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MOVING TOWARDS UNIVERSAL HEALTH COVERAGE: HEALTH INSURANCE PROGRAMME IN NEPAL

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ABSTRACT

This paper aims to highlight an overview the provision for Health Insurance from the government as Social Health Security and now Health Insurance Board since it is a major means to meet the global agenda of access for health to all and also for addressing the constitutional provision of Nepal regarding health. Practice of Health Insurance has not so longer experience in Nepal so the programme could face different opportunities and challenges as well. Pooling, purchasing and providing of health services remain challenges as the services that are not being utilized fully even that are at free of cost. So, appropriate interventions should be adopted to meet the international and national commitments by the Nepal government.

INTRODUCTION

In 2005, the member nations of World Health Organization (WHO) committed themselves to develop their health-financing system that would enable Universal Health Coverage (UHC)to all the citizen through access to health services without any financial hardship (World Health Organization, 2010) which is one of the 13 targets under third goal of Sustainable Development Goals (SDGs)(Mishra, Khanal, & Dhimal, 2016). The World Health Report 2010 suggested modifying health system and health financing as an strategy to pave the pathway for UHC(World Health Organization, 2010). There are basically two dimensions for progress towards UHC, the first being equitable coverage of population with essential health services and raising sufficient funds to reduce direct payment resulting financial protection against catastrophic health care out-of-pocket (OOP) expenditure(World Health Organization, 2010).

Countries have achieved UHC by adopting different pathways and their diverse health systems, however political commitment, rise in health care spending and increase in pooled health care expenditure rather that OOP expenses are the common features (Savedoff, De Ferranti, Smith, & Fan, 2012). Earlier in 2007, the government initiated free health care program to provide essential health care services (EHCS) free of charge to poor, disadvantaged and vulnerable groups which was expanded to all the population in 2009 (Witter, Khadka, Nath, & Tiwari, 2011). Later, the constitution of Nepal 2015 described health as a fundamental right and ensured the right to free basic and emergency health care services (Legislature Parliament of Nepal, [2015]. which is in line with National Health Policy 2014 have prioritized UHC as policy strategies to ensure access to quality free basic health services.

Furthermore, the National Health Sector Program (NHSP) 2015-2020 has committed to increase package of essential health care services to move towards UHC (Government of Nepal, 2015).

Table I Steps towards Universal Health Coverage in Nepal since 2005

Date	Major Actions
December 15, 2006	Declared free health care at district hospitals and PHCCs (impatient and emergency) for targeted groups
January 15, 2007	Health as fundamental right for first time in constitution
October 8, 2007	Declared free health care by abolishing of users fee at HPs/SHPs
January 16, 2008	Free health care initiated from HPs and SHPs
November	Expanded free health care to PHCCs level

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Date	Major Actions
18, 2008	• Declared free outpatient care from district hospitals to targeted population
January 15, 2009	• Declared 40 free essential drugs free to all at district hospitals • Declared all essential drugs free to targeted groups nationwide
2010	NHSP-2-IP (2010-2015) introduced that planned to introduce social health protection scheme for catastrophic illness (Ministry of Health and Population, 2010)
2013	Formulation of National Health Insurance Policy
2014	National health Policy 2014
February 14, 2014	Establishment of Social Health Security Development Committee (SHSDC)
2015	NHSP (2015-2020) committed to increase free health package and implement health insurance(Government of Nepal, 2015)
September 20, 2015	Health as fundamental right and free basic and emergency care ensured in constitution
2016	Health insurance program initiated from 3 districts

Although, the health care expenditure in Nepal is better than average of other low-income countries, it is still less. For instance, the total health care expenditure is 5.5% of Gross Domestic Product (GDP), which is below the global average of 9.2%. Moreover, government health expenditure is only 2.2% of GDP (Adkihari, 2015). This is because of significant proportion of donor financing.

Health Financing Mechanism in Nepal

Collection of revenue: Raising sufficient resources in health and ensuring consistent increase in funding over the time is crucial to achieve UHC. There are several approaches to raise the resources in health. Increasing general taxation and insurance contribution from public, prioritizing health in allocating national budget, support from donors and increasing taxation in harmful products like alcohol and tobacco are the

