EpiAFRIC

A Review of Community-based Health Insurance Schemes: Lessons from Nigeria, Ghana and Sub-Saharan Africa

Undertaken for Christian Aid Nigeria, October 2014

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Project description

EpiAFRIC has been 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 was 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 it 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). 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[1] 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.

[1] 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 would always come back to address the key issues during any interview.

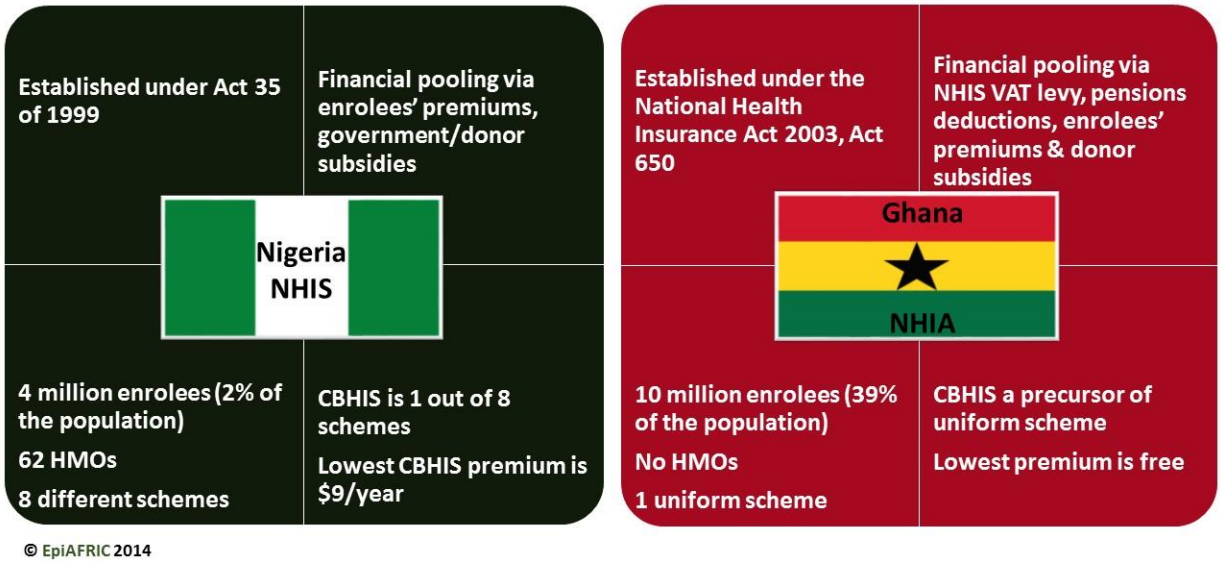
Findings

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 enrollees 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 percent 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 percent 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 two percent of the Nigerian population have enrolled as at 2014 (National Health Insurance Scheme, 2005; Odeyemi, 2014).

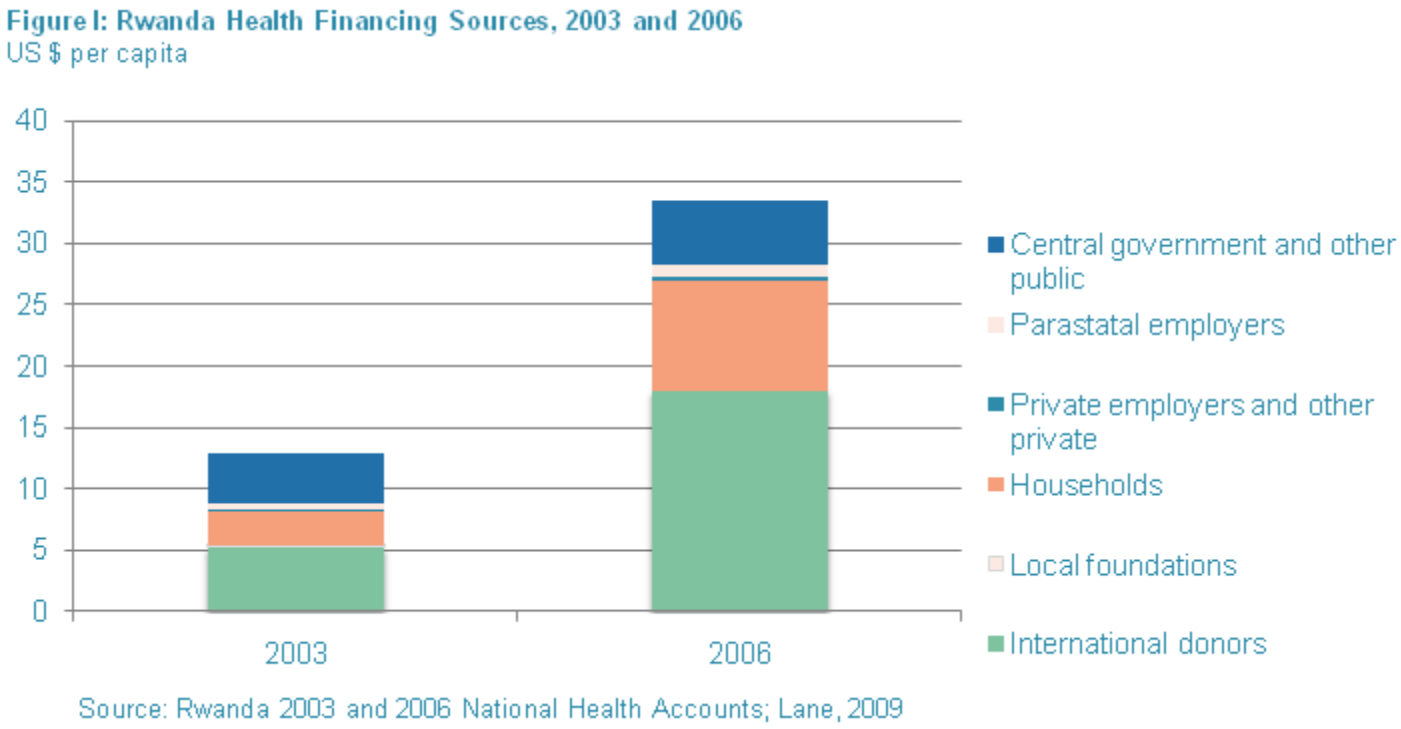
Insight 2: *It has generally been accepted that a tax-funded model with co-payments is an inefficient and impractical way of funding healthcare in Nigeria. The fragmented federal structure and the lack of clear delineation of responsibilities across the different tiers of government make the situation 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 channeled into CBHIS.



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, ongoing 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 percent 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 enroll 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 installment 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 preexisting chronic disease conditions, they in fact welcome them (*Federal Republic of Nigeria. Community Base Health Insurance*, 2011; Hendricks & et.all, 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.all, 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 enrollees 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 reevaluation 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 enrollees. 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 percent 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.all, 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 of similar factors.**

Either of these two approaches will enable CA achieve its strategic objective of increasing access to healthcare.

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Appendix 1 NHIS GUIDELINES FOR THE OPERATIONS OF RURALCOMMUNITY SOCIAL HEALTH INSURANCE PROGRAMME

1. Definition

The Rural Community Social Health Insurance Programme is a non-profit Health Insurance Scheme for a cohesive group of households or individuals registered as Mutual Health Associations (MHAs), formed on the basis of the ethics of mutual aid and the collective pooling of health risks, in which members are responsible for its management.

2. Membership

Membership is by individuals/families (which may include retirees) in the Community who voluntarily register to participate in the Programme.

3. Contributions

i. A flat rate contribution per individual will be paid monthly or seasonally in advance.
ii. There shall be a processing period (waiting period) of sixty (60) days before a participant can access services.

4. Health Benefit Package

The health benefit package is liberalized, and the contribution rate will be determined by the package selected by the participants.

5. Provider Payment System

The capitation payment system will be used at the Primary level, while the fee-for service will apply for secondary services.

6. Administration

Participants shall have a Board of Trustees which shall be made up of representatives who will be elected by the contributors.

