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Social Health Security Program in Nepal: Opportunities and Challenges

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Abstract

The study aims to assess the opportunities and challenges of the health insurance program carried out by Health Insurance Board as a social insurance program by Government of Nepal. Data have been collected through in-depth interview with 21 persons including the social health insurance policyholders, and non-policyholders who are inhabitants of Rantanagar Municipality- 6, and Bharatapur Metropolitan City- 10 of Chitwan district. Besides, experts in insurance and senior managers of insurance companies were also interviewed. It has followed the interpretive-naturalistic approach with the method of interviewing. As per the opinion of respondents HIP is effective in cost reduction of rich, and access to health service for poor. In government hospitals policyholders suffer from prolonging waiting, lack of facilities and experts and in private hospitals there is undue expenditure and discrimination in expert service. Even though the objective of the social health program is established social justice, cash-payer and insurance-payers are discriminated; corroborating the nature of neoliberal society. There are still uninsured persons because of ignorance, lack of premium, and distrust of HI service. The study suggests that HI service should be delivered through non-profit hospitals, the highest quality without discrimination of cash-payer and insurance-payer, and prolonged waiting.

Keywords: Health Insurance Board, Premium, Social justice, Social health insurance

1. Introduction

Social Health Insurance (previously known as Social Health Security Program) began in 2016. The program is implemented by Health Insurance Board (HIB). SHS program is a flagship insurance program ever supported by the government. It is contributory program where per family need to contribute minimum NRs. 3,500 ($ 29) per year for a family of up to 5 members and NRs. 700 ($ 6) for every additional family member. The HIB has the provision to provide subsidy for the poor and vulnerable to get enrolled into the scheme (100% subsidy for ultra-poor families, elderly population, Female community health volunteers, and patients with HIV/AIDS, MDR-TB, Leprosy, Null-Disability). The benefits package consists of services from primary health care centres, hospitals, and public and private referral hospitals including outpatient, inpatient, and emergency care. The maximum amount of

benefit is NRs. 100,000 per year per family of up to 5 members, with additional NRs. 20,000 for each additional member and maximum benefits for a family does not exceed NRs. 200,000).

According to the Health Insurance Board (2018) opportunities of HI specially with respect to targeted population are: a) the health insurance scheme will be able to better negotiated prices than the patient would be able to secure as an individual, b) private health care providers have been contracted into the scheme with their strong commitments to provide services in the given prices as per benefit packages, c) gradual increase in access and outrage of people in health services with the improving quality of health services along-with infrastructure, d) increasing people's awareness towards health insurance and services. Similarly, Board mentioned some challenges viz. a) HIB is unable to provide free of cost services to poor families due to the absence of poverty card to the poor families, b) there is a problem in supply-side i.e. the availability of drugs, diagnostic services and doctors are significant drivers of enrolment and service utilization, c) there is still a lack of enroll all the targeted population due to lack of awareness.

The above-mentioned opportunities and challenges were generated logically based on national data of official records. An empirical, in-depth, and qualitative study has been realized to carry out to assess the health insurance program from the perspective of identifying the availability- access gap.

The best opportunities are reducing health service cost to the people who can afford and access to the poor, otherwise, they would never get. The most challenging aspects are: getting expert service without discrimination and waiting in a long queue for getting service in terms of policy buyers. Still, there are challenges to include all people in quality service without prolonging waiting.

Knowledge from this study contributes to the HIB and signatory hospitals in terms of quality service, and the board for including all people in the HIP. This study lacks observation, solely relied on interview, therefore, this study indicates for and filed-based study on how the HI clients are treated in government and private hospitals.

The study aims to assess the opportunities and challenges of the health insurance program carried out by Health Insurance Board as a social insurance program by Government of Nepal. Remaining text is divided in four sections as review of literature discusses in second section followed by methodology and result and discussion in third and fourth section respectively. Final section concludes the paper.

