International Labour Organization

Social Protection in Action: Building social protection floors for all

Country Brief: Nepal

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Extending Social Health Protection in Nepal: Accelerating progress towards Universal Health Coverage

1. Introduction

The 2009 and 2015 constitutions of Nepal have laid the foundations of the country's path towards Universal Health Coverage (UHC), with the goal of UHC institutionalized through the Health Sector Strategy (2015—2020), which emphasizes the importance of supporting vulnerable groups. In order to achieve this goal, a programme of free basic health care (FHCP) has been implemented, alongside three social health insurance schemes, namely the Health Insurance Board (HIB), the Social Security Fund (SSF) and the Employee Provident Fund (EPF). Despite these efforts, the coexistence of various schemes has led to fragmentation and inefficiency (Nepal Ministry of Health and Population 2018; Sharma, Aryal, and Thapa 2018). As a consequence, a burden of high out-of-pocket (OOP) payments constitutes a major challenge in ensuring access to health services for all.

2. Context

A large number of public health programmes have been implemented over the years to increase access to health care services in Nepal. Such programmes include Ama Surakshya (a programme targeting expectant mothers to promote institutional deliveries), community-based integrated management of neonatal and childhood illness, as well community-based health insurance schemes and projects promoted by the government and private initiatives. Notably, the aforementioned Free Health Care Programme (FHCP) [1] was introduced through the Free Health Care Policy between 2006 and 2009, in four phases: targeted free care, universal free care, free primary health care and free hospital care. The Employee Provident Fund (EPF) medical scheme for civil servants was later established in 2013, in line with the Employee Provident Fund Act, 2019 (1962).

[1] A further development can be observed here: the Constitution and the Strategy now use the terminology "Basic Health Services"—intended to unite the previous programme and the vertical schemes. The corresponding Basic Health Service Package has not yet been endorsed.

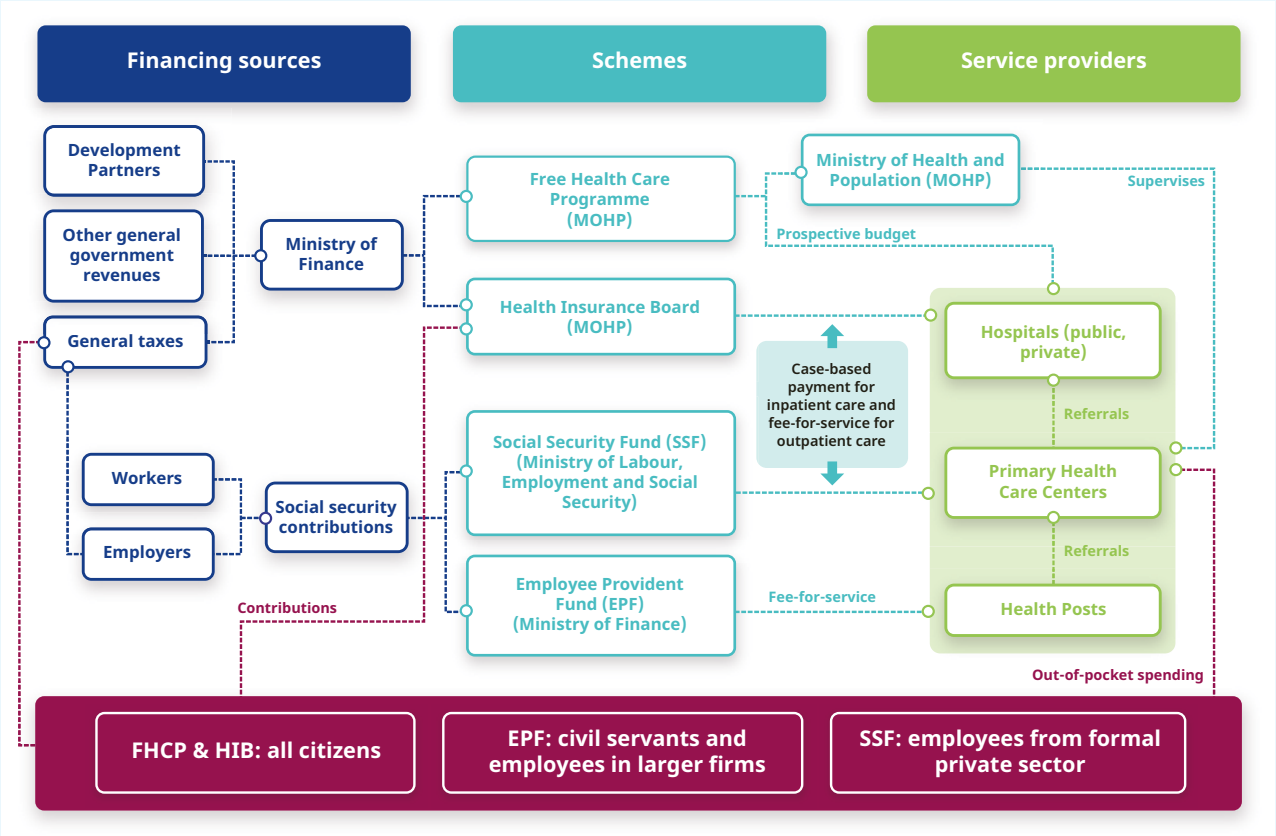
The National Health Policy 2014 and the National Health Sector Strategy (2015—2020), together with a number of regulations, such as the Health Insurance Regulation 2075, have served as the basis to lead interventions towards UHC, and develop a national health insurance system (Dahal et al. 2017). Building on these efforts, the Social Health Security Development Committee, from which today's Health Insurance Board (HIB) emerged, was founded in 2015, eventually constituting Nepal's national health insurance scheme. This was initially focused on the poor and the informal sector, but is now intended to cover the entire population. Parallel to the introduction of the HIB national health insurance scheme, a further social protection mechanism, known as the Social Security Fund (SSF), targeting the formal sector, was initiated under the Contribution Based Social Security Act 2017 (2074). A Medical and Health Protection Scheme and a Maternity Protection Scheme were stipulated under the sixth chapter of the Act, as part of the SSF. The Public Health Service Act was later implemented in 2018, through which the right of every citizen to receive high quality health care was emphasized.

