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SOCIOLOGY | REVIEW ARTICLE

Advancing alternative health care financing through effective community partnership: A necessity for universal health coverage in Nigeria

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Additional information is available at the end of the article

Abstract: This paper sought to advance alternative health care financing for the attainment of universal health coverage (UHC) in Nigeria considering the widening inequality, dwindling government spending, and non-inclusive health insurance scheme in the country. An adoptive narrative review of existing literature and authors' experiences and observations of health care financing system was used to develop an overview of health care financing system in Nigeria. The results showed that Nigeria has a long way to go in attaining universal health coverage considering her high burden of disease and low health care expenditure, especially in comparison with Africa and similar countries across the globe. The results further showed that out-of-pocket spending dominates health care expenditure in Nigeria, and that the only way to curb heavy reliance on unsustainable and inequitable health care financing is to encourage risk-pooling of resources. This article therefore argues that alternative health care financing through effective community partnership is a necessity to achieving health for all. This understanding could inform health

Isaac Akintoyese Oyekola

ABOUT THE AUTHOR

Isaac A. Oyekola holds B.Sc. and M.Sc. degrees in Sociology and Anthropology, Obafemi Awolowo University, Ile-Ife. He is an upcoming scholar with keen interest in social change and development studies, sustainable health care financing, public sector careers and informal sector. With background interest in public and informal sectors, he had written a number of journal articles and book chapters. He later extended his academic interest to social support and reliable health care financing few years ago due to his experience in and observation of the Nigerian health care financing system; and his PhD thesis is being written in that academic area. In the process, he had strengthened his social network and has built strong research team in that area among which are the co-authors who are also familiar with the Nigerian health care system. Currently, he is an Assistant Lecturer at Landmark University, Omu-Aran and a Doctoral Candidate at Obafemi Awolowo University, Ile-Ife.

PUBLIC INTEREST STATEMENT

Health care cost per capital is increasing and the cost of health is beyond the capacity of average Nigerians considering the widening inequality in the country. The proportionate contribution of various sources of health care financing (such as out-of-pocket payment and compulsory prepayment) in the Nigerian total health expenditure shows that the health care financing is not sustainable in the country. Alternative health care financing through effective community health partnership that will drive compulsory prepayment schemes and address the present alarming health indices in the country has therefore become imperative for the attainment of universal health coverage (UHC). The framework put forward in this article suggests practical steps on how financial resources can be obtained at the community level without resulting in catastrophic or impoverished health spending. If followed, the framework could inform health care policies by annexing necessary connections with the promise of extending primary health care to all, especially the vulnerable groups, in a rapidly changing but highly unequal society.

policies by annexing necessary connections with the promise of extending primary health care to all, especially the vulnerable groups, in a rapidly changing but highly unequal society.

Subjects: Sociology & Social Policy; Development Studies; Health & Development; Sustainable Development; Health & Society; Public Health Policy and Practice

Keywords: Health care financing; health governance; community health partnership; universal health coverage

1. Introduction

Safeguarding population health is necessary for the attainment and sustenance of economic and social development. In 1978, the Alma-Ata Declaration was adopted at the international conference on primary health care, Alma-Ata (now Almaty), and it affirmed the need for concerted efforts of stakeholders including governments, health workers, and world community in promoting health for all. This first international declaration underlines the importance of primary health care which calls for a new drive in order to attain universal access to quality health. Since then, universal health coverage (UHC) has become a major objective of every member state of the World Health Organization. Universal health coverage describes people's freedom from financial catastrophe and impoverishment when paying for health services they need, ranging from prevention, promotion, treatment, and rehabilitation to palliative care (World Health Organization & The World Bank, 2017). In other words, UHC emphasizes that everyone has equal access to quality health services without financial hardship. These objectives are determined by many factors. Some of these factors are outside the health sector such as people's social environment, education, housing and food, among others (World Health Organization, 2008). Other factors within the health sector are also critical in achieving and sustaining health for all. However, without a good and well-functioning health care financing system, UHC cannot be achieved.