2. Review of Literature

The concept of health insurance policy widespread from Alma Ata declaration of 1978. Primary health care "based on practical, scientifically sound and socially acceptable methods and technology made universally accessible through people's full participation and at a cost that the community and country can afford" was to be the key to delivering health for all by the year which emphasized the provision of community-oriented preventive, promotional and curative health service and evident by the establishment of a network of primary health care facilities and development of community health workers to provide essential health service at the community level (Gilllam, 2008, p. 536).

Constitution of Nepal, 2015 has the provisions of social security as a fundamental right and social security matters are included under article 51. Under these policies, the state has the responsibility to ensure easy, convenient, and equal access of all citizens to quality health services; provide health insurance to all citizens; guarantee social security. The Social Health Security Program-2015 is not a free policy started by the government of Nepal though it does not cost the senior citizen above 70 years old and people below the poverty line. The concept of social security is not fixed and has evolved over a period of time (Garcia & Gruat, 2003). Beveridge Committee Report (1942) defined where social security is as "freedom from want" (Majumdar & Borbora, 2013). The Universal Declaration of Human Rights (1948) stipulates a right to social security. Article 22 established that "Everyone, as a member of society, has the rights to social security and is entitled to realization, though nation effort and international co-operation and by the organization and resources of each state, of economic, social and cultural rights indispensable for his dignity and the free development of his personality.

In 1952, the International Labor Organization (ILO) adopted a comprehensive convention No or no. 102 on social security, where the term social security refers to medical care, sickness benefit, employment injury benefit, family, and maternity benefits (SECSOC, 2006). The concept of social security has been further widened to include the provisions for housing, safe drinking water, sanitation, health, educational, minimum wage, cultural facilities which can guarantee workers' a descent's life (Matto, 2000). The right to social security and social insurance, in particular, has been discussed on several international human rights conventions (e.g. Revised European Social Charter, 1996/1999; Protocol of Salvador, 1988/1999).

There are, of course, other forms of social protection; pure welfare measures in the form of employment benefits or social security for indigents are offered in many countries, on the assumption that the state has its primary responsibility to look after the poor citizens. Free or subsidized healthcare is another way the state fulfills its responsibility in a majority of countries, especially in the developing world (Gupta & Trivedi, 2005).

None of the African or Asian countries have a 'pure' form of health insurance model; all national insurance plans are mixed, or 'hybrid' schemes combining elements of Social Health and Publicly-financed National Health Insurance (UNICEF, 2012). In India, the government provides free public health care system but it does not work because of shrinking budgetary support to the public health services, poor management, low-quality service, and lack of responsiveness to patients' needs and demands. A case study of community-based health insurance It was found an appropriate way of reaching the poor in comparison to the market mediated or government-provided insurance. The private health insurance policies were pretty much inclined toward those who can afford to buy the insurance and those poor who can't afford must suffer until and unless if there is no public subsidy provided by the government. CBHI full form was found effective and good because of its features such as the voluntary participation of people, not for profit, objective scheme management by the community itself, and some degree of risk pooling. Two types of CBHI schemes were found in India: Non-Governmental Organization (NGO) base where it works as an intermediary between a formal insurance provider and the insured community, for example, SEWA in

Ahmedabad, ACCORD in the Nilgiris and the second one is NGO itself who is providing insurance to the targeted community for example Sewagram Hospital (Ahuja, 2004).

Social democratic countries like Sweden and Netherland had approached privatization in a significantly different way. Now in Sweden, some private providers came to participate in the delivery of medical service; the Netherlands has taken even more dramatic steps toward privatization. Until 2006, the Dutch health care system had near-universal coverage with generous public financing. Unlike Sweden, however, it also includes some private insurance and private provision of care. In a dramatic move, the Health Insurance Act of 2005 abolished public health insurance and introduced a system of managed competition among private insurers. Under the new Dutch plan everyone is required to purchase a basic health insurance package (individual mandate), with government subsidies provided for lower-income families based on a sliding scale. Premiums must be community-rated and insurers must accept all applicants (guaranteed issue) with no pre-existing condition exclusions, to discourage cherry-picking. The government's role is limited to protecting consumers and making insurers compete solely on price and quality (Rosenau & Lako, 2008)

3. Methodology

As the study aims to assess the opportunities and challenges to the health insurance program from the empirical and in depths, qualitative perspective, the subjects were selected through accidental sampling those are readily available and convenient for a qualitative interview, and purposeful to my research in terms of data-rich (Etikan & Bala, 2017). A total of 21 were selected who were the inhabitants of Ratnanagar Municipality- 6, and Bharatapur Metropolitan City- 10 of Chitwan district. Among them 8 had bought HI policy in 2018 and renewed in 2019, 5 had purchased last year (2018) but did not renew this year (2019), and 8 are never enrolled in HI policy.

