FCT Community Based Health Insurance Scheme (CBHIS): Progress, Problems and Prospects

FHSS

INTRODUCTION/EMERGENCE OF COMMUNITY BASED HEALTH INSURANCE SCHEME

- **NHIS decree no 35 of 1999 formally launched on 6th July 2005**

Objectives

- **To provide health insurance to insured persons & dependants to benefit from prescribed good quality & cost effective health services**
- **Formal and Informal Sector**
- **FCT EXCO Resolution 2006, FHSS formally launched in 2009**

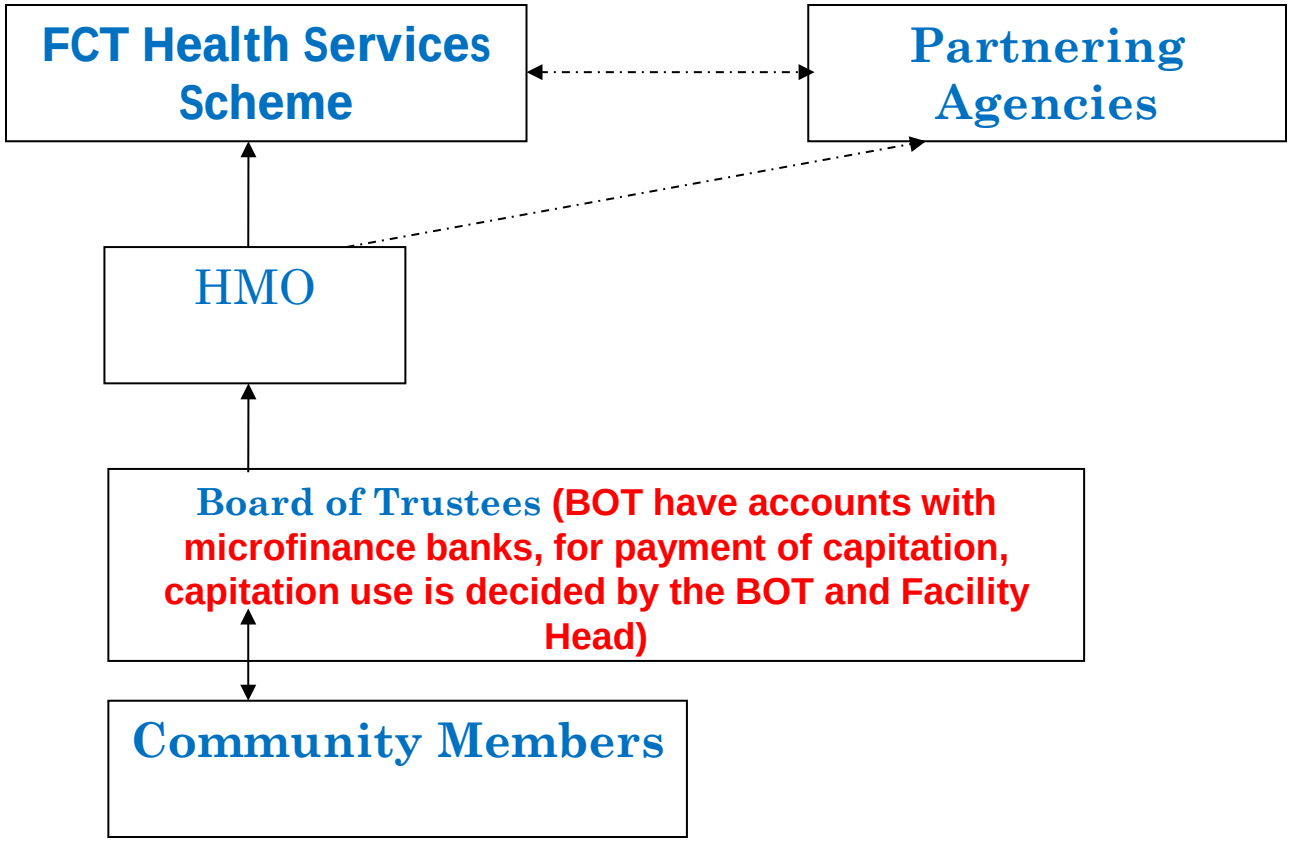
The FCT- CBHIS was officially launched in August, 2012 as informal sector in FHSS

Having Access to Needed Quality Healthcare for All Without Having Financial Hardship (UHC)

a) Ensure every Community in the FCT has access to good health care services
b) Protect families from the financial hardship of huge medical bills (OOP)
c) Ensure equitable distribution of health care costs among different income groups
d) Ensure efficiency in health care services

- Follows MDGs Agric Empowerment Schemes
- MDGs Rural Free Mobile Health Services
- FCT-MDGs Donated seed money N10M, FCTA gave approval for N186M
- Existing Agric Cooperative Groups/Societies

FCT CBHIS IMPLEMENTATION STRUCTURE



Subsidy Level	0%	10%	20%	30%	40%	50%	60%	70%	80%	90%	100%
Family Rate	15,000	13,500	12,000	10,500	9,000	7,500	6,000	4,500	3,000	1,500	0
Extra-Dependants	2,500	2,250	2,000	1,750	1,500	1,250	1,000	750	500	250	0

ACHIEVEMENTS

- Operational guidelines published
- Training modules for various categories of stakeholders also published
- Lab tops available for 10 PHCs to upload data for M&E
- Financial management structure well outlined & monitored by BOT
- Public Private Partnership in place (United Healthcare International)
- Thirty three communities with 7300 enrolled, 6,100 as at today
- After a year, three thousand one hundred 3,100 enrolled, renewed their premium.

CHALLENGES

- Expansion is difficult, subsidy not coming as and when due
- Pool has no clear distinction with the formal sector
- No legislation in place
- Frequent staff rotation and leadership change without formal handover (FHSS Structure & Staff Mix) No autonomy as agency
- Advocacy and sensitization not done in all communities– inadequate follow up paucity of funds
- Inadequate staffing in most primary health centres serving as health care providers

CHALLENGES

- Some health care centres in dilapidated state.
- Poor communication because of difficult terrains
- Facility based -service utilization rate not up to date/Poor monitoring/paulcity of fund
- Epidemiological trend & disease burden not ascertained

IMMEDIATE/SHORT TIME PLANS

- Aggressive grass root advocacy, sensitization and community mobilization
- Targeted premium collection for the year at time of harvest
- Strategic stationing of Ambulances for emergencies
- Upgrade of PHCs to meet minimum standards
- Construction of new PHCs where possible
- Communities without PHCs, use the nearby PHC
- Annual review of premium based on utilization pattern
- Improve number and mix of human resource for health

LONG TERM PLANS

- Expansion to cover every community in the FCT (861)
- Sustainability through direct involvement of the Area Council and FCTA to establish UHC fund or CBHIS Trust Fund in FCT to take care of the vulnerable group
- Compulsory health insurance enrolment for all beneficiaries of social intervention programs in FCT eg CCT
- Follow up for legislation

CONCLUSION

FCT CBHIS has evolved over the four years with notable achievements and challenges that could be overcome with dedicated leadership and political commitment from all the stakeholders

Thank you for listening