

Annex 4

HEALTH INSURANCE MODELS IN NEPAL: SOME DISCUSSIONS ON THE STATUS OF SOCIAL HEALTH INSURANCE ¹¹³

Background

The socioeconomic conditions of Nepal, a rural, agricultural economy with low human development¹¹⁴ and presence of endemic poverty, have made the health sector a priority for sustained economic development. Equitable access to quality health care to meet the needs of the poor and reduction in poverty by achieving of the Millenium Development Goal (MDG) are the key concerns of the health policy. Delivery of Essential Health Care Packages (EHCP) to all regardless of the ability to pay, availability of the health needs beyond EHCP, regulation of the private health market/sector within the context of decentralization, and public-private/NGO partnership are important features of the health sector reform strategy. His Majesty's Government (HMG) of Nepal has acknowledged this within the context of 20/20 implementation and the declaration to provide essential health care package. Nevertheless, the problem of financing of the health sector is a matter of serious concern to the government since there are indications of paucity of resources in general.

The incremental increase in per capita expenditure of the Ministry of Health (MoH) (proxied for public health expenditure)¹¹⁵ over the past decade has averaged about one per cent only (Economic Survey, "Various Issues and first appendix) – this is far below the WHO-recommended target of 5% of GDP spent on health. Further the per capita health expenditure of HMG/N is estimated to be around US\$5 in the recent Public Expenditure Review carried out by the Health Economics and Financing Unit (HEFU/MOH) which is much lower than the international benchmarks for a package of essential health care

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¹¹⁴ Nepal is ranked 32nd from the bottom out of 175 (i.e. 143rd of 175) countries in UNDP's Human Development Report 2003 with a per capita income of \$236 in 2002 (Economic Survey, 2002)

¹¹⁵ For caveats, see NHEA (2002)

(US\$35-WHO Commission on Macroeconomics and Health 2000). This situation is further compounded with the mediocre performance in economic activity, due in part to the unstable economic environment, implying limited resources flow to the government for meeting the expenditure of the MoH. There is indication that the level of health expenditure will continue to be low with a scarcity of public resources in general, which may have a sharp impact on health expenditure, as it will be unable to meet the growing demands of the people.

Mention may also be made of the geographical reality of the country. The mountainous terrain with altitudinal and climatic variations ranging from sub-tropical to arctic climate within 50 km distance has diverse populations of more than 60 ethnic groups with their own socio-cultural values. The distance to be covered for delivery of the service is for the most part vertical. About 80% of the population live in rural area and are to be provided with health services of reasonable quality as available elsewhere in other parts of the country in the spirit of equity and social justice. Though Nepal is one of the richest countries in the world in terms of biodiversity, it is one of the poorest in economic terms. More than 40% of the population live below the poverty line. Its ranking in terms of Human Development Indicators is low as Health Indicators are still poor e.g. Infant Mortality Rate at 64, Child Mortality Rate at 91, Crude Birth Rate 33, Crude Death Rate 9.6 each per 1 000 population (see the first Appendix for trend). The Maternal Mortality Ratio is nearly 500 per 100 000 population. The indicators point to the need for a large investment in health even to reach the norm of South Asian countries in the context of a significant health financing gap in Nepal.

In the past, this health financing gap had been met largely by out-of-pocket (OOP) expenditure; for example Hotchkiss et al. (1998), in their 1995/96 estimation, find that nearly threequarters of health expenditure are borne by households.¹¹⁶ This information along with the low level of public health expenditure, suggest that HMG has not been able to effectively meet the health financing demand of the country. This inability of public expenditure for meeting the general health expenditure of the population

¹¹⁶ This observation is consistent with Adhikari et al (2002), who concluded from a regression analysis of a Nepalese health production function that public health expenditure did not have a significant effect on the social indicators reflected in reduction of the child death rate, child mortality rate, infant mortality rate and increase in the life expectancy rate

underlines the need for alternative health care financing mechanisms to bridge this gap – this has been highlighted in the first and second Long-Term Health Plans, Nepal Health Sector Strategy Programme etc. While various alternatives are available, such as user fees, evidence from developing countries suggests that they do not have a beneficial impact in the context of “equity, efficiency and consumer satisfaction” (WHO, 2003). In this regard, there has been greater interest on health insurance in Nepal. While a number of papers overview the health insurance in Nepal, this paper is limited to: an overview of the policy environment for alternative financing; the different models of health insurance existing in Nepal followed by a brief discussion on Health Insurance and Social Health Insurance (SHI) ending with some concluding remarks.