As per the research aim, the study was guided by naturalist or constructivist paradigm assuming that knowledge is established through the meanings attached to the phenomena studied; researchers interact with the subjects of study to obtain data; inquiry changes both researcher and subject; and knowledge is context and time-dependent (Krauss, 2005). With this relativist ontology, the knowledge has been constructed inter subjectively through the meanings and understandings developed socially and experientially. Therefore, it has followed the interpretive-naturalistic approach with the method of interviewing. There are adequate dialogs between the researchers and interviewees with whom meanings are collaboratively constructed. Meanings are emergent from the research process, and mostly analysed the 'interview vignette' (Jenkins, et al., 2010, p. 7). analysis on the one hand was inductive but aimed to identify the different aspects of opportunities and challenges mentioned in HIB.

For the authenticity of the study as triangulation information was generated through a qualitative interview from the other two stances too- a scholar of insurance and managers of insurance companies.

4. Information Analyses and Findings

The information generated from the qualitative interviewees was transcribed. After reading and re-reading, the 'half-baked information' (Kouritzin, 2002) against the opportunities and challenges mentioned above from HIB, the following themes have been generated.

4.1. Opportunities

The HIP has been interpreted as a good opportunity because on the one hand, it reduces the health cost of even rich people and on the other provides access to the costly health facilities for poor otherwise, they would never get these facilities.

Reduces the Out of Pocket Expenses

Among 21, 8 has the experiences of the HIP, for two years 2018 and 2019. They have realized that the benefits of health services of many more cost that they invested by HIP in general. The respondent seems quite satisfied with the HI scheme. In the absence of the scheme, it would have been problematic for him to manage the household expense and to run the business. It was helpful to him otherwise it would have cost more than 60 to 80 thousand rupees to get operation in the government hospital itself. Private hospitals are even expensive. The provided scheme gave relief to the middle income and poor family to reduce out of the pocket expenditure.

In order to validate this truth vignettes of some of the subjects are presented here. The interviews were conducted from 2018 June to July. A housewife of age 46:

> *"I am very happy and satisfied with the HI scheme. I already took 50,000 rupees' facilities from the hospital and renewing the HI scheme annually. My elder son had a motorbike accident. The hospital authority provided operation and medicine facilities within the offered price. In the absence of the HI scheme, it would have been a big burden for me to run the restaurant, home, and day-to-day household expenses including the treatment cost of my son. Now, I have had realized that I did a good thing at the right time.*

Similarly, another respondent age 40 responded that,

> *"HI program is not expensive, it is affordable. I am an auto-rickshaw driver. This is my job. I have to look after my family from this driving occupation. It is a challenging job to feed five family members and to facilitate other expenses like education, clothing, and entertainment including mobile phone expenses for the family members. Getting ill or accidental injuries are an unpredictable expenditure. I am very lucky to participate in the HI program. I, including my family members, are taking services from the hospital and saving unnecessary expenses. This became possible through the HI program otherwise it would have been a big headache for me".*

The mentioned respondent represents the characteristic of a poor family. He is facing challenges to maintain a family's hand to mouth problem and not able to manage proper income and saving for the time of need.

Accessibility of Poor and Marginalizes Groups

People are found happy with the HI program. Moreover, the hospitals are easily accessible by public vehicles too. They can have a day to visit, take hospital facilities, be assure even in simple health problems.

A male respondent age 49 said,

> "*My family members are visiting the hospital to treat general fever. The hospital is 10 minutes away from my home. For me, this service is very good because I am visiting the nearest hospital and having treatment facilities within the offered price of the HI program*".

