors, 3 midwives, CHO’s and other complementary staff such as receptionist and cleaners. . The provider is also required to maintain a proper documentation to facilitate the monitoring and utilization of services by members. Members requiring secondary level care/services are referred to Gbagada General Hospital, a State owned secondary care facility, where they are entitled to a 25% discount.

The current primary provider is the third provider contracted by the scheme since its launching in 2008, though the support staffing has remained the same. The scheme management and members had issues with the two previous providers related to management and quality of care issues (waiting time, health providers’ attitude, unavailability of doctors, drugs availability etc.).

The provider is selected through a bidding process (advertisement in newspaper/ selection/ interview).

The provider is paid by **capitation**, or the equivalent of N.1, 600,000 for 5,000 beneficiaries. Currently, an estimated 3,000 enrollees are 100% subsidized by the LGA and 60% of additional premiums are subsidized by the LSMOH. The Memorandum of Understanding signed with the provider ensures to the provider a flat payment rate of N.1, 600,000 monthly even if the pool of members is below 5,000 beneficiaries. However if the number of members is above 5,000 beneficiaries, the scheme has to pay N 200 per each additional beneficiary.

The capitation payment is made on 25th of the month against the coming month (pre-payment).

The current provider is the third since 2008. This provider lives in the community and has strong ties to it. Based on the feedback from the Focus Group Discussions, this provider is very well liked. The Local Government (LGA) commented that in hindsight they would recommend seeking a provider from the community (rather than one externally located) as well as utilizing midwives from the government sector as they typically have extensive experience and better outcomes than midwives in the private sector who likely have managed fewer deliveries than observed in the public sector.

Services provided at the secondary level included complicated deliveries, hypertension and diabetes complications. The current product includes a 25% reduction of costs at the secondary treatment level. The CBHIS does not reimburse the 25% discount to the secondary care facility. Anecdotaly the distance to the secondary facility can be a hardship for those unable to secure travel. These issues can be addressed through better self management of health issues, evaluating the access to ambulance services, as well as means testing for those unable to afford the cost of the travel in a non-emergent situation.

Currently the provider’s compensation is being studied through an Activity Based Costing exercise for current primary care being offered. The data are currently being analyzed and will likely be available in the next few months.

Pros and Cons

The experience of Ikosi-Isheri and provider management yielded some important critical success factors. Specifically,

- It’s ideal if the Provider running the clinic is a member of the community that the clinic serves. This increases the commitment to the community and provides a strong relationship within the community.
- Initially, consider midwives from the public sector so that their vast experience can be used to train the private sector midwives. In healthcare, good medical outcomes are the result of many aspects including evidence based protocols, safe work environments, transparency in the workplace, access to equipment, training and perhaps most importantly sufficient volume.
- Identify quality measurements (clinical and administrative)
- Introduce Activity Based Costing (ABC) as a way to monitor the effectiveness of the capitation rate and communicate growth requirements and investment to the BOT.

Challenges in the current process include the inability for the provider to manage first level issues like hypertension and diabetes. Today these cases are referred to the secondary level. While uncontrolled cases are best treated at the secondary level, there is an opportunity for the current product to be expanded and include primary care management of these issues. This expansion would be a positive development as those with treatable conditions may be encouraged to join (and potentially deflect secondary care out of pocket costs). However, care must be taken to manage potential adverse selection.

Recommendations

	Item	Expected Impact
1	When new Provider Manager completes his Activity Based Costing, compare with the Actuarial Study for gaps and opportunities	Fair pricing

Item	Expected Impact
2 Purchase scan for the primary care center (The Provider Manager indicated they are planning to purchase a scan.)	Increase member satisfaction with the plan, potentially increasing membership growth and keeping current members.

3.4 Premium

The premium is paid monthly at the MHA office at the Primary Care Center. For a family of up to six members, the premium is N800.00 per month; while the individual/single person premium is N400.00 per month. The premium determination was based on the willingness to pay survey conducted by LSMOH/steering committee.

The LSMOH (Lagos State Ministry of Health) contributes N320 per member per month (PMPM) based on 5,000 enrolees (whether or not there are 5,000 enrolees active in the Scheme). Individual enrolees pay N400 PMPM and a Family rate of N800 covers up to 6 members. Additional family members can be added at N200 PMPM, though this information does not seem known to the community based on feedback from the Focus Groups.

According to the Willingness to Pay survey⁸, the average income per household for the socio-demographic profile is between N5,000 and N 14,000. The study recommends a fixed premium between N300 and N400 per month. It also recommends Scheme participation is for 5 years. The disparity in reported income points to different abilities to pay. If 10% of income were allocated to a health insurance product, the ability to pay would fall between N500 and N1,400.

Membership premium is paid from 1st to 7th of each month. Late payments attract a 20% surcharge. After a default period of six months, services are suspended for the defaulting member. Renewal of membership for defaulting members is conditioned to the payment of all dues in arrears plus the 20% surcharge.

A **copayment** of N50.00 is paid each time a member is attended to at the facility (New case).

In March 2010, **Alexander Forbes Consulting Actuaries Nigeria Ltd** performed an analysis of current premium adequacy based on the membership demographics, expected utilization and costs, and related expenses. Their analysis concluded that the current capitation rate is insufficient to cover the expected incidence and expenses.

⁸ Project Welfare, Study on prospects of proposed community based Health Insurance Scheme in Lagos, CMRG Job No. 012/0204, by CMRG Ltd. February 2007

Table 2: Pricing of medical costs and expected utilization⁹

Primary Care Treatment	Utilization per 1,000	Cost of Care N	Expected Cost PMPM N
Malaria	278.22	1,200	13.91
Typhoid Fever	23.91	1,200	2.39
Hypertension	104.84	500	4.37
Diabetes Mellitus	27.47	1,200	2.75
Respiratory Tract Infection	109.11	1,100	9.09
Peptic Ulcer	21.96	1,000	1.83
Sexually Transmitted Infections	7.11	1,500	0.89
Arthragia	7.16	500	0.30
Arthritis	10.62	500	0.44
Neuralgia	4.13	500	0.17
Gastro Enteritis	10.44	950	2.18
Ante Natal Care ¹⁰	29.69	1,000	2.47
Immunization ¹¹	57.82	50	0.24
Others (including emergency)	163.73	20,000	272.89
Total medical costs Per member Per month (PMPM)			327.39 ¹²
Required Medical cost contribution PMPM (allowing for 85% claims ratio)			385.17
Total Admin expenses with 5% margin PMPM			57.27
Required Contribution PMPM			442.44

While the LSMOH contribution is N320, there is an additional N50 that the LGA contributes to fund the administrative expenses associated with the Scheme. The total premium allocation (medical expenses + administrative expenses) equals N350. The Study states that the difference between the Required Contribution of N442.33 PMPM and the Current Contribution of N350 points to a deficit of **N92.44 PMPM**.

⁹ Alexander Forbes Consulting Actuarial Report, March 2010; Section 4, Table 4.2 Pricing of Medical Cost

¹⁰ While the State offers free services for certain procedures, there are access concerns. For example, there is a primary care center in Isheri, but some focus group participants noted that there was not always a medical doctor available. Providing access through the CBHIS offers a safe quality channel with 24 hour medical doctor availability.

¹¹ Ibid

¹² Note that a manual calculation of the expected PMPM equals 313.92 and not 327.39; however, it is likely that the table has an error rather than the total PMPM because the table on the previous page of the Study has the Malaria Cost of Care equaling 600 and not 1,200. For purposes of this report, the overall PMPM is considered accurately reflecting the study.

Discussions with the Managing Provider (new to the practice in April 2011) indicated that he also believed the capitation rate did not reflect his current activity. Therefore, over the last three months, the Clinic has been tracking Activity (Activity Based Costing) to assess the actual costs associated with the current practice activity. Once these data are available, they can be compared to the Actuarial Study and recommended contribution rate to determine an appropriate course of action.

Additionally, the actuarial study suggested modification of the current pricing approach, as there appears to be some inequality in a N400 premium for an individual and a N800 premium for a family of 6, in which case the individual premium is N133. While there are good arguments to charge a higher premium for an individual who may not include his family as they are not ill, there are individuals in the community who have not yet married and may not be part of a household that can purchase insurance. The Actuarial reports recommended a 4:1 structure whereby the family rate is based on a size up to 4 participants. Any family with members above 5 should pay at an additional premium based on the individual rates. Thus in effect, for a family of 5 one person enters the scheme for free given an incentive for family members without penalizing individual members.¹³

The Study pointed to the fact that there is a low renewal rate in the Scheme, therefore the actual exposure base for the Scheme membership is not clear cut. This complicates the financial planning process. Additionally, it states that the low renewal rate signifies that relaxed eligibility requirements are in place, and this will likely pose a high risk of anti-selection, whereby only people that need healthcare services will contribute to the Scheme at one time.

There are excellent recommendations in the Actuarial report regarding data collection and individual member identification, premium collection anomalies, and a revised premium structure to ensure adequate premiums are collected.

Pros and Cons

The current premium structure requires review from two perspectives: adequacy and impact on member retention. From an adequacy perspective, the Actuarial Study provides good direction on utilization and cost statistics suggesting that the current premium is insufficient and needs to be increased. However, this increase may result in reduced membership. At the same time, there is discussion of product changes, which may result in attracting additional members of the community. Therefore:

- Based on the communities and organization, identify the health care issues adversely impacting life that could be managed in a primary care setting. These could include maternal mortality, important diabetic complications and increasing incidence of hypertension. Methods to manage include not only clinical best practices, but also lifestyle changes.
- Evaluate the product offerings at a primary care level that will help alleviate some of the financial and physical burden of the health issues identified at the community level.

¹³Alexander Forbes Consulting Actuaries Nigeria Limited; “Actuarial Investigation on Lagos State Community Health Insurance Initiative” Section 4, p 9

- Create a framework to identify those who are able to finance their healthcare, based on association membership, type of informal work and identify an average salary scale.
- Identify a budget of enrollees and expected utilization so that adverse trends can be managed effectively
- Ensure the premium for the product can cover the expected utilization and create membership milestones
- Consider “pull” incentives like rewards programs

Recommendations

Item	Expected Impact
<p>1 Strategies to increase persistency, evaluate:</p> <ul style="list-style-type: none"> - Stacked premium structure with higher premiums early in the year tapering off to lower premiums at the end of the year - Create a bonus reserve with the new product structure that can be accessed by reaching select community milestones (membership growth, reduced maternal mortality rates, etc.) 	<p>Membership growth is important, as is increasing the renewal rates. Specific persistency strategies are required to balance the marketing to new individuals and ensure a solid membership base</p>
<p>2 Evaluate alternative financing including:</p> <ul style="list-style-type: none"> - CBHIS pooling so that more successful Schemes can support challenged areas - Outreach to groups including The Association of Nigerian Physicians in the Americas (www.anpa.org) to discuss options to receive additional financial support from practicing providers active in the Nigerian expatriate community 	<p>The current membership needs to grow and renewal rates need to increase with improved products, services, and outreach.</p> <p>Opportunities to cross subsidize (or create a reinsurance pool) CBHIS across the State (in the future) could reduce heavy reliance on government funding.</p> <p>Accessing the expatriate Nigerian community might offer additional funding avenues</p>

3.5 Benefit Package

Medical care is provided by a private doctor who is the third since the Scheme’s inception in July 2008. This provider is different from the previous two as he is from the community and tied to the people.

