

# A Review of Community-Based Health Insurance Schemes

Lessons from Nigeria and Ghana

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## List of Acronyms

BHCPF	Basic Health Care Provision Fund
BOT	Board of trustees
CA	Christian Aid
CBHIS	Community Base Health Insurance Scheme
CBOs	Community Based Organizations
CHIS	Community health insurance scheme
CSOs	Civil Society Organizations
CMH	Commission on Macroeconomics and Health
FBOs	Faith Based organizations
FMoH	Federal Ministry of Health
HMOs	Healthcare Maintenance Organizations
LGA	Local Government Area
LGHD	Local Government Health Department
MHA	Mutual Health Association
NAPEP	National Poverty Eradication Programme
NGOs	Non-Governmental Organizations
NHIS	National Health Insurance Scheme
NPHCDA	National Primary Health Care Development Agency
OOP	Out-of-Pocket
PHC	Primary Health Care
SES	Socio-Economic Status
SMoH	State Ministry of Health
UHC	Universal Health Coverage
WHO	World Health Organization

## Project Description

EpiAFRIC was commissioned by Christian Aid to conduct a scoping study to examine the feasibility of rolling out or supporting the roll out of a community health insurance scheme.

Specifically, the mandate given to EpiAFRIC were to do the following:

- i) Review policy documents for rural community health insurance schemes in Nigeria to establish the level of political support for such a programme in Nigeria.
- ii) Review emerging best practice in rural community health insurance programmes in Nigeria and selected African countries, using Ghana as a case study
- iii) Interact with key stakeholders/participants (community members, local partners, finance institutions, Health Management Organisations, Government Agencies and departments) at various levels and document their perception, interest, potential barriers and opportunities for the establishment of rural community health insurance.
- iv) Advise Christian Aid on the feasibility of supporting a rural community health insurance and the requirements to do this.

## Background

An overwhelming volume of evidence shows a direct link between health risks and poverty (Carrin, 2003; National Health Insurance Scheme, 2009; Onwujekwe et al., 2009). Exposure to health risks can lead to poverty due to catastrophic spending (Chuma & Maina, 2012; Odeyemi, 2014), poverty in turn, can predispose a household to health risks; which can further aggravate their socio-economic status through decreased productivity and high out-of-pocket (OOP) healthcare costs (Doorslaer & et.al., 2007). It has therefore become clearer that Nigeria can only reap the full benefits of her economic growth when improvement in its health sector becomes evident (WHO, Macroeconomics, & Health, 2003).

Since the right to health is fundamental to all humans and cannot be separated from socioeconomic development, addressing poor health outcomes is a priority for enhancing the lives of the Nigerian people. This is why the recommendations offered by the Commission on Macroeconomics and Health (CMH) to emerging economies like Nigeria, include developing a plan for providing universal health access for their people (WHO, Macroeconomics, & Health, 2000). This links to the concept of Universal Health Coverage (UHC), a movement adopted by many nations of the world including Nigeria. The goal of UHC as backed by the WHO is to eliminate the financial difficulty associated with obtaining the necessary health services that ensure the wellbeing and productivity of a society. Mechanisms that offer health security through risk pooling like a Community Based Health Insurance Scheme (CBHIS) is one possible tool in achieving universal health coverage.

The decentralized nature of health services in Nigeria is fraught with various challenges, hampering efforts towards universal health coverage. While the National Health Policy delineates responsibility between the three tiers of government (the federal level is responsible for tertiary services, states for secondary services, and LGAs for primary services (PATHS2 Technical Brief)), this is not explicitly dealt with by the constitution. It is envisaged that if the National Health Bill becomes law, a federal annual grant of not less than 1% of its consolidated revenue fund would provide finances for the proposed "Basic Health Care Provision Fund (BHCPF)". The bill proposes that that 50% of the BHCPF shall be used for the provision of basic minimum package of health services to citizens, in eligible primary/or secondary health care facilities through the National Health Insurance Scheme (National Health Bill, Harmonised Senate and House).

Christian Aid works in Nigeria to improve the health of poor and marginalised people, particularly women, children and people with compromised immunity ([www.christianaid.org.uk/nigeria](http://www.christianaid.org.uk/nigeria)). With their partners, they seek to strengthen community-based health systems to increase the accessibility, affordability and quality of public and private healthcare. Christian Aid seeks to enable community members to understand and adopt health-seeking behaviour. It works to increase the accountability of duty bearers and the involvement of rights holders in health policy formulation, budget allocation and oversight of primary healthcare facilities in line with national policy. Christian Aid also puts pressure on government to increase its spending on healthcare and regulate the private health sector. The premise of this assessment is that a CBHIS may be a means to achieve these objectives.

Based on findings from the review of the National Health Insurance Scheme (NHIS) policy and other related documents on CBHIS, this paper will focus on describing the CBHIS model for healthcare financing. We will begin with a presentation of the evolution of health financing up to the birth of the CBHIS model in Nigeria. This is followed by a discussion on the viability of the CBHIS as a mechanism for achieving UHC and the legal framework under which it operates in Nigeria. Based on a combination of investigative review visits and documented literature, we will present a description of existing schemes. This will include selected health insurance schemes in Kwara State, the Federal Capital Territory (FCT) and in Ghana. We will also discuss the healthcare context in Plateau State based on findings from an investigative visit which examined the feasibility of introducing the CBHIS model in the state. The key output from this review is the development of a set of recommendations for Christian Aid as a potential donor on the establishment of a CBHIS in Plateau State.

