HEALTH INSURANCE IN NEPAL

Posted on June 6, 2020 by Dip Narayan

Quality of health services, financial viability, adequate enrollment and proper management of an insurance program is must for its success in long term to contribute towards universal health coverage.

Follow us

Facebook: /publichealthonline.net

Twitter: @PubHealthOnline

Instagram: /publichealthonline_net

YouTube: Public Health Online

Pinterest: /publichealthonline

Category: Blog Articles

Tags: health insurance in nepal, uhc, universal health coverage in nepal

Universal Health Coverage (UHC), a mother target of health related Sustainable Development Goals (SDGs) is defined as ensuring that all people have access to needed promotive, preventive, curative and rehabilitative health services, of sufficient quality to be effective without suffering from financial hardship when paying for these services.[1] It has three dimensions viz. service coverage, population coverage and financial protection. Adequate financial investment and its proper management is must for financial protection. According to WHO, the essentials for UHC are health financing, health workforce, essential medicines and health commodities, health statistics and information system, health system governance, and service delivery and safety.[2] In Nepal, public expenditure in health sector as % of GDP over past 10 years ranged between 1.59 and 3.24, with highest in 2011.[3] Also, total health expenditure as % of GDP over those years ranged between 5.72 and 6.73, with highest being in 2011[4], which is par low in comparison to WHO standard. Health is also a human capital as it increase productive capacity and plays key role in economic development, poverty reduction and overcoming income inequality.[5] It is two way relation and a vicious cycle. Evidence also suggest that 10 percent increase in per capita income leads to fall in IMR and CMR by 7 and 11 percent, respectively, and increase life expectancy rate by 2 percent.[5] Out of pocket expenditure, which can push people to poverty and impoverishment, has been dominant payment mechanism in Nepal. Over last two decades it has ranged between 41.38 and 69.56% of total health expenditure, with lowest being in 2011. It has again raised to 47.65 percent in 2014.

Initially there was no any financial protection for general people in Nepal till 1970. With the aid of INGOs, Community Based Health Insurance was introduced in Nepal for the first time, in a community of Lalitpur. Thereafter, there was no any step for financial protection until 2004, when public provider-based community health insurance was introduced in Nepal as pilot schemes at six health facilities (Lamahi Primary Health Care Centre (PHCC), Tikapur Hospital, Mangalabare PHCC, Dumkauli PHCC, Chandranigahapur PHCC and Katari Hospital)[6]. Besides, some privately-operated CBHI schemes have been established and were supported by NGOs (like Saubhagya Community Health Insurance of Dhading supported by DEPROSC Nepal, Sanjivani Community Health Insurance of Banke supported by Nirdhan NGO, Syafru Health Post based CBHI supported by Karuna Foundation Nepal and so on) and cooperatives (Bikalpa CBHI run by Bikalpa Cooperative, Jivan Bardan Surgical

support Program run by Sahara Nepal Savings and Credit Cooperative). Studies suggested that most of them were not promising, citing reasons like low coverage of the population, inability to provide equitable protection for poor against health related costs (government grant to premium ratio was always more than one), unknown or less viable financially and poor management like managing information on ad-hoc basis, poor monitoring and supervision mechanism, poor accounting and auditing.[6] Some of them are still running.

Nepal introduced universal free health-care services up to the level of district hospitals, and targeted these services to poor and marginalized people in regional and sub-regional hospitals progressively from 2006 to 2009. A study found that out of total poor and marginalized people who visited Western Regional Hospital and Lumbini Zonal Hospital, just 8.4% and 2.7% were exempted from payment, respectively.[7] Beside this, there was unintended use of services by non-target population as well. Major reasons behind such practice were lack of awareness of free health-care services among clients, and lack of awareness regarding target groups among staff at the hospitals.[7] Various studies done in the past has led to conclusion that there is need to ensure adequacy of the benefit package, availability of essential drugs and availability of human resources; and improve governance and accountability at local level. Studies also suggests identifying poor and ensuring free care at district level.[8] Further, some referral hospitals under Ministry of Health and some tertiary hospitals there is social security unit established, which offers discount or waiving of treatment cost depending upon their ability to pay. Previously such unit worked for targeted free care to senior citizen, disabled, ultra-poor and FCHV, but now their beneficiary has increased to eleven categories (ultra-poor/poor, helpless, disables, senior citizen, victims of gender abuse, FCHV, national disaster, martyr family, malnourished children, and people from police custody and people in accidents).