While there are public services available in Lagos State, there are access concerns. For example, there is an Isheri Primary Care Center, but focus group participants indicated that there was not always a medical doctor on staff, whereas the Ikosi-Isheri Facility offers 24 hour medical doctor availability. The current CBHIS offers an alternative to individuals and families interested in accessing healthcare at the Isheri Facility. The scheme covers only the basic minimum package of care at the Primary Health Centre in Olowora with treatment of common ailments, provision of prescribed essential medicines, deliveries, short-stay admissions, etc. The Facility is also used as a place for MCH immunizations. However, instead of encouraging that these cases be funnelled into the State system, the Ikosi-Isheri Facility is important for two reasons:

1. Access at the public facilities is not assured
2. By offering high quality care at the primary care level, women specifically have a better chance for a positive medical outcome because of access to quality reliable pre natal care. This is important draw to the community. Specifically, one of the women in the focus group said that her first pregnancy ended in the baby's death and that was why she joined the Scheme. Offering reliable access to quality care is a strong motivation to encourage the development of a primary care mindset.

Regarding deliveries, they can only be supported by the scheme if the beneficiary has been a member throughout for the past 6 months at least. If the member joins while pregnant at three months or greater, payment for part of the case is required.

Members requiring secondary level care/services are referred to Gbagada General Hospital, a State owned secondary care facility, where they are entitled to a 25% discount.

The Focus Group Discussions yielded important information regarding additional benefits (primary diabetes and hypertension monitoring) as well as adding a scan to the premises rather than having to go directly to the secondary level for this care (and adding out of pocket expenses). Adding benefits to a package requires actuarial assistance in terms of premium and expense impact, and marketing assistance is required to ensure the new benefits are balanced with incentives for the healthy to join. Additionally, these benefits can be effectively managed with education and lifestyle changes. If these benefits are added, consider specific nurse education on coaching individuals with diabetes and hypertension.

Pros and Cons

The current benefit package is effective and provides solid quality services at the primary care level. The disadvantages of the current package include it covering some services that are technically available from the State (potential double payment) as well as not covering other important services including scans, diabetes care as well as hypertension management. Care must be taken to balance additional coverage with membership growth strategies to encourage full community participation.

Recommendations

Item	Expected Impact
<p>1 Decide if the goal is to maintain current product or expand into additional coverage. Expanded coverage should include additional services that are available at the secondary care level or not available at the State level.</p> <p>If current product will remain for the next 6 months, re-evaluate the premium calculation.</p> <p>If new product agreed upon, complete an actuarial study of the new premium and membership requirements to include primary diabetes and hypertension.</p> <p>Include a study of the manpower costs to educate and manage diabetic and hypertensive patients (modified disease management approaches including education, availability of testing materials, etc.)</p>	Increase membership growth

3.6 Financial Analysis

The following outlines the revenue and expenses associated with the Scheme based on the current capitation rates and not those stated by the Actuaries above. To summarize the financing:

- The administrative cost of the scheme is theoretically covered out of the premium collected, on the basis of N30 per beneficiaries; i.e. N150, 000 per month. However in practice, the administrative cost is also a flat amount paid to the BOT/MHA for the running of the scheme regardless of the number of enrollees/beneficiaries. The administrative cost is also somehow subsidized by the LSMOH. However, the Ministry occasionally helps in some requests such as internet connectivity
- The capitation payment to the provider, i.e. N320.00 per each beneficiary (N1600,000/5000 beneficiaries), is subsidized by the LSMOH; to the tune of at least 58% for a family of up to 6 beneficiaries.

- The LCDA ensures the payment of salary for the 3 staff working in the MHA, as well as for the support staff (1 messenger, 2 security personnel)
- The LCDA supports 500 indigent/vulnerable families

Moving to a break-even point and slowly reduced subsidization is simulated through planned 20% growth in family membership as well as a 10% growth in individual membership. When membership reaches 6,000, subsidization levels can begin to decrease.

For purposes of the analysis, Capitation to the provider and MHA for membership > 5,000 has been reduced to 20% of the capitation rate. Therefore, based on the fact that the current provider believes the staffing levels will remain stable for membership up to approximately 7,000 to 10,000 enrollees (all things being equal), the following data can be simulated to test the effects of different net growth rates. Current subsidization rates can be reduced with membership of > 6,000 (See Annex 8)

Pros and Cons

The government subsidizes the plan so that plan remains sustainable for the current membership. This leadership role is critical to the success of the plan. However, the current premium does not cover expected utilization (see Actuarial Study), and as the Scheme is considering additional benefits, it is wise to review the current membership strategy and distribution channels before making any changes to the financial structure of the plan. However, based on the analysis, the stress of the Scheme is reduced with a base of 6,000 members.

Recommendations

	Item	Expected Impact
1	Based on product and distribution decisions, simulate membership size and contribution levels.	Increase membership growth

SECTION 4: LEKKI AND IKOSI ISHERI COMPARISON

Although the Lekki Scheme has been in existence for only three months, there are some opportunities to review and compare the approaches. As mentioned in many of the interviews, Scheme development must take into consideration the attitude and approaches of the environment. Whereas in Ikosi Isheri the provider is private, in Lekki there are two public facilities used for the Scheme and so far both settings support quality healthcare. The following matrix outlines some important characteristics and aspects to consider:

Table 4: Comparison of Lekki to Ikosi Isheri for opportunities

Item	Lekki	Ikosi Isheri	Opportunity
Length of service	@ 3 months	3 years	The Ikosi Isheri Scheme experienced positive enrolment increases in the beginning. Although Lekki is experiencing some growth, it is unclear if it will suffer from the Ikosi Isheri attrition issue. Therefore a review of utilization and member data may help identify a turning point.
Premium	The current premium is lower than Ikosi though the benefits are comparable	Ikosi Premium is considered under –priced by <i>Alexander Forbes Actuarial Consultants (Nigeria)</i>	The consulting actuaries concluded that the Ikosi Isheri utilization trends can be applied to other regions (Chi square Goodness of Fit). Lekki is not specifically stated in the analysis, but other State regions are included. Evaluate the potential to apply the proposed premium rate to Lekki.
Subsidized premiums for the most vulnerable	50% subsidization for 1,500	100% subsidization for 500	Conceptually, developing the community expectation that healthcare requires some form of payment (and responsibility), the approach in Lekki of sharing premium costs at 50% for the most vulnerable expands access to healthcare to a much broader segment. Recommend adopting this methodology in Ikosi-Isheri
Operational Processes	As the Scheme is new, important opportunities to train MHA staff	The current loss of the MHA supervisor has to be dealt with before looking to share expertise with Lekki	Begin cross-training in Schemes when new Ikosi-Isheri Supervisor is trained

SECTION 5: RECOMMENDATIONS

5.1 Recommendations

Each operational area described above yielded recommendations to increase the strength of the Scheme's foundation, increase operational efficiency and effectiveness, and to create strategies for increasing distribution channels. There are two phases of the process: enhanced foundation and structure for growth, and expansion strategies. The following tables include the recommendations in the text above with ease of implementation and pre-requisites outlined.

Phase 1: Foundation and Structure

Ensuring a solid foundation to manage the Scheme and its' growth is critical to sustainability and growth. The following recommendations are offered:

	Item	Expected Impact	Ease of Implementation	Requirements
1	Governance Increase BOT involvement with each community to ensure visible representation from each	Increase loyalty and trust	Average	Generate ideas regarding increased visibility of each community on the BOT.
2	Governance Increase BOT knowledge of other CBHIS in the region by sending the BOT Chairman to observe another successful CBHIS in the region (Rwanda, Ghana, etc.)	Increase operational and managerial know-how	Difficult	Funding source
3	Governance Share external studies with the BOT (e.g., Actuarial Study in 2010)	Increased transparency on issues and answers	Easy introduction	Organizational process to identify and circulate important studies
4	Governance Communicate MOU responsibilities with all the stakeholders to ensure common understanding	Increased transparency on responsibilities	Easy introduction	See Annex 7

	Item	Expected Impact	Ease of Implementation	Requirements
	(specifically LGA in regard to electricity and water)			
5	Governance Modify Member Registration process to remove requirement of having capitation payment receipt and instead MHA provides a monthly list of PAID CAPITATION members to the Facility's Receptionist	Reduce the obstacle of member required to carry current premium receipt	Easy introduction	MHA creates a monthly "paid member" list to the Registration Desk
6	Governance Create and communicate a Complaints process	Increase ability to respond to issues from all communities methodically	Easy introduction	Create a process including a grouping of type of complaint: Product, Service, Cost, etc. Identify ways to communicate the complaint process and to report back to the individual with a response
7	Governance Consider changing MHA staff to private hires financed by the LGA instead of LGA hires (civil servants) Training and transitioning hires is complex in health administration. During	Health administration is complex and takes time to understand. The funding from the LGA is valuable, however, to ensure quality administrative services, private hires might offer longevity	Difficult (but important to scale up)	Propose the modification to the BOT, discuss with the LGA

	Item	Expected Impact	Ease of Implementation	Requirements	
	the site visit the MHA supervisor was taken from his role into another LGA role without warning				
8	Governance	Increase frequency of communication with constituents	Increase loyalty and trust with the individual communities	Average	Wait to increase communication with constituents until the current issues regarding non-renewal are understood so that they can be addressed
9	Membership/Enrolment	Review the “500” Families and evaluate the impact of modifying the benefit from 100% subsidization to 50% subsidization Consider community elections for the “500” to increase transparency and community involvement in the process	Increase community acceptance of the concept as well as helping Families understand that there is still some out of pocket expense associated with it.	Difficult	Would need to modify the structure of the BOT to include all communities, create and implement a means testing approach or community elections and work to communicate the reason for the change
10	Membership/Enrolment	Create a “Positive List” that is shared with the community Include the advantages of membership, the reduced maternal	Community sensitization of the outcomes of the Scheme and Facility	Easy	Create groupings of positive issues, sample members for “success stories” and

	Item	Expected Impact	Ease of Implementation	Requirements	
	mortality rates, and other positive results that came from membership in the Scheme			identify ways to disseminate into the community	
11	Provider	When new Provider Manager completes his Activity Based Costing, compare with the Actuarial Study for gaps and opportunities	Fair pricing	Average	Requires first analysis of the Provider Manager's study
12	Premium	Strategies to increase persistency, evaluate: -Stacked premium structure with higher premiums early in the year tapering off to lower premiums at the end of the year -Create a bonus reserve with the new product structure that can be accessed by reaching select community milestones (membership growth, reduced maternal mortality rates, etc.)	Membership growth is important, as is increasing the renewal rates. Specific persistency strategies are required to balance the marketing to new individuals and ensure a solid membership base	Difficult	Understand target markets

Phase 2 items may be done simultaneously with Phase 1 items. They are separated as they are focused on long term growth of the CBHIS membership.