Health care financing plays a critical role in sustaining the health of the present and future generations. This is because health care financing determines the existence and affordability of health services when needed (World Health Organization, 2010). As a result, World Health Organization encouraged member states to commit themselves toward developing sustainable health care financing system (World Health Organization, 2005). Also, the 2012 United Nations General Assembly's resolution urges governments to move towards UHC through a strong health care financing mechanism (United Nations Organization, 2012). These give the government of every member state the responsibility of developing sustainable health care financing system that would protect people from financial hardship and encourage optimal use of available health resources.

The governments of African countries met in April 2001 to address health care financing problems, being one of the key determinants of UHC. The outcome of the 53 African Heads of States' meeting led to the signing of the Abuja Declaration, thereby committing every member state to allocate 15 per cent of their national budgets to health. In 2015, except for Madagascar (15.6 per cent), no African country could achieve the target (World Health Organization, 2018). While the agreement was reached in Abuja, Nigeria has remained a perpetual defaulter. Available statistics indicate that Nigeria has never budgeted 15 per cent of the national budget to health (World Health Organization, 2019). With low government expenditure on health, high out-of-pocked payment for health services, and exclusion of majority of the Nigerian population from existing health insurance schemes, advancing alternative health care financing through effective community partnership will help in facilitating the attainment of UHC in Nigeria. This is critical in order to safeguard the population of, for example, those who are rejected or detained in the hospital as a result of their inability to pay for health services (Pulse Nigerian News, 2017; The Guardian, 2017; Vanguard Newspapers, 2009; Yates et al., 2017). This article therefore aims at

advancing alternative health care financing that will incorporate all stakeholders at the community level and as a result strengthen capacity at that level. Community health partnership is vital for any country aspiring to make health services available to all its citizens without experiencing financial burden.

2. Methods

Narrative review of key articles on health care financing was conducted to develop an overview of health care financing in Nigeria in order to advance alternative health care financing system that will aid the realization of universal health coverage in Nigeria. Relevant journal articles and books were obtained from Scinapse, Google Scholar, Elsevier/ScienceDirect, and PubMed database (between 2009 and 2019) using "health care financing in Nigeria" as the major search term (Green et al., 2006). In addition, websites of key organizations such as World Health Organization and United Nations Organization were visited to generate current health statistics in Nigeria. Authors' experiences and observations, hand searches of some relevant references from retrieved literature and books from personal and university libraries were also utilized to further enrich this work (See Table 1 for further details).

3. Findings

3.1. Health statistics

Health-associated indicators are grouped into seven thematic areas and are used to measure burden of disease: reproductive, maternal, new-born and child health; infectious diseases; non-communicable diseases (NCDs) and mental health; injuries and violence; universal health coverage and health systems; environmental risks; as well as health risks and disease outbreaks (World Health Organization, 2018). Overview of Nigerian burden of disease with that of the world and Africa in the recently released world health statistics by WHO shows that the country has a long way to go in attaining UHC. In 2015, an estimated 814 women per 100,000 live births died due to maternal causes in Nigeria, a ratio higher than that of Africa (542) and the world (216) (World Health Organization, 2018). Almost all (99 per cent) maternal mortality occurred in low and middle-income countries (LMIC) with 64 per cent found in the WHO African Region (World Health Organization, 2015, 2018). In addition, 15,000 under-five children died daily in 2016 across the globe, representing 40.8, 76.5 and 104.3 deaths per 1000 in the world, Africa and Nigeria, respectively (United Nations Childrens Fund, 2017; World Health Organization, 2018). The rate of new HIV infections is 1.23 per 1000 unaffected population in 2016, compare to Africa (1.24) and the world (0.26) (World Health Organization, 2016). For tuberculosis, the incident rate was 219 per 100,000 population in 2016, compared to Africa (254)

Table 1. Overview of the method

Search sources
• Scinapse from 2008—Dec. 2019; Keyword: Health care financing in Nigeria
• Google Scholar from 2008—Dec. 2019; Keyword: Health care financing in Nigeria
• Elsevier from 2008—Dec. 2019; Keyword: Health care financing in Nigeria
• PubMed from 2008—Dec. 2019; Keyword: Health care financing in Nigeria
• Key organizations websites
• Authors' experiences and observations of health care financing system in Nigeria
• Hand searches of the references of literature retrieved
• Books on health care financing from personal and university libraries

