IMPROVING FINANCIAL ACCESS TO HEALTH SERVICES FOR THE POOR IN NIGERIA

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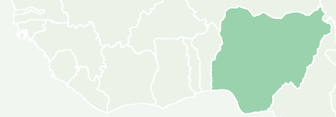
Community-based Health Insurance

Brief: Nigeria



▸ Priority Actions

- Learn more about community-based health insurance schemes (CBHIs)
- Support communities and local government areas to plan and implement CBHIs
- Identify funding to subsidise CBHI start-ups, operations, and expansion of coverage
- Ensure that national laws and by-laws allow private facilities to operate and participate in CBHIs

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Overview

Community-based health insurance schemes (CBHIs) apply the principles of insurance to the social context of communities, guided by their preferences and based on their structures and arrangements. CBHIs can help communities manage healthcare costs and provide access to basic healthcare for the poor and other vulnerable groups. The schemes are especially useful in reaching rural residents and the informal sector—the part of the society that is not easily insured—including self-employed people (e.g., farmers, petty traders, and laborers). These people tend to be unable to pay out-of-pocket costs for basic healthcare at the point of service use, which if persistent, could possibly drive them into poverty.

Typically, CBHIs are organised and managed by a local community organisation. The CBHI plan establishes agreements with various health providers, thereby forming a network of facilities. Most schemes cover basic healthcare services (e.g., antenatal care, deliveries, and child healthcare) and family planning services, while some schemes may also cover costs of hospital treatment. The value of CBHIs is that they engage community members as enrollees and volunteers,

ensure that health services meet community needs, and make primary healthcare accessible and affordable to members by pooling their resources and sometimes supplementing them with external funds.

The weakness of CBHIs is that they are often highly dependent on external funding from the government and donor agencies. Such schemes tend to cover a relatively small, low-income group of enrollees and thus they do not have a sufficiently large risk pool to cover their operating costs. Premium payments and local subsidies are usually inadequate to cover the costs of healthcare, since most enrollees are poor and cannot afford high premiums. Also, while community involvement is beneficial to CBHIs, it is sometimes ineffective due to weak management and technical skills of serving members of the community within the CBHI structure.

CBHIs should be part of a broader package of financing mechanisms—such as fee exemption schemes, equity funds, vouchers for beneficiaries, and results-based financing—that extend health coverage to under-served groups. CBHIs may not fit all situations, but they can make an important contribution to healthcare programmes.

Assessing Two CBHI Models in Nigeria

In Nigeria, CBHIs have been implemented on a relatively small scale, with the aim of extending health coverage to people in the informal sector. CBHIs in the Lagos and Kwara states provide useful information on ways to structure CBHIs and some of the challenges in implementation within the country context.

Valuable Insights on Implementing CBHIs

- Planning and budgeting. An overall design strategy is insufficient, as it needs to be tailored to each area. An operational plan and a realistic budget targeted at the specific schemes should be developed prior to implementation.
- Balancing income and costs. Given the need to subsidise healthcare for low-income groups, policymakers, planners, and implementers need to pay close attention to financing elements, including premium charges, fixed costs for service delivery, and ways to diversify income sources.
- Obtaining high-level commitment. Leaders from the national level down to the LGAs must be strongly committed to providing healthcare to the poor and vulnerable groups, such that they can commit to providing subsidies for CBHIs.
- Engaging local communities. CBHIs rely on community members not only to keep up enrolment rates but also to participate in programme management, monitor implementation, and educate community members on health issues.
- Building a service network. The CBHIs with large memberships offer a range of health services through a network of public and private providers. Private providers can provide cost-effective services when involved and regulated to ensure provision of high-quality care. Payment mechanisms need to be carefully determined, with transparency and accountability ensured.
- Assessing progress. CBHI managers and funders need to conduct a baseline survey, regularly review service delivery and cost data, and undertake periodic assessments regarding the strengths and weaknesses of the programme. Impact evaluations are equally advised.
- Aligning incentives. Other financial mechanisms—such as performance-based financing (used in Rwanda) and requiring small user premiums (as in Kwara State)—can contribute to the effectiveness of CBHI schemes.

