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What's in a Name? A Lot—When It's "Community-Based" Health Insurance in Nigeria

As global policymakers have refocused efforts to promote universal health coverage (UHC), prepayment for health services has emerged as a key to achieving sustainable and effective health systems. Community-based health insurance schemes (CBHIS) have addressed this need for about 20 years, but they fall short of the goal. Meanwhile, the Nigeria National Council on Health (NCH) recently approved implementation of State-Supported Health Insurance Schemes (SSHIS). These plans often include a "community" component, which has led to confusion of SSHIS with CBHIS. This SmartLesson shares lessons from the implementation of critical reforms in Nigeria's health systems and addresses the need to clarify the use of the term CBHIS in Nigeria.

BACKGROUND

Since the 1990s, CBHIS have been implemented in several African countries, including Burkina Faso, Ghana, Rwanda, Senegal, and Tanzania,[1] and some people see them as an "ideal" risk-pooling mechanism for minimizing catastrophic payments in low-resource settings, and ensuring responsiveness to local health needs.[2] However, despite some major accomplishments in countries with strong national-government stewardship, most CBHIS have been limited in scope and success: they face major challenges with initiation, sustainability, and scale-up; they usually are unable to reach high levels of population coverage; and with small and fragmented risk pools, they most often require subsidies for poor and vulnerable segments of the population.

As Nigeria looks toward achieving UHC through a strategy that recognizes a role for the states, with support from a central equity fund, it is imperative that the terms CBHIS and SSHIS are clearly defined in the Nigerian context—with lessons for other countries that face the same set of dilemmas due to confusion related to terminology.

Below are lessons from the implementation of critical reforms supported by the World Bank Group's Health in Africa Initiative (HiA) at the Nigeria National Health Insurance scheme and close involvement in the design and implementation of state schemes in Ogun, Kwara, Lagos, and Delta states. The program also assisted with closing the Bank-

1 Odeyemi, "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, no. 20 (February 21, 2014). http://www.equityhealthj.com/content/13/1/20.

2 H. P. P. Donfouet and P-A. Mahieu, "Community-based health insurance and social capital: A review," Health Economics Review 2, no. 5 (2012). http://www.healtheconomicsreview.com/content/2/1/5; and H. Wang and N. Pielemeier, "Community-based health insurance: An evolutionary approach to achieving universal coverage in low-income countries," Journal of Life Sciences 6 (March 30, 2012): 320–29.

supported Nigeria Pre-Paid Health Scheme pilot project with CAPDAN[3] in Lagos State.

The extensive experience of the Nigeria HiA in critical policy reforms geared toward Nigeria's UHC aspirations, and implementation of these state schemes provides insight for distinguishing clear differences between CBHIS, as described by the literature, and state-sponsored health insurance schemes as increasingly seen in Nigeria. Establishment of the first wave of SSHIS in Nigeria has substantial community involvement, although they do not qualify as traditional CBHIS. The term CBHIS is a misnomer as used in several schemes in Nigeria. (See Box 1.)

Despite substantial government involvement, communities also play a major role in the running of SSHIS. It is this feature that has stubbornly led to the continued use of the word "community" in referring to them. (See Table 1.)

Box 1: CBHIS or SSHIS?

CBHIS have traditionally focused on rural and informal communities in the global South, empowering members to determine their benefits and participate in scheme management. This process is seen as revolutionary in reaching out to large swathes of underserved lower-income groups previously excluded from formal social security mechanisms. While CBHIS vary in design and organizational practice, they share five core characteristics focused on community empowerment:[a]

- Community-based social dynamics and risk pooling, targeting individuals who share common characteristics (geography, occupation, and so on);
- Solidarity, where inclusion is independent of individual health risks;
- Community participation in decision making and management;
- Nonprofit character; and
- Voluntary affiliation.

The CBHIS concept owes its success primarily to the principles of solidarity and trust, aiming to optimize social capital within the community to achieve maximum population coverage.[b] But CBHIS, as defined, mobilize insufficient resources, lack the technical capacity to go to scale, and exclude the poorest and those most in need.[c]

SSHIS, on the other hand, are initiated and supported by state governments. They are usually pro-poor risk pools and are run either as an agency of government or as an independent government-funded agency. SSHIS provide resources to ensure that the poor and vulnerable are cared for, provide mechanisms to ensure sustainability and viability, and are backed by significant technical capabilities. They also ensure the platform for implementation of the critical partnerships with the national government, as seen in the support of premiums for the poor by the NHIS through the implementation of the Basic Health Care Provision Fund.

