A review of community-based health insurance in Nigeria

Nura T¹, Fatma MB¹, Fatehelrahman Elmahadi MM¹, Suriani I²*, Aidalina M²

¹Master of Public Health Student, Department of Community Health, Faculty of Medicine and Health Sciences, Universiti Putra Malaysia
²Department of Community Health, Faculty of Medicine and Health Sciences, Universiti Putra Malaysia

*Corresponding author: Suriani Ismail email: si_suriani@upm.edu.my

ABSTRACT

**Background:** The primary goal of many countries is to establish a healthcare financing system that guarantees universal health coverage (UHC) through equity in access to healthcare services as well as financial risk protection to the people. Community based health insurance (CBHI) has emerged as an alternative to reduce out-of-pocket (OOP) expenditures and improved financial risk protections in developing countries like Nigeria. The aim of this study is to review the CBHI in Nigeria and highlight the issues, weaknesses and strengths of the system.

**Materials and Methods:** A systematic literature review on the CBHI was conducted using relevant studies searched from electronic databases: MEDLINE, Pubmed, scienceDirect.com, PLOS and public search engine (Google). It was done on 16th January, 2017. The phrases used are ‘health financing’, ‘community health insurance’ in ‘Nigeria’ which were put together by Boolean operator “and” articles or reports. Relevant materials for the past 7 years were included. A total of 5 articles fulfilled the criteria for review. SWOT (strength, weakness, opportunity and threat) tool was used for the analysis.

**Result:** The strengths of CBHI scheme in Nigeria are it reduces OOP health expenditure and improves utilization rate on healthcare. However, the weaknesses are that the scheme tends to cover a comparatively small proportion of the social class, namely the lower social class. Also, involvement of the community sometimes is ineffective due to inadequate funding. The opportunities are that the CBHI scheme increases efforts towards improving healthcare system in the country and enables equity in access to healthcare. The threats are weak policy, lack of political commitment to health, poor funding especially in primary healthcare and poverty.

**Conclusion:** Nigeria must start to make more commitment to health care, if they want to achieve UHC. The rate of out of pockets health expenditure is still very high and catastrophic on Nigerian healthcare system. Recommended strategies needs to be addressed urgently in order to improve equity in access to health care service as well as effective financial risk protection. CBHI may not be suitable in all situations but can play an important role in to health care programs in Nigeria.

**Keywords:** Community based health insurance, Nigeria, universal health coverage
1.0 Introduction

Vigorous strengthening of the health care financing structure is the fundamental key towards universal health coverage (UHC) of a country. Community-based healthcare financing (CBHF) plays a major role in the healthcare financing reform of many low and middle income countries like Nigeria because CBHF is able to reach population groups that government and profit based healthcare financing schemes could not. Therefore CBHF, particularly community-based health insurance (CBHI) deserves serious consideration for its ability to offer these “missed” population groups with financial risk protection as well as access to quality healthcare. Furthermore, CBHI schemes have been reported to decrease the out of pocket (OOP) health expenditure of the people hence raising their healthcare services utilization rate (WHO, 2010).

1.1 Healthcare financing

World Health Organization (WHO) declared “health a fundamental human right and commits to ensuring the highest attainable degree of health for all.” Universal Health Coverage (UHC) means that all people receive sufficient and effective health care services (promotive, preventive, curative, rehabilitative and palliative) they need as well as protection from financial suffering or consequences of paying for the services. UHC is one of the Sustainable Development Goals (SDG) which all United Nation (UN) member states agreed to achieve by 2030. Meanwhile, WHO estimated about 400 million people has no access to basic healthcare services worldwide, also about 100 million people become poor and 150 million undergo financial hardship as a result of out of pocket (OOP) payment on health services every year. It also projected more than 18 million additional health professionals will be required to achieve the SDG 2030 targets on UHC. Nevertheless, a good organization and transformation of healthcare financing, management and service delivery leads to equity in access to healthcare (WHO, 2016).

