Health Insurance Programme in Nepal: Analysis of Implementation Status

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Abstract

The government of Nepal started health insurance programme in 2017. Health service is under all levels government's authority and responsibility. The health insurance programme is a citizen participatory programme which aims to reach the goal of universal health care coverage by the government and people's right to receive special health services at a reasonable rate. This research is carried with the objective of finding the legal-institutional status of the programme and implementation status using a descriptive method. Participation of public and private health institutions in health service provision has made the service affordable, easy and convenient to the people. This scheme has reduced out-of-pocket expenditure of people in health service. The location of service providers mainly in urban areas, more distance for receiving service, and the complex process and referral system have made the service somehow problematic. Delays in payment of the claims and lower rate of services are discouraging health service providers in the scheme. Participatory management, cooperation and collaboration among stakeholders can make the programme more efficient and smoothly working. The finding of this research can help to strengthen the good practice of the programme and overcome the existing problems faced by the implementing agencies.

Keywords: *health insurance, subsidy, pro-poor, registration*

Introduction

The government of Nepal has started free basic health services to the targeted groups to meet the constitutional obligation and international commitments. Maternal security, free health service programme and targeted group health programmes are being run by the government in government expenditure/ subsidy. There has been a special programme for Heart disease, kidney disease, cancer etc. Health insurance programme has been running since 2003 in different districts as a pilot programme (GoN, 2014).

As per the Health Insurance Act, 2017, a family is taken as the unit of the health insurance programme. Every citizen of Nepal should have health insurance, and the family head should be responsible for the enrollment of the children, old aged, disabled members of the family. Managers of the orphanage home and elderly house should enroll the people living there and the employees should be enrolled through the office. Based on the economic status and physical condition of the person government pays the premium of enrolling the health insurance verified by their identity cards as poor or disabled (red card)(GoN, 2017).

This scheme has covered services including (preventive, promotive, curative and rehabilitative services) yoga, nutrition education, psychological counseling, immunization, family planning, safe motherhood, OPD, Indoor service, emergency service, operation, drugs, health instruments aid, curative and rehabilitative services, ambulance, etc and another service as listed. It excludes services like abortion, drug addiction-induced accidents, dental services like Root cavity treatment, expensive glasses or hearing aids, plastic surgery, artificial insemination, etc. This scheme has included essential service provision rather than fancy, non-essential, and costly services to provide basic treatment and drugs to people in a cashless form up to the family limit.

The government bears the cost of deprived, poor, marginalized people's service in receiving health services as a subsidy. The government of Nepal has established the Health Insurance Board, that signs the contract to the health service-providing institutions (public and private hospitals, health centers) to provide the service under this system. The claim made by the health service providers of expenditure reimbursements is paid by the HIB after verifying it. The beneficiaries should go to the health institutions which they have mentioned in the enrollment paper as a first service center. They can go to higher institutions after the referral paper from the listed (first) health service institutions(GoN, 2018).

As per the national health policy, the special health service is supposed to be availed to the public through the health insurance programme. As mentioned in the policy the services/treatment that is not included now is planned to be strengthened and integrated into the insurance system. The Health insurance programme is being implemented as a pro-poor programme, where poor people can get health services/ treatment and drugs at lower out of pocket expenditure.

Health Insurance Board has its own fund as **Health Insurance Fund** which compromises the amount allocated by the government of Nepal, Provincial governments, and local governments, the amount paid by people as insurance premiums, amount given by

national organizations, individuals, or foreign individuals or the organizations and so on. As this scheme is a government programme, the total transaction by the Health Insurance Board (HIB) is audited internally by treasury controllers' office and finally by the auditor general's office of Nepal.

Objective of the Study

This research is carried out to find out the present status of the Health Insurance Programme from the existing literature. This research aims to know about Constitutional-legal-institutional-framework for Health Insurance and find the status of implementation. After finding the present status some measures can be recommended to overcome the problems faced.