The state has significant institutional and governance responsibilities, including defining benefit packages, empaneling providers, bearing financial risk, and supporting the payment of premiums for poor and vulnerable people. In Nigeria, the most singular unique characteristic of SSHIS is the enabling legislation, which clearly provides the legal instrument for setting up such schemes.

a. Wang and Pielemeier.
b. Donfouet and Mahieu (2012).
c. B. Ekman, "Community-based health insurance in low-income countries: A systematic review of the evidence," *Health Policy and Planning* 19, no. 5 (2004): 249–70. http://heapol.oxfordjournals.org.

LESSONS LEARNED

Lesson 1: Community participation is required for implementation of a successful state-sponsored health insurance scheme to promote social capital and ownership.

One of the key principles of functional CBHIS is the solidarity and trust between members, which motivates members who are susceptible to risk to put together their resources for common use. The following three examples illustrate how states have implemented SSHIS with community involvement:

- **Ogun State.** To ensure community participation and ownership in the Araya SSHI program management, the state government put in place several democratically elected boards of trustees to represent and manage each scheme in each community. Each scheme consists of a maximum of 4,000 enrollees. A seven-member board of trustees (chairman, secretary, treasurer, and four others), elected from within each community for a four-year term, manages the funds accrued in the accounts of each (public) provider, together with the local government administration (LGA) board, and runs its own scheme. Each board employs a salaried scheme manager to administer day-to-day activities, including addressing the complaints of enrollees and being accessible to the public. Board members receive token incentives and are entrusted with identifying the vulnerable groups (poor, aged, under-fives). Using tools provided by the state, the proposed groups are then verified to receive "free" health care. (See Figure 1.)

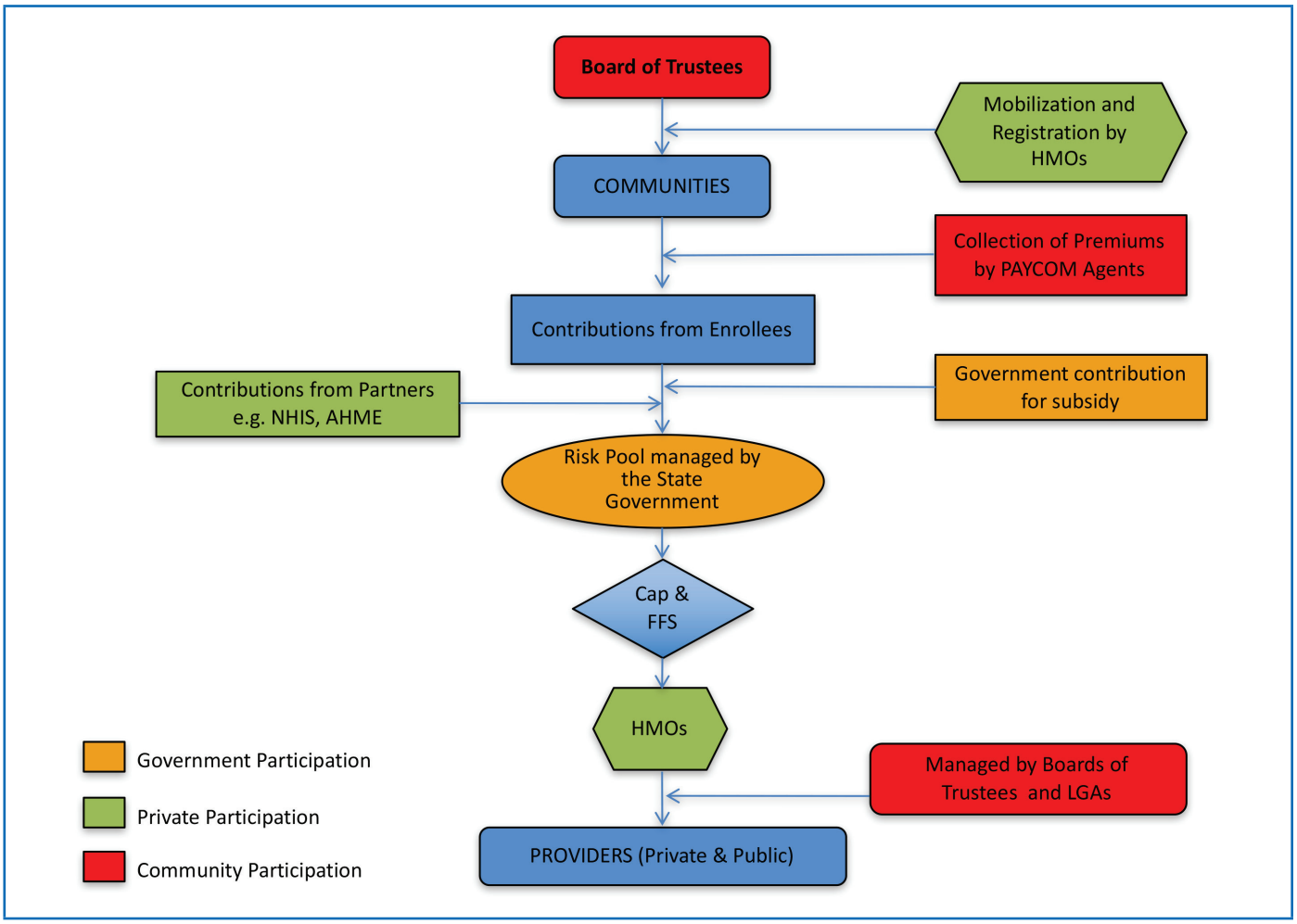
3 CAPDAN = Computer and Allied Product Dealers Association of Nigeria.