## Methods

### Literature and document reviews and examination of legal framework

A literature search of Google Scholar and PubMed was conducted using the search string (“community-based health insurance scheme” OR “universal healthcare” OR “healthcare financing in rural or poor communities”) AND (Nigeria OR “Sub-Saharan Africa” OR Africa NOT Asia). Reports, policy reviews, studies or discussion papers that presented information on existing or previously existing CBHIS were included. Papers that describe mechanisms for financing health insurance schemes in resource poor settings were also included. We also conducted an examination of key documents, which present the legal framework for CBHIS in selected African countries including Nigeria, from official government websites or in hard copy from NHIS headquarters in Abuja Nigeria. We also searched the official website of the World Health Organization (WHO) for information especially on UHC.

### Stakeholder interviews

Interviews were conducted with stakeholders of both existing and proposed CBHIS including representatives of local PHCs and Healthcare Maintenance Organizations (HMOs) and community members. Additional interviews with key stakeholders from both Federal and State NHIS personnel and State government officials were conducted. Most interviews were semi-formal<sup>1</sup> and in person. However, two of the interviews conducted with potential CBHIS members and a healthcare provider both in Gamankai Langtang South LGA, Plateau state, was in form of a conference call. This was due to the difficult terrain and the poor road connection to Gamankai during the rainy season.

### Investigative Site visits to successful CBHIS locations

Three CBHIS providers in Nigeria and the NHIS in Ghana were visited for this exercise. In Nigeria, CBHIS providers of the pilot scheme in FCT and the scheme in Kwara State were visited. Finally, we visited Ghana and interviewed key health insurance providers within the National Health Insurance Authority, private health insurance and community groups that hold government accountable for social services.

We will attempt to describe operational schemes in Nigeria and Ghana. The attached appendices present a detailed presentation of the three selected CBHIS respectively. In an attempt to learn from old and new schemes in the region and to keep a narrow focus, the CBHIS in Kwara and the pilots in FCT, Nigeria and the NHIS in Ghana were selected as case studies. The findings are from investigative site visits and literature review where applicable. We will attempt to give a clear picture of the operational similarities and differences of a CBHIS in the region.

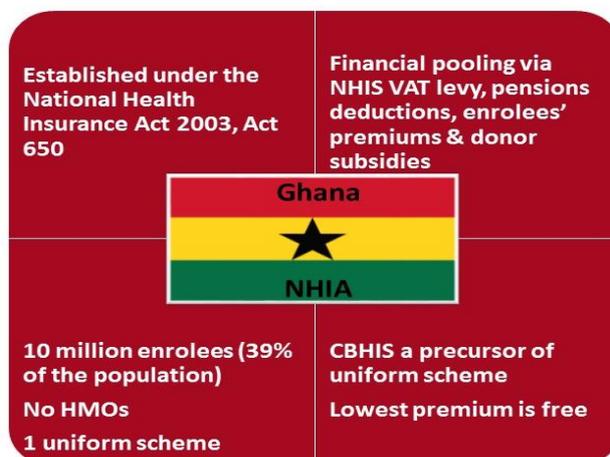
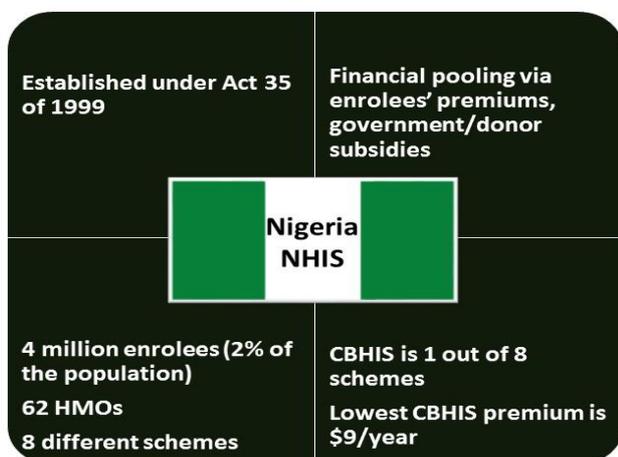
## Findings

### Policy framework

Achieving UHC is the stated goal of the Nigerian Government (WHO & Nigeria, March, 2014). Achieving UHC in resource-poor settings requires mechanisms to ensure that members of a society maintain high quality health status. Keeping productivity high and avoiding poverty due to out-of-pocket (OOP) healthcare expenditure are key outcomes of UHC. The Nigerian government identified National Health Insurance as its primary mode for achieving UHC (WHO & Nigeria, March, 2014) The government signed the NHIS into law in 1999. It took another six years before it made an operational debut in 2005. According to the operational guidelines of the NHIS, all informal workers and rural members of the Nigerian population are the target population for CBHIS (National Health Insurance Scheme, 2005).

The NHIS policy states that the target groups for participation in non-profit social health insurance via the CBHIS model are the informally employed and rural communities. Any community that intends to establish such a scheme through the NHIS must follow steps laid out in the NHIS operational policy. First, they must form and register a mutual health association (MHA) with an associated bank account. Membership to such an association is voluntary and agreed contributions are made by each member (individual or household). Contributing enrolees are to elect a representative board of trustees (BOT) to manage the scheme. The NHIS operational policy stipulates details such that the BOT is to be made up of seven members who include the Chairman, Treasurer, Secretary and four other members. The BOT has executive powers and the responsibility of collecting the contributions, paying the healthcare providers and opening and operating an NHIS accredited bank account. The NHIS has been directly involved in the establishment of some CBHISs in Nigeria.

*Insight 1: The policy frame-work for CBHIS is laid out in the NHIS operational manual (Appendix). The role of NHIS in CBHIS for Nigeria is one of both a regulator and an implementer and, at the moment, there are significant gaps in both roles. Its “regulatory” powers are not clear and there are no obvious examples where it has insisted that CBHIS schemes are managed as they have stipulated. In other cases, they have tried to directly implement CBHIS schemes, but none of these have been sustained over time. At the moment, there is presidential directive to the NHIS to increase the population covered by health insurance; so the NHIS is encouraging any organisation seeking to establish a CBHIS as it contributes to the achievement of this target.*



## Health Sector Funding

The execution of UHC cannot be achieved without addressing how it will be financed. One of the healthcare financing recommendation for UHC within the context of a country is increased budgetary allocation for health by the government (WHO, 2010). With budgetary allocation significantly below the recommended 10 to 15% allocation for health in Nigeria (National Health Insurance Scheme, 2005), it became imperative to consider additional strategies for financing UHC.

