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Determinants of Community-Based Health Insurance Enrolment in Africa: Reflections from Rural Nigeria

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Abstract

Community-Based Health Insurance (CBHI) in the recent decades is being promoted in the Low-and-Middle Income Countries (LMICs) as an effective alternative model for accessing healthcare services among the poor. Cost of accessing care under the programme is comparably cheaper, and it is also seen as a means towards attaining Universal Healthcare Coverage (UHC). This is being promoted due to the perceived inefficiency of the primary healthcare system in most developing countries. However, healthcare services can only be accessed under such programme by those who enrol in it. This study, therefore, examines the determinants of CBHI enrolment in rural Kwara in Nigeria. The study adopted mixed methods research design. A total of 1,583 questionnaires were administered, and 33 in-depth interviews were conducted in the study area. SPSS and Atlas.ti were adopted for quantitative and qualitative data analyses respectively. Findings reveal that although the programme has received considerable patronage, but since access to healthcare under CBHI is not free, enrolment remains a contentious issue of discourse based on its importance to the success of the policy option. The study concludes that the government must take responsibility by financing access to healthcare especially for those who lack affordability.

***Keywords*:** community-based health insurance, universal health coverage, enrolment, out-of-pocket payment, health policy

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Introduction

Transformative social policy refers to the fundamental structural changes in the economy, social relations and institutions towards common good and well-being. It approaches policymaking from the standpoint of creating an embedded synergy between the social and economic spheres of society. In part, the normative framing of transformative social policy is anchored on the pursuit of nation-building (Adésínà, 2011). It is argued that a transformative underpinning of social policy programmes such as health are not solely social, but also economic in outcome (Adésínà, 2011; Kangas & Palme, 2000). Transformative social policies are designed in quest of a wide range of benefits such as securing the wellbeing of citizens through the "reproduction of society through social policies, and enhancing the productive capacity of citizens" (Adésínà, 2008, p. 3). Thus, primarily transformative social policy is tasked with re-orienting the productive levers of society through social investments that portends for the socioeconomic advancement of society beyond the liberal approach of resorting to redistributive devices for resource generated in a different domain.

For instance, evidence from Organisation for Economic Cooperation Development (OECD) countries shows the salience of social policy in micro and macro-economic development (Kangas & Palme, 2000). As such, transformative social policy is a "'productivist' rationale" that emphasises developing states in Africa and elsewhere to adopt a greater welfare foregrounding of social policy design necessary for institutionalising social and economic development withing the current neoliberal system. Hence, at the core of the ideational foundation of transformative social policy are equality and social solidarity for the collective wellbeing through public policy instruments that draw on, and synergise the resources and needs of all segments of society (Adésínà, 2009, 2011). This includes broad membership and coverage of all, irrespective of socio-economic status in healthcare provisioning. Social policy fosters state cohesion or nation-building as the "development outcomes feed not only social and economic development (growth with structural transformation), but also political development"(Adésínà, 2011, p. 465).

However, the current neoliberal economic variant has shaped social policy thought and design in ways that render social policy in the form of liberalised social assistance programmes as a residual function of development. Especially with proliferation of policy merchants and their

agents from the West, together with local collaborators oscillating between African states, prescribing standardized sets of 'social policies' without recourse to internal conditions and contradictions, including policy capacity and autonomy (Adésínà, 2020). Hence, with the current neoliberal socioeconomic conditions, African policy actors are under constant constraints by the policy merchandisers from the Global North to demonstrate the productive benefits of social welfare policy prescriptions within the calling of the markets (Gilson, 2012). All of these have negative consequences for healthcare provision. Also, such demands have led to the adoption of market-driven social policies such as out-of-pocket (OOP) health insurance schemes, and cash transfer policies to mitigate and contain the excesses of the market, instead of transforming the reproductive norms and institutions that condition the market and give rise to such excesses. This is understood in the context of the provision of adequate and affordable healthcare as an important pre-requisite for attaining higher levels of development and building a collective national polity.