Board of Trustees

The Board shall have seven elected officers made up of the Chairman, Secretary, Treasurer and four others. A clerk shall be appointed to carry out clerical and accounting duties.
The Board of Trustees shall have executive powers. The Board shall be responsible for the collection of contributions from participants, paying Providers for services rendered, and opening and operating a bank account with the NHIS-accredited Bank. The MHA shall have an office where meetings will be held.
Three (3) members of the Board of Trustees, the Chairman, the Secretary and the Treasurer shall be signatories to the account. The Chairman and any one of the other two can sign the cheques.
The Board of Trustees, through the Clerk, shall document all income and expenditure of the MHA. The Board shall keep administrative costs to the minimum.

7. Fraud Control Measures

The success of the Rural Community Social Health Insurance Programme will, to a large extent, depend on how effectively moral hazards and adverse selection are eliminated or minimized. To guard against moral hazard, a Gatekeeper and a Deputy Gatekeeper who must be members of the Board of Trustees will be chosen by the contributor. A participant will have to get a utilization form from the Gatekeeper or his Deputy before he can access any level of service.

Emergency cases can be treated without a utilization form. However regularization with the Gatekeeper should be done as soon as possible. If an emergency is found not to be as claimed, the participants will be surcharged an agreed sum to be determined by the Board of Trustees.

To ensure adequate pooling of resources, at least 500 individuals in the community must participate. Any participant, who defaults in the payment of contributions, will pay all outstanding contributions before he will be allowed to re-access service, after a thirty-day waiting period.

8. Actuarial Reviews

An actuarial review will be carried out every six months by the NHIS.

9. Role of the NHIS

i. Setting standards for Health Care Providers;
ii. Approving Mutual Health Associations for participation;
iii. Carrying out actuarial reviews to determine contribution rates and payment rates to Providers;
iv. Drawing up Agreements and Memoranda of Understanding between MHAs and Providers to safeguard members' interests;
v. Ensuring the training of members of the Board of Trustees in elementary management, bookkeeping and the NHIS mode of operations;
vi. Training of Health Care Providers;
vii. Embarking on sensitisation campaigns through handbills, lectures, radio adverts, drama, local musicians and town criers, schools, churches and mosques;
viii. Collaborating with other relevant agencies to offer technical support in the provision of health education to combat infectious and preventable diseases;
ix. Seeking the support of Development Collaborating Partners in the implementation of the Programme;
x. Facilitating MHA/Provider meetings and also monitoring the negotiations and interactions between the MHAs and the Providers; and
xi. Liaising with the owners of public health facilities on the use of such facilities and the retention of funds by the facilities.

10. Registration of Mutual Health Association

All Mutual Health Associations shall register with the Corporate Affairs Commission and the NHIS.

11. Referrals

The need for referrals will depend on the benefit package chosen by the Association. However, referrals will end at the Secondary level of health care.

12. Rules and Regulations

i. All Mutual Health Associations shall register with the NHIS.
ii. No Mutual Health Association registered with the NHIS shall discriminate against any member on arbitrary grounds, including race, gender, marital status, or ethnic background.
iii. The NHIS may use its own staff or appointed agents to visit any Mutual Health Association and assess its structure and performance.
iv. The NHIS shall issue a certificate of registration to each Mutual Health Association registered by it and enter such name in its register.
v. Upon registration, each Mutual Health Association shall open a bank account with any bank from the list of NHIS-accredited banks and inform the NHIS accordingly.
vi. Upon registration, no person shall have claim on the assets or rights of any Mutual Health Association.
vii. Registration of any Mutual Health Association may be cancelled if the registration is based on fraudulent misrepresentation, the Association ceases to exist, or is unable to maintain the financial conditions stipulated by the NHIS.
viii. Upon registration, the Mutual Health Association shall enter into an agreement with a chosen Healthcare Provider or Providers, after due negotiations.
ix. Upon registration, Mutual Health Associations shall sign Memoranda of Understanding with the NHIS.
x. No Mutual Health Association shall be allowed to invest its funds.
xi. Every Mutual Health Association shall evolve an appropriate dispute resolution mechanism, which shall be made known to its members.
xii. Every Mutual Health Association registered with the NHIS, in collaboration with NHIS, shall set up a Quality Assurance Committee to ensure quality of service by the Provider.
xiii. The NHIS shall carry out periodic evaluation exercises for registered Mutual Health Associations and assess their level of performance and efficiency.
xiv. Identity cards shall be provided by the NHIS to members.
xv. The Board of Trustees shall meet at least once a month while the general meetings of the Associations shall be held quarterly.
xvi. Every Mutual Health Association shall set up a Health Education Committee.
xvii. The NHIS shall attend the meetings of Mutual Health Associations and Board of Trustees as observers.
xviii. Membership of the Board of Trustees shall be voluntary attracting no remuneration.

13. Standards for Health Care Providers

13.1 Primary Health Care Provider

Facility Requirements

The facility of the Primary Health Care Provider must meet the following requirements:

1. Waiting and Reception Area

i. At least 4 x 3 metres
ii. Sitting facilities
iii. Reception table
iv. Registration table v) Medical record keeping facilities
v. Wheel Chair/Patients Trolley
vi. Adequate ventilation
vii. Weighing scale
viii. Stadiometre for heights
ix. Washable floor

2. Consulting Room

i) At least 4 x 3 metres
ii) Examination couch

iii) Wash hand basin
iv) Thermometer
v) Good light source
vi) Stethoscope

x. Diagnostic set

xi. Sphygmomanometer
xii. Table and chairs
xiii. Adequate ventilation
xiv. Washable floor

3. Treatment Room

i) At least 2 x 3 metres
ii) Instruments cabinet u
iii) Dressing trolley/tray
iv) Injection trolley and equipments
v) Wash hand basin
vi) Dressing stool
vii) Washable floor

4. Patients' toilet facilities with adequate water supply

5. Sterilizer/Autoclave

6. Containers for sharps disposal

7. Emergency tray

i. - Needles and syringes
ii. Resuscitative equipment

8. Appropriate fire fighting equipment

9. Adequate waste disposal facilities

10. Refrigerator

Personnel requirements

i. One medical doctor who must be registered with the Medical and Dental Council of Nigeria, and must possess a current license to practice
ii. Two registered nurses, one of whom must be a midwife and both must be registered with the Nursing and Midwifery Council of Nigeria, and must possess current licenses to practice.
iii. Two hospital assistants
iv. One administrative staff for medical records and secretarial work

13.2 Secondary Health Care Provider

Facility Requirements

In addition to the requirements for Primary health care providers, the Secondary health care provider shall possess the following:

i. Laboratory
ii. X-ray and allied diagnostics
iii. Surgical operating theatre
iv. Pharmacy (in-house)
v. Lying-in ward with minimum distance of one metre in-between adjoining beds, and 1 x 3 sq. metres between two rows of bed
vi. A locker and an over bed table for each bed

vii. Separate wards for male, female and children
viii. Delivery room where applicable to be 12sq. metres
ix. Sterilizer/Autoclave
x. Wheel Chair/Patients trolley
xi. Ward Screen
xii. Sluice room
xiii. Adequate illumination
xiv. Clean water
xv. Clean toilet and bath facilities with adequate water supply
xvi. Washable floors
xvii. Adequate drainage
xviii. Fire fighting facilities that are appropriately distributed throughout the premises
xix. Mosquito screening for the wards
xx. Nurses ' bay
xxi. Doctors room
xxii. Possession of required malpractice/professional indemnity insurance as stipulated in the NHIS *Guidelines*
xxiii. Possession of appropriate equipment and staff to render services in the field of specialization
xxiv. Registration of premises by the Government of the State in which they operate, where applicable
xxv. Alternative power supply in good condition
xxvi. Any other facility that may be prescribed by the NHIS

13.3. Minimum Requirements for the Theatre/Labour Room

Labour room at least 12sq metres

i. Resuscitative equipment:- At least 1 bed
ii. Adequate toilet facilities
iii. (e) Adequate lighting
iv. (f) Adequate water supply
v. (g) Adequate waste disposal
vi. (h) Washable floors

Operating Theatre

i. (i) Standard theatre room
ii. (j) Operating table
iii. (k) Anaesthetic machine
iv. (l) Autoclave
v. (m) Adequate air conditioning units
vi. (n) Adequate resuscitative equipment
vii. (o) Operating light source.

Appendix 2 – Visit to Kwara

As part of the scoping exercise for community health insurance schemes, the EpiAFRIC team together with Mrs Theresa Adah of Christian Aid Nigeria visited Ghana on a learning trip from Tuesday 21 October to Thursday 23 October 2014. This trip included visits to various stake holders of the Kwara Health Insurance Scheme as facilitated by EpiAFRIC.