Literature Review

Constitution, existing laws, policies, rules, regulations, literature in health insurance, newspaper articles, and news are used for the review of literature. Constitution is the main guiding principle for any plans/ policies to be made and implemented in any country. Health care and services are also guided by the policy of the constitution and promises of the political parties in their manifesto along with the needs of the people. Some of the newspaper coverage and programmes papers are the source of data and literature for this research. Constitutional provisions, National Health Policy, Health Insurance Policy, Health Insurance Act, Health Insurance Rules are mainly discussed and analyzed relating to specific health insurance programme of Nepal.

Constitutional Provision

The Constitution of Nepal has made a provision for Right to health in the article in fundamental rights. It also has a provision of health insurance for the citizens in the policy of the state in article 51 h (15) as it provisioned as "to arrange for access of medical treatment while ensuring citizen's health insurance." Similarly in policies relating to the basic needs of the citizens 51(h) 5 investment in public health sector by state to make citizens healthy, 51(h)6, 7, 8, 9, and 10 includes: ensuring easy, convenient and equal access to quality health service to all; promote and protect alternative health service; promotion of private sector investment in a regulated way in health service; focus in research in health sector; focus on family planning and population management and improvement in maternal and child health care respectively (The Constitution of Nepal, 2015).

Legal Provision

There is legal documentation that guides the health insurance programme in Nepal. Based in the constitution of Nepal following legal foundations are channeling

health insurance programme to operate. Different acts, rules, and policies of the Nepal government are the basis for this programme. Annual budget, policies and programme of the government, and periodic plans also have an important role in continuing the programme. Some of them are listed below:

» Health Insurance Act 2017 (2074 BS)

» Health Insurance Rules 2018 (2075 BS)

» National Health Policy, 2019 (2076 BS)

» Health Insurance Policy 2014 (2071 BS)

» Periodic and annual programmes (Budget) of the Nepal Government

Institutional Provision

The Ministry of Health and Population and the Health Insurance Board are the major actors in running this programme. Multi-stakeholders of this programme include different layers of government and health service providers including health institutions, and personnel (GoN, 2023). Institutional involvement in running this programme includes:

- Ministry of Health and Population
- Department of Health Service
- Social Health Security Development Committee
- Health Insurance Board
- Provincial governments
- Provincial Social Health Security Coordination Committee
- Local governments
- Local Social Health Security Coordination Committee
- Health service-providing institutions both public and private
- Enrollment officers/ assistants at districts and the local levels

Research Methodology

This is explanatory research using descriptive research design. This paper is based on secondary data, mainly data from the Nepal government, especially from Ministry of Health and Population, Health Insurance Board, Central Bureau of Statistics (now: National Statistics Office), and other publications.

Findings

Present Situation

This programme has covered all 77 districts, and all local levels from fiscal year2079/080. This programme has started the pooling of risk and contribution among different levelsof people as rich to poor, high-risk people of low-risk people, or active people to less active people. As per the report of the board and the Nepal government's policy and programme for the running fiscal year, 32.4% of the total families are enrolled to the insurance programme which is 17,43,047 families. Similarly, 21.5% of the total population has been registered in the health insurance programme, which means 56,57,725 people. On 16thJuly, 2022 total of 450 health institutions have signed a contract and started treatment under this scheme. As the policy and programme of the Nepal government for the fiscal year 2022/023, includes the aim of extending the service of health insurance programme to all 753 local governments and covering the population of 50 % of the total (GoN, 2022) (Upreti, 2022).

The beneficiary registration/ enrollment process is being started at all local levels. Each family is taken as a unit and a family with up to five members is registered with the payment of Rs 3,500 as premium. They can receive treatment of up to Rs 100,000 within one year. If there are more than five members each additional member should pay an extra Rs 700 as a premium. Each additional insured family member can receive a benefit of Rs 20,000 per year. The government bears the contribution of elderly people up to 70 years and they can get benefits of up to NRs 100,000 for families of up to 5 members annually (GoN, 2018).

Membership in the health insurance scheme is annually renewable by paying the premium contribution of the same amount as registration. The registration process is IT-based process, as enrollment assistants register/enroll families through their smartphones. People's lower attraction, the far away location of health institutions, and lower awareness about the scheme have resulted lower rate of registration in the programme. Local governments are also encouraging people to enroll in the scheme and some are even paying the premium for the poor people as a pro-poor programme to meet the public's demand for health services.