Phase 2: Growth Strategies

	Item	Expected Impact	Ease of Implementation	Requirements	
1	Membership/ Enrolment	Create Enrolment Strategies (and Distribution Channels) per Community non-enrollees and defaulters when issues have been	When product, service and representation issues have been resolved, begin a targeted mobilization	Difficult	Requires resolving current open issues including expanding

	Item	Expected Impact	Ease of Implementation	Requirements
	<p>resolved (e.g., incentives for low utilizers to stay in the plan)</p> <p>Discuss the opportunity for government employees to be capitated to the Scheme (as is done in Lekki), or small employer groups in the area</p> <p>Distribution channels include Collectors and possibly MFIs (though the current status of MFIs in Nigeria is not high)</p> <p>These strategies focus on two components: Community Marketing, Individual Marketing</p>	<p>and sensitization project</p> <p>Step 1 Identify and evaluate capacity and cost of alternative distribution channels at both the group (associations¹⁴, small employers) and individual level</p> <p>Step 2 Create operational processes to support these channels</p> <p>Step 3 Create a marketing strategy and training program to support the development of the distribution channels</p>		<p>BOT structure, expanded product offering, member incentives, increased premium collection options and communication channels (how to sell the concept one house at a time)</p>
2	<p>Membership/ Enrolment</p> <p>Introduce local premium notification and collection either through:</p> <ul style="list-style-type: none"> - Mobile banking/SMS alerts (the NHIS is developing this approach) - Utility companies - Use of Collectors - MHA staff remotely stationed in Isheri and 	<p>Increase ease of premium payment and tacitly encourage low utilizers that it is convenient to stay in the plan</p> <p>Increase opportunity to market directly to the community</p>	Difficult	<p>Operational changes, MHA instruction, Communication with Communities about the new process</p>

¹⁴ Discussions with the LSMOH indicate that initial efforts to work with informal associations were not successful. Key criteria for solid associations include regular meetings and strong affiliation with the group.

	Item	Expected Impact	Ease of Implementation	Requirements
	Magodo for 3 days a month			
3	Membership/ Enrolment	<p>Increase loyalty and services with low utilizers by:</p> <ul style="list-style-type: none"> -giving them a free full check up or wellness benefit - creating a “rewards” points system¹⁵ that can be traded in for something of value 	Average	Develop incentive proposal, organize the operational process, communicate the new offering to the community
4	Membership/ Enrolment	<p>“Name the Facility”, a catch phrase, and a song</p> <p>The goal is to increase brand awareness of the Facility’s message beginning the process of individual sensitization</p> <p>This could bind the communities if you create a community “contest” and the winner is selected by the communities and gets a free month of premium or something of value</p>	Average	Organize the process, select the method of judging and the prize, communicate the contest, advertise the contest, organize a community meeting to make the final decision

¹⁵ *Discovery Health South Africa* studied the impact of a rewards program for members (Vitality) performing active healthy actions including HIV/AIDs tests and regular exercise. Points are accumulated so that individuals can trade them in for small rewards like movie tickets. The study suggests that this program attracted healthier risks into the pool rather than changing the behavior of higher risk individuals.

	Item	Expected Impact	Ease of Implementation	Requirements
5	Provider Purchase scan for the primary care center (The Provider Manager indicated they are planning to purchase a scan.)	Increase member satisfaction with the plan, potentially increasing membership growth and keeping current members.	Average	Sufficient reserves to purchase
6	Premium Evaluate alternative financing including: - CBHIS pooling so that more successful Schemes can support challenged areas - Outreach to groups including The Association of Nigerian Physicians in the Americas (www.anpa.org) or the Rotary to discuss options to receive additional financial support from practicing providers active in the Nigerian expatriate community	The current membership needs to grow and renewal rates need to increase with improved products, services, and outreach. Opportunities to cross subsidize (or create a reinsurance pool) CBHIS across the State (in the future) could reduce heavy reliance on government funding. Accessing the expatriate Nigerian community might offer additional funding avenues	Difficult	Relies on growth of CBHIS schemes in the State and sustainability of the current Scheme before considering
7	Benefit Package Decide if the goal is to maintain current product or expand into additional coverage. Expanded coverage should include additional services that are available at the secondary care level or not available at the State level.	Increase membership growth	Average	Make decision to consider expanding product.

	Item	Expected Impact	Ease of Implementation	Requirements	
	<p>If current product will remain for the next 6 months, re-evaluate the premium calculation.</p> <p>If new product agreed upon, complete an actuarial study of the new premium and membership requirements to include primary diabetes and hypertension.</p> <p>Include a study of the manpower costs to educate and manage diabetic and hypertensive patients (modified disease management approaches including education, availability of testing materials, etc.)</p>				
8	Financial	Based on product and distribution decisions, simulate membership size and contribution levels.	Increase membership growth	Average	Product and distribution decisions

5.2 Proposed Next Steps

After discussing the content of this report with the local stakeholders and potentially modifying the list of recommendations, discuss a prioritization plan. This plan should take into consideration what the local stakeholders believe are the most important issues to manage. Include attainable membership growth and distribution channel targets reviewed on a monthly basis.

With a prioritization completed, appoint a local manager for each phase of development that will be responsible for ensuring the tasks within the recommendation are completed and reported back to the local stakeholders. Timelines for the tasks and specific inter-dependencies can be identified during this process.

SECTION 6: ANNEXES

ANNEX 1: Terms of Reference for the Assignment

TERMS OF REFERENCE FOR

Budget activity code: 16044-6201	Output and Initiative: Lagos – Output 2 – Rapid Assessment of CBHI schemes
Date of Draft: April 7, 2011	Consultant(s) Reporting to: Hong Wang
Decision Date:	Responsible for Sign-off of SoW/ToRs: Ayman Abdelmoshen
SOW Status: Draft / Final copy	Person responsible for Quality Assurance (QA) and technical sign-off: Hong Wang

Purpose of Assignment:

To assess and summarize the pros- and cons- of the existing CBHI schemes in Lagos State in order to provide evidence for the improvement and expansion of CBHI schemes in Lagos State, Nigeria.

Rationale / Justification for Assignment (for conducting this piece of work and how it contributes to project outputs):

This activity follows a request by the Lagos State Ministry of Health to PATHS2 to provide TA to complement the work of their own staff, by bringing independent and external insights to enrich the outcome of the review.

Scope of Assignment:

Specifically, this activity will provide a comprehensive review to the IKOSI ISHERI scheme in order to provide: recommendations for the scheme's improvement; and to improve the design of the new scheme at Lekki Ibeji.

Brief Background:

IKOSI ISHERI scheme

CBHI scheme in IKOSI ISHERI was launched in July 2008. The current scheme has about 10,000 membership (individuals), representing an enrolment rate of about 14% of the total population of about 70,000 in the catchment area.

Key features of the scheme include:

1. It is a voluntary based scheme organized and operated at the community level.
2. Premium contribution is 800 Naira per family (with up to 6 family members) per month. Additional 200 Naira is required for each additional family member. The premium for individual enrollment is 400 Naira per person per month.
3. Benefit package focuses on primary healthcare. For the primary healthcare service utilization, patient needs to pay 50 Naira per visit, and then obtain free services and free drugs within essential drug list (about 70 drugs). For referral care (secondary care), patient pays 75% of total healthcare expenditure, and government pays the rest (25%).
4. The scheme is managed by the community.
5. The capitation payment method is used to pay primary healthcare provider. The level of capitation is 320 Naira per enrollees per month.
6. Health care provider is private provider who provides services in public primary care facility.
7. The scheme is subsidized by government. Government pays MHA administrative cost; 25% secondary care cost, heavily subsidized capitation payment (for example, a family with 6 members pays 800 Naira per month). However, the capitation to the provider is 320 Naira per person per month. Therefore, for a family with 6 members, total capitation for a family is 1920 Naira. The difference between 1920 and 800 is paid by government. Therefore government subsidy rate to this family can be as high as 58%) for the primary care. In addition, government pays the premium up to 500 members who are among the poorest of poor, and pays 25% of secondary healthcare service cost.

b). Lekki schemes

Represent two additional CBHI schemes in only launched in February 2011. Currently 2,000 community members have participated in these scheme (including local government staff members).

The two schemes are similar to IKOSI ISHERI scheme design, except for some key variations:

1. Premium increased to 1200 Naira per month with up to 6 family members
2. Local government staff members also participated in this scheme. In this case, individual family pay 700 Naira, local government pay 500 Naira)
3. Capitation to the provider is 1400 Naira per family with up to 6 members.
4. Provider is a HMO provider who has experiences on insurance related issues.
5. New scheme used electronic information system.

Specific Tasks:

Given that Lekki schemes only started one month ago, this rapid review will mainly focus on the IKOSI ISHERI scheme. The scope of review can be categorized into six groups.

The specific tasks for the consultants are:

(1) Enrolment

This group will try to review following issues

- a. Promotion/mobilization package and its implementation
- b. Premium collection process
- c. The registration system
- d. Membership profile and potential adverse selection
- e. Reasons for participation, not participation, renew, and not renew

(2) Scheme management

This group will try to review following issues

- a. The role of BOT
- b. The role of MHA
- c. Information system

- d. Contract with providers
- e. Poorest of poor identification
- f. Over use of service

(3) Service quality

- a. Benefit package review, possibility of providing services that are not covered by CBHI in primary health center, and extra charge for those services
- b. Provider choice
- c. Referral
- d. Patient complaints

(4) Financial analysis

- a. Scheme break even analysis
- b. Premium review
- c. Provider payment review
- d. Possibility of reduction of government subsidy and its impact on sustainability.
- e. Alternative financing

(5) History review

This review will focus on the history of scheme development, and will start immediately, with PATHS2's Health Financing Officer in Lagos Office responsible for collecting and reviewing background materials related to the scheme. The output of this, will form inputs into the other elements of the review.

(6) Role of government

- a. Leadership role
- b. Financial role
- c. Technical role
- d. Roles in design, implementation, and M&E

- The consultants will also write a short trip report of no longer than 10 pages on the assignment. A draft version will be submitted to Hong Wang before the end of the in-country work and a final version within 10 working days of the end of the assignment.

Key Deliverables & Expected Outputs:

By the end of the assignment the following outputs will be expected:

- By May 31 a draft report outlining the strengths and challenges of the IKOSI ISHERI CBHI scheme and, to the extent possible, the Lekki CBHI schemes.
- By June 30 a final report

Profile /Type of Consultants Required:

The team for this work will be made up of 3 health insurance experts. The first is a PATHS2 staff member – **J. Damascene Butera** – with prior experience with CBHI. The other 2 are international Health Insurance Experts:

Cheikh Mbengue (Abt Employee) is an expert on institutional development with fifteen years of experience in West African regional institutions and USAID-funded projects as a technical expert and researcher on social aspects of HIV/AIDS and reproductive health programs, community health and health sector reform throughout West and Central Africa. Particular emphasis on health financing, making decentralization support priority services in health, networking to face the HIV/AIDS epidemic, developing mutual health insurance movement, maximizing donor coordination to leverage support for health activities, supporting National Health Account activities and developing social marketing. Cheikh is currently the team leader for pilot projects on “Integrating Child Health Products Into Community Based Health Insurance (CBHI) schemes In Rwanda” and the “Liberia Health Financing Policy Technical Assistance” and supervises Health Systems 20/20 (USAID funded project) regional activities on CBHI.

Lisa Beichl (international consultant) has over twenty years of professional insurance experience including both US and international markets.

- Skilled at developing and assessing global health insurance strategies (public/private) and related programs, highlighting strengths and weaknesses of stakeholders and arriving at feasible operational and product solutions to improve/measure quality.
- Extensive international health insurance (public/private)operational experience including ability to assess market conditions and regulations, performing gap analyses to determine local capacity building requirements, and develop effective techniques to manage growing insurance portfolios.

- International health insurance and reinsurance on-the-ground experience in the Middle East, Latin America, Asia and Central and Eastern Europe.
- Strong understanding of insurance data and IT issues surrounding life/health insurance companies (both public and private) in the US, Central and Western Europe, the Middle East, Asia, Latin America, and Africa.