Policy Environment Regarding Alternative Arrangements in Health Care Financing

The above scenario highlights the need for alternative financing for health care since public health expenditure has been unable to fully meet the inherent demand by the public. This inherent demand by the Nepalese people has been enunciated in the National Health Policy 1991 (NHP, 1991) the primary objective of which is “to upgrade the health standards of the majority of rural population by extending basic primary health care services up to the village level and to provide the opportunity to rural people to enable them to obtain the benefits of modern medical institutions by making them accessible”.¹¹⁷ Unfortunately, the implementation for public health expenditure has been weak which can be reflected in the level of mortality and morbidity which is high especially in children from malnutrition, parasitic and infectious diseases (appendix 1)¹¹⁸ Likewise complications at childbirth, nutritional disorders and endemic diseases such as malaria, tuberculosis, leprosy, STDs, vector-borne diseases continue to prevail.¹¹⁹ This weakness has been generally

¹¹⁷ It has directed towards two important goals: a reorientation of health sector towards basic primary health care, incorporating preventive as well as curative care and improvement in the distribution of health care facilities throughout the country. Hence people will have opportunities to enable them to obtain the benefits of modern medical facilities. It is in line with the wish of most governments to improve accessibility, quality and efficiency of health care services

¹¹⁸ This is seen in numerous reports and publications such as World Bank (2000)

¹¹⁹ Absence of service providers in health facilities compounded with shortage of essential drugs and supplies act as a deterrent for the patients to visit the institutions. Naturally they fall trap to the local faith healers and quacks. It must

acknowledged by encouraging the exploring of alternative sources of health financing. In this regard there are a number of documents which further elaborate this vision viz. long-term health plans, development plans and the Medium Expenditure Framework; these are:

- Long-Term Health Plans: Both the First (1976-1996) and the Second Plans (1997-2017) have emphasized the provision of universal access to primary health care.¹²⁰ Provisions have been made to make use of public, private and NGO sector. Priorities have been given for establishing baseline data for developing policies for public-private mix and exploring the feasibility of various public-private mix options. The plan has underlined the importance of health sector reform and health insurance scheme in the country. (NHP, 1991)
- Development Plans: While there have been a number of development plans since their initiation in 1956, the importance of the health sector was highlighted in the seventh plan in 1975 which still continues. However, it has only been since the ninth plan that emphasis has been given to expand the community drug programmes and to continue to develop health insurance schemes already introduced, though limited, in the country. It also emphasized on various measures to be undertaken for implementing and monitoring the drug policy. Top priority has been given to improve the health of rural people.
- Medium-term Expenditure Framework (MTEF): The MTEF concept has recently been initiated and tries to operationalize the long term health plans and the development plans. In MTEF, the areas of the health reforms have been identified and prioritized which are expected to contribute to both the strategic policy and reform measures, by enhancing efficiency, equity, transparency and accountability.¹²¹ There has likewise been an acknowledgement of

be borne in mind that poverty, illiteracy, lack of health education and socio-cultural factors by themselves act as constraint for service demand. The rugged terrain by itself further limits access. These adversely affect the utilization of service particularly by the vulnerable and socially disadvantaged groups

¹²⁰ The second plan is more specific on the provision of essential health care service on priority basis at the district and below and assured that they will not be neglected in term of financial and technical resources

¹²¹ This, along with the concept paper to the 10th Plan embodied in the Interim Poverty Reduction Strategy Paper (I-PRSP), had been presented and discussed at the recently concluded Nepal Development Forum held in Kathmandu

deficiency of public expenditure with cost sharing and cost recovery schemes.