This scheme provides cashless service to the families, as they need to pay no out-of-pocket money for their treatment and drugs up to the limit of families. The amount the patient should pay is claimed by the service providers (hospitals) to the service purchaser (Health Insurance Board) and after verification and evaluation, HIB reimburses the claims to the hospitals. So this system is cashless to the clients(HIB, 2022).

Opportunities

- Decentralized roles and responsibilities of all tiers of government in health service management and distribution.
- The scheme empowers patients as they have a greater voice on account of having paid for the services; as individuals can get service in better-negotiated prices than the individual bargained price than the government can do collectively (Lohani, 2018).
- Ministry of Health and Population pays for the government hospitals, primary health care centers and health posts irrespective of their productivity including maternal and child care. After the insurance programme implemented health institutions both public and private can sign contract, and they can make a claim based on the case, and other services charge to the Health insurance board of Nepal.
- Private sectors participation has also increased as a number of private healthcare providers have been contracted into the scheme with their strong commitments in providing services atthe given prices as mentioned in benefit packages (annual report of Health Insurance Board,2022)(HIB, 2022).
- The additional money generated for health care facilities by the scheme (in the form of payment of claims) might encourage more 'business-like thinking' on the part of public health care providers.
- Gradual increase in awareness, access, and outrage of people in health services as the number of literate people and access to media and local government has been increasing.
- The number of health service providers and the quality of health services is getting improved along-with infrastructural development.
- The government bears a contribution amount of ultra-poor, Tuberculosis patients, leprosy patients, HIV/AIDS and disabled people's families having poor family identity cards and red cards of disability respectively.
- Systematic and reliable reimbursement as the claims (amount to be reimbursed for their service) by the health service providing institutions received through insurance management information system (IMIS) are reviewed and evaluated by a committee chaired by specialist physicians including radiologist, pathologist, pharmacist, nursing officer, public health specialist and officer from health insurance board before reimbursing to them(GoN, 2018).

Threats/ Challenges

- As the health service-providing institutions are fragmented into three tiers of government and management and operation of them is their duty respectively. However due to low revenue, lack of human resources and infrastructure in local and provincial governments may be difficult to sustain those institutions and the Health Insurance Programme too(Lohani, 2018).

- There is a provision of subsidy for the poor, disabled and marginalized, targeted group people. But objective identification of poor people is a quite difficult task; to serve many people in subsidy can create a burden to the board and government, so it can be a threat to the successful implementation and sustenance of the programme.

- Treatment/ service provision to the poor can be based on poor family identity cards. But the haphazard distribution of poor family identity cards without a clear and objective measurement (though there are criteria) as there is no objective measure of income can create problems in this programme as well.

- Supply-side issues may arise as private, public health service-providing sectors may have unnecessary claims for reimbursement. Some issues of fake claims are found to be reported by the service providers; such activities on the one hand hinder the pace of reimbursement and on the other hand make the service provision unethical.

- Without sufficient awareness campaigns enrollment has been made mandatory so there may be less coverage than targeted. There is still poor information to the public about health insurance programme, which hinders the achievement of targets set by the board and government.

- Due to such slower a pace of registration (enrollment), lower awareness, and a lower rate of renewal in the scheme as the rate of renewal of insurance by families is around 70%; it may be difficult to meet the higher target of enrollment as 50% household coverage in 2022 and 100% household coverage in 2030 (HIB, 2022).

- The densely Presence of health institutions and health personnel (workers) in urban areas leaves rural areas deprived: it is difficult to avail of health services, and continue, and increase access to health services in all places. The sparse presence of service providers in rural areas can be a threat in achieving the goal of the health insurance programme.

» As per the National Health Policy 2019, the health service may be affected due to the complexities associated with the development of health infrastructures, organizational reforms and management of the health related human resources. Unforeseen diseases, pandemics, or other incidents (like COVID-19 did previously) can have negative impacts on the programme(GoN, 2019).

