

Assessing the Prospects of Community Based Health Insurance Scheme (CBHIS) in Sokoto State

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Abstract: - Community based health Insurance scheme also known as Community contributory health Scheme in Sokoto State is a veritable instrument that has been used to tackle the health related problems arising from the rural areas. It is a mechanism that is been employed the world all over in the pursuit of Universal Health Coverage (UHC). The paper examined the prospects of Community based health Insurance scheme (CBHIS) in Sokoto state. The paper finds out that Community based health Insurance scheme (CBHIS) since its inception in Sokoto State has been accepted. Result shows that Community based health Insurance scheme can help to bridge the gap between urban and rural areas in terms of access and provision of health facilities. Community based health Insurance scheme (CBHIS) can help in addressing the issues of prevalence and outbreak of diseases such as Malaria, Cholera, dysentery, meningitis, Chicken pox e.t.c. and other related health problems. Community based health Insurance scheme in Sokoto also serve as a Social programme whereby community members actively participate to proffer solutions to matters that affect them.

Keywords: Community based health Insurance scheme, Universal Health Coverage, Out of pocket payment.

I. INTRODUCTION

“Health is wealth” the popular saying goes, impliedly the mechanism or tool of attaining health should be paramount and not undermined. The World Bank Report July 2007 states: “Good health and sound health system have been recognized as major inseparable contributions to economic growth. On that note one of the mechanisms being employed to achieve a healthy Society is Health Insurance. The mechanism is deployed as a means for achieving Universal Health Coverage. Health is a significant form of social capital, and there exist a substantial agreement in the literature on the relationship between health and economic growth through relationship between capability and need. Health insurance is not for its own sake, but for enabling an insured Person to need health care services when in need. Health insurance is of little value if the supply position is light. The state could take on an active part in matching up the provision of health Services (Tanko et al, 2015).

The seventy percentage of the total population in Nigeria still lives in rural areas. These rural areas are blessed with abundant mineral resources, most of which have not been exploited. The few whose resources appear explored are living with extensive damage to the rural setting (Agbonoga, 1998).

Aloba, 1998 & Akinola, 1997 cited in Tanko et al., 2015 affirm that only a few roads in the rural areas are partially motor able during the short peak time of the dry season. This will seriously affect the removal of agricultural production to urban centers. As per World Health Report (2005), forty-four countries of the WHO African Region spend less than 15% of their national annual budget on health; 29 national governments used less than \$10.00 for every individual for every year; fifty percent of the sum expenditure on health in 24 nations hail from government sources; the prepaid health financing mechanisms incorporate just a miniscule size of communities in the Region; private expenditure constituted over 40% of the sum use on health in 31 nations; out-of-pocket expenses constitute fifty percent of the private health expenditure in 38 nations (Tanko et al, 2015).

This is to state that there is the high rate of out-of-pockets spending on accessing health care among the rural dwellers in Nigeria which if persistent could possibly push them into poverty. 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.

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, and Health, 2003).

II. LITERATURE REVIEW

Community-based health insurance schemes (CBHIs) apply the principles of insurance to the social context of communities, guided by their preferences and based on their structures and arrangements. CBHIs can help

communities manage healthcare costs and provide access to basic healthcare for the poor and other vulnerable groups. The schemes are especially useful in reaching rural residents and the informal sector—the part of the society that is not easily insured—including self-employed people (e.g., farmers, petty traders, and laborers). These people tend to be unable to pay out-of-pocket costs for basic healthcare at the point of service use, which if persistent, could possibly drive them into poverty. Community-Based Health Insurance (CBHI) is a form of private health insurance whereby individuals, families, or community groups finance or co-finance costs of health services (Adinma ED & Adinma BJ, 2010). In low-income countries health insurance is increasingly recognized as a promising tool for the financing of equitable health care. By pooling risks and resources it promises to ensure better access and provide risk protection to poor households against the cost of illness (Bennett et al. 1998; Dror & Jacquier, 1999; Preker et al. 2002; Ekman 2004; Carrin et al. 2005).

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, and 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.

Community-based Health Insurance Scheme (CBHIS) is a not-for-profit type of health insurance that has been used by poor people to protect themselves against the financial risk of illness. In CBHI schemes, members regularly pay small premiums into a collective fund, which is then used to pay for health costs if they require services. Based on the concepts of mutual aid and social solidarity, many CBHI schemes are designed for people that live and work in the rural and informal sectors who are unable to get adequate public, private, or employer-sponsored health insurance (Bennett et al. 2004).