In sum, the above-mentioned are good plans and provide a conducive environment for alternative financing of health care. However, as mentioned above, there has been preference of health insurance since it helps pool the financial risk. As such, the next section discusses the different models of health insurance existing in Nepal.

Models of Health Insurance Existing in Nepal

The problem of financing the health sector has been of serious concern to the government, and the MOH of HMG/N intends to initiate alternative financing schemes as a means to supplement the health sector-financing source.¹²² The types of alternative health care financing systems in operation in Nepal include user charges – registration fee etc, community financing schemes, community drug schemes of various types, besides, community insurance schemes. Most of these schemes have in-built mechanism for direct payment by the users though there may be provision of safety net for the poor in some cases. Presently, the formal sector health insurance as such, exists in a limited way. There are a small number of agencies which provide medical benefit packages, including membership of private insurance schemes to their employees. In addition to this, there exists social health support schemes for employees in the government sector, labour organizations and some others in various firms. These are largely involuntary and have some insurance characteristics (i.e. charging contributions), others without and still while some others are without any such characteristics, and still others which have characteristics which are more of a privilege.

There are basically three other models of health insurance presently under operation, namely the hospital based micro-social health insurance scheme; Community, Health Post-based Insurance model; and Health Cooperative Model. These are explained in detail in the first table, given below:

¹²² This problem is partly due to the social change in Nepal from the joint family system with community-based initiative e.g. Guthi system, to the present trend of nuclear families

Table 1. Health Insurance Models Existing in Nepal

No.	Insurance Model
1.	<p><i>Hospital based micro-social health insurance scheme:</i> Initiated in 2000, the BP Koirala Institute of Health Sciences offers services to rural and urban household members through linkage with Village Development Committees (VDC), co-operatives, business associations, educational institutions etc. The premium for urban areas is four times higher than rural areas and the scheme covers 2 400 members from 565 households. The service package includes free consultations and investigations in Out- and In-patient Departments, free hospital beds and medicines and operation charges beyond certain limit. The entire premium, contributions from VDC etc. go to hospital. The income shows surplus, but does not include expenditures borne for manpower, equipment costs etc.</p>
2.	<p><i>Community, Health Post-Based Insurance model:</i> Initiated in 1976 as Lalitpur Medical Insurance Scheme; this scheme has a coverage of 19 to 52 per cent rural population in six health posts. The premium varies and is set up by the local committee with the drug subsidy coming from the government. Registration fee-based and free clinical service is provided in the clinic, although for the referred cases in Patan Hospital, the charges are discounted. There is no surplus revenue over the expenditure. It is observed that sustainability may be a problem with existing premium.</p>
3.	<p><i>Health Cooperative Model:</i> A Nongovernmental Organization (NGO), PHECT (Public Health Concern Trust) Nepal, offers health service through Cooperative Society with the members maintaining a daily savings of nominal amount to contribute for health, both in rural and urban areas. Community clinics provide primary services and referrals for Kathmandu Model Hospital (KMH). Fifty per cent of total collections go to KMH. Subsidy is provided to the poor on referral cases. There is coverage for 2 038 persons from 438 households.</p> <p>The General Federation of Nepal Trade Union (GEFONT) supports another cooperative scheme for transport and industrial workers. A monthly premium is paid by workers to establish a Health Cooperative Fund, which runs a clinic for primary service and the referred cases go to KMH as above. For the poor, PHECT Nepal provides financial support as solidarity. It covers only 500 families (2 members from each family) out of 300 000 GEFONT members.¹²³</p>

Source: British Council; DFID/District Health Strengthening Project, Teku, Kathmandu; and The ILO/STEP programme in Nepal, 2003.