Table 1: Comparative Analysis of CBHIS and SSHIS

S/N	Component	CBHIS	SSHIS
1.	Funding	Pooled at the level of the community	Pooled at the level of the state, with significant government contributions
2.	Membership	Voluntary	Voluntary/Mandatory
3.	Reliance on an ethnic mutual aid/solidarity	yes	no
4.	Legislative process	no	yes
5.	Pro-poor component	yes/no	yes
6.	Nonprofit objective	yes	yes
7.	Risk pooling	yes	yes
8.	Linked to a provider	yes (usually public with no choice of private)	yes
9.	Donor support	yes	yes
10.	Technical capacities and link to other state institutions, such as Quality programs	no	yes
11.	Link to national/central governments/major sponsor, such as the NHIS	no	yes
12.	Community participation for enrollment, marketing, and governance	yes	yes

Source: Adapted from Donfouet and Mahieu (2012).

Figure 1: Levels of Community Participation in the Ogun Araya Program



Source: Nigeria HiA.

- **Lagos State.** The Ikosi-Isheri Mutual Health plan was initiated to target the informal population in the catchment areas. The management of the plan is by the board of trustees, which includes representation from the Lagos State Ministry of Health, LGA, a technical insurance specialist, and members of the community, predominantly from Olowora.[4] (See Figure 2.) Inclusion of community members not only engenders loyalty to the scheme but also is a marketing strategy to brand the concept and create a strong emotional bond with the community.[5] According to a 2011 report, the pilot witnessed enrollment rates in excess of 10,000 enrollees—just three years after its launch!

- **Kwara State.** The state-supported scheme has an enrollment figure of over 139,000. Critical to the success of the Kwara scheme is the influence of the traditional ruler in Shonga, where the pilot was launched. He is a retired public-health physician and a huge proponent of the scheme. The emir's leadership position also provided leverage for the wide dissemination of the Kwara State-supported CBHIS to other parts of the state. He became the face of the scheme and supported the efforts of the state in spreading it to surrounding communities, using his relationships with other traditional rulers, and was always at the forefront of any advocacy visits to facilitate enrollment. In recognition of its innovative engagement with the community, the Kwara State program recently won an FT/IFC award for achievement in sustainable development in the area of maternal and infant health with its implementing partners PharmAccess.

Lesson 2: Successful schemes benefit from extensive learning and knowledge transfer.

- **Ogun State.** The team benefited from a study tour to Kwara state, facilitated by HiA. The Kwara State insurance scheme is supported by the state government and managed by the Kwara SSHIS established by law, with technical oversight from PharmAccess Foundation and the Hygeia Community Health Care.