Immediate payment at health facilities can be disastrous for the economic situation of poor people and may cause drastic constraints of essential means for daily needs (Mcintyre et al., 2006; Leive & Xu 2008). Household members with chronic diseases may constitute a tremendous financial burden (Russell 2004). Mutual health organization insurance schemes were, therefore, considered effective. Membership in community-based health insurances have, in fact, raised utilization rates of maternal health services in

Mali, Senegal and Ghana. However, economic prosperity was associated with insurance membership and concurrent adherence to pre-natal consultation and delivery in appropriate health facilities (Smith & Sulzbach 2008). Abolition of fees led to an increase in health facility utilization in South Africa and in Uganda (Nabyonga-Orem et al, 2008).

Typically, CBHIs are organized and managed by a local community organization. The CBHI plan establishes agreements with various health providers, thereby forming a network of facilities. Most schemes cover basic healthcare services (e.g., antenatal care, deliveries, and child healthcare) and family planning services, while some schemes may also cover costs of hospital treatment. The value of CBHIs is that they engage community members as enrollees and volunteers ensure that health services meet community needs, and make primary healthcare accessible and affordable to members by pooling their resources and sometimes supplementing them with external funds. It is designed to provide financial protection from the cost of seeking health care. It has three main components, namely: prepayment for health services by community members, community control, and voluntary membership (Mladoysky & Mossialos, 2008).

Since the late 1990s, due to the limited ability of publicly financed health systems in developing countries to provide adequate access to health care and the shortcomings of informal coping strategies to provide financial protection against health shocks, in the international development discourse (for instance see WHO, 2000) various forms of community-based health care financing have been proposed as an alternative approach. This increasing policy attention has led to the implementation of a number of Community-Based Health Insurance (CBHI) schemes, in several developing countries (Wiesmann and Jutting, 2001; Defourny and Failon, 2008). Typically, such CBHI schemes are non-profit initiatives built upon the principles of social solidarity and designed to provide financial protection against the impoverishing effects of health expenditure for low-income households in the informal urban sector and in rural areas (Ahuja and Jutting, 2004; Carrin et al. 2005; Tabor, 2005; Jacobs et al., 2008).

Existing reviews of related work are provided by Jakab and Krishnan (2001), Preker et al. (2002) and Ekman (2004). Based on 45 published and unpublished works, Jakab and Krishnan (2001) concluded that there is convincing evidence that community health financing schemes are able to mobilize resources to finance healthcare needs, albeit there is substantial variation across schemes. They also argue that the schemes are effective in terms of reaching low-income groups although the ultra-poor are often excluded. Preker et al. (2002), reach a similar conclusion and point out that there is strong evidence that CBHIs are successful at mobilizing resources, enabling access to care for the poor and providing financial protection.

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). Community-based health insurance scheme (CBHI) covers a wide spectrum of programs that share at least three attributes: not-for-profit prepayment plans for healthcare, community control, and voluntary membership. The community in question can be defined geographically for example, a village or via some other well-defined affiliation. The large variety of CBHI schemes encompass programs that cover high-cost, low-frequency events as well as those that cover low-cost, high-frequency events. CBHI programs are often referred to as health insurance for the informal sector, mutual health organizations (mutuelles de santé), and micro-health insurance schemes (Gottret and Schieber, 2006). They are quite common in sub-Saharan Africa, especially in West and East Africa. It is designed for people living in the rural area and people in the informal sector who cannot get adequate public, private, or employer-sponsored insurance (Onoka CA, et al, 2011). Usually, it is voluntary compared with SHI schemes which tend to be mandatory.

Several approaches have been suggested of how to improve universal coverage in areas where those employed in formal sector are small. Among the options are "contributory schemes" like community-based health insurance (CBHI), where households in a particular community contribute to insurance scheme... (Tangcharoensathien V, et al, 2011).