Table II Features of Health Insurance System in Nepal

Feature	Description
Funding	The fund comes from Contribution Amount • NPR 2,500 for family of 5 members and additional NPR 425 for each additional member • NPR 500 for an individual member (not part of family) Government Contribution • 100%, 75% and 50% subsidies for extremely poor, poor or vulnerable respectively based on the identification and identity card issued by Ministry of Poverty Alleviation and Cooperatives Special Fund where the find comes from • Local bodies, Individual citizens and different organizations, Foreign assistance, SHSDC
Membership	• Membership is voluntary with family as a unit • Each individual or family member can become member of program • Membership application is proceeded through enrollment assistant, who is a local resident • Provided to temporary residents if he/she has lived in the certain area for more than 6 months • The membership is valid up to one year and shall be renewed each year
Exclusion	• Cosmetic surgery, Dental treatment services, Artificial insemination/ pregnancy, sex alteration, Injuries related to confrontation or alcoholism, Expenses above 500 for the spectacles, artificial limbs or hearing equipment, Diseases like Dementia or Alzheimer disease
Benefit Package	• All lab services provided by Government of Nepal's regular health program and additional 69 tests as described elsewhere (Government of Nepal, 2014) • Radiological/ other diagnostic services described elsewhere (Government of Nepal, 2014) • Treatment of additional120 diseases/ condition beyond free health program(Government of Nepal, 2014) • 70 additional drugs beyond 35 drugs under free health program **Ceiling** • NPR 50,000 for family up to 5 members and additional NPR 10,000 for each member with maximum ceiling of NPR 100,000 per year per family(Government of Nepal, 2014) • If member requires further treatment beyond maximum ceiling for complex diseases like Cancer, Heart diseases, Kidney, Liver, Head Injuries, Diabetes, Sickle-cell Anaemia, Ebola, AIDS and Sexually Transmitted Diseases, Influenza, Parkinson's, Asthma, Jaundice, Alzheimer's and Dementia, the committee may avail up to NPR 50,000 (Government of Nepal, 2014)
Eligible Providers	• Public health facilities are service providers by default • Private providers that want to provide services under the program, and meets the determined criteria • The private providers under this program are basically the referral centers • Accreditation for private providers is reviewed in every 5 years
Reimbursement	1. The service providers are eligible to receive o NPR 80 and 140 from PHC and hospital respectively for outpatient care, however, the service is not counted as OPD if the patient is provided with regular medicine, follow-up visit within 7 days or is emergency care, o NPR 80 for PHC (excluding medicine) and NPR 175 for hospital for emergency care o Any one of the following, for impatient services as per agreement o Accumulated rate determined by committee on Diagnostic Related Group (DRG), OR Per day rate for each disease OR Rate agreed in the agreement OR Providing lump sum payment 2. The committee scrutinize all the claims and invoices and make payment within 21 days of claim 3. The committee can pay advance as per agreement
Organizations	• Social Health Security Development Committee (SHSDC) in central level to oversee social health security program. • District Health Security Coordination Committee (DHSCC) in the district level to increase access to the program • Health Facility coordination committee to raise awareness and facilitate enrollment
Accountability	• DHSCC to implement program in the district which is represented by stakeholders from District Administration Office, District Development Committee, District Health Office, District Education Office, Financial Comptroller general Office, Municipality or VDCs, and service providing health facilities • The committee can form another committee for monitoring and quality control, that constitutes technical persons like specialized doctors, Radiologists, Pathologists, Pharmacist Public health expert

broad approaches of collecting revenue for UHC (World Health Organization, 2010), however a large portion of find is generated from OOP in most of LMIC (Lagomarsino, Garabrant, Adyas, Muga, & Otoo, 2012). Not surprisingly, OOP payment remains the major source of financing in health care in Nepal (Adkihari, 2015; Mackintosh et al., 2016; Saito et al., 2014) constituting almost 50% of total health expenditure although the government has been providing free basic health services. This is because of limited benefit package under basic health care services which does not cover the treatment of major non-communicable diseases that accounts 80% of OPD visits (Mishra, Neupane, Bhandari, Khanal, & Kallestrup, 2015). Moreover, the external development partners (EDPs) contribute one-fifth of total health financing (Adkihari, 2015).

Rist Pooling: Risk pooling is spreading the health care cost among the households of varying health status that prevents catastrophic health are expenditure as a consequences of health problems. The progress towards UHC depends on raising enough funds from a large pool of individual as larger pool enables cross subsidies from rich to poor population(World Health Organization, 2010).

DISCUSSION

Governance: In health care, good governance implies that health care systems function effectively and efficiently (Lewis, 2006). A sound institution is crucial for good governance. According to Kaufman and Krayy (2003), governance of health encompasses capacity of government to formulate and implement policies and mange resources. The SHSDC has formed a committee to make the policy and implementation level decision. The Board of Director (BOD) is led by the Secretary of Ministry of Health and majority of the BOD members are the Bureaucrats. Similarly, in district level, ad-hoc committee has formed who made the field level decision by having periodic meeting. The complaints and grievances are handled in the central level mainly by toll-free phone number. It shows current governance structure of health insurance implementing agency is ad-hoc basis in nature. The similarly, different committees have been formed to devise and revise the scheme and all these are the loose committee.

