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Illness, Healthcare, and Health Insurance: Socio-economic Perspective in Nepalese Context

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Abstract

The Government of Nepal has introduced a health insurance programme since 2016. The main essence of the program is to reduce the gap in the utilization of health services between poor and rich, to reduce the out-of-pocket expenditure while receiving the healthcare services, and to protect the family from poverty due to catastrophic healthcare expenditure. Researchers review the policy, programme and existing practice

Data from Health Insurance Board shows that the programme appears not so effective in many districts but it looks successful in some districts where private healthcare providers are existing as a referral hospital. It is still unanswered whether the HIP is going to boost industrialists in the name of basic rights, health equity and social justice. The paper studies socio-economic and political perspectives of healthcare and health insurance with reference to Nepal and concludes that the healthcare system needs to reform for real welfare, social justice, and citizens' access and right to healthcare.

Keywords: ***Disease and Illness, Health Inequality, Health Insurance, Seller of Illness and Healthcare***

1. Introduction

The welfare states should provide basic health services to its people free of cost since the state has a responsibility to provide it. The Constitution of Nepal [CoN] 2015 has assured basic health service as one of the fundamental rights of the citizens. Article 35 of CoN has guaranteed basic health services as the basic right of people and the state has a responsibility to assure it (Nepal Law Commission, 2015). Being a member state of the United Nations, the Government of Nepal [GoN] is one of the signatory members and was committed to assure 'Health for All' by 2000, achieve Millennium Developments Goals by 2015 and later Sustainable Development Goals [SDG] by 2030 especially Universal Health Coverage [UHC] (Government of Nepal National Planning Commission, 2015). GoN has declared basic health services at free of cost from its local-level health institutions [health posts and primary health centres] since Mid-January of 2008 (Development Resource Centre, 2012).

Despite the international commitments and constitutional provision of health, the reality is so far from the targets. Most of the local level health institutions remain stock out of essential medicines, still vacant the position of sanctioned posts of human resources for health, and poorly equipped in terms of the physical infrastructure of health facilities (Subedi, 2015). On the other hand, the GoN has allocated less than three (2.75)

and less than four (3.67) percent of the total national budget for the health sector in the fiscal years 2017/18 and 2019/20 respectively which is said to be insufficient to meet the targets of the SDGs, and the GoN's commitments in relation to the mandatory provision of the CoN (Department of Health Services, 2019; Ministry of Finance, 2019a). Consequently, nearly one fifth (19%) of the total population is still living below the poverty line and cannot pay for healthcare which may be the problem of access to health services (Ministry of Finance, 2019b).

As per the agenda of the UHC which is targeted as no-one left behind the mainstream of health services. In 2005, the member states of the World Health Organization were also committed to developing the health financing system aiming to access health services and should not suffer financial hardship while receiving the health services as per world health assembly resolution 58.33 (Binnendijk, 2014). An alone effort by the GoN is not enough to assure the commitments since just 3-4 percent of the total budget has been allocated for the health sector (Department of Health Services, 2019). So, an alternative mechanism is needed for sustainable health financing to make health for all, and all for health (Health Insurance Board, 2019). People's participation and contributions seem compulsion to assure their commitments. Considering these facts, the GoN has initiated the so-called health insurance programme [actually treatment support programme] initially as social health security since 2016 in three districts and committed to expanding throughout the country by end of this fiscal year (Health Insurance Board, 2019). The paper aims to discuss the socio-political perspective of healthcare and health insurance in the context of Nepal.