¹²³ Mention may be made of the ILO's Strategies and Tools against Social Exclusion and Poverty (STEP) global programme in Nepal, which is providing technical assistance to civil society groups to carry out feasibility studies to set up and manage micro-insurance system which are based on solidarity in the grass root level. The aim is to extend social protection measures through health micro-insurance (SPHMI) schemes, which are gender sensitive, accessible and affordable for the poor, vulnerable and excluded workers in the informal economy of Nepal. Support has been provided to the Credit and Savings Cooperatives, GEFONT, Social protection for porters and their families in Solokhumbu district etc.

The health insurance models discussed above are different variations of the community health insurance (CHI) scheme. CHI seems suitable for informal sector and it covers a variety of schemes with variations in (a) target groups, (b) provider arrangements, (c) benefits of services, (d) exemption arrangements for vulnerable groups, (e) means of contributing, (f) degree and type of cross subsidy and (g) administrative mechanisms. The CHI schemes are attractive in providing an opportunity to link the activities into local management processes and MOH seems interested to work closely with different CHI schemes

Discussion on Health Insurance and SHI

While different models of health insurance are existing, the high level of OOP in the county, which is consistently around three quarters of household expenditures, suggests that there is still a long way to go for Nepal to provide total health financing. Nevertheless there is a move for providing higher levels of health care financing in the country in a sustainable manner. There is justifiable concern that the nature of the above-mentioned CHI, while important for reaching the mentioned objective and which will be started in pilot form, may not be able to capture the deprived and poverty -afflicted portion of society due to its **voluntary** nature. Likewise, there is concern that a CHI may not be sustainable for providing more specialized services, without substantial government support (WHO, 2003 a). Because of this, and from the equity perspective, an alternative form of health care financing which is slowly gaining favor is SHI – this is conceptually attractive since membership and contribution are **mandatory** and pooling it involves of resources and risks of the population with cross-subsidy, leading to overall financial protection.¹²⁴ Recently the government has publicly committed to the introduction of SHI for the people and it is considering the implementation of pilot SHI schemes and replicating the appropriate schemes based on experience. (MOF 2003/2004 budget speech) While a true SHI **does not** exist in Nepal so far, support is growing for this model of health insurance.

Beyond doubt, the SHI scheme is an ideal model and something which can be possibly developed for the country. In cognizance of the fact that there

¹²⁴ For an overview of SHI, with some examples given in the South-East Asia Region, see Sein (2003); also, see WHO (2003 b)

are many operational difficulties existing in terms of resource management viz. financial, manpower, drug supplies etc.(NHEA 2002) and no less poorer skills in organizational management culture, proper monitoring and evaluation must be in-built in the implementation plan. As Nepal is a country of great diversity, flexibility in the planning and implementation must be seriously considered. Commitment and accountability of the staff to provide service with quality assurance is the key to success.¹²⁵ This situation therefore suggests the need for a comprehensive study relating to: (i) the existing economic and political context; (ii) appropriate sequencing, (iii) explicit timetable, and (iv) proper implementation. (An example of programme management at village level is given in Appendix 2)

Conclusion

Insurance is an important mechanism for bridging the health financing gap in Nepal, besides offering greater protection to the poor and the vulnerable groups against high cost of ill-health in the form of social protection. Alternative models exist in Nepal, which largely are variations at the existing CHI model, although presently SHI is a desired form of alternative financing because it addresses equity, fairness of financing and quality of services. It is important that the CHI models currently in operation should be further reviewed in depth and the strengths and weakness analysed. Bold decision should be taken to continue the successful ones only and discontinue the weak schemes. Newer schemes should be formulated based on experiences particularly in rural areas. However, for the effective operationalization of SHI in Nepal, a comprehensive and integrated study is necessary along with appropriate sequencing and sincere implementation, to guarantee success. In our view, and having taken the above factors into consideration, an SHI can be started as a pilot project at the microlevel among government salary workers, whose recommendation is consistent with that of NHEA (2001).