Healthcare financing in Nigeria is a mixed bag of funding methods. The Nigerian public healthcare system is decentralized. The Federal Ministry of Health (FMOH) is at the top of the system followed by the State Ministry of Health (SMOH) and the Local Government Health Department (LGHD). The SMOH and LGHD operate, own and manage the primary healthcare facilities, which are the major points of healthcare delivery for most of the rural and poor population. In addition, there is the National Primary Health Care Development Agency (NPHCDA), a semi-autonomous agency under the Federal Ministry of Health charged with the responsibility of ensuring adequate primary care services for all Nigerians (<http://www.nphcda.org/>). Its mandate is to promote the implementation of high quality and sustainable primary healthcare for all through resource mobilization, partnership, collaboration, development of community based systems and functional infrastructure.

Although allocations are inadequate, tax revenue (which mainly comes from gas and oil sale) generated at all three levels are a source of funding for healthcare. Other sources of healthcare financing include donor funding, which accounts for about 4% of national healthcare spending, and (out-of-pocket) OOP, which accounts for more than two thirds of healthcare financing in Nigeria (Olakunde, 2012). In response to a need to reform Nigeria's healthcare system, infrastructure and improve access to healthcare, the Nigerian government signed the NHIS into law in 1999. As mentioned earlier, operations began in 2005 but only about 2% of the Nigerian population have enrolled as at 2014 (National Health Insurance Scheme, 2005; Odeyemi, 2014).

*Insight 2: It has generally been accepted that a tax-funded model with co-payments is an inefficient and impractical way of funding healthcare in Nigeria. The fragmented federal structure and the lack of clear delineation of responsibilities across the different tiers of government make the situation worse. Both the financial resources available and the assignment of responsibility will be improved when the new National Health Bill is signed into law. However, it will still not solve the challenge of how to create ownership in a tax funded model. The "ownership" created by a CBHIS, as demonstrated by those that we visited makes it an appealing model for financing healthcare in Nigeria.*

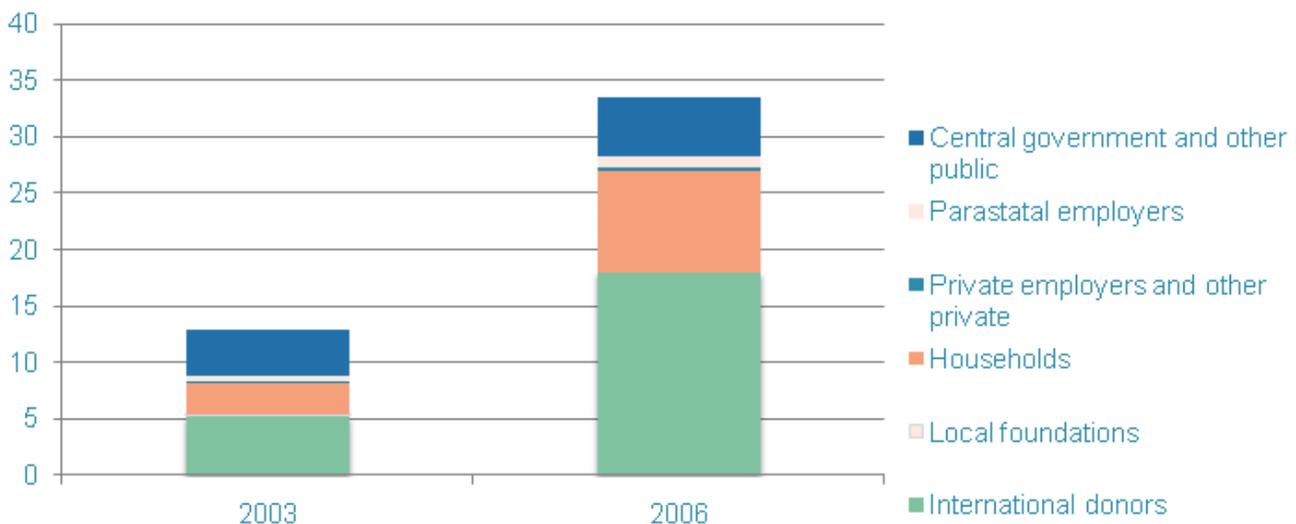
## CBHIS Funding

CBHIS can be described as a mechanism where households in a defined geographic area with varying demographic characteristics finance the costs associated with health services for their community and as such are involved in the management of the scheme and the organization of the healthcare services (Carrin, 2003). The Nigerian government and its partners at a conference in Tinapa in 2011 acknowledged the viability of CBHIS in improving the health security of a large percentage of the county's population. Thus it is one recognized mechanism within the NHIS through which the informally employed and rural members of the population can obtain healthcare coverage (National Health Insurance Scheme, 2005, 2009). In addition, evidence shows that, to a large extent, CBHIS has been a successful model for achieving UHC in some regions of Nigeria and other parts of sub-Saharan Africa (Carrin, 2003; Odeyemi, 2014; Onwujekwe, et al., 2009)