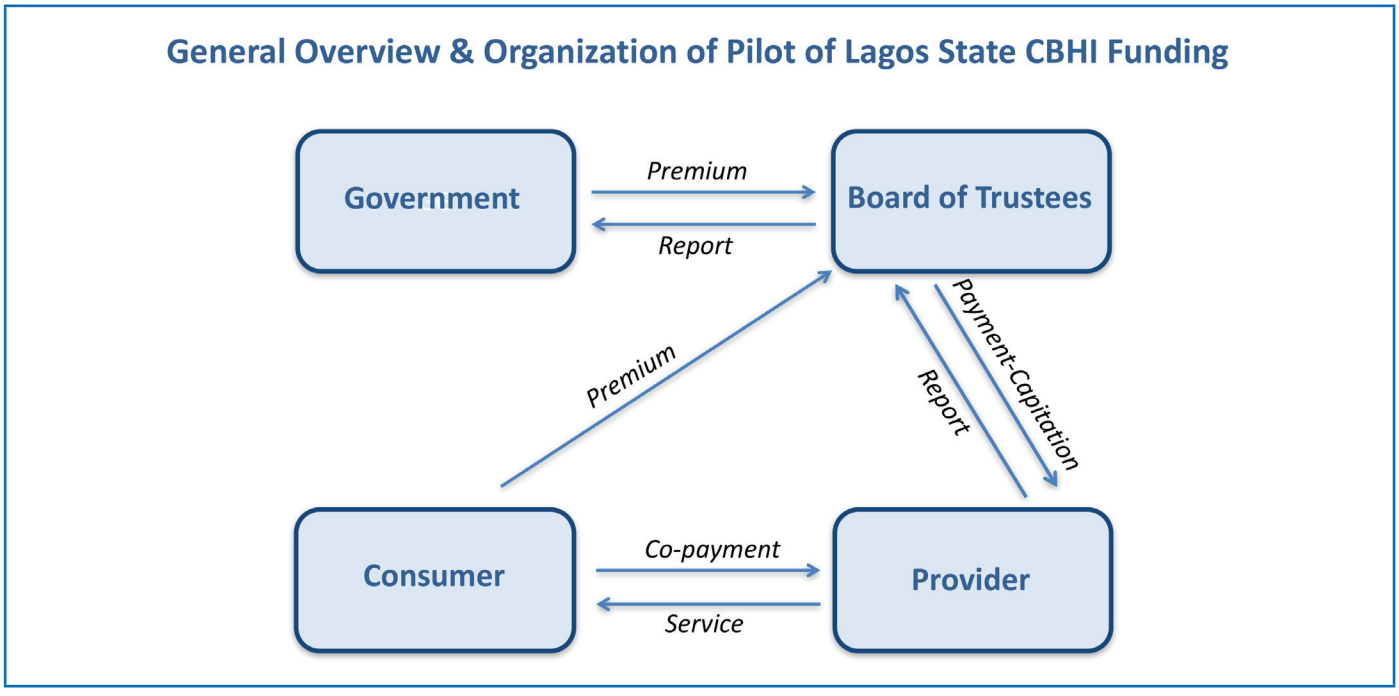
  The Ogun team's key learnings from the Kwara tour included the benefit of legislation in ensuring sustainability, the need to wean off donor support early, the creation of an equity fund to support the enrollment of poor and vulnerable people, the use of private providers in service delivery, and the use of technical partners to put in place several of the operational guidelines to facilitate quick takeoff. A detailed comparative analysis of both programs shows great similarities.

- **Lagos State.** The HiA collaborated with the NHIS to organize a study tour to Rwanda. The tour provided a solid foundation for the passage of the Lagos State Health Management Bill and the subsequent development of its operational processes.

4 A. Onyemelukwe, B. Obonyo, et al., *Improving Pathways to Health: Rapid Assessment of CBHIS Schemes in Lagos State* (Lagos, 2011).

5 Ibid.

Figure 2: Overview of Lagos State Scheme Funding and Involvement of Boards of Trustees



Source: O. Akaoma, et al., *Rapid Assessment of CBHI Schemes, Lagos State, PATHS2* (July 2011).

- **Delta State.** Passage of the bill that institutionalized health insurance in the state was supported by a learning process. Key stakeholders, including top government officials and a number of technical partners, attended an HiA/IFC-facilitated workshop on state-supported health insurance, where several states elaborated on the different stages in attaining passage of their bills, with technical partners guiding them. This workshop equipped the Delta State team members with the requisite knowledge to implement their SSHIS. Since then, the state, with assistance from the HiA-IFC team, has established not only its SSHIS but also the implementing agency directly under the office of the executive governor!

Lesson 3: To enhance continuity and ownership, it is essential for governments to create a policy environment conducive to the support of any health-insurance scheme.

Use of line budgets: The CAPDAN pilot scheme subsidized the insurance premium for low-income employees (and families) of small businesses in CAPDAN in Ikeja, Lagos. The project benefited from funds received from GPOBA.[6] This pilot represents another variant of community-based schemes, albeit without the significant government presence seen in Kwara. (See Table 2.)

6 GPOBA = Global Partnership on Output-Based Aid of the World Bank Group.

Despite being heavily funded, the project never exceeded 46 percent of its intended target population, and there was a gradual decrease in enrollment when premiums were increased as subsidy payments decreased. Uptake also declined following an increase in copayment to compensate for the gap created by the reduction of project funding. The CAPDAN project illustrated the need for government budgetary allocations to insurance schemes to ensure sustainability; as soon as donor funds dried up, the scheme ceased to exist. Having a competent technical partner to implement the scheme did not guarantee its survival, because the state government had no skin in the game!