» Difficulty for the clients to receive service and in the documentation process, uneasy referral process (go first health service providers for referral and the referral letter works for a short time only) which directs people to withdraw from the health insurance scheme. People temporarily living in urban areas should go to their family residing place and health service point to get a referral letter, and should come to a hospital to treatment, which is costlier than the cost of treatment without insurance. Such procedures may make insurance scheme more complex and less attractive to the people(Onlinekhabar, 2022).

» Lower quality and uneasy procedures can have a negative impact on the overall health insurance programme. Referral process, fake claims by hospitals, weaker service quality, prescription of new medicines from doctors that are not available in hospital pharmacy, long waiting time for service (eg. 1 month for x-ray), lower renewal rate by the families for the programme etc are found to be problems and challenges for the successful implementation of health insurance programme (Onlinekhabar, 2022).

Discussion

There have been issues related to the payment claim and timely reimbursement of the claim, with the increment of patients and service providers. The health centers, hospitals etc have been so crowded that long time queue has become common. Private hospitals have shown lower interest participating in the scheme as some participantsthere complaint about late reimbursement of the claims. As private hospitals can get a higher amount for the treatment of the patients, the health insurance programme pays quite a lower rate and delayed payment can reduce their profit, resulted to the lower interest. But the necessary health-related or legal help from the ministry and programmes' advantage also encourage them to run health insurance programme.

Health centers in rural areas do not have health workers, beds, and essential equipment, so they are not able to join in the health insurance programme. The people in rural areas need to go long distance health institutions as the first point of health service. Health service providers in urban areas are so crowded that one

needs to wait for too long time to receive service even in public health service centers it may take from one to many months to wait for the services like USG (video X-ray), operation, X-ray, or similar services and drugs are not available in hospital pharmacy or there is also long queue to wait. Health insurance programme has been initiated to cover all Nepalese citizens after a certain time, but due to high ambition and poor quality, complex processes and unmanaged services, there is the risk of being unsuccessful programme (Chaulagai, 2022).

The program covered one-third of the population by 2022, out of which the majority of them pay a premium of insurance, someone's will cannot make the programme failed or unsuccessful. The infrastructures of government hospitals are not sufficient for the treatment of a large number of insured people, so private health centers must be continued to service through this programme. Due to large number of claims for payment from health institutions the payment is delayed, but there is a process of change as it is one of the major programme in the health sector of Nepal aimed to serve the large sphere of population (Basaula, 2022).

People are getting some services easier than the before and it has reduced out of pocket expenditure by risk and financial burden sharing. But the presence of less number of supply side (service provider and longer hours to wait) discouraging the new families to enroll into the scheme or to renew to those who are already in the scheme. It is welfare scheme good to the people but the weakness should be corrected to make it working well. The less number of enrollment assistant or officers and more claims and similar works made slow work of Board. Infrastructure and small number of human resource can be the major cause of slower and inefficient service provision in health service providing centers to the health insurance scheme as well. How can one imagine timely service in a situation like only one staff working for 100,000 people involved in health insurance as a client in one district (Rastriya-Samachar-Samiti, 2023).

From the budget of fiscal year 2080/081 government has amended the rule that only public, community and cooperative hospitals/ health service-providing institutions can run health insurance programme (MoF, 2023). There were a total 464 hospitals/ health institutions that signed the contract with the Health insurance board and run health insurance-related programme out of which 52 were private sector hospitals/ health institutions. Health insurance programme has been discontinued from 26 private health institutions/ hospitals which were running health insurance-related services from this Fiscal year(Onlinekhabar, 2023). Policy stability can have an important role in meeting the goal of some specific programme, but this programme once included the private hospital as a service provider in the health insurance

scheme and after some years again they are not in the service of this scheme. Public sector hospitals are already crowded, and they do not have sufficient infrastructure and human resources to provide services to people in general.Again higher pressure of insured people can create more havoc in the service delivery. The board planned to cover more diseases and costs of the insured people as the policy aims to cover 100% of people in the programme by 2030 (Upreti, 2022). There can be problems due to prevailing Public Procurement Act and rules, longer and complex tender processes, mismatch between prescription and availability of drugs in the pharmacy, and pressure from patients to make unnecessary checkups(Poudel, 2022).