Summary description of the project

In 2009 the Kwara State Community Health Program was launched when the Kwara State Government signed a tripartite Memorandum of Understanding (MoU) with PharmAccess (Dutch Health Insurance Fund) and Hygeia Community Health Care (HCHC) towards ensuring a state wide expansion of the state's Community Health Insurance Scheme (CHIS). The Public Private Partnership (PPP) programme currently in nine out of 16 Local Government Areas (LGAs) is expected to be expanded to cover the entire state by 2017. [2] Kwara CHIS was set up to provide heavily subsidized health insurance to the people of Kwara, to ensure access to high quality health care, targeting primarily the rural poor. The program is co-funded by the Dutch Health Insurance Fund with support from the Dutch Ministry of Foreign Affairs and implemented by Kwara State Community Health Insurance Office (CHIS), PharmAccess and a health maintenance organization; Hygeia.

> *In 2006, the Dutch Health Insurance Fund (HIF) was founded with the aim of improving adequate healthcare and this included building feasible healthcare infrastructure systems that would enhance a stress-free access to inexpensive quality healthcare for uninsured communities in Africa. The Dutch Ministry of Foreign Affairs and the HIF signed a contract in October 2006 to make available easy access to inexpensive quality healthcare among low-income residents in Africa with an outline of inventive financing tools that would enable improved healthcare quality. The following year (2007) Kwara State was introduced into this scheme*[1]

The proportional funding by the primary donor has been reducing from the initial 100% at the inception of the scheme to 40% today in 2014. The funding from the Kwara State Government has been increasing and it now supports 60% of the scheme and has committed to extend the program to 600,000 people (60% of the adult population) by 2018[3]. In addition to funding the scheme, this will require infrastructural improvement of 50 primary health care centres. This program is unique because it represents the first time that a state government in Nigeria has partnered with the private sector and an NGO to provide state-wide health insurance for its citizens. The health services included in the Kwara program cover the most common medical problems found among the target groups and covers primary care, secondary care, medication provision and reproductive health services. About 90,000 people in rural Kwara State are currently enrolled (October 2014). All healthcare providers on the scheme are involved in a continuous quality improvement program called

[2] Hygeia, Other Partner Kwara on Health Insurance, Available at http://businessdayonline.com/2013/03/hygeia-others-partner-kwara-on-health-insurance/#.U_w1afldVQf [accessed August 21, 2014]

[3] http://www.safe-care.org/index.php?mact=News,cntnt01,detail,0&cntnt01articleid=35&cntnt01returnid=27

"SafeCare".
Health facilities involved in the scheme have improved the quality of their services[4], and many people are now able to visit healthcare facilities when they are ill. Healthcare utilization has increased by more than 90% among enrolees and more than 15% among the total population in the treatment area. At the same time, out-of-pocket expenditure has decreased by 50%, even when including the cost of the premium[5].

The Kwara State Health Insurance Legislation was passed by the House of Assembly in 2012.
The scheme was initially rolled out to only the rural areas, but the plan now it to achieve state wide coverage. It is currently in nine of the 16 Local Government Areas.

Hygeia Community Health Care has 21 project staff working in Kwara and the Kwara CHIS has about 14 members of staff supporting the scheme.

Why was the project undertaken?

This project was undertaken to improve access to quality healthcare, child and maternal care, family planning services, treatment for HIV/AIDS for the people of Kwara and contribute to the achievement of the Millennium Developments Goals[6]

What are the aims of the project?

The primary objective of the CHIS is for improved access to quality healthcare through subsidized health insurance and improving quality healthcare.[4]

How is enrolment organised?

Enrolment is carried out by agents of the Hygeia Community Health Care, they are paid a base salary and the rest of their earnings depend on the number of clients enrolled. When patients are enrolled they are issued a card with which they attend their primary health care provider. On arrival at the facility, their card is checked against a database to check that its validity.

[4] Hendriks et al. Cardiovascular disease prevention in rural Nigeria in the context of a community based health insurance scheme: QUality Improvement Cardiovascular care Kwara-I (QUICK-I). http://www.ncbi.nlm.nih.gov/pubmed/21439057

[5] Professor Akande during the inaugural lecture at University of Ilorin, Nigeria on 24/02/14

What health care facilities provide care

Both public and private health care providers are used. Patients have to be registered with one facility for their primary care. This centre receives the capitation fees for that patient from Kwara CHIS. However, in most cases, the hospital does not actually receive the funds – it is held by the central CHIS and used to procure the drugs, reagents and any other needs of the facility. It is also use to pay the salaries of the causal workers employed for the health facility. When secondary care is needed, patients are referred to a secondary care facility. They have to receive a "PA" number which enables them receive secondary care for which the provider will be reimbursed.

How is quality assured in the programme?

Health facilities involved in the scheme have been able to improve the quality of their services[6], and become attractive to more people who are now able to visit healthcare facilities when they are ill. Healthcare providers on CHIS go through a quality improvement process called "Mycare". Healthcare utilization has increased by more than 90% among enrolees and more than 15% among the total population in the treatment area. At the same time, out-of-pocket expenditure has decreased by 50%, even when including the cost of the premium[7].

Centralised training has been deemphasized for more innovative, in-facility training using innovative approached including roll play to emphasize the doctor/patient relationship.

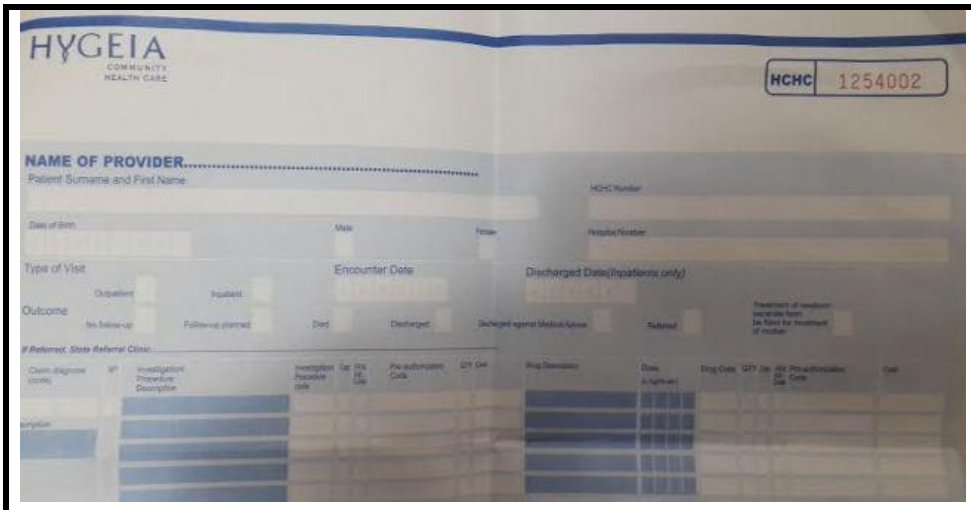
Health care facilities are enrolled in a strict monitoring programme, where they are assessed two times a year. If they fail on two consecutive occasions then they can be taken off the scheme.

How is data from the programme collected?

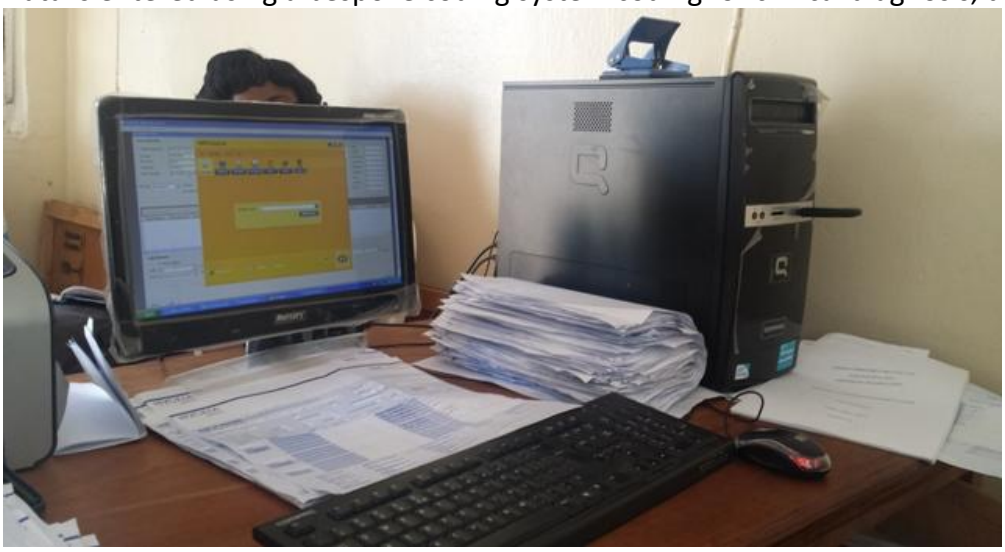
During every patient visit the doctor, nurses, laboratory and pharmacy all fill out data into a form (below). This is taken to the data room as the last point of call during the hospital visit.