Lagos State

In Lagos State, the State Ministry of Health (MOH), one local government area (LGA), and three communities set up the Ikosi-Isheri Mutual Health Plan (MHP) in 2008. Representatives of these bodies, plus a technical insurance specialist, form the Board of Trustees, which provides oversight to the MHP. Members pay a monthly fee of 400 Naira (US$2.49) for single people and 800 Naira (US$4.97) for a family of six. This fee covers consultation, antenatal care, and basic healthcare services. Enrollees pay directly for referrals and higher-level care. The MHP is heavily subsidised by the State MOH and the LGA.

A 2010 programme assessment reported some positive outcomes as well as some challenges. The researchers found that the quality of services was good in terms of contributions to lower maternal and neonatal mortality rates, as well as drug availability and patient satisfaction. The community had an excellent relationship with the MHP. On the other hand, the researchers noted some high turnover among the health providers, who are civil servants, and recommended that the MHP hire private health providers. Financial viability was a key issue. Member attrition was high, and members who used the services infrequently were asking for a discounted premium. Furthermore, the LGA was paying the premiums for more than half of the 1,000 active member families.

The researchers recommended that the MHP take steps to improve its financial situation by analyzing its costs to provide services; expanding its membership to private sector employees, associations, and small- and medium-sized enterprise employers; increasing membership in under-represented areas; encouraging defaulters to re-enrol; offering a discount for low service utilisation clients; introducing means testing; providing partial subsidies; possibly adding services such as medical imaging (scans) and care for diabetes and hypertension to increase uptake; and setting up a community fund that accepts donations (Zamba, 2011).

Kwara State

The Hygeia Community Health Plan (CHP) in Kwara State is based on a managed care system similar to a health maintenance organisation. It uses a network of public and private health facilities to provide comprehensive health services. The benefit package covers inpatient and outpatient visits, hospital care, consultation with specialists, provision of prescribed drugs, laboratory and diagnostic tests, radiology, and treatment of HIV/AIDS, malaria, and tuberculosis. The plan introduced one scheme in 2007 and a second one in 2009. Both schemes focus on rural farmers.

The 55,807 enrollees (as of October 2011) pay a premium of 300 Naira (US$1.90) per year. Nearly all (93%) of the costs are subsidised by the Dutch government and the State MOH. Enrolment is below target, and many enrollees have dropped out due to migration. Some of the challenges the programme has experienced are enrollees' inability to pay premiums, inadequate number of providers, and uneven quality of services.

Some of the lessons learned from the Hygeia CHP are that community involvement is important to ensure member retention; intensive marketing by community members or commissioned agents is required; pricing needs to reflect the ability and willingness of enrollees to pay and should reflect the disease prevalence in the community; continuous monitoring of service delivery is needed to ensure quality of care; and CBHIs that provide generous benefits cannot be funded solely by low-income communities (Adenusi, 2011). Another key lesson is that private facilities can make important contributions to CBHIs, even in rural areas, despite skepticism regarding the role of the private sector. Also, charging a token premium fee, even to the poorest members, ensures that enrollees value their membership; it also discourages inflation of enrolment rosters with non-existent members.


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Learning from its pilot schemes, the Nigerian National Health Insurance Scheme plans to launch pilot re-designed CBHIs in selected sites to extend community-level health coverage. If the pending National Health Bill becomes law, its allocation of funds for primary healthcare could boost subsidies to CBHIs.

Drawing Lessons from Regional Experiences

Rwanda Covers Nearly the Entire Informal Sector

Among African countries, Rwanda is most advanced in its health coverage of the informal sector. With high-level political support, the government has made health insurance compulsory for everyone. Today, about 90–95 percent of Rwandans in the informal sector are enrolled in CBHIs. This system was built in just a decade. In 2001, healthcare use was very low. Accordingly, the government introduced CBHIs and pilot-tested them during 2001–2005. Results of the pilots showed that the scheme had improved some health indices, but service quality and uptake of antenatal care and delivery in health facilities were low. Accordingly, in 2005, the government supplemented the CBHI plan by introducing performance-based financing (PBF) in facilities to provide an incentive to health workers to improve service quality. It is also testing community PBF to encourage pregnant women to use antenatal and delivery services. During 2005–2011, deliveries at health facilities increased by 78 percent, new curative consultations by 51 percent, and family planning users by 209 percent. The long-term sustainability of these schemes is not yet assured; donors and the Rwandan government pay about 30 percent of CBHI contributions (Humuza, 2011).