Reporting & Timing of Consultancy

Work is expected to begin on April 18 and continue through the end of June, 2011

Duty Station/Location

Lagos Nigeria & Consultant's respective home locations

Activities	International (2)	National consultants (1)
Carry out assessment in Lagos -	20-30 days	10-15 days
Draft Report	10 days	5 days
Finalize Report	10 days	5 days
	days	days
	days	days
TOTAL	40 – 50 days	20 – 25 days

ANNEX 2: CBHIS Review Matrix Final (26 may 2011)

#	Item	Goal	Approach	Survey	Measurements
1	Historical review	<p>To identify the track and growth of interest in health insurance and the current role of government.</p> <p>This review will focus on the history of CBHI development, and will start immediately with PATHS2's Health Financing Officer in Lagos Office responsible for collecting and reviewing background materials related to the CBHI. The output of this, will form inputs into the other section.</p>	<p>From inception to today, phases of development, tie to strategic plan/ direction. From this information deduce current role.</p> <p>Access: regulations, how well the regulations encourage providers and communities to cover vulnerable populations</p> <p>Oversight: rate filings/products and modifications, correction actions and consumer fairness, regulations on risk filings</p> <p>Enforcement: if a deviation exists, mechanisms to correct and enforce corrections</p>	<p>LSMOH (Dr Zamba, Director, Commissioner) interview (to identify the vision and roll out)</p> <p>Day to day operations and oversight</p> <p>Lessons learned and how these lessons have been integrated – showcasing strengths and suggestions to strengthen gaps</p> <p>BOT interview (what experience you had) – perception of how CBHI was initiated, response, reaction, changes</p> <p>Local government and Community groups- perception of how CBHI was initiated, response, reaction, changes</p> <p>Enrollee/community interview – reaction, perception, acceptance, fears, etc.</p> <p>Role of Microfinance</p>	N/A

#	Item	Goal	Approach	Survey	Measurements
				Institutions	
2	Role of government	<p>The government role in movement toward alternative financing for the vulnerable</p> <p>Role of Government</p> <ul style="list-style-type: none"> a. Leadership Role b. Financial Role c. Technical Role d. Roles in design, implementation and M&E 	<p>Leadership</p> <p>Technical assistance</p> <p>Financial assistance</p> <p>Design, implementation and M&E</p>	<p>Same questions as above, but prospectively</p> <p>Specifically suggestions regarding alternative financing (Member Interview) through fundraising, savings accounts, middle class subsidizing vulnerable, etc.</p>	N/A
3	Scheme	<p>Understand how the roles/sectors/environment processes meet the needs of stakeholders (including providers and members)</p> <p>Review the following issues:</p> <ul style="list-style-type: none"> a. The role of BOT 	<p>BOT interviews</p> <p>MHA interviews</p> <p>Local government</p> <p>LSMOH interview</p> <p>AGMPM – providers who are approached to run the CBHI are part of assoc</p> <p>IT system capability and data elements (MOH,</p>	<p>BOT interview</p> <p>MHA interview</p> <p>Local government</p> <p>Community Groups</p> <p>LSMOH interview</p> <p>AGMPM interview</p> <p>Claims/enrollment audit</p>	<p>Penetration rate</p> <p>Capitation break even</p> <p>% referrals to enrollees</p> <p>Complaint ratio</p> <p>Provider retention</p> <p>Existence of Bylaws (legislation document)</p> <p>MOUs with providers</p>

#	Item	Goal	Approach	Survey	Measurements
		<ul style="list-style-type: none"> b. The role of MHA c. Information systems d. Contract with providers e. Poorest of poor identification f. Over use of services 	<p>MHA)</p> <p>Provider contracts (MOH)</p> <p>Retention rates (MOH)</p> <p>Utilization stats (MOH)</p> <p>Administrative audit (MHA)</p> <p>Product analysis</p> <p>Provider placement (how far the secondary care facilities are from the enrollee)</p>	<p>Provider interview (primary and referral)</p>	<p>Method to identify Most Vulnerable</p>
4	Enrollment	<p>Determine effectiveness of current enrollment process and coverage</p> <p>Review the following issues:</p> <ul style="list-style-type: none"> a. Promotion/ mobilization package and its implementation b. Premium collection process c. The registration 	<p>Data analysis (member profile including age/ occupation/ financial, family or not, defaulting members) (LSMOH)</p> <p>Catchment population and how that compares to covered lives (LGA)</p> <p>BOT Interviews (how do you reach membership and communicate product, other CBHIs or arrangements)</p> <p>What is the current product</p>	<p>Focus Group (current, defaulting and non-enrollees)</p> <p>Community Groups</p> <p>BOT interview</p> <p>Provider interview (different utilization stats for member versus self pay)</p>	<p>Retention rates</p> <p>Penetration rate (per catchment population)</p>

#	Item	Goal	Approach	Survey	Measurements
		<p>system</p> <p>d. Membership profile and potential adverse selection</p> <p>e. Reasons for participation, not participation, renew, and not renew</p>	<p>coverage (LSMOH, BOT, MHA)</p> <p>Willingness to pay (LSMOH)</p> <p>Product coverage</p>		
5	Service Quality	<p>To ensure high quality administrative processes and medical outcomes, and internal quality assurance (meetings/goals)</p> <p>Review the following issues:</p> <p>a. Benefit package review, possibility of providing services that are not covered by CBHI in primary health center, and extra charge for</p>	<p>Identify quality groupings: admin, medical, internal</p> <p>Data analysis</p> <p>Focus groups with members</p> <p>Provider interview</p>	<p>AGMPM interview</p> <p>MHA/ Claims audit (to see if we can generate these figures today)</p> <p>Provider Interview</p> <p>Focus Group (members access to pharmaceuticals, covered versus non-covered benefits)</p> <p>BOT interview</p> <p>Local MOH interview (presence and enforcement of guidelines)</p>	<p>Member satisfaction rates</p> <p>Provider satisfaction rates</p> <p>Readmission rates</p> <p>Turn-around time (TAT) for claims</p> <p>% of enrollees referrals</p> <p>Average number of visits per person</p> <p>Availability of Rx (through patient interview)</p> <p>Use of guidelines (administrative or medical)</p>

#	Item	Goal	Approach	Survey	Measurements
		<p>those services</p> <ul style="list-style-type: none"> b. Provider choice c. Referral d. Patient complaints 			
6	Financial Analysis	<p>To ensure financial sustainability and study reliance on government</p> <p>Review the following:</p> <ul style="list-style-type: none"> a. CBHI break even analysis b. Premium review c. Provider payment review d. Possibility of reduction of government subsidy and its impact on sustainability e. Alternative financing 	<p>Underwriting versus financial results</p> <p>Breakeven analysis</p> <p>Referral costs across time</p> <p>Provider costs across time</p> <p>Administrative costs across time</p> <p>Willingness to pay (LSMOH)</p>	<p>Provider interviews</p> <p>Member interview (is the premium affordable)</p> <p>Local MOH (subsidization)</p> <p>Study analyses and monthly BOT reports (LSMOH)</p> <p>Referral costs (LSMOH)</p> <p>Capitation actuarial report (LSMOH) - 2009</p>	<p>% of enrollee out of pocket rate to Capitation rate</p> <p>% of locally subsidized enrollees</p> <p>% of administrative costs in capitation (BOT/MHA) (est. 30N PE/PM)</p>

ANNEX 3: Schedule of Meetings and Stakeholders Met

Date	AM	PM
Monday 23 May	Discussion of general approach including development of goals, approach and agreement on general survey tools	<p>Generation of first level questions based on groupings: Historical, Governance, Scheme, Enrollment, Service Quality, and Financial.</p> <p>Agreed on measurements to evaluate the success of the goal or to create benchmarks.</p>
Tuesday 24 May	Continued development of questions including generating an improved understanding of the role of the different stakeholders.	Finalized internal draft, shared with LSMOH for feedback.
Wednesday 25 May	<p>Based on internal and LSMOH feedback, as a group re-wrote questions and increased breakdowns of stakeholders to better reflect interests.</p> <p>Feedback included selecting focus group participants from Olowra, Magado, and Ischeri (3 groups for each classification of enrolled, defaulted, and non-member, n=9)</p>	<p>Finalized internal draft 2 shared with LSMOH review. Provided additional feedback to consolidate and re-work items including an improved understanding of stakeholder interests and responsibilities.</p> <p>LSMOH suggested including the private provider association AWGDA and also the CDO and if possible, a religious association.</p> <p>Created overview of focus group discussion (FDG) approach and ability to organize through correct channels (LSMOH and BOT).</p>
Thursday 26 May	<p>Final changes reviewed with LSMOH management team including request to see finalized FGD participant criteria.</p> <p>Group visit: Ikosi Isheri Primary</p>	<p>Akoama: (1) train facilitators on questions, (2) call potential FGD participants for willingness; (3) organize consent discussion, releases for photos.</p> <p>Akaoma organized and wrote formal</p>

Date	AM	PM
	<p>care visit</p> <p>Tasks: Akaoma (1) identified facilitators; (2) organized groups in 3 catchment areas</p>	<p>letters to Provider Manager and LGA Chairman</p> <p>Thierry, Bisi, Benson, Dr. Zamba (LSMOH) and Lisa: informal meeting with LSMOH (Commissioner) discussing vision for the future of healthcare.</p>
Friday 27 May	<p>FGD contact and pilot</p> <p>Group: BOT interview (Chairman)</p> <p>Akaoma and Cheikh: finalized selected FGD participants; trained facilitators in approach including mock FGD and possible challenges.</p>	<p>Group: Dr Zamba (LSMOH) interview</p> <p>Group: MHA interview (administrative staff)</p>
Saturday 28 May	Meeting with BOT technical specialist Dr. Femi Obunkegun	Reading/analysis of documents from LSMOH (see list above)
Monday 30 May	LEGAL HOLIDAY, spent working on report and analysis	LEGAL HOLIDAY, spent working on report and analysis
Tuesday 31 May	Preparation for Focus Group	<p>Trial Focus Group</p> <p>Modification and Adjustments to process</p>
Wednesday 1 June	<p>Focus Groups</p> <p>Interview with LGA and MOH</p>	<p>Focus Groups</p> <p>Interview with Provider Manager</p>
Thursday 2 June	Evaluation and analysis	Evaluation and analysis

Date	AM	PM
Friday 3 June	Discussion with LSMOH on final issues	Group Debriefing and outline of core recommendation

Name	Position	Organisation
Dr Jide Idris	Honourable Commissioner	Lagos State Ministry of Health
Dr Femi Olugbile	Permanent Secretary	Lagos State Ministry of Health
Hon 'Kunle Soname	Executive Chairman	Ikosi Isheri Local Council Development Area
Hon Dr. Ajibayo Adeyeye	CBHI Service Provider	Ikosi Isheri (Company Name)
Dr. Joyce 'Omodele Osunkiyesi	Director Planning Research and Statistics	Lagos State Ministry of Health
Dr. Emmanuella Zamba	Head of Planning	Lagos State Ministry of Health
Dr. Ijimakinwa Tosin	Health Financing Officer	Lagos State Ministry of Health
Joan Oluayemi	Medical Officer of Health	Lagos State Ministry of Health
Osuagwu Chinyere	Medical Officer of Health	Lagos State Ministry of Health
Dr. Ibukun	Kosofe LGA Medical Officer of Health	Local Government
Kunle Sholesi	Chairman BOT	Board of Trustees
Adeyaniyn Fatimin	Member	Board of Trustees
Ibukun Olatunbosun	Manager	Ikosi Isheri