Health financing is concerned with the generation, allocation and use of the money to cover the health needs of the people. It focuses on how and from where to generate adequate money for health, financial risk protection as well as equity and efficiency in health service. Health financing system is one of the major challenge in poor developing countries. Thus, effective health financing system is of utmost importance especially in countries with limited economic resources, poor economic growth, constraints on the public sectors and low organizational capacity (WHO, 2010).

1.2 Healthcare financing in Nigeria

Nigeria is the most populous nation in Africa with more than 180 million people and 7th in the world. The annual population growth rate is 3.2% and fertility rate of 5.5 with some variations across the regions and states. Under 5 mortality rate (U5MR) reduced from 201 deaths / 1000 live births in 2003 to 124 deaths /1000 live births in 2011. Infant mortality rate was 78 deaths per 1000 live births. About 545 maternal mortality (MMR) per 100000 live birth (2nd only to India). Reproductive health status in Nigeria has remained poor with only slight improvement over time as reflected in the high MMR, high U5MR and low contraceptives prevalence rate which was only 15% in 2014 (MOH, 2014).
The economic growth rate was 6.4% and 7.4% in 2007 and 2011 respectively, and it is one of the fastest growing. However, poverty rate remained persistently high over the past years. In 2004 it was 54% later reached 69% in 2010, reduced to 61% in 2012 and about 63% in 2015. The poverty level in 2016 was almost the same with 2015 (National Bureau of Statistics, 2015 and UNDP, 2015). Even though the global framework for health financing, recommends at least 5% spending of the country’s gross domestic products GDP on health, Nigeria spent only 1% of its GDP on health in 2013, which was almost the same percentage since 1995. Likewise in 2014, the total government revenue was 9.7% of the GDP (Africa Health Budget Network, 2015 and UNDP, 2015).

Health care financing in Nigeria is shared among the 3 tiers of government: federal, states and local governments. The federal government is responsible for the university teaching hospitals and federal medical centers. The states government coordinates the affairs of the state hospitals (specialist and general hospitals) while the local government manage the dispensaries and primary health centers (Lucky & C, 2012). However, the source of funding can be classified in to 2 major groups: the public (federal, state and local governments) and the private (household, firms and donors) with combined share ratio of 1:3 respectively. Out-of-pocket (OOP) payment was estimated to be 60% - 74% of the total health expenditure thus it creates a great financial consequences on individuals and the community (Medical World Nigeria, 2015).

WHO identified 3 basic and inter-correlated issues, preventing countries towards UHC:
1. Inadequate resources especially in developing countries like Nigeria, where there is no access to basic amenities (constant electricity) and lack of modern medical equipment. There is also lack of qualified health personnel especially in the rural areas which results in big disparities between urban and rural areas
2. Overdependence on direct payment (out-of-pocket) when health care need arises, which include payment for procedures, consultation or over the counter payments for drugs or even co-insurance (contributing some percentage) for those with health insurance. In Nigeria, OOP is between 66% - 74% of the total health expenditure and this will restrict millions of people from obtaining care since they have to pay directly for the services at the time of need.
3. Inefficient and inequitable use of resources, where an improved efficiency and reducing waste of health resources will generally improve health systems of the country (WHO, 2003 and Medical World Nigeria, 2015).

Nigeria implemented national health insurance scheme (NHIS) in order to improve UHC in the country. The scheme was backed by an enactment of a law in 2004. The NHIS consist of programs that covers formal and informal sectors workers and vulnerable groups. The initial plan was that all the 36 States of the federation will adopt the program for their workers, however only 2 States implemented the program due to slow in the uptake. Efforts are being made for the achievement of total coverage with the introduction of national health bill which aim to establish a framework for the regulation, development and management of healthcare as well as source of funding to support primary health care (Uzochukwu et al., 2015 and Medical World Nigeria, 2015). Presently it’s mainly for workers in the federal sectors and their families with an increased in the coverage from 150000 people in 2004 to 5 million in 2014. This translate in to approximately 3% of the total population while the rest of the population are not covered including about 75% of the those working in the informal sector (Bukola, 2013, Ufuoma John, et al. 2015 and Medical World Nigeria, 2015).
1.3 Community Based Health Care Financing System (CBHF) in Nigeria

Health plays a major role in the economic development of a country. Likewise effective and quality healthcare financing is a major challenge in developing country like Nigeria. It is for this reason Nigerian government has increased their efforts towards improving health care in the country especially in the rural areas.