A major element of CBHIS funding is generating revenue. This is usually specific to the relevant population for which the CBHIS will be established. Their level of poverty and the value they attach to healthcare coverage significantly influences their participation and the amount of revenue generated. The major questions that need answering prior to launching a CBHIS is what percentage of the funding do the beneficiaries cover (in

the form of premiums) and who is responsible for the remaining percentage (in the form of subsidies)? There is no documented formula for establishing this. However, existing CBHIS have shed light on factors that influence the beneficiary-donor funding proportion balanced with raising adequate and sustainable revenue. The Rwandan Mutuelles, created after the genocide in an attempt to decrease out of pocket fees and catastrophic health spending, is an example of a successful CBHIS. The Mutuelles has enrolled about 90% of the defined population (Lu et al., 2012). Approximately 50% of Mutuelles funding is comprised of annual member premiums, while the remaining half is obtained through transfers from other insurance funds, charitable organizations, nongovernmental organizations, development partners, and the government of Rwanda (Joint Learning Network, 2008). In view of its success, the Mutuelles suggests that a sustainable and “equitable” premium is influenced by the presence of funding from the government and donors. In Nigeria, out of pocket expenditure (OOP) accounts for 69%, government accounts 24% and development partners less than 4% of total health expenditure (PATHS2 Policy Brief). Potentially the huge portion of total health expenditure accounted for by OOP could be channelled into CBHIS.

**Figure I: Rwanda Health Financing Sources, 2003 and 2006**  
US \$ per capita



Source: Rwanda 2003 and 2006 National Health Accounts; Lane, 2009

Source: <http://programs.jointlearningnetwork.org/programs/compare/funding/127>

This is critical at the point of establishing a CBHIS. This is because, in most cases, community participation is initially low due to the minimal value attached to the scheme and consequently low willingness to pay (Onwujekwe, Okereke, et al., 2010). Studies conducted in southeast Nigeria showed that belonging to a rural or an urban population and socio-economic status (SES) had a significant impact on willingness to pay (Onwujekwe, Okereke, et al., 2010; Onwujekwe et al., 2011). Members of lower SES and of a rural population were less “willing to pay” any or significant premiums compared to urban populations with higher SES. Thus, a significantly high involvement by donors and the government through subsidies and the inclusion of payment exemptions offered to populations in the lowest poverty quartile is essential for setting a sustainable and equitable beneficiary-donor funding proportion. Such donor contributions are subject to revision as donors exit gradually while government and beneficiaries take on more responsibility for generating the revenue for the CBHIS. This is evident in the Mutuelles, where household premium was within the range of 4.72 and 20.83 US dollars per household at inception and before 2007 but has decreased and stabilized to only about 1.18 US dollars per household since 2007 (lu, et al., 2012).

The financial pooling, which provides the revenue is a combination of the membership premiums and subsidies. Subsidies are provided either by the government or third party donors or from both. In all the three CBHIS that we visited, there were partnerships with one or more arms of the government thus stressing the need for government involvement in achieving success. In the schemes in Nigeria, the purchase of the primary care services is covered through capitation while the secondary and tertiary services are covered with a negotiated fee-for-service model.

*Insight 3: Funding is a major challenge for CBHIS generally and is a specific challenge in Nigeria. Even in the fairly successful schemes, the level of subsidisation by government and donors is very high (up to 95% in Kwara). The risky inherent assumption is that government will continually be able to provide this level of subsidy. In addition, people generally lack confidence in “insurance” based models as there are no obvious examples where this has worked in other sectors. The contribution and contributors to the financial pool needs to be modelled and agreed for the short and long term. Increasing premiums from a very low base is difficult, as being experienced by the Kwara programme. The availability of government/donor support also needs to be assured for an agreed length of time, otherwise there is significant reputational risk in not being able to continue when start-up funds are exhausted.*

## Community Selection

For the most part, when implementing this model, a CBHIS caters to a settlement of people organised as a community. Geographical delineation is the commonest factor used for defining a community in the schemes we examined. The scheme visited in Kwara was in Afon, a community in central Kwara, and the scheme is now being scaled up to cover the entire state. One of the schemes visited in Ghana started as a CBHIS in Dodowa within Dagme West District. The pilot in the FCT covers rural communities within the FCT. Another variable used for delineation is type of residency (rural or urban) of the community. In Plateau State, the HMO proposes using professional associations as community groups. For instance, the “Keke NAPEP” riders have a functional membership association and could be registered as a mutual health association. That way, it is easy to pool thousands of people to meet the NHIS requirement on numbers of people in a community. In all the schemes that we visited, on-going community mobilization was critical for the long-term sustainability of the schemes, as they needed continuous reminders of benefits of investing in a CBHIS compared to all the other demands on family funds.

*Insight 4: It is critical to define a beneficiary community and engage with this community in-depth. A natural community is easier to manage than a community entirely defined by socio-economic circumstances or political boundaries. It is critical that they understand CBHIS as an “insurance” scheme for health where they are active participants and the value it brings. It is critical that they do not perceive this to be a model for “free” healthcare. It is also critical that they understand that even if they are paying a subsidized amount, someone else is paying the rest.*

## Enrolment

Participation in a CBHIS is voluntary, which is based on the sharing of health risks of all enrollees known as risk pooling. However, this “voluntary” characteristic of CBHISs introduces the pitfall of adverse selection. This is the phenomenon where a higher proportion of those enrolling for the scheme have higher health risks (Cutler & Zeckhauser, 2000). In other words, there is a poor mix of individuals with low and high health risks. This is also an outcome of having a small risk pool. Existing CBHIS have included enrolment clauses that attempt to limit the effects of adverse selection. One of such techniques is the inclusion of a wait period to curtail people from enrolling only at the onset of illness. Mutuelles, the Rwandan CBHIS model implements a one month wait period, (Lu et al., 2012; Shimeles, 2012) and in the Ugandan model, a three month wait period is observed by enrollees before they gain access to healthcare services (Basaza, Criel, & Stuyft, 2007). The NHIS regulates the establishment of CBHIS through guidelines laid out in its CBHIS blueprint. Currently, NHIS

operates State offices that are mandated to register mutual health associations that qualify as CBHIS. Prior to the Presidential mandate to NHIS, CBHIS operated without NHIS oversight. The NHIS guideline for CBHIS implementation in Nigeria calls for a 60 day processing (wait) period before accessing the scheme's benefits (National Health Insurance Scheme, 2005). However, as described earlier, its poor regulatory influence makes it difficult for the NHIS to enforce this 60-day wait period especially in an environment where the political goal is increasing enrolment. As such, there is no evidence of any of the implementing CBHISs in Nigeria that has the stated wait period as part of its operational clause.

