Health Insurance for Equitable Healthcare Services in Nepal: A Situation Analysis

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ABSTRACT

Constitution of Nepal has recognised basic health services as a fundamental human right. Implementing health insurance will be an important vehicle to achieve Nepal's aim of universal health coverage. Nepal in recent years has seen considerable improvement in the health status through rich network of healthcare institutions complimented by private sectors. But they are mostly centred in urban area, hence, health access and equity remain a challenge. Community-based health insurance started long back but failed. Social health insurance is at inception with challenges of varying degrees for its successful implementation and bringing equity in health and achieving universal coverage. There are histories of success and failure around the globe in adopting various models of health insurance. Various concerns comprise governance, strengthening of primary healthcare setup, quality assurance, proper identification of poor, single pool of fund, financing, enrollment option, retention, human resources, medicines and equipment, third party administrator, monitoring and evaluation, etc. Disappointment due to any shortcomings of the programme can decrease enrollment and service utilisation and ultimately, the programme may fail. Rigorous discussions and debates on minute details of every aspect, adopting models and right actions pertinent to our circumstances and suitability for a sustainable yet attainable model is needed.

Keywords: Health equity; international experiences; Nepal; social health insurance; universal health coverage.

INTRODUCTION

Constitution of Nepal, in its article 35 under segment 3, has established basic health services as a fundamental human right.[1] Moreover, Nepal aims to fulfill its commitment of achieving Goal 3 of the United Nations Sustainable Development Goals, which is, ensuring good health and wellbeing of people by 2030 AD. For this, Nepal has been formulating many health strategies and conducting various programmes. For Universal Health Coverage (UHC), government has envisioned overall health improvement of people through social health security, ensuring the access to preventive, curative and rehabilitative health services. It is obvious that without proper application of health insurance plan, various components in UHC, namely equity, access, quality, and cost cannot be addressed appropriately and sufficiently. It means health insurance will be an important vehicle in converting healthcare into people-centric healthcare.[2]

HEALTHCARE SYSTEM IN NEPAL

Nepalese healthcare system has a rich network of government health institutions till community level. In fiscal year 2073/74, 123 hospitals, 200 primary health centres, 3808 health posts, 12180 primary healthcare outreach clinics, 16022 expanded programme of immunisation clinics provided basic and primary healthcare services. These services were duly supported by 49,001 female community health volunteers.[3] Assistance from mothers group adds more grass root level reach. The provision of these tiers of health institutions aims to enhance health access and equity throughout nation. This framework has gained success in improving various health indicators despite political instability and geographical and socioeconomic constraints.

There has been a substantial contribution from private sector to bring out the obvious changes in the health status of Nepalese people. In fiscal year 2073/74, 1715 non-public health facilities provided health services.[3] Nepal has seen a substantial upsurge of private sector in health in last two decades. Among all Nepalese hospitals, private hospitals increased to 78% from 23% through 1995 to 2008.[4] Likewise, there were 24 medical colleges established till 2015.[5]

There has been a considerable enhancement in the health status in Nepal in recent years through contributions from both public and private health sectors. For example, infant mortality rate has declined from 107 in 1991 to 46 in 2011 and maternal mortality rate has declined from 850 in 1991 to 170 in 2011.3 Government of Nepal (GoN) has regarded health sector as a priority area and its commitment can be evidenced by rising trend of government health expenditure in recent years. The key healthcare expenditure indicators like government budget allocation to fund health sector, government health expenditure in terms of Gross Domestic Product (GDP) and per capita are encouraging than most of the Low-Middle Income Countries (LMICs) despite being far less than global average.[6] Health infrastructure is expanding with a total of 533 hospitals from both the public and private sides which also includes specialised health facilities relating to eye, cancer, heart, kidney, neurology, orthopaedic, and plastic surgery.[3] There are a total of 23 medical colleges that have been producing all levels of human resources required. Some of them have super specialty programmes like Doctorate of Medicine (DM) and Magister Chirurgiae (MCh). Contribution of these medical colleges have been very apparent, particularly in terms of installing newer technology and adding newer avenues of specialised services like neonatal intensive care units, pediatric intensive care units, dialysis, etc. Upliftment of laboratory services and diagnostic centres with newer technologies and modern equipment has strengthened our diagnostic ability and quality of care, which has largely been attainable through investments from private sector in addition to government's commitment. Similarly, about four dozens of pharmaceutical companies currently operating in the country have a combined capacity of producing 40% of medicine required within the country,[3] which is decreasing our dependence on imported medicines.