Community based health care financing come in various forms: 1) Community controlled user fees. In this form, the user fees generated at the time of healthcare needs are controlled by the community; 2) Community prepayment scheme. In this scheme the community manages the advanced generated funds and pays the healthcare providers on behalf of the subscribers of the scheme; 3) Community provider-based health insurance. In this form, the healthcare provider in the community generates prepayments funds from the subscribers and also provide the healthcare services to them; 4) Community revolving health funds. In this form, there will be some form of agreement between the agent of the government or social health insurance and the community. The funds generated will be used to fund the scheme.

In Nigeria, the community prepayment scheme or also referred to as community-based health insurance (CBHI) is the most relevant as it gives subscribers to designed how and when to pay their premium (Onwujekwe et al., 2010 and WHO, 2003). CBHI scheme has 3 main and common features: 1) Community mobilizations, where the community has a major role in organizing, pooling, allocating, managing as well as supervising the healthcare resources. However, the government and other external donor assistance remain the major factor to the successful implementation and sustainability of the scheme; 2) Beneficiary group, where CBHI scheme provides coverage to the people who are in the informal sectors (with no financial risk protection) and vulnerable groups; and 3) Social values and principles which consist of voluntary participations, solidarity and mutual benefit (Jakab & Krishnan, 2017).

CBHI scheme is usually run by an organization other than government or a private for profit generating company, and the scheme provides risk pooling to cover the cost of the health care service. CBHI is a method of mobilizing community resources to share in the financing of local health services. The basic principles are the mobilization of community members as enrollees and volunteers, ensuring accessibility and affordability of health care services to the communities by pooling their resources and ensuring that health services meet the community needs (Health Finance Nigeria, 2011). CBHI scheme help lower social class manage and improve their financial risk protection. The role of government in CBHF scheme can be in form of coordination, facilitation, training of managers, control of finance, advocacy, dissemination of information and best practices, monitoring and evaluation. Government can also assist in terms of infrastructure, equipment and staff contribution (Bukola, 2013).

CBHI scheme assists in controlling healthcare cost as well as accessibility to health care for the lower social class and other vulnerable groups, rural residents and informal sectors. CBHI scheme also creates a network of facilities through agreements with different health providers so as to cover basic health care services like maternal child health, family planning and hospital treatment cost.

That is why when it was noted that there was loss of financial risk protection (as evidenced by the high OOP expenditure for health care service among a large number of people especially in the lower social class and those working in the informal sector) the government, non-
governmental organizations (NGOs), international institutions and civil societies had to look for other alternatives in order to achieve UHC. As a result, they considered a community based health insurance as a way that enable not only equity in access to healthcare services, but also improves poverty among populations (Lucky & C, 2012 and Uzochukwu et al., 2015). CBHI schemes were designed and implemented in many places across Nigeria. However, most of the schemes have been dormant as a result of changes in the government combined with a lack of interest, support and trust on the schemes from the beneficiaries.

2.0 Materials and Methods

Literature review was done in a series of steps using scoping review method, the framework consist of 6 main stages (Arksey & O’Malley, 2005): (1) Identifying research question, ‘What are the strength and weakness of community based health care financing in Nigeria? 2) Identifying relevant studies using systematic literature searching based on the formulated research question. It was done on 16th January, 2017 from the electronic databases: MEDLINE, Pubmed, scienceDirect.com, PLOS and public search engine (Google). The phrases used are ‘health financing’, community health financing’, community health insurance’ in ‘Nigeria’ which were put together by Boolean operator “and”. 3) Selecting the study: Articles or reports for the past 7 years (2010 - 2017) were used, and that referred to the community health financing in Nigeria. Three stages screening methods were used: the primary screening was done by reviewing only titles, the secondary was done by reviewing titles and abstracts while in the final screening, full text of the articles were reviewed. 4) Charting the data was done using a form with: authors, year of publication, objectives of the research, study design and results. 5) Collating, scrutinizing, summarizing and reporting the results 6) Consultation exercise. The last stage is optional and was not included in this review. The analysis was done using SWOT method. Comparison with some others African countries were also highlighted.