The unit of enrolment is another valid mitigation technique for adverse selection in a CBHIS. The literature shows that the most favourable unit of enrolment comes in the form of enrolling a composite unit of people like, the household, villages, cooperatives or mutual benefit societies (Basaza et al., 2007; Carrin 2003). By requiring a minimum proportion of the unit of enrolment as justification for initiating a CBHIS, a large and evenly mixed risk pool can be achieved from the onset. This is employed in the Ugandan CBHIS model where village-based enrolment is required for establishing a CBHIS (Basaza, et al., 2007) and in the case of a mutual benefit society called engozi, a 60% unit of registration clause is enforced before the launch of a CBHIS for the group (Carrin, 2003).

Membership is generally open to all members of the defined geographic settlements or political delineation. We found that in the FCT CBHIS, although an individual can enrol he/she is treated like a household on the premise that he or she may eventually have dependents (FCTA, 2013). Premiums are paid annually and sometimes with flexible instalment arrangements based on the enrolment unit. As such in most of the CBHIS, each household pays a premium that ranges from 0.70 USD per annum in Ghana to over 9.00 USD per annum in Nigeria. The employment of social marketing strategies is the common mechanism for improving enrolment and encouraging increased membership. In Ghana, the success of the NHIS project has spread and has boosted membership.

Except for the pilot in FCT, the two other operational CBHIs of interest in this report have a large membership population of over 10,000 people. This indicates that a clear understanding of the impact of a large risk pool in the success of a CBHS is clear to most managers. This is especially important considering that most do not have any exemptions on membership.

*Insight 5: Enrolment cannot be taken for granted even if the benefits of enrolment appear obvious. The size of the risk pool is critical to the scheme's success. Adverse selection is likely, but can be managed as in Kwara when there is a clear strategy to do so. Maintaining enrolment after the first few years is even more difficult than initial enrolment, especially when members of the population have not sort care. In all the schemes visited, there is no mechanism for "automatic" continuation of enrolment so the enrolee has to physically attend a location to renew enrolment.*

## The benefit package

The subject of what services to include in the benefit package and how the scheme intends to purchase the healthcare services it seeks to provide is a key component of the CBHIS framework. This should be based on the healthcare needs of the beneficiaries while compensating the healthcare providers adequately. A failure to define benefit packages at inception, thus offering every service that happens to be available at the participating health facility can incapacitate the scheme (Basaza, et al. 2007; Carrin 2003; Onwujekwe, Onoka et al. 2010). In turn, this contributes to adverse selection as enrolment of members with high health needs (especially those with chronic diseases), is disproportionately high (Cutler & Zeckhauser 2000; Onoka et al 2013; Onwujekwe, Onoka et al. 2010; Onwujekwe et al. 2009). In such situations, all it takes to cripple the scheme's revenue is a few expensive health procedures. Unfortunately, when such schemes attempt to reform and improve their models to achieve sustainability and avoid continuous loss of revenue they end up excluding the most vulnerable populations like the elderly and losing the trust of beneficiaries. Thus, defining

the benefit package at inception and employing strategic models for purchasing services is essential to avoid this pitfall.

To overcome this, unique purchasing practices are employed by the Hygeia CBHIS scheme in Kwara and Lagos State. Instead of excluding individuals with pre-existing chronic disease conditions, they in fact welcome them (Federal Republic of Nigeria. Community Base Health Insurance, 2011; Hendricks & et.al, 2011), and have organised a specific programme to address their needs. Through contracts with both public and private hospitals, beneficiaries have access to a range of health services including chronic disease service. Beneficiaries' health needs are met using healthcare personnel who are committed to providing relevant specialized services. Thus, a strategic model for purchasing services is for the CBHIS to investigate and ascertain the healthcare services most needed by the population served. Accordingly, a benefit package that offers the relevant healthcare services for that population is developed.

Purchasing services via contracts entails an active role by CBHIS management. This is achieved by seeking out healthcare facilities and providers who respect and appreciate the cause of providing affordable care. This is seen in the Hygeia schemes in Kwara and Lagos states (AIID, UITH, & AIGHD, 2013; Hendricks & et al, 2011). In purchasing services, a number of different mechanisms can be employed in paying providers including capitation, fee-for-service and salary (Cutler & Zeckhauser 2000). In addition, purchasing can be done for facilities and providers and transport companies can be engaged for ambulance services as is the case in Guinea Conakry (Carrin 2003). This implies that there is a need to conduct surveys and/or research studies to determine the prevalent health needs of the population and the existing healthcare outline of the community. Such exercise informed the Mutuelles decision to focus on maternal and child health issues especially when developing the hospital benefit packages (Shimeles 2012). Gatekeeping presents another alternative for negotiating benefits. It allows for broad benefit packages for enrolees receiving health services but following a strict referral system guided by healthcare providers at the PHCs, for services outside their facility (Carrin, 2003; Shimeles, 2012).

In the selected schemes, the primary point of service is within the community and the facilities provide a variety of primary care services. In the Nigerian schemes, such primary care services are paid via capitation for an enrolled member. When secondary or tertiary care is needed, then members are referred to a different facility (AIID, et al., 2013). In this case, the healthcare providers at the referred facility are reimbursed through a fee-for-service mechanism.

