MD/CEO's ADRESS AT THE DEFENCE HEALTH MAINTENANCE LIMITED STAKEHOLDERS MEETING WITH MILITARY HEALTH CARE PROVIDERS

1. I formally welcome you all, the Commanders, and heads of military Health Care Providers to this crucial Stakeholders Meeting. For me to have summoned you all to Abuja from all over the country at this time, despite the security challenges in the country underscores the urgency and importance attached to this meeting. The Military healthcare system is a large and complex one and health insurance has come to stay as a major feature in this healthcare system.

2. Any institution or establishment without a mechanism for introspection is inviting failure. Periodic introspection or review enables flaws to be identified early enough and workable solutions proffered before such flaws destroy the establishment. In this case, all of us here today are the main elements of a great establishment, the military healthcare delivery establishment. Our collaborative effort is at the heart of the healthcare delivery to the serving and retired military personnel, their families, and other dependants. Our goal and objectives are mutual. Therefore, for sustainability, there is

need for periodic introspection and review of the system in the form of stakeholders' meetings for the early detection and rectification of fault lines capable of undermining the system. This underscores the importance of this gathering.

3. During our deliberations here today, we shall examine the elements of the HMO system of NHIS currently in operation in Nigeria. We shall also discuss some of DHML's observations as regards compliance with NHIS Guidelines in the preparations and submission of Bills and Claims by HCPs and proffer solutions. This brings me to the Aim of this Presentation.

AIM

The Aim of this Presentation is to discuss operations of NHIS in the military Secondary/Tertiary Health Care hospitals with a view to making recommendations.

SCOPE

The Scope items will cover the following:

a. Essence of the HMO System of Health Insurance.
b. Sundry Observations on operations of NHIS by Secondary/Tertiary Military HCPs.
c. The Way Forward.

THE ESSENCE OF THE HEALTH MAINTENANCEORGANIZATION SYSTEM

4. Following the establishment of the NHIS Act (2004) by the Federal Government of Nigeria, the Scheme settled for the instrumentality of the Health Maintenance Organization (HMO) system in carrying out its mandate of providing easy access to healthcare for all Nigerians. Accordingly, the military, as one of the earliest institutions to benefit from health insurance, established Defence Health Maintenance Limited (DHML) as the HMO for the military in 2005. In its 16 years of existence, DHML has remained one of the leading HMOs in Nigeria and health insurance in the military has become a benchmark for other institutions. A case in point is that of Nigeria Police HMO which came here to understudy DHML before establishing its HMO.

5. However, to continue to operate successfully and to sustain health insurance in the military, we need to remind ourselves of the tenets of the HMO system. The HMO system operates on 3 cardinal foundations. These are accurate capture of eligible enrollees, fidelity in the Bills and Claims system and prompt disbursement of funds by the HMOs. Let us take a look at each.

a. **Accurate Capture of Eligible Enrollees**. One of the major mechanisms that enable successful HMO-based health insurance

system is accurate register of eligible enrollees. This is because capitations are calculated based on the number of registered enrollees. Where the system is abused and ineligible persons are registered, the result is a failure of the system as these illegal entries who are not capitated do not contribute anything to the system they are benefiting from. Consequently, HCPs must scrupulously ensure that only eligible persons access care on the Scheme. HCPs must also resist registration of overaged children (>18years), added/additional wives, friends, parents, extra children and so on to access care under the Capitation element of the Scheme. Such practices are not only illegal but could lead to collapse of the HMO system. Consequently, it is now mandatory that military HCPs open Family Medical Records Files for all enrollees and their dependants, with evident proof of relationship. This should commence immediately as persons not captured in such family files may not be able to access care under the Scheme as from 01 April 2022.

b. **Fidelity in the Bills and Claims System**.The operation of the HMO system depends heavily on the payment of Capitations for Primary Care and the settlement of Fee-for-Service bills for Secondary/Tertiary Care of eligible enrollees by the HCPs. However, submission of such FFS claims must be in line with the extant NHIS Guidelines. In both cases, absolute transparency of the HCPs is the key. In situations where the bulk of the Capitations paid to HCPs for Primary

Care of enrollees is diverted to serve purposes other than the provision of Primary Healthcare, the access of eligible enrollees to quality healthcare is adversely affected. Similarly, as regards FFS claims, unwholesome practices have been observed in some HCPs. Under such circumstances, the integrity and sustainability of the system are at stake. FFS Claims must follow the NHIS Guidelines, must be defensible and must be professionally prepared. To further strengthen the FFS Claims system, DHML has now developed a specialized interactive software to make the process of such claims more seamless. This system, currently being test run, would be deployed in the First Quarter of 2022 and it is expected to substantially reduce the many deficiencies observed in the current FFS Claims system. To adequately key into the new system, all HCPs are enjoined to acquire computer / internet device as contained in the NHIS Guideline for accreditation of HCPs and appropriately train manpower in computer operations to be able to work with the specialized software when deployed in 2022.

c. **Prompt Disbursement of Funds by the HMOs**. The strength of any health insurance system is the pooling of funds for healthcare needs. The pooled funds may be disbursed as Capitation or FFS Claims settlement. Timely release of

Capitations and prompt settlements of FFS are very important to the system. DHML has to a large extent exceeded expectations on both fronts, being very prompt in payment of Capitations as released from the NHIS HQtrs and FFS claims after due processing. Apparent delays when observed are usually either due to late release of funds from the NHIS or to late submission of bills by the HCPs. DHML has this policy of settling bills within 4 weeks of submission.