2. Literature Review

2.1 Marxism: social class and conflict

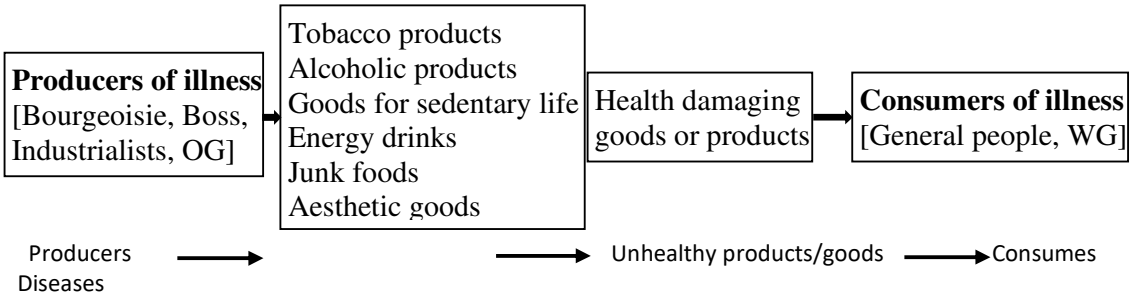
Society consists of specific links between characteristics of mode of production and attitudes and behaviours of individuals live in the capitalist society (Thomson, 1983). According to Marxist, there are two classes in the society: Bourgeoisie and Proletariat (Koseoglu, 2017; Kruger, 2015). Bourgeoisie are known as employers, capitalists, rich, owner, dominating people or boss who hold state power even courts, police, law, and orders protect them since they can influence politics and the overall systems of state including media, and even state's economy whereas, proletarians are employee, worker, poor, dominated people or servant who work for bourgeoisie (Edlund & Lindh, 2015; Neesham & Dibben, 2016). Since the upper class or elite groups influence the overall system of the state, the state provides special treatment and privileges to protect them and their property. The overall system of the state safeguards the bourgeoisie even they are in a minority. Whereas the majority of people who are proletarians work for these elite groups and they cannot control institutions, politics and state's governing systems even they are in the majority (Edlund & Lindh, 2015). So, the state generally does not hear them in capitalist structure. If the working groups work against the bourgeoisie then the police, judge, court punish them to protect the capitalism, elite group who can earn without working considering that they are the backbone of the state's economy. Obviously, the state protects capitalists. In this way, the social and political system runs. The basic assumption of Marxism is the human and all arrangements of life are administrated by commodity in capitalism (Kellner, 1988) and how the transformation of politics and practices influences in healthcare (Soares, Maria, Campos, & Yonekura, 2013).

The working group [lower class] [WG] demands equality where the owner group [upper class] [OG] demands economic freedom and rights (Edlund & Lindh, 2015). The upper class influences the mass media to advocate in favour of them and control the overall system of governance and political system even the social and governmental institutions support them in the name of 'rule of law and order'. The WGs demand for teamwork, capital sharing, and a high wage for their work and state's control over the property whereas, the OGs demand for individualism, business freedom, should have right to control over the WG, and low wages to employee for more profit in their business (Neesham & Dibben, 2016). In this way, class conflicts exist in the society. Therefore, the political and economic system of the capitalist society makes the rich richer and poor into poorer that makes various forms of disparities in the society. The OG believes that money creates power and it can control everything. So they are motivated to earn more money by using the WG at lower wages (Edlund & Lindh, 2015). There are both criticisms as well as a commendation of Marxism. Some idealists comment that Marxism creates tension with its own objectivity, engagement, and imagination (Burawoy, 2000) that it could not be possible to create a classless society.

2.2 Producers and consumers of illness

Most of the health reform plans and policies prioritize financing and medical care than to preventive aspects in relation to diseases (Godwin, 1871; Navarro, 1994). Healthcare industries are more benefited to produce healthcare products than create preventive measures in the community. Most of the patients have been blamed that they got ill because of their own unhealthy behaviours rather than a socio-political imbalance (Bierlich, 1999). Physicians use to counsel patients as the disease appeared to them because of their own unhealthy behaviour and advise them not to do so however the reality is far from the observation (Wyk, 1996). The disease presents with patients is not only due to their own behaviour rather it presents from entire unhealthy products that they consume the foods or goods produced by industrialists [the bourgeoisie]. In this sense, the OG produces unhealthy products and the WG consumes it so the OG is the illness producer and the WG is the consumer. The OG produces various health-damaging products [unhealthy products], disseminates creamy, and attractive messages to consume their products from mass media. Then, the WG consumes the products since they are influenced by advertisements and even they need it (Bierlich, 1999; Wyk, 1996).

Figure 1: **Producers and consumers of illness**

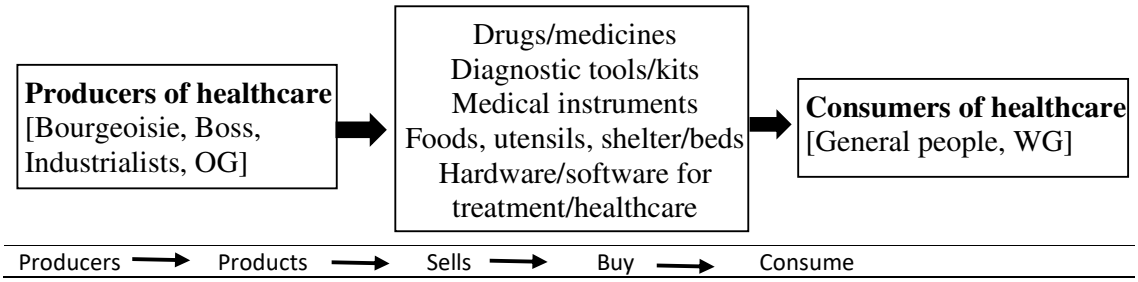


The bourgeoisie and or industrialists produce different types of products that might harm health but their concern is profit rather than people's health. On the other side, the state protects and recognizes them as

respectful taxpayers, considers them that they should be protected, and treats them accordingly (Bierlich, 1999). Whereas people are buying illness through the means of their products and goods which tend to consume by WGs since they are attracted by the creamy advertisement and messages. Gradually, the health condition of the people is going to decrease and disease starts to manifest (Wyk, 1996).