[6] Hendriks et al. Cardiovascular disease prevention in rural Nigeria in the context of a community based health insurance scheme: QUality Improvement Cardiovascular care Kwara-I (QUICK-I). http://www.ncbi.nlm.nih.gov/pubmed/21439057

[7] Professor Akande during the inaugural lecture at University of Ilorin, Nigeria on 24/02/14



A data clerk does data entry continuously and the data is sent off to a central server by email and collated. Data is entered using a bespoke coding system coding for clinical diagnosis, diagnostics and treatment.



The data is used centrally primarily for payments.

Who are the stakeholders involved in the partnership and what are their key responsibilities?

- The Kwara State Government has been the main driver of the scheme and was open to innovating on health financing at a time all other states were primarily using direct tax funding and patient co-payments as the only way of funding health crae. It provided the initial hospital infrastructure and has continually improved these. The Government renovated the General Hospital in town as well as 15 other public healthcare facilities to meet acceptable standards.[8] It announced that it is committed to take over the financial responsibility for the program completely by 2016 and recently explained that it has reserved 34

[8] Community Health Insurance Scheme : The Kwara Model, Available at, http://thenationalpilot.com/17%2003%202014/Community%20Health%20Insurance%20Scheme-%20The%20Kwara%20Model.html#sthash.STW9lu9e.bCkMqcwF.dpbs [accessed August 21, 2014]

million euros with the aim to renovate and improve 50 primary healthcare centres across the state every year thereby ensuring that at least 60% of the residents in Kwara State do have access to affordable quality healthcare.[4]

- The Dutch Health Insurance Fund supports the scheme through the PharmAccess Foundation. In 2006, the Dutch Health Insurance Fund (HIF) was founded with the aim of improving adequate healthcare and this included building feasible healthcare infrastructure systems that would enhance a stress-free access to inexpensive quality healthcare for uninsured communities in Africa. The Dutch Ministry of Foreign Affairs and the HIF signed a contract in October 2006 to make available easy access to inexpensive quality healthcare among low-income residents in Africa with an outline of inventive financing tools that would enable improved healthcare quality. The following year (2007) Kwara State was introduced into this scheme[1].
- The Hygeia Community Health Care (HCHC) is the only HMO involved in the scheme. It has supported CNHI schemes in Lagos and Kwara states and plans to other communities across Nigeria. Hygeia developed the concept of the pioneer Kwara CHIS in conjunction with PharmAccess Foundation, a Dutch Network with the donor support of the Dutch Health Insurance Fund.
- Hygeia Group and its technical partners PharmAccess Foundation were able to secure additional donor funds from the World Bank and the Dutch Health Insurance fund. The sustainability plan is to keep Hygeia and Pharmaccess as technical partners only post 2016 when the State Government plans to take full financial ownership of the scheme.

What financial resources are needed for the scheme.

The current premium rate for health Insurance is N4, 500 per annum.

Almost 100% of funding initially came from the Dutch Health Insurance Fund, with enrolees paying a token N100. This third party funding was critical to enable take-off of the scheme. The Kwara State Government has take on increasing responsibility with funding, firstly moving to 40% and now 60%. The plan is to take full financial ownership by 2016. It is estimated that it will cost the Kwara State Government N14B between 2014 and 2018. The premiums paid by enrolees have also increased from N100, to N300 and now to N500 (about $3) per annum. Presently, the total no of enrolees KCHIS is close to 90,000 with children and women making the majority. This means that presently there is at least N45,000,000 (90, 000 x 500) available annually as a result of the risk-pooling to fund healthcare. The funds from the three sources of funding (Kwara Government, Pharmaccess and premiums) are all collated into a fund managed by Kwara CHIS, and then disbursed as capitation for primary health care or fee-for-service for secondary care.

Kwara state is also seeking other funding sources to supplement its contribution to the scheme. In addition to cash – other parties can come in by supporting enrolment, infrastructure or staffing.

What have been key lessons learnt

- Political will is extremely important for the success of the scheme. The political leadership must understand clearly how the scheme helps their population and how they can gain political capital by investing in it.
- Having a champion for the scheme is always great. The Emir of Shonga was a great champion for the Kwara

CHIS when it started and the pilot site was in his community.

- Enrolment will always be difficult, irrespective of how low the premiums are placed, so avoid the putting it too low at the beginning as every increase will be met with a lot of resistance.
- In rural communities that also lack access to proper education, there will be lots of myths around health care. One challenging one has been a perverse impression in parts of the community that by taking out health insurance, one is inviting illness.
- Decide early on whether to use one HMO and have the benefits of a good mutually beneficial partnership or go with several HMOs to encourage competition. It is difficult to move from one model to another once the scheme has started.
- Bring in the community to provide governance and oversight at the local level. In Kwara this is done by a Board of Trustees.
- A lot of time and resources needs to be spent on improving quality of health care facilities before the onset of the scheme. This should include both renovation of facilities and ensuring they are well equipped as well as the training and re orientation of healthcare workers working in them.
- People will only re-enrol if they are satisfied with the quality of clinical services they receive, so a constant focus on quality is important.
- The Local Governments were left out of the initial planning process in Kwara. It is now thought that this was a mistake and they are always included as coverage widens. LGAs are key to mobilising local interest.
- A good information management system is critical for the functioning of the scheme. Each clinical centre enters data into a local database and these are then emailed at agreed intervals to a central server. This requires both internet access and electricity.
- Community entry is a carefully planned process. Initially the community is studied and approached, often through a leader that has integrity and is politically neutral (as much as possible). The traditional rulers are extremely important to have onside.
- The benefits and costs of health insurance should be clearly stated. Even if the premiums are low, the community should be told how much their coverage is actually costing.
- In larger hospitals a customer relations officer is employed to manage any problems that may arise. Regular enrolee forums are held to get feedback. This has contributed to an increased sense of empowerment by enrolees.

What challenges has the scheme faced

- Despite the very low premiums, enrolment and renewal are still a major problem. This is not surprising as Onwujekwe et al [9]show in their paper that there is a very low willingness-to-pay in many Nigerian communities and that this is even lower in the rural areas. In the community they studied, the average

[9] Onwujekwe et al: Willingness to pay for community-based health insurance in Nigeria: do economic status and place of residence matter?

amount that respondents were willingness-to-pay as a monthly premium for themselves ranged from 250 Naira (US$1.7) in a rural community. To address this, the Hygeia is undertaking intensive advocacy and communication activities across target areas in the state. Another strategy often used is for community leaders or politicians to pay for the initial enrolment of a collection of people, who are then expected to maintain enrolment after they have felt the benefits of the scheme.

- Increased enrolment inevitably leads to increased work for healthcare workers in health care facilities where the scheme is working. Therefore the CHIS has had to support these facilities with extra staff and pay existing staff some financial incentives.
- Some of the existing health care facilities were in a very bad shape and required significant investments in upgrading. In some cases, the community came forward to do this.
- Surprisingly the NHIS, which also has a CHIS with premiums higher (N1800) than the KCHIS (N500) has also come to parts of the state to offer CHIS. This causes misunderstanding in the community.
- The culture of functioning insurance generally is very poor so people often need a lot of convincing that they will receive the care when needed.
- Adverse selection is a problem, and this is most likely to be related to the very low premiums. You can only use the scheme in the calendar month after the one that you have registered, but sometimes this is as short as a week.

What outcomes/improvements have they achieved?