A female of age 50:

> "*HI scheme is not very expensive. I became a member of the HI scheme on 14 of Chaitra, 2074. I have already renewed the service for further facilities and I found it is very good for poor families".*

A female of Ratnanagar said- *I have had renewed the policy and frequently visiting the hospital for treatment and found the HI program is very much effective and not expensiv*e.

4.2. Challenges: despite the above mentioned two opportunities of HIP serving people there are three challenges too. These are:

Service for the HIP is Time Consuming

The government of Nepal aimed to incorporate all the population of Nepal into HIP but It is found challenging to incorporate all citizens into the HI Program. Few respondents were those who already enrolled in the HI scheme but they dropped the scheme. The reason behind the dropping are (a) the government hospitals who are offering HI service are not patient-friendly, and (b) the process for treatment is very lengthy, complicated and discriminatory, (c) People felt difficulties to participate in government health insurance program because improper infrastructure and negligence of hospital authority like doctors, nurses and supporting staffs including pharmacy people.

A male of age 33 said,

> "*We are only two, husband and wife, we did not purchase HI premium because we don't have enough time to stay in line for the treatment in the hospital. I prefer to go to a private hospital because it is very easy and fast*".

A female of age 28 said,

> *"I know the HI scheme is very good and cheap. I want to take HI premium but I have not enough time to follow it. I am a very busy person and running a business so, it is very difficult for me to go to the government hospital and be in line for the turn".*

He replied that it is a very good scheme but have not time to follow the process. To easily access the process, the policy provider must provide an online registration system and pay system so those who have no enough time can have the policy through the online system. The technology is in advance stage, so the HI provider must rethink upon the easy access to the process and make the program effective and reachable to all people.

Respondent had replied that it is a very good scheme but have not time to follow the process. To easy access the process, the policy provider must provide the online registration system and pay system so those who have no enough time can have the policy through the online system. The technology is in advance stage, so the HI provider must rethink upon the easy access to the process and make the program effective and reachable to all people. A male of age 52 said-

> *"I have no time to go for checkup. It is hard to get leave from school". It will be better if the government accept the HI card on holidays also. The offered HI scheme is very good; it is affordable but complicated to manage time for a jobholder.*

A man of age 32, from the Ratnanagar said- "*The vision of HI Program is very good but in practical level it is very poor. It takes hours to reach in doctor though queue.* A man age 32, teacher by profession, said- I am not planning to buy HI premium because of limited time. He further added that, if HI program available in private hospital and flexible time then only he will have HI policy.

Cheating Policy Buyers with the Motive of Money making

Some respondents reported- HI related pharmacies are cheating the patient. The costs of medicines were high in comparison to market prices.

A man of age 61- *"No, I have heard that hospital authority and pharmacy people are selling expensive medicine to HI cardholders to meet their target of 50,000 as early as possible. The cost of every medicine for the HI cardholder is expensive in comparison to those who are not participating in the scheme. This is big discrimination". In CMC, I had gone to test thyroid, but the doctor demanded other different tests of cost 21,000. I asked- is it essential? He said- why to worry, your money is not gone".*

We want to manage the money for the whole year and family but hospitals want to snatch all the money immediately. Private profit-making hospitals compel patients for unnecessary tests and checkups to make money. the patient gets a little benefit- only save form time loss, despite the loss of sate fund.

Low Service Quality

While inquiring on the topic of Hospital's Infrastructures, Treatment Facilities and Service, a male of age 61 said- *"There are no good infrastructures in the government hospital to meet the demand of the patient. It will be better if the government organized a moving hospital campaign in each ward and Tole with HI facilities. It will stop the flow of people toward the hospital." A male of age* 33 said- *"Government must be vigilant and strict to the rules and regulation. More corruption is going on in the nation, and the hospital is among one". A female of age*40- *"Hospital staffs are rude and not polite. It will be better to educate them on how to deal with the patient and to extend this service in a private hospital as well because people of the private hospital are somehow polite than the staff of government hospitals". A female of age* 38- *" The environment of government hospital is not patient-friendly. The service is very poor so, I did not renew the program".*

Insured patients are discriminated

The reputation or credibility of the HI Program is somehow not good amid the general public because of government hospital staff's negligence. The service provider needs to be serious in their responsible duties otherwise the government will not achieve the targeted goal. The hospital staff must train to be social and polite while dealing with patients.