Healthcare provisioning is a global challenge especially in the developing countries, particularly the financial sustenance of health systems (Kutzin, 2013). This places limitations on the ability of public officials to implement health financing policies that enable access to adequate healthcare for the populace especially the poor segments of society. The major source of healthcare funding in the nations is out-of-pocket payments (i.e. cash payments made at the point of using healthcare services). Globally, over 100 million people fall into extreme poverty every year due to terrible economic conditions, negatively affecting spending on healthcare for "about half of the world's population who lack full healthcare coverage as an essential services" (World Health Organization, 2021, p. 5). In Africa, 11 million people slip into poverty yearly and OOP spending has increased from 15USD per capita to 38USD between 1995 and 2014 (World Bank, 2016). As of 2019, only 3 out of 55 African countries are able to commit 15% budgetary allocation to the healthcare sector (Sands, 2019).

In view of the challenges, scholars (see e.g., Bennett et al., 1998; Wiesmann & Jütting, 2000) have argued that financial barriers can be reduced or removed for the poor and individuals in the informal sector through health policies related to insurance schemes such as Community-Based Health Insurance (CBHI) programmes; especially when they are subsidised (World Bank, 2016). It is further anticipated that CBHI has a

positive role in the bid to establish social health insurance (Mahmood et al., 2018) and ultimately attain universal health coverage (UHC) (Nshakira-Rukundo et al., 2019). It is also viewed as a means of guaranteeing access to care for the rural dwellers (Odeyemi & Nixon, 2013). This led to the encouragement towards adopting and expanding CBHI programmes in the LMICs. Presently, the CBHI policy has been implemented in many other countries around the world like India, Nepal, Bangladesh, Philippines, China etc. In the same way, "CBHIs have been implemented in several African countries, including Burkina Faso, Ghana, Rwanda, Senegal, Tanzania etc. since the 1990s" (Odeyemi, 2014, p. 1).

Moreover, willingness to enrol (i.e. interest and readiness of people to join CBHI programme) appears to be high among people in some African countries. For instance, studies conducted in Northwest and Northeast Ethiopia reported 80% and 77.8% respectively on willingness to pay (i.e. interest and readiness to pay the enrolment premium for CBHI programme) and enrol in CBHI programmes (Minyihun et al., 2019). Rwanda and Ghana have been recognised as countries with ability to scale-up CBHI in order to attain UHC. Specifically, Rwanda has the highest enrolment in health insurance in Sub-Saharan Africa (Chemouni et al., 2018). Study revealed that CBHI coverage of the Rwandan informal sector rose from less than 7% in 2003 to 74% in 2013 (Kalisa et al., 2015). The programme achieved this feat through the implementation of mandatory enrolment by all citizens.

To mitigate the effects of current neoliberal economic prescriptions on the healthcare provision by the state on society, especially the vulnerable population, attempts have been made by policy actors in Nigeria to institute risk polling CBHI scheme. This paper examines the issues that shape citizens decision to enrol on the programme with evidence from rural Kwara. The Kwara CBHI was started in 2007 as a partnership between the Kwara State Government of Nigeria and the Dutch Health Insurance Fund to provide healthcare coverage for individuals in the rural areas and covers primary and some secondary healthcare services (Hendriks et al., 2014). Enrolment was voluntary, with the initial annual enrolment premium pegged at N500 (3.13 USD) per person as at 2016 (Hendriks et al., 2014). However, enrolment in the programme between 2007 and 2016 was less than 140,000 – a very low figure compared to the population of Kwara State. There is a need therefore to investigate the determinants of enrolment in the programme with a view to understanding the factors behind the low

enrolment rate that characterised the programme, especially with the common anticipation that the model could be used to attain universal health coverage. To the best of our knowledge, there is dearth of studies on CBHI programme that focus on the determinants of enrolment. Rather, most existing studies paid attention on enrolment rate, willingness to enrol, utilization, health outcomes etc. (Brals et al., 2017; Odusola et al., 2016; Odusola et al., 2015). Thus, this study investigates the reasons for enrolment and non-enrolment in the CBHI programme in rural communities in Kwara State Nigeria.