Institutionalization of schemes through passage of a state law: Following approval from the National Council on Health on the implementation of SSHIS, the NHIS extended technical support to interested states by providing a legal-document template to assist in the drafting of their bills. Key factors include the following:

- Mandatory nature of the scheme
- Establishment of an equity fund
- Commitment of government funds to the scheme
- Use of both private and public providers

Relationship with other state agencies: Lagos State, in the implementation of its health-insurance scheme, understood the critical role that other state government parastatals can play. In a bid to prevent redundancies in the state, the honorable commissioner for

Table 2: Comparison of Health Insurance Plans

S/N	Factor	Kwara	Ogun	Lagos	Delta	CAPDAN
1.	State Supported	yes	yes	yes	yes	no
2.	Donor Supported	yes	yes	no	no	yes
3.	Creation of line in annual budget	yes	yes	yes	yes	no
4.	CBHIS Act	yes	yes (In progress)	yes	yes	no
5.	Use of both private and public providers to deliver services to public	yes	yes	yes	yes	no
6.	Community involvement (Ownership)	yes	yes	yes	yes	yes
7.	Pro-poor component	Targeted at the poor (rural) without involvement of urban dwellers. Also with copayment	Creation of an equity fund. No contributions required from indigents.	Creation of an equity fund financed by ≥1% of the State CRF to cater to vulnerable and indigent groups	yes	no

Source: Nigeria HiA

health (HCH) approached other ministries, through executive council meetings, to assist in the implementation of the Lagos State Health bill. The Health Facilities Monitoring and Accreditation Agency was assigned the role of accrediting facilities and ensuring quality services within the scheme, while the Lagos State Residential Registration Agency was saddled with the responsibility for ensuring the mandatory nature of the scheme and the registration and enrollment of residents.

Lesson 4: State-supported schemes benefit from high-level leadership: Involvement is bottom-up; commitment is top-down!

Beyond extensive community participation, SSHIS exhibit strong relationships with national and subnational governments. For instance, the National Health Insurance Scheme in Nigeria, as part of efforts to expand coverage, now recognizes the power of states to set up their SSHIS through a memo approved by the National Council on Health in March 2015. By this action, the National Health Insurance Scheme in Nigeria, besides serving as a regulator, also serves as a sponsor for the poor and vulnerable by supporting the states in subsidizing the premiums of such populations. The newly established SSHIS will also play an important role in the implementation of the National Health Act—a scenario unlikely with small CHIS-type schemes.

Commitment of the leadership of the state was also important to the sustainability of the program. Besides engaging with the legislature to pass the required legislation, the executive arm has a crucial and paramount role. For the Araya scheme, the state governor committed to a risk-pooling mechanism with its attendant long-term benefits, rather than implementing a "free health" scheme. The wife of the state governor also became a champion in the drive for increased use of services and marketing efforts. The Ogun State team's study tour to Kwara State included a joint team of State Ministry of Health officials led by the HCH and members of the Ogun House Committee on Health.

To further engender participation from the lower levels of government to ensure sustainability, the Ogun State Ministry of Health invited the 20 LGA chairmen to a consultative meeting where the scheme was discussed to improve awareness of its policies. This not only stimulated support from the 20 LGAs but also led to the signing of a communiqué in which they promised to contribute ₦1,000 for every enrollee that contributes to the scheme. These contributions are to be set aside to pay the premiums of indigents.

In Delta and Kwara states, the state governors were directly involved at various stages of program design and implementation—providing substantial input to legislation, flagging off the program at several communities, and ensuring that government contributions are paid on time. Such high-level commitment guarantees sustainability.

CONCLUSION

The NHIS has provided the required leadership for setting up the state schemes, providing a template for legislation, and offering to build the required ICT infrastructure, which will go a long way toward offsetting the impact of fragmentation in the development of the several state schemes. Enforcement of these back-end activities through substantial financial incentives is a good omen. Adoption of community structures in governing these schemes, as inherited from the original CBHIS designs, represents an essential innovation for marketing, enrollment, identification of the poor, and sometimes prevention of fraud.

However, despite the significant state involvement mentioned above, the integration of the elements of community participation into the state schemes has led to the continued misuse of the term CBHIS. The next time you read about CBHIS in Nigeria—or other developing countries—be sure to find out what exactly is being referred to. It might well be SSHIS with extensive community participation and involvement, as distinct from CBHIS, which in most cases are unsustainable, mostly nonprofit, and without the technical capacity expected in insurance schemes.