2.3 Producers and consumers of healthcare

Figure 2: **Producers and consumers of healthcare**



Proletarians believe in the mass media, and accept the socio-political system that the bourgeoisie are providing the healthcare to them. But in the real sense, the bourgeoisie is benefited when the proletarians become ill by selling their products of healthcare (Edlund & Lindh, 2015). Sometimes, the bourgeoisie influence the total healthcare system to purchase their healthcare products to people claiming that the state has provided the healthcare and services at free of cost, for example, mass immunization, mass treatment like deworming, vitamin A distribution, Iodine and Iron tablets distribution. Actually, the bourgeoisie has already been paid by the state or from any other mechanism for their healthcare products (Bierlich, 1999).

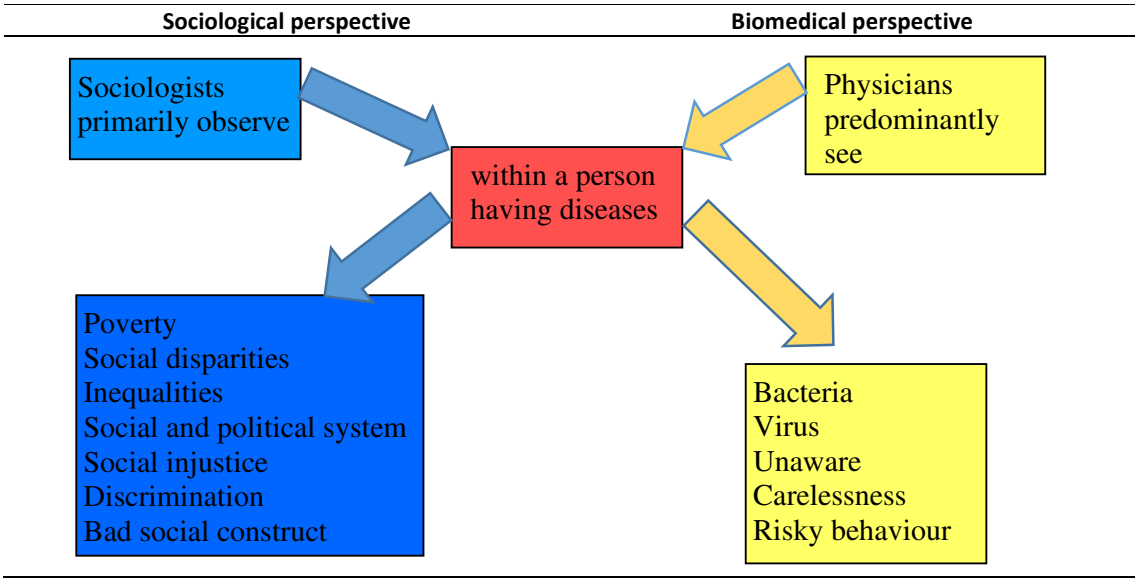
2.4 The social and biomedical perspective of health and illness

Physicians or medical officers see the patients from a biomedical point of view whereas, sociologists view them from the socio-political and environmental perspective (Edlund & Lindh, 2015). Physicians see bacteria and or viruses in the patients having STDs whereas; sociologists observe poverty, the social disparities and inequalities. Physicians treat the patients in an individual approach to fix the problems but sociologists see the problems in the social structure so the entire political and economic system is responsible for diseases or illness. Therefore, they want to treat the illness accordingly.

Physicians are said to be an agent for direct marketing of drugs. It is claimed that medicine often causes bad than good and millions of people are affected by unnecessary prescription of antibiotics (Null, Dean, Feldman, & Rasio, 2005). Generally, it is considered that they have a high level of knowledge and skills concerning medicine and health so they should have power. Therefore, they can make a final decision about medication to overcome the illness. They are often awarded if they recommend more medical tests, more medicines, and more days to stay in the hospital so that the patient might pay more and more in the name of quality healthcare. Besides these, healthcare industries provide an incentive for those who prescribe their products even the patients. However, diseases do not need to consume the products [medicine] for being healthy or treat the disease (Edlund & Lindh, 2015). The sociological and biomedical perspective of the illness and health care

has been presented in the Figure 3.

Figure 3: Sociological and biomedical perspective on disease



3. Methodology

The article is based on published and unpublished literature related to healthcare, health insurance, and socio-economic and political perspectives. Published online articles were searched from PubMed, HINARI, ReserchGate, Academia, and Google Scholar. Whereas, unpublished article and data were collected from the Health Insurance Board [HIB], Department of Health Services, Teku, Kathmandu. Some documents were obtained from Tribhuvan University Central Library. The opinion is presented as per the qualitative and quantitative data available from the literature published till 2019.