- Increased access to health care in Kwara State *(I am requesting for numbers)*
- Increase utilisation of health care facilities
- Increased efficiency in the management of healthcare services
- Attractive model for private sector and donor participation

A visit to one Kwara CHIS General hospital in Afon

We visited Afon general Hospital. This actually works as a very busy primary health care centre. Most of the patients are out-patients with the occasional in-patient mostly following a delivery. It currently has one doctor

and six nurses and sometimes sees up to 200 patients a day. Utilisation of the centre was very low until the introduction of the scheme. Now it receives up to 200 out-patients daily and over 95% of these patients belong to the scheme.

The doctors and nurses with whom we interacted said that despite the increase in workload it has become a much more fulfilling work environment. Also the burden of turning away poor patients who are unable to pay for services has been removed from them. In this hospital, out of 50 members of staff, 60% of them are causal workers directly employed by CHIS. Both internet access and electricity are often challenges so that there are backups for both to enable the data collection continue as every other thing depends on the data reaching CHIS.

Appendix 3 – Visit to Ghana

As part of the scoping exercise for community health insurance schemes, the EpiAFRIC team together with Mrs Nanlop Ogureke of Christian Aid Nigeria visited Ghana on a learning trip from Monday the 6th of October to Wednesday the 8th of October. This trip included visits to various stake holders of the Ghana health insurance Scheme as facilitated by Christian Aid Ghana.

History of Mutual Health Associations in Districts

Prior to the establishment of the National Health Insurance Scheme, mutual health insurance schemes existed in some communities. This comes closest to the Community Health Insurance Scheme (CBHIS), envisioned by Christian Aid in Nigeria.

Many of the mutual health insurance schemes in communities were initiated by faith based organisations such as churches. They initiated the pooling of funds in communities to assist members with their healthcare expenditure when this is needed. An example is a scheme that was supported by the Catholic Church in the northern part of the Volta Region.

We visited Dodowa District, one of such communities which had an existing scheme. The likelihood of a community forming a mutual health insurance organisation depended on many factors including the homogeneity of that community and the existence of a supportive third party with organisational capacity.

Prior to the establishment of the NHIS, the Government of Ghana intervened in mutual health associations and promoted the establishment of companies limited by guaranty. Subsequently they became regulated by government, but with significant autonomy at the local level. Sources for financial pooling included premiums, government and donor supports.

Subsequently, membership increased, utilisation of health services increased and in comparison, pooled funds started to dwindle. The success of mutual health insurance schemes paradoxically led to increasing challenges and they often applied to government for re-insurance.

Large crowd waiting for biometrics capture at NHIA Dodowa District, Greater Accra

The Ghana National Health Insurance Scheme

The National Health Insurance Scheme in Ghana was established by the Government of Ghana, with a goal to provide equitable access and financial coverage for basic health care services to Ghanaian citizens. The scheme was introduced under the National Health Insurance Act 2003, Act 650, and subsequently replaced by a new law, Act 852, in 2012 to consolidate the NHIS[10]. Under the law, there was the establishment of Ghana National Health Insurance Authority which licenses, monitors and regulates the operation of health insurance schemes in Ghana. We visited the offices of the National Health Insurance Authority at the regional level for Greater Accra and two district offices: Dodowa and Ashiaman.

All the operations of the NHIS in Ghana are managed by the NHIA from registration, to the accreditation of service providers to claims management. This is a huge task and has required extensive investment in building up the skills and infrastructure required.

The image below depicts the staffing requirement for this in the Greater Accra region:

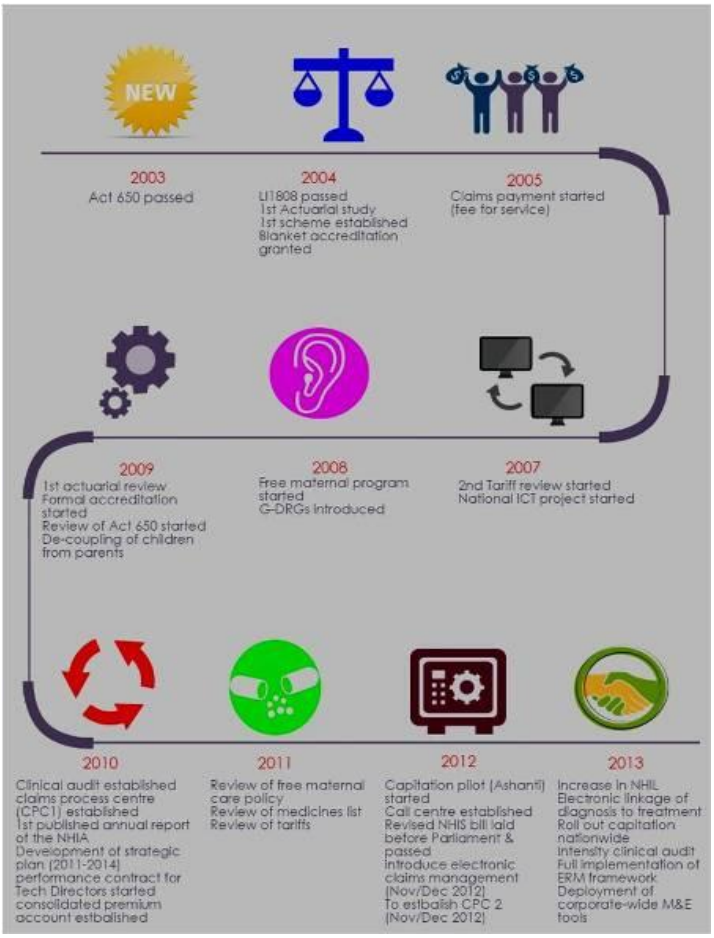
Financial pooling for NHIS

The Ghana NHIS is financed through 4 main sources.

1. 2.5% out of 17.5% VAT is considered as NHIS levy
2. A proportion of social insurance (pensions) deductions
3. Enrolee premiums
4. Donor support

Since inception, the scheme has achieved various milestones depicted as below.

[10] http://www.nhis.gov.gh/nhia.aspx



NHIS Premiums

Enrolee	Premium/annum (Cedi)	Premium/annum ($)
SNED Contributor	4 cedi	1.3
Non-SNED contributor	24 cedi	8
Non-SNED contributor (promo)	15 cedi	5
Above 60 years of age	2 cedi	0.7
Below 18 years of age	2 cedi	0.7
Core poor	Free	Free

5.

NHIS coverage

8-10 million out of total country population of 24 million are covered.

Accreditation of service providers by the NHIA

The accreditation of providers of clinical services for the NHIA takes the following steps:

- Interested providers collects forms from the regional NHIS office, complete this form with all the required information and submits to the Quality Assurance Office within NHIA
- The QA Office sets up an assessment team comprising of professionals (not staff of NHIA) to visit the provider; these are called “Surveyors”
- Visits to the providers are scheduled and conducted. The candidates are informed of impending visits and areas to be assessed.
- A letter of award is given to successful candidates. The approval is for 5 years but renewable annually by contract.
- The regional NHIA periodically conducts routine monitoring visits to ascertain the status of each candidate against the approval given.
- At the onset of the scheme all public and some private health facilities were given blanket approvals. However, all facility types are required to undergo an assessment process before accreditation as service providers are awarded.

Assessing quality of care

The NHIS tries to maintain quality of care at accredited facilities through the following;

- Spot visits are carried out to review of drugs availability
- There is a helpline for enrolee feedback and support managed by the Corporate Affairs department of the NHIA
- Questionnaires are sent to randomly selected clients to assess waiting periods, manner in which they are treated by health facilities

Biometric membership cards

This is a recent introduction in 2014 to increase the level of transparency throughout the NHIS and has now been rolled out in four regions in Ghana. It improves the administration of NHIS and reduces the opportunity for fraud by some service providers. However, because the registration is web-based and can only be done at specific service points, located mostly at the district offices, its implementation has led to long queues all across the country. The roll-out is being supported by The World Bank. It is being rolled out in phases across the regions. With good internet connectivity, it takes an average of 15 minutes to register an enrolee. But internet connectivity is often slow, especially in the rural districts hampers this drastically increases waiting times. In one of the districts that we visited – the Dodowa district; despite a 24-hour service, clients often waited over 24 hours to be registered and often had to sleep over at the district office. The elderly and pregnant women are prioritised during the registration process. Finger print machines are installed with all service providers for the authentication of patient information before care is provided. This is waived during medical emergencies. One of the major challenges facing the NHIA at the moment is a large indebtedness to service providers. It is anticipated that by improving the verification process for claims, the introduction of biometric cards will reduce the volume of claims.