Dr. Femi Ogunbekun	Technical Advisor	Board of Trustees
Mike Sarumi	Supervisor	MHA
Funke Edukpe	Staff	MHA
Olatunji Julius Olayemi	Facilitator	Survey group
Oluwafemi Matthew	Facilitator	Survey group
Titilope Akosa	Facilitator	Survey group
Moradejo Toyin	Facilitator	Survey group
Tokunbo Idowu	Facilitator	Survey group
Folarin-Williams Adeola	Facilitator	Survey group

Introductory Meetings

Tuesday May 24, 2011; Wednesday May 25, 2011; Thursday May 26, 2011

Introduction to the LSMOH; discussion of approach; review of interview and survey questionnaires

Dr. Joyce 'Omeodele Osunkeyesi, LSMOH

Dr. Emmanuella Zamba, LSMOH

Dr. Ikimakamwa Tosin, LSMOH

Thierry van Bastelaer, Abt, DC (*Thursday only*)

Cheikh Mbengue, Abt, DC

Damas Butera, Paths2, Abuja

Akaoma Onyemelukwe PATHS2 Lagos

Benson Obonyo, Paths2, Abuja

Lisa Beichl, Paths2, External Consultant

Site visit to Ikosi Isheri, Olowora

Joan Yemi, LSMOH

Kunle Sholesi, Chairman, BOT

Thierry van Bastelaer, Abt, DC

Katherine Brouhard, Abt, DC

Cheikh Mbengue, Abt, DC

Benson Obonyo, Paths2, Abuja

Akaoma Onyemelukwe Paths 2 Lagos

Damascene Butera, Paths2, Abuja

Lisa Beichl, Paths2, External Consultant

Meeting with Commissioner, LSMOH

Dr. Jide Idris, Honorable Commissioner

Dr. Emannuella Zamba, LSMOH
Bisi Tugbobo, Paths2, Lagos
Benson Obonyo, Paths2, Abuja
Dr. Thierry van Bastelaer, Paths2, Abt, DC
Lisa Beichl, Paths2, External Consultant

Friday May 27, 2011 meeting with the BOT

Meeting attendees:

Kunle Sholesi, Chairman, BOT
Adeyaniyn Fatimin, BOT
Ibukun Olatunbosun, Ikosi Isheri
Joan Yemi, LSMOH
Ikimakamwa Tosin, LSMOH
Osuagure Chinyere, LSMOH
Akaoma Onyemelukwe, Paths2, Lagos
Cheikh Mbengue, Paths2, Abt, DC
Damascene Butera, Paths2, Abuja
Lisa Beichl, Paths2, External Consultant

Friday May 27, 2011 meeting with the MHA

Mike Sarumi, MHA Supervisor and Data Manager (note: the LGA moved him from this role during the visit which presents an important operational challenge to the office)

Funke Eclukpe, MHA
Akaoma Onyemelukwe, Paths2, Lagos
Cheikh Mbengue, Paths2, Abt, DC

Damascene Butera, Paths2, Abuja

Lisa Beichl, Paths2, External Consultant

Tuesday May 31, 2011 meeting with Facilitators for the survey, pilot survey – Focus Group Discussions (FDGs) took place (8) on Wednesday June 1, 2011; Debriefing from Facilitators took place Thursday June 2, 2011

Facilitators:

Olatunji Julius Olayemi, M

Oluwa Femi Matthew A, M

Tehlope Akosa, F

Morade To Tothin, F

Mayoma Adeniran, M

Tokumbo Idowu, F

Folarin-Williams, Adeola, F

Team participants:

Akaoma Onyemelukwe, Paths2, Lagos

Cheikh Mbengue, Abt, DC

Lisa Beichl, Paths2, External Consultant

Overview of Focus Group Schedule

Tuesday

Time	Number	Group type	Location
12:00 to 2:00 pm	12 people (max)	Members (trial)	Baale's House Olowora

Wednesday

Time	Number	Group type	Location
10:00 to 12:00 pm	12 people (max)	Defaulters	Baale's House Isheri
10:00 to 12:00	12 people (max)	Women	PC Facility Olowora (because Wednesday is ante-natal day)
10:00 to 12:00	12 people (max)	Non-members	Baale's House, Magodo
2:00 to 4:00	12 people (max)	Members	Baale's House Isheri
2:00 to 4:00	12 people (max)	Defaulters	Baale's House Oloworu
2:00 to 4:00	12 people (max)	Non-members (instead was Members)	Baale's House, Magodo

Facilitators meeting Tuesday 31 May 2011

Provided an overview of the Scheme organization and coverage including the following points:

Group of persons at a community level to save money together to create a pool of premiums to cover the community's primary care health costs

- Scheme is managed by the community (not just a client)
- Land from local govt
- Equipment from state govt
- Ongong expenses from local govt
- Premiums insufficient to cover all costs, so subsidized by the government

The questionnaires were reviewed and appropriate translations into Yoruba were decided as a group.

Wednesday June 1, 2011 Interview Local Government (LGA)

Hon. 'Kunle Soname, Executive Chairman

Dr. Ibuken, O.A. Medical Officer of Health (MOH)

Wednesday June 1, 2011 Interview Provider Manager

Hon. Dr. Ajubayo Adeyeye, Deputy Majority Leader, Kosofe II

Kunle Sholesi, Chairman, BOT

Cheikh Mbengue, Abt, DC

Lisa Beichl, Paths2, External Consultant

Friday June 3, 2011 Interview LSMOH

Dr. Joyce 'Omeodele Osunkeyesi, LSMOH,

Dr. Ikimakamwa Tosin, LSMOH

Cheikh Mbengue, Abt, DC

Lisa Beichl, Paths2, External Consultant

Annex 4: Documentation Received

Sunday May 29, 2011, received the following documents per email from the LSMOH

- Overview of the Community Based Health Scheme (Power point)
- Next Steps Final (Power point)
- The Pilot Scheme – final (Power point)
- Revised MHO Proposal 1
- Workplan for Ikosi Isheri Pilot CBHI
- MHA Combined Three Month Report Final Draft
- Criteria for Provider Selection
- IMHPF February 10
- 1 year MHA report
- Overview of Informal Health Sector HI Policies 052911 TVB

Physical documents received on **Wednesday June 2, 2011**

- Excerpts of Draft Articles of Association Ikosi-Isheri Mutual Health Association
- Community Base Health Insurance Scheme Health Plan – Basic Operations Booklet
- Project Welfare, Study on prospects of proposed community based Health Insurance Scheme in Lagos, February 2007
- Actuarial Investigation on Lagos Community Health Insurance Initiative, 29 March 2010 (Alexander Forbes Consulting Actuaries Nigeria Limited)

Additional document received on **Friday June 3, 2011**

- MOU between BOT and the Provider
- MOU between Local Government (LGA) and the Provider
- MOU between LGA and the BOT

Annex 5: CBHIS Survey Instruments – Final (26 May 2011)

Enrollee Focus groups, including potential target groups:: current, defaulting and non-enrollees

Require: consent form

Current Enrollees:

#		Question
1		Introduction: Are you a member of the CBHI? For how long have you been a member?
2	Hist	How did you learn about the CBHI? What prompted you to join the CBHI?
3	Hist	Did you ever have health insurance before, or what did you do if you were sick?
4	Scheme	How long did it take you to register?
5	Scheme	How many people are in your household? Is everyone in your household covered? How do you select the members?
6	Scheme	What are the major benefits?
7	Hist	What do you know about how the CBHI developed and how it was introduced to the community? Can you explain the structure of the CBHI? How was the BOT elected? Are there any members of the BOT who are leaders in the community (associations, etc.)? Probe for differences within the CBHI of the various communities.
8	Hist	Are you involved in the CBHI's decision making, and how? How many meetings are there yearly? Do you go to the meetings? Do you observe changes based on the meeting outcomes and/or complaints?
9	Hist	Does the CBHI inform and sensitize the community to its services and how often do you see activity?
10	Scheme	How was the provider selected? Are there other health facilities in the neighborhood?
11	Prov	Have you been to the primary clinic? About how often do you go? From your family, who comes to the clinic most?
12	Prov	Do you always get drugs when you go to the clinic? Have you been asked to pay for anything?
13	Prov	What do you think about the services provided? When you visit the clinic do you feel satisfied with your attendance? (the provider's attitude) Note: want to

#		Question
		probe to find if the individual equates quality medicine with an injection, pharmaceutical Rx, or any other intervention that is more than a doctor consultation alone.
14		Do you think there is a difference in medical care if you are in the CBHI or not? If yes, please describe
15	Prov	Have you ever been referred? Where and for what procedure/test?
16	Prov	At present you have a new primary provider today. Do you like him? (unique to Ikosi)
17	Prov or Scheme	Have you ever complained about a problem? What kind of a problem was it (administrative or medical?) Or have you heard of anyone who ever complained about a problem? Do you know where to complain?
18	Fin	What is your premium? Ideally there is means testing for this). This premium has been the same for 3 years. We know that nothing has been stagnant since then. Don't want to compromise on quality of care, .. Do you think that the stage is set for the increase in premiums? In view of the current inflationary trends which have been spared in the health sector. --- if volume were sufficient What do you understand by late payments? For all payments made did you get a receipt each time?
19	Scheme	What other benefits would you like to see included? Does the CBHI cover the most important services to you?
20	Hist	How has your impression of the CBHI changed? Has that changed over time? How could the CBHI be made better?

Defaulted Enrollees:

#		Question
1	Struc	Why did you to join the CBHI initially?
2	Struc	How long were you a member and when did you leave? Why did you leave?
3	Scheme	How would you describe your experience in the CBHI?
4	Prov or Scheme	Did you ever complain about a problem? Or have you heard of anyone who ever complained about a problem? Do you know where to complain? If so, how was it handled?

#		Question
5	Hist	How many people are in your household? Was everyone in your household covered? If no, who did you cover – the whole household? How do you select the members?
6	Scheme	What were the major benefits? Did the CBHI cover the most important services to you?
7	Scheme	What do you know about how the CBHI developed and how it was introduced to the community? Can you explain the structure of the CBHI? How was the BOT elected? Are there any members of the BOT who are leaders in the community (associations, etc.)? Probe for differences within the CBHI of the various communities.
8	Prov	How were providers selected? Were you happy with the providers? Were there other facilities in the neighborhood?
9	Prov	During the time of your membership, Did you go to the primary clinic? About how often did you go? Did you always get a prescription when you go to the clinic? Were you asked to pay for anything? From your family, who comes to the clinic most? Did you receive receipts each time you paid for something?
10	Prov	Were you ever referred? Where and for what procedure/test?
11	Prov	Do you think there is a difference in medical care if you are in the CBHI or not? If yes, please describe.
12	Scheme	How could the CBHI be made better? What would it take for you to re-enroll?
13	Scheme	What do you do if you have a healthcare problem right now? Do you now see a different provider Did you receive receipts each time you paid for something? How do you pay for it? If they talk about difficulties before the next question helps them consider alternative financing.
14	Fin	What is your premium? Ideally there is means testing for this). This premium has been the same for 3 years. We know that nothing has been stagnant since then. Don't want to compromise on quality of care, .. Do you think that the stage is set for the increase in premiums? In view of the current inflationary trends which have been spared in the health sector. --- if volume were sufficient What do you understand by late payments? For all payments made did you get a receipt each time?
15	Scheme	Instead of subsidizing, there are alternative financing to help pay for health care. Have you heard of MFI's before? Are you involved in an MFI? If yes,

#		Question
		what is the name?

Non Enrollees:

		Question
1	Know	Do you know what health insurance is? What do you do if you have an emergency problem today? How do you pay for it? On average how much do you pay wherever you go now?
2	Scheme	Have you heard of Ikosi Isheri CBHI before? What have you heard? What are the rules, do you know how many people can enroll in a family? Do you know which providers are included? Do you know what it costs? What do you think of it? Prompt for the issue of inability to pay and alternative financing being through MFI's.
3	Know	Why didn't you join the CBHI?
4	Scheme	What public or private clinic do you go to? About how often do you go?
5	Know	Do you belong to any other associations? Have you heard of MFI's before? What do you think of them?
6	Prov	Do you think there is a difference in medical care if you are in the CBHI or not? If yes, please describe
7	Know	What information would you need to decide if this CBHI was right for you and your family?