It was declared that poor citizens will get free treatment facilities under the HI scheme but no poor have been identified till the date so it is challenging to fulfill the projection. The provided service hour for the HI program is 10 to 5 pm which is indirectly discriminating against the policyholders and non-policy holders. Those who are having HI policy are positive with the government initiation but not satisfied with the service providers like nurses, doctors, pharmacy staff, and other supporting staff of the hospital. Those who are having HI policy are regarded as second-class citizens. The HI policyholder does not fall in the priority of the doctor's list. In the government hospitals, HIP patients are kept in a separate queue which is many times longer than cash-payers. Due to the long waiting, some insured seem frustrated with the system so they did not renew the policy for the next time.

Lacking in Information and Support

Eight people never enrolled in the HIP. among the, 5 are ignorant about it. No agent informed them about the importance of HIP, persuade them, or help to find the government support to buy a policy. It is a challenge for the government could be an insufficient financial capacity to incorporate all the demands of the population like good infrastructures, treatment equipment, quality service, and administrative cost. The government had made the HI scheme compulsory to all citizens of Nepal where this program has been already launched though people are not enrolling in the scheme. To know the challenges, I have categories this section into (1) Incorporation of all the population and (2) Quality Health Care. The HI program should be compulsory and improves access to quality health services and increase accessibility to, and equity in, the provision of health care services by removing financial barriers to the use of health care services, focusing on the poor and marginalized.

A female of age 27:

"I am an economically poor family group. My daughter age 6 had right hand fractured while playing with other kids. My works in foreign employees even-though I have no enough money in hand to enroll in the HI scheme. My daughter had an accident. I have already paid Rs. 3,000 to hospitals and pharmacies for the medicine. Hospital is still asking money to put plaster in the fractured hand of my daughter. I have no money to pay additional hospital fees".

She had known about the HI scheme but she had no cash in hand at the time of purchasing the premium. It shows that most of the people are aware of the HI scheme but they are not able to have the service because they have no cash in hand when they supposed to enroll. To handles such issues, it will be better if each government hospital offers a compulsory HI scheme to the patient before they proceed for a checkup. Those who are identified as poor or below the poverty line and marginalized group should be recognized on time and provided the identity card on time so they can have provided facilities at the time of need.

Incorporation of all the population

Two cases hope including poor and excluding rich so that the government will be free from unnecessary burdens. A male of age 33 said- "*I am still young. I can earn and do my treatment if it requires it. I don't want to be a burden to the government of Nepal. Yes, I will have a HI premium when I become old. Now, I can earn and I am capable to look after myself and family".* A different type of message recorded during the interview- *"the youth of the nation must work, earn and pay for their treatment, at the list until the age of 40. If corruption stop, everything becomes good."*

To find the ways of incorporation of all the population, opinions of experts have been collected.

The experts opined that It is a time to evaluate the implementation process and impact study of the HIP. Rabindra Ghimire, a *scholar on* insurance opined that- *"It should be compulsory. Its benefit needs to be increased and the premium should be fixed based on affordability. The service quality of the health / medical / hospital needs to be increased. Priority should be given to the patient having a health insurance policy and all medicine and a surgical treatment needs to be provided".* Ghimire said- "*The scheme is ambitious but required to all people. There is a lack of qualified human resources in the Health Insurance Board. The structure delivery system is not sufficient. Government-owned hospitals are far from villages so that people are not interested to go there. Private hospitals are not included in the schemes. A medical professional working in the private sector also should be included in this sector".* Krishna Bahadur Basnet, former CEO of Sagarmatha Insurance Company opined that *"Universally, the social health insurance policy has some common features. It is contributed by the government, there is no means-tested, adverse selection is not applied, it is for all disregarding the economic status, caste, gender, education, profession. The amount of benefits is equal. These all features are compiled by the Nepalese health insurance schemes. There is a subsidy to policyholders in Nepal".*

The HI seekers are facing difficulties to arrive in the hospital. The road to the hospital is not a motorway in rural areas. The available hospitals are also far away from the villages. Private sector hospitals are not included in the scheme. Private hospitals can play a big role to mitigate the gap.