Meanwhile, KOICA Nepal supported existing and formed new health insurance schemes through its Health Insurance Model Activity and Level Up (HIMAL) project in 2012. Later in 2013, Government of Nepal developed national health insurance policy, based on which Social Health Security Program, also known as Social Health Insurance (SHI) program was started in 2016 from Kailali, Ilam and Baglung district. The program was scaled up to 22 districts by September 2017.

Quality of health services, financial viability, adequate enrollment and proper management of an insurance program is must for its success in long term to contribute towards universal

health coverage. Government subsidized CBHI schemes had not performed well. Their quality of services have been limited by their capacity to provide services, their enrollment rate has always been low and in absence of government subsidies their financial viability is unknown. Management committee also don't want to increase enrollment as they believe loss doing so because government subsidized them in lump-sum. While some NGO supported schemes have done sparkling performances (like Saubhagya and Sanjivani Community Health Insurance (CHI), both being coordinated by financial institutions and supported by Save the Children) others have faced different kinds of problem like poor community ownership and lower enrollment. Syafru Health Post based CHI, which was terminated soon after Karuna Foundation stopped financial support and community didn't take ownership. Even lab established during the insurance program had become dysfunctional after that. Cooperative run health insurance schemes has always been limited only to their members. Though some of them had been exemplary at their own. For example, Jivan Bardan Surgical Support Program run by Sahara Nepal Saving and Credit Cooperative with technical support from Family Health Nepal, has enrolled members more than 20,000 and pay NPR 2,000 annually to receive surgical care up to NPR 0.2 million. This one is good example of self-sustainable and financially viable scheme. Quality of service provision in NGO supported, has been variable as some offers wide range of service providers while other offers very limited number of providers often local health facility and a referral site. For example, Sanjivani and Saubhagya CHI have large number of listed hospitals and clinics so people can choose between them whereas Syafru Health Post based CHI schemes had the health post itself as primary provider with limited capacity and a referral site in Kathmandu. Good things in successful CBHI schemes are strong community network and ownership of the program. Community based health insurance programs have improved health seeking behavior among their members. Although such initiatives has never been the complete solution to achieve universal health coverage in any country, they have always played crucial role in preparing platform on which national level health insurance could flourish.

SHI program which is in expanding phase has to deal with trust, which was broken by past bad experiences with other insurance schemes or service providers (particularly when there is limited choice for service providers). Dominant public service providers have not gain trust of general people yet. Readiness to provide service is must but most of the public health facilities lack medicines[9]. So are people compromising with quality of health service after being enrolled in avidity to get service at low cost? Public attitudes and perceptions

regarding public health facilities has not changed much. People's expectation increased when they have paid premium. Enrollment under SHI is not promising, it is less than five percent of target population. Knowledge and understanding of health insurance is key for enrollment, but even people enrolled in the schemes lack understanding of health insurance and knowledge regarding schemes. In Kailali, renewal rate was just around 30 percent.

Affordability and ability to pay in low income countries like Nepal always comes to discussion while talking about health insurance. Plan to enroll poor and ultra-poor household in the SHI by providing subsidies is yet to be implemented, which means real needy people are yet to be covered.

In voluntary insurance, people who prefers traditional healers often ignores to enroll in insurance scheme where often providers are allopathic.

Still 18.7 percent people in rural areas have to travel more than one hour to reach their nearest public health facility which includes health posts[10]. Considering PHCC as primary service contact point, the percentage is even higher. There is nothing special in this insurance program to reduce this accessibility issue and deal with geographical inaccessibility. Rules of scheme is to regulate schemes but that should also ensure easy access to health services. One must take referral from primary contact point to receive service from elsewhere. Such rules make service user to travel even longer to receive service as PHCC is limited by its capacity to provide wide range of services. Liberal choice of visiting service provider like Japan or conditional liberal choice would be helpful is issue of further discussion.