3. Design of the social health protection system

- Financing

In general, a rough distinction can be made between four funding sources within the Nepalese health system, including budgets calculated prospectively by the state (financed by taxes and donations from development partners), social security contributions and OOP expenditures. The latter, which comprised 57.8 per cent of health expenditures in 2017, account for the largest share of funding, and are paid directly to health facilities.

Figure 1. Overview of main financial flows of the social health protection system in Nepal



Source: Authors.

As Figure 1 shows, with the exception of the FHCP, the schemes are inter alia financed by contributions. The SSF and EPF schemes receive income-related payments from employers and employees, while HIB charges a uniform fixed contribution per household and receives tax-funded contributions from the government budget to subsidize coverage for the poor.

- Governance

Administratively, the schemes are managed by autonomous institutions under the responsibility of different ministries, without an overall coordination mechanism in place at the time of writing. However, the need for coordination between HIB and SSF was anticipated, which is reflected in the initially planned composition of the HIB Board, outlined in the National Health Insurance Policy 2013. According to this policy, a representative of the SSF should be nominated on the Board. However, the current composition of the Board does not currently reflect this initial intent.

The HIB and FHCP are both under the responsibility of the Ministry of Health and Population (MOHP). The HIB was constituted as an autonomous institution under the responsibility of the MOHP, though the institution is still in the process of building this autonomy. SSF on the other hand was established as a "separate entity", which means that the SSF Board includes wider representation of interest groups, including the executive director and representatives of the government, employers and employees.

EPF, under the responsibility of the Ministry of Finance, is composed of two previously separate funds: Sainik Drabya Kosh (Army Provident Fund) and the Nijamati Provident Fund (NPF) for civil servants working in Kathmandu. The Board of the EPF is the most important decision-making body governing the scheme. Members are nominated by the government and representatives of government, banks, financial institutions and other bodies. No available information was found on the participation of workers and employers in the board.

- Legal coverage and eligibility

Based on the legal coverage of each scheme, overlapping target group definitions can be identified. In terms of the legally established target groups of FHCP and HIB, both schemes are intended to cover all citizens on a mandatory basis, and they both define particularly vulnerable groups who receive special attention, though both systems use different methods of identification. In the case of the HIB, contributions for vulnerable population groups are fully subsidized by the government, which identifies eligible beneficiaries through the national poor-targeting process.

With regard to the SSF, in principle, the scheme covers all employees (including those from the informal sector and the self-employed) and enrolment is mandatory. However, in reality, only employers and employees from the formal private sector have registered so far (Niti Foundation 2019).

Within the EPF, civil servants are automatically covered. Moreover, employees of institutions with more than 10 permanent employees have the option to join. In 2015, the insurance scheme was opened to self-employed persons. Unlike the HIB and SSF, the EPF only covers employees and not their dependents, with the exception of maternal health.