Ghana Finances District-level Plans

Ghana has made considerable progress extending healthcare to people in the informal sector, thereby moving towards universal health coverage. The 2003 National Health Insurance Act set up Ghana's National Health Insurance Scheme (NHIS) and authorised district mutual health organisations (DMHOs), which operate in every district and are subsidised by the national government. The DMHOs are funded through a 2.5 percent value-added tax and 2.5 percent of the social security contributions from the employees or employers in the formal sector, coupled with premiums between US$5 and US$33 per person from adults working in the informal sector. It is noteworthy that 95 percent of NHIS resources in 2008 came from tax-related income.

The DMHOs' benefit package covers ambulatory care, hospital admission, surgery, diagnostics, consultation, and specialised care. The scheme exempts payments from children under age 18, the poor, pregnant women, people age 70 and older, and pensioners. As of June 2010, 15.6 million people were registered under the DMHOs. About 30 percent of these registrants were from the informal sector and 48 percent were under age 18 (Atim, 2011).

While challenges remain, especially in terms of long-term sustainability and equity, Ghana's scheme offers potential lessons for Nigeria's NHIS as it expands to cover more people in the rural and informal sectors. Specifically, Nigeria could replicate aspects of Ghana's experiences in designing benefit packages and determining exemptions. Two key features that enhance equity are cross-subsidies, which entail using profits from one part of the scheme to meet losses from another part, and pooling of registrants from the informal and formal sectors, which ensures that the risk related to financing health interventions is borne by all individuals regardless of employment (Atim, 2011).

Actions Needed

Nigerian agencies can undertake the following key actions to extend the benefits of CBHIs:

Federal

- Build awareness of the benefits and challenges associated with CBHIs
- Provide guidance through manuals and training guides for adaptation and use by states, LGAs, and ommunities
- Collect data on the improved health outcomes associated with CBHIs and calculate the cost-benefit ratio of subsidised services

State

- Assist LGAs to plan and implement CBHIs, with adequate attention to the costs of service delivery, the ability of the membership to pay premiums, and factors that could promote long-term sustainability
- Provide technical assistance to LGAs to build local management and technical skills to operate CBHIs
- Pass legislation guaranteeing free healthcare for pregnant women and children under age 5 and fund this mandate
- Ensure open participation of private healthcare providers

LGA

- Help to mobilise and organise communities to implement CBHIs
- Raise budgetary provisions for primary healthcare systems and facilities
- Provide technical assistance to communities to build local management and technical skills to operate CBHIs

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Health financing and equity were the main themes of the landmark national conference on **Improving Financial Access to Maternal, Newborn, and Child Health Services for the Poor in Nigeria,** held in November 2011 in Tinapa, Calabar. The conference brought together 255 experts from all 36 Nigerian states and the Federal Capital Territory, including high-level government officials, political leaders, healthcare managers and planners, health economists, insurance specialists, and media representatives. These experts discussed strategies to improve financial access to integrated MNCH services, inclusive of sexual and reproductive health interventions, towards achieving universal health coverage. Among the various strategies discussed during the meeting were the need for advocacy and policy change, innovation in the design and implementation of health financing schemes, strengthening of the social health insurance scheme in the country, and the needed collaboration with private sector health providers. The conference organisers included three federal agencies, the African Health Economics and Policy Association, four United Nations agencies, three donor countries, and five health projects.

This brief is one of four in a series: "More Health for the Money," "More Money for Health," "Innovative Financing Mechanisms," and "Community-based Health Insurance." A complete list of sponsoring agencies and all conference materials and presentations are available on the conference website at **http://www.healthfinancenigeria.org**.