Table 2. Health and health care financing statistics

Health statistics	Year	Nigeria	Africa	Global
Maternal mortality ratio (per 100 000 live births)	2015	814	542	216
Under-five mortality rate (per 1000 live births)	2016	104.3	76.5	40.8
New HIV infections (per 1000 uninfected population)	2016	1.23	1.24	0.26
Tuberculosis incidence (per 100 000 population)	2016	219	254	140
Malaria incidence (per 1000 population at risk)	2016	349.6	239.6	90.8
Health care financing statistics Population (in millions)	2016	185,990	1,019,922	7,430,261
UHC Service coverage index as % of total health expenditure	2015	39	44	64
Household out-of-pocket payment as % of total health expenditure	2017	77.22	40.48	41.06
Development assistance for health as % of total health expenditur	2017	7.62	21.36	3.93
Voluntary prepayment as % of total health expenditure	2017	0.43	4.55	4.83
Social health insurance schemes	2017	0.73	2.94	19.03
Compulsory prepayment as % of total health expenditure	2017	14.48	38.57	47.89
Domestic general government health expenditure (GGHE-D) as percentage of general government expenditure (GGE) (%2015		5.3	6.9	9.9
Current Health Expenditure (CHE) per Capita in PPP	2017	221.10	225.37	1,376.87
Current Health Expenditure (CHE) per Capita in US$	2017	73.92	86.00	1,051.14

Sources: IHME (2018); United Nations Childrens Fund (2017); World Health Organization (2015, 2016, 2018, 2019)

and the world (140); and 349.6 per 1000 population was at risk of malaria incidence in 2016, lower than Africa (239.6) but higher than global statistics (90.8) (World Health Organization, 2018).

Although the burden of disease in LMIC (especially in Africa) is higher than that of the high-income countries, the latter expend far more on health despite their smaller proportion in global population (Institute for Health Metrics and Evaluation [IHME], 2018; World Health Organization, 2019). By implication, the LMIC accounted for higher percentage of global population, higher proportion of the burden of disease, but smaller share of global health expenditure (IHME, 2018; World Health Organization, 2019). It should be noted that Nigeria has always been ranked low in the global health ranking (World Bank, 2008; World Health Organization, 2000). To deliver the African countries, Nigeria inclusive, from high burden of disease, alternative health care financing through community health partnership is an important prerequisite and imperative. This must begin with an overview of Nigeria's health care financing, having found that "financial and social risk protection" is one of the outcomes of health governance (Barbazza & Tello, 2014).

3.2. Health care financing

In Nigeria currently, compulsory prepayment, voluntary prepayment, development assistance for health (or external funding) and household out-of-pocket payment are classified as sources of health care financing (Olatubi et al., 2018; Uzochukwu et al., 2015). There is consensus that compulsory prepayments (including government and compulsory contributory health care financing schemes) are critical for achieving UHC, and that it is important to reduce OOPs in order to ensure financial protection (Dieleman et al., 2017; Freeman et al., 2017). Given that only 39 per cent of the Nigerian population are able to access the health services they need without the risk of financial hardship when paying for them (World Health Organization, 2018), objective appraisal of various sources of health care financing becomes vitally important so as to establish good and sustainable health care financing system and better the lives of Nigerians.

3.2.1. Out-of-pocket (OOP)

Also known as user-charges, OOP is the earliest method of financing health and it refers to payments made by individuals or households for health services (IHME, 2018). This source of health care financing is the most inequitable and unsustainable, and the proportion of OOP in the total health expenditure determines the progress of every country towards achieving UHC (Gottret & Schieber, 2006; IHME, 2018). However, OOP payment for health services in Nigeria was 77.22 per cent of total health expenditure in 2017 compare to Africa (40.48 per cent) and the world (41.06 per cent) (World Health Organization, 2019). If millions of Nigerians need to pay for health services when needed, mortality rate will be on the increase since many cannot afford health services considering the poverty rate and health spending per person.