BOT Interview questions

#	Group	Question
1	Hist	How did the CBHI scheme start and how did people learn about it in the community? How does the CBHI interact with the LGA and State MHOS?
2	Hist	Describe your CBHI. How does it interact with the LGA?
3	Hist	How long have you been a member of the Board? What is your responsibility? What did you think about the CBHI when you started? Has your opinion changed?

#	Group	Question
4	Hist	Do you think the community will stay with this CBHI? If not, why not?
5	Gov	How is the CBHI organized? How is the BOT selected? How does it work?
6	Gov	If an enrollee has questions, who does he/she talk to?
7	Gov	How does the CBHI organize the community and how often do you see activity? Are specific associations like women's associations active? Are any of these leaders active in the BOT?
8	Gov	How often do you meet with your members, how do you motivate the local community to participate? Do these efforts work?
9	Gov	How do you monitor the CBHI? Financial? Clinical? Satisfaction? Other? Do you see this as your role? If not, whose role?
10	Gov	Do you update yourselves with reports from the MHA office where the data is provided or from the provider or from the ministry?
11	Gov	What are some problems that you face today that you'd like to resolve? What would you change about the way the CBHI works? Knowing what you know now, what would you do differently or advise others to do? Can you describe the challenges and lessons that you have learned? What has been your greatest achievement?
12	Scheme	Explain the current benefits? How were benefits decided? When does coverage begin, immediately? Are there any types of illness or individual who are excluded? What do you think of the cost of care for non-member emergency claims?
13	Scheme	Do you have an IT system, What kind of information do you collect and what specific data elements do you collect? Are there any standard forms that you use? Can we do an admin walkthrough (see below)?
14	Scheme	What do you do when you receive a complaint? How well documented is the process? Is it formal or informal? Can you identify the profile of complainers – mostly men or women? Number? Frequency?
15	Scheme	What's the average waiting time for a person who goes to the primary clinic for a service?
16	Scheme	What other CBHIs exist in the market?
17	Scheme	What are the required capabilities to be in the role that you have today? Are there any gaps that you see? What do you think about your current voluntary status – how do you think about your remuneration?

#	Group	Question
18	Enroll	How did/do target potential enrollees?
19	Enroll	How does your enrollee profile compare to the catchment profile? Do you have any catchment statistics? How many lives are covered? What's the number of active people? How many renewals, new enrollees/lives or defaulters did you have this month?
20	Prov	How did/do you select providers? Is there a standard process to select providers? In the event that the scheme grows and there is increased member retention, would you consider engaging an additional provider? Do you perceive a difference in quality between public and private providers? Can you clarify?
21	Prov	Do you have MOUs with providers? Are there guidelines for them?
22	Prov	What is quality to you, how do you define quality? (administrative and medical) What is your perception of the quality of service? (primary, secondary levels). Are there quality standards and protocols in place?
23	Prov	How would you describe your relationship with the primary provider? How is your current provider different from previous providers? Is it a different relationship with your referral provider(s)?
24	Process	What do you think of the primary/secondary provider? How is the communication between you when transferring a patient?
25	Fin	What is included in capitation? What happens if something is not covered under capitation?
26	Fin	How did you set the premium? Who creates the capitation rate, and is it adjustable?
27	Fin	What issues attract penalties? How much are they? Who communicates these?
28	Fin	How much are your costs to run the place? What do the costs cover? What's your breakeven? If the premium should increase, what should it be? Could the community pay for these costs? What alternatives do you see?
29	Fin	What is the most frequently occurring diagnosis? Do you have an idea of the cost of medical care? Can you provide reports on utilization and cost data?
30	Fin	What is the subsidy and when it was withdrawn (perhaps in phases), how would you survive?

MHA Interview questions (government staff employees, clerical staff)

#	Group	Question
1	Hist	How long have you worked here? How did the CBHI start and how did people learn about it in the community?
2	Hist	Describe your CBHI. How does it interact with the LGA?
3	Hist	How long have you worked here? What do you do? What did you think about the CBHI when you started? Has your opinion changed?
4	Hist	Do you think the community will stay with this CBHI? If not, why not?
5	Gov	How is the CBHI organized? How is the BOT selected? How does it work?
6	Gov	If an enrollee has questions, who does he/she talk to?
7	Gov	How does the CBHI organize the community and how often do you see activity? Are specific associations like women's associations active? Are any of these leaders active in the BOT?
8	Gov	How do you monitor the CBHI? Financial? Clinical? Satisfaction? Other? Do you see this as your role? If not, whose role?
9	Gov	What are some problems that you face today that you'd like to resolve? What would you change about the way the CBHI works? Knowing what you know now, what would you do differently or advise others to do? Can you describe the challenges and lessons that you have learned? What has been your greatest achievement?
10	Scheme	Explain the current benefits? How were benefits decided? When does coverage begin, immediately? Are there any types of illness or individual who are excluded?
11	Process	What do you think of the primary/secondary provider? How is the communication between you when transferring a patient?
12	Scheme	Do you have an IT system, What kind of information do you collect and what specific data elements do you collect? Are there any standard forms that you use? Can we do an admin walkthrough (see below)?
13	Scheme	How are premiums collected and stored in the IT system?
14	Scheme	What do you do when you receive a complaint? How well documented is the process? Is it formal or informal? Can you identify the profile of complainers – mostly men or women? Number? Frequency?
15	Scheme	How are referrals approved or denied?

#	Group	Question
16	Scheme	How do you process claims? What operational and or clinical guidelines do you have? Are they enforced?
17	Scheme	What's the average waiting time for a person who goes to the primary clinic for a service?
18	Scheme	What are the required capabilities to be in the role that you have today? Are there any gaps that you see?
19	Prov	What is quality to you, how do you define quality? (administrative and medical) What is your perception of the quality of service? (primary, secondary levels). Are there quality standards and protocols in place?
20	Prov	How would you describe your relationship with the primary provider? How is your current provider different from the past? Is it a different relationship with your referral provider(s)?
21	Fin	How are penalties affected? How much are they? Who communicates these?
22	Fin	What is the most frequently occurring diagnosis? Do you have an idea of the cost of medical care? Can you provide reports on utilization and cost data?

LSMOH, LGA Interview questions

#	Group	Question
1	Hist	How did the CBHI start? What was the initial vision? How was it introduced in the community? Can you provide milestones or benchmarks?
2	Hist	Describe the CBHI. How is the CBHI organized?
3	Hist	What role have you played in the development/management of the CBHI? What role played the LGA?
4	Hist	What's your understanding of the role of the BOT and the MHA? How is the BOT selected? What is the process? Do the BOT and MHA fulfill their responsibilities?
5	Gov	How does the CBHI sensitize and organize the community? Are specific associations like women's associations active? Are any of these leaders active in the BOT? What promotional avenues have you explored (i.e. radio stations)?
6	Gov	How the CBHI are they monitored? Financial? Clinical? Satisfaction? Other? Do you see this as your role? If not, whose role?

#	Group	Question
7	Gov	How are the poor identified in community (subsidized by the local government)? If the poor were somehow unable to pay for reduced subsidization, how would you identify the most vulnerable in your community and options to continue their coverage? What do you think of MFIs as a vehicle?
8	Gov	Do you receive CBHI management reports? If so, how often? What do you do with the reports?
9	Gov	Are you satisfied with the current functioning of the scheme?
10	Gov	What are the obstacles currently faced by the scheme that you'd like to resolve? What would you change about the way the CBHI works? Is your vision the same or has it changed? Knowing what you know now, what would you do differently or advise others to do? Can you describe the challenges and lessons that you have learned? What has been your greatest achievement?
11	Scheme	What do you think about the current benefit package? How were benefits decided? Did you have access to data to identify frequency or cost?
12	Scheme	Is the IT system comprehensive and generating the needed information? Can we see the reports?
13	Scheme	How are complaints managed? How well documented is the process? Is it formal or informal?
14	Scheme	How is the referral system working?
15	Scheme	How are the claims processed? Are there operational and or clinical guidelines? Are they enforced?
16	Enroll	How many lives are covered by the scheme? What is the penetration rate of the schemes? How is the membership renewal? Is there membership drop out? What are the reasons?
17	Prov	How were the providers selected? Is there a standard process to select providers? Are there other providers that could be contracted to add more choice? Are these public or private providers? Do you perceive a difference in quality between public and private providers? How do measure effectiveness?
18	Prov	How many MOUs guide scheme operations? (provider, local govt) Are there guidelines for them?
19	Prov	What is quality to you, how do you define quality? (administrative and medical) What is your perception of the quality of service? (Primary, secondary levels). Are there quality standards and protocols in place?

#	Group	Question
20	Prov	How would you describe the relationship between the scheme and the primary provider? How is the current provider different from the past? Is it a different relationship with the referral provider(s)?
21	Prov	How was the provider fee schedule (if you have one) calculated?
22	Fin	Has a feasibility study/formal demand assessments conducted? If so, how were they organized and received?
23	Fin	How was the premium set? Who creates the capitation rate, and is it adjustable? What is included in capitation? What happens if something is not covered under capitation?
24	Fin	What is the most frequently occurring diagnosis? What is the highest cost diagnosis or referral? Can you provide reports on utilization and cost data?
25	Fin	How are the administrative costs calculated? What do these costs cover? What's the breakeven?
26	Fin	What is the subsidy? What part of the contribution is LSMOH and LGA financed? What is your vision in terms of the long-term use of subsidies?
27	Fin	If the premium should increase, what should it be? Could the community pay for these costs? What alternatives do you see?

Provider (primary and secondary) Interview questions

	Group	Question
1	Hist	How did this CBHI start? How did you introduce the CBHI to the community? What was the process to be linked to the CBHI?
2	Hist	How often do you meet with the BOT or talk to them about the CBHI?
3	Structure	About how many patients do you see a day? Did you bring patients from your former practice to this clinic? What would you estimate the size of your practice to be?
4	Structure	About how many support staff do you have? Do you have a formal or informal training program? How often do you meet to discuss your practice?
5	Structure	What is the profile of your patients? Average age? What proportion of what you deal with is outside primary care?