3.0 Results

The searches identified 97 relevant records. After a systematic screening of the potentially relevant records 5 articles were identified as shown in the PRISMA diagram in Figure 1. Table 1 shows all the five studies were performed in Nigeria, three (3) of which are systematic review on the impact of CBHI, issues on the successful implementation of the program and the challenges in achieving UHC. While the remaining 2 are cross sectional studies of which one is conducted with interventional component. They highlighted the impact on CBHI as well as the level of acceptability.
Figure 1.0: PRISMA diagram on the literature selection
Table 1.0: The results of the reviewed of selected articles

<table>
<thead>
<tr>
<th>No</th>
<th>Authors/Year</th>
<th>Objective</th>
<th>Study design</th>
<th>Result</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Odeyemi 2014</td>
<td>The aim to provide an overview of the present status of CBHI in Nigeria and other countries in SSA to identify and summarize the issues that affect the successful implementation and sustainability of these programs</td>
<td>A systematic literature review of 26 articles.</td>
<td>Inadequate support for CBHI with lack of legislative and regulatory frameworks, poor funding as well as lack of enrolment policies are the major challenges. The poorest population still found difficulties in participation financially. OOP remains significant in healthcare systems Regressive flat-rate payments are a problem in Nigeria</td>
</tr>
<tr>
<td>2</td>
<td>Uzochukwu et al., 2015</td>
<td>To determine challenges in achieving universal health coverage in Nigeria</td>
<td>A systematic review on literature, policy documents and grey articles from the PubMed, Medline, the Cochrane library, Popline, and WHO library database</td>
<td>The review identified barriers to efficient health care financing as the major challenge in achieving universal health coverage in Nigeria.</td>
</tr>
<tr>
<td>3</td>
<td>Ufuoma John, et al., 2015</td>
<td>To evaluate the impact of health insurance on primary healthcare delivery</td>
<td>A systematic literature review on health insurance with 9 articles</td>
<td>There was moderate to high strength in the literature on the positive influence of CBHI to access on primary health care delivery. There was also moderate to high evidence indicating the scheme improved the quality of care. But it remain unclear in some situations</td>
</tr>
<tr>
<td>4</td>
<td>Adinma et al., 2011</td>
<td>To determine the impact of government – community health care co-financing on maternal and child healthcare services</td>
<td>Cross sectional study with intervention component</td>
<td>There was significant improved in accessing health care services after a one year of the program. For intervention group (26.7% pre and 85.6% post scheme) and for the control group (27.5% pre and 29.6% post scheme).</td>
</tr>
<tr>
<td>5</td>
<td>Onwujekwe et al., 2011</td>
<td>To determine the level of acceptability of CBHI among different population groups</td>
<td>Cross sectional survey</td>
<td>CBHI was acceptable to all groups. The acceptability level was significantly and directly related to financial status of the respondents. They also believed that, CBHI would improve their access to good health care services. In terms of willingness to enrol in to the scheme, the poorest respondents are more willing to enrol than lest poor respondents, suggesting that as financial status improves, the willingness to enrol may be less. The financial risk protection could not be assessed in the study as it does not indicate potential for equity of access.</td>
</tr>
</tbody>
</table>
Literature review findings revealed factors that influence the successful implementation of CBHI scheme, for example a study in Anambra state where there is government/community healthcare program through co-financing. This program gives community members the freedom to determine the premium to enroll which was 100 and 50 Nigerian Naira in a month for the adult and child respectively. The rate of enrolment was 48.4% in a successful community, reason being high level of awareness of the program while in some other community it was not successful about 16% only, reason being lack of trust and managements in the program (Odeyemi, 2014).