3.2.2. Development assistance for health

Development assistance for health (DAH) refers to external health expenditure or external aids geared toward the progress of population health and it often flows from developed countries and donor agencies like the World Bank, WHO, Funds and Foundations through grants and loans to the developing countries (World Health Organization & The World Bank, 2017). This source of health care financing is capable of contributing to the attainment of UHC if well governed and it usually has impacts on specific health interventions. However, the share of this source of health care financing in Nigeria's total health spending was 7.62 per cent in the year 2017, compare to 21.36 in Africa and 3.93 in the world (World Health Organization, 2019). In fact, in the year 2016, the total net official development assistance for health per capita, by recipient country, was 2 USD.87 for Nigeria: ranging from 34 USD.17 in Seychelles to 0 USD.02 in Algeria within Africa (World Health Organization, 2018). Unless alternative health care financing is sourced, current Nigerian health care financing system will not be capable of achieving UHC. Effective Community Health Partnership (CHP) will aid in driving this source of health care financing in order to increase its share in the Nigerian total health funding.

3.2.3. Voluntary prepayment

Voluntary prepayment is a private health insurance scheme that is funded from non-public programmes prior to obtaining health care services (IHME, 2018), and it includes health care financing schemes through not-for-profit private health insurance, voluntary community-based health insurance, and government-run voluntary prepayment (McIntyre & Kutzin, 2016). In the year 2017, this source of health care financing only account for 0.43 per cent of total health care expenditure in Nigeria (World Health Organization, 2019). Considering high income inequality in the Nigerian society and the low proportion of this source of health care financing in the total health expenditure, this source of health care financing is not sustainable. Hence, the need for alternative health care financing through community partnership.

3.2.4. Compulsory prepayment

Compulsory or mandatory prepayment comprises health expenditure obtained from government revenues such as government-owned enterprises and taxes as well as from social health insurance contributions (McIntyre & Kutzin, 2016). Government expenditure refers to the amount of money

government expends on health projects including spending on public health system services and infrastructure and is mutually exclusive of OOP, private health insurance scheme and external aids (IHME, 2018). Nigeria is currently Africa's most populous country and seventh in the world, projected to be the third by 2050 (Population Reference Bureau, 2018). In addition, she is the country with highest gross domestic product (GDP) in Africa (FocusEconomics, 2018). Despite her wealth and being the giant of Africa, Nigerian government spends 5.3 per cent of general expenditure on health, less than the proposed 15 per cent of Abuja Declaration in 2001 (Oganization of African Unity, 2001; World Health Organization, 2018). This percentage is negligible, and renders millions of Nigerians helpless in financing their health.

On the other hand, National Health Insurance Scheme (NHIS) is a body responsible for the provision of effective and qualitative health care services to all Nigerians and it aims at safeguarding equal access to quality health care services without financial hardship. The social health insurance was first flagged off in 2005 to provide health cover for federal civil servants and their dependents. Today, the scheme has designed several other programs covering different segments of the Nigerian society (National Health Insurance Scheme, 2015). However, the program has not been evenly distributed and many Nigerians have not benefited from the scheme (Adefolaju, 2014; Dutta & Hongoro, 2013; Eboh et al., 2016; Onoka et al., 2014, 2016). For examples, in 2014, only 3.3 per cent of the total population enjoyed the scheme (Adefolaju, 2014). A more recent statistics showed that only 0.73 per cent of total health expenditure was received from social health insurance contributions in 2017 (World Health Organization, 2019). This is worrisome as it indicates high non-inclusiveness in the scheme. The 2017 Nigerian estimation of compulsory prepayment (14.48 per cent) that would have aided the attainment of UHC is lower than that of Africa (38.57) and the world (47.89). Since pooled resources is the only reliable and sustainable source of health care financing that can guarantee UHC (IHME, 2018; National Health Insurance Scheme, 2015), a more inclusive community health partnership (CHP) (targeting more than 70 per cent of total population) is therefore required to achieve UHC in Nigeria.