SUNDARY OBSERVATIONS ON THE OPERATIONS OF OUR PARTNER HCPs.

4. As earlier noted, the most successful segment of the Nigerian health insurance has been the military. However, constant review of the operations of the Scheme remains vital to sustain the system. Over the years, DHML has catalogued some unwholesome practices on the part of HCPs that are inimical to a sustainable system. I wish to highlight some of these practices so that we can properly address the issues involved.

a. **Abuse of Dental Care**. I choose to start with some of the troubling observations on dental care as it is the most recent to creep in. There is this pattern of unnecessary procedures for majority of the patients attending Dental Clinics. In a certain Dental Clinic, about 70 per cent of patients

attending this Clinic had a novel kind of scaling procedure done. Furthermore, this procedure was claimed to have been performed on more than 70 per cent of the patients' teeth. Consequently, FSS claims for each of such patient came to an average of N60,000 on dental cases alone (some as high as N90,000). This is not sustainable and defeats the purpose of health insurance.

b. **Abuse of Ophthalmic Care**. Closely following dental cases are indefensible claims from Ophthalmic Units. The pattern observed is that almost all patients visiting the Eye Clinics in most HCPs are apparently subjected to barrage of procedures. Patient coming in with ostensible refractive errors are subjected to a battery of procedures, resulting in huge FFS bills. The argument could be made that such unwarranted procedures may pick up something. However, lets draw an analogy thus, if a patient presents in the GOPD with fever, do we do an MRI of the brain on such a patient with the argument that it may be meningitis or encephalitis? The saying that 'common things occur commonly' remains a valid and fundamental medical philosophy. Conducting a battery of unnecessary tests on all patients because these are listed in the NHIS Guidelines is not in line with the tenets of health insurance. It is professionally dishonest and unethical to

conduct unnecessary procedures on patients just to extract money from the HMO. I urge you all as professional heads of your facilities to ensure that all such unprofessional and inimical practices are done away with.

c. **Charging of Primary Care as Fee-for-Service**. Fee-for-Service is strictly for Secondary/Specialist Care which have been duly referred with Authorization Codes from the HMO. Primary care is exclusively covered by Capitation. Some HCPs are in the habit of charging conditions which ought to have been covered under Primary Care to FFS. Examples of these are antenatal care, and primary laboratory tests amongst others. If unchecked, this practice can weaken the system.

d. Military Specialists charging for Specialist Care in a Military HCP should know that such charges are to be paid into the hospital account and not to the specialist doctor concerned.

e. **Incomplete Documentations of Claims**. It has been noted that many HCPs submit claims without the necessary supporting documents. Drawing from the NHIS Guidelines, this is totally unacceptable. It should be noted that medical claims are legal instruments. A claim without valid supporting documents might amount to forgery and may be treated as

such. Over the years, DHML has bent over backwards to accommodate the lapses of military HCPs and pay for such unsubstantiated claims. Furthermore, HCPs not accredited often submitted claims which have been paid in the past. Henceforth, only claims with valid and complete supporting documents from fully accredited HCPs will be treated.

f. **Poor Medical Records**. Closely related to incomplete documentation is the issue of poor medical records. This is very unprofessional. Several cases of bills were sent without the necessary biometric records of the patients, such as full names, age, sex, date of treatment. In other instances, prescription sheets are not signed by the doctor. Henceforth, such bills will be returned unprocessed to the HCPs.

g. **Polypharmacy**. Polypharmacy is another evolving, very worrisome trend, among our healthcare practitioners. It is a practice that has the potential to undermine the health insurance system if unchecked. Commanders/Commanding Officers are hereby enjoined to check this trend by impressing on their medical officers the need to be professional and prudent in the prescription of drugs.

h. **Essential Drugs List**. There is an Essential Drugs List as issued by the NHIS. The essence of this list is to

prioritize the needed drugs that can comfortably be accommodated under the health insurance system. Commanders/Commanding Officers are enjoined to ensure that prescription pattern from their units take cognizant of this fact. However, where necessary, prescription may go outside the NHIS Essential Drug List. This should be an exception rather than the rule.