Another study conducted in Enugu, identified some of the barriers to the effective healthcare financing system in Nigeria which included: inadequate commitment from the policymakers, poor funding, lack of effective health policy, over-dominance of OOP etc. study concluded that, for Nigeria to achieve UHC using healthcare financing as a strategy, there is urgent need to review the system and ensure fully implementation of national health bill (Uzochukwu et al., 2015)

Several literatures revealed that insurance programs improved financial access to quality healthcare in provider centers with examples in Anambra and Ebonyi states. However, the impacts is still unclear especially in Ebonyi state, as results from several studies did not measure or address the impacts of the programs (Ufuoma John et al., 2015).

Results from the study conducted by Adinma revealed the impact of CBHI in the form of utilization rate which improved from 26.7% before the CBHI intervention to 85.6% a year later. Although the literature review did not detect findings on the equity in access on CBHI among different population, there was an improved access to good healthcare services (Onwujekwe et al., 2011)

Table 2.0: SWOT analysis of the reviewed articles on CBHI scheme in Nigeria

<table>
<thead>
<tr>
<th>Internal factors</th>
<th>Strengths</th>
<th>Weaknesses</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>• It is a community mobilization scheme.</td>
<td>• The schemes tend to cover a comparatively small proportion of the population, which is people in the lower socioeconomic group</td>
</tr>
<tr>
<td></td>
<td>• Ensure healthcare services becomes more affordable and accessible to the communities.</td>
<td>• Involvement of community sometimes is ineffective.</td>
</tr>
<tr>
<td></td>
<td>• It helps population in the lower social class socioeconomic group manage and improve their financial risk protection.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Reduces OOP while improving utilization rate of healthcare services</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• The government role on the scheme can be in form of coordination, facilitation, training of managers, control of finance, advocacy, dissemination of information and best practices, monitoring and evaluation.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Government can also assist in terms of infrastructure, equipment and staff contribution</td>
<td></td>
</tr>
</tbody>
</table>

| External factors |

|  |  |
|  |  |

Nura T, Fatma MB, Fatehelrahman Elmahadi MM, Suriani I, Aidalina M
Opportunities

- An opportunity to increase efforts towards improving healthcare system in the country.
- It creates an avenue for government to look for other alternatives in order to achieve UHC.
- It enable equity in access to healthcare services.
- Improves poverty among populations (Lucky & C, 2012 and Uzochukwu et al., 2015).
- It creates more awareness to the community since it is done within the community (Odeyemi, 2014).

Threats

- Inadequate funding
- Lack of political commitment.
- Overdependence on external funding from donor agencies or government.
- Weak policy
- Lack of infrastructure and poor service quality
- Dominance of OOP.
- Poverty
- Lack of trust from the beneficiaries

4.0 Discussion

CBHI is designed for the people who cannot obtain public, private or employer sponsored insurance (people living in rural household and those working in the informal sector). Literature review discerned that the impacts of CBHI on equity in access, quality and efficiency as well as financial risk protection on healthcare services in Nigeria are still unclear (Olakunde, 2012). The level of acceptability of CBHI among population is determined by the improvement in the financial risk protection as well as equity in access to quality healthcare services. However, results from the review revealed that despite an increased in its acceptance level and willingness to enroll, there were still challenges. One of these challenges in in equity in the contributions of CBHI (Onwujekwe et al., 2011). The poorest population still found difficulties in financially participating in the program, even though the user charges were low. Meanwhile the less poor people are more likely to participate and have improved access to healthcare services and financial protection (Olakunde, 2012).

The literature review noted that utilization rate of healthcare services declined with increased distance between the health care facilities and the communities. Fortunately the review showed that CBHI have a tremendous impact on the improvement of health care through increase utilization and quality of care (Ufuoma John et al., 2015 and Adinma et al., 2011).