III. PROSPECTS OF CBHIS

In recent years the international community has displayed an unparalleled optimism as to the positive role CBHF will play in meeting the health funding needs of poor communities and increasing their access to quality health care. A review in 1997 identified only 81 documented CBHF schemes the world over, majority of which were in sub-Saharan Africa and Asia. The number of CBHF schemes today can be counted in thousands. In Ghana for instance the number of CBHF schemes grew from four to 159 over a two year period. (Partners for Health Reform Plus, March 2004; Bennett, et al 1998). In Nigeria CBHI has not developed to the extent expected of a country of its size and importance, and

furthermore yearning for an accelerated effective development of its health care. Researchers in Cameroon and Nigeria have documented a clear desire on the part of less well-off households to join the scheme, and over 3000 Nigerian survey respondents stated that CBHI was an acceptable means of paying for health regardless of socioeconomic background or location (Onwujekwe O, Public Health. 2011;125(11):806–808). Interestingly, the poorest households expressed the greatest willingness to enroll.

There is evidence that the CBHIS model can be one of the solutions for providing healthcare coverage to the large population of informal and rural citizens of Nigeria (AIID, *et al*, 2013; Hendricks, *et al*, 2011). Moreover, it has the potential of providing the improved healthcare access and needed financial security through the decrease of OOP expenditures. An ongoing study is assessing the ability of the HCHP (Hygeia Community Health Plan) to provide cardiovascular disease preventive care in a low resource setting. (Hendricks M, *et al*, 2011;11:186).

Benefits of community based health Insurance schemes in Nigeria

- i. Reduce preventable deaths and morbidity due to low access to healthcare, access implies healthcare should be (a) available (b) affordable.
- ii. Reduce unexpected out of pocket expenditure on health, which is a major cause of poverty in developing countries.
- iii. Augment government expenditure on health, which is quite low in Nigeria.
- iv. Pooling of health resources creates equity and equality in healthcare provision for the society.
- v. Regular income to health care facilities encourages progressive improvement in quality standards within the health facilities.
- vi. Data generated for claims processing allow for disease profiling and provides useful information for public health plans.
- vii. Increase utilization of health care facilities at all levels due to elimination of payment at point of service.
- viii. Increase efficiency in the healthcare delivery system.
- ix. Provide massive scale-up of health insurance especially to rural populated who has the highest disease burden in the population.
- x. Increase the capacity to insure people with chronic disease due to the large risk pool.

IV. METHODOLOGY

This paper adopts the quantitative approach where questionnaires were designed to be administered to the beneficiaries of Community-based health insurance scheme in Sokoto South local government of Sokoto State.

Questionnaires were administered to 92 beneficiaries of the scheme to represent the whole population of the study

which stood at 3211 as at the time of conducting this study. The Instrument used for the collection of data was a close ended type in order to save the respondents the pain of writing.

The data collected were analysed using SPSS(Statistical Package for Social Science) version 20.0. Data gathered were analysed using frequencies and tables and Hypotheses of the study were tested using Chi-Square.

V. FINDINGS

The findings of this research after the analysis of the data collected are as follows:

1. CBHIS is effectively functioning in Gagi A,B,C and GidanDahala of Sokoto South Local government in Sokoto State.
2. The monetary requirement per head is the token of ₦150.
3. Children under age 5 and pregnant mothers are exempted from payment as National Health Insurance Scheme (NHIS) do pay for this category of people through the CBHIS account.
4. Treatment of diseases such as malaria, typhoid and other killer diseases are treated by CBHIS in the Primary health Centers.
5. The CBHIS in the area have committees charged with different responsibilities. Some of the committees are;
 - i. Ward Development Committee: They are responsible to organize sensitization programmes to educate the people on changing bad health attitude to good health attitude. e.g To allow their wives to attend Ante Natal Care.
 - ii. Women Committee: They are community based health volunteers who move from house to house to mobilize housewives and educate them on health issues.
 - iii. Youth Committee: This committee comprises of male and female responsible to educate youth on drug abuse, to watch out for outbreak of diseases and report it to the Ward Development Committee or Primary Health Centre. e.t.c

VI. CONCLUSION

The call towards UHC is a global call by World Health Organization (WHO) which entails that everybody no matter the geographical local or financial status should have access to basic healthcare. Towards attaining that lofty objective Community based Health Insurance Scheme was established as a mechanism towards ensuring that. Since the establishment of CBHIS in various Countries of the world it has recorded unprecedented growth. The Nigerian Government needs to embrace CBHIS as a means of tackling

health problems that abound in its rural communities. CBHIS improves resource mobilization for health and provide financial protection for members in terms of reducing their out-of-pocket expenditure. CBHIS brings with it a feeling of belongingness that allows rural people to contribute in solving health related problems that arise within their geographical location. It also guide against driving rural individuals into poverty when they are sick because it provide a pool of fund that is used to cater for the health of the members of the Scheme.

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