Remesh Kumar Bhattarai, CEO of United Insurance Company said- *"The constraints of the health insurance schemes are: awareness towards the health insurance, lack of technology, limited health service providers, limited medicines and services. Private health facilities providers are not included in the program".*

5. Conclusion

As the study aimed to assess the opportunities and challenges of the HIP, concerning intend and practice, arrive to identify both. From the opinion collection of 21 persons, reported that HIP is effective in cost reduction of rich, and access to health service for poor. But, getting, services is very difficult; (a) if go to government hospitals, suffer from prolonging waiting, lack of facilities and experts; (b) if go private hospitals, in Chitwan two medical colleges are allowed for those who enrolled since 2018, a victim from undue expenditure and discrimination in expert service. HIP, drag the insured in prolonging, low quality, discrimination the cost of saving money. Social Health

Insurance Program is for social justice and creating equal society, ironically, cash-payer and insurance-payers are discriminated; corroborating the nature of neoliberal society.

There are still uninsured persons because of ignorance, lack of premium, and distrust of HI service. The study suggests that HI service should be delivered through non-profit hospitals, the highest quality without discrimination of cash-payer and insurance-payer, and prolonged waiting.

References

Ahuja, R. (2004). Health insurance for the poor. *Economic and Political Weekly*, 39 (28) 3171-3178.

Etikan, I. and Bala, K. (2017). Sampling and sampling methods. *Biom Biostat Int J,* 5(6). DOI: 10.15406/bbij.2017.05.00149.

Garcia, A. B. and Gruat, J. V (2003). Social protection: a life cycle continuum investment for social justice, poverty reduction and sustainable development. Geneva: ILO.

Gilllam, S. (2008). Is the Declaration of Alma Ata still relevant to primary health care? *BMJ*, 336(7643):536-8. DOI: 10.1136/bmj.39469.432118.AD.

Gupta, I and Trivedi, M. (2005). Social Health Insurance Redefined: Health for all through coverage for all. Economic and political weekly 40(38),Pp. 17-23

Health Insurance Board (2020). Brief annual report (FY 2075-76). Kathmandu: Author.

Jenkins, N., Bloor, M., Fischer, J., Berney, L., and Neale, J. (2010). Putting it in Context: The use of Vignettes in Qualitative Interviewing. *Qualitative Research*, 10(2), 175-198 doi: 10.1177/1468794109356737.

Kouritzin, S. (2002). The "half-baked" concept of "raw" data in ethnographic observation. *Canadian Journal of Education*, 27 (1).

Krauss, S. E. (2005). Research paradigms and meaning making: A primer. The Qualitative Report, 10 (4), 758-770.

Majumdar, A and Borbora, S. (2013). Social security system and the informal sector in India: A review. *Economic and Political Weekly,* 48 (42).

Mattoo, N. (2000). Social security, paper presented on global conference on poverty, social welfare and social development challenges for the 21st century. Cape Town, South Africa.

Rosenau, P. V. and Lako, C. J. (2008). An experiment with regulated competition and individual mandates for universal health care: the new Dutch health insurance system. *Journal of Health Politics, Policy and Law,* 3 (6).

SECSOC (2006). The ILO Social Security (Minimum Standards) Convention, 1952 (No 102), International Labour Organization, retrieved 2 March 2010. R. from http://www.ilo.org/public/english/)

UNICEF (2012). National health insurance in Asia and Africa. Retrieved on 23 September 2018, R. from (https://www.unicef.org/socialpolicy/files/National_health_insurance_in_Asia_and_Africa.Final-22MAY12.pdf)