4.1. Situation analysis

Analysis of CBHI scheme in Nigeria was done using SWOT which is the tool that evaluates the following elements: Strength, Weakness, Opportunity and Threat. The analysis aimed to determine the main internal (strength and weakness) and external (opportunity and threat) factors in effective community based healthcare financing schemes in Nigeria.
4.1.1 Strength

Community mobilization scheme is the main strength of CBHI, as it mobilizes community members as enrollees and volunteers, ensuring accessibility and affordability of health care services to the communities by pooling their resources and ensuring that health services meet the community needs (Health Finance Nigeria, 2011). It covered a large number of population in the lower socioeconomic group who has no financial risk protection.

The role of government in CBHF scheme can be in form of coordination, facilitation, training of managers, control of finance, advocacy, dissemination of information and best practices, monitoring and evaluation. Government can also assist in terms of infrastructure, equipment and staff contribution (Uzochukwu et al., 2015 and Bukola, 2013). CBHI schemes reduces the rate of OOP health expenditure and CBHI can increase the healthcare services utilization rates (Jakab & Krishnan, 2017).

4.1.2 Weakness

There are weaknesses in the execution of the CBHI scheme. CBHI programs tend to cover a comparatively small lower socioeconomic group. Hence they do not have adequately large risk pool to cover their cost. The premium payments as well as local subsidies are normally insufficient to cover the healthcare cost, as most beneficiaries are poor and unable to pay for high premium. The extremely poor people may not enrolled in the CBHI scheme as a result of inability to pay for the premium. Likewise, high social class are less likely to enroll in the pooling arrangements at the community level because they can afford to pay OOP for the services they received (Onwujekwe et al., 2011). Additionally, involvement of community sometimes is ineffective as a result of weak leadership, management and practical skills of the members of community within CBHI organization (Odeyemi, 2014).

4.1.3 Opportunity

CBHI gives Nigerian government an opportunity to increase their efforts towards improving health care in the country especially in the rural areas. The loss of financial risk protection, evidenced by the high OOP percentage in health care expenditure for a large number of people must especially the lower socioeconomic group as well as those working in the informal sector has creates an avenue for government, non-governmental organizations (NGOs), international institutions and civil societies were forced to look for other alternatives in order to achieve UHC. As a result, they considered a community based health insurance as a way that enable not only equity in access to healthcare services, but also improves poverty among populations (Lucky & Nwankwo, 2012 and Uzochukwu et al., 2015).

Another opportunity is increasing the quality of healthcare, as several studies revealed that CBHI improves the quality of healthcare services as well as awareness since it is done within the community.

4.1.4 Threat

The threat in achieving effective community based healthcare financing schemes in Nigeria are numerous and complex, as detailed below:
1) Inadequate funding. There is lack of political commitment to health resulting in poor funding especially the primary health care. Nigeria spent only 1% of its GDP on healthcare in 2013, which almost the same since 1995 - against the global framework for health financing which recommended at least 5% spending of the GDP on health. Overdependence on external funding from donor agencies or government is another major limitation of the CBHI scheme (Odeyemi, 2014 and Uzochukwu et al., 2015).

2) Weak policy. There is absence of clear health policy that explains how to allocate and spend funds in the health sector and unclear role of the government at all levels in the financing of healthcare. This weak legal framework results in high level of uncertainty and low level of public trust, resulting in decreased interest of people to invest in healthcare infrastructure. The national health bill, a framework for the regulation, development and management of healthcare, source of funding to support primary health care and the aim to achieve universal coverage with at least basic healthcare through CBHI, was signed only two years ago after 10 years deliberation by the national assembly. Its implementation has been very slow (Adinma et al., 2011 and Medical World Nigeria, 2015).

3) Lack of infrastructure and poor service quality. With the CBHI scheme, there was uncertainty in the revenue flow to improve infrastructure in the majority of healthcare providers. In addition to that most of them lack access to basic amenities (constant electricity), modern medical equipment, and qualified health personnel especially in the rural areas which resulted in big disparities between urban and rural areas (Onwujekwe et al., 2011).

4) Dominance of OOP and poverty. OOP is between 60% - 74%, despite more than 75% of the population works in the informal sector and more than 60% are below the poverty level. OOP weighs severely on household budgets, pushing many into poverty as a result of unpredictable disastrous health expenditure. Dominance of OOP leads to a possibilities of oversupply or under supply of services depending on the financial status of the people. (Uzochukwu et al., 2015 and Medical World Nigeria, 2015).

