Policy Brief by

Centre for Population and Environmental Development, CPED

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COMMUNITY HEALTH INSURANCE SCHEME AND ITS CHALLENGES: *CPED Experience*

Introduction

Despite the fact that maternal and child health statistics remain the most credible indicators for measuring the quality of human development worldwide, the rate of women dying during child birth have become worrisome in Nigeria. UNICEF has estimated that on the average, 145 Nigerian women of childbearing age die every day, while about 2,300 children under-five years die daily. These high ratios are indications of poor maternal, newborn and child health which have been attributed to issues of availability, accessibility and non-use.

It is believed that one of the major objectives of a responsible government is to provide good and affordable healthcare for her populace. Interestingly, successive administrations have made one policy or the other in an attempt to reduce this ugly situation that has stigmatized the country for years. One of such was the promise by the government at various levels to abide by the Alma-Ata declaration of September 1978 which defined the concept of PHC as essential care based on practical, scientifically sound and socially acceptable health care methods and technology, made universally accessible to individuals and families in the community through their full participation and at a cost that the community and country can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination. (Emaka & Masemote, 2011).

Background

This policy brief is based on the findings of CPED in the concluded implementation research titled *"Improving Maternal, Newborn and Child Health (MNCH) in Underserved Rural Areas of Nigeria"* The project which was supported by Think Tank Initiative (TTI) arm of International Development Research Centre (IDRC), CPED, ICWA and the Delta state government was a small scale implementation research programme carried out in Okpe local government area of Delta state, Nigeria.

The main objective of the project was to improve MNCH in rural areas in Nigeria through the implementation of an innovative community-based MNCH model. The ability to test diverse MNCH implementation pathways and to identify what works in rural community settings is critical to the improvement of MNCH care in Nigeria. This policy brief will therefore draw the attention of healthcare stakeholders and policy makers on a practicable model implemented by CPED project team.

The PHC is arguably the first level of contact for individuals, the family and the community within the national health system, bringing health care as close as possible to where people live and work, and constitutes health care services (Emaka & Masemote, 2011).

Although PHC centers were established in both rural and urban areas in Nigeria with the intention of equity and easy access, regrettably, the rural populations in Nigeria are seriously underserved when compared with their urban counterparts (Abdulraheem & Olapipo). On the other hand, the issue of people(especially mothers and children under-5) living in the rural communities not being able to afford the services rendered at the primary healthcare facilities located in their area is one to bother about. This is because many households living in rural communities are poor and may not be able to afford quality healthcare services at the primary health care facilities. Research shows that the healthcare needs of individuals living in rural areas are different from those in urban areas, and rural areas often suffer from a lack of access to healthcare. These differences are the result of geographic, demographic, socioeconomic, workplace, and personal health factors. For example, many rural communities have a large proportion of elderly people and children. With relatively few people of working age (20–50 years of age), such communities have a high dependency ratio. People living in rural areas also tend to have poorer socioeconomic conditions, lesser education, higher rates of tobacco and alcohol use, and higher mortality rates when compared to their urban counterparts (Canadian Institute for Health Information, 2006).

With the various aforementioned issues bedeviling health system and the problems being faced by a larger population of the rural settlers in accessing PHC centres then, establishing health insurance schemes at the rural communities with the primary healthcare facilities used for service delivery, is now long overdue. If this is done, it will make the Nigeria government achieve the universal health coverage (UHC) policy which advocates that all people and communities ought to be able to use the promotive, preventive, curative, rehabilitative and palliative health services they need, of sufficient quality to be effective, while also ensuring that the use of these services does not expose the user to financial hardship (WHO).

Coverage of the Community Health Insurance Scheme

The community health insurance scheme proposed by CPED would cover every community member residing in the community whether the person is an artisan, farmer, sole proprietor of business, street vendor, unemployed, youth, women, men and children, as long as they are enrolled in the scheme and are living in the community.

