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METHODS USED

- Case studies of two communities judged to have different levels of success in implementing CBHI
- Document reviews
- In-depth interviews with state and local level policymakers, managers, health workers, and members of Community Health Committees
- 8 Focus group discussions with members and non-members of CBHI
- Household survey data from 1000 respondents

INTRODUCTION

Community based health insurance (CBHI) is a not-for-profit type of health insurance that has been used by poor people to protect themselves against the high costs of seeking medical care and treatment for illness. In CBHI schemes, members regularly pay small premiums into a collective fund which is then used to pay for health services that they require. Many CBHI schemes are designed for people that live and work in rural areas or the informal sector who are unable to get adequate public, private, or employer-sponsored health insurance.

CBHI was piloted in Anambra State in Southeast Nigeria in 2003 as a way of increasing the provision and utilisation of health services. This policy brief identifies the factors that influenced the development, implementation and ultimate failure of the scheme in 2005 and provides recommendations for policy-makers responsible for designing and implementing health insurance policies. The brief is based on research conducted in 2006-2007 which compared the experiences of two communities that had different levels of success in implementing CBHI in terms of community involvement and support for the scheme and levels of enrolment.

BACKGROUND TO CBHI POLICY IN ANAMBRA STATE

The CBHI policy in Anambra State was conceived and promoted by the Commissioner for Health and endorsed by the State Governor in 2003. Pilot schemes were established in one urban and nine rural communities, each with a health centre that served 4-7 villages. Membership of CBHI comprised of individuals and households in a community with a minimum of 500 persons required to form a group. Individuals paid a flat rate fee monthly, yearly or at convenient instalments to use health facilities and receive services, and their payments to the facility were matched by the State government. People that were not members of the scheme, or defaulted on payment, paid for health services directly through user fees.

The development and implementation of this health insurance policy followed a period of political transition with the introduction of a new State Governor who aspired to improve access to quality health care and who was personally responsible for driving the policy forward at rapid pace. However, it was also a time of political insecurity, and in March 2006 the Governor was removed following a court order that found his election victory in 2003 has been rigged. After his removal, State government interest in and support for CBHI diminished, and, to date, there has been no subsequent expansion of the scheme.

FACTORS AFFECTING THE IMPLEMENTATION OF THE CBHI SCHEME

The research identified several factors that affected implementation of the scheme in the two case-study locations.

Relations between state and local government authorities

As shown, the CBHI policy was developed at the State level by a small number of key political figures. Officials working for Local Government Areas (LGA) were not involved in the formulation of the scheme and they did not participate on the Task Force set up to supervise its development and implementation. This is despite the fact that they are responsible for overseeing health activities in local areas and function independently to the State. In some cases, poor communication and lack of mobilisation of the LGA officials resulted in resistance to the scheme and a lack of wide-spread support. As a consequence, the policy lacked local-level 'champions' to promote its uptake at community levels and committed officials to ensure that it was implemented appropriately by health workers.

Community support and participation

Community support was an important factor in achieving high levels of uptake and continued enrolment of the scheme. In the area where the scheme was considered to be more successful, members were involved in a variety of activities including overall coordination, community sensitization, encouragement and advice, and providing infrastructure. Importantly, they perceived CBHI to offer benefits in the form of financial risk protection and access to good quality care. In the other community, managers and health workers did not mobilise the community, partly due to a lack of information, and this resulted in lower levels of uptake.

Power dynamics between community actors

In the more successful case-study, the community leader who was respected and carried a lot of influence, controlled the CBHI drugs and ensured accountability. In doing so he secured trust in the scheme by community members, thus increasing enrolment. In the other community, the person responsible for coordinating the scheme was viewed as being dishonest and untrustworthy. As a consequence, community members lost interest in CBHI leading to low levels of uptake.

Health workers attitudes towards the scheme

In both sites, health workers expressed reservation about the health insurance scheme. This was mainly because, as a consequence of altered payment mechanisms, they lost out on income that they would otherwise have earned through user fees. Health workers' ability to implement the scheme was also constrained by a lack of information about CBHI from the local government, limited training before and during its implementation and inadequate supervision from the doctor in charge of the facilities. It is likely that these factors resulted in health workers not following the guidelines for implementing CBHI. Instead they focused their efforts on other duties. Further, health workers' apparent reluctance about CBHI was observed by some community members and created distrust between the two groups.

Parallel drug acquisition and delivery systems

Parallel systems for purchasing and prescribing CBHI and non-CBHI drugs at the facility level created additional problems for health workers in implementing the policy. The design of the CBHI scheme meant that drugs purchased as part of the scheme were stored alongside other drugs belonging to the LGA and health workers. This created an administrative burden for facility staff who had to manage two separate processes. It also resulted in health workers prescribing and selling their own drugs from which they could generate an income, rather than the CBHI drugs.

POLICY RECOMMENDATIONS

- **Make efforts to secure widespread backing among groups (both within and outside the Ministry of Health) with the power to sustain implementation.** An important reason why the CBHI scheme was not successful was that the policy was designed by a small group of influential actors who did not seek to gain widespread backing from others within the Ministry of Health, local government officials, or State legislators. Not only did this create resentment and distrust, but also when the State Governor was removed from power, there was no one left who was committed to sustaining the implementation of the policy.
- **Include local actors who can either sustain or block implementation in the development of new policies, in particular health workers.** It is evident that the implementation of the CBHI policy was constrained by policy-makers' limited understanding of how policy objectives and design can provoke local-level opposition and derail implementation. In the case of CBHI, health workers and LGA officials were not involved in the formulation of the policy, and as a result there was no consideration for how it would affect their incomes. This in turn meant that policy guidelines were not followed, few health workers actively promoted the scheme to community members, and CBHI drugs were wasted.
- **Take into consideration power dynamics between local community actors when designing policies that will be implemented at the local level.** Effective implementation of local level policies depends on local level factors including the relationships between different community members. The CBHI scheme was developed at the State level and did not succeed in getting enough local level political support. Managerial roles for local actors and clear mechanisms for accountability of local implementers are important in maintaining the trust and support of communities.
- **Ensure that policy guidelines are clearly communicated to those responsible for implementing the policy and to community members.** Poor communication about the policy from State to Local level, from policy-makers to implementers, and from health workers to community members was a major barrier to implementation and uptake. In the case of CBHI, policy guidelines were not communicated to nurses and health workers received inadequate training in the scheme. Health workers limited understanding of the policy meant that they did not follow the guidelines and that they did not effectively communicate the benefits of CBHI to community members.

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