Biometrics Capture in Session at NHIA Ashiaman District, Greater Accra Region

We also visited the NHIA in the Ashiaman Dictrict, Greater Accra; and urban area. This district has a total population of 280,000 and about 168,000 citizens are currently enrolled in the NHIS (60% of the population enrolled – but note that residents of Ghana can register anywhere in the county). On the day we visited, there was a large crowd waiting to register; crowd control was managed by the issuance of numbers. A prospective enrolee fills the form, is given a receipt, bio data and finger prints are captured, and cards are issued immediately. People of all ages are registered – minors and babies as well. The process is faster than in the other district that we visited; Dodowa due to better internet connectivity. An average of 300 enrolees are registered daily, on "good" days, up to 400 are registered using six data capturing machines working from 4 am to 8 pm. The plan is to completely phase out non-biometric cards used in the district by April 2015. Dodowa is predominantly rural while Ashaiman is Urban. In both situations the distance to enrolment points as well as the time it took to be enrolled was a difficult challenge to overcome.

Claims payment

There is currently a six month backlog to payment of claims. The NHIA has a window period of 3 months to settle each monthly claim submitted and verified. This is causing a lot of dissatisfaction on the side of providers in the country.

Bouquet of services covered under NHIS

- 95% of disease conditions in Ghana
- All cancers are excluded except cervical cancer
- Mental health was recently included

Free services for the "Core Poor"

The "core poor" receive free services. They are identified either by their communities of via a set of factors including;

- Individuals who receive subsistence allowance from the government
- The aged above 70 years
- Unemployed persons living with disabilities
- Children under-5
- People living with disabilities
- People in remand homes
- There are plans to add people in prisons

Pilot using capitation

A new model using capitation to pay for primary care services is being piloted in Kumasi. The intention is to implement this nationwide in phases.

Citizen involvement

Christian Aid's frontline partner in Ghana is an NGO; SEND-Ghana. SEND-Ghana works through grassroots infrastructure, which is an amalgamation of CBOs to form monitoring committees. They work in 50 out of 275 districts in 4 regions of Ghana. Selection of regions is based on equity considerations; the northern regions are the poorest while Greater Accra represents the urban poor. SEND-Ghana intervenes in the following areas; 1) Budget 2) Governance 3) Accessibility Their activities include work in the following areas:

- Collecting data to influence policy
- Identifying policy gaps with the NHIS implementation
- Engaging with NHIS and other key stakeholders in health
- Assessing the effectiveness of NHIS implementation

In 2002, SEND took a strategic decision and started the implementation of its flagship research and advocacy programme. The purpose of the project was to demand transparency, equity and accountability in the use of resources that the government of Ghana accessed as a result of reaching the decision point of the HIPCs' initiative. From 2002-2004, through 25 District Monitoring Committees, SEND monitored the use of HIPC funds in the implementation of Ghana Poverty Reduction Strategy (GPRS). The HIPC watch project of SEND-GHANA resulted in greater transparency, equity and accountability in the use of the HIPC funds making it a reference point for civil society work and engagement on public expenditure monitoring.

District Citizens Monitoring Teams (DCMT)

- SEND-Ghana set up voluntary, non-partisan monitoring teams across districts in Ghana
- These teams are involved in Community-based Health Planning and Services
- Membership of these teams consists of individuals that represent various organisations within the community.
- Organisations represented include youths, NGO, small-scale farmers, women, district assemblies, people living with disabilities
- Monitoring teams monitor various social activities and submit data to SEND-Ghana
- SEND-Ghana analyses the data and uses findings to advocate to government

Example of work done by DCMT on the National Health Insurance Scheme (NHIS)

SEND-Ghana commenced quarterly monitoring of NHIS and has assessed its workability, drugs dispensed, health services provided, and the relationship between providers and patients.

- Findings revealed that NHIA gets most of the backlash from enrolees rather than the service providers.
- Lots of complains relate to the non-availability of some prescriptions in health facilities. Following SEND-Ghana advocacy, health facilities were mandated to inform enrolees about Pharmacy shops that are registered under the NHIS to provide such drugs.
- A 1-month window is required between registration and the use of NHIS. SEND-Ghana advocated for the exclusion of pregnant woman from this requirement. One year free membership period covers 9-month pregnancy period and an additional 3 months for the baby during the post-natal period.
- SEND-Ghana advocated for the establishment of registration points within health facilities rather than just in the district offices because of the long distances to travel by community members to get registered.
- Awareness of and utilization of the NHIS has improved with feedback from current enrolees especially by pregnant women. There is increased pressure on health facilities due to increased utilization

We asked what motivates members of the District Citizens Monitoring Teams to engage in this voluntary work, and got the following responses:

- To have a "just" society where their participatory governance with people empowered with the right kinds of information
- Passion to help society
- To bring development to the District
- To fight for the rights of people
- Meeting important personalities as a result of the advocacy work done

Study team in discussion with the Ashiaman District Citizens Monitoring Team

A visit to NHIA Dodowa, Dangme West District, Greater Accra Region

Demographics
This district has an estimated population of the district of 160,000. There are four towns (traditional councils) in the district and most of the population are poor. Most inhabitants are farmers and very few people are engaged in the formal sector. The volume of harvest dictates the level of poverty. Of all the enrolees in the NHIS in Dodowa, 35% of enrolees are classified as "core poor" – and enrolled for free.

This district was part of the NHIS pilot because it already had a history of having a mutual health association, which was established in 1996 following a PHD research thesis. A major driver for this was to alleviate the effects of poverty. Third party support was crucial in providing additional funds at the inception of the scheme. Donors included EU, UNICEF, DANIDA and ILO. Community members were persuaded to join through systematic education and sensitization. The district health management team nurtured the scheme until it was taken over by the NHIS in 2005. Enrolment and utilization have increased over the years.

Private Health Insurance

In addition to the NHIS, Ghana has a rapidly evolving and vibrant private health insurance scheme. We visited "Nationwide Mutual Healthcare". This is a Private Mutual Health Insurance scheme promoted by the Society of Private Medical and Dental Practitioners (SPMDP) in 2003. This is a mutual fund into which the contributions of all members are paid, and it is utilised to provide healthcare services to members who so require. It is managed as an autonomous not-for-profit organisation based on solidarity between its members and is accountable to them[11]. The NHIA has recently directed that all private health insurance companies convert to a for-profit status. Nationwide Mutual currently has

[11] http://nationwidemh.com/index.php

50,000 enrolees. Most of them are employees of corporate organisations, but an emerging strategy is to target individual clients. The rapid growth in membership is thought to be as a result of a general increased awareness of health insurance that was created by drive for the public NHIS. Nationwide has a –partnership with OracleMed of South Africa as well as an Indian firm to provide international health packages for her clients. The private health insurance space in Ghana is becoming increasingly competitive; there are 20 other organisations in that space. The challenges currently being faced by the public NHIS and the poor perception this creates plays in the favour of Nationwide; as more individuals in the informal sector are likely to subscribe to Nationwide health plans. Nationwide and NHIS often use the same providers for clinical services.

Nationwide premiums

S/N	Plan	Cost/person/year
1	Essential	$122
2	Executive	$197
3	Premier	$303
4	Privilege	$2000
5	International health	

Governance
Provided by a Board of Trustees comprising of service providers, clients and Nationwide Mutual Healthcare

In summary we found that the Ghana National Health Insurance Scheme has many strong points;

- It has definitely increased accessibility to healthcare in Ghana and reduced the effects of poverty on health
- There is strong political will to grow the scheme and high awareness among the population about the scheme.
- It is supported by an elaborate national ICT platform
- There is a strong enabling Act that established the NHIA which includes details down to premiums
- There is active citizens' engagement and participation
- It has improved efficiency of healthcare delivery and improved the standing of the overall health system

The scheme however is facing some challenges;

- Most of the funding for the scheme is through VAT and Social Insurance deductions rather than premiums (premiums account for below 5% of total financial pool)
- The funding from VAT and Social Insurance deductions does not come directly into the coffers of the scheme, therefore may be open to other uses depending on government priorities
- The general perception is that the premiums paid are too low to support the scheme and there is a very high proportion of non-paying membership.
- Ghana has a large uneducated population who need extensive and continuous education on the benefits of the scheme.
- Poor and inconsistent internet connectivity is hampering migration to the biometrics management system
- There have been a few instances of claim fraud by service providers
- Sustainability is threatened when providers are not paid when due. Providers were last paid in February 2014 (visit happened in October).
- There is increased political pressure to include more people and cover more disease conditions.