i. **<u>Out-Of-Stock Syndrome</u>**. This is another sore point in the operations of the NHIS in most of the military healthcare facilities. In some instances, patients are given list of drugs to go and buy outside the hospital. Feedback from enrollees during the last Annual Monitoring and Evaluation Exercise confirmed this. This practice defeats the essence of the Scheme. To avoid out-of-stock-syndrome, HCPs should make deliberate efforts at establishing a very good understanding with reputable pharmacies for the supply drugs to their facilities. If properly handled this could help address the issue of out-of-stock-syndrome.

j. **<u>Poorly Prepared Encounter Data</u>**. The periodic enrollee Encounter Data is an important but often overlooked document. Some HCPs do not accord to the document the necessary due diligence. This has resulted in situations where doubtful, inaccurate, and incomplete Encounter Data Sheets

are submitted. Ambiguous and ridiculous entries such as toothache in a 2-month-old baby have been submitted in the past. Please note that the Encounter Data sheets are a veritable tool for necessary documentation and research. They are also submitted to the NHIS periodically.

k. **Enrollee Registration Malpractices**. As earlier mentioned, one of the major pillars of health insurance through the HMO system is accurate register of eligible enrollees. Capitation is based on the number of eligible enrollees, therefore if ineligible persons are captured on the enrollee register, the system is undermined. It is important for HCPs to ensure that only eligible persons (the Service Personnel, One spouse and 4 biological children below the age of 18) access care under the Scheme. There are other NHIS Programmes that accommodate additional spouses and overaged children of Service Personnel and retirees. Enrollees should be enlightened on such Programmes. DHML has documented cases of service personnel attempting (in some cases, even succeeding) in using grandchildren, children of other relations, girlfriends, and relatives as legitimate enrollees under the Scheme. A serving personnel was once noted to have attempted to register his parents on the health insurance scheme in a major HCP.

l. **Frequent Change of HCP NHIS Account Name**.

All HCPs receiving regular funds disbursement must have dedicated accounts for such funds. While there may be changes in the person of the Commander/Commander Officer of such units (i.e. signatories to the accounts), the account names are expected to remain unchanged. Communications to DHML notifying it of changes in accounts details of HCPs are commonplace. This will no longer be tolerated except such directives come from the Services HQtrs.

m. **Improper Channel of Referral.** It has been observed that some HCPs refer service personnel and their families to civilian or private facilities for secondary care where such care are available in nearby military healthcare facilities. NHIS Guidelines frowns at this. Such cases are better referred to military secondary HCPs as a first choice except where military secondary HCPs are not available.

n. **Vibrant NHIS Standing Committees in the HCPs**.

The institution of functional NHIS Committees in every HCP is a neglected but very vital pillar in the success of health insurance operations, using the HMO system. The Committees

exist to ensure prudence in the utilization of funds disbursed to HCPs, especially, Capitation. Where NHIS Committees are not in place, not properly constituted nor given the necessary freedom to operate, funds disbursed for healthcare of eligible enrollees are likely to be misappropriated. Utilization of Capitation for purposes other than healthcare of eligible enrollees amounts to misappropriation of the funds and must be resisted. Simply put, it is illegal, many unfortunate situations where large chunks of these funds go into ancillary expenditure, not directly related to patient care is commonplace. Such situations could be checked by the presence of functional NHIS committees. For transparency, the Committees should be headed by healthcare professionals other than the Commanders/Commanding Officers of healthcare facilities. Remember the approving authority in this instance remains the Commander or the Head of the medical unit.

WAY FORWARD

5. To preserve the health insurance system in the military, collective efforts on the part of all stakeholders is required. Therefore, the following are recommended:

1. Professional heads of all military HCPs are urged to immediately resolve to work to sustain the military health insurance system.

2. HCPs should ensure that only eligible enrollees (principal and dependants) access care under the scheme. Consequently, the need to open Family Files for enrollees has become mandatory.

3. HCPs should ensure that Capitation is used mainly for the provision of primary healthcare for which it is provided.

4. HCPs should ensure that Fee-for-Service claims are professionally prepared and must be justified with relevant documents.

5. Charges for specialist care by military specialist should be paid into HCP designated account.

6. HCPs should ensure the immediate composition of standing, full and functional NHIS Committees.

7. While strict adherence to NHIS Guidelines at all times is the ultimate, efforts should be made not to abuse same as observed in dental and ophthalmic care.

8. Polypharmacy – Considerations for judicious prescribing habits must be embraced by HCPs at all times to stem the tides for polypharmacy.

9. HCPs should have a good working relationship with reputable pharmacies to avoid Out-of-Stock Syndrome.

10. Commanders are enjoined to work closely with NHIS Essential Drug List.

11. Change of HCP NHIS account details must have approval from the Services headquarters before it can be effected.

12. First-line referral from military PHCP must be to the nearest military SHCP.

13. Strict adherence to NHIS Guidelines at all times.

December

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