*Insight 6: Defining a benefit package is not as easy as it appears and needs to be as detailed as possible. For example a delivery can start as a "normal" delivery and progress to a caesarian section, which can lead to complications for the mother and baby, etc. Hence setting very clear guidelines on what services are included or excluded in a "Maternal Care" package is essential as failure to do this quickly leads to an erosion of confidence in the scheme.*

## Assuring quality

It is critical to the survival of a CBHIS that it recognizes quality control mechanisms as essential for achieving financial security and sustainability. Through the quality control mechanisms put in place, the quality of service remains high, which conversely encourages membership retention and increase in enrolment. Types of quality control mechanisms include routine audits, accreditation and re-evaluation of health providers and facilities and survey of members.

The distance between point of service and members' homes also affects the success of the CBHIS. The impact distance has on the success of a CBHIS plays out that the farther away the point of service is, the lower the utilization.

*Insight 7: Among all the factors, the quality of healthcare provided is most important to recruit and keep enrolees. If there is no confidence in the current capacity of healthcare providers, there is no reason that it will change when the financing model changes to a CBHIS, especially when there are multiple providers in the scheme. There are some existing schemes in the country using a model “Safecare” specifically designed for developing countries.*

## HMO selection

To provide financial security, the schemes adopt the use of Health Maintenance Organizations (HMO) to manage the operation of the scheme. The NHIS Act provides the legal framework for schemes that do not have donors. However, where donors exist, there is an attempt to balance the donor’s legal framework with that of the NHIS Act. This is seen in the Hygeia CBHIS in Kwara State. Equity is achieved through a partnership with all stakeholders. This involves interaction and participation in the management of the scheme by all stakeholders including the members, the HMO (if part of the management), the government and participating donors. Some schemes such as Araya in Ogun State use multiple HMOs while some like the Kwara CBHIS uses one HMO – both models have advantages and disadvantages. When a HMO is present, they are responsible for the purchasing mechanisms used for providing necessary and affordable health services to members of the community. In the Kwara State scheme, contracts with health facilities and/or health providers are also employed for providing healthcare services to the members.

*Insight 8: The relationship of the scheme sponsor with HMO(s) is critical in thinking about the delivery of CBHIS. The relationship can be a tight partnership (as in Kwara State) or with multiple HMOs in a competitive model (as in Ogun State).*

## Administrative costs

The administrative costs of running a CBHIS can affect funds available for purchasing services. Hence, its ratio to overall available revenue must be kept low. Evidence shows that a ratio below 10% was associated with some of the successful schemes (Carrin, 2003). This translates to a need for administrative efficiency without adversely affecting the quality of managing and running the scheme.

*Insight 9: Administrative costs are not inconsequential. It needs to be kept low by various mechanisms such as intelligent use of information technology, bulk purchase agreements etc.*

## Political will and community trust

Other factors that affect the success of the CBHIS include trust. Trust is necessary for membership and can best be gained if the point of entry for a CBHIS is an existing organization whom potential beneficiaries already have trust in, like a local mutual. Another mechanism for gaining the people’s trust is by considering their preference. One sure way is to set up the CBHIS with a major focus on transparency by creating a forum where beneficiaries participate in the decision-making process of how the CBHIS operates. The NHIS has

included this by insisting on community member representation on the CBHIS's board of trustees (BOT) (National Health Insurance Scheme, 2005). The relevance of community participation in this capacity is presented in the tripartite CBHIS in Lagos. The presence of a member of the Olowora community on the scheme's BOT appeared to have a direct impact on the high level of participation from that community in comparison to the other two member communities (Onyemelukwe et al 2011). It is also good to note that the point of service for this CBHIS is also in Olowora.

*Insight 10: Political will and trust is critical to the success of a scheme. There are several ways of achieving and maintaining trust that will have to be considered before the inception of a CBHIS. Political will is required from the various levels of government.*

## Conclusions on the future of Community Based Health Insurance in Nigeria

There is evidence that the CBHIS model can be one of the solutions for providing healthcare coverage to the large population of informal and rural citizens of Nigeria (AIID, et al., 2013; Hendricks & et.al, 2011). Moreover, it has the potential of providing the improved healthcare access and needed financial security through the decrease of OOP expenditures. However, for this to become a reality, the peculiarities of the healthcare system, infrastructure, the demographic and economic makeup of the communities in Nigeria must be considered with the auspices of NHIS and the obtainable frame work in Nigeria.

A careful appraisal of the selected schemes reveals that strong government partnership is imperative for establishing CBHIS. This is especially important considering the high odds that the primary point of service for most schemes will be a government owned and run PHC facility. The government's role will differ by community. Some may require that the government subsidize the premiums as seen in the FCT pilot (See Appendix 1). Other communities will need the government to support by improving their PHC facilities providing both personnel and supplies needed to serve members of the community (AIID, et al., 2013). In some cases the community will need both forms of support. For some communities, government support will have to be supplemented by a donor. This will be the case in communities where an overwhelming proportion of the population is within the very poor socio-economic category. In addition, the government either through the NHIS or alternative approaches will need to provide regulatory support to ensure that the rights of members within the scheme are protected.

Gaining the trust of members is as essential as government support. In order to fit the framework that calls for voluntary membership and to generate a sustainable risk pool, the members need to trust and believe in the benefit of CBHIS in their community. This will require educating the members of the community through existing channels they trust. This will include using NGOs, FBOs, CBOs and CSOs who already work in the community and have earned their trust in the past. The inclusion of community members in the establishment and operations of the CBHIS can also introduce the trust necessary for the sustainability of the scheme. Generating adequate revenue for running the schemes is interconnected with both the risk pool and the financial pool. Thus using a wide geographic indicator for defining a community can provide an answer to the challenge of ensuring a large risk pool and consequently sufficient revenue for the operational needs of the scheme. For instance the use of the relevant political ward or LGA is a viable option.