In the proposed CHIS, the primary healthcare facilities are to be used to deliver services, and the services that can be delivered are the ones the PHC providers are permitted under the law to provide. Any severe illness are actually referred to the secondary healthcare facility. The people must be made to know what services they the scheme can provide, any failure to do so will most likely result to anarchy and unnecessary argument between the healthcare providers and the patients.

The CHIS will cover six(6) neighbouring communities namely Okwabude, Okuogholo, okuofoma, Oyenke, ijakpa and Okolovu, all located in Ward 17 in Okpe LGA of Delta state. Okwabude primary healthcare facility was chosen for service delivery.

Challenges Faced in the Establishment of CHIS

The challenges encountered by CPED in her bid to establish the community health insurance scheme in Ward 17 in Okpe LGA were somewhat daunting. Some of these challenges are explained below.

a) **Poor State of Medical Equipment, Infrastructure and Personnel at the PHC**: It is generally believed that for effective delivery of Healthcare services, there should be availability of equipment and well-trained medical personnel on ground. Results from our baseline study of some PHCs in Okpe Local Government Area of Delta state show little or no presence of some essential drugs, basic equipment, medical disposables as well as inadequate medical personnel manning each PHC centre. What is even more worrisome is the fact that some of these centres have no functioning toilet facilities and are also in a poor sanitary state. The health facility that CPED eventually chose was without good portable water supply and the environment was very bushy.

All these aforementioned challenges were addressed before kick-starting the community health insurance scheme. In the case of low medical personnel, we had to work with key stakeholders to ensure the posting of some other staff to join hands with the ones on ground. Although there were initial resistance from some of them because they didn't want to work in the rural area but they were coerce by the Head of department and the LGA authority. Furthermore, to ensure a robust workforce, the project team trained six (6) Village Health workers / Lay community health workers. Their role is to be able to educate community members on: Hygiene promotion, Malaria prevention in pregnancy, pre/post natal care, understanding childhood illness, family planning, especially child spacing, food

demonstration/Nutrition through pregnancy life cycle, home visit and care, and referring sick people especially mother and children under five(5) to the PHC centre for checkup and treatment.

b) **Lack of Basic Statistics at the PHC**: Our team discovered that the primary healthcare had no proper data collection and record keeping system. The Health Management Information Systems (HMIS) are one of the six building blocks essential for health system strengthening. We believe that for the community health insurance scheme to be sustainable, an enhanced HMIS is desirable. The project team acknowledging this fact and then helped in designing a reliable system which was user friendly.

c) **Household Enumeration**: In order to capture the population as well as know the average size of a family in the communities, the household enumeration became very key. From this, we were able to know some of the prevailing illnesses suffered by members of these communities and decide on how we should define household in the CHIS context. The major challenge we had was that some family heads were indisposed during the day because their main occupation is farming. They leave for farm very early and come late in the evening. The field workers were told to re-strategize and were able to capture many on market days and Sundays.

d) **Opening of a Corporate Bank Account:** Opening of a corporate bank account for the running and management of the community health insurance scheme surprisingly posed a very serious challenge. The requirements were too stringent for community group to comply with. This disrupted the smooth registration of community members for the scheme. The Okpe LGA chairman had to intervene at a time for the exercise to be completed.

e) **Setting up of a More Viable and Efficient Ward Development Committee:** Unfortunately, for almost a decade now, the activities of the WDC have been paralyzed in most of the wards in Okpe local government area and this could be the general situation in Nigeria. This is due to lack of commitment and willingness of selected members of the committees as well as adequate support from the various government organs.