- Long distances people from remote communities have to travel and amount incurred to register for biometrics, sometimes costing as much as 32 Cedis ($9.70)

Pharmaceutical companies threaten to suspend drug supply to NHIA

Sylvester Mensah, NHIA boss

PHARMACEUTICAL companies in the country have threatened to suspend drug supplies to accredited National Health Insurance Scheme facilities across the country.

The companies reached the decision at a meeting Kumasi yesterday, to consider numerous proposals about their dealings with the NHIS.

The National Health Insurance Authority has not paid for services rendered by the providers for months, making it impossible for them to pay their suppliers.

The service providers are preparing to go to court to compel the NHIA to make full payment for services rendered to NHIS accredited institutions.

Director of Operations and Communication of Health Insurance Service Providers Association, Tony Amekah, said on Joy FM that most of the pharmaceutical companies were in financial distress.

"Since February, with some dating as far back as August last year, payments have been in arrears", he said.

The companies, he said, had had discussions with NHIA but they had discovered the delay was caused by the Ministry of Finance.

Tony Amekah explained that some pharmaceutical companies which went for loans at interest rates as high as 45% to make supplies, had been burdened by huge debts because of the delays in payment.

Joseph Christian Amoah, a member of the Association, accused the government of breaching an agreement to make payment within 90 days of service.

He charged government and NHIA to "be up and doing", and warned the companies will not accept any piecemeal payment of the amounts accrued. *Credit: Myjoyonline.com*

"The New Statesman" publication on challenges with settling claims by service providers – Issue: 6 No. 70 ISSN 39/11 Wednesday October 15, 2014

Things to consider from our experience with the Ghanaian NHIS

- It is critical to perform actuarial study before the project which will include projections for long term funding of schemes.
- Think about financial sustainability from inception
- Develop a robust funds management system
- Define various bouquets of health care to be delivered from inception
- Create awareness and acceptance of the scheme amongst community members
- Consider how the poor and vulnerable can be identified and how their premiums can be supported to ensure social inclusion so that the genuine inability to pay premiums is not be a barrier to enrolment
- Registration of minors under-5 should be uncoupled from parents and should be free.
- Make use of biometric management system from inception; saves time and money
- Re consider the provision of free services to ALL pregnant women. Many can and are willing to pay.
- There should be a differentiation in premiums based on rural versus urban residence.
- Very low premiums may be politically expedient but may cause a loss of confidence in the scheme if funds are insufficient to pay for claims.
- Do not fix premium levels by law.
- Huge crowds at registration centres themselves pose challenges for infectious disease spread.

Appendix 4 - – Visit to FCT-Community Based Health Insurance (Pilot schemes)

As part of the scoping exercise for community health insurance schemes, the EpiAFRIC team visited the FCT_CBHIS on a learning trip at the FCT Health Services Scheme (FHSS) office. This trip included visits to the FCT MDG office and the FCT-NHIS office

Summary description of the project

In response to UHC for all Nigerians, the Federal Government approved the institution of the National Health Insurance Scheme (NHIS) in 1989. Launched as the national regulator for all health coverage schemes in Nigeria in 2005 and has since assisted in establishing schemes especially for the formally employed Nigerian. Likewise, under the guidance of the Federal Capital Territory Administrative (FCTA), the FCT Health Services Scheme (FHSS) was created to guide the provision of affordable, assessable and quality healthcare coverage for rural residents of the FCT. One of the models provided through the FHSS is the Community Based Health Insurance Scheme (CBHIS).

The CBHIS was launched in 2012 on a pilot bases and the target population are residents of the rural communities in the FCT. Sixty of the 861 communities in 6 area councils in the FCT were selected as targets for launching the CBHIS pilot. However, as of April 2013 only 20 communities have successfully initiated CBHIS pilots. The underlying assumption behind the CBHIS includes risk and revenue pooling through contributions made by community members when they are not ill encourage health care provision for everyone in the community when they need to access it. Hence achieving the goal of, sharing the burden of disease and health financing across all participating community members.

The biggest attraction of community health insurance as a model for delivering universal health coverage is probably its inclusion of the community, the insurer, the provider and sometimes a third party in its management. In this case, the enrolled members of the CBHIS and the FCT government share the revenue generation in 10% to 90% ratio respectively. Due to some challenges with the FCT CBHIS over the years, the scheme is not currently functional but in the process of being revived by the FHSS.

Across Nigeria, various CBHIS models are increasingly making healthcare accessible to the poor and underserved: Hygeia community health plan[12]; Auchi Allied Association Mutual Health Scheme[13]; and Isanlu mutual community based national health insurance scheme[14] are some examples. Some new ones such as the Ogun State Community-Based Health Insurance Scheme[15] are in their infancy.

What are the objectives of the project?

The primary objective of the CBHIS is to provide affordable, assessable and quality healthcare coverage for rural residents of the FCT. It is expected that the insurance scheme would involve all stakeholders; people, government, the healthcare management organization and donors with responsibilities and benefits and creating the possibility of a sustainable programme.

[12] Hygeia Community Health Plan, available at http://www.pharmaccess.org/RunScript.asp?Page=156&p=ASP\Pg156.asp [accessed July 24, 2014]

[13] Health insurance sheme to cover nigeris in 2015, available at http://www.punchng.com/news/health-insurance-scheme-to-cover-nigeria-in-2015/ [July 24, 2014]

[14] Lambo inaugurate 80m community health centre in Isanlu, available at http://www.kogireports.com/lambo-inaugurates-n80m-community-health-centre-in-isanlu [accessed July 24, 2014]

How did organisation(s) go about planning for the project?

An actuarial study was conducted to ascertain the viability and practicability of initiating the CBHIS in the FCT.

Who are the stakeholders involved in the partnership and what are their key responsibilities?

- The FCT Executive Council provides the legislative framework, health systems support, provides 90% subsidy for the scheme, ensures adequate staffing in the facilities
- FHSS-Regulators sets standard for running the scheme; approves financial institution for the scheme; monitoring and evaluation and a host of other responsibilities that ensure the scheme is operational and sustainable.
- One HMO: United Healthcare International who manages the providers and administers the scheme and does so as part of their corporate social responsibility.
- Community members: They appear involved and critical for the survival and growth of the CBHIS. After rigorous engagements with the community and years of building trust they appear now to be major champions of the scheme. In the FCT CBHIS, the community elects and leads the Board of Trustees, which provides governance. The community also supports the project by participating in general meeting and supporting general logistics
- Development partners (UNFPA and FCT MDGs Office) contribute to funding the subsidies and providing technical support

What is the revenue structure needed for implementing the scheme?

Evidence has shown that pooling of funds as practised under the FCT CBHIS is viable and a sustainable way of ensuring access to healthcare and eliminating out-of-pocket payment in poor-resource settings. Below is a breakdown of the resources used to fund the scheme:

- The cost of health care was determined to be ₦15, 000 per annum. Thus all enrolees which is done per household, pays ₦1,500 per annum while the government subsidizes the remaining ₦13,500.
- The scheme has made healthcare accessible to 4,000 enrolees so far.
- Therefore, there is at least ₦60, 000,000 (4,000 x 15,000) available annually because of the risk pooling to fund healthcare.
- 60% of contributions are for capitation payments, 20% for fee for service (referral), and 20% for ICT/data management.

How are healthcare services Purchased

Public and Private facilities and providers participate in the scheme

- Providers sign contracts with the HMO and are assigned to specific communities. They are also expected to give regular feedback to HMOs and FHSS regulators
- PHCs offer a robust package of primary care services to registered members including the management of common disease and injuries; child health services; maternal and neonatal health including family planning and control of locally endemic and neglected diseases to registered members. In addition, health promotion and disease prevention activities are also offered to members. They are also responsible for facilitating two-way referral systems
- Records of services rendered and payments received are maintained

What are the mechanisms employed to ensure Quality control and sustainability?

Quality Assurance is enforced by the FHSS regulators with the aim of ensuring that the quality of health services provided to members is expected to be up to the minimum standard of care. They are tasked with accrediting participating health providers before they can participate in the CBHI scheme. The health providers are re-accredited every 2 years.