4.2 Comparison with some other Sub-Sahara African (SSA) countries

When comparing with some other SSA countries, the National Health Insurance Scheme (NHIS) in Ghana was comparably successful, with 66.4% of the total population covered in 2010 of which about 30% adults in the informal sector. This is because, there is an effective planning, implementation, control and support by the government. The country also designed NHIS in combination with CBHI scheme with clear source of funding (the national health insurance funds) to ensure potential nationwide coverage and sustainability. Hence Ghana remains one of the role models in terms of healthcare system (Odeyemi, 2014).

The CBHI scheme in Senegal was better too in comparison to Nigeria, especially in the reduction of OOP payments. In 2007 there was 17.9% of coverage in the non-formal CBHI. In 2003 they developed a legal framework for the successful implementation of CBHI which was even before Nigerian government introduced NHIS (Odeyemi, 2014).

In Mali, CBHI is very poor and unpopular and OOP payments was even increasing. Their government tried to solve the problems by combining their 3 existing schemes: formal sector coverage, medical assistance for the indigenous people and mutual health organization.
Also Cameroon has very poor CBHI scheme when compared to Nigeria. There was about 94.5% OOP expenditure in 2007. There was plan to introduced CBHI in every district in order to reduce the problems, however there was no clear national umbrella organization and the programme lacks financial support (Odeyemi, 2014).

5.0 Conclusion and recommendation

In order to achieve UHC in the near future Nigeria needs an effective and transformed healthcare financing system that can sustain and improve healthcare delivery to the whole nation irrespective of the financial status of the patients. CBHI should be part of wider package of financing method for example - equity funds and result oriented financing. The following strategies are recommended:

1) A planned strategy in each community must be implemented for the CBHI to succeed. Realistic budget should be developed before implementation of the CBHI scheme and balancing income and cost must be done.

2) High level of commitment from the leaders at all levels of the government (federal, states and local governments) must be present to provide quality healthcare to the lower socioeconomic and vulnerable groups, in such a way that CBHI will succeed.

3) Local Community involvement strategy will increase the rate of enrolment, as CBHI depends on community members to take part in the management programme and health education.

4) Regular assessment and review of financial status, service delivery, cost and assessment of strengths and weakness of the scheme must be carried out.

5) Ensure the full implementation of the national health bill which can provide legislative clarification and source of funding to support PHC. It also consist of basic health care provision fund (BHCPF) and targets universal coverage with at least basic services. This will significantly increase government financing for PHC. The funds is to be financed from federal consolidated fund, grants by the international donor partners as well as fund from any other source.

6) Transformation and restructuring of the NHIS so that it covers CBHI in order to achieve better coverage of the grass root people. NHIS in Nigeria has been disappointing to date, but experience elsewhere recommends that increase uptake by the states as well as sustainability could be improved through policies that inter-grate informal and formal sectors under the existing NHIS with an increase advocacy and awareness and more involvement of the beneficiaries in the program planning and managements.

7) Eradicate poverty by providing jobs for the majority of the citizen, so that health inequities, inequalities in access and utilization will no longer create hardship on the low social class and vulnerable in the country.
8) Eradication of corruption from the health sector and ensuring accountability

9) Infrastructural developments.

Nigeria must start to make more commitment to health care, if they want to achieve UHC. The rate of out of pockets health expenditure is still very high and catastrophic with the current Nigerian healthcare system. Recommended strategies need to be addressed urgently in order to improve equity in access to health care service as well as effective financial risk protection. CBHI may not be suitable in all situations but can play an important role in health care programs in Nigeria.

Declaration

Authors declare that there is no conflict of interest regarding this article.

Authors contribution

Author 1, 2 and 3: Literature search, analysing and writing the draft.
Author 4 and 5: Reviewing and editing.

References


Lucky O., Nwankwo N. C. (2012). A review of the Nigerian health care funding system and how it compares to that of South Africa, Europe and America. *Journal of Medicine and