Community-Based Health Insurance in Nigeria: A Health Policy Option

In Nigeria, the adoption of CBHI policy was partly influenced by the inability of the National Health Insurance Scheme (NHIS) to cover a good number of the population in the formal sector and given that majority of the Nigerian population in the informal sector (mainly in the rural areas) needs to be covered. The NHIS is yet to cover up to 5% of the Nigerian population with over 70% of the population in the informal sector (Ejughemre et al., 2015). A number of CBHI schemes exist across the country (e.g., Kwara, Lagos, Ogun, Anambra states). However, partly due to enrolment challenges, these schemes were mostly able to provide access to healthcare for a little fraction of the target population. For instance, "many studies conducted around the country (even where the programme is not operational) indicate readiness among the people to enrol, mainly because of the perceived potentials of CBHI in reducing OOP expenditures and increasing utilisation among Nigerians" (Nura et al., 2017, p. 110). There was a very high readiness to enrol in CBHI in Southeast (98.3%) (Onwujekwe et al., 2011) and North central (93.6%) parts of the country (Banwat et al., 2012). In addition, a study found 75% willingness to pay for CBHI among respondents in Katsina State (Falaki et al., 2017).

Most of these studies examine willingness to pay for CBHI established and less concern about the actual ability to pay. However, evidence of mixed reactions abound in some studies regarding enrolment in CBHI. This is because there are other factors that may influence the decision to enrol when the programme is eventually established. For example, in a study in Edo State, 60% of the respondents were willing to pay (Oriakhi et al., 2012). In contrast, those not willing to pay gave reasons such as "lack of trust in the scheme administrators and government policies [which are considered

very unstable]" (Oriakhi et al., 2012, p. 99). Similarly, another study conducted in Osun State (Bamidele & Awobimpe, 2013), found 82.4% willingness to pay out of which 74% preferred that the government organise the scheme. This indicates a disparity in the level of trust in government by different people.

As found in Bangladesh (Sarker et al., 2018), Ethiopia (Jembere, 2018), Uganda (Basaza et al., 2008), etc., enrolments into CBHI schemes are generally low in most cases. Even the enrolment successes recorded in Rwanda and Ghana have been subjected to contestations (Kotoh et al., 2018; Rubogora, 2017; Mukangendo et al., 2018). In the same way, the achievements documented in some studies regarding CBHIs in Nigeria have also been challenged (Ejughemre et al., 2015; Nura et al., 2017). Thus, this provokes the need to carefully assess the reasons for low enrolment by identifying the various factors that determine enrolment in CBHI programmes. For instance, Onwujekwe et al. (2009) identified successful and non-successful CBHI schemes in Anambra State. They found that low enrolment (15.5%) in the non-successful community (Neni), and higher enrolment (48.4%) in a thriving community (Igbo-Ukwu), both less than half the target population with regressive contributions. Generally, Fonta et al. (2010) noted that the programme could be partly adopted for healthcare of the poor until NHIS is capable of providing a cover for all. It, however, becomes concerning that NHIS involves a higher health insurance premium, which is a 'threat' to enrolment.

Onwujekwe et al. (2009) opined that enrollees' premium be complemented by funds from other relevant sources to ensure efficiency. This is worrisome, given the level of poverty in Nigeria and the financial requirement of the programme. While scholars such as Onwujekwe et al. (2011) suggested the adoption of various types of health insurance, the efficacy of deploying many types of health insurance is contentious. Meanwhile, in a study by Vaughan et al. (2016) in Rivers State, findings indicate that the rich benefitted more than the poor who the programme was designed for.

More precisely, the Kwara programme is one of the earliest in the country. At the beginning, it appeared that the CBHI was promising particularly in the rural areas. Conversely, certain challenges erupted and threatened its stability and progress. Some of them are poor enrolment, inability to pay premium, and inadequate healthcare providers and poor

quality of treatment (National Health Insurance Scheme, 2011). More so, Christian Aid (2015) reiterated the problems of ability to pay and deficient facilities and raised concern about the funding mechanism for the programme.