Ultimately, the need for actuarial, health and demographic studies cannot be overlooked. In order to ensure that the parameters for which the scheme will be established will meet the needs of the members while successfully achieving sustainability the reality of the health, demographic and economic status of the community must be understood. An inability to gain a true picture will affect all aspects of the framework. Through such research, answers to questions like "what type of support the community needs" or "the true cost of health coverage for a household" will be obtained. It will also serve as the basis for future evaluations of the impact of successfully established schemes as part of a sustainability measure.

## Recommendations to Christian Aid on the feasibility and practical considerations in the establishment of a Community Based Health Insurance Scheme

Our findings show that the establishment of a Community Health Insurance Scheme in Nigeria is an attractive model for delivering healthcare in Nigeria. Its attractiveness is predicated on these characteristics:

1. **It encourages ownership and engagement of patients with their health care.**
2. **It enables predictability in costs of healthcare provision per enrollee**

All CBHIS schemes we visited and those not visited are all founded on four pillars;

1. **A defined community**
2. **A single or set of health care facilities**
3. **A Health Maintenance Organisation**
4. **A “promoter”/ or “donor” or a combination of these**

The recommendation to Christian Aid (CA) is based on the 10 insights above. It is recommended that while CBHIS is in itself a potentially viable mechanism to deliver healthcare to a community – CA should take the following conditions into consideration when considering investing resources in this. It is recommended that CA should seek a situation where all of the 10 questions below can be answered in the affirmative before it invests resources in a scheme. Some questions are answered using Plateau as a case study but this can be reviewed with any other location. The answers are colour coded GREEN, ORANGE and RED, to depict where the criteria has been met, partially met or unmet using Plateau as an example.

1. Does the policy environment encourage the establishment of CBHIS?

**Answer: Yes – the NHIS is focused on achieving the President's mandate of increasing enrolment into any health insurance scheme**

2. Has the State Government in which the identified community is located prioritised health care financing?

**Answer: Yes – In this case it appears that the Plateau State Government has identified Pankshin LGA as one of the pilot areas for a CBHIS. The Chigon community that Christian Aid is interested in is located in this LGA.**

3. Is there a significant pool of funds identified that will support the initiation and sustenance of a CBHIS in the short and medium term?

**Answer: Plateau State has apparently made some budgetary allocation to support/finance the CBHIS. However, there is uncertainty about the timing and conditions for the release of these funds.**

4. Is there a community identified that is keen on a CBHIS and willing to contribute resources towards this?

Answer: Yes – this appears to be the case in Plateau

5. Is it likely that a risk pool big enough to support a scheme can be enrolled from the beginning (about 10,000)

Answer: Unlikely at this stage unless there are significant funds to subsidize the premiums

6. Can an adequate benefit package be delivered by the healthcare facilities currently in existence in the identified community

Answer: No

7. Can high quality care be provided by the healthcare facilities currently available in the identified community

Answer: No

8. Has a HMO(s) been identified to manage the finances of scheme

Answer: It appears the state has chosen United Healthcare International as the preferred HMO to manage the CBHIS; although it is not mandatory for any community or groups wishing to start a CBHIS to engage United Healthcare International.

9. Have funds and the requisite expertise been identified to manage a scheme

Answer: Not yet

10. Is there existing political will from government and trust in the community of the intentions third parties to provide CBHIS

Answer: There are pledges of support by the state government but this has not been tested

## Summary

Two approaches are suggested to Christian Aid.

1. To identify a community desirous of a CBHIS and with some of the requisite infrastructure to deliver this and support this community through a “CBHIS preparation process” that could lead to a successful scheme through the targeting of the areas identified above.
2. To identify a community or set of communities with an existing CBHIS and support a set of processes to increase enrolment and access to members of the community that are limited in their ability to register by poverty, disability or similar factors.
3. Either of these two approaches will enable CA achieve its strategic objective of increasing access to healthcare.