- Benefits

Basic free health care services are provided through FHCP in all public facilities. Vulnerable persons not only receive free essential health care services through FHCP, but also emergency services and inpatient and outpatient treatment in public facilities. For other groups, supplementary services are covered by "social health protection arrangements", namely SSF, EPF and HIB. HIB and SSF are characterized by ceilings that limit the maximum amount of benefits available to beneficiaries. In addition to medical care services, SSF also offers cash benefits, for example, in the event of maternity. A list of explicitly excluded benefits is also available for HIB and SSF — for example, neither of the schemes cover treatments related to plastic surgery.

The benefit packages offered by all existing schemes are intended to be extended over time. The experience of the Free Drug List of the FHCP illustrates the demand for this expansion. When first implemented, 40 drugs were included in this list, which was not sufficient to treat patients with various common diseases. For example, amclox (ampilicillin and cloxacillin), third generation antibiotics (agithromycin) and anti-hypertensive and anti-diabetes drugs were missing. As such, the list was extended to 70 drugs. Media sources have indicated that the number of drugs on the

list is set to increase further to 93 (Poudel 2019; Prasai 2013; Singh et al. 2017).

- Provision of benefits and services

Facilities in Nepal are differentiated by level, including local facilities (health posts, community health units, urban health promotion centres and primary hospitals), provincial facilities (secondary hospitals) and federal level facilities (tertiary hospitals). Basic health services such as preventive and curative measures are mainly offered at health posts. In primary health centres, which are comparatively better equipped, beds for births are also provided. The most advanced and comprehensive treatments are provided at secondary and tertiary level hospitals. This range of facilities is complemented by an increasing number of private providers (Kullabs 2020; Nepal Ministry of Health and Population 2019). Out of a total of 316 providers, 249 are public and 67 are private. Both public and private care providers are regulated by the MOHP.

When accessing care, HIB members have to follow a referral mechanism. Their first point of contact is the nearest primary health care centre or hospital, from which the patient is directed to another hospital, if necessary. Only public health facilities are eligible as first point of contact facilities. If a contract has been concluded with a private clinic, private clinics can also be consulted when making a referral. This process does not have to be followed in cases of emergency treatment (Social Health Security Development Committee 2017b). A cashless system has been implemented so that the patient only has to present their card received when registering, and the service provider checks whether there is still sufficient credit for the treatment in question.

Contracted private and public health care providers are paid for services through fee-for-service and case-based payments. In most cases, the schemes reimburse the providers directly, through a third payer mechanism. For HIB and SSF, fee-for-service applies for outpatient services, and case-based remuneration applies for inpatient care and hospital admissions. As for the EPF, service providers are paid through fee- for-service. With regard to FHCP, the MOHP pays prospective defined and population-based budgets to various administrative government levels.

- Implementation/administration

To assist the registration process for the HIB scheme, enrolment assistants (EAs) (one EA per 1,000 families) work on a voluntary basis in their municipalities. The selection of EAs is based the Guidelines for Selection of Enrolment Assistants (second amendment) 2074 BS, which stipulates that female community health volunteers are to be prioritized for selection. To further support registration, as well as renewal, claim management, feedback and reporting, the open-source software insurance management tool, openIMIS, was introduced alongside the HIB. The tool, which plays a key role in the provision and administration of health insurance, can be accessed by all relevant parties both within and outside the HIB system, including EAs, enrolment officers, district managers, claim reviewers and health care providers (Social Health Security Development Committee 2017a). This tool not only assists in the context of routine activities, but also serves a function at a higher level. Notably, its implementation during the design phase of the HIB helped to sharpen decisions and has facilitated a rapid expansion of affiliation (Grainger 2018).

▶ 4. Results

- Coverage

Compared to coverage targets, affiliation rates to each of the schemes are relatively low. As of June 2019, there were 509,540 households covered by HIB and 1.68 million affiliated persons (Health Insurance Board 2019). With 20 million considered as eligible for the scheme, only 8.4 per cent of the coverage target has been achieved. As of April 2021, HIB was reported to cover about 12.8 per cent of the total population (3.8 million). However, this figure does not take into account the drop-out rate, which, according to national sources, stands at 30 per cent. This encompasses affiliated persons who have decided not to renew their social health insurance membership after one year, which reduces the number of effectively protected persons. As for SSF, registration began during the fiscal year 2019/20, which led to the coverage of 147,643 registered workers (about 1 per cent of the population) and 12,157 employers by the end of 2019. With regard to EPF, as of 2018, 600,000 insured persons out of a target group of 700,000 were insured under the scheme.