Improved service seeking behavior has increased patient flow particularly those with chronic diseases. Doctors with no extra incentives for treating insured patients often show unwelcoming behaviors, particularly in public sector. It will be great challenge to improve patient provider relationship.

Their planned restructure in context of federalization is more or less similar to existing in terms of human resource and another challenge though insurance board has restructured. Coverage of benefits versus premium is another aspect to consider. Comprehensive Benefit Package. Payment modalities and reimbursement is important factor to consider for an insurance scheme in long term prospect. Units of enrollment and premium collection, whether household or individual.

Cashless system is good move to maintain financial transparency. Automated Insurance

Management Information System (IMIS) can control lots of fraud cases. Besides, there is medical review committee to cross verify sampled cases against treatment protocols and norms. There is also system for receiving grievances from service users though only at central level.

Small sized household may not will to enroll as per head premium for them would be high. Learning from CBHI like per head premium with family floater system could be better option. Recently Health Insurance Act – 2017 has been passed, which opens the way for mandatory inclusion formal sector, foreign employee and elderly in care homes. Also, service ceiling amount is about to double i.e. up to NPR 100,000. These would help in increasing enrollment.

Major challenges for health insurance in Nepal are increasing enrollment, increasing awareness regarding schemes and understanding about health insurance, ensuring quality of service and their accessibility, providing subsidies for poor and their identification and retention of workforce. Enrollment in SHI implemented districts ranged between 1.5% and 5%, which is very low. Despite awareness campaigns through radio and TVs, people are not much aware about the health insurance program and its schemes including benefit package and listed health facilities. Geographical terrain in hilly and mountain region creates barriers in service accessibility while inadequate infrastructures, health workforce and logistics pose another challenge to provision of quality of services. National Health Insurance Act state that poor will be subsidized for their premium based on category but government is yet to distribute poverty card and so real target people of the insurance program is yet to be benefitted. Enrollment officers as well as district managers are recruited based on contract of few months. Despite provision of renewal, their uncertainty often lead them to find another jobs. Beside this, enrollment assistant at community level has very high turnover and lack of motivation as well, which may have been due to volunteerism and low incentives including no accommodation and transport support.

One of the reason behind demotivation of doctors at PHCC or even district hospital is their inadequate incentives, salary and benefits. Their motivation is crucial to success of insurance program and overall health service improvement. Government should build capacity of public health facility and make them competitive with private health facilities. One door policy only works when government system is strong/strengthened. There should be strong referral mechanism with adequate quality referral sites. Referral channel should be matched like if Medical Officer from PHCC refer a patient then s/he should directly be able to visit consultant but now in many cases referred patient of MO is handled by another

MO at referral sites.

Subsidies for ultra-poor and poor as mentioned in rules of the program, should be done as soon as possible so the real needy will get benefited from the program. Moreover, process for mandatory consolidation including formal sector should also be carried out.

While doing so, service ceiling amount under current national level health insurance scheme should be increased. People generally get impoverished or pay catastrophically for highly expensive services like surgeries some of which may cost more than NPR 50000. Premium redefinition can be done, while shifting service package under current social health security program to special services only. Basic health care package should be expanded to a range of services and at the same time public health facility should be strengthened enough to provide quality of service and improve people's trust in public facilities.

Health insurance board should rethink on their current enrollment strategy. Volunteer EAs have not performed better so alternative options like enrolling through local health worker or FCHVs, handing the responsibility of enrolling to cooperatives or financial institutions can also be considered. Else, incentives along with certain basic salary should be given to EAs. The same amount of incentives to health workers or cooperative can boast enrollment. These options of using HWs or cooperatives has their own merits and demerits, former can be useful in increasing awareness as well while later one can be useful collecting premium well. Another option could be providing basic salary along with incentives to EAs. Most importantly, while selecting EAs priority should be given to their counselling and convincing skills.

Another strategy like making mandatory to bring health insurance card to make citizenship or passport or getting admission in school/colleges can be good option as well.

Despite certain community activities, EAs and media coverage awareness among general public is not good. Exposure to mass media is one of the determinants of increased enrollment[(11)]. Timing, contents and methods may need revision. Even members do not know details of the scheme and service providing sites. A small bag pack containing all necessary information related to IEC materials can be prepared for a family who enrolls. Another option could be development of smart phone app from where one can get all latest and updated information related to insurance program. Adding features like sign in option for members can also help members in knowing about what services they have received and how much amount has been consumed from benefit ceiling. Additional feature like

news related to program could be another asset. Use of this technology can be cheaper than producing paper based IEC materials. Beside this use of FCHV and HWs in increasing awareness about health insurance program.