## References

- AIID, UITH, & AIGHD. (2013). A short term Impact Evaluation of the Health Insurance Fund Program in Central Kwara State, Nigeria: Amsterdam Institute for International development (AIID), University of Ilorin Teaching Hospital (UITH), Amsterdam Institute for Global Health and Development (AIGHD Foundation).
- Basaza, R., Criel, B., & Stuyft, P. V. d. (2007). Low enrolment in Uganda Community Health Insurance Schemes: underlying causes and policy implications. *BMC Health Services Research*, 7(105). doi: 10.1186/1472-6963-7-105
- BUSINESSDAY. (June 20, 2014). Towards achieving universal health coverage in Nigeria, Editorial, *BusinessDay*. Retrieved from [www.businessdayonline.com](http://www.businessdayonline.com)
- Carrin, G. (2003). *Community based Health Insurance Schemes in Developing Countries: facts, problems and perspectives*. World Health Organization, Geneva.
- ChristianAid.org.uk. Christian Aid in Nigeria, from christianaid.org.uk
- Chuma, J., & Maina, T. (2012). Catastrophic health care spending and impoverishment in Kenya. *Biomedical Central (BMC) Health Services Research*, 12(413). Retrieved from <http://www.biomedcentral.com/1472-6963/12/413> website:
- Cutler, D. M., & Zeckhauser, R. J. (2000). The Anatomy of Health Insurance. In A. J. Culyer & J. P. Newhouse (Eds.), *Hand Book of Health Economics* (Vol. 1, pp. 563 - 643): Elsevier Science B.V.
- Doorslaer, E. V., & et.al. (2007). Catastrophic payments for health care in Asia. *Health economics*, 16(11), 1159 - 1184.
- FCTA. (2013). FCT-Community Based Health Insurance Scheme (CBHIS): Implementation Manual. Abuja, FCT: Fedral Capital Territory Administration, FCT-Millennium Development Goals (MDGs), United Nations (UNFPA), Canadian International Development Agency (CIDA).
- Federal Republic of Nigeria. *Community Base Health Insurance*. (2011, November, 2011). Paper presented at the Improving Financial Access to Health services for the Poor in Nigeria, Tinapa, Calabar, Nigeria.
- Hendricks, M., & et.all. (2011). Cardiovascular disease prevention in rural Nigeria in the context of a community based health insurance scheme: Quality improvement Cardiovascular care Kwara-I(QUICK-I). *BMC Public Health*, 11(86), 1471-2458. Retrieved from <http://www.biomedcentral.com/1471-2458/11/186> website:
- Ilu, C., Chin, B., Lewandowski, J. L., Basinga, P., Hirschhorn, L. R., Hill, K., . . . Binagwaho, A. (2012). Towards Universal Health Coverage: An Evaluation of Rwanda *Mutuelles* in its First Eight Years. *PLoS One*, 7(6). doi: 10.1371/journal.pone.0039282
- Joint Learning Network (2008). Rwanda. Retrieved from <http://www.equitablehealthfinancing.org/countries/rwanda>
- National Health Bill, Harmonised Senate and House. Retrieved from [http://nigeriahealthwatch.com/wp-content/uploads/bsk-pdf-manager/746\\_894\\_NATIONAL\\_HEALTH\\_BILL\\_%28HARMONISED\\_\\_SENATE\\_&\\_HOUSE%29\\_15T\\_H\\_JULY\\_2014.PDF](http://nigeriahealthwatch.com/wp-content/uploads/bsk-pdf-manager/746_894_NATIONAL_HEALTH_BILL_%28HARMONISED__SENATE_&_HOUSE%29_15T_H_JULY_2014.PDF)
- National Health Insurance Scheme, N. (2005). *The National Health Insurance Scheme: Operational Guidelines*. Abuja.
- National Health Insurance Scheme, N. (2009). *Blueprint for the Implementation of Community-based Social Health Insurance Programme*. Abuja: Interactive Media Services.
- Odeyemi, I. A. (2014). Community-based health insurance programmes and the national health insurance scheme of Nigeria: challenges to uptake and integration. *International Journal for Equity in Health*, 13(20), 1 - 13.
- Olakunde, B. O. (2012). Public health care financing in Nigeria: Which way forward? *Annals of Nigerian Medicine*, 6(1), 4 - 10.
- Onoka, C. A., Onwujekwe, O. E., Uzochukwu, B. S., & Ezumah, N. N. (2013). Promoting universal financial protection: constraints and enabling factors in scaling-up coverage with social health insurance in Nigeria. *Health Research Policy and Systems*, 11(20).
- Onwujekwe, O., Okereke, E., Onoka, C., Uzochukwu, B., Kirigia, J., & Petu, A. (2010). Willingness to pay for community-based health insurance in Nigeria: do economic status and place of residence matter? *Health Policy and Planning*, 25, 155 -161. doi: 10.1093/heapol/czp046
- Onwujekwe, O., Onoka, C., Uguru, N., Tasié, N., Uzochukwu, B., Eze, S., . . . Petu, A. (2010). Preferences for benefit packages for community-based health insurance: and exploratory study in Nigeria. *BMC Health Services Research*, 10(162).

- Onwujekwe, O., Onoka, C., Uguru, N., Tasié, N., Uzochukwu, B., Kirigia, J., & Petu, A. (2011). Socio-economic and geographical differences in acceptability of community-based health insurance. [Short Communication]. *Public Health*, 125, 806 - 808.
- Onwujekwe, O., Onoka, C., Uzochukwu, B., Okoli, C., Obikeze, E., & Eze, S. (2009). Is community-based health insurance an equitable strategy for paying for health care in Nigeria? Experiences from Southeast Nigeria. *Health Policy*, 2(7). doi: 10.1016/j.healthpol.2009.02.007
- Onyemelukwe, A., Obonyo, B., Mbengue, C., Butera, D., & Beichl, L. (2011). Improving Pathways to Health: *Rapid Assessment of CBHIS Schemes Lagos State*. Lagos.
- PATHS2 Policy Brief, National Health Accounts (NHA) in Nigeria: Concepts, Approaches, and Findings. retrieved from <http://www.paths2.org/images/resources/1346302396NHA%20Policy%20Brief%20No1.pdf>
- PATHS2 Technical Brief, Developing and Integrated and Decentralised Health System. Retrieved from [http://www.healthpartners-int.co.uk/our\\_projects/documents/Integratedanddecentralisedsystems\\_000.pdf](http://www.healthpartners-int.co.uk/our_projects/documents/Integratedanddecentralisedsystems_000.pdf)
- Shimeles, A. (2012). Community Based Health Insurance Schemes in Africa: the Case of Rwanda. *Working Paper Series*, 120. Retrieved from
- WHO. (2010). *World Health Report: Health Systems Financing: The Path to Universal Coverage*. [http://www.who.int/whr10\\_en.pdf](http://www.who.int/whr10_en.pdf)
- WHO, Macroeconomics, & Health. (2000). *Macroeconomics and Health: The Ten Recommendations*. <http://www.who.int/macrohealth/background/recommendations/en/>
- WHO, Macroeconomics, & Health. (2003). *Increasing Investments in Health Outcomes for the poor: Second Consultation on Macroeconomics and Health*. Geneva. [http://www.who.int/macrohealth/events/health\\_for\\_poor/en/](http://www.who.int/macrohealth/events/health_for_poor/en/)
- WHO, & Nigeria. (March, 2014). *Presidential summit on Universal Health Coverage (UHC) ends in Nigeria*. Paper presented at the Presidential summit on Universal Health Coverage (UHC), Abuja, Nigeria.

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## End notes

- <sup>1</sup> While we had a structure of questions agreed, we did not always follow the structure strictly. Rather we let the conversation drive the emphasis. We always sought to address the key issues during any interview.