The overlapping target groups of the schemes has led to inefficient parallel systems, causing confusion among the population regarding entitlements, which contributes to overall limited coverage. For example, when SSF was introduced, which was made mandatory, its interaction with EPF was not clearly defined or regulated. Finally, the Ministry of Labour, Employment and Social Security (MOLESS) announced that the decision on which scheme to register with would be made individually by the insured, which somewhat contradicts the objectives of mandatory coverage and broad risk pooling (Poudel 2019). Similarly, while in the initial stages of discussions on the Health Insurance Law, it was foreseen that all formally employed persons would be affiliated under HIB on a mandatory basis, but this was never implemented in practice. The initial idea of a single pool, with two relatively secured sources of funding (from mandatory social contributions from the formally employed on the one hand and from government contribution subsidies for the poor on the other) would have left the institution with some room to concentrate on innovative solutions for the "missing middle", particularly informal economy workers. However, this has not materialized in practice, leading to coverage gaps and exposing the scheme to adverse selection.

- Adequacy of benefits/financial protection

The proportion of OOP payments as a share of health expenditures in Nepal is very high, comprising almost 58 per cent, with an increasing trend since the year 2000, and a significant jump since 2006. This has been attributed to an increasing use of privately provided health services. Although various government measures to provide free health care in public facilities have facilitated better access, the increasing market share of poorly regulated private facilities has led to a corresponding increase in OOPs (Gupta and Chowdhury 2014). This is reflected in the share of OOP payment flows to private hospitals, which was reported at 13.2 per cent for the year 2011/12 and 16 per cent for the year 2015/16 (Nepal Ministry of Health and Population 2019; Nepal Ministry of Health and Population and Nepal Health Sector Support Programme 2018). This trend is exacerbated by the limited coverage offered by Nepal's social health insurance mechanisms. Accordingly, the incidence of catastrophic health spending at more than 10 per cent of total income or consumption was experienced by 10.71 per cent of the total population.

Shortly after the introduction of HIB, it became clear that the scope of benefits did not meet the needs of the population. For example, there has been criticism that the imposed ceiling for a family is not sufficient to cover the treatment of one family member. For this reason, HIB adjusted the benefit package accordingly and increased the ceiling from 50,000 to 100,000 Nepalese Rupee (The Kathmandu Post 2018). Despite this increase, the ceiling still limits the financial protection provided by the scheme.

- Responsiveness to population needs
    - Availability and accessibility

The health sector in Nepal is characterized by significant urban/rural disparities (Mehata et al. 2017; Pandey et al. 2013), which has contributed to the fact that only 34 per cent of Nepalese households have access to medical facilities within 30 minutes of their house (Mehata et al. 2012). This not only limits the attractiveness of social health insurance, but also the feasibility of visiting a doctor. Reimbursement of travel costs has been proposed as a solution to reduce the financial burden of a visit to the doctor, in recognition that the actual cost of care may be less of a barrier than other non-medical costs (Mishra et al. 2015). In this context, the absence of sickness benefit coverage for most of the population is an additional factor constraining access to care in times of need.

In addition to geographical barriers, the social inequalities inherited from the caste system, although officially abolished in Nepal, continue to act as a significant obstacle to accessing health care. This is evidenced by the Nepal Demographic and Health Survey 2011, which demonstrated a marked difference in utilization rates between different ethnic groups, particularly in relation to disadvantaged members of minority groups, namely Dalit and Janajati women. A 2015 study attempting to identify underlying factors in this context highlighted barriers that women experience in accessing services, including lack of awareness that the facility or services exist, being too busy to attend, poor services, embarrassment, disrespectful care, and financial issues (Milne et al. 2015). It remains to be seen whether such obstacles can be eliminated through targeted communication strategies in connection with the establishment of federal structures. More broadly, this issue calls for concerted action within the social protection

system as a whole to address gender and other social inequalities.

Despite these disparities, among the Nepalese population as a whole, an increased rate of utilization of health care services has been observed as a result of the implementation of the FHCP (Suvedi et al. 2012, XV). However, system-wide and current data on the usage rate (especially after the introduction of SHI) could not be found. According to three independent studies exploring the use of health services among the elderly [2] (from 2012, 2016 and 2019 respectively), a lack of awareness on entitlements was as an obstacle among this group (Acharya et al. 2019; Gurung, Paudel, and Yadav 2016; Sanjel et al. 2012).