A number of short-term and long-term strategies are in place to ensure the sustainability of the FCT CBHIS.

Short Term:
This includes: the institution of enabling legislature; intensive sensitization and community mobilization; strengthening of existing health system, establishing institutional processes for risk management and understanding and improving determinants of enrolment and performance of the scheme

Long-term:
This includes: expansion of the scheme to include all the communities in the FCT with collaboration from the traditional and non-traditional partners; harmonization of all schemes into one pool with a potential of linking to the formal sector scheme; increasing competition by engaging other HMOs and the identification of additional sources of funding

Appendix 5 - The context in Plateau State for Proposed launch of CBHIS in two Communities

As part of the project – the study team visited Plateau state to gain a better understanding of the context.

Visit to NHIS Plateau State
The NHIS has recently set up state offices. A discussion with the newly established Plateau State NHIS personnel shed more light on their role. Staff working at the state office are responsible for meeting the mandate for extending healthcare coverage through CBHIS. Their goal is to assist any settlement of people or group with a common characteristic (like belonging to the same occupation), within the state to set up CBHIS. They have recognized two communities of interest in Plateau. They also established a relationship with the Center for Gospel Health and Development (CeGHaD) a non-government organization (NGO) assisting with the process of CBHIS implementation in Plateau State. They also verified receiving their letters of interest from communities and confirmed their role in providing the technical help necessary for setting up the CBHIS. Enrollment is voluntary and open to all communities in Plateau State who meet requirements stated by the NHIS act for CBHIS. One key requirement is setting up a mutual health fund with an associated bank account. In addition, meeting the qualifying minimum population count for initiating and maintaining CBHIS set at 5,000 members per community. The minimum requirement for participating health facilities is based on the WHO standard for primary health care system.

Meeting with the Chairman Plateau State NHIS implementation committee
A discussion with the Chairman Plateau State NHIS implementation committee within the State Ministry of Health revealed additional insights from the State Government on executing CBHIS. Plateau State has selected three LGAs where CBHIS pilots will be launched. These LGAs include Pankshin, Barkin Ladi and Lantang North. Coincidentally, Chigoncommunity selected by Christian Aid partner (CeGHaD) as one of the pilot areas is located in Pankshin LGA. The state has made budgetary allocation to support/finance the CBHIS. However, there are concerns that funds release may be delayed due to bureaucratic bottlenecks. 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.

Meeting with United Healthcare International (HMO) representative
The Plateau State Branch Head of United Healthcare International HMO was interviewed. Their actions in supporting CBHIS are guided by the NHIS framework. United Healthcare International expects to support qualifying communities who make the choice to engage their healthcare management services. There are plans to conduct an actuarial study in collaboration with the state NHIS prior to the launch of CBHIS. Its aim is to determine the cost of healthcare coverage for each family per annum. In an attempt to ensure quality, the HMO intends to implement regular audits of health facilities and will delist and revoke accreditation for any facilities who fail to meet standards. In addition, easy access to HMO representatives for enrollees to lay complaints and garner solutions for any problems they encounter will also be part of quality assurance.

The Proposed Communities for launching CBHIS
There are currently no existing CBHIS in Plateau State. However, some communities in the state have experienced the benefits of a rudimentary risk-pooling scheme as part of Savings and Loans Associations. Through CeGHaD, two communities have been voluntarily making small monetary contributions. Interviews were secured with both communities and the findings are presented below. This was borne out of an existing

mutual economic fund where members of the community made monthly voluntary contributions. Access to the pooled funds is made available to community members after they make a strong case for the economic empowerment the requested money will bring to the family. The success of this mutual economic fund, served as the primary motivation for initiating the contributions towards a healthcare fund.

Findings from -Chigon Community, Pankshin LGA

Chigong is a village within a larger community known as Chigong. The absence of a primary health care (PHC) facility encouraged their decision to begin contributing towards a "healthcare" fund to aid procurement of a first aid kit and medicines. Through CeGHAD, they have been made aware of the opportunity to turn their modest contributions into a legally established community based health insurance scheme through the NHIS act. As such, they have initiated the processes by writing a letter of intent to the NHIS and commenced putting all requirements in place. Some of such requirements include, registering a mutual health fund with an attached bank account based on a minimum of 5,000 members; determining an affordable contribution and setting up a Board of Trustees. Prior to this knowledge of a CBHIS, community members voted and set up a committee who served as the informal board of trustees led by a Chairman. This committee has been retained as the acting managing body until they are fully registered. Currently they are responsible for collecting and managing the monthly contribution of 200 Naira per month for males and 150 Naira per month for females. They also serve as the link between the Community members and other partners including NHIS and CeGHAD.

The cost of insuring an individual or household in the area has not been determined and no partnership has been established. Community members estimate a household contribution of 500 Naira per month. However, this may not be feasible or sustainable considering that some members are already find it difficult to contribute 150/200 naira per month. The current rate of enrollment holds at only 27 individuals: 14 males and 13 females. This is only a scratch at the recommended minimum of 5,000 enrollees, but the BOT expect to use strong and aggressive community mobilization to ensure enrollment. This includes using: religious leaders via churches and mosques, existing health advocacy structures, local information dissemination, community meetings and women leaders within women organizations in the community. They also anticipate setting the premium per household and to encourage all households in the village to enroll. The major quality control mechanism proposed by the BOT is the prudent use of services. This will be governed by clear guidelines developed as part of developing the CBHIS scheme.

The community expects to establish a CBHIS scheme that will provide primary care and an opportunity for obtaining secondary and tertiary care when needed. However, the absence of a PHC in the community presents a major challenge as to where the point of primary care will be. Although a community member has donated a structure for this purpose, one of the first actions will be to outfit this structure with medical equipment, resources and personnel. This can potentially make the opening costs higher and will require strong State and local government supports.

Proposed Gamankai CBHIS, Langtang South LGA

This community has an improved rate of participation by its members with 353 enrollees: 186 Females and 167 Males. Their contribution is 50 Naira per month and the same for both gender. They have garnered 17,650 Naira in contribution since the inception of collection in March 2014. This contribution is low compared to the previous community and any CBHIS currently running in Nigeria. Although not all residents of the community participate in contributing towards the fund, those members who do, have not defaulted. The premium was set in anticipation of government subsidy.

Community members expect to follow the NHIS Act. They expect that the scheme will offer a standard bouquet of services to all registered members but will make provision members to pay for additional services. Rigorous mobilization through town meetings and education is the proposed mechanism for encouraging enrollment.
In keeping with the need to set up a BOT as part of the NHIS Act, the community expects to elect women leaders to participate in this capacity. Their participation in the BOT is expected to gain the trust of the people as they are deemed responsible and efficient managers within the community. The current Chairman expressed his confidence in the value of an operating CBHIS in the community. His major concern and area of personal input is in working hard to educate community members who were originally skeptical about the viability of the scheme. He is working with NHIS and CeGHaD staff to prepare all the necessary factors for registering a mutual health fund and to encourage enrollees to make bigger contributions. There is a need for both State and third party financial support for successful launch in this poor and rural community. The chairman is convinced that once its takes off, community members who are beneficiaries will be able to share their experiences with other community members and encourage increased enrollment.

PHC personnel from Gamankai in Langtang South LGA of Plateau State
An interview with healthcare provider from the PHC in the second community of interest was conducted. She disclosed that there are 11 healthcare providers at this location and the head provider is a registered nurse. There are no doctors on staff however, volunteer doctors lend their expertise for surgeries and specialized care when needed. The PHC currently offers immunizations, out-patient services and minor surgeries which the volunteer doctors come in to facilitate. Currently they observe traffic of about 15 patients per day, which is mainly due to the rainy season, and the associated increase in the incidence of Malaria. All referrals made by the PHC are to two different health facilities one in Shendam, which is about 30 minutes away and another in Mabudi which is about an hour away.

NHIS and CeGHaD have sensitized the healthcare providers at the Gamankai PHC on what a CBHIS is. As such, they have a clear understanding of the makings and benefits of a CBHIS and agree that it is a necessity for the communities they serve. However, they forsee that skepticism on the part of community members on the effective management of the funds and a low capability to pay the stated monthly premium of 150 Naira may stall or hinder the establishment of the CBHIS.