6	Process	What is your pharmaceutical sourcing? Is it managed through the government?
7	Process	What is the process if you need new equipment or additional staff?
8	Process	How much time do you typically spend with a patient? (physician only)
9	Gov	What is the most frequently occurring diagnosis? What is the highest cost diagnosis or referral? Can you provide reports on utilization and cost data?
10	Process	Do you typically provide a prescription every time a patient visits?
11	Quality	How do you manage preventive care? What kinds of preventive care do you offer?
12	Fin	What is included in capitation? What happens if something is not covered under capitation?
13	Quality	How do you define quality? How do you measure medical quality? Administrative quality? Do you use or have access to operational and clinical guidelines?
14	Scheme	What do you think of the benefits package? What is your understanding of the arrangement copayment system for drugs and for non-member emergency cases?
15	Process	What do you think of the primary/secondary provider? How is the communication between you when transferring a patient?
16	Structure	How would you describe the difference between public and private providers?
17	Fin	If primary: how do you get paid under capitation? Monthly?
18	Fin	Do you use any managerial reports to study diagnoses, frequency and possibly costs? If so, can we see a copy of a sample report? If yes, where do the data come from?
19	Gov	Do you supply any reports to the LSMOH or LGA? If yes, what kind and how are they used?
20	Fin	How do you calculate breakeven? What do you include (consumables, drugs, nurses, administration, rent, etc.) Primary: how do you manage with the current capitation rate?
21	Fin	What do you do if you are running a deficit?
22	Fin	How do you calculate the administrative cost of your practice?
23	Quality	What kinds of patient complaints have you received? Any about waiting time? How are patient complaints handled? How do you train your staff to manage the CBHI enrollees? Have you had any concerns with this?
24	Quality	Is quality assurance the role of the MOH?

25	Structure	How could this CBHI be improved? What changes would you recommend? Do you have any ideas about how the CBHI could be financed alternatively?
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Administrative Walkthrough overview (draft) – outline of walk through focus

Department	Process	Look for
Enrollment	Eligibility determination Matching eligibility to premium Process when an enrollee drops coverage	Dates in system or manual collection that indicate initial and termination date, matching of premium to enrollee specifically (claim is not accepted if enrollee has terminated or premium not received)
Premium collection	Collection and correct financial inputting	Written standard protocols for processing premiums and methods to collect bad debts and remove enrollees from active member status
Referral Authorization	Guidelines for referral and elevating issues for Medical Director approval (if needed)	Standard protocols and guidelines for accepting a referral for reimbursement including an estimated fee schedule
Capitation approval	If and how claims are adjudicated in the system	If claims are submitted as zero billed and paid to calculate the incidence rates required to ensure correct capitation rates. If not, identify how plan calculates number and types of primary care visits.
Enrollee Satisfaction	Standard collection of enrollee satisfaction rates or wellness	TBD
Provider Satisfaction	Standard collection of annual provider satisfaction rates including quick turnaround time and capitation remuneration	TBD

Annex 6: Focus Group Discussion Results

The focus groups were divided into the three communities.

1. Isheri

GENERAL COMMENTS FROM FACILITATORS:

- Poverty is ruining their lives, so they want a reduction to 300N per family (versus 800N)
- Not a local government but a state government, so they think that the state should do it for free. Facilitators explained that this is an insurance scheme (local, community and state govt). But they still want a lower premium rate.
- Majority old and poor, saying that they don't have money to eat. The accumulation of debt (paying arrears) is a heavy burden.
- They are saying that if they re-join they have to pay accumulated back premium and this is too difficult.
- The state has a facility in Isheri that is abandoned.
- Do not see themselves as involved in the BOT, don't know anything about the system, they don't feel engaged in the process.
- The 500 free families that are subsidized by the LGA are not needy. They are political families who get favors. Though the local government says the most vulnerable are selected by the CGAs, the the Isheri and Magodo participants do not believe that this is the case. They say that the Chairman selected these families and they think they are poorer.
- Regular members there because they are families.
- Defaulters default because they are so poor that the backlog and accumulated debt is detrimental.

DEFAULTERS:

- Average age 55-60 (80% female)
- All of them joined in 2009 but can't remember the month. Most of them were members for a month and some for 3 months. All of them left due to accumulation of debt.
- (Facilitator comment) You see poverty in their eyes. They asked "Did you bring something for us, we haven't eaten today." They are more concerned about eating than healthcare.
- Some left because of the cost that 800 N is too much to afford.
- All of them like the way they are attended to at the center except for one woman who was referred because of the type of sickness (uncontrolled diabetes).
- Respondents didn't complain because they don't know where to complain, they don't know the Chairman at all. Don't know where to complain.

- Major benefits: members of the community, access to care 24 hours,
- Didn't know anything about the development of scheme or the BOT
- Don't know about the provider selection. Isheri facility (an LGA Primary clinic) is not functioning and there are no nurses, etc..This is in compared with the CBHI facility in olowora.
- When they were members didn't go often except one of the persons used to go.
- Always received receipts.
- None referred except one who was referred for hypertension.
- All believe that being a member will make a difference because of the proximity of the facility and high perceived quality.
- Would like to re-enroll and reduce premium but the issues are still there (arrears, inability to pay)
- There should be forgiveness of arrears
- Registration dates should be extended to the 10th of the month (one complained that the 7th fell on a Sunday and so the policy lapsed)
- Since leaving the plan, have been visiting private hospitals and taking drugs.
- Prefer private hospitals or herbs
- Seemed very happy want (1) reductions in premium (2) cancel backlog of premiums (3) age 60 and above should be free healthcare – it is free at the secondary care center. (age 60 and above) Notes: number of people in the catchment area that are >60 can access care, may want to create a subsidized premium payment for those in that age group (like the 500)

MEMBERS

- All the members joined the scheme since 2009
- Learned about this through political meetings
- Not all that active in the Meetings
- 55 and above (1 or 2 were older)
- She normally receives treatment at the private facility
- Isheri PHC not functioning since the Olowora mutual health project (Isheri is a public facility and olowora now used for the scheme)
- They are in Isheri there is a PHC before the establishment of the Olorowa facility. Baale has tooth pain and has to go to the doctor in Isheri and have to wait for the doctor. PHCs don't always have doctors available 24/7
- It takes them a day to register and treatment effected immediately
- Most of them covered in their household but some and include first wife and second wife and 2 grandchildren (adversely selective) (15, 9) – some were not covered
- Benefits are staff dedicated and caring, close facility, good quality services

- There is no knowledge CBHI and BOT, structure, none of the Isheri leaders are in the BOT
- Not involved in decision making
- BOT is chosen by selection not nomination
- They don't know about the provider selection
- Other facility (Isheri PHC) in the area but not functioning since CBHIS
- Have been to the Primary care and she and her husband went to the clinic
- Get drugs whenever they go to the clinic. One diabetic can't get her drugs there.
- Pay 400N for a blood test – Lab tests are not part capitation (this was prior to the new provider)
- Provider friendly want him to stay
- Some referred some not, for diabetes
- Want other benefits included like hypertension and diabetes at a primary level
- Reduction of premium to 300N
- Don't want accumulation of debt to continue
- CBHIS could be better by putting Isheri into the BOT
- Want more awareness to be made to explain the benefits and enlighten them about the benefits

2. Magodo

GENERAL COMMENTS FROM FACILITATORS:

- Want a bank in their neighborhood to pay (too far to go to pay premium)
- Don't feel representation from their political structure
- Some too old to get to the facility (how to work on transport for the most vulnerable)

NON-ENROLLEES

- Not members (n=16) men only – mixed middle aged and old and young women
- Have they heard about it, yes and 7 had not heard anything about (mostly young)
- Heard and explained what they knew – about family coming together to get insurance
- How do pay for health needs – cash on the spot
- Spend an average of 500 – 1500 every time they go to see a doctor
- Some heard about the scheme and how it operates
- Didn't know which providers are included because they are not in the system
- Know that the insurance costs about 800N per month
- See it as a good scheme for the community, but that it has to be reviewed

- Don't favor alternative financing through MFIs because they don't want anything to do with them
- Ability to pay – from the answers it's unclear if poverty is the reason not to pay. One lady said amount is too high for a single person – don't think poverty is the reason to join. Many different reasons, one said that he was initially short listed to join the plan as LGA subsidized (500 are considered to be the members). He was not ultimately selected and he felt annoyed and didn't want to join because he could have gotten it for free.
- Elderly person enjoys the elderly free care so he doesn't need to join.
- Community has a town hall where they can get free healthcare on Wednesday – provided by the CDA and they don't pay
- They have private facilities but no public facilities
- Would cost 400N to get to Olowora, so they don't want to have to travel there to pay the costs.
- Is there another health facility in the area? Go to Isheri, private hospitals, chemists and traditional healers.
- One uses holy water
- Most belong to trade associations and political parties (market women, etc.)
- There would be a difference if they were enrolled and if they were on the scheme they would get better benefits
- Believe they will get free drugs
- Premiums should be reduced
- Payment of backlogs would be great.
- Any way to restate the names of the persons removed.

MEMBERS

- All current enrollees (13) mixed 30, 40, 50 men and women
- Joined in 2008
- Heard about from father in law, community subsidization, primary healthcare facility, made an announcement
- Some joined because they place is very neat and cheap
- Before they joined went to other PHCs and private hospitals and traditional healers and chemists
- Immediate registration
- Covers all family members
- Widow who does not include all members of the household. Was given the impression that had to be immediate family. Some of them tried to put new people in the scheme and they refused because she enrolled with 3 and wanted to increase by 1.
- They allowed some to increase more but not the 500 totally subsidized families – once you select your family that is all.

- One of the 500 wants to add more members to the family now.
- What are the benefits – enjoy good attention and good quality drugs, saves time, cheap, availability of the facility
- Knowledge of the CBHI they had some knowledge of the plan in 2008. Initiative of the LGA. Made to believe that the CBHI was community driven but so far Magodo is not a member of the BOT so they are not involved in the community.
- In terms of decision making not involved and don't know how decisions. Don't know anything about the AGM (the July annual meeting).
- Not aware of any sensitization except one participant who saw a leaflet outside of the community
- Selection of providers, don't know how
- Can receive health care in the other facility in Isheri and also the free Wednesday doctor visit
- Most have been to the facility
- 4 of them have not been there but are paying members – family members go
- Only visit when ill
- Mostly used by wives and children
- Have enough drugs given to them. One individual presented with pain in hands. Doctor couldn't attend to her and she wasn't given any drugs despite the intense pain. She was told to bear the pain. (This could have been under the previous provider.)
- Initially services ok but along the line the service delivery changed. Don't have good doctors there anymore. Tests are not conducted before giving drugs. (not sure which provider)
- Cashiers not available on Sat and if not working on Sat they can't get paid on time and then have a penalty
- Good benefits
- Referrals, do refer patients especially to the general hospital
- Also complained about the services there
- Referral for hypertensive diabetic patient
- Service provider is new. Have a nickname for the doctor Baba JJ (very well liked)
- He is very patient – think he is performing well
- Complaints: don't know who to complain to but they usually complain to their political leaders. Don't know the BOT and there isn't a member there so they don't know how to complain
- Other benefits and improvements: want provision of specialty care, want a scan, they want urine tests and fecal tests. (Note: both urine and fecal tests are covered under capitation – this may have been under other provider, points to need for education on benefits)
- Wants leaders of Magodo to be part of BOT
- Discount to persons who pay regularly

- Want SMS alert to be sent to them to remind them of the expiration of the plan
- Bank should be designated instead of physical journey to Olowora
- Up to date comprehensive lists so that they don't have to bring receipts to the facility. Wanted a complaint center (or some kind of process)
- New facility – too far for them in Mogodo (would prefer to start their own scheme)
- Oissa, Unilaga state, Gateway, and Magodo instead of Olowora. Seems too far for them.
- Regular awareness of the scheme

3. Olowora (where facility is located)

PREGNANT WOMEN AT THE SITE FOR ANTE-NATAL CARE

- All enrollees and pregnant with various registrations from May 2008 to 2010. Most of them are new members (12 – 15)
- Introduced to the scheme by friends, in-laws, and neighbors
- What prompted them? Came to confirm the truth of the scheme, is it real, low cost was interesting, 2 women lost their babies to spina bifida at the private hospital and this is why they joined. Because it's free and they get their drugs.
- One woman joined because her child had sinusitis. The minute she got there she was referred to the secondary center and then came back and joined the plan.
- Before scheme, went to Rx, local herbs, some visited private hospitals
- One person joined because she is pregnant for the first and it's cheaper to have the child there – and the antenatal care is excellent
- How long to register? Not a problem
- How many benefit 2, 3, or 4, the highest is 5. Registered in the middle of the month, had to start in the beginning of next month.
- Major benefits: prompt attention by provider, no delay; availability of drugs that are free; cheap services, getting genuine drugs (original products), one said they get free treated nets, cheap antenatal services, good referral system, 24 hour doctor attention.
- How was the CBHI developed? Were they part of the process? They don't have any idea. Say that they were sensitized twice.
- Believe the doctors are Lagos State providers (note: the provider is private)
- There are lot of private and one public facility in the area. The public facility is in Isheri
- Say children and mothers use the clinic most.
- Get drugs any time but they pay just 50Naira copay (it's nothing to them)
- Satisfied with the services because they see docs 24 hours, health education
- Referral: woman brought child to the clinic, after delivery had jaundice and referred to the hospital and now back to the scheme
- The love the present provider, he listens he assures them and he shows love and he is sent by God. One woman comes from Ogun state for care.