Methodology

The study took place in Kwara State Nigeria, North Central Zone of the country. Kwara has an estimated population of 3.2 million inhabitants (National Bureau of Statistics, 2018). Agriculture is the main economic source especially in the rural areas of the state, though on a small scale and does not generate large income for many. Of the 16 Local Government Areas (LGAs) in the State, the study was carried out in 11. Participants for the study were purposively drawn from rural communities with the highest CBHI enrolment in each of the 11 LGAs selected for this study (because the programme operated in more than one facility in some LGAs). The communities are: Aboto-Oja, Gure, Bacita, Osi, Idofian, Oro, Edidi, Kaiama, Bode Saadu, Odo-Owa and Erinle. For assessing the determinants of CBHI enrolment, both the former enrollees and the non-enrollees were sampled for the study. Multi-stage sampling technique was adopted in the study. Semi-structured questionnaires (separate designs for former enrollees and non-enrollees) and In-Depth Interview (IDI) guides were used for data collection across the selected communities. Additionally, two Focus Group Discussions (FGDs) (male and female session) were conducted in the six communities with highest enrolment population in the programme to enhance the designed instruments for data collection.

Enrolment population in the 11 selected communities was 95,151. For high precision and reliability and minimize sampling error, we used a Survey System Sample Size calculator (see www.surveysystem.com) at a confidence interval of three percent to proportionally select a sample size of 1,055 from the 11 communities. Since there was no reliable data to determine the population of each of the community, half of the former enrollees sample size (i.e. 528 non-enrollees) were evenly selected from each of the 11 communities. For gender sensitivity, the study sampled equal male and female heads of household. Further, we conducted 33 IDIs (a male, a female, and a community leader – per community) for a deeper understanding of the study. Statistical Package for Social Sciences (SPSS) and Atlas.ti were adopted for data analysis. The Table below gives an overview of respondents sampled for this study.

Table 1

Selected Communities and Number of Questionnaires Administered

S/N	Community	LGA	Total Enrolment Per Community	Selected Sample		
				Former Enrollees	Non-Enrollees	Total
1	Aboto Oja	Asa	11,993	133	48	181
2	Gure	Baruten	8,961	99	48	147
3	Bacita	Edu	6,731	74	48	122
4	Osi	Ekiti	24,550	272	48	320
5	Idofian	Ifelodun	11,009	122	48	170
6	Oro	Irepodun	12,306	137	48	185
7	Edidi	Isin	1,119	12	48	60
8	Kaiama	Kaiama	5,213	58	48	106
9	Bode Saadu	Moro	5,963	66	48	114
10	Odo Owa	Oke-Ero	1,682	19	48	67
11	Erinle	Oyun	5,624	63	48	111
	Total		95,151	1,055	528	1,583

Results

Socio-Demographic Characteristics of Respondents

The mean age of respondents was 41.7 years and 37.8 years for both former enrollees and non-enrollees respectively, indicating respondents were mostly young adults. In addition, over 60% of the total respondents had a minimum of secondary school education. This suggests that the majority of the respondents went through some kinds of formal education. Slightly above 60% of the respondents were Muslims. Less than 1% had other religions and the remaining respondents were Christians. More than 80% of the formerly-enrolled respondents were also married. Though farming is the main occupation in the rural areas, most of the respondents indicated they were traders and engaged in subsistence farming. The household size for many ranges from 4 to 6. Half of the respondents earned monthly income of ₦12,000 or less. This indicates that most of them earn a little above ₦10,000 – one-third of the ₦30,000 minimum wage that was recently approved by the federal government.