The government negotiated the price for treatment (services) at a lower price than the hospital's charge under the health insurance scheme; people get services at a cheaper rate than they can get by their own bargaining. Private sector health service providers also provide services at a negotiated rate from the government, so people can get services at a cheaper rate from insurance scheme than the regular service by them.The state of coverage is satisfactory, but the management of service to the insured patients should be arranged in such a way that people can access health services in easy and convenient way. Settlement of the delayed payment to health service providers, more counters for insured patients, and coordination between pharmacy management and physicians can make health service to the insured people easily accessible. The aim of pro-poor health service and universal health service coverage will only meet with the success of the programme.

Conclusions and Recommendations

Conclusions

i. Based on the above study this can be concluded that the health insurance programme is one of the important welfare programmes of the government of Nepal. It has access to almost all local levels within a short period of time. This can be the result of the active participation of local governments in enrolling families in the health insurance programme.

ii. It has become easy for the poor/ elderly people as it covers the treatment and drugs and avails them at a relatively low cost in comparison to the regular treatment and drug purchase. This programme has also provisioned an additional subsidy for some dreadful diseases like cancer, kidney diseases, Parkinson, heart diseases etc which has covered their cost of a ceiling of Rs.100,000.

iii. Treatment for diseases which is not possible at the first-stop health center the patient needs a refer ticket but each time going to the same

health center to receive only the Referral service has made it boring and costly. Youths living in urban areas need to go to their family residing area to get referral tickets to receive the health service under this scheme, so youths and families with some members living in urban areas have a lower tendency to register in this scheme.

iv. Resource constraints, increasing demand for health services, lower budget and small a number of health personnel, transfer or temporary transfer of the health personnel, trend of unwillingness to serve in rural areas, etc has made the health insurance programme difficult to implement in many health institutions in rural areas and even in more health institutions in urban areas. As the number of people enrolled in health insurance scheme is increasing, the small number of enrollment officers and assistants cannot make the insurance-related services easy and efficient.

v. Participation of private and public health institutions in health insurance scheme has made their business run well, as it provides patients and payment regularly to them. But delayed payment and lower rates of payment from the government sometimes discourage private health institutions as they charge lower for their service and get even later from the government after their payment claims get verified from the Health Insurance Board.

vi. Discontinue of service from private hospitals can make public health service-providing institutions overcrowded, making treatment (service) under the scheme more inefficient and slower.

Recommendations

i. Based on the above study and status, opportunities and challenges the following can be recommended:

ii. The government should Increase the share of the budget in health insurance to address the increasing demand for health services and health care. Pharmacy in hospitals should be equipped with essential drugs and should run more counters based on the flow of patients.

iii. To address the demand for health services in rural areas all governments should collaborate to run health service centers so that there will be lower pressure on urban health center from rural people. Human resources management should be based on the strict implementation of rules and regulations of human resource management i.e. regular

hiring, appointing, and transfer based on law and needs of the institution rather than the needs of the person.

iv. The number of health service providers in service delivery should be increased to reduce the crowd in health service centers by encouraging them through legal regulation or financial or another forms of incentives. More private sector hospitals and health centers should be encouraged to run health insurance scheme so that they can get more business and the public can get services easily. More health institutions in the private and public sectors can increase the demand of health personnel who are unemployed or waiting to go abroad for a job.

v. Timely decisions and reimbursement of the claims by health service providers should be made to sustain hospitals in the scheme. Private sector health service-providing institutions should be included again in the service and incentivized so thatmore services can be availed to the people.

vi. Expansion of health service along with Insurance to rural areas as well is a must. Stable and committed leadership and stability in employee tenure should be managed.

vii. Awareness to the public at all local levels should be raised utilizing locally active means of communication like FM radios, online portals, or local publications. Sharing of risk and resources through such programmes should be made universal so that poor and needy people can get easier and cheaper health services.

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