- Quality and acceptability

The quality of service provision remains a weakness of the Nepalese health care system, as illustrated by the results of the Health Facility Survey, which indicates that less than 1 per cent of health facilities met minimum standards of quality of care at point of delivery in 2015 (Nepal Ministry of Health and Population et al. 2017). In contrast, private providers are perceived to offer higher quality and better equipment. Notably, Nepal's social health insurance schemes do not have quality criteria in place (Prasai 2013).

Low quality of services is driven in part by human resource deficiencies. According to the Service Tracking Survey, the "percentage of sanctioned posts filled" for medical doctors at district hospitals was 56.4 per cent in 2012, and according to the Health Facility Survey, in this indicator stood at 51.9 per cent. This has had negative effects on the effective implementation of the FHCP. The fact that staffing expectations have not be met has been attributed to regulatory inadequacies, whereby improvements were predicted as a result of the implementation of the Health Service Act (Prasai 2013). This issue was addressed in the National Health Sector Strategy (2015–2020) under the title "Rebuilt and strengthened health systems: Infrastructure, HRH management, Procurement and Supply chain management", in which a target value of 0.52 doctors per 1,000 persons was set for the year 2020 (the baseline figure for 2013 was 0.18 doctors per 1,000 persons).

▶ 5. Way forward

In recent years, many programmes have been implemented and much has been achieved to pave the way towards UHC in Nepal. The fact that HIB prioritizes the extension of coverage to workers in the informal economy is particularly noteworthy. Over the next few years, it will be crucial to raise awareness among the entire population on the benefits of social health protection, and to further develop the existing mechanisms in a coordinated manner. Important principles for the further development of the health care system and strategies to drive progress towards UHC in Nepal were outlined in the National Health Sector Strategy, including the explicit goal to harmonize the various schemes.

A good starting point in this context is the use of a uniform IT system, with work currently underway to enable SSF to use the same system as HIB, namely openIMIS. The existence of a shared database would provide an important basis for evaluations and evidence-based decisions in the future. Not only at the level of health care but also in the area of social protection as a whole, efforts are being made to achieve greater coordination and cooperation. Current work on a National Social Protection Framework, which began in 2010, is one example of these efforts. Motivated by this framework to consolidate the fragmented range of schemes, a National Steering Committee on Social Protection was set up on behalf of the Planning Commission.

Increased utilization of health services and more equitable distribution have also been outlined as key outcomes of the National Health Sector Strategy. Particular focus is placed on access to health services and an expanded service network with a referral system, in an effort to effectively cover the "unreached population". In the NHSS Progress Report 2018–2019, the distribution of doctors trained under a government-financed scholarship in various provinces was cited as a major step forward. Ensuring the provision of high-quality care is also an important factor in widening access and utilization, by encouraging enrolment and reducing dropouts. Although a number of quality-related indicators have already been defined and legislation has been introduced, strengthening the role of strategic purchasing through the provision of financial and

[2] Limitations of comparability: Different focus regions in terms of urban/rural areas.

non-financial incentives could actively contribute to improving quality through service providers.

6. Main lessons learned

- Subsidization of contributions for vulnerable population groups facilitated a step towards the "universality of protection". The government's decision to subsidize contributions for defined groups of vulnerable households facilitates access to health care and increases the number of those protected by both the FHCP programme and the HIB scheme. However, the participation rate of these population groups, measured in terms of the number of insured persons eligible for contribution subsidies and utilization rates, still appears to be low. Awareness programmes and expansion of the identification process have proven to be key activities in this regard.
- Overlap between the three parallel public health insurance schemes is an obstacle to extending coverage. The co-existence of the country's three public health insurance schemes not only leads to limited coverage and confusion among the population, but also prevents systemic efficiency gains and limits risk pooling and solidarity in financing. At the national level, the establishment of a coordinating body could help to avoid overlaps.
- Satisfaction with service provision increases willingness to subscribe to programmes that aim at stimulating demand. Distrust of public service providers has led to a rejection of registration with the public health insurance system. The intended role of HIB as a purchaser, and the introduction of various quality measures could provide the right impetus in this area in future.
- The interrelated introduction of public health insurance and digital administration through openIMIS has proven to be target-oriented. This not only forced the necessity of concretization during the conceptualization of the entire health insurance setup (programmers needed precise information when programming the IT system), but also simplified and accelerated the registration process. In the future, this database will make an important contribution to monitoring, verification and management.
- Enrolment assistants established in communities have played an important role in reducing knowledge gaps among the population and were able to contribute to an initially high enrolment rate through personal contact.

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