Enrolment in the CBHI Programme

Generally, decisions to enrol or otherwise are usually premised on specific socio-economic reasons such as ability to pay for enrolment. Various reasons advanced by participants for enrolment and non-enrolment in the programme are as thus:

Table 2

Reasons for Enrolment among the Formerly-enrolled Respondents (*N* = 1,043)

Reason	Frequency	Percentage
Illness	195	18.6
Affordability	169	16
Benefits package	501	48
Testimony of others	161	15
Maternal Care	1	0.9
Others	16	1.5

Table 2 shows that the majority joined the programme based on the benefits package offered (48%) and the opportunity to access healthcare during illness (18.6%). Others joined because of the affordability of the enrolment premium (16%) and testimony of people who have enrolled and utilized the service (15%). Only one person enrolled due to maternal care and 16 people (1.5%) enrolled for some other reasons. Also, the qualitative data showed that benefits package motivated almost half (10 of 22) to join the programme. According to some participants:

"What prompted me to enrol was that we were told at that time that after paying an enrolment premium of ₦500, we would benefit free access to healthcare for a whole year without paying a dime" (IDI, Female, 26/06/2019, Oro).

"I was pregnant at that time (IDI, Female, 13/06/2019, Erinle)."

"I was prompted to enrol with the believe that good quality of care would be provided for the enrollees under the programme (IDI, Male,15/06/2019, Edidi)."

Another participant added that:

> I was prompted to enrol in the programme because I saw people who benefitted and confirmed that it was real. There were many

healthcare challenges in this community that required treatments. I then decided to enrol my entire household, and my wife was within reproductive age. However, I would not have enrolled if I was not prone to sickness (IDI, Male, 19/06/2019, Bacita).

Reasons for Non-Enrolment

The reasons for non-enrolment are as follows:

Table 3
Reasons for Non-Enrolment among the Non-Enrolled Respondents

Reasons for Non-Enrolment	Frequency (N = 511)	Percentage
Financial Constraint	98	19.2
Enrolled in another health insurance scheme	25	4.9
Lack of trust	52	10.2
Lack of interest	135	26.4
Not fully around in the community	145	28.3
Late Awareness	23	4.5
No belief in hospital care	5	1
Spiritual healing	1	0.2
Always healthy	8	1.6
Misinformation that it is meant for the aged	4	0.8
Negative feedback from former enrolees	2	0.4
Distance to a healthcare facility	1	0.2
Others	12	2.3

Table 3 shows that in spite of the sensitization exercises on the programme, not everyone was aware – especially among those that were not fully resident in the communities (28.3%) or had interest (26.4%) in the programme. Financial constraint (19.2%) and lack of trust of trust (10.2%) were parts of the reasons for non-enrolment. In addition, some respondents advanced enrolment in other health insurance programmes (4.9%), late awareness (4.5%), lack of sickness (1.6%), non-belief in hospital care (1%), misinformation that it is meant for the aged (0.8%) negative feedback from enrolees (0.4%), belief in spiritual healing (0.2%) and distance to healthcare facility (0.2%) as reasons for non-enrolment. There are others who did not

enrol for other reasons (2.3%). Also, the qualitative data indicated that out of the twenty-nine participants that reacted to the question during the FGDs conducted, twelve noted that they were not around in the community when the programme was active; six claimed that they were not aware of the programme and three participants each identified lack of interest and non-satisfactory conduct by the Healthcare Providers as their reasons for non-enrolment. One of the non-enrolled participants in an FGD explained that:

"Though, I did not register but had the intention to register. However, after a while, they started removing some services from the coverage of the programme. With this, some people became discouraged and did not enrol" (Male FGD, 30/05/2019, Bacita).

Other participants stated their reasons for not being able to access the scheme in the following words:

"I did not enrol because I was not living in this community when it was operational" (Female FGD, 31/05/2019, Aboto-Oja).

"I did not join because I was not aware of the programme" (Male FGD, 27/05/2019, Osi)

"I did not enrol because I was not satisfied with the services rendered" (Male FGD, 29/05/2019, Idofian).

While indicated by some respondents through the questionnaire, none of the participants in the FGDs and IDIs gave financial constraint as the reason for non-enrolment. Financial constraint was not the main reason for non-enrolment in the programme there is possibility that they were not comfortable to state it. For instance, one community member in Bacita noted that:

"I did not enrol due to my nonchalant attitude or busy schedule because I have close associates who were enrolled" (Female FGD, 30/05/2019, Bacita).