CPED project team, therefore, saw the need to re-vitalize and strengthen the WDC in the target project location to play key roles in improving MNCH service delivery. Their roles include:

- Identify health and social needs and plan for them,
- Identify local human and material resources to meet these needs,
- Raise funds for community programmes when necessary at the village, facility and ward levels,
- Supervise the activities of VHWs
- Liaise with Government, NGO and other partners in the implementation of health programmes etc.

f) **Funding:** Community Health Insurance Scheme (CHIS) can be described as a mechanism where households residing in a community (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. The major element for the sustenance of this CHIS is funding. Since the level of poverty in rural communities in Nigeria is quite high and the importance the people place on healthcare coverage is also low, the people found it difficult to trust the scheme with their money.

Prior to the launching of the CHIS, the project team deliberated with members of the target communities in order to arrive at what percentage of the funding the beneficiaries are willing to pay (in the form of premiums) and who is responsible for the remaining percentage (in the form of subsidies). The CPED team gave an initial start-off grant for the scheme in form of subsidy but for the sustainability of the scheme, there should be a major financial player that will be ready to assist each household registering for the scheme. After several consultations with the Delta state government, the government through the Delta State Contributory Health Commission agreed to support the scheme in the area of fund.

g) **Constituting a CHIS Management Committee:** The management committee in this regard will help manage the scheme to ensure checks and balances. In constituting the management committee, for the purpose of fairness, the project team and the WDC agreed that each participating community should be represented. Also, there should be representatives from the local government secretariat (H.O.D, PHC), the healthcare facility (Head) and then the WDC (chairman). Although we got quick responses from the local government secretariat, the health facility and the WDC but we discovered that names from the communities were delayed. A closer look at what the

issue was revealed that there were disagreements among community members on who to represent them because they thought the position was a lucrative one.

h) **Enrolment into the Scheme:** Taking a lift from what obtain in the national insurance scheme, the project team alongside WDC and CHIS management committee decided to base the enrollment on a household. There were several questions that were asked by the people. Some of the questions asked are:

i. Is the enrollment of a household restricted to a particular number size?
ii. Are the men included or is it just for children under 5 and mothers?
iii. What of the case of a man with more than one wife and many children?
iv. Should we register sons and daughters who don't reside in the community?
v. Is the enrollment of household members (excluding expectant/nursing mother) age-restricted?

Those were some of the questions begging for answers. In addressing these questions, the team realized that the definition of a household in this context is very germane, we needed to define it in order to solve pending issues. In one of the consultation meetings held with the members of communities, we arrived at the meeting on how best we should define the household. We then define the household as 'a group of people (often a family) who dwell under the same roof and eat together from the same pot. But we were quick to add that for a man who is married to more than one wife, each of the wives forms a household. Consequently, the man can only be the head of a household while the other wife or wives will become the head of their respective households. This was however challenged by some community stakeholders but they were later made to understand the reasons why that clause had to be attached.

Conclusion And Recommendation

It is evident that Nigeria's health care system is very much not be exempted. The national health insurance scheme exist at the federal level and some states like Delta state have made MNCH services free at their secondary and tertiary health facilities but no such at the PHC centres which is the first point of contact for the people in the rural communities.

The daily staggering statistics in the death of women of childbearing age and children under-five years old in Nigeria should be of great social and public health concern to all governments and stakeholders. It is even more worrisome because the causes of death are well known and are preventable. If we applaud the government of the day for building primary healthcare facilities in most communities, we will definitely not applaud them for not making these facilities accessible by all citizens especially the poor and vulnerable ones in the rural areas. We have vividly shown from our various health researches (visit cped.org.ng) that out of pocket health expenditure in Nigeria is high and this is one factor that has dissuaded many from using the PHC facilities.

The government must standup to their promise of given universal healthcare coverage to all her citizens and the vulnerable women and children in the rural communities must

CPED through her project team have discovered that establishing community health insurance scheme will drastically reduce the woes of maternal and child mortality in the country. It is in this light, by way of recommendation, that we plead the indulgence of government at the local, state and federal level, policy makers, private sector and major stakeholders in the healthcare industry to as a matter of necessity, by way of scaling-up, establish community health insurance scheme at the various PHC facilities in the rural communities.

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