4. Discussion

Current world health statistics calls for a good health governance and very strong health care financing system, especially in Sub-Sahara Africa: Nigeria inclusive. The cost of health in Nigeria is beyond the capacity of average person in view of the poverty rate and health spending. The inability of the poorest citizens to afford treatment aggravated the problem because, in comparison with other developing countries especially in Africa, out-of-pocket payment (OOP) for health services in Nigeria was high and social health insurance scheme that had the capability of distributing health financial risks and increasing access to health services was very low (World Health Organization, 2019). With the projection that per capital health spending will increase by 4 per cent every year (Dieleman et al., 2018), alternative health care financing becomes inevitable. The only way to curb heavy reliance on unsustainable and inequitable health care financing, especially OOP payments, is to encourage risk-pooling of resources whereby financial resources are collected and managed in such a way that the unpredictable individual financial risks become foreseeable and are distributed among members of the pool (World Health Organization, 2010). Most advanced countries that are near to achieving universal health coverage (UHC) followed this path. In other words, the feasibility of UHC depends largely on population access to pooling mechanisms. While it is important that Nigeria increases her efficiency of revenue collection, reprioritizes her budgets, engages innovative financing, and seeks external aids (World Health Organization, 2010), financing health services through more pragmatic approach that involve community partnership could be used to provide health care for all.

Community Health Partnership (CHP) is broadly considered a not-for-profit prepayment scheme that spreads risk across different demographic categories such as sex, age, socio-economic, occupational, and health statuses, among others. Existing literature often refer to it as informal sector health insurance, community-based health insurance program, mutual health organization (MHO), or micro-insurance scheme (Geng et al., 2018; Gottret & Schieber, 2006; Ko et al., 2018). The scheme is not novel in many parts of the world considering its existence for over centuries in some advanced countries

(Bennett, 2004; Gottret & Schieber, 2006; Purohit, 2014). However, the scheme is gaining ground in West Africa due to its increased number and as a result of its recognition as being capable of facilitating UHC especially in the informal sector and rural areas (Adomah-Afari & Chandler, 2018; Bennett et al., 2004; Onoka et al., 2016; Smith & Sulzbach, 2008; Waelkens et al., 2017). In Nigeria, the importance of CHP and its awareness among community members have not been adequately known (National Health Insurance Scheme, 2015; USAID, 2016). Recognizing the fact that UHC is only achievable with a significant coverage of more than 70 per cent of the Nigerian population that constitutes the informal sector (National Health Insurance Scheme, 2015; Ogbuabor & Malaolu, 2013; Onwe, 2013), more strategic and effective CHP is therefore highly imperative in achieving UHC. The model in Figure 1 advances alternative health care financing system through CHP with the aim of achieving UHC and invariably, socio-economic development in Nigeria.

The governance of CHP comprises a number of stakeholders. Importantly, CHP principally consists of NHIS—the body established by an Act and charged with the responsibility of providing effective health care services to all Nigerians; Governing Body (GB)—responsible for the management of the scheme at the community level; Healthcare Providers (HP)—liable for the provision of health care services to enrollees and liaise with the Governing Body for financial settlement; and Community Members (CM)—responsible for prompt contribution to the governing body for continuous beneficiaries of the scheme. The composition, recruitment and interactions of the stakeholders are in turn largely determined by three key factors: context, strategy and capability (see Figure 1 for CHP model).