Table 4

Chi-Square Test of Association between Selected Variables and Enrolment Decision

Variables	Former Enrollees (*p*-value)	Non-Enrollees (*p*-value)
Gender	.990	.222
Age	.001	.424
Religion	.636	.016

As shown in the table above, the study found no statistically significant association between gender and enrolment decision among the former enrollees (χ^2 = .260, *p*-value = 0.992) and the non-enrollees (χ^2 = 8.227, *p*-value = 0.222). This suggests that the decisions to enrol or otherwise were taken without gender considerations. Further, the study found a statistically significant association between age and enrolment decision among the formerly-enrolled respondents (χ^2 = 75.407, *p*-value = 0.001). The study however found no statistically significant association between age and enrolment decision among the non-enrolled respondents (χ^2 = 49.213, *p*-value = 0.424). This indicates that the decision not to enrol in the programme among the non-enrollees was not determined by age.

Further, the study found no statistically significant relationship between religion and enrolment decision among the former enrollees (χ^2 = 9.774, *p*-value = 0.636). This may be related to an understanding of the distinction between the roles of modern healthcare and religious belief system. It however found a statistically significant association between religion and enrolment decision among the former enrollees (χ^2 = 33.089, *p*-value = 0.016). This is confirmed by the submission of a participant in Bacita. She stated that: "I did not enrol because I am a pastor's wife, and we believe in prayer. We pray, and God has always answered us" (Female FGD, 30/05/2019, Bacita).

Non-Enrollees and Access to Healthcare

The majority (11 out of 19) of the participants in the IDIs confirmed that they catered for non-enrolled household members through OOP. Some community members stated that:

"Non-enrolled members of my family received healthcare at the hospital, and we paid OOP" (IDI, Female, 15/06/2019, Edidi).

"We paid OOP for treating the non-enrolled household members" (IDI, Female, Odo Owa, 17/06/2019).

Another participant explained that:

"Like half of the non-enrollees in the community still used hospital care, but they paid higher while the other half resorted to the use of herbal care and self-medication" (IDI, Male, 19/06/2019, Bacita).

These may be related to the importance attributed to the need to provide access to care for the affected household members regardless of income and size of the household. This is affirmed by the submission of a non-enrolled participant that:

"As a non-enrolee, I patronised our family doctor and we paid OOP" (Female FGD, 28/5/2019, Oro).

This suggests that irrespective of the level of education, the respondents had tendencies to attend to the healthcare needs of their non-enrolled household members when necessary. Apart from improving access to care, protection of community members from OOP was one of the reasons for the introduction of the programme. However, the attainment of this goal optimally was affected not only by non-enrolment of some members of the communities but by some enrolled members leaving the programme.

Discussion

Assessing determinants of CBHI enrolment is important for understanding the relevance and success of CBHI policy. The majority of the respondents were enrolled in the programme because of the benefits therein, and the anticipated protection against illness and Out-of-Pocket (OOP) payments. Thus, prevented from making OOP payments for treatment whenever they were ill, participants felt the need to enroll in the programme. Study on the programme found that income, education, household size and occupation are determinants of enrolment. This finding is consitent with a similar study that reported healthcare benefits as enablers of enrolment in the Ghanaian National Health Insurance Scheme (NHIS) programme (Kotoh et al., 2018). Similarly, a recent study reported that persons with chronic diseases had tendencies to enrol in a CBHI programme in rural Bangladesh (Mahmood et al., 2018).

The decision to enrol or not to enrol in CBHI programmes are many and vary from one study to another. However, in this study, the main reasons for non-enrolment were that respondents were not fully resident in the community during the period, lack of interest and financial constraint. This partly aligns with the findings of another study indicating that non-enrolment, late renewal of enrolment and decision to enrol members of

households are linked to financial constraints (Amsterdam Institute for Global Health and Development, 2015). The poor income of the majority of the respondents as indicated in the study suggests that financial constraint play significant role as a determinant of non-enrolment, though some of the non-enrollees indicated lack of trust/interest in the programme. Nevertheless, since illness is relatively inevitable these people would have enrolled in the programme if they had the financial means as there was no closer alternative to them in the rural communities. Also, the findings on lack of trust and interest in the programme aligns with the finding of a study in South-West Nigeria where most of the respondents were sceptical with the involvement of government in the provision and management of health insurance programme (Adewole et al., 2015).