On contrary to these improvements, access to healthcare and utilisation of health service is still inadequate and remains a challenge. Despite rich network till grass root level, health programmes are inadequately applied to community level which account to lower level of health status in a significant section of communities.[7,8] Private hospitals are mostly centred in urban region.[3,4] Such tendency has created a high urban and rural discrepancy in availability of health services. Private sector holds 70% of entire health expenditure among which 81% is generated through out of pocket payment (OOP).[9] In a country struggling with poverty, OOP challenges the purchase capacity of the people and creates an additional barrier to health access and makes them vulnerable to financial catastrophe during illnesses. In Nepal, cooperation among primary, secondary, and tertiary centres is poor. Likewise, there is meagre integration between government and private sectors with disproportionate use of resources causing underuse and overuse in different settings.[7,8] On this ground, health insurance is the need of time in our country.

HISTORY OF HEALTH INSURANCE IN NEPAL

LMICs like Nepal rely mainly on OOP payment system due to unavailability of insurance schemes. In order to prevent financial catastrophe, the health financing practice was stared at community level in Nepal.[10] An early initiative in Nepal began from 1976 by United Mission to Nepal as Lalitpur

Medical Insurance Scheme in Ashrang, which was later extended to other facilities.[2] Community based health insurance (CBHI) incepted in 1990 could not make a leap due to low enrollment, limited services coverage, and failure of financial risk protection.[10,11] Similarly in 2003, government funded CBHI programme was initiated in two districts which got further extended to additional four districts in fiscal year 2005/06. Additionally, small scale health insurance programmes were implemented by few private sectors, public corporations and some non-government organisations but it couldn't flourish as expected. Despite various efforts, government is still facing numerous challenges to promote the health insurance scheme to ensure access to healthcare and reduce healthcare costs.[11]

Despite a history of five decades in the insurance sector of Nepal, it has just been few years that the government, people, and insurance companies have been discussing and debating about national level health insurance. With the historic move of GoN in offering health insurance plan targeting common people, it is anticipated that all the health service outlets at all levels will attract more number of patients owing to increased purchase capacity of the insured public who are enlisted into the plan. There have been many social security schemes of different models and coverage in healthcare by the government in different fiscal years. However, health insurance as such in Nepal is still in a creeping phase. As every cloud has a silver lining, GoN came up with a scheme that started from Kailali district having more than nine lakhs insured individuals and now has already been extended to 43 districts.[12] Likewise, seven insurance companies out of 20 non-life insurance companies operating in Nepal have offered cashless insurance plans of different sizes. Recently, Karmachari Sanchay Kosh (Employees Provident Fund, Nepal) announced coverage of up to one lakh rupees for their six lakhs depositors.[6] This reflects the prospect of health insurance for upcoming years. Many discussions and predictions have started on several aspects of health insurance in Nepal. Even the national donor agencies have shown interest on it. After the discussion on new labor act which secures the coverage of one lakh rupees for treatment each year for every employee, the role of health insurance providers has compounded significantly.

The concept of insurance is to have contribution from all and secure the health of diseased ones. Thus, it is imperative to have higher retention.[11] The newly endorsed health bill faces several challenges in terms of governance and leadership, financing, information, health service, workforce, and essential medicines and technologies.[13] It is advised to have high coverage, enrollment of poor through fair identification, representation of interest of insured and financial viability.10 The present health insurance bill requires strong health system to ensure responsiveness, efficacy and equity, and financial protection.[13] Mandatory enrollment can be an alternative of voluntary basis if the implementation strategies, particularly in the presence of large informal sector can be worked out.[11]

GoN commits to arrange for premium of people below poverty line. Like other Asian countries, Nepal is also moving towards a tax-based financing which is the most progressive one in this region.[14] It can help to fulfill this commitment to some extent. Strengthening of the existing primary healthcare for demand and supply equilibrium along with quality assurance is very important for effective implementation of health insurance.[11] The government needs to take a timely initiation to address this. Disappointment due to any shortcomings of the programme can decrease enrollment and service utilisation and ultimately, the programme may fail.