4. Findings and Discussion

Government of Nepal has formulated the Health Insurance Board [HIB] to administrate so-called 'health insurance' throughout the country to achieve the basic targets of the UHC since 2018. Before its establishment, the Social Health Security Development Committee had operated the programme as the social health security since 2016 (Health Insurance Board, 2019). The Member of Parliament endorsed Health Insurance Act in 2017. According to health insurance regulations 2019, there is a mandatory provision to enroll for those who are engaged in the formal employee system i.e. civil servants, teachers and other workers who receive a salary from governmental budgeting system that also includes the informal sectors (Office of the Prime Minister and Council of Ministers (OPMCM), 2019). As per the provision, a certain amount of employee's salary is deducted for health insurance that is the range of 3,500 to 10,000 Nepali Rupees as per the position and income that formal sector workers received. The coverage amount is equivalent to Rs. 100,000 per year with maximum ceiling of Rs. 200,000. The programme has covered more than half of districts throughout the country and committed to expanding to all districts of the country by the end of this fiscal year (Health Insurance Board, 2019; Office of the Prime Minister and Council of Ministers (OPMCM), 2019).

The term 'health insurance' is not actually fit as per its working nature and practices. Health Insurance [HI] should try to reduce the health-damaging behaviours such as smoking, alcoholic, sedentary lifestyles. There should not be an equal premium [contribution amount] to all and should not be a ceiling of the same coverage amount in real HI practices. There is a debate on the fundamental issue that individuals who care less about their health should be fined more than those who care about their health in terms of food intake, proper exercise, regular check-up, and other health concerning behaviour. HI is a kind of co-operation too. When insured do not get ill, their contribution amount is paid for others who get sick and paid vice-versa. The question may arise that why you should pay for those who do not care for their own health since you are more cautious about your own health and do health-protecting behaviours to promote and maintain my health (Edlund & Lindh, 2015).

On the other hand, there is a provision of free health services for basic health care though it has not been effectively implemented due to the shortage of medical professionals, stock-out of drugs, and poorly managed infrastructure (Development Resource Centre, 2012; Transparency International Nepal, 2016). Besides these, patients with critical (life-threatening) diseases such as Cancer, Heart Diseases, Kidney Diseases, Sickle-cell Anaemia, Head and Spinal injury, Alzheimer's disease, Parkinson's disease can receive some financial support [up to Rs. 400,000] during transplant/post-transplant and treatment in special terms and conditions which is not included in insurance coverage (Ministry of Health and Population, 2018). Civil servants, police staff, army staff, teachers and other employees engaged in formal and informal sectors can receive treatment support, treatment subsidy and or amount for healthcare. Ex-employees other than in Nepal have also received medical care facilities. These types of treatment support are not included in the mainstream of so-called health insurance.

Various private insurance, banking, and financing companies have also been providing treatment support for critical care in special terms and conditions. These companies are only for profit-making may or not sustain in the future. The governmental service delivery system seems weak compared to private ones. The process of receiving service from governmental health facilities is lengthy, time-consuming, and procedure based than result-oriented. So, private healthcare industries may attract people by disseminating attractive and creamy message for health care. In such a case, all these social and political systems may support the elite group in the name of protecting the deprived community.

The HIB shows that the health insurance programme seems more successful where the private and community type hospitals are listed as service providers, for example, Palpa, Chitwan, Kaski Districts where private medical colleges are listed as service provider [referral hospital] of the programme (Health Insurance Board, 2019). The HIB is ultimately boosting the private sectors. Actually, private sectors are being more benefited from the programme since they are the seller of healthcare products [services and goods] in the name of universal health coverage, rights of citizens, and or sustainable development goals. Therefore, there is a nexus between the government and elite industrialists.

The political forces influence the healthcare system (Muntaner, 2013). So the main issues of health need to be addressed by the mainstream of politics. The national healthcare system should be reformed since the system firstly boosts the elite industrialists and second it does not cure the patients rather leads to the problems of drug resistance due to unnecessary application of antibiotics (Null et al., 2005) which makes of people dependable to healthcare products that are produced by elite industrialists. Another dark side of the programme is the

programme could not able to justice the people who live in a remote area such as people who live in Kathmandu and Karnali have an equal medical coverage whereas, the people from Karnali have to pay nearly the same amount in transportation cost while receiving the tertiary level health services. Therefore, it is unfair and illogical in terms of social justice and equity for healthcare.

5. Conclusion

The healthcare system needs to reform since it could not reduce the gap of health-related disparities created by socio-political and economic system. Healthcare is not only the issue of the hospital and the doctors but it should also be considered in a holistic approach and addressed from the mainstream of the political system. Positive discrimination is needed for needy persons and places, and should not be treated equally throughout the country.

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