Financial Sustainability: The health sector has threatened by increasing economic inequality and economic certainty (Lycourgos & Goranitis, 2015). The sources of health financing determine the sustainability of the health care finance. The source of national health insurance program finance is general tax and contribution from the members. The fiscal year 2016/2017 budget has allocated huge amount (25 million USD) of money to implement the health insurance, which include subsidy to poor. The current benefit package is comprehensive and services costing of few diseases are made. The study shows that Nepal's health sector is largely financed by the external development partner's (MoHP, 2010) and after end of development partners support, program suffered the financial shortage. As Nepal is in juncture of political turmoil, it is difficult to predict that government will continue to allocate the adequate budget to subsidize the poor people. In this context, earmark budget for the health insurance program and strong administrative capacity to implement national health insurance system is critical for financial and political sustainability (World Bank, 2006). Therefore, government needs to consider to link with formal financing arrangements so that no shortage of budget can be happened in further.

Equity And Access: Universal health coverage lies on strengthening physical access through improving geographical coverage of health services and financial access by extension of financial risk protection mechanism(Tangcharoensathien, Mills, & Palu, 2015). Terrain remains major barrier in access to health services in mountainous region, socio-cultural barrier among women, poor and marginalized population in Terai have resulted low service utilization among Dalits and Muslims(Government of Nepal, 2015)

The access to health facilities in Nepal is not sufficient enough as only 47.2% population were living within 30 minutes travel to health post or sub-health post in 2012(Daniels et al., 2013). In contrast, the first service contact point for seeking health services under health insurance program is Primary Health Care Centers (PHCCs) which are in each constituency. Thus, access to seek health care services from these centers is not sufficient enough to encourage the public to enroll in health insurance program. Furthermore, raising health care cost and raising tendency to seek the services from private providers have forced the people to spend substantial share of their income in their health (Government of Nepal, 2015).

Payment Methods/Reimbursement: SHSDC is the purchaser of health care services. It provides payment to the service providers based on the agreed rate of services during the agreement. The health service providers that have agreed with SHSDC are providing the services to the insured and reimbursing the money from SHSDC on fortnightly basis. The service providers claim the expenses in the IMIS and the technical and cost review team reviews the claim and recommends for payment accordingly. Currently, SHSDC is supported by external two consultants in reviewing the claim. Furthermore, there is ad-hoc claim review committee, which approves the claims on the basis of recommendation from the consultants. As the districts are expanding, the work-load for external consultant will be more. The existing manpower will not be enough to review and provide feedback on the claims. Thus, it would be crucial to establish separate unit for claiming review and payment for effective implementation of health insurance program.

Issues In Design: Some issues related to its expansion, sustainability, service utilization and its access are found to be modified at present. The design of an entire program has to be addressed properly. The followings are some aspects as issues to be focused;

1. It should address not only enrollment but the quality, access and institutional strengthening as well.
2. It should address about sustainability by ensuring renew for its continuation.
3. The government should focus on improving the optimal use of available rather than raising the revenue.
4. The government should make realistic way to identify the poor and make subsidies to them.

Issues In Implementation: The concept of health insurance obviously supports welfare provision of the state but it has to be answerable to following issues to make easy access to insured people;

- An issue is raised on its working approach now. No single pathway works as it is anticipated. To make it more realistic, multiple ways are needed to cover insured people well.
- Amount to be spent by the government is another issue to be addressed now. There should be clear outlines to ensure the amount to be contributed by the government.
- Poor expanding ability of government may lead to budget freeze situation.
- Intend is an issue now. It should not be just the political stunt but realistic approach to make people benefited. Technical expertise is needed for its smoothing functioning. The government authority as implementer should think of its rationale with clear vision about its needs in Nepalese context. It should answer whether it is emerged with ground reality or just because of international pressure. Technical competence, adequate supply of drugs and support of civil society are needed for its effective implementation. It can be managed though public awareness.
- An ability to pay has been another issue to be addressed. Implementation should focus on the ability to pay / willingness to pay from people's side. Access to poorer should always be priority from state side.
- Some issues related to service delivery approach have seen now. There should be trustworthy environment between provider and people who are insured. Availability, cost, regularity of staffs and of course the dealing on behalf the service providers are the aspects to be thought.
- Effective monitoring has been another issue to be maintained. People who have insured should be benefited at any cost.
- Lack of good governance and corruption can be an issue for its effective implementation. The government should make strict and reasonable provision to ensure good governance on health insurance.
- Private public partnership has been another issue to count. Involvement of private sector has to be emphasized for its sustainability.

CONCLUSION

Out-of-pocket expenditure is high during the time of receiving health services in Nepal. It increases the gap between poor and rich for health care. Universal health coverage is global agenda and Government of Nepal is also committed to ensure it. However, appropriate strategy for pooling, purchasing and providing of health services are the challenges. To meet such challenges, an appropriate intervention is needed for ensuring constitutional provisions and international commitment.

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