LEARNING FROM INTERNATIONAL PRACTICES

Health systems around the globe still fall short of providing accessible, good-quality, comprehensive and integrated care. As the global health community is setting ambitious goals of UHC and health equity in line with the 2030 agenda for sustainable development, there is increasing interest in access to and utilisation of primary healthcare in LMICs.[15] There have been variety of models in practice around world with varying success and failure histories. There are 16 healthcare systems currently floating in world. Among them, the most commonly used four models are Bismarck model, Beveridge model, National health insurance model, and OOP model (having no healthcare insurance).[16]

T.R. Reid, the writer of 'The Healing of America: A Global Quest For Better, Cheaper And Fairer Health Care,' did an extensive study and drew contrasts

between healthcare systems in seven nations throughout the world - America, France, Germany, Japan, the United Kingdom, Canada, and India.[16] Among these countries, India followed OOP model, undoubtedly the worst model causing disparity in healthcare delivery based on the purchase power of the individual family. To address the problem of social exclusion from healthcare provision in India, a national health insurance scheme called Rashtriya Swasthya Bima Yojana (National Health Insurance Scheme), was introduced in 2008 with the aim to improve access to the quality medical care and surgical treatment for families living below poverty line.[17]

A single pooled Social Health Insurance (SHI) fund seems preferable to multiple funds as seen from practices in Germany, Korea, Taiwan, Columbia, Ghana, Philippines, Kenya and Thailand.[18] There can be three policy options in reducing fragmentation in pooling of SHI funds. Keeping existing structure but integrating policies, merging of better-off minor funds together to create 2-3 larger funds can be the initial steps and prerequisite for single national SHI scheme.[19] CBHI in Nepal failed while it was successful in developed nations like Germany and Japan.[20] Learning from our firsthand experience and by critically analysing success and failure histories around the world, we should be open to adopt most suitable practice pertinent to our circumstances and capacity. To move ahead, mix practice can yield success in achieving UHC by 2030.[10]

THE ORGANISATIONAL WAY FORWARD

Health insurance in itself differs from any other insurance plans mainly in a way that health insurance have to work in a trilateral coordination fashion instead of bilateral collaboration between insured and insurer as in other insurance plans. In health insurance, role of healthcare providers and their services generally play a pivotal role. Therefore, health insurance plan of GoN should contemplate bringing all stakeholders on board and try its best to impanel more number of hospitals. Similarly, there should be a robust discussion on the need for provision of third party administrator (TPA) for the most effective coordination and claim management.

TPA provides a cashless service at hospitals and are intermediaries that bring physicians, hospitals, clinics, long-term facilities, and pharmacies together. Since there are complexities in demand and supply side of health insurance and healthcare market, TPAs act as a link between insurance companies, healthcare providers and policyholders. The primary aim to have TPAs is to provide hassle-free services to consumers, make insurance companies pay for cost effective and efficient services and help service providers get timely reimbursements. On contrary, it may cause an overall increase in the charge of premium. Likewise, there are many associated shortcomings and complications in proper execution of this provision.[21] Furthermore, analysis of TPA engagement in an Indian state suggests its abandonment as it reduces benefits to the beneficiaries and causes fund block to the government hospitals. It also increases an additional layer and augments administrative costs.[22] Nevertheless, it seems as a vital element to enhance, promote, and extend our SHI at national level efficiently and swiftly.

There are multiple strategies that can bring out the best possible results out of the provisions of the health insurance act. A thorough planning and strategic workout on every minute detail through healthy participation of experts, equal involvement and dialogue between the stakeholders, working out on international models, having research based policies, and strategies backed by effective monitoring and evaluation mechanisms can help in adopting a successful and sustainable SHI model in Nepal.

SUMMARY

We have a long history of CBHI in Nepal but SHI is at inception. There are immense complexities in the healthcare system and SHI schemes practiced around the world. Even though we have rich network of healthcare system complimented by private sector, there are challenges like health access and equity as well as public-private collaboration and integration. Strengthening of our primary healthcare, multisectoral involvement, applying lessons from global SHI successes and failures and adopting sustainable yet attainable model of SHI are the basic requisites in present situation. Moreover, scientific dynamism will bring about timely improvements in the national healthcare system.

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