- When they have complaints? That has not happened so far. They are satisfied with the services. They know some people complain, but not them. Do they know where to complain, etc. some said no they don't know, they are names pasted on the wall in the health facility with numbers so they can lodge their complaints. Others didn't know about that.
- Don't get receipts for copay.
- Don't know why they need the receipt it's such a small amount of money.
- Want facility to include secondary care, to get scanning and to get a surgeon.
- May not be affordable, but is affordable based on their past experience in the private sector. If there was a public facility they might go there, but there is a private facility nearby and so that's their experience. Average cost 15 – 25,000 Naira for a delivery versus (800*12 = 9,600).
- **ANNEX 7: MOU outline for Ikosi-Isheri Scheme**
- A. BOT and Provider**

Obligations of the Association	Obligations of the Service Provider
Registration of members on the Scheme	Provision of staffing
Collection of Contributions from members and on behalf of members on a monthly basis	Management of the Olowora PHC Facility including but not limited to repairs, painting, electrical supplies, cleaning, plumbing, maintenance of installed generator and solar energy systems
Receipt of premium subsidy contributions from government on a monthly basis	Maintenance of medical equipment through service agreements
Payment of Provider capitation in advance on a monthly basis	Provision of services as listed to members of the scheme without charging at point of service
Retention of administrative fee for operating the scheme	Provision reliable drug and consumable stock
Monitoring the Scheme	Invoice members for co-payment for every prescription
Receipt of Copayment fees from the service provider on a monthly basis	Receive capitation in advance on a monthly basis
Ongoing marketing and social mobilization to increase and sustain membership	Guarantee quality of care services on offer
Performance of data management and reporting functions on the scheme using	Verification membership of scheme before care

community based Health Insurance Database	
Provision of membership ID cards for registered beneficiaries	Encounter Data entry into CBHI database
Verification of scheme membership and payment status of members prior to receiving care	Institution of Facility-based Health Quality management system
Coordination of referral of members to Gbagada General hospital for secondary care	Participation in State's Health Quality Management Initiatives

B. LSMOH and Provider

Obligations of the LSMOH	Obligations of the Service Provider
Participation in Board of Trustees of Ikosi-Isheri MHA	Employment and maintenance of adequate staffing levels at the Olowora Primary Healthcare Facility as evidenced by submission of a monthly roster to the Lagos State Ministry
Provision of Technical Support to Ikosi-Isheri MHA operations	Management of the Olowora PHC facility (repairs, painting, electrical supplies, cleaning, plumbing) including but not limited to repairs, painting, electrical supplies, cleaning, plumbing, maintenance of installed generator and solar energy systems
Coordination of Referral Cases at Gbagada General Hospital	Maintenance of medical equipment through service agreements
Provision of Basic Equipment (as in list) for Olowora Primary Health Care Facility	Responsible utilization of installed solar energy system
Payment of subsidy premiums for 5,000 persons per month on Ikiso-Isheri Mutual health Plan for up to 12 months	Maintenance of log records for solar and generator use
Monitoring and Evaluation Ikosi-Isheri Mutual Health Plan	Provision of 24 hour medical services at facility
Ensures Vaccine Supply and Cold Chain maintenance in Olowora PHC	Provision of services as listed to members of the scheme without billing at point of service

Obligations of the LSMOH	Obligations of the Service Provider
Provision of LASAMBUS Ambulance Access (24 hour) for transfer of emergency cases to next level of care	Adherence to Scheme's clinical guidelines/protocols
Installation of solar power as alternative power supply	Provision of safe and reliable drugs and consumable stock as guided by Lagos State Essential Drugs List
Provision of 5.5 KVA generator for alternative power supply	Invoice members and collect N50 copayment for every prescription
	Receive capitation in advance for up to 5,000 registered members on a monthly basis
	Strict compliance with spatial designations of Olowora PHC Facility
	Guarantee quality of care and services on offer
	Submission of monthly utilization returns to MHA, LSMOH
	Encounter Data Entry into CBHI database
	New construction/remodeling of center to optimize centre capacity upon approval by state government
	Verification of membership of scheme before care
	Coordination of referral of members requiring secondary care
	Remittance of copayment fee to Ikosi-Isheri MHA on a monthly basis
	Institution of CME program for all clinical staff
	Institution of weekly Morbidity and Mortality reviews for quality purposes
	Institution of Facility-based Health Quality Management System
	Participation in State's Health Quality

Obligations of the LSMOH	Obligations of the Service Provider
	Management initiatives
	A clause that mentions conditions of payment after enrolment of more than 5,000 persons to be included

C. LSMOH and LGA (highlighted LGA obligations to be re-communicated)

Obligations of the LSMOH	Obligations of the LGA
Provision of basic medical equipment and furniture for the Olowora PHC Facility	Maintenance of facility grounds and surroundings
Rehabilitation of Olowora PHC facility and construction of MHA office through a financial contribution of N500,000	Waste management
Furnishing of Ikosi-Isheri MHA office	Ownership/Provision of the Olowora Primary Healthcare Facility
Provision of seed stock of stationery	Joint rehabilitation of the Olowora PHC facility with State Government participation to include but not limited to: Redesign of PHC Facility Construction of MHA administrative office Construction of immunization shed Painting Graveling of facility grounds
Provision of seed stock of printed official stationery	Provision of (4) nos of administrative staff from LCDA (of requisite training/educational background) for the MHA office
Installation of computer hardware (3 complete systems, 3 UPS)	Provision of two cleaners from LCDA

Obligations of the LSMOH	Obligations of the LGA
Installation of internet connectivity with one month subscription on 2 installed systems	Provision of one security guard from LCDA
Development of web-based community health insurance database	Payment of premiums for up to 500 families sponsored by LCDA amounting to N400,000 per month for up to 12 months
Provision of equipment and staff for production of ID cards for scheme members	Direct deduction of monthly premiums from LCDA State allocation
Training of MHA management team in CBHI management	Organisation and participation in social mobilization for scheme membership
Design and implementation of initial social mobilization strategy within Olowora community	Participation in Board of Trustee membership
Organisation of periodic stakeholders meetings between different partners (State Government, Local Government, Mutual Health Association, Service Provider)	<i>Provision of electricity (mains) supply for Olowora PHC facility</i>
Implementation of quality management systems for the CBHI	<i>Provision of water supply for Olowora PHC facility</i>
Installation of Solar Power System (alternative power supply)	
Provision of 5.5 kva generator	
Access to LASAMBUS ambulances on demand for transfer of emergency referrals to next level of care	
Reservations of the rights to policy, technical control of the project	
Facility medical Waste Management Coordination	
Participation in Board of trustee membership	

ANNEX 8: Ikosi Isheri revenue spreadsheets and membership growth

	Estimated May 2011	Year 1 Average monthly target	Year 2 Average monthly target	Year 3 Average monthly target	
Revenue					
Community		20% growth	20% growth	20% growth	
Families (Members)	300	360	432	518	
# enrollees	1,800	2,160	2,592	3,110	
Average Premium	800	800	800	800	
SUBSIDIZED Premium	1,120	1,120	1,120	1,120	
Total premium	1,920	1,920	1,920	1,920	
<i>SUBTOTAL Community Premium</i>	<i>576,000</i>	<i>691,200</i>	<i>829,440</i>	<i>995,328</i>	
LG 100% Subsidized					
Families (Members)	500	500	500	500	
# of enrollees	3,000	3,000	3,000	3,000	
SUBSIDIZED Premium	1,920	1,920	1,920	1,920	
<i>SUBTOTAL LG 500</i>	<i>960,000</i>	<i>960,000</i>	<i>960,000</i>	<i>960,000</i>	
Individual		10% growth	10% growth	10% growth	
Members	200	220	242	266	
Premium	400	400	400	400	
SUBSIDIZED Premium					
Total premium	400	400	400	400	
Total enrollees	5,000	5,380	5,834	6,377	
<i>SUBTOTAL Individual Premium</i>	<i>160,000</i>	<i>160,000</i>	<i>160,000</i>	<i>160,000</i>	
Total premium received	1,696,000	1,811,200	1,949,440	2,115,328	
Emergency Room		10% increase	10% increase	10% increase	
# of visits	158	174	191	210	
Avg cost/stay	500	500	500	500	
Total received	79,000	86,900	95,590	105,149	
Copayments					
# of visits	1,500	1,650	1,815	1,997	
Copayment	20	20	20	20	
Total received	30,000	33,000	36,300	39,930	
<i>(Note 40% of copayments are given to MHA, but actuarial report says 100% of these copayments are given to the MHA, therefore they are excluded as revenue as they appear to be refunded to the LG)</i>					
TOTAL REVENUE	1,775,000	1,898,100	2,045,030	2,220,477	

Expenses				
			<i>Current provider performing activity based analysis to determine adequacy of capitation; Actuarial study suggested it should be 385.17</i>	
Provider Capitation	320	320	320	320
Total Families	800	860	932	1,018
Average number of enrollees per family				
	6 #	6	6	6
Total family enrollees	4,800	5,160	5,592	6,110
Total individual	200	220	242	266
Total enrollees	5,000	5,380	5,834	6,377
CAPITATION RATE PAID TO 5,000 MEMBERS, INCREMENTAL INCREASE > 5,000 (20% OF CAPITATION RATE)				
Capitation paid for 5,000 members	1,600,000	1,600,000	1,600,000	1,600,000
Additional 20% of capitation paid for members above 5,000				
Enrollees > 5,000	-	380	834	1,377
20% of 320 capitation	-	24,320	53,376	88,102
Total capitation paid	1,600,000	1,624,320	1,653,376	1,688,102
MHA staff capitation	30	30	30	30
Capitation paid for 5,000 members	150,000	150,000	150,000	150,000
20% of 30 capitation	-	2,280	5,004	8,260
Total MHA paid	150,000	152,280	155,004	158,260
Electricity	75,000	75,000	75,000	75,000
Water	100,000	100,000	100,000	100,000
Subtotal running expenses	175,000	175,000	175,000	175,000
Total Expenses	1,925,000	1,951,600	1,983,380	2,021,362
Profit (Loss)	(150,000)	(53,500)	61,650	199,115

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