In addition, the study found no association between gender and enrolment decision. This is similar to a previous study in Burkina Faso (Parmar et al., 2014) which found no association between gender and enrolment in CBHI programme. However, another study found that gender and age were related to CBHI enrolment in the LMICs (Dror et al., 2016). The relationships between age and enrolment found in this study are documented in other studies conducted in Nepal and Burkina Faso. For instance, Adhikari et al. (2018) found that households with persons above 60 years were likely to enrol in a CBHI programme while Schoeps et al. (2015) found no association between age and enrolment in CBHI in rural Burkina Faso.

The study found an association between religion and enrolment and the finding is confirmed by a recent study in South India (Reshmi et al., 2018). Some individuals with religious inclination may likely not use hospital care or enrol in CBHI programme. Moreover, there are some christian and islamic sects in Nigeria whose doctrines do not support the use of hospital care (Olusanya et al., 2010). Furthermore, the programme was primarily introduced to improve access to health among the rural dwellers and protect them against catastrophic healthcare expenditure. Unfortunately, as found in this study, most of the non-enrolled community members still visit the hospital for accessing healthcare whenever they fall ill. Perhaps, they did not enrol in the programme because it was not convenient to pay the enrolment premium, however, were compelled to make OOP payments for hospital care due to illness.

The relatively high population coverage experienced in Ghana and Rwanda in the past could be associated to the mandatory enrolment and exemption policies. However, mandatory enrolment can only be successful in settings where majority of the people can afford to pay. A good exemption policy would thus provide a waiver for the indigent, and this would likely reveal that a large proportion of the population lives below the poverty line and are eligible for waiver. In such instances, there is a need to review the policy with a view coming up with a robust, long-term and enduring policy option. This situation calls the attention of policymakers to approach the design of such programmes with a transformative mindset. Such an approach will demand that CBHI in Nigeria is crafted to accommodate all segments of the society irrespective of socioeconomic status. More so, the health of the society has a proportionate relationship with the productivity of a country. Conceptualised this way, current drawback of the scheme which is financial would be taken as a trade-off for citizens' contribution to national development through labour services by policymakers. This way, the financial commitment by the state to make the scheme easily accessible becomes an investment in human well-being as a pre-condition for general economic output and societal cohesion for the benefit of all.

Conclusion

Healthcare provisioning is a global challenge especially in the developing countries. External social policy prescriptions have therefore led to the implementation of Community-Based Health Insurance (CBHI) in Africa in the last three decades as an effective alternative model for accessing healthcare services among the poor. The adoption of CBHI policy in Nigeria was partly influenced by the inability of the National Health Insurance Scheme (NHIS) to cover a good number of the population in the formal and informal sectors. Findings based on the mixed methods approach adopted for the study show that the majority joined the CBHI programme in Kwara based on the benefits package offered, opportunity to access healthcare during illness and affordability of the enrolment premium. Age and religion were found to be parts of the determinants of enrolment in the programme.

The study deepens the theoretical understanding of the adoption and implementation of CBHI programme in Nigeria; particularly, using the lens of transformative social policy which canvasses for a fundamental change

in the socio-economic structure of a nation for a common well-being. On the practical front, the study offers actionable insights for policymakers and development partners on sustainable policy options that are result-driven. The finding on poor income of the majority of the enrollees suggests that it may be a reason for enrolment or otherwise. More so, there are also indications that if the services are provided for free, utilization rate would increase, and the population would be healthier. As such, we argued that beyond CBHI, a strategic and long-term ideational policy plan would assist in mitigating possible challenges that can come with the population growth which necessitate increased healthcare utilization. Future researchers should engage in comparative analysis across states in Nigeria and the African region, assess policy implementation gaps and involvement of non-state actors in health and CBHI policy programmes.

Conflict of Interest

The authors of the manuscript have no financial or non-financial conflict of interest in the subject matter or materials discussed in this manuscript.

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