¹²⁵ Karki (2003) puts these problems as: Inadequate supervisory/monitoring support; No guideline to utilize the money collected; Local community had no authority to spend the money collected; Money improperly spent or swindled by corrupt staff; Money collected was labeled as illegal and it was directed to be deposited in the government treasury; The basic purpose was to provide drug to all patients all the time; Government had not taken health insurance seriously in spite of it being mentioned even in the 9th plan

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Appendix 1

Input-output model for health sector*

I	Fiscal year	MoH of HMG/N Expenditure on health		Per capita RGDP At 1984/85 price (Rs)	Outputs				
		As % of total budget	As % of GDP		Infant mortality rate	Child mortality rate	Crude birth rate	Crude death rate	Life expectancy rate
N	1989/90	4.60	0.93	3102.3	128	197	41.6	16.9	53.5
	1990/91	3.84	0.88	3230.7	107	197	39.6	14.8	54.0
P	1991/92	3.62	0.84	3308.5	107	197	39.6	14.85	54.0
	1992/93	3.40	0.64	3329.2	102	165	39.6	14.85	54.02
U	1993/94	4.85	1.08	3501.8	102	165	39.6	14.0	54.0
	1994/95	4.91	1.21	3531.2	102	165	37.5	14.0	54.0
T	1995/96	5.99	1.44	3642.9	102	165	37.5	13.8	54.0
	1996/97	6.19	1.42	3727.1	79	118	37.8	11.9	54.5
S	1997/98	5.70	1.37	3766.8	74.7	118	35.4	11.5	56.1
	1998/99	5.69	1.34	3829.9	69.42	111.72	34.54	10.7	57.52
S	1999/00	6.09	0.80	3987.6	66.78	108.78	34.1	10.3	58.25
	2000/01	4.52	0.56	4164.3	65.3	105.44	35.58	10.0	59.0
	2001/02	5.26	1.06	4248.8	64.20	91.00	33.00	9.60	59.7

Note: The following are the raw data for Infant Mortality Rate (per 1000 live births), Child Mortality Rate (per 1000 live births), Crude Birth Rate (per 1000 live births) and Crude Death Rate (per 1000 live births) respectively. The public health expenditure as a percentage of national budgets and the GDP are based on actual figures while the figure for 2001/02 is based on estimate.

* These are figures for expenditures on health made through the MOH of HMG/N Nepal only. Expenditures made in health through other ministries such as the expenditures of Teaching Hospital under the Ministry of Education, Police Hospital under the Ministry of Home Affairs and Army Hospital under Ministry of Defense have been excluded from the present analysis.

Source: Economic Survey, 2002 and various issues of Nepalese budget speeches

Appendix 2

An example of Health Insurance Programme Management

- (1) As a first step, a list of all residents in the VDC will be prepared with the help of local VDC secretariat
- (2) Respective Sub Health Post (SHP) or an institution as decided by the SHP-HI Committee will collect the premium and deposit it in the account of the Ico/SHP/VDC.
- (3) Upon receipt of the list of Insurance Fee Payees Ico will issues ID card and a record book of treatment to all insured people. Since repeated addition and change in the list complicates the whole process effort will be made to make it a one time affair in a year.
- (4) HCF will provide health services based on the instruction given to them in the treatment record book
- (5) Upon completion of the treatment of the patient or as indicated in the book HCF will immediately request for payment from the Ico.
- (6) A Local HI Committee under the Chairmanship of the respective VDC will be formed including NGO or Clubs existing in that VDC. They will be involved in planning, implementing and monitoring this programme.
- (7) Large joint family or ethnic group or some form of community group insurance may be decided by the local committee in which a separate rate of premium may be decided by the Insurance Company.
- (8) Discussion and decision may be made locally that how other dependent members in the family can be considered to be included in the HI scheme.

Source: Karki, B. B. (2003).

Note: VDC = Village Development Centre; Ico = Insurance Company; HCF = Health Care Facility; HI = Health Insurance; and NGO = Non Governmental Organization.