Even after paying premium, people are asked to receive service from those PHCC and district hospital from where people have already lost their trust. Health workers in public health facilities are still not committed to clients. Ministry of health should play crucial role ahead in improving capacity of health facilities to provide quality of service else public health facility may not utilize this opportunity to improve their quality of service. As now they have to compete for quality with private service provider to prosper.

Further, primary contact point (mostly PHCC in current situation) is very far especially in hilly region posing challenge to service access. One solution to this can be mobile health camps (at least two in a year). In addition, primary contact point should be liberal.

Many members, especially those who are illiterate has to face difficulty while receiving service. I-display at health facility showing service receiving process, benefit packages and other health promoting messages could be good option. Establishment of help desk at service provision sites could be another option.

Basic health care services, which are to be provided free of cost as per constitution of Nepal, should be well defined and informed so that service beyond that can be covered through health insurance without confusion. Service users receives essential medicines for free of cost from local health facilities but have to pay for the same when one visits to zonal hospital or higher. Clearly defined package for free basic health care at all level is important to resolve this issue. This should be in priority of federal government. Beside, targeted free care and disease specific subsidies should be merged with insurance program. It would be better if amount allocated for disease specific care is given to insurance pooled fund and ensure all needy people are covered by the insurance program with accordingly increased service ceiling.

Possibilities

Family not using any service for three consecutive years can be awarded as healthy family so that family will not be demotivated. Another option could be certain cash back in such case but that may make people inactive in receiving service in general illness. Another option which could be better and is about to be tried is certain discount in premium while renewing to the family who didn’t receive service throughout the year.

Further, livelihood promotion is important to enhance income generation, which can help in generating money for contribution as premium or tax, if they have to pay.

Conclusion

Efforts from different communities, civil societies, and health facilities are really appreciable as learnings obtained from those community level programs had helped in designing scheme and package for national level health insurance program. Learning from experiences and acting on to overcome challenges would help the insurance program to success.

References

1. WHO. Universal Health Coverage 2012 . Available from: http://www.who.int/healthsystems/universal_health_coverage/en/.
2. WHO. Essentials of universal health coverage 2017 . Available from: http://www.who.int/universal_health_coverage/en/.
3. The World Bank. Health Expenditure, public (%GDP). The World Bank,; 2017.
4. WHO. Global Health Expenditure Database. In: WHO, editor. 2017.
5. RTI International. Assessment of Health System Performance in Nepal. Research Triangle Park,: 2010.
6. Stoermer M, Fuerst F, Rijal K, Bhandari R, Nogier C, Gautam GS, et al. Review of Community-based Health Insurance Initiatives in Nepal. Deutsche Gesellschaft für Internationale Zusammenarbeit (GIZ) 2012 December 2012. Report No.
7. Mahato PK, Paudel GS. Access to free health-care services for the poor in tertiary hospitals of western Nepal: a descriptive study. WHO South-East Asia Journal of Public Health. 2015;4(2).
8. Prasai D. Review of Studies on Nepal’s National Free Health Care Programme. 2013.
9. Ministry of Health/Nepal, New ERA/Nepal, Nepal Health Sector Support Program - NHSSP/Nepal, ICF. Nepal Health Facility Survey 2015. Kathmandu, Nepal: Ministry of Health and ICF, 2017.
10. Ministry of Health - MOH/Nepal, New ERA/Nepal, ICF. Nepal Demographic and Health Survey 2016. Kathmandu, Nepal: MOH/Nepal, New ERA, and ICF, 2017.
11. Kimani JK, Ettarh R, Warren C, Bellows B. Determinants of health insurance ownership among women in Kenya: evidence from the 2008–09 Kenya demographic and health

survey. International Journal for Equity in Health. 2014;13(1):27.

Comments

Why healthcare is so costly? | **Public Health Online** – 2020-06-26 01:53:52
[…] Health Insurance in Nepal […]