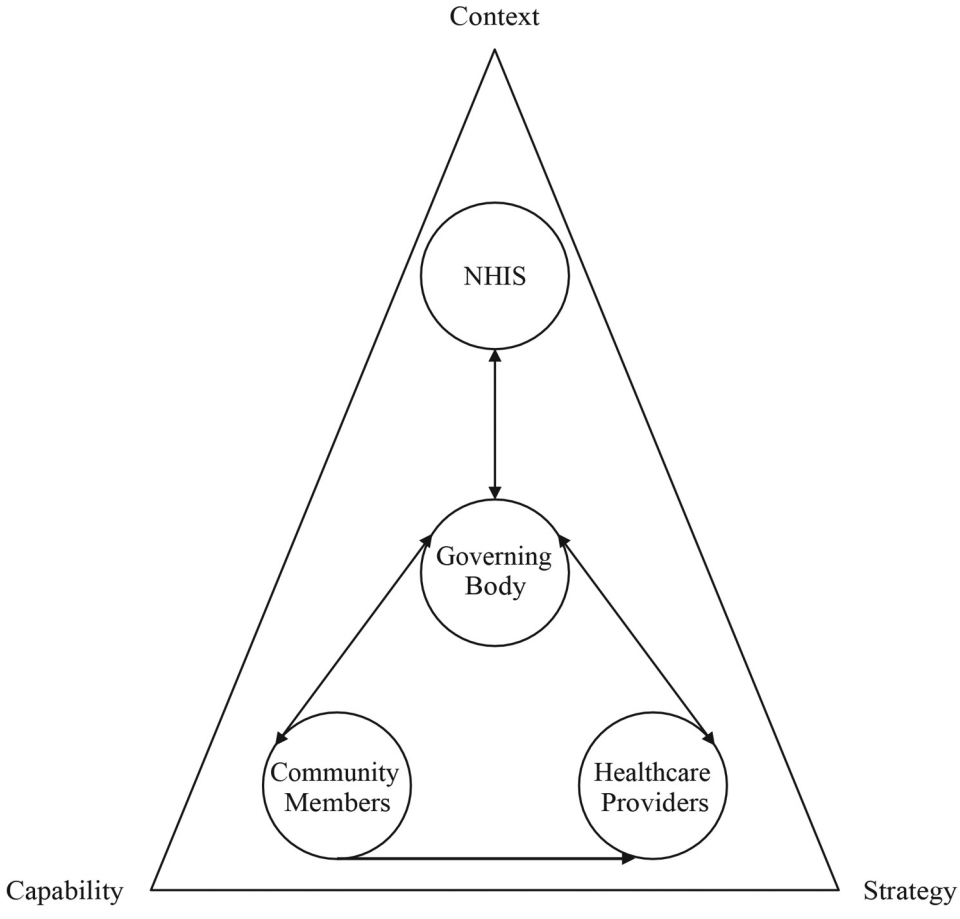

Figure 1. Community Health Partnership Model.

4.1. National health insurance scheme (NHIS)

As the body responsible for providing health care finance for all Nigerians through the pooling of resources, NHIS controls and regulates the CHP in collaboration with GB. It determines, reviews, and promotes, along with GB, the practice of CHP. For instance, it assists in determining contribution rates and service charges for CM and HP respectively. In addition, it sets and checks the standards for HP as well as recruits, accredits, dismisses or sues them. The NHIS also collaborates with other stakeholders such as community members, external agencies, government and policy makers, among others, in generating financial supports. The role of NHIS cannot be overemphasized in determining the establishment and continuity of CHP. This body creates awareness to community members in collaboration with community leaders for CHP to be established. Once established, the body hand over the day-to-day management of CHP to Governing Body for continuous effective operation.

4.2. Governing body (GB)

The management and sustenance of CHP relies heavily on its governance, which is the sole responsibility of Governing Body (GB). Members of GB are recruited or appointed from CHP stakeholders and are relatively unstable (that is, members keep changing periodically), having shown their financial commitment and integrity in sustaining the CHP. Governing Body is vital to the sustainability of CHP because of the innumerable functions it performs. In other words, the success or failure of CHP rests heavily on the performance of GB. As a result, GB is a very sensitive stakeholder in ensuring the sustainability of CHP. Specifically, GB defines the goals and membership composition of CHP as well as strategically obtains and accountably utilizes financial resources for the benefits of community members (Mitchell & Shortell, 2000; Stephen & Stemshorn, 2016). Since it manages the financial resources of CHP, checks and balances must be ensured. This is achieved by ascertaining that all financial resources obtained are kept such that only HPs have access to it subject to the approval of GB and under the supervision of NHIS. This will help in reducing mismanagement of financial resources.

In addition, the body provides community awareness for local policy makers as well as occupational, educational, opinion and religious leaders; supervises and monitors program activities; signs agreements with participating community and health care providers; pools contribution collected and ensures prudent financial management; organizes general meetings; purchases health care services for participating communities, conducts medical auditing and quality assurance; registers and regularly updates members' records, collects and keeps contributions from community members, provides community level quality assurance, as well as sends regular reports to the NHIS, communities members and health care providers (Arredondo et al., 2018; Mitchell & Shortell, 2000; National Health Insurance Scheme, 2015; Stephen & Stemshorn, 2016).

4.3. Healthcare providers (HP)

Healthcare providers are primary, secondary and tertiary health care facilities engaged by stakeholders (especially NHIS and GB) to provide health care services to CM. Importantly, they sign contractual agreement with GB and offer quality health care services (including prevention, promotion, treatment, rehabilitation and palliative) to registered CM, maintain all records of services given, as well as provide regular feedback to GB. Healthcare providers ensure that every health care service rendered is duly signed by the beneficiary and the beneficiary in turn file such report with the GB after treatment for checks and balances.

4.4. Community members (CM)

This is a group of people who have agreed to pool their resources for the purpose of prepaying health care services and spreading health financial risk. This group of people shares common characteristics mainly geographic proximity (Jakab & Krishnan, 2004). Specifically, they pay contributions periodically, appoint (or recruit as the case may be) members of the GB; receives quality care health services from HP, attend general meetings, and provide regular feedback to GB. Members of the community are strongly involved in managing the CHP and are not beneficiaries of other forms of social health

insurance financing methods or health coverage. Since CHP targets informal sector that comprises more than 70 per cent of the Nigerian population (National Health Insurance Scheme, 2015; Ogbuabor & Malaolu, 2013), it is believed that members are not (i) included in the existing formal sector programmes of the NHIS, (ii) gaining access to government-funded services and (iii) paying for premiums in any voluntary private health insurance except for other CHP (Gottret & Schieber, 2006). Membership of CHP is mandatory so as to enhance the sustainability of the scheme but limited to a particular geographical community. In addition, members express deeply rooted principles, values and ethics that ensure CHP's sustainability (Gottret & Schieber, 2006).

4.5. Context, strategy and capability

Aside the stakeholders hitherto mentioned, effective CHP requires understanding of a number of factors which determines its maintenance and sustenance. All stakeholders operate within and are conditioned by these factors: context, strategy and capability. Context refers to both the internal and external environment of CHP where goals and objectives are achieved. The internal environment defines the structure of relationship between and among stakeholders. For instance, the GB must persuade CM to drive a shared vision and mission. Also, the NHIS and GB must ensure day-to-day management of CHP through implementation of plans and strategies, GB and HP must maintain members' commitments and interests, GB must resolve conflict (whenever it arises) between HP and CM, ensure accountability and meet stakeholders' expectations. Externally, all stakeholders must deal with the social and political-economic situation of the environment such that adequate resources required to sustain CHP's objectives are obtained. The activities of all stakeholders are contingent upon the provision of enabling legislative and policy environment, and the functioning of existing health care facilities. This understanding is necessary for effective governance, management and funding of CHP.

The second factor that determines the maintenance and sustenance of CHP is strategy. Community health partnership must devise and align its strategies to meet the demands of both the internal and external environments and such strategies must be capably executed. Workable strategy that will address health care challenges of the community while putting into consideration the dynamic social-cultural and political economy situation of the community as well as the impact of globalization on such community (Oyekola, 2018) is required in order to achieve the objectives of CHP. Specifically, how CM's contribution will be calculated and made, how HP will deliver health care services, and how GB will pool health resources are all strategies that must be well developed. Furthermore, the composition of stakeholders is another strategic goal that will determine the longevity and successful operation of CHP. For instance, formation processes of stakeholders must be well laid out such that will accommodate diversity of membership and not limit members to one social group. If CHP is characterized by geographical proximity for instance, then its members must come from all works of life such as different professions, age-groups, geographical areas, religion, educational attainments, among others, that is representative of the community.

Last is capability, such as resources, which CHP need to implement its strategy that will meet the demand of both the internal and external environments. The CHP must be capable of establishing a diversified resource base. (This requires an innovative and a well-planned strategy.) Reliance on single source of funding (such as CM's contribution) can render CHP unsustainable and therefore divert it away from its objectives. Drawing members from various works of life but having united goal of pooling health resources will strengthen the resource base of the partnership and increase the capability to achieve CHP's objectives. The quality of strategies employed will determine the capacity of CHP. For instance, the more diversified homogenous CM are selected, the greater the capability of CHP; and the more objective HP are selected, the more likely their capability to deliver quality health services. In addition, when members of GB are well experienced, educated and exposed, they will have stronger capability to pool external resources for the benefits of CM. These dynamics of operations are captured in Figure 1.

5. Conclusion

Nigerian health care financing system is complex. Any effort that fails to put this complexity into consideration will only make health care financing policies remain at the level of theory and will not be able to translate it into practice. Implementable health care financing policies are crucial and timely in order to address the present alarming health indices and unsustainable health care financing in the country. The health indices of Nigeria are still far from the desirable levels that will position Nigeria for universal health coverage (UHC). Also, the current proportion of unsustainable OOP payment in the Nigerian total health expenditure is too high and poverty level imposes financial barrier to access quality health care services. While NHIS has capability of providing health for all, the scheme shows very high non-inclusiveness. There is now dire need for alternative health care financing through effective community partnership in order to achieve universal health coverage in Nigeria. The framework of CHP advanced in this article could inform health care policies by annexing necessary connections with the promise of extending primary health care to all, especially the vulnerable groups, in a rapidly changing but highly unequal society.

6. Recommendations

6.1. Establishment of community health partnership

Although community members can be defined by their occupation, religion, and place of work, defining them by their place of residence in Nigeria will be more appropriate for two reasons. First, landlord/tenant association is already in existence and this allows ease interactions among community members. Second, traditional rulers or community head exist in virtually all village communities and cities in Nigeria, one or few of which are duly recognized as key actors to the development of the community. All these create platform for the commencement of CHP. Although these key actors are very important in establishing CHP, they need not be given the task of overseeing the GB. In addition, establishing CHP in all Nigerian communities at once should be discouraged. Instead, such should be done phase by phase, and the lessons learned in one phase, in addition to the dynamic nature of human beings, should be put into consideration in subsequent establishment.

6.2. Functionality of CHP in every community

Having established CHP in different communities, all stakeholders especially the NHIS and GB should ascertain that CHP functions well. First, being government representative, NHIS should always suggest areas where government can intervene and such intervention should be given directly to the GB subject to the approval of the NHIS. In addition, appropriate and affordable premium should be charged. Since health is expensive, government has very key roles to play in this regard and donations from external bodies and wealthy private individuals must be highly encouraged for effective pooling of resources.

6.3. Compulsory participation of community members

National Health Insurance Scheme (NHIS), under the auspices of government, should ensure that every member of a community participates in the scheme, financially. That is, every individual who has attained statutory adult age should be mandated to participate in the scheme so as to encourage wider pooling of resources. To achieve this, no individual member should be allowed to see medical personnel or enjoy any other community benefits without showing proof of membership of CHP, except during emergency. Government is expected to play another vital role by supporting the more vulnerable CM such as fourth-agers (older people who are unproductive as a result of poor health after their retirement).

6.4. Compulsory participation of healthcare providers

All HP in a community, especially private HP, should be mandated to participate in the scheme as this will in turn encourage CM participation. It is therefore the responsibility of GB to ensure that medical expenses are paid to HP in time so as to avoid unnecessary delay of patients, and HP should also be checked periodically in order to avoid unacceptable increase of medical bill.

6.5. Voluntary multiple participation of community members

Members of community (CM) should be allowed to participate in more than one CHP if they so desire. This is important especially for CM who are resident in more than one community. Since financial resources determine the sustainability of CHP, voluntary multiple participation should therefore be encouraged among financially committed members of community so as to increase the financial base of CHP.

6.6. Non-discrimination of any kind

Community members with serious ailment should not be discriminated while participating in the scheme, and their premium should not be raised unworthily due to their peculiar conditions. Every member of community should be treated equally